

National Forum on Drug-related Deaths in Scotland

Annual Report 2007

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Foreword

Drug-related deaths fluctuate from year to year and the trend over five or more years should be considered. When in late 2002 the then Deputy Justice Minister, announced a *National Investigation into Drug-related Deaths* it was in response to a high number of deaths in that year. By the time the investigation took place in 2003 the number had fallen.

These numbers do not, however, represent the totality of mortality and morbidity of addiction. This circumscribed category of deaths caused by overdose takes no account of HIV, HCV, accidents and other causes.

As currently recorded the total is small compared with deaths from alcohol abuse and insufficient for proper statistical analysis to detect a valid underlying trend. It may need many more years before any real trend can be identified. Even then the number can never be precise because recording drug-related deaths depends on having an accurate definition. It may be too difficult to distinguish accidental overdose from suicide or death from other causes of someone who happens to be a drug user. An analogy might be drawn from deaths due to smoking; lung cancer and chest disease give useful indicators but should we include accidental deaths from fires inadvertently started by smokers?

Secondly the denominator, i.e. the number who use drugs, is impossible to measure with absolute accuracy. Furthermore the extent of their drug abuse would be relevant but remains immeasurable. It is, however, important to attempt a measure of this problem which has such a profoundly damaging effect on families, communities and society in general.

It should be noted that the report examines statistics collected by the General Register Office for Scotland (GROS) and represents the opinions and ideas of the wide range of professionals from the statutory and voluntary sectors that make up the National Forum on Drug-related Deaths. In addition there is a sub-group of representatives of drug users and their comments are included.

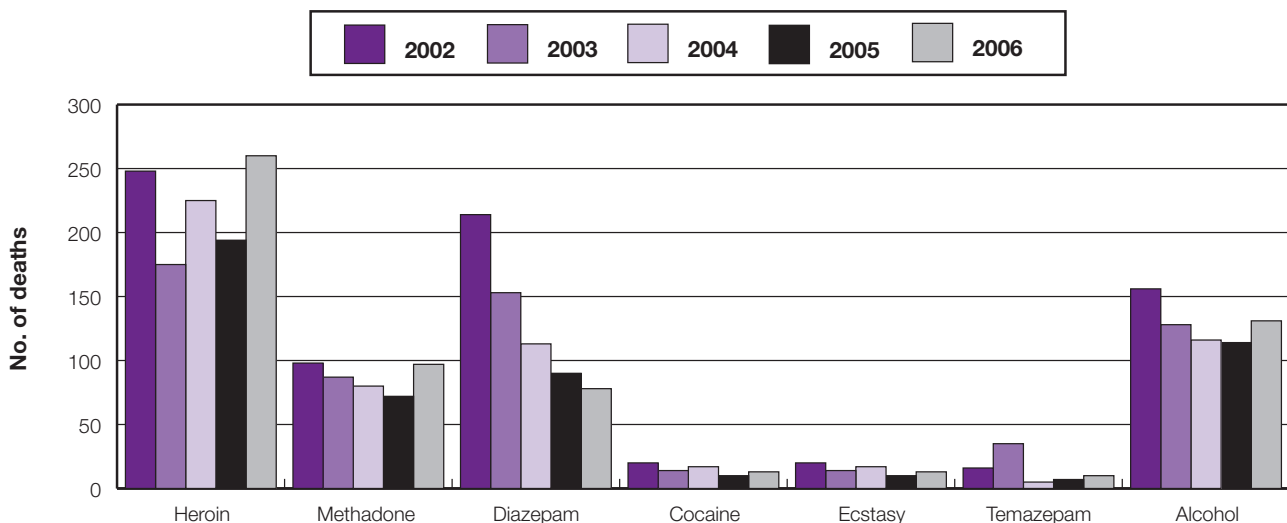
Whatever the uncertainties and the unavoidable limitations, it is important work and deserves to be read with insight rather than prejudice.

JANE JAY

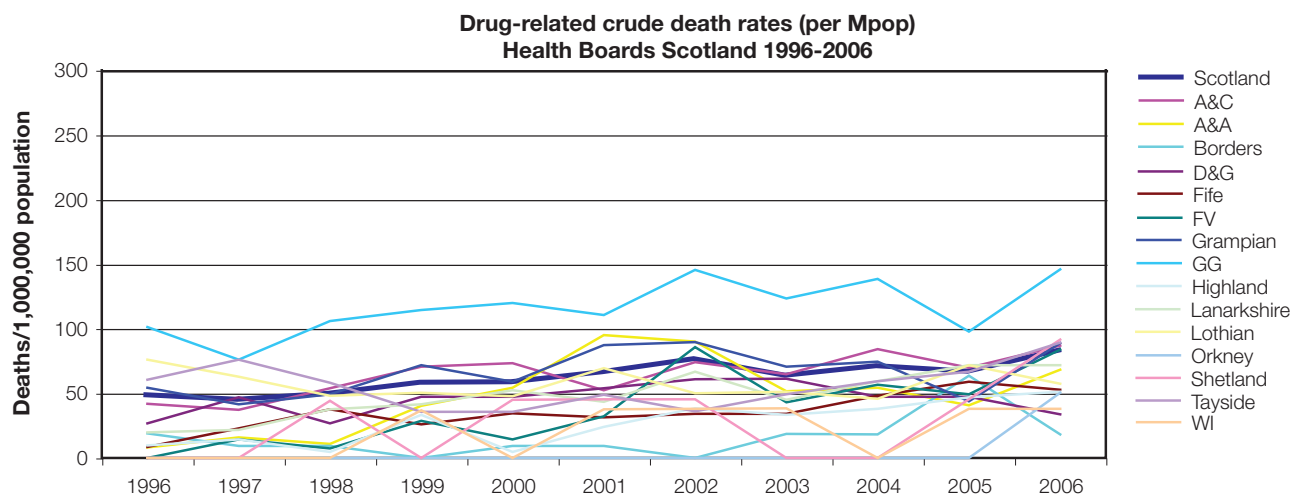
Chair, National Forum on Drug-related Deaths in Scotland

1. Introduction

- 1.1 Since the late 1990s, when a continuing rise in the number of drug-related deaths caused increasing anxiety, there has been an accumulation of information on the topic and several attempts to define the data gathering and definitions involved.
- 1.2 The chart below demonstrates the fluctuations of drugs involved in deaths since 2002, the most prominent drugs involved being heroin, methadone, diazepam and alcohol. Over recent years methadone-related deaths have been steadily decreasing from 98 in 2002 to 72 in 2005. However, they rose to 97 in 2006 almost matching the 2002 figure. There are at the same time, more people being prescribed methadone. Prescribing rates have risen by 45% over the last five years, from 62 per 1,000 general population in 2001-02 to 90 per 1,000 general population in 2005-06.
- 1.3 Deaths involving diazepam have decreased significantly, from 214 in 2002 to 78 in 2006. Deaths involving cocaine fell from 44 in 2005 to 33 in 2006, whereas deaths involving heroin/morphine have fluctuated: 248 in 2002, 175 in 2003, 225 in 2004, 194 in 2005 and 260 in 2006. More detailed data collection may help us understand the reasons behind these fluctuations.



- 1.4 The chart overleaf shows the number of deaths per million population across each NHS Board area covering the period 1996 to 2006.
- 1.5 There have been many statistical reports and an abundance of research around drug-related deaths. There is increased interest and enthusiasm for systematic, robust national data which can identify not only absolute numbers but trends over a longer period of time.



- 1.6 There have been several attempts, over many years, to develop a systematic approach to investigating drug deaths at an individual level. However, none have shown the full circumstances that led to the person's death.
- 1.7 There is also an academic imperative to explain and describe an important public health phenomenon, to put interventions in place to prevent unnecessary deaths and to allow comparisons beyond Scotland and the UK. The benefits of reliable information are likely to be many and may influence national strategies and policies as well as the needs of individuals.
- 1.8 There are several documents in the public sector which need to be taken into consideration when planning development of future audits and research. Examples of these are:
- *A Confidential Enquiry into Methadone-related Deaths – Addiction Scott et al.* (1999): 94(12); 1789-1794.
 - *Reducing Drug-related Deaths – Advisory Council on the Misuse of Drugs (ACMD)* (2000): The Stationery Office, London.
 - *The National Confidential Enquiry into Methadone-related Deaths (Scotland)*, Bruce et al. (2004).
 - *National Investigation into Drug-related Deaths in Scotland, 2003*, Zador et al. (2005).
 - *The Scottish Advisory Committee on Drug Misuse (SACDM) Working Group on Drug-related Deaths, Report and Recommendations*: Scottish Executive (2005).
- 1.9 How the Forum intends to take forward this work is covered in section six of this report (pages 22-23).

2. Background and Remit

2.1 The Action Plan *Taking Action to Reduce Scotland's Drug-related Deaths*¹, was launched on 13 December 2005. One of the main actions was to establish a National Forum on Drug-related Deaths, to look at trends and disseminate good practice. The Forum's main aims are:

- to make recommendations to Scottish Government Ministers, Alcohol and Drug Action Teams (ADATs) 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, for example from the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) and those countries with active research agendas such as Australia, Netherlands and the USA. 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*², published on the Drug Misuse Information Scotland (DMIS) website; and
- to report annually to Scottish Government Ministers with recommendations for further action as required.

2.2 Members of the Forum include senior representatives from:

- Academia
- Accident & Emergency (A&E)
- Choose Life (suicide prevention)
- Crown Office and Procurator Fiscal
- Family Support
- Forensic Medicine
- General Practice
- General Register Office for Scotland (GROS)
- NHS Scotland, Information Services Division (ISD)
- Police
- Scottish Ambulance Service (SAS)
- Scottish Association of Drug & Alcohol Action Teams (SADAAT)
- Scottish Crime and Drug Enforcement Agency (SCDEA)
- Scottish Drugs Forum (SDF)
- Scottish Government
- Scottish Prison Service (SPS)
- Statutory Sector
- Voluntary Sector

Full membership of the Forum can be found at **Annex A**.

¹ <http://www.scotland.gov.uk/Publications/2005/12/12114228/42283>

² http://www.drugmisuse.isdscotland.org/publications/local/drugs_deaths_newsletter_ed3.pdf

3. National Forum Progress

- 3.1 The Forum meet quarterly and to date there have been seven meetings. Many topics have been discussed. Some examples are:

Funding

- 3.2 The Forum has recognised that none of the following recommendations can be delivered without adequate funding to support them. There are considerable dedicated resources for suicide prevention in Scotland – £20.4m over the five years covering 2003-04 to 2007-08. In addition, the UK Department of Health *Action Plan to Reduce Drug-related Harm* was launched in 2007, with a dedicated budget of £2m to implement the activities in the plan, which cover the following three areas: campaigns; improving delivery; and surveillance.

Recommendation 1: Funding

There is a need for a dedicated fund to encourage new responses to reduce drug-related deaths in Scotland. It is therefore recommended that the Scottish Government considers allocating funding specifically for initiatives aimed at reducing drug-related deaths.

Action: Scottish Government

Psychological Autopsies

- 3.3 The Forum looked at work carried out for the National Treatment Agency (NTA) by Sheffield University on Psychological Autopsies³. The study demonstrated the potential of the psychological autopsy methodology to provide a detailed summary of the psychological characteristics and social circumstances of those who die from an opiate-related poisoning. The research concluded that preventative strategies for reducing mortality from heroin overdose require a co-ordinated approach. This broadens the traditional passive educational messages such as avoiding co-administration of heroin and other depressants and using after periods of abstinence and includes more proactive monitoring of the psychological well-being of heroin users.

Memorandum of Understanding (MOU) Between Police and Ambulance Service

- 3.4 An overdose scene can be complex. The presence of police can be threatening for those at the scene and ambulance crews can feel at risk of violence. There can be a perception on the part of drug users that, when the emergency services are called, an arrest for culpable homicide will invariably follow if a death has taken place. In reality an arrest at the scene is a rare event. The benefits that follow from the MOU do not seem to be known or

³ A Psychological Autopsy Study of Non-deliberate Fatal Opiate-related Overdose. Oliver P, Horspool M, Rowse G, Parry M, Keen J, Mathers N. April 2007, National Treatment Agency (NTA)

understood. The main objective of the MOU is *'to provide a safe, secure environment for the rescue, treatment and transport of patients from incidents involving the misuse of controlled drugs'*. While recognising that there is a danger that too much attention could be paid to the MOU, the Forum agreed that it is important to educate drug users that the first priority of the police at the scene of an overdose is the **preservation of life**.

Scottish Prison Service Data

- 3.5 At each meeting the Forum considers data through reports provided by the SPS. The main aims of the reports are to:
- identify trends in relation to ex-prisoner drug-related deaths in Scotland;
 - identify information that may inform gaps in service provision within prisons and on release into the community; and
 - inform strategies designed to reduce the incidence of drug-related death among current and recently released prisoners.
- 3.6 SPS use data provided by the SCDEA to track ex-prisoners who have died following liberation. Data are collected to identify those who have died between 0-3 days of liberation, 4 days to 4 weeks following liberation, greater than 4 weeks and less than or equal to 28 weeks following liberation, greater than 28 weeks and less than or equal to one year following liberation and over one year following liberation.
- 3.7 The analysis of this data has allowed the prison service to identify areas where there are gaps in service provision, e.g. following up people who miss Harm Reduction Awareness Sessions (HRAS) on admission and pre-release, and monitor referrals to the Enhanced Addiction Casework Service (EACS) for those in custody 31 days or more following the core screen process. Data analysis also enables SPS to highlight where improvements can be made between SPS clinical and wraparound services.
- 3.8 A common picture from the data is of a young person (usually male) with a chaotic drug abuse pattern who is remanded to prison, serves a short period of time and then returns to resume the same pattern as when he arrived but is now more at risk from overdose.

Recommendation 2: Prisoners

The number of deaths amongst prisoners on release and gaps in services offered to people on short-term sentences, continue to cause concern. It was felt important to recognise the dangers faced by this group and it is therefore recommended that:

- There should be more support and overdose awareness training for short-term prisoners, i.e. those on remand or serving sentences below 31 days.
- SPS consider revising access criteria for pre-release to prisoners serving 31 days or more.
- There is consistent policy implementation and practice regarding delivery of overdose awareness sessions, prescribing practice and detoxification across the prison service nationally.

Action: Scottish Prison Service

Insomnia and Benzodiazepines

- 3.9 Benzodiazepines were discussed at various meetings of the Forum and it was recognised that their use was widespread and a major clinical problem in Scotland. Often linked to risk-taking behaviour with higher rates of needle sharing, poly-drug use and injecting while on a methadone script, the overall picture of the benzodiazepine user is one of a chaotic lifestyle with poorer health and social functioning, and an increased risk of overdosing.
- 3.10 Insomnia and anxiety are the usual reasons for self medication. The prescribing of benzodiazepines remains an unanswered question, with many GPs preferring not to prescribe other than in the short-term due to fear of diversion on to the illicit market and concerns about the long-term effects. Illicit supplies are easily obtained via the internet and the police have some difficulty in identifying such supplies.
- 3.11 Although toxicological analysis appears to show that benzodiazepines are less implicated in drug deaths over the years it was agreed that their presence could be significant in terms of psychological profiling. The Forum thought that complementary therapies to reduce anxiety e.g. Cognitive Behavioural Therapy (CBT) should be explored.

The Danger of Combining Alcohol and Drugs

- 3.12 The Forum cannot stress strongly enough the danger of combining alcohol and drugs and its contribution to drug-related deaths. The report, *Does the Combined Use of Heroin or Methadone and Other Substances Increase the Risk of Overdose?*⁴, published by the NTA in April 2007, demonstrates the risks associated with combining alcohol and drugs. The

⁴ http://www.nta.nhs.uk/publications/documents/nta_rb27_combined_opiate_overdose.pdf

NTA document stated that ‘Alcohol concentrations, even those associated with mild intoxication, appear to lower the amount of heroin required to fatally overdose’. The NTA recommended that ‘Treatment agencies and policymakers should consider alcohol use to be a principal risk factor – alongside reductions in tolerance and quantities of opioids consumed – in developing their opioid overdose prevention strategies’. The Forum concurs with this recommendation.

Sub-Groups

- 3.13 The Forum established four sub-groups for service users, pathologists, local ADATs and a data collection group.
- 3.14 Service users are uniquely placed to contribute in that some have had personal experience of losing a relative or friend or have had an overdose themselves. This group felt able to discuss agenda items and put forward their own opinions and experiences. A representative reports to the main Forum.
- 3.15 Pathologists and representatives of the Procurator Fiscal service meet to exchange information about current practice in different areas of Scotland and discuss matters of mutual concern.
- 3.16 The ADAT sub-group is currently looking at local data collection and how it is used. Many ADATs have Critical Incident Groups or Drug Death Review Groups who can look in more detail at the circumstances behind individual deaths in their area. Along with the data collection group, they are developing a database which will identify patterns over several years.
- 3.17 There are several sources of data on drug-related deaths. The data collection sub-group was established to look at information available nationally and locally. Monthly reports from the SCDEA provide an indication of the number of deaths in ADAT areas but they do not provide any background to individual deaths. The SCDEA only records deaths where there has been police involvement. In contrast, the GROS provides detailed summaries for all deaths, of the causes of death and the drugs involved. However, the results are not published until August of the following year. The National Programme on Substance Misuse Deaths (np-SAD), based at St George’s Hospital Medical School (SGHMS) University of London, also uses data from the SCDEA to provide national information for Scotland in their annual report⁵. These data are limited and published in the following year. The Scottish Government is represented on np-SAD and receives reports on their work. Further information from these groups is available in Chapters 4-7 of this report.

⁵ <https://portal.sgul.ac.uk/services/news/services/news/documents/Executive%20Summary%20np-SAD-2007.pdf>

Presentations

3.18 At the first meeting of the Forum it was felt that members would benefit by hearing from experts in their respective fields and that they could be invited to brief the Forum on areas of concern. Members also felt it was important to hear about research. Brief extracts from the presentations are provided below:

The National Programme on Substance Abuse Deaths (np-SAD) – John Corkery, International Centre for Drug Policy (ICDP), St George's Hospital Medical School (SGHMS), University of London

3.19 The presentation covered the origins and history of np-SAD, the information they collect and how it is used, their achievements, challenges and future aspirations. np-SAD works primarily under ICDP's research and development stream, but also covers education and training as well as prevention initiatives. SGHMS has a history of data collection on substance deaths, e.g. Volatile Substance Abuse (VSA) and the Home Office Addicts Index. It was explained that np-SAD was the official custodians of the Addicts Index, which covered data from the period 1968-97. Data were collected relating to the deaths of addicts notified to the Home Office (HO). Data were collected initially from the HO Drugs Inspectorate (responsible for the Addicts Index) and then the HO Research and Statistics Department. This formed the nucleus of the Dead Addicts Database and enabled the publishing of academic papers.

3.20 The first report, covering the period July-December 1997, was published in April 1998. It included information from seventeen coroner areas. There are now in excess of 100 areas reporting at any one time. In addition, data are received from the SCDEA and the Northern Ireland Coroners Service, as well as from coroners in Guernsey, Jersey and the Isle of Man.

3.21 The Department of Health in England now provides funding for the Programme. The Programme aims to collect and collate drug-related mortality data; identify substances implicated in drug-related deaths; monitor and examine patterns and trends; act as an early warning system for new trends in mortality and use data as an indicator to estimate prevalence of substance problems and assess hazards associated with substance abuse. In addition, np-SAD collaborates with relevant agencies in research on substance-related mortality; informs and facilitates discussion of prevention of drug-related deaths; provides data for local and national drug abuse policy and programme planning; disseminates information on drug-related mortality to the scientific community, clinicians, policy makers and other interested parties; and shares experience and expertise on setting up and maintaining drug-related mortality surveillance systems.

3.22 The programme is overseen by a steering group comprising experts from a range of disciplines and stakeholders including the devolved administrations, GROS and the SCDEA. Data are collected on drug-related deaths using a wide definition, covering both acute deaths such as drug poisoning and deaths of suspected drug abusers. The definition excludes VSA.

The Role of the Forensic Pathologist – Dr Marjorie Black, Consultant Forensic Pathologist, Glasgow University Department of Forensic Medicine

3.23 The presentation explained the role of the pathologist in the event of a suspected drug-related death and some of the issues that arise. The role of the pathologist was primarily to establish the cause of death and the factors contributing to that death. This is done by conducting a full post-mortem examination taking account of histology and toxicology and to exclude death from natural causes.

3.24 The toxicology looks at what drugs are present at death and the levels of these drugs. It does not necessarily provide the cause of death and not all drugs are contributory. The forensic pathologist provides an interpretation of the toxicology in the circumstances and post mortem findings. This is particularly important as the supplier of the drug(s) causing death may be charged with culpable homicide.

3.25 A drug-related death is determined by the definition set down by GROS, i.e. *‘where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved’*. This definition excludes infection but includes deaths not as a result of illicit drug use. A new definition which includes infection, e.g. necrotising fasciitis and Hepatitis C or road traffic accidents where drugs were involved, would perhaps provide a more accurate picture of deaths in drug users. It would, however, significantly increase the numbers. Such a definition would require clear, appropriate and relevant sub-categories and there would have to be effective and efficient means of communication of data.

3.26 Some of the issues that arise include the contribution made by benzodiazepines in deaths. Recommendation 14 of the *Scottish Advisory Committee on Drug Misuse (SACDM) Working Group Report on Drug-related Deaths* (Scottish Executive, 2005), stated that a new definition would trawl all deaths from benzodiazepines. They are found in a large percentage of deaths, however, there are few well documented fatal cases of diazepam overdose. Benzodiazepines are generally considered to be relatively safe drugs and there may well be high levels in the living.

3.27 A further issue was substitution therapy, mostly in relation to methadone. The increase in the number of people being prescribed methadone has been followed by an increase in the number of deaths where methadone is mentioned. Multiple take-home doses, sometimes prescribed when a pharmacy is closed, may lead to inadvertent overdose or facilitate diversion of legitimate supplies. However, the finding of a drug in the blood does not mean that it caused (or even contributed) to death.

3.28 The current situation is that numbers are increasing but the age, sex distribution and drugs involved remain static. For the future:

- there needs to be established a consistent, appropriate and thorough investigation of suspected drug deaths and an established protocol for doing it;
- there needs to be an agreed standard definition of a drug-related death;
- there should be a review or audit investigation of the deaths and attributed cause of death; and
- the number of drug-related deaths needs to be reported accurately as does the information on the drugs which cause deaths.

Drug-related Deaths in Lothian and Prior Contact with Hospital Based Services – Dr H K R Thanacoody, Consultant Physician, Scottish Poisons Information Bureau (SPIB), Royal Infirmary of Edinburgh (RIE)

3.29 Outside Strathclyde, Lothian has the second highest rate of drug-related deaths. There has also been an increase in hospital admissions relating to drug misuse from 600 in 2001-02 to 900 in 2005-06. In previous studies of drug-related deaths and previous hospital contacts the following points were noticed. In Brighton & Hove A&E Department in 1998, 60% of drug misusers who died attended there within one year of death. Also, in Glasgow in 1999, 90% had seen a GP, 48% had attended A&E and 22% had had a psychiatric assessment prior to death.

3.30 The presentation focused on a study which examined the demographic details of drug-related deaths (excluding suicide) obtained from Lothian & Borders police in the years 2003-05. It also examined information from RIE, which sees 85,000 attendances to A&E per year and has a 10-bedded toxicology bay with 3000 admissions per year in the Combined Assessment Unit.

3.31 The study then cross checked the demographic details with two databases, the hospital episodes on MedTRAK⁶ database and the toxicology database held within SPIB. The number of emergency department attendances, the number of toxicology admissions and the number of admissions to other services within five years of death were examined. Outpatient attendances and emergency department attendances at time of death or leading to hospital admission were not included. For toxicology admissions, the diagnosis was checked to confirm whether they were toxicologically-related.

⁶ MedTRAK – IT system used in all Lothian hospitals which provides records of all clinical activity, A&E attendances, hospital admissions, outpatient attendances and electronic patient records

- 3.32 The results of this study showed that in 90 drug-related deaths in Lothian, 71 were male and 19 female with a mean age of 32 years. Seventy-five lived in the catchment area of RIE and 15 in West Lothian (St John's Hospital catchment area). Of the 90, 48 (53%) were seen in RIE within five years and 31 of the 48 had been seen within 12 months. Of the 75 deaths in the RIE catchment area, 45 (60%) had been admitted within five years, 21 (28%) had been admitted to toxicology with previous overdoses or self-harm and 41 (55%) attended A&E or were admitted to toxicology.
- 3.33 The study concluded that there was:
- prior use of hospital services in up to 60% of drug-related deaths in RIE catchment area; and
 - opportunity for intervention at time of hospital contact, perhaps through a drug liaison nurse who could put the patient in contact with their GP, drug addiction service, drug action team or other services who may be able to help.

The Glasgow Naloxone Project – Samantha Perry, Consultant – Accident and Emergency, Glasgow Western Infirmary

- 3.34 Glasgow has had a significant number of drug-related deaths for many years. Drug-related deaths began to escalate from the 1980s onwards as heroin use became more widespread and there is a strong link between heroin use and fatal overdose. In the three years 2003-05, there have been over 300 drug-related deaths in Greater Glasgow.
- 3.35 A high proportion of these deaths involve heroin/morphine (195) and methadone (102). It should be noted that they usually involve a cocktail of drugs and are rarely from one drug alone. With the availability of naloxone, which reverses the effects of opiate drugs, we may now have an opportunity to make an impact on reducing such deaths in the future.
- 3.36 The majority of deaths involve people who mix depressants such as heroin, methadone, benzodiazepines and alcohol together. Individually these drugs can slow down vital bodily functions such as breathing and heart rate but when used in combination these dangerous physical effects can be increased dramatically.
- 3.37 Many drug users report personal experience of overdose, often on multiple occasions, and many report being witness to numerous overdose events that do not result in a fatality. In managing these events drug users often report successfully employing interventions such as inflicting pain and consequently will use such approaches whenever confronted with an overdose in the expectation of a successful outcome.
- 3.38 These interventions appear to work but in reality the overdose was in all likelihood a non-fatal overdose whose positive outcome was not influenced by the actions taken. It is the passing of time and the metabolism of the drug that leads to recovery not the inappropriate interventions. If such actions are administered to a person with life threatening levels of drug(s) they will have no impact and the likely outcome will be a fatality.

- 3.39 Naloxone is routinely used by healthcare professionals. It is a non-addictive, non-arousing drug and works by blocking opioid receptors thus stopping opioids from acting on them.
- 3.40 Many drug-related deaths could be preventable if those at risk had quick access to a supply of naloxone and prior training in actions to be taken when an overdose occurs. *The Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005*⁷ contained provision for the administration of naloxone (by anyone) in an emergency in order to save a life. Witnesses to overdose with access to a supply of naloxone and with appropriate training could potentially save many lives.
- 3.41 In an attempt to reduce the number of accidental overdose deaths due to opiates, a pilot project giving a supply of naloxone to drug users and their families, was introduced in Glasgow in February 2007. The pilot includes training in overdose awareness, basic life support, how to inject naloxone and how to place someone in the recovery position. During the training it is emphasised that naloxone provides a window of opportunity to call an ambulance.
- 3.42 As a background to the pilot a multi-disciplinary and multi-agency group undertook a fact-gathering mission to Chicago to learn first hand from the experiences of the Chicago Recovery Alliance (CRA). The CRA has been issuing naloxone through their outreach services for five years and claim to have reduced the number of opiate-related drug deaths by 20% in this time. The visiting group learned from the experience and knowledge of this service and it has facilitated the development of the pilot. The Forum was shown a short film about the naloxone project in Chicago in which people described their personal experiences and told how they had used naloxone to save lives on many occasions. The Glasgow pilot is a new service development operated by Glasgow Addiction Service.

Recommendation 3: Providing Naloxone in Order to Save Life

With take-home naloxone being more widely used across the world to save lives, e.g. in Berlin, San Francisco and Chicago, consideration should be given in Scotland to extending take-home naloxone provision beyond Glasgow into other areas. This recommendation is made with the understanding that any pilot is rigorously evaluated to prove effectiveness.

Action: Service Commissioners

⁷ <http://www.opsi.gov.uk/si/si2005/20051507.htm>

The Use of Naltrexone in the Prevention of Drug-related Death – Dr Lucy Cockayne, NHS Fife

- 3.43 With detoxification comes a high risk of drug-related death. Support and maintenance with antagonists is required to give protection from overdose and reduce the chance of drug death. It can be two to three years before a drug user is ‘drug-free’. They need to unlearn previous behaviours and be given the chance to rehabilitate and live without the fallback of use of opiates when under pressure.
- 3.44 If addiction is regarded as a brain disease the pathways do not return to normal and social support and treatment may be required for a very long time. Treatment is often driven by personalities. ‘Postcode prescribing’ can occur as can stopping a prescription because clients are continuing to use illicit drugs, which is a dangerous practice.
- 3.45 Naltrexone is used to maintain abstinence from heroin and other opioids once a person has been successfully detoxified for 7-10 days. It works by blocking opioid receptors in the brain. It produces no euphoria and is non-addictive. Naltrexone can help prevent relapse into opioid addiction and there is also evidence that it is effective against alcohol and cocaine. It comes in two forms, a tablet – licensed for the treatment of drug dependency, and an implant – not licensed for the treatment of drug dependency. The tablet form can be a problem in that most users stop taking them after as short a time as two weeks. This can be very dangerous as naltrexone effectively blocks all opioid drugs and this results in no tolerance to opioids. The half-life of naltrexone is under 24 hours so the patient is extremely open to overdose if they return directly to their usual heroin use after stopping naltrexone.
- 3.46 Implants, which are not licensed, can increase compliance and they carry a reduced risk of accidental overdose should relapse occur. However, there are also problems with implants in that minor surgery is involved which can carry the risk of infection and some patients may develop localised swelling and irritation.
- 3.47 A new development is an injectable form of naltrexone which is licensed for use in the United States (US) for alcohol addiction. One injection lasts for a month. This method gives people a chance to engage, provides respite from opiate use, gives an opportunity for other interventions to work and acts as a preventative measure. This method may provide an alternative treatment choice for young starters, post-prison release and experienced users with multiple detoxifications or overdose history. It could be an early intervention to prevent escalation and overdose.
- 3.48 In conclusion, a pilot study could be undertaken using the newest form of naltrexone to create an evidence base. Such a trial would need to be measured against other forms of interventions for comparison.

Recommendation 4: Research

The Forum believe that in addition to accurate data collection there is a need to continue to investigate the circumstances and settings of drug-related deaths and how such factors contribute to them.

The Forum also recommend that research should be commissioned into other treatments that may assist addicts to become drug free, e.g. the use of naltrexone highlighted in this report and the effects of the introduction of Subutex and Suboxone in drug treatment.

Action: Academics, the Scottish Government Research Team and Chief Scientist Office

Suicide: Epidemiological Trends in Scotland and Links with Drug Misuse – Professor Steven Platt, University of Edinburgh

- 3.49 Suicide rates in Scotland are not markedly high by international standards and the rate has generally been lower or around the European Union (EU) average since the 1980s. However, there was a worsening trend compared to many other countries over the period 1970-2000, which was more marked amongst men. More recently (2001-02 to 2004-06) there has been a 14% decrease among males and 9% decrease among females.
- 3.50 Scotland does have a higher suicide rate than the rest of the United Kingdom (UK). The male rate is 50% higher than the overall UK rate and the female rate is almost double. Suicide is a leading cause of mortality in the under 35s and the age-groups associated with the highest risk of suicide have become younger over recent decades. Scottish suicide rates vary across Health Boards and Local Authorities, the highest rates being in Glasgow (where there is also the greatest number of suicide deaths) and the Highlands and Islands. There has been a suicide cluster in east Glasgow over the last two decades, which may be explained by a concentration of deprivation. There appears to be a distinct relationship between deprivation and suicide at both area and individual levels. The higher the rate of deprivation, the higher the rate of suicide. The lower the individual's socio-economic position, the higher the suicide rate; the excess of suicide deaths among unskilled manual workers in the most deprived areas is particularly notable.
- 3.51 The top five most common single risk factors associated with completed suicide are: 1) major depressive illness, affective disorder; 2) substance misuse (alcoholism, alcohol dependence and drug misuse); 3) prior non-fatal suicidal behaviour; 4) suicide ideation, talk, preparation; and 5) use of lethal method (especially hanging and firearms). It is notable and that substance misuse is the second most common single risk factor. It would appear that people who misuse drugs have a high suicide rate, the highest risk being in those with multiple drug misuse problems. The combination of sedative and illicit drug misuse is associated with a 14-fold increase in risk. Interestingly, there is a similar elevation of risk found in severe mental illness.

- 3.52 If you look at drug misuse among general population suicides, almost half the deaths among opiate addicts are from unnatural causes, mainly overdose deaths not classified as suicide. Drug misuse is over-represented among people who complete suicide. There have been adverse trends over time. A recent study of suicide in Northern Ireland found 8% of people were suffering from psychoactive substance dependence/misuse (43% from alcohol dependence/misuse), usually in addition to primary mental disorder. If you compare these findings with a study conducted in 1960s in England, 3% were dependent on substances (in all cases these were barbiturates), while 15% were alcohol-dependent. Drug misuse is more common among younger people, however, many studies quote data only for drugs and alcohol combined. In the US, 60-70% of adolescent/young suicides are alcohol/drug abusers. A lower range, 30-40%, is reported in Europe. Despite methodological limitations, there is little doubt of the importance of drug misuse in suicide among young adults or that the increase in drug-taking is implicated in the increase in suicide among young men in the last few decades.
- 3.53 In looking at drug misuse among people with mental illness, the *National Confidential Inquiry into Suicide and Homicide among People with Mental Illness*⁸, collects data on contacts with mental health services in the previous 12 months. Twenty-seven per cent of patients who died had ‘dual diagnosis’ of severe mental illness and substance dependence or misuse. Most of these suicides were among young, single, unemployed males living alone. Three per cent had drug dependency as the primary diagnosis and 8% alcohol dependence. A further 30% had a history of drug abuse and 44% of alcohol abuse.
- 3.54 In conclusion, there would appear from studies that there is a clear link between suicide, mental illness, substance misuse and deprivation (both area-based and individual).

Recommendation 5: Suicide Prevention

Approximately 23% of all drug-related deaths in Scotland are intentional self-poisoning or where the intent is undetermined. Prevention of suicide amongst drug users should therefore become a key priority as part of the drive to reduce drug-related deaths in Scotland. It is therefore recommended that:

- Suicide prevention be incorporated within the ethos of reducing drug-related harm and becomes a key priority for the attention of ADATs, drug agencies and related services.
- Action to prevent suicide should include prioritising suicide prevention training for front-line agencies and developing greater awareness of heightened risk factors for drug users, particularly in relation to intentional overdose.
- ADATs take a lead role in utilising the linkages to local Choose Life (suicide prevention) networks to access training and other resources and promote greater understanding of mental health problems (such as depression and bi-polar disorder) as likely determinants of suicide.

Action: ADATs and Choose Life

⁸ <http://www.medicine.manchester.ac.uk/suicideprevention/nci/>

4. Service User Forum

- 4.1 The Service User Forum has provided constructive feedback on the key themes raised in the National Forum and brought further issues to the them for consideration. The group members have been recruited through service user groups from around Scotland with representation from areas such as Grampian, Highland, Fife, Glasgow, Perth and Dumfries & Galloway.
- 4.2 The group discusses issues raised by the National Forum and feed back the topics they feel are important in relation to drug-related deaths. A representative from the group attends the National Forum meetings which is viewed by them as a positive experience. Recruitment is a constant task because members are quite rightly moving on to education and employment and leaving opportunities for others to contribute.
- 4.3 Topics discussed within the group have included the definition of acute and chronic drug-related deaths and the inclusion of drug users' deaths resulting from Hepatitis C; the MOU between the police and ambulance service; issues around support for people at risk – particularly young people leaving care, homeless persons and prisoners; family consultation and support following a drug-related death in the family; opportunities for interventions and information on or referrals to drug services at A&E departments when accessed for overdose; and the provision of critical incidents training and naloxone.
- 4.4 The service users have welcomed guests such as Jane Jay (Chair, National Forum); Yvonne Miell (Includem Young People's project); Ally Prockter (Grampian Police); David Spiers (Lanarkshire Procurator Fiscal); Derek Loutitt (Scottish Ambulance Service); and Marion Logan (Scottish Government, Quality Standards Advisor). The inclusion of professionals within the group has been viewed positively by members and has allowed them to discuss issues and air concerns on an equal basis.
- 4.5 Members have described the Service User Forum as a 'breath of fresh air' and have enjoyed being able to put their views across. They feel there is a need for the user group to feed into the National Forum and for the Forum to hear the views of people affected by these issues including both users, friends and family.
- 4.6 Some members travel long distances which can make it difficult to attend every meeting. However, attendance is good and their dedication and interest is a testimony to their determination to improve outcomes for drug users and the wider community and something which the National Forum greatly appreciates. Meetings are held in Perth, which is central for travel purposes. However, there will be opportunity to move the meetings to other parts of Scotland to allow wider inclusion and voice local concerns. Highland members have raised the issue of support for drug users in remote areas, particularly around suicide. Most of the members currently come from the central belt. The group is facilitated by the SDF.

The following are examples of issues that raised particular concern amongst members:

Methadone prescribing

- 4.7 Members pointed out that more people are consuming alcohol with methadone, particularly street methadone, unaware of the potency of methadone when combined with alcohol. Fatalities have resulted when people who may never have used opiates before have combined methadone and alcohol.
- 4.8 There was further discussion about the inconsistencies of methadone prescribing and the inadequate support given to people on methadone programmes. Among the problems highlighted were over and under-prescribing, with examples such as 700 ml of methadone being returned to the chemist every week on one hand, and people topping up on the other. It was agreed that each individual's methadone programme should consist of appropriate support. At the same time, easily accessible methadone clinics, with trained methadone nurses, were seen as a cornerstone of a successful national methadone programme. There should be improved screening for methadone prescribing.
- 4.9 Members felt very strongly that improvements were needed in the treatment and support of drug misusers.

Recommendation 6: Treatment and Support

The revised *Clinical Guidelines on the Treatment of Drug Misusers* (Orange Guidelines), published in September 2007 should be properly implemented by practitioners. The guidelines make it clear that if properly implemented, the treatments outlined in the document will reduce drug-related deaths. The document also highlights areas which are not effective or can be dangerous such as rapid detoxification, long waiting lists and under-medicating patients. In addition, there are examples of those treatments which need further research before they can be recommended or discarded.

Services should comply with the *National Quality Standards for Substance Misuse Services* to improve the consistency and quality of substance misuse service provision in Scotland.

Specialist services need to monitor waiting times and retention rates. The *Drug Outcome Research in Scotland* (DORIS) study highlighted a wide variation in retention rates across Scotland. Services need to do more to retain people in treatment, particularly those who have a history of previous overdose.

Action: Practitioners, Service Managers, ADATs, Scottish Prison Service

Young people in care

4.10 It was generally felt that there is a lack of support for young people in care in terms of rehabilitation. Some services do not seem to have the expertise to deal successfully with the many young people whose circumstances are complex and difficult. It was felt that programmes should be tailored to individual needs and that they should be open-ended. This has proved to be highly successful in some services and there was agreement that this person-centred approach is the ideal model for rehabilitation programmes.

Recommendation 7: Young People in Care and Leaving Care

There should be continuing practical 'wraparound' support for young people whilst in and leaving care including harm reduction and overdose awareness training. There should also be easy access to essential services that are specifically tailored to young people's requirements and where assessment of risk can be carefully undertaken.

Action: Services and Residential Establishments including Young Offenders Units

Piloting Innovative Projects

4.11 Members believe that overdoses, drug-related deaths and transmission of blood-borne viruses could be reduced if users, particularly older, chaotic and homeless addicts, could inject in safe and hygienic circumstances.

4.12 The recently published Joseph Rowntree Foundation (JRF) *Report of the Independent Working Group on Drug Consumption Rooms (2007)* provided a detailed examination on whether Drug Consumption Rooms (DCRs) should be introduced in the UK. Chaired by Dame Ruth Runciman, the Independent Working Group included UK experts from the police, legal and health sectors. For 20 months, the group reviewed the growing body of evidence, commissioned research where data were lacking, visited drug consumption rooms in five countries and interviewed relevant witnesses. The group found that drug consumption rooms:

- can avert drug-related deaths, prevent needle-sharing and improve the general health of users;
- can decrease injecting in public places and reduce the number of discarded, used syringes and drug-related litter;
- do not appear to increase levels of acquisitive crime;
- were generally not associated with public order nuisance or other problems, especially with good inter-agency co-operation in place; and
- are mostly used by local drug users.

- 4.13 The group concluded that well-designed and well-implemented drug consumption rooms would have an impact on some of the serious drug-related problems experienced in the UK.

Recommendation 8: Piloting Innovative Projects

There is a particular need to look at those who are known to be at high risk of overdose. If they are not given intensive support they may be more likely to die. These are typically males in their thirties and forties with a long history of substance misuse, marginalised from their families and society, often homeless and in poor general health.

Consideration should be given to identifying and piloting methods used in other countries that have been shown to have an impact on drug-related deaths with this target group, e.g. piloting a safe injecting clinic such as those established in Australia, Canada and Switzerland. If a scheme is evaluated and has proved to be effective we should think about trying it in Scotland. The JRF report should be considered carefully by service commissioners.

In Canada, for example, the results of an evaluation of an injection clinic called Insite, in the Downtown East Side area of Vancouver, showed that in the 500 overdoses that had occurred at the site over a two year period, none had resulted in a fatality. If these overdoses had happened elsewhere the outcome may have been very different.

Action: Service Commissioners

5. Pathologist Sub-Group

- 5.1 The group began by trying to compare information on pathology in relation to drug-related deaths and how it is gathered, collated and rationalised in different areas of Scotland. There were discussions about the timing of the issue of the death certificate, the post-mortem examination itself, the sampling, toxicology and causes of death.
- 5.2 There was general agreement that it was essential that a unified definition, consistent with definitions used by other groups, should be established. It was explained that the GROS use the UK Drug Strategy definition⁹ to produce statistics for their annual report on drug-related deaths in Scotland. This definition was agreed eight years ago in consultation with other departments in London, following a report by the EMCDDA recommending a standard definition to enable the monitoring of drug-related deaths. This definition is also used by the Office of National Statistics to produce figures for England and Wales.
- 5.3 Other definitions are used for which the GROS supply data. For example, the EMCDDA asked for information from mortality databases where data are recorded according to ICD-10 codes¹⁰. However, their methodology is flawed as it includes deaths involving dextropropoxyphene, the principal component of co-proxamol. This is a drug that has been involved in many suicides in Scotland. The number of such cases in the UK should fall as co-proxamol has now been withdrawn but this will continue to be an issue in terms of international comparability.
- 5.4 The conclusion was reached that it would be virtually impossible to arrive at one single definition that would meet unanimous agreement for all purposes. Flexibility is required in order to produce figures for different purposes. It was suggested that a centralised, comprehensive database of drug-related deaths would be of benefit. This would mean the recording of all drug deaths in Scotland without omissions.
- 5.5 The group agreed that the current form used by the GROS to collect information on drug deaths, which was originally drawn up eight years ago, was no longer serving the purpose for which it was produced. It was found that, although the original intent was for the form to be generated automatically by the pathologist, this had not been the case universally, and an enhanced GROS form would be beneficial in the production of more accurate and comprehensive statistics. It was agreed that using the expertise on the pathologist group a new form would be designed to allow better information to be provided to the GROS by the pathologist.

⁹ UK Drug Strategy definition – ‘a death where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved’.

¹⁰ ICD Codes – The International Classification of Diseases provides the ground rules for coding and classifying cause-of-death data.

6. Data Collection Sub-Group

- 6.1 During the early meetings of the Forum the need for reliable information was identified along with associated issues such as definitions that were compatible between involved agencies. It was also agreed that standardisation of data and the ability to gather similar and comparable information year by year was required. This would allow accurate observations to be made in trends and emerging patterns.
- 6.2 Figures from the GROS and the SCDEA clearly identify the essential basic information surrounding each death from a drug-related cause. However, local detail and the overall interpretation clearly require an additional exercise in assembling and interpreting suitable material. A system needs to be in place whereby interventions that may prevent death can be identified quickly.
- 6.3 The essential requirements of a new system must have the following capacities and capabilities and might be summarised as follows:
- it must be able to gather accurate information on each death at a local level drawing on information supplied by the police and SCDEA in a format compatible across all regions and authorities in Scotland;
 - these data will be centralised in a format suitable for comparison with other national data sources and by an agency capable of interpreting and analysing statistics and trends over time; and
 - the system should have the ability to identify local variations, individual aberrations and novel occurrences as well as interpreting emerging questions resulting from changes in policy and implementation of new practices.
- 6.4 The sub-group is currently working with ISD to design a proposal to take this work forward to the next stage. ISD will prepare a paper for consideration by the Scottish Government and with the help of the sub-group, design a data-collection form to be used by local co-ordinators.
- 6.5 It is hoped that data can be cross-matched with the Scottish Drug Misuse Database (SDMD) to provide a treatment history for the deceased and enable a better look into their backgrounds. This may help establish why people are dying.
- 6.6 Further work is required to consider, with aid of the Pathologist Sub-Group, how early reporting of autopsy and toxicological findings might be achieved. It is essential to engage the enthusiasm and co-operation of all ADATs in Scotland to enable this work to progress. In addition, it is important to identify and assess methods of co-operation between other groups (SCDEA, GROS, ISD, GPs, specialist treatment agencies and friends and relatives of substance misusers).

Recommendation 9: Data Collection

Drawing from the SACDM *Working Group on Drug-related Deaths, Report and Recommendations* (2005) and after discussions with ADATs, the GROS, SCDEA and ISD, the following recommendations emerged. A new system for data collection should be constructed as follows:

- ADATs should be asked to gather data in a systematic format on each death after being notified of these by the police or SCDEA.
- That data should be standardised and compiled by ISD in a suitable electronic format which will allow analysis and reporting.
- The national dataset will be augmented by adding information from other ISD files, in particular each case will be matched with information from reports from treatment agencies (SMR25) and mortality statistics concerning hospital admissions (SMR01 and SMR04) as well as GROS cause of death information.
- An expert group should supervise these exercises and will provide accurate clinical interpretations in order to correctly brief Scottish Government Ministers, the National Forum, the media and the public.

Action: Scottish Government, ISD and local ADATs

7. Alcohol & Drug Action Team (ADAT) Sub-Group

- 7.1 This group was convened after it was identified that ADATs were uniquely placed to access potentially useful data and other information regarding drug deaths in their area. Although the group has only been formed recently, there are a number of points arising which will be explored in greater depth in the future. The group members also agreed the process of developing a national standard data set, currently being undertaken by the Data Collection Sub-Group.
- 7.2 Across Scotland, the picture of a 'typical' drug death was one of a single male in his late thirties, although one ADAT had a significant number of young males in recent times. Alcohol has been a feature in many deaths with some areas recording that 75-80% of toxicology results had found alcohol present.
- 7.3 Most ADATs had Critical Incident Groups within their area. It was thought that Procurator Fiscal involvement helped increase the group's effectiveness. A register of 'near misses' was a feature of a small number of ADATs. It is thought that when the Scottish Ambulance Service (SAS) brings in its new computer system non-fatal overdoses will be better recorded, allowing earlier interventions. The introduction of substance misuse liaison nurses in some A&E units has enabled identification and referral to treatment services.
- 7.4 Overdose awareness training has been identified as useful and has been established in most ADAT areas. It was suggested that information on what to do in the event of an overdose could be transmitted by mobile phone – a piece of equipment carried by the majority of drug users.

Recommendation 10: National Campaigns

There is a need for targeted national information campaigns. Up-to-date information should be disseminated to those most at risk. For example, dangerous combinations of drugs and alcohol, in particular methadone and alcohol and cocaine and alcohol, need to be highlighted to drug users.

The Forum recommends that the Scottish Government review and update materials available on overdose and consider using information technology to highlight issues. For example, a dedicated drug deaths website to provide up-to-date information on available materials and where to get help would be very useful.

Action: Scottish Government

Summary of Recommendations

The following recommendations highlighted in the body of this report have been determined by members of the National Forum and its sub-groups. They focus on key areas where there have been gaps in service provision or interventions to reduce drug-related deaths.

Recommendation 1: Funding

There is a need for a dedicated fund to encourage new responses to reduce drug-related deaths in Scotland. It is therefore recommended that the Scottish Government considers allocating funding specifically for initiatives aimed at reducing drug-related deaths.

Recommendation 2: Prisoners

The number of deaths amongst prisoners on release and gaps in services offered to people on short term sentences continue to cause concern. It was felt important to recognise the dangers faced by this group and it is therefore recommended that:

- There should be more support and overdose awareness training for short-term prisoners, i.e. those on remand or serving sentences below 31 days.
- SPS consider revising access criteria for pre-release to prisoners serving 31 days or more.
- There is consistent policy implementation and practice regarding delivery of overdose awareness sessions, prescribing practice and detoxification across the prison service nationally.

Recommendation 3: Providing Naloxone in Order to Save Life

With take-home naloxone being more widely used across the world to save lives, e.g. in Berlin, San Francisco and Chicago, consideration should be given in Scotland to extending take-home naloxone provision beyond Glasgow into other areas. This recommendation is made with the understanding that any pilot is rigorously evaluated to prove effectiveness.

Recommendation 4: Research

The Forum believe that in addition to accurate data collection there is a need to continue to investigate the circumstances and settings of drug-related deaths and how such factors contribute to them.

The Forum also recommend that research should be commissioned into other treatments that may assist addicts to become drug free, e.g. the use of naltrexone highlighted in this report and the effects of the introduction of Subutex and Suboxone in drug treatment.

Recommendation 5: Suicide Prevention

Approximately 23% of all drug-related deaths in Scotland are intentional self-poisoning or where the intent is undetermined. Prevention of suicide amongst drug users should therefore become a key priority as part of the drive to reduce drug-related deaths in Scotland. It is therefore recommended that:

- Suicide prevention be incorporated within the ethos of reducing drug-related harm and becomes a key priority for the attention of ADATs, drug agencies and related services.
- Action to prevent suicide should include prioritising suicide prevention training for front-line agencies and developing greater awareness of heightened risk factors for drug users, particularly in relation to intentional overdose.
- ADATs take a lead role in utilising the linkages to local Choose Life (suicide prevention) networks to access training and other resources and promote greater understanding of mental health problems (such as depression and bi-polar disorder) as likely determinants of suicide.

Recommendation 6: Treatment and Support

The revised *Clinical Guidelines on the Treatment of Drug Misusers* (Orange Guidelines), published in September 2007 should be properly implemented by practitioners. The guidelines make it clear that, if properly implemented, the treatments outlined in the document will reduce drug-related deaths. The document also highlights areas which are not effective or can be dangerous such as rapid detoxification, long waiting lists and under-medicating patients. In addition, there are examples of those treatments which need further research before they can be recommended or discarded.

Services should comply with the *National Quality Standards for Substance Misuse Services*¹¹ to improve the consistency and quality of substance misuse service provision in Scotland.

Specialist services need to monitor waiting times and retention rates. *The Drug Outcome Research in Scotland* (DORIS) study highlighted a wide variation in retention rates across Scotland. Services need to do more to retain people in treatment, particularly those who have a history of previous overdose.

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There should be continuing practical ‘wraparound’ support for young people whilst in and leaving care including harm reduction and overdose awareness training. There should also be easy access to essential services that are specifically tailored to young people’s requirements and where assessment of risk can be carefully undertaken.

¹¹ <http://www.scotland.gov.uk/Publications/2006/09/25092710/0>

Recommendation 8: Piloting Innovative Projects

There is a particular need to look at those who are known to be at high risk of overdose. If they are not given intensive support they may be more likely to die. These are typically males in their thirties and forties with a long history of substance misuse, marginalised from their families and society, often homeless and in poor general health.

Consideration should be given to identifying and piloting methods used in other countries that have been shown to have an impact on drug-related deaths with this target group, e.g. piloting a safe injecting clinic such as those established in Australia, Canada and Switzerland. If a scheme is evaluated and has proved to be effective we should think about trying it in Scotland. The JRF report should be considered carefully by service commissioners.

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There is a need for targeted national information campaigns. Up-to-date information should be disseminated to those most at risk. For example, dangerous combinations of drugs and alcohol, in particular methadone and alcohol and cocaine and alcohol, need to be highlighted to drug users.

The Forum recommends that the Scottish Government review and update materials available on overdose and consider using information technology to highlight issues. For example, a dedicated drug deaths website to provide up-to-date information on available materials and where to get help would be very useful.

National Forum Membership

Dr Jane Jay (Chair)	Community Drug Problem Service, NHS Lothian (until September 2007)
Professor Anthony Busuttill	Regius Professor of Forensic Medicine – Emeritus, University of Edinburgh
James Egan	Scottish Drugs Forum
Marnie Hodge	Development Manager, Turning Point Scotland
Neil Hunter	Joint General Manager, Glasgow Addiction Service
Stevie Innes	Scottish Crime and Drugs Enforcement Agency
Graham Jackson	General Register Office for Scotland
Jackie Johnston	Signpost, Forth Valley
Derek Louttit	Scottish Ambulance Service
Bill Mason	Scottish Ambulance Service
Willie MacColl	Scottish Crime and Drugs Enforcement Agency
Mike McCarron	Scottish Association of Drug & Alcohol Action Teams
Anthony McGeehan	Principal Depute, Procurator Fiscal Deaths Unit, Glasgow
Professor Neil McKeganey	Centre for Drug Misuse Research, Glasgow
Karen Melville	Principal Pharmacist, Substance Misuse Services, Dundee
Karen Norrie	Scottish Prison Service (until September 2007)
John O'Sullivan	Emergency Services Manager, Glasgow Homeless Partnership
Ruth Parker	Scottish Prison Service (from November 2007)
Dougie Paterson	Scottish Government, Choose Life, National Operations Manager
Steve Pavis	NHS Services Scotland, Information Services Division
Samantha Perry	A&E Consultant, Western Infirmary Glasgow
Inspector Ally Prockter	Northern Constabulary (until July 2007)
Dr Alison Richardson	Consultant Clinical Psychologist, Spittal Street Centre, Edinburgh
Dr Roy Robertson	Reader, Department of Community Health Sciences, Edinburgh University and Muirhouse Medical Group, Edinburgh
Dr Maria Rossi	Consultant in Public Health Medicine, NHS Grampian

Jim Sherval	Drug Policy and Research Co-ordinator, Lothian NHS Board
David Speirs	Crown Office Procurator Fiscal Service – Area Procurator Fiscal, Lanarkshire
Ruth Whatling	Scottish Government, Police and Community Safety Directorate, Analytical Services
Leon Wylie	Scottish Association of Drug & Alcohol Action Teams

Secretariat

Sandra Wallace (Secretary)	Scottish Government, Drugs Policy Unit
Gordon Hastie (Minutes)	Scottish Government, Drugs Policy Unit (until July 2007)

Membership of Sub-Groups

ADAT Sub-Group

Dr Jane Jay (Chair)	Community Drug Problem Service, NHS Lothian (until September 2007)
Leon Wylie	Scottish Association of Drug & Alcohol Action Teams

ADAT members

Sandy Kelman	Aberdeen
Grahame Cronkshaw	Aberdeenshire
Ian Turnbull	Angus
Lesley Robb	Ayrshire & Arran
Julie Murray	Borders
Jackie Davies	Dumfries & Galloway
Gareth Balmer	Dundee
Chris Denmark	Edinburgh & Lothians
Kenny Cameron	Fife
Elaine Lawlor	Forth Valley
Caird Forsyth	Forth Valley
Bob Pollock	Highland
Dougie Montgomery	Highland
Andrew McAuley	Lanarkshire
Esther Jack	Moray
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Data Collection Sub-Group

Dr Roy Robertson (Chair)	Reader, Department of Community Health Sciences, Edinburgh University and Muirhouse Medical Group, Edinburgh
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Pathologist Sub-Group

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Dr Elizabeth Lim	University of Dundee, Trainee
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Graham Jackson	General Register Office for Scotland
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Professor Gerhard Kernbach-Wighton	University of Edinburgh, Consultant

Service User Forum

April Shaw	Scottish Drugs Forum (Facilitator)
Anne-Louise	Aberdeen
Darren	Aberdeen
Mary	Dumfries & Galloway
Peter	Dumfries & Galloway
Anne	Edinburgh
Garry	Edinburgh
John	Fife
Katie	Fife
Stephen	Fife
Derek	Forth Valley
Jason	Greater Glasgow
Katey	Greater Glasgow
Katrina	Greater Glasgow
Alison	Lanarkshire
Gary	Lanarkshire
Angela	Perth & Kinross
Kevin	Perth & Kinross
Thomas	Renfrewshire

Glossary

ACMD	Advisory Council on the Misuse of Drugs
ADAT	Alcohol and Drug Action Team
CBT	Cognitive Behavioural Therapy
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
CRA	Chicago Recovery Alliance
DCR	Drug Consumption Rooms
DMIS	Drug Misuse Information Scotland website
DORIS	Drug Outcomes Research in Scotland
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
EU	European Union
GROS	General Register Office for Scotland
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HO	Home Office
HRAS	Harm Reduction Awareness Sessions
ICD Codes	International Statistical Classification of Diseases and Related Health Problems
ICDP	International Centre for Drug Policy
ISD	Information Services Division
JRF	Joseph Rowntree Foundation
MOU	Memorandum of Understanding
np-SAD	National Programme on Substance Abuse Deaths
NTA	National Treatment Agency
RIE	Royal Infirmary of Edinburgh
SACDM	Scottish Advisory Committee on Drug Misuse
SADAAT	Scottish Association of Drug & Alcohol Action Teams
SAS	Scottish Ambulance Service
SCDEA	Scottish Crime and Drug Enforcement Agency
SDF	Scottish Drugs Forum

SGHMS	St George's Hospital Medical School
SMR01	Data source for Hospital Discharges
SMR04	Data source for Psychiatric Discharges
SMR25	Data source for Scottish Drug Misuse Database
SPIB	Scottish Poisons Information Bureau
SPS	Scottish Prison Service
UK	United Kingdom
US	United States
USA	United States of America
VSA	Volatile Substance Abuse



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Government**

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