

# National Forum on Drug Related Deaths in Scotland

Annual Report 2008-09

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## **FOREWORD**

The drug death statistics published each year in the General Register of Scotland (GROS) report are fundamental to the work of the National Forum. This year the GROS report was more detailed than ever before. The report confirmed a disappointing but not unexpected trend. Drug-related deaths increased 8% from 421 in 2006 to 455 in 2007. Eighty-six per cent of deaths occurred in males and the majority were in the 25-44 age group with an increasing median age, now 34 years (28 years in 1996).

In May 2008 the Scottish Government published its strategy *The Road to Recovery* for tackling Scotland's drug problems. Alongside it the Government published its response to the Forum's 2007 Annual Report and, in doing so, accepted the need for more systematic data collection, the need for dedicated funding, and for up-to-date, focused national information campaigns. The Forum recognises there is a need for more information about the circumstances surrounding individual drug deaths than will appear in the statistics which a GROS report might provide. In the past year the Forum has therefore developed a dataset which will reveal more detailed background information. It was devised after a long consultation with members of the Forum and their organisations, Alcohol and Drug Action Teams (ADATs), service users and Information Services Division (ISD). The proposals were tested in three pilot studies and the national Drug-related Deaths Database was launched on 1 January 2009. It will look more closely at the circumstances around each individual death. The data is being collected at local level by ADAT co-ordinators and is being collated and analysed centrally by ISD.

Even with this detailed national data collection it will still be important for local critical incident groups to continue to review their own data as there may be important local variations. For example, one ADAT area (Borders), has a cluster of deaths which fall into a much younger age group than the national average.

It is hoped that the extra information will provide us with a greater understanding of the relative importance which we should attach to various premonitory features, such as, the length of drug taking history, previous overdose, alcohol abuse, the general state of mental and physical health, previous engagement with medical and social services and heavy snoring as a warning of imminent death. This information should help us develop a policy which will reduce the number of deaths.

**JANE JAY**

**Chair, National Forum on Drug-related Deaths in Scotland**

## 1. INTRODUCTION

1.1 The General Register Office of Scotland (GROS) published their report, *Drug-related Deaths in Scotland in 2007* on 7 August 2008. The main points included:

- 455 drug-related deaths in 2007 (on the basis of the standard definition<sup>1</sup>), 8% more than in 2006 and roughly double the number in 1997;
- almost two-thirds of deaths involved heroin and/or morphine;
- men accounted for 86% of drug-related deaths; and
- about a third of drug-related deaths were of people aged 25-34, and a further third were 35-44 year-olds. Over the past 10-or-so years, the median age at death has risen, and the percentage increase in the number of deaths has been greatest for 35-44 and 45+ year-olds.

1.2 The publication is available via:

<http://www.gro-scotland.gov.uk/statistics/publications-and-data/drug-related-deaths/index.html>

1.3 It is clear from the GROS data that poly-drug use is becoming more prevalent and also many deaths are in conjunction with alcohol.

1.4 As a result of the GROS data the Forum invited guest speakers who would reflect and stimulate discussion on many of the points which arose from the report. These included:

- Joy Barlow, Head of Scottish Training on Drugs and Alcohol (STRADA), about the evaluation of their Fatal and Non-fatal Overdose Module;
- Eleanor Robertson, Chair of the Scottish Network for Families Affected by Drugs (SNFAD), who spoke about the Network and the role of families;
- Andrew Rome of Figure 8 Consultancy who presented the findings from research which looked at reducing drug users risk of overdose;
- Alex Baldacchino of the University of Dundee who provided his expertise on data collection;

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<sup>1</sup> Standard Definition – 'Deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drug Act (1971) are involved'

- Steve O’Rawe of the University of Paisley who spoke about the links between problem drinking and drug users who are prescribed methadone;
- Professor Sheila Bird of the University of Cambridge, who outlined a proposal to carry out a randomised controlled trial giving naloxone to prisoners on release;
- Andrew McAuley formerly of Lanarkshire Drug Action Team, who presented the findings from the Lanarkshire naloxone pilot; and
- a paper presentation from Frank Dixon of the GROS who was asked by the Forum to look at areas with high numbers of drug deaths.

A fuller look at these presentations can be found in Chapter 4 of this report. This also includes observations from the Forum.

1.5 GROS report that the new form, which was revised in 2007 by the National Forum’s Pathologist Sub-group, for the collection of information from pathologists, is now being used (sample attached at Annex A). There do not appear to be any significant difficulties in its introduction and the standard of completion is very good. The quality of information provided is better, and the response rate is similar to the previous years.

1.6 The Forum welcomed the revision in 2007 of the *Drug Misuse and Dependence: UK Guidelines on Clinical Management*<sup>2</sup> (otherwise known as the ‘Orange Book’) and was happy to see that the Chief Medical Officer (CMO) has been looking at how these guidelines are being implemented across Scotland. More detail on this is provided later in the report (on page 17).

1.7 The Forum also welcomed the launch, on 1 January 2009, of the first National Drug-related Deaths Database in Scotland, which will look more closely at the circumstances around each individual death. The Forum has been at the forefront of the development of the database and looks forward to seeing, in due course, the data analysis and with the help of an expert group, looking at how this data can help in determining interventions that may lead to a reduction in drug-related deaths. More information on the database is provided on page 24.

1.8 In 2008 we also saw the Service User Forum develop and publish a valuable resource for bereaved families. *Overdose: Bereavement – What Happens Now?*<sup>3</sup> was published in conjunction with the launch of the

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<sup>2</sup> Department of Health (England) and the devolved administrations (2007): <http://www.scotland.gov.uk/Publications/2007/09/drug-clinical-guidelines>

<sup>3</sup> Overdose Bereavement: What Happens Now?: <http://www.scotland.gov.uk/Resource/Doc/259247/0076870.pdf>

database and will go a great way to help families and the friends of the deceased to cope with the stress that death brings to those who have lost a loved one. You can read more about the Service User Forum in Chapter 3.

1.9 The Forum has summarised their conclusions in Chapter 5 of this report and will be actively pursuing issues raised through the research carried out by Figure 8 Consultancy and from the presentations.

1.10 The Scottish Government has published a new drugs strategy, *The Road to Recovery*<sup>4</sup>. The strategy puts recovery as the main aim of all drug treatment and rehabilitation services. If this is successful we should, in the long term, have less people dying from drug overdoses. We look forward to seeing how the strategy will be implemented in the coming years.

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<sup>4</sup> *The Road to Recovery – A New Approach to Tackling Scotland’s Drug Problem*. Scottish Government (May 2008) <http://www.scotland.gov.uk/Publications/2008/05/22161610/0>



## **2. PROGRESS IN 2008**

2.1 The Forum published its first report in December 2007. Below are the recommendations<sup>5</sup> made at that time and the Government response<sup>6</sup> to those recommendations. The recommendations and Government response are not new, they are taken from the previously published documents (see footnotes). These are given in order to report on progress since the publication of our 2007 report.

### **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 consider allocating funding specifically for initiatives aimed at reducing drug-related deaths.***

### **Scottish Government Response**

2.2 The Drug Misuse Programme budget includes funding allocated specifically to tackle drug-related deaths. Some of this funding is being used to take forward key recommendations from the Forum including establishing a database to collect and analyse information on drug deaths.

2.3 Substantial resources are already being ploughed into tackling the problem of drug misuse in Scotland. The drug misuse budget within the Justice portfolio is £29.5m/£32.0m/£32.8m for the period 2008-9 to 2010-11. This represents a 14% increase in spending overall by 2010-11. It may not be a question of allocating new resources but of using existing funds and targeting them in a more effective way that produces better outcomes for all.

2.4 In addition, local partners fund initiatives aimed at raising awareness of the dangers of overdose such as information campaigns. We are also funding the Scottish Drugs Forum (SDF) to deliver critical incident training, produce a training manual and to train key workers to deliver the overdose awareness training within their own services.

### **Progress**

2.5 Just over £191,000 has been specifically spent in 2008-9 on work around drug-related deaths. Drug addiction costs society £2.6 billion<sup>7</sup>

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<sup>5</sup> The full text of this document can be found at <http://www.scotland.gov.uk/Publications/2007/12/17095935/0>

<sup>6</sup> The full text of this response can be found at <http://www.scotland.gov.uk/Publications/2008/05/27154627/0>

<sup>7</sup> Source – *Audit Scotland Report: Drug and Alcohol Services in Scotland*. (March 2009) - [http://www.audit-scotland.gov.uk/docs/health/2009/nr\\_090326\\_drugs\\_alcohol.pdf](http://www.audit-scotland.gov.uk/docs/health/2009/nr_090326_drugs_alcohol.pdf).

per year but the human cost saved – the cost of people recovering their lives from addiction – is incalculable and beyond price.

2.6 A good example of how Government funding has been used is the SDF manual, *Overdose Prevention and Intervention – A Training Resource*. The manual was produced as an aid to training for workers in contact with groups such as, amongst others, those in supported accommodation, in needle exchanges, in drug services and in prisons. In addition, SDF provide training to user groups, family groups and others. Further information on training for families, drug users, their friends and key workers can be obtained by contacting Scottish Drugs Forum, 91 Mitchell Street, Glasgow G1 3LN or by telephoning 0141 221 1175.

## **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.***

## **Scottish Government Response**

2.7 The Scottish Prison Service (SPS) have either actioned or are currently working to the recommendations within the Forum's report. They deliver Harm Reduction Awareness Sessions (HRAS) to all eligible admissions to custody (including remands) within 5 days of admission. As from 1 August 2007, pre-release sessions are offered to those in custody 31 days or more (including remands). The HRAS is being revised and updated in partnership with the Scottish Drugs Forum to include overdose awareness and basic life support. Alerting vulnerable drug users to the dangers of lower tolerance, such as those being released from prison, may help prevent some of the deaths.

2.8 Overdose awareness is a part of the Harm Reduction Awareness Session delivered on admission to all prisoners as well as at the pre-release session for those in custody for 31 days or more.

2.9 SPS are committed to consistency in prescribing practices in relation to substance misuse. All doctors working in prison settings will be

undergoing Royal College of General Practitioners (RCGP) training on substance misuse. This will ensure there is a level of consistency in prescribing practice. Doctors now have a consistent approach to continuous professional development both in terms of relevant training, supervision and support. Doctors now also have access to training courses run by Scottish Training on Drugs and Alcohol (STRADA) on substance misuse and dual diagnosis.

2.10 Current SPS policy around prescribing recommends that a move away from detoxification and towards stabilisation and maintenance happens as a matter of priority.

2.11 SPS routinely conducts Critical Incident Group Reviews in respect of drug-related deaths soon after release. This process enables 'lessons learned' to be identified in relation to systems, processes and practice and recommendations for improvement are put in place. The drug death analysis reports and relevant information are shared with key stakeholders including the National Forum, Scottish Government and ADATs.

## **Progress**

***There should be more support and overdose awareness training for short term prisoners, i.e. those on remand or serving sentences below 31 days.***

2.12 All prisoners whether remand or convicted and regardless of sentence length, attend the HRAS within five days of admission. This session currently includes a brief introduction to overdose awareness, Blood Borne Virus (BBV) risks and how to access services within the local establishment. A revised and updated session in conjunction with SDF was piloted successfully in HMP Barlinnie at the beginning of 2009 and will replace the current session across the prison estate. The new session will have a greater focus on overdose and the most appropriate ways of dealing with one.

2.13 SPS is an active member of the Glasgow 'Preventing Risk of Overdose in the Vulnerable' group and takes part in all their seasonal campaigns. The Glasgow campaign was aimed at those at risk in Glasgow, however, SPS made their materials available to all prisoners throughout Scotland.

***SPS consider revising access criteria for pre-release to prisoners serving 31 days or more.***

2.14 Pre-release sessions continue to be offered to all prisoners, both remand and convicted, who will be in custody for 31 days or more. The session will also be revised to incorporate a new film made by an ex-prisoner about overdose and include basic first-aid training for prisoners.

***There is consistent policy, implementation and practice regarding delivery of overdose awareness sessions, prescribing practice and detoxification across the prison service nationally.***

2.15 Delivery of services continues to remain consistent across all SPS establishments. There are standards and assurance processes in place to ensure consistency and the first intake of SPS doctors and nurses to the RCGP, part 2 Certificate in the Management of Substance Misuse are nearing completion of their training. SPS and the RCGP have also developed a new two-day module on Management of Substance Misuse in Secure Environments. This course is aimed at a range of new and existing staff within SPS.

2.16 Prescribing within SPS is consistent with *Drug Misuse and Dependence: UK Guidelines on Clinical Management*.

**Additional initiatives:**

- Scottish Ministers have agreed to NHS provision of health care for prisoners. The process of transferring services from SPS provision to NHS provision is expected to take three to five years.
- HMP Edinburgh has recently concluded an Integrated Addiction Process pilot which involves automatic access to addiction support services for those prisoners on substitute prescribing to provide more than just a prescription. Evaluation of this pilot continues.
- SPS collates drug-related death statistics which results in a case file analysis for all ex-prisoner deaths within two months of liberation (previously this was within six months).
- N-ALIVE is a randomised control trial of the provision of naloxone (the heroin antidote) to 'at-risk' prisoners leaving custody. The trial is being funded by the Medical Research Council (MRC) and is subject to a decision on additional funding being secured to employ staff within the prison service. If successful in securing the additional funding, the trial will take place in prisons across England and Wales as well in Scotland. The trial is expected to run a maximum of seven years.

**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 and Lanarkshire into other areas. This recommendation is made with the understanding that any pilot is rigorously evaluated to prove effectiveness.***

## **Scottish Government Response**

2.17 It will be sometime before the real impact of naloxone provision can be determined. We will be looking at the evaluation of the pilot studies which have taken place within Glasgow and Lanarkshire with interest.

2.18 Local planners should consider the findings from the evaluations and decide if naloxone is an intervention they would wish to adopt in their area to prevent fatalities. Before any roll-out of the programme a thorough training programme would have to be in place which covered the use of naloxone and overdose awareness, such as the training programme devised for the Glasgow pilot. Naloxone should not be distributed without such a training programme being in place first.

2.19 Rigorous follow-up procedures should be in place to test the effectiveness of naloxone in reducing drug-related deaths.

## **Progress**

2.20 Following two successful pilots in Glasgow and Lanarkshire both areas are now extending their naloxone provision. In addition, other areas across Scotland are now considering naloxone introduction.

2.21 For example, Fife will employ an overdose co-ordinator, initially for one year, who will start preparing an overarching strategy and implementation programme on all aspects of overdose including naloxone implementation.

2.22 In Highland, they have studied the results of the Glasgow and Lanarkshire trials and would like to carry out a similar trial. This follows a number of drug-related deaths in the area, which may well have been reduced if there had been some basic overdose training for users, or naloxone had been available.

2.23 Dumfries and Galloway is also considering a pilot and other areas are intending to discuss the need for naloxone provision at meetings in 2009.

2.24 Several police custody suites throughout Scotland now have naloxone available to staff who are trained in its use. In addition, police custody suites have started to integrate NHS staff, nurses and doctors into their structures to care for those in police custody and this is seen as a positive step for the safety and care of custodies in the longer term.

## **Recommendation 4: Research**

***The Forum believes 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 recommends 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.***

### **Scottish Government Response**

2.25 The Scottish Advisory Committee on Drug Misuse (SACDM) Evidence Sub-Group will consider a range of research topics and deliver a more systematic and co-ordinated approach for feeding the evidence base into national and local policy making and practice and for identifying gaps.

2.26 Dissemination of the evidence will be key to ensuring that the research and good practice that flows from the evidence group is used to its best advantage. Improving the evidence base on reducing drug-related deaths will undoubtedly form part of the group's remit.

### **Progress**

2.27 Two research projects were funded during 2008. The first, mentioned earlier in this report, looked at *Reducing Drug User's Risk of Overdose*<sup>8</sup>. It examined how to increase the number of those who witnessed a drug overdose calling for help quickly and considered measures that could be effective in preventing death from overdose while help is on its way. The key findings of the report published on 3 November 2008 were:

- The presence of overdose witnesses attempting resuscitation techniques plays a crucial role in preventing overdose deaths. There is a need to provide likely witnesses (peers, family and friends) with information and training on prevention strategies including the need to remain with the casualty.
- Overdose witnesses are willing to intervene although barriers may exist to calling emergency services promptly. The perception and fear of repercussion, especially if children are present, is a key barrier. Drug users, peers and family members need a clear understanding of current policy on police attendance at overdose events.

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<sup>8</sup> Reducing Drug User's Risk of Overdose:  
<http://www.scotland.gov.uk/Resource/Doc/243164/0067668.pdf>

- Those users who present at hospital with opiate overdose may have unmet health and social care needs. There is a need to develop integrated care pathways for the management of opiate overdose.
- Overdose awareness training should be made available to emergency service staff, clinical staff and service professionals including prevention and management of overdose and harm reduction principles.
- Given the current limited opportunity for reducing the risk of overdose for users who are not ready to engage in structured treatment modalities, patients admitted to hospital following an opiate overdose should be routinely provided with written information on overdose prevention and details of local drug and harm reduction services.
- The Scottish Government and NHS Boards should develop an information system that accurately collects and collates information on fatal and non-fatal overdose to inform local service planning processes. This should include information on overdose related calls, ambulance attendances and A&E activity.
- The progressive disease burden of heroin use increases susceptibility to overdose as users get older. Regular health screening of problem drug users may be beneficial, including targeting high risk users such as harmful dependent drinkers and/or users who experience moderate to severe depression and suicidal ideation.

2.28 The second piece of research, Senior Drug Dependents and Care Structures (SDDCare), which has been commissioned by the EU and partly funded by the Scottish Government, is covered in the Government response to recommendation 8 of the 2007 report. Funding will continue into 2009-10. The final report is expected in 2011. Findings from this report and the one from Figure 8 will feed into the Forum's deliberations in the future.

2.29 Glasgow Addiction Service is commissioning research into drug deaths which occur after injecting in public places (10% of cases where this happens are in the Glasgow City area).

2.30 The Scottish Government National Drug Evidence Group agree that drug-related deaths are a high priority area which must be investigated as part of the evidence review programme currently being commissioned to support their work.

## **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 Alcohol and Drug Action Teams (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.***

### **Scottish Government Response**

2.31 Some local Choose Life areas report engagement with Alcohol and Drugs Action Teams (ADATs) and substance misuse agencies about suicide prevention – there was a pan-Ayrshire conference in Suicide Prevention Week last year – and there is some work being done with Scottish Training on Drugs and Alcohol (STRADA) to see how Choose Life can incorporate ASIST (suicide prevention) training into their programmes (or at least promoting the training to substance misuse networks) and tailoring such courses to drug/alcohol related situations. Other local work includes providing suicide prevention training to frontline staff who are most likely to come into contact with substance misusers who may be suicidal – especially at the more chaotic end of the scale.

2.32 The recommendations in the National Forum report are designed to enlist greater ADAT engagement in the area of suicide prevention and highlight suicide prevention as a cross cutting area particularly in the reduction of drug-related deaths – intentional self-harm and undetermined deaths are included as part of the overall suicide deaths by the General Register of Suicides. Viewing suicide prevention as part of the ethos of reducing drug-related harm is perhaps a helpful way to illustrate this. It also underlines that substance misuse staff are key gatekeepers for drug users who are at increased risk of suicide.



2.33 The recommendation in the report about mental health simply highlights the needs for continued and expanded understanding, training, policy and service developments around dual diagnosis whereby substance misuse staff have a working knowledge of mental health issues and vice-versa for mental health staff. Prevention of suicide is only part of this – but the ability to work with and respond appropriately to presenting mental health issues by substance misusers can only have a positive impact in preventing suicide – particularly in response to crisis.

2.34 Choose Life anticipate that suicide prevention becomes part of local substance misuse strategies thereby mainstreaming suicide prevention across key policy areas. This may also enhance take-up of suicide prevention from the menu of local Single Outcome Agreements (SOAs). Meantime, Choose Life will be working to ensure the capacity for training and other supports are in place to facilitate take-up of suicide prevention activity across the substance misuse sector.

## **Progress**

2.35 Capacity building with ADATs through provision of suicide prevention and awareness training has continued to develop over the past year. Growing links between ADATs and Choose Life groups recognise that substance misuse staff are key gatekeepers for drug users who are at risk of suicide. Suicide prevention training skills training appears an increasing priority for many ADATs, with the *National Confidential Inquiry into Suicide and Homicide: Lessons for Mental Health Care in Scotland*<sup>9</sup> (University of Manchester, 2008) providing further evidence of substance misuse as a key determinant of suicide in Scotland.

2.36 ADATs and Choose Life groups have joint memberships and are increasingly linked to wider mental health improvement and well-being structures. For example, the Choose Life co-ordinator in Shetland is also the Alcohol and Drug Development Officer and sits on both the ADAT and the strategic Mental Health Partnership group.

2.37 A consistent approach to joined-up working is required across Scotland and should be encouraged by all ADATs. This will be supported by considerable investment in suicide prevention training at national as well as local level. Scotland now has 400+ trainers to support both local training efforts. Access to 'training for trainers' courses for addictions staff will be encouraged, in order to disseminate suicide prevention training into all substance misuse service training.

2.38 In Glasgow they have developed clearer service pathways for individuals with mild to moderate mental health problems whom they believe to be at a significant risk of self-harm, suicide and non-accidental drug-related deaths.

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<sup>9</sup> <http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/>

## **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.***

### **Scottish Government Response**

2.39 The Drug Misuse and Dependence: UK Guidelines on Clinical Management – sometimes known as ‘the Orange Book’ – are based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most instances. They emphasise the need for both pharmacological and psychosocial treatments for people with problem drug use, with individual care plans and co-ordination of care across professional groups, including health and social care. The Government strongly supports these Guidelines as the basis on which clinicians and other professionals should consider the treatment of patients with drug misuse problems.

2.40 Scotland's Chief Medical Officer (CMO), Dr Harry Burns, has made it clear that he expects NHS Boards to discuss with local service providers how the guidelines will be implemented by practitioners at local level. There is a clear expectation that the guidelines will be adopted as good practice by treatment providers as a means to achieve optimal outcomes for drug users and their families.

2.41 We developed National Quality Standards for Substance Misuse Services to highlight the necessity of addressing all client’s needs through partnership working and having clear exit strategies.

2.42 The Government accepts that long waits for treatment are unacceptable. Access to effective treatment and rehabilitation is critical to the long-term goal of recovery from drug misuse, and it is clear that services need to improve. The Government have already written to ADATs pointing out the importance of improving access to treatment and the need to make progress in this area.

2.43 The Government are determined to have the right structures in place to tackle drug misuse effectively. As part of their new drugs strategy, they are reforming local structures to improve the range, access to and quality of drug services delivered locally and to hold local partners more strongly accountable to the Government.

## **Progress**

2.44 Following the CMO's commitment to follow-up with local areas on the expectation that they would all adopt the UK Guidelines as good practice, an audit on compliance has been carried out to ensure that this has happened at local level. From this we are able to confirm that all areas of Scotland are operating within the UK Guidelines. Some examples of responses are:

- **Borders** – Community Addiction Team (CAT) are using the clinical guidelines in their daily practice and have updated their operational policy document to take account of them. They are providing the vast majority of substitute prescriptions for the Borders and are adhering to best practice as recommended in the guidelines. They also set up a monthly education meeting for the team and clinical governance issues are to the forefront.
- **Forth Valley** – the newly developed Forth Valley Substance Use Strategy has used the guidelines as the basis for best practice in the clinical management of illegal substance misuse. In addition, in discussion with local services they confirmed that within their Community Alcohol and Drug Service their treatments comply with the UK Guidelines. The local MAT and BAT (methadone and buprenorphine assisted treatment) guidelines are based on the UK Guidelines.
- **Lanarkshire** – alcohol and drugs services in NHS Lanarkshire are provided within the framework of the revised 2007 *UK Guidelines* (Orange Book). Their prescribers, including psychiatrists, GPs with Special Interest (GPwSI), and pharmacist prescribers, adhere to the guidelines in relation to pharmacological interventions. Similarly, staff within the various addiction teams work to an operational policy that reflects the essential elements of treatment provision inherent in the guidelines. Within the Clinical Leadership Group for Addictions, their Clinical Governance sub-group has been developing policies, protocols, and guidelines for best practice. This includes not only

pharmacological interventions, but extends to the wider, essential-care services such as psychosocial interventions.

- **Shetland** – has been working with their local providers on the national guidelines for some time, in fact they piloted them with their local Community Drug and Alcohol service along with the National Quality Standards and performance reporting last year. Though they only have community services in Shetland and commission any residential services off island, so there are limited applications for the guidelines in some areas, they continue to work with local providers on the national standards and their local ADAT continue to monitor local services compliance.
- **Tayside** – the clinical lead for substance misuse services, who was also the lead for Scotland on the UK Guidelines development group, has confirmed that local practice standards are in line with those contained in that document. The East Central Scotland Addiction Services Managed Care Network also produced a detailed response to the consultation on the guidelines, involving all key clinical staff.

2.45 For the first time the Scottish Government has adopted a national Health, Efficiency, Access and Treatment (HEAT) target that will offer those with drug problems faster access to a range of appropriate drug services to support their recovery. During 2009-10 the Government will work with NHS Boards and other partners to improve the quality of data and set targets. A clear target for shortening the length of time those with drug problems have to wait will be set in 2010-11. In Grampian they are building a new wraparound treatment centre in Aberdeen. Although it will take time to develop, this initiative should go some way to easing waiting times in the Aberdeen area and across Grampian as a whole.

2.46 The joint Scottish Advisory Committee on Drug Misuse (SACDM) and Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) Delivery Reform Group was established to develop proposals around the future of alcohol and drug delivery arrangements. The Group recently concluded its work and submitted its report to Ministers. The Scottish Government, CoSLA and NHS Scotland considered the report in advance of issuing a joint statement on 20 April 2009, that set out an agreed national delivery framework, the aim of which is to promote consistently effective arrangements across Scotland and ultimately ensure better outcomes for service users.

2.47 This framework outlines a set of arrangements which encompasses not only community planning partners but also makes clear the role and responsibility of the Scottish Government. As well as providing record levels of resource there are a number of ways in which Scottish Government will be supporting the framework's delivery and developing an environment that ensures effective investment decisions are made. Scottish Government will:

- strengthen efforts to promote the use of the National Quality Standards for Substance Misuse Services published in 2006, which clearly outline national minimum standards that should apply to the quality of services across the country;
- work with partners to develop or update frameworks outlining essential services on alcohol and drugs; and
- examine the scope for extending the HEAT target for access to drugs services to cover alcohol services too, providing the same minimum standards for access across the country.

2.48 Scottish Government will also recruit a group of national co-ordinators with a background in delivery to help local partners and partnerships meet the challenges presented in this new framework.

2.49 This team will make an important contribution to improving the quality, range and standards of service planning, commissioning and information exchange across the country.

### **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.***

### **Scottish Government Response**

2.50 Local authorities have a duty to ensure that all looked after children and young people have a care plan. This care plan should fully reflect all health care needs and in drawing up the plan the authority should ensure that the child is provided with adequate health care.

2.51 The publication *Looked After Children and Young People: We Can and Must Do Better*<sup>10</sup>, recognised that life outcomes for looked after children and young people need to be improved. A key theme of this Action Plan centres around *being emotionally, mentally and physically healthy* and this theme has action points aimed at ensuring looked after children and young people have access to a range of appropriate services designed to meet their emotional, mental and physical needs.

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<sup>10</sup> *Looked After Children and Young People: We Can and Must Do Better* Scottish Government January 2007  
<http://www.scotland.gov.uk/Publications/2007/01/15084446/0>

## Progress

2.52 In September 2008, Scottish Government published *These Are Our Bairns – guidance for community planning partnerships on how to be a good corporate parent*<sup>11</sup>. 'Corporate parenting' refers to the collective responsibility that councils and their partner agencies have under the Children (Scotland) Act 1995 for looked after children and young people and care leavers. This guidance, combined with other resources emanating from the actions contained in *Looked After Children and Young People: We Can and Must Do Better*, such as multi-agency training materials, emphasises the need for all services and individuals working with and for 'Looked After' children and young people and care leavers to work together in a child-centred way. The guidance demonstrates how we can ensure that young people in care receive the support and guidance that they need to live full and healthy lives and that support should continue when they leave care, just as young people in conventional families continue to receive the support they need from their parents.

2.53 The Council as a 'corporate parent' must work with members of the extended 'corporate family', such as health and voluntary sector services, to make sure that all the young person's needs are identified and met in an appropriate way which reflects their individual needs and circumstances. Every young person leaving care should be prepared for independence through the Pathways Planning<sup>12</sup> process and the assessment of their individual needs should include an assessment of their need for drug-related services, with an appropriate plan to meet those needs. Not all care leavers will need those services, although we acknowledge that these young people are more likely than their peers, who have not been in care, to need them.

2.54 Advice to health boards supplementing the messages in *These Are Our Bairns* is due to be issued shortly. That advice describes health services' responsibilities and sets out actions which will help them to be able to identify 'Looked After' children and young people and care leavers and to take their needs into account when designing and delivering services. This applies to specialist services such as substance misuse, sexual health and mental health as well as universal health services. Following consultation, the Looked After Children (Scotland) Regulations 2008 are being reviewed. The revised regulations will

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<sup>11</sup> *These are our Bairns: A guide for community planning partnerships on being a good corporate parent*: Scottish Government. (September 2008)  
<http://www.scotland.gov.uk/Publications/2008/08/29115839/0>

<sup>12</sup> Pathways Planning: The plan is drawn up prior to leaving care and looks at accommodation, health, education/employment, training, personal support, financial support and leisure.

underscore the statutory duties of agencies such as health boards to identify and meet all aspects of a young person's needs.

2.55 The 'corporate family' approach sets specific services such as health within the context of a more holistic, integrated approach to improving outcomes for 'Looked After' children and young people and care leavers, and the guidance reflects the Scottish Government's commitment to early intervention and prevention, i.e. by giving a child the best possible start in life, with as much family support as is required, fewer children will find themselves at risk of involvement in risk-taking behaviour such as drugs misuse. For those who do find themselves in that situation work to improve the 'corporate parenting' experience aims to reduce the likelihood of young people continuing or escalating their risk-taking behaviour by making sure they have the opportunities, skills and support to live healthy, happy and responsible lives.

### **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, for example, 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 here. The Joseph Rowntree Foundation (JRF) report should be considered carefully by service commissioners in Scotland.***

***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.***

### **Scottish Government Response**

2.56 The Scottish Government accepts that there is a need to look at innovative projects that help people to get drug free for good. We have already commissioned research to look at services who are producing better outcomes for homeless substance misusers. Research looks at the links between homelessness and substance misuse to identify the models of service available for people who are homeless and have problem drug

or alcohol use. The research is expected to report in the summer of 2008 and findings will be widely disseminated to service commissioners.

2.57 We are also part funding a Scottish Drugs Forum European project that will explore and monitor the situation of senior drug dependents in different age brackets and by gender (starting at age 35 up to 70 and older) in partner countries in Europe (Scotland, Germany, Austria and Poland). The Senior Drug Dependents and Care Structures (SDDCare) project will, via re-analysing existing data sets on a European level, on a national level and at community level (of the partner cities), look at the older users mental and physical health status (including chronic infectious diseases such as HCV-infections, HIV etc.), their life circumstances and their social networks, their accommodations and their needs of care and treatment. The project is expected to report in 2011.

2.58 We are also already funding a number of innovative pilot projects. One of those is FV-Tox in Forth Valley. The overall aim of FV-TOX is to provide a structured, standardised, evidence-based care package to help clients dependent on opiates who seek to become abstinent. The programme gives people support through the effects of detoxification, encourages lifestyle and behaviour change and aims to improve their health and well-being, their family relationships and access to employment and training.

2.59 The Government however, does not support the need for drug consumption rooms. There are legal and ethical issues around their introduction that cannot be resolved easily. The Misuse of Drugs Act 1971 makes it an offence to allow the use of drugs on premises. We have no plans to introduce consumption rooms in Scotland.

## **Progress**

2.60 SDF is taking forward the SDDCare research that is referred to earlier under recommendation 4. Scottish Government are closely monitoring progress and are represented on the European Governmental Advisory Board. A second meeting of the group was held in January 2009. Progress continues to be made on data collection and the legal framework of the participating countries. The next stage of the project will be to undertake a survey of workers and older drug users. SDF will survey workers who have specific knowledge or understanding of the needs of older drug users. These surveys across the four partner countries will be used to inform the development of guidelines for good practice. In addition, a Scottish conference on older drug users is to be held with a European conference next June in Frankfurt at the conclusion of the project.

2.61 In Forth Valley, FV-TOX, a front line detoxification service, was funded by the Scottish Government in September 2006. It was one of five projects funded across Scotland to deliver a 'different model of treatment'



from what was previously available. The aim of the service is to work with individuals addicted to opiates at an earlier stage and offer something different. The ethos of the service is that by providing a structured programme with an intense level of support, individuals could address their addiction. An independent evaluation of the service has been carried out and the report will be published in the near future. In light of a positive evaluation the service will continue to be delivered as part of a range of options for treatment in Forth Valley.

## **Recommendation 9: Data Collection**

***Drawing from the SACDM report and recommendations (2005), and after discussions with ADATs, the GROS, the SCDEA and NHS Services Scotland, 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 Ministers, the National Forum, the media and the public.***

## **Scottish Government Response**

2.62 We have taken forward this recommendation as a matter of urgency and fully agree that this work should be taken forward. Discussions have already taken place with NHS Scotland, Information Services Division (ISD) and ADATs to develop a standard national database for the collection of detailed information on drug-related deaths.

2.63 The database will cross link with existing ISD datasets to give a picture of the drug user's life prior to death which, following analysis, will assist in identifying interventions that may prevent deaths in the future. ISD will provide the analysis to the National Forum and local ADATs to help future planning.

2.64 As mentioned in the introduction a sub-group of the Forum has also redesigned the form used by pathologists to gather information for GROS, which they use to produce annual National Statistics on drug deaths in Scotland.

2.65 We also recognise the need to look closer at those people who are classed as 'near misses', i.e. those who go into overdose but recover or are brought round by the intervention of others. The Forum report pointed out opportunities for intervention at A&E departments and by ambulance crews. We will work with the Forum to look at addressing ways of utilising these points of contact to their best advantage.

## **Progress**

2.66 The Scottish Government launched a national drug-related deaths database on 1 January 2009. The Forum worked closely with the Scottish Government, ADATs and NHS Scotland, ISD to develop the database which will look at the circumstances of each individual death to help us understand why people are dying, rather than simply counting numbers, so that local partners can put in place interventions to help prevent deaths in the future.

2.67 The database has already been piloted successfully in Lanarkshire, Ayrshire and Arran and Dumfries and Galloway and this has been particularly helpful in resolving operational barriers in relation to the data collection.

2.68 The database will gather personal details about the drug user including information on their drug taking history; where they were living and who with (including children); whether they were known to services or were on waiting lists; what drugs were found at the scene of their death and in their toxicology; whether they were on methadone or other drugs and whether the drugs were prescribed to them or not.

2.69 The database will be hosted by ISD. Information is being collected locally by ADATs or another nominated person at a local level on an Excel spreadsheet and submitted to ISD. ISD will analyse the data on a regular basis to give a national picture and local ADATs will be able to receive reports to help them identify any trends or patterns in their area.

2.70 Once the database has been up and running for a while it will be cross-referenced with other ISD data sources such as those on Hospital Discharges (SMR01), Psychiatric Discharges (SMR04) and the Scottish Drug Misuse Database (SMR25a). This will be a unique opportunity to look at all hospital, psychiatric and treatment incidents prior to death.

## **New Data Collected by the Scottish Ambulance Service on Non-fatal Overdoses**

2.71 Up until September 2007 the Scottish Ambulance Service (SAS) used entirely paper Patient Report Forms (PRFs), which numbered around quarter of a million per year for Glasgow and Lanarkshire Division alone.

2.72 Upon examination it was discovered what appeared to be repetitive non-fatal near misses involving possible controlled substances.

2.73 It was felt a new electronic PRF (ePRF) would be able to generate reports so that individual areas/Divisions could take appropriate action in relation to those patients who may only surface on the 'drug support radar' systems once they had died.

2.74 In the autumn of 2008 the SAS started to download the report screen onto the ePRF to allow crews to record, for example, where they had attended a suspected heroin overdose, where the patient after successful resuscitation had refused to go to hospital. This is important because if no criminality takes place, i.e. the crew are not assaulted or threatened, then they do not routinely request the police. It is also important as many of these 999 calls are not communicated initially as a potential overdose, but as a collapse commonly.

2.75 The text from the bulletin advising crews of the update is as follows:

*Substances Report – this is an option on the PRF Review screen. It should be used whenever a particular substance (alcohol and recreational drugs) has been taken in sufficient quantity/timescale to cause physiological changes to vital signs, and may be/become a factor in the on-going treatment of the patient. It is not intended (and will not be used) as an indicator of illegality or drug abuse. It is a clinical tool only.*

2.76 At the moment the reports are not in sufficient quantity to run. This is something the SAS are currently working on.

2.77 The intention is to be able to identify where a person was a risk to themselves and be able to, with permission, pass their details onto an agency who could offer help and support to save their life.

### **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.***

## **Scottish Government Response**

2.78 There is material already available on drug overdose which centres around recognising the signs of overdose and what to do in the event of it happening. However, the Government accepts there is a need to develop more targeted material and will work with the Forum in identifying ways of doing that.

2.79 Future work may focus on the dangers of drug taking and alcohol consumption, poly-drug misuse, drug injecting or the development of material for 'older drug users', who make up the majority of the population of drug deaths, to highlight the dangers they face and the need for general health care within this group.

2.80 A new national drug misuse interactive website (<http://www.scotland.gov.uk/topics/justice/drugs-strategy>) has been developed which has a dedicated area that focuses on drug deaths. We will use this area to highlight dangers like those mentioned above, to champion innovative practices, report on new research and keep others up-to-date with any developments.

2.81 We will continue to produce the newsletter 'Drug Death Matters' as another means of raising awareness of issues and for reporting the excellent work of the Forum.

## **Progress**

2.82 The Government has been working with SDF and other key interests to develop new awareness raising materials on drug overdose. These include a pocket-sized wallet with information on the risks and signs of overdose and what to do in an emergency and a booklet which goes into the issues in more detail. They will be issued to drug services, families, libraries, police drug awareness officers and homeless services across Scotland by summer 2009. Further copies can be obtained by calling 0131 244 5051.

### **3. SERVICE USER FORUM**

3.1 The Service User Forum was set up to ensure that service users were given the opportunity to provide advice on issues relating to drug-related deaths. Representatives provide feedback to the National Forum and are represented in their own right on the group. This also provides service users the opportunity to feed into government policy. The group met on five occasions at locations across Scotland.

3.2 There have been presentations on a number of issues throughout the year which have been informative and produced lively discussion and debate. A short summary of each of the presentations follows:

#### **Working Together to Reduce Drugs Overdose and Death – Presentation by Bill Mason, Scottish Ambulance Service with support from Willie MacColl, Scottish Crime and Drug Enforcement Agency (SCDEA) – 29 April 2008**

3.3 The purpose of the presentation was to explain the Memorandum of Understanding (MOU) between the police and ambulance service. This is an agreement between the services on situations where police may be called to attend an overdose incident.

3.4 Various scenarios were presented where the police would attend at an emergency call. These included:

- emergency call where drug misuse is associated with domestic violence or vulnerable children are identified;
- where there were repeat calls to same person or location for drug misuse; where the user is vulnerable or socially excluded e.g. homeless, mentally ill, has reduced capacity or no health care provider; and
- where the crew are at risk through previous violence, dangerous situation or non co-operation.

3.5 It was emphasised that the police priority is always the preservation of life.

3.6 Bill Mason explained how the MOU was developed from what was seen as the UK best practice to prevent drug deaths. It came from a recommendation from the SACDM. It was accepted by Scottish Ministers and has been in place for over five years with annual reviews. It complies with the Data Protection Act 1998 and with information sharing between NHS Scotland and the police.

3.7 Bill Mason went on to explain it was an information sharing MOU which built on what was already known. It was shared between control centres. Specific training was provided and monitoring and liaison arrangements were in place. All this was done for one reason – to save lives!

3.8 In summarising, Bill Mason explained that the police and ambulance were services in the front line. The management of any incident was not without risk and overdoses invariably involve vulnerable individuals who are at serious risk of dying. There was direct contact with 'patients' who may not come to the attention of other agencies. There was a need for the ambulance service to be seen as independent and helping, caring for the family, user and friends. A service which works within the law and follows good practice and finally a service that looks at avenues for patient disposal and interventions that may not currently exist.

***What needs to happen now?***

The service users felt there was a need for further action as follows:

- There was a need for an information leaflet to be developed for the ambulance service for those who refuse treatment.
- Better first-aid training for the police to include information about drug overdoses and the factors that discourage early contact with emergency services.
- Specific advertising campaigns to reinforce the fact the police are primarily interested in the preservation of life.

**Proceeds of Crime Act – CashBack for Communities – Presentation from Billy McKenzie, Scottish Government Community Safety Unit – 1 July 2008**

3.9 The fundamental point of CashBack for Communities is to use the proceeds of crime to improve the lives of Scotland's young people through the provision of a wide-ranging programme of fun, healthy and creative activity. CashBack has built a solid foundation for future success. The more young people we help achieve their potential, the fewer will be committing crime. Responsible young people do not behave criminally.

3.10 This is built even more clearly into the programme through the focus of activity in areas where crime and anti-social behaviour are a particular problem, and therefore where young people are at particular

risk of being a victim and a perpetrator. CashBack activity is intended to mitigate that risk through diversion and intervention.

### 3.11 The story so far:

- 'CashBack for Communities' scheme launched on 11 January 2007 with an announcement on a ground-breaking partnership with the Scottish Football Association (SFA) through which more than 30,000 young people across Scotland will be offered free football coaching and playing opportunities.
- On 15 February 2007, there was an announcement of a £3 million grant scheme which will be administered by YouthLink Scotland to fund a wide range of youth projects for young people in every local authority area in Scotland. The application process closed with bids for over £12m received.
- On 18 April 2007, an announcement that over £1.4 million seized from criminals would be used to provide free rugby coaching and playing activities for over 32,000 young people throughout the country by 2011.
- On 15 May 2007, an announcement that £600,000, matched by £600,000 of private sector investment, will go to the 'CashBack for Communities Arts and Business Match Fund' to support increased cultural activities for vulnerable youngsters.
- Early 2008, announcement that £400,000 is to be reinvested in each of the next three years to build further capacity in the legal recovery process to help maximise disruption of criminal networks.

### **Substitute prescribing within the Scottish Prison Service – Presentation by James Taylor, Scottish Prison Service and N-ALIVE, Randomised Control Trial by Stephen Heller-Murphy, Scottish Prison Service, 13 August 2008**

3.12 James Taylor explained that he is the co-ordinator for mental health and suicides in prisons and is also responsible for drafting mental health policy in the SPS. His presentation was an informal discussion on emergency medical health responses and processes and on how healthcare has operated in prisons over the last 13 years.

3.13 The prison healthcare service was similar to the primary healthcare service in GP practices, albeit the majority of services are nurse led. There were around 200 nurses across the SPS with half a dozen health staff in each prison. GP's surgeries in prisons vary and can be as little as 2 hours per day. Each prison has an addiction and mental health area.

Prisons do not have health night staff (apart from HMP Barlinnie) but they do have first-aid trained staff who can deal with emergencies or if a prisoner is unwell. Some prisons also have mental health first-aid staff. The health centre is usually the first point of contact if a prisoner takes ill, however, overnight it is an on-call GP, with prison custody staff able to provide first-aid. It is not uncommon for a recommendation being made by the GP to send the prisoner to hospital. The prison healthcare is distinct from NHS, however, it is likely that they will integrate in the next couple of years.

3.14 The following questions were asked by service users and answered by James Taylor:

*Q. Are prisoners prescribed methadone?*

Yes, to maintain the methadone programme the doctor will liaise with a prescriber before deciding to keep prescribing. Stopping and starting prescription is for the person's safety. Doctors, across Scotland, can have different opinions on the prescribing of methadone, however, the SPS has a specific healthcare standard for the delivery of addiction services and substitute prescribing.

*Q. Do prisoners get their medication stopped as punishment?*

Policy does not allow medication to be stopped to punish prisoners.

*Q. If a GP gets a dirty sample from a prisoner are they taken off methadone?*

This used to happen in the past but should not happen routinely now.

3.15 With regards to suicide risk management James Taylor said that SPS has direct working relationships with a number of voluntary organisations, many of whom contribute to the development and delivery of its national strategy.

3.16 James Taylor reported that there are around 10 suicides a year in prisons which is significantly less than it had been 10 years ago, and that there are anecdotal suggestions that being in prison lessens the chances of completing suicide as compared to someone attempting this in the community. In the last five years there have been no female suicide deaths.

3.17 James Taylor explained about the emergency healthcare response policy, commonly called the 'code red/code blue' process. This is a standardised process in every prison. 'Code blue' is called for an emergency where someone has stopped or has restricted breathing and



'code red' is for significant blood loss, irrespective of cause. There is also a local contingency process in each establishment for accessing emergency ambulance services.

### **Stephen Heller-Murphy**

3.18 Stephen Heller-Murphy, Addiction Development Officer in the SPS provided information on a proposed national trial of naloxone for prisoners on release entitled, N-ALIVE.

3.19 Naloxone is an antidote to heroin. If someone overdoses, naloxone will stop the overdose for around 20 minutes, which should be enough time for emergency services to arrive. SPS already provides harm reduction awareness around overdose risk but SPS are in the process of improving this session as well as including information about naloxone.

3.20 Stephen explained that the trial will involve 14 prisons in England and Wales and 11 in Scotland. N-ALIVE is designed as a double-blind trial, which means neither the nurse issuing the naloxone pack for the prisoner or the research team are aware whether they are in the naloxone or the control arm of the study.

3.21 Fifty per cent of prisoners who are at risk of overdose will be randomised to receive naloxone and 50% will be in the control group and will receive a dummy pack. The prisoner will not know whether they have been issued with naloxone until they open the pack after release.

3.22 The research team will compare the national drug-related death statistics for the prisoners who received naloxone to those who were in the control group. In order to show a significant difference the trial needs to recruit thousands of prisoners, which is why it will run for 5 years or so after a two-year pilot phase. The full research trial is funded by the Medical Research Council (MRC). The Scottish part of the trial is due to start in the summer of 2009 although this is dependent on staff costs being met from other sources and the trial getting multi-centre research ethics approval. The outcome of the trial will be a definitive answer to the question of whether this intervention is effective in this population group.

### **Service User Group Contribution to Government Policy**

3.23 The group met with the Scottish Government in the development of the drugs strategy – *The Road to Recovery* – in order to input their views. Representatives also attended the launch event in Edinburgh on 29 May 2008. Some members contributed to the publication of a compilation of 'recovery' stories entitled – *Journeys to Recovery* – which were published alongside the drugs strategy.

### ***Overdose: Bereavement, What Happens Now?***

3.24 A major piece of work undertaken by the service users was the production of a booklet to help the bereaved cope with the aftermath of a drug-related death. The group felt that there was no appropriate information booklet available for those who had lost a loved one to drugs that gave information on what happened after a death that was drug-related. The group developed a bereavement booklet which would address this. The booklet was published in December 2008 and disseminated widely. The booklet will also be distributed by police family liaison officers in the event of a drug death. A PDF of the booklet can be found at <http://www.scotland.gov.uk/Resource/Doc/259247/0076870.pdf> or copies can be obtained by phoning 0131 244 5051.

### **Service User's Training and Development Away Day**

3.25 The service users attended a training and development away day on 6 February 2009. Graphic recording was used to capture the views of service users on how they could go forward and develop as a group, influence Government policies and make an impact and also share their vision for the future.

3.26 Since this meeting the service users have, with assistance from SDF, gone on to manage their own meetings, setting their own agendas, chairing the meetings and writing up their own reports of proceedings. Two representatives attend each Forum meeting and their views are greatly appreciated by everyone. The insight that is gained from a service user viewpoint is invaluable to the Forum as it is quite unique. The service users are currently developing a programme of work for the coming year which includes overdose awareness training for the group.

#### **4. PRESENTATIONS – WHAT HAVE WE LEARNED?**

4.1 The following are extracts from presentations given to the Forum in the duration of this report.

##### **STRADA Evaluation: Drugs And Alcohol Fatal And Non-Fatal Overdose Training Module – Joy Barlow, Head of STRADA**

4.2 A presentation to the Forum in February 2008 focussed on a small 'snap shot' evaluation of the efficacy and effectiveness of a one-day training module entitled, 'Drugs and Alcohol – Fatal and Non-Fatal Overdose'. The following data are based upon evaluation responses from twenty three courses delivered across Scotland from April 2006 – September 2007.

4.3 The learning objectives of the course covers knowledge of the topic and the necessary statistical data and policy perspectives. They focus on harm reduction advice and information as well as skill-based approaches to responding to an overdose situation. Both managers and frontline practitioners' responses to the training programme were sought, as well as in-depth telephone interviews with ten randomly sampled participants.

4.4 Managers expected, and have evidence of participants' increased confidence, and improved knowledge and awareness of signs and symptoms of overdose risk. Front line practitioners reported a significant degree of success in the achievement of the course's learning objectives, and significant improvement in working with service users in terms of identifying the signs of overdose, risk factors and assessment associated with people who attempt to commit suicide and responding appropriately to this risk. The provision of harm reduction advice was a top priority for respondents and this learning objective had been met.

4.5 The interviews with sampled participants illustrate a number of learning themes:

- identification of risks and risk assessment;
- provision of harm reduction advice;
- responding to emergencies and supportive listening; and
- responding to someone at risk of overdose.

4.6 Increase in confidence is illustrated in this quote:

*".....it's something I'm not afraid to actually approach now with clients.....service users. I have the confidence to talk about it and I have the knowledge to back it up in a lot of ways I just didn't have*

*before. Like.....actually being more confident now about the drugs involved, their effects, and just what to do. It's hard to explain but I just have the confidence now because I have the knowledge and it wasn't there before".*

4.7 The provision of harm reduction advice is illustrated in this quote:

*".....I think it changed my practice because I'm more aware of the need to look at harm reduction from a different perspective than maybe I did before.....actually being ready to put harm reduction measures in place in a way I couldnae have before.....".*

4.8 Whilst the evaluation data provides evidence of increased confidence, awareness and ability to provide harm reduction advice, a number of barriers to putting learning into practice were noted. These include the lack of time to embed learning in practice; high workload and lack of staff resources. Perhaps most importantly there was evidence in the data that for some workers, particularly those in a support role, there was a lack of permission to work with the service user on overdose risk. It might be inferred from this that there is, in some areas, a lack of recognition that working on overdose risk is everyone's job.

### **What did we learn from this presentation?**

Workers in drug services are not being allowed to put their training into practice.

## **The Scottish Network For Families Affected By Drugs (SNFAD) – Eleanor Robertson, Chair**

### **Who is SNFAD?**

4.9 SNFAD is a national charity that is led and managed by a key number of family representatives from across Scotland, some of whom are involved in local organisations that support families of substance users.

4.10 Areas represented include Ayrshire and Arran, Borders, Grampian, Greater Glasgow and Clyde, East. SNFAD also benefits from advisers from the Scottish Association of Alcohol and Drug Action Teams (SAADAT), SDF and Scottish Government.

## **How did SNFAD develop?**

4.11 A national family support conference was held in 2002, where one of the main points raised was the need for family support groups to work together to further the cause of families and carers and also to develop a national helpline offering support and information.

4.12 A steering group of family members and representatives from the then Scottish Executive and the SAADAT worked to develop a structure for a national network. The first management committee was duly elected, made up of family members, at the second national family support conference in 2003. The name for the network was agreed and the constitution was formally adopted.

## **Why does SNFAD exist?**

4.13 SNFAD works with families and family support groups across Scotland that have been affected by drug misuse. These families and family support groups often feel isolated and forgotten. SNFAD brings these families and family support groups together to create a louder voice. This enables them to address issues of concern and to present a cohesive view to policy makers. This is done locally with family support groups to provide information about services and support they can access in their area and to raise awareness of their existence and ensure they are plugged into local decision making.

4.14 SNFAD also works nationally to ensure that families and family support groups can access and feed into government consultations; like the *Looked After Children (Scotland) Regulations 2008*. SNFAD also played a full part in the consultations prior to the publication of the drugs strategy *The Road to Recovery*.

## **Helpline**

4.15 A dedicated helpline for families was identified as a priority and SNFAD launched the national helpline at the end of 2004.

4.16 The helpline has not developed in the way that was envisaged, which was, available 24/7 and answered by volunteers who were family members. Following an evaluation of the helpline a co-ordinator was appointed in February 2009.

4.17 Thanks to the national drugs helpline training programme offered in partnership with Stirling family support services there are now a number of trained volunteers available to answer calls.

## **Developing new family support**

4.18 SNFAD have been working in partnership with SDF to support families to set up their own local family support. Support is based on the 'eight steps in action model for family support groups'. This was developed through work with Quest family support group in the Borders and Out in the Open in Buckie, Fife.

4.19 The programme involves a period of intense facilitation with the core group of family members and a training needs analysis. This allows the development of a tailored training programme to build the capacity of the groups. It is important that the family support group retain the ownership of the development and dictate the timescale to suit and fit their needs.

## **Capacity building**

4.20 This can range from signposting people to other groups or linking them in with their local Council for Voluntary Service (CVS) or ADAT.

4.21 SNFAD provide access to a wide range of training programmes for established family support groups and information on resources. Although, some of the larger well established family support groups have the capacity to provide this internally there are many small family support groups who need this information and support.

## **Networking**

4.22 SNFAD seek and support as many networking opportunities as possible. In the Aberdeenshire area – a networking event brought five groups from the area together. SNFAD recognises that to best support families it must work in partnership and network with other organisations where there are strong links. Families Outside and the Carers Coalition are among the organisations with whom links are being forged.

## **What SNFAD want to achieve**

4.23 By raising the awareness of the effects that someone's substance misuse has on the family, SNFAD wants to make sure that families don't feel they are alone and that they are not isolated. There is a growing recognition that the impact of drug use on the family is equal to that of the substance user and that by supporting families not only do you help the family but, if appropriate the family might want to play a role in the recovery of their loved one.

4.24 SNFAD will garner the views of families from across Scotland and ensure that these are fed to policy makers in local and national settings.

## **What did we learn from this presentation?**

The Forum learned that family groups often feel very isolated and their concerns are frequently forgotten. SNFAD brings these families and family support groups together to create a louder voice.

### **Reducing Drug Users' Risk Of Overdose – Andrew Rome, Director of Research and Consultancy, Figure 8 Consultancy Services Ltd**

4.25 On 9 April 2008, Andrew Rome, Director of Research and Consultancy at Figure 8 Consultancy Services Ltd presented an outline of the work undertaken to date, by Figure 8 and SDF, on a research study commissioned by Scottish Government on how to reduce drug users' risk of overdose. The research methodology for this study included quantitative and qualitative methods to capture the breadth and depth of views across Scotland in relation to drug overdose.

4.26 Implications for practice were drawn from a literature review and the findings used to guide the selection of samples for the qualitative study. Examples of innovative practice aimed at reducing drug users' risk of overdose were collected from ADATs throughout the UK, including overdose training for ambulance staff, drug users and pilot take-home naloxone projects, amongst other initiatives.

4.27 Two thousand five hundred self-completion questionnaires were sent to statutory and voluntary drug services across Scotland for distribution to drug users and family members. A further 1200 questionnaires were sent to Emergency Service Control Room (ESCR) and NHS 24 staff, often the first professional point of contact for witnesses at a drug overdose. In addition, 58 semi-structured interviews with drug users who had witnessed or personally experienced an overdose (or both) and 10 interviews, with family members who had witnessed an overdose, were carried out. An additional 45 interviews were conducted with police, ambulance staff and Accident and Emergency consultants.

4.28 Although response rates to the surveys were lower than anticipated, the findings offered useful insights into people's experiences of opiate overdose and the challenges faced. Drug users and family members expressed the view that there is an element of personal responsibility in preventing overdose situations. They believed that the dangers are clear and well-known and that people should be aware of their own tolerance levels.

4.29 The role of ESCR staff was identified as an important component in the management of an overdose situation providing an element of reassurance and practical support for witnesses. However, half of the ESCR and NHS 24 staff surveyed reported that they had had no specific

training on overdose management and the majority felt they did not have enough resources to manage overdose situations.

4.30 The findings from the interviews with drug users and family members suggested they have good knowledge and awareness of opiate overdoses in terms of risk factors, signs and symptoms, and most showed a willingness to intervene and respond appropriately. Barriers to calling for help included fear of the police and possible repercussions, particularly if children were present. Contact with emergency services was found to be relatively widespread, however, the majority of casualties attended by emergency services were not offered information on safer drug use or local drug services.

4.31 Interviews with emergency service personnel highlighted a range of views regarding the provision of naloxone to drug users in case of overdose. Most agreed that it should be made available, however, some interviewees were concerned that it may be used inappropriately and that other dangers, such as polydrug use, would not be addressed.

4.32 A&E consultants reported that managing opiate overdose is a regular, if not daily, occurrence in many A&E Departments in Scotland. However, identified protocols or Integrated Care Pathways are not routinely used to manage opiate overdose, and the opportunity to engage people in drug treatment is not often acted on by health professionals. In addition, although it was felt that the families of drug users would be receptive to information about overdose and overdose management, such information was not routinely offered or displayed in waiting areas.

4.33 This research study was published on 3 November 2008 and is available to read and download at:

<http://www.scotland.gov.uk/Publications/2008/10/30132711/0>

### **What did we learn from this presentation?**

This was considered to be a very important piece of work which identified key areas of priority with practical recommendations.

### **Governance Implications And Drug Deaths: The Fife Model – Alex Baldacchino, University of Dundee, Clinical Senior Lecturer in Addictions Psychiatry and Consultant Psychiatrist**

4.34 The Scottish Government funded project on analysing the Drug Deaths in Scotland for 2003 conducted by the Centre for Addiction Research and Education Scotland (CARES) highlighted that the information that forms the basis for drug deaths analysis can only be as



good as the data collected by practitioners and clinicians (Zador et al 2005)<sup>13</sup>.

4.35 There was a high level of missing data about any treatment package provided six months prior to these drug deaths. Crucially, information on the presence or otherwise of a dependence syndrome and on alcohol use was given in only three percent of cases. Stimulant and nicotine use was not recorded at all. This was more obvious when identifying the medical and psychiatric history recorded (12%), and blood-borne viral status (17%).

4.36 This study pointed to areas for improved governance, which can help us understand and hopefully prevent drug deaths in Scotland. Fife therefore instigated to spearhead this process by establishing sound and accountable governance processes. These include:

**Clinical:** Information gathering and record keeping processes is recognised as an integral part of good clinical practice. The Fife drug death data collection process forms part of quality outcomes frameworks within the NHS Fife and Fife police.

**Research and evaluation:** A standardised clinical and social circumstances data information sheet was set up, complemented by a detailed medico-legal report. This would provide the necessary framework to introduce the psychological autopsy model technique already in use in suicide and deliberate self-harm studies. The CARES questionnaire was initially used and piloted with all agencies in Fife. A revised version has now been used for last three years with close to 90% returns. This also includes GP summary details. The time between a drug death incident and all information collected into the questionnaire and inputted into a secure Fife drug death database is 10 weeks.

An annual systematic analysis on the basis of the routine and complete information collected and inputted into the database helps to identify quickly the risks and patterns of drug deaths in the locality. This is complemented by a three-yearly analysis of the same data.

Comparison of other data collated from, for example, the Scottish Choose Life (Suicide Prevention) Campaign and the *National Confidential Enquiry into Suicide and Homicide by People with Mental Illness*<sup>14</sup> on issues around suicide and deliberate self-harm was conducted to allow a better understanding of this population.

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<sup>13</sup> National Investigation into Drug-related Deaths 2003:  
<http://www.scotland.gov.uk/Resource/Doc/57346/0016442.pdf>

<sup>14</sup> <http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/>

**Policy:** Fife also established a patient death (where misuse of drugs is suspected) information sharing procedure. This was signed off by NHS Fife, Fife Council and Fife constabulary together with the approval of the Fife Area Procurator Fiscal, SPS and the GP specialist group (Local Medical Committee). This established a framework for secure, appropriate, timeous and accurate information sharing in relation to drug deaths in Fife.

4.37 It also provides an assurance that the information being shared meets legal and professional obligations and the legitimate expectations of patients/clients. This policy and associated procedures are applicable to all staff and contractors working within NHS Fife. It is offered as advice to independent GP, dental, pharmacy and optometry contractors. It is acknowledged that the accountability arrangements of these independent contractors differ from those of NHS Fife employees, and therefore this policy must be seen as good practice guidance and used in conjunction with the requirements of their own professional body.

4.38 A sound governance structure as established in Fife will:

- Facilitate secure information sharing between the prescribed agencies within a secure and ethical framework.
- Identify perceived gaps or shortfalls which may prevent loss of life in future by evaluating social, medical and other issues experienced by the deceased.
- Ensure information is managed strategically by providing evidence of trends, patterns, issues and difficulties experienced to the core group.
- Ensure that guidance is available to all staff in Fife who may require to share information on drug deaths.
- Encourage the full reporting of relevant information.
- Within NHS Fife, authorised access to all systems holding person identifiable information is via username and password.
- Within NHS Fife, professional liability and accountability for the security and application of information obtained is assumed to lie with the authorised users, and through them the Chief Executive.
- Ensure the Annual Report from the Drug-related Death Group is submitted to the NHS Fife Information Governance Group, to the GP Sub-Committee and all stakeholders upon request.
- Become an integral part of NHS Fife's system for managing risk as described within NHS Fife's Risk Management Strategy. Failure to comply with this procedure could lead to breach of the Data Protection Act 1998, Human Rights Act 1998, Common Law<sup>15</sup> and the Caldicott Recommendations (see Glossary).

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<sup>15</sup> The common law is that aspect of the law comprised of decisions by the courts.

### **What did we learn from this presentation?**

This is an excellent example of data collection work which highlighted the need for local partnership agreements and the problem of data sharing.

### **Investigating levels of problem drinking among those on methadone maintenance programmes: Implications for individuals and services – Steve O’Rawe, University of Paisley**

4.39 The aim of this study was to examine levels of problem drinking among a population of problem drug users being prescribed methadone. There has been little or no research carried out in Scotland to enlighten us as to the extent of this phenomenon, which has many implications for individuals and treatment agencies alike. Eighty participants were chosen from a drug treatment agency in Ayrshire in the west of Scotland, split into two groups (one prescribed less than one year, the other for five years and over) and asked their alcohol intake by way of the AUDIT (Alcohol Use Disorders Identification Test) scale (Babor & Grant, 1989) (see Glossary).

4.40 Of the 80 asked to participate, 42 had been prescribed five years or more and 38 for less than one year. A three strata approach to the AUDIT scale was adopted. That being, those who scored <8 were deemed to be drinking at safe levels, those who scored between eight and 14 were drinking hazardously (i.e. indicative of, but not necessarily, problem drinking) and those scoring 15 and over were problem drinkers.

4.41 Overall, 48.8% scored eight and over, while 22.5% scored 15 and over. The lowest score was zero, of which 13 (16.25%) achieved, while the highest was 38, reached by one individual. The highest possible score being 40.

4.42 These findings represent a high prevalence of problem drinking among the whole group. When the group is split and results compared through Chi-Square analysis, it emerged that those prescribed five years and more were drinking at significantly higher levels than those who had been prescribed less than a year. This has serious implications for services in that these tend to be the group that is less in touch with their treatment provider, and tend to be the group that is thought of as being more stable in their *illicit* drug use.

4.43 This may be the case, however, if drinking is to continue at this rate then serious health consequences lie in wait for that individual, particularly if they are hepatitis C positive (HCV+), not to mention the social, legal and economic costs that are associated with problem

drinking. All of this places potential added burdens on the resources that are already targeted at treating problem drug users.

4.44 Hypothesis: *Excessive alcohol consumption will be significantly more prevalent among service users on long-term methadone maintenance – i.e. more than five years – when compared to those prescribed less than one year.*

### **Main findings**

4.45 Of the total sample of 80 service users, 39 (48.8%) scored 8+, indicating hazardous drinking. So, almost half of those sampled are drinking to excess according to the World Health Organisation (WHO) definition.

4.46 Eighteen (22.5%) scored 15+, meaning over one-fifth of this population were drinking to problem levels. Of this 18, 15 were from those prescribed >5 years. When statistically analysed using Chi-Square tests there is a significant difference between the two groups sampled, therefore upholding the hypothesis.

4.47 Also of significance was that only 16 from 80 had ever sought advice or treatment for their drinking. Among the highest category, 10 of 18 (55.6%) had never received any intervention on alcohol.

### **What did we learn from this presentation?**

This small local study highlights the high prevalence of problem drinking in methadone maintenance patients. The results are consistent with the current evidence base from outside Scotland, including large studies such as, National Treatment Outcomes Research Study (NTORS): Alcohol Outcomes at 4-5 year (Gossop et al., Journal of Substance Abuse Treatment 25 (2003) 135–143); but in this study, the higher prevalence of problem drinkers in the cohort after five years of methadone treatment is particularly a cause for concern.

### **N-ALIVE: Randomised Controlled Trial – Professor Sheila Bird, Cambridge University**

4.48 Professor Sheila Bird presented the background, statistics and examples of studies that led to the development of the current N-ALIVE proposal. The main points were presented as follows.

4.49 Seaman, Brett & Gore (BMJ 1998)<sup>16</sup> looked at overdose deaths in the two weeks after HIV injectors' releases from HMP Edinburgh from

<sup>16</sup> Mortality from overdose among injecting drug users recently released from prison: database linkage study  
BMJ 1998;316:426-428 <http://www.bmj.com/cgi/content/abstract/316/7129/426>

1983 – 1994. They found that they were eight times higher than comparable other fortnights at liberty. A follow-up study looked at male index releases from Scottish prisons in July to December 1996 – 1999. (Bird & Hutchinson: Addiction 2003)<sup>17</sup>. They found that drugs-related mortality in 1996–99 was seven times higher in the two weeks after release than at other times at liberty and 2.8 times higher than prison suicides by males aged 15–35 years who had been incarcerated for 14+ days. It was estimated one drugs-related death in the two weeks after release per 200 adult male injectors released from 14+ days' incarceration. Non drugs-related deaths in the 12 weeks after release were 4.9 times more than the 4.3 deaths expected.

4.50 The study design was developed on the following assumptions: that there would be 20,000 eligible releases; at least 40% adult and 20% young offender male releases were injecting drug users (IDUs); drug-related deaths occur mainly in IDUs; in 1990s one drug-related death per 3000 recently released IDU (as opposed to 1 in 1000 as Seaman); and relative risk of drug-related death in first fortnight after release was four.

4.51 In 2005, naloxone was added to exempt list of Prescription Only Medicines (POM) for administration by anyone in an emergency in order to save life. It then became possible to look at providing naloxone to families and friends of drug users. This led to the first discussions about the trial which took place with SPS. The reasons for choosing prisoners were: one in eight Scottish drug-related deaths occurs in the four weeks after release; there is a concentration of adult heroin injectors at very high risk; and over half injectors have been in prison in the past year.

4.52 The main N-ALIVE trial will aim to randomise 56,000 eligible prisoners in 50 UK prisons over five years. N-ALIVE study assumptions were: eligibility 18-44 years with a history of heroin injection and seven days plus incarceration; in 80% of overdoses someone else was present; there was a 50% chance naloxone will be administered but as weeks go on this reduced to 30% after four weeks and 20% between five to 12 weeks; and one overdose death in first four weeks per 200 IDUs randomised to the control group.

4.53 Naloxone or the control pack would be given at release. The control pack would include an information leaflet and prepaid reply card. Naloxone would be randomised, blinded until release. Follow-up of recidivists would be by self-completion questionnaire at point of return to custody should this occur (in Scotland only).

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<sup>17</sup> *Male drugs-related deaths in the fortnight after release from prison: Scotland 1996-99*  
<http://pt.wkhealth.com/pt/re/addi/abstract.00008514-200302000-00009.htm;jsessionid=KVwVL9vgyPL7d2wphdhv3K7QfTZTxWTRnFzhTNtd34mkMG8X23yy!-701738752!181195629!8091!-1>

## What did we learn from this presentation?

There is an opportunity to use naloxone in a group who are very vulnerable due to loss of tolerance whilst incarcerated. The study may reveal whether naloxone might be an important intervention in this population.

## Lanarkshire Naloxone Pilot – Andrew McAuley<sup>18</sup>, Research and Information Officer, Lanarkshire Alcohol and Drug Action Team

### Background

4.54 Opiate/opioid related fatalities are increasing (Zador et al, 2005; GROS, 2007). Between 2001 and 2006, 89% (n=120) of drug deaths in Lanarkshire had been either as a direct result or associated with the misuse of heroin, morphine or methadone. Fifty-nine per cent of these deaths occurred where others were present. Fifty to seventy per cent had overdosed in the past and twenty to thirty per cent in the past 12 months.

4.55 Naloxone hydrochloride is an opiate antagonist which reverses the effects of opioid respiratory depression. When administered intramuscularly it is a potential life saver. Take home naloxone was successfully piloted abroad such as in Jersey, Berlin, Chicago, New Mexico, San Francisco, New York City, Boston and Baltimore.

4.56 The table below demonstrates the various schemes/trials/pilots that have taken place and the outcomes from them.

Study	No. Clients	No. Followed up	No. Client Uses	Outcome
Berlin 1999 (see Dettmer et al, 2001)	124	40 (32%) 16 months	29	No Deaths No Adverse
Jersey 1999 (see Dettmer et al, 2001)	101	Not reported 16 months	5	No Deaths No Adverse
Chicago 2001 (Maxwell et al, 2005)	3500	Unknown	319	1 Death (polydrug) No Adverse
New Mexico 2001 (see Huang, 2002)	80	Unknown	7	No Deaths No Adverse
San Francisco 2005 (see Seal et al, 2005)	24 (12 pairs)	24 (100%) 6 months	15	No Deaths No Adverse
New York 2006 (see Worthington et al, 2006)	204	22 (88%) 3 months	40	No Deaths No Adverse

<sup>18</sup> Andrew McAuley now works for NHS Health Scotland.

## **The Lanarkshire pilot**

4.57 In an initial pilot project naloxone training and distribution was conducted on the basis of a 'buddy' scheme in which user trainees were required to bring a friend or family member to participate in the training, thus providing an important safety net in the event of the users overdosing themselves.

4.58 Training was delivered by the Scottish Ambulance Service and lasted around four hours encompassing basic life support, the unconscious patient and administration of naloxone. Clients were also asked to sign an 'agreement of trust' before being issued their naloxone which ensured they were aware of their roles and responsibilities of being part of the pilot and the risks involved should the naloxone be diverted to an untrained individual.

4.59 Clients completing the course successfully were given a 0.4mg naloxone 'kit' and a £10 voucher for participating. The nursing staff distributed the naloxone via a Patient Group Directive (PGD). During the pilot (six month) period 22 naloxone kits were given to 19 different clients (with two verified successful saves both validated by police and paramedics) and 13 to frontline addiction workers. All reported overdoses were subjected to collateral verification with interventions involving the ambulance service or police checked by the research team with the respective groups. No inappropriate use of naloxone was reported.

4.60 This pilot scheme has now been rolled out as standard practice within Lanarkshire with monthly naloxone training courses for clients which began in November 2008.

## **In summary**

4.61 Take home naloxone:

- Is not a panacea for all overdose;
- Non-specialists can be trained effectively in its use;
- Can be managed responsibly by clients;
- Can be administered intramuscularly by non-specialists;
- No evidence that it increases risk of blood borne viruses;
- No evidence that it provides a 'safety net'; and
- Has the potential to reduce drug-related deaths in Lanarkshire and beyond when used in combination with other preventative measures.

## **What did we learn from this presentation?**

Use of naloxone seems to have produced significant benefits.

### **Geographic Concentrations – Paper presentation by Frank Dixon, General Register Office for Scotland (GROS)**

4.62 Two findings from the analysis of GROS's data on drug-related deaths were of particular interest. Both followed enquiries made at a Forum meeting.

*Based on the area of usual residence of the deceased, drug-related deaths are widespread across Scotland: they are not concentrated in a few geographical areas.*

4.63 In the eight years from 2000 to 2007 (inclusive) there were 2,893 drug-related deaths in Scotland (on the basis of the standard definition). Of the postal districts, 'G21' had the largest number (67 - an average of 8.4 per year). Four other postal districts had totals of 50 or more drug-related deaths for that period: 'G33' (54); 'G20' (53); 'G32' (51); and 'AB24' (50). There were 25 postal districts which each had 29 or more drug-related deaths over the eight years: each of them accounted for more than 1% of the total for Scotland for that period. Taken together, these 25 postal districts accounted for about a third of all drug-related deaths in Scotland between 2000 and 2007.

4.64 In consequence, two-thirds of drug-related deaths in that period were deaths of residents of postal districts which had, at most, 28 such deaths over the eight years - i.e. areas which had, on average, at most 3½ drug-related deaths per year (many of which averaged less than one drug-related death per year). In conclusion: while some postal districts have markedly more drug-related deaths than others, the problem is clearly a very widespread one, with most deaths being of people whose usual areas of residence had relatively few drug-related deaths.

*Estimates of male 'life expectancy' for postcode sector 'G40 2' (the Calton area of Glasgow) would be unusually low, even if there were no drug-related deaths or suicides.*

4.65 In August 2008, a WHO report was published which included estimates of life expectancy for different parts of Scotland. Considerable publicity was given to the estimated life expectancy of about 54 years for males in the Calton area of Glasgow and the contrast with the figure of 82 years for Lenzie in East Dunbartonshire. The estimate of life expectancy for males for Scotland as a whole was around 73 years.

4.66 About one-eleventh of the male deaths in Calton were drug-related or suicides. An analysis of GROS data (which is described in detail in



**Annex B)** established that excluding the drug-related deaths might raise the estimate to around 58 years; and excluding the suicides as well would raise it to about 59 years.

4.67 The effect of factors such as hostel accommodation, population movement and future changes in health mean that one should not regard such an estimate as the expected number of years of life for a child who is born in that area.

4.68 The other main causes of deaths of males aged up to 74 in Calton at that time were ischaemic (coronary) heart diseases, alcohol dependence and chronic liver disease etc, malignant neoplasms (cancers) and diseases of the respiratory system.

4.69 For females, life expectancies were estimated as being about 75 years for Calton and around 79 years for Scotland as a whole. In the relevant period, there was only one female drug-related death, and no suicides, so excluding them would raise the estimated life expectancy only slightly.

**What did we learn from this paper?**

Initiatives aimed only at a few areas which have relatively high numbers of drug-related deaths might not make much difference to the overall total number of such deaths. The estimate of 'life expectancy' for males in the Calton area of Glasgow would be unusually low even if there were no drug-related deaths, because of other deaths, at a relatively young age, from causes which are linked to heavy smoking and/or drinking.

## **5. CONCLUSIONS**

5.1 The following observations have been made by the Forum and its sub-groups and these will be considered as part of the Forum's work programme for 2009.

### **Observations**

- Drug deaths continue to be a top priority for Government and this group. There has been a lot of activity throughout 2008 and our ability to understand why drug deaths are happening is improving. There is no one single reason for these deaths it is a combination of factors. That is why it requires a range of different actions and activities such as the expansion of overdose awareness training to key workers in services, including homelessness services.
- UK Guidelines on drug treatment were introduced in 2008 and the CMO is committed to their introduction by all NHS Boards.
- Services should pursue improved treatment options for people with mild to moderate substance misuse co-morbidity. As in the Glasgow model referred to at paragraph 2.38 on page 15.
- There is a continuing need for all services, statutory and otherwise, to identify substance misuse issues to ensure that referral to a specialist service is considered and followed up.

### **Achievements**

5.2 A lot of good work has been carried out by the Forum and others over the past year, key achievements are set out below.

- There is an increase in suicide training through joint working between ADATs and Choose Life teams.
- The National Drug Deaths Database was launched on 1 January 2009. An expert group will review the data and early analysis is expected towards the end of 2009.
- New overdose awareness materials have been developed and distributed to drug services throughout Scotland.
- Prisons have introduced improved training and prescribing practices.

- The naloxone pilots in Glasgow and Lanarkshire are being extended and interest is being shown in introducing similar practice in other areas.

## **Work Programme**

5.3 The following findings will inform the future work programme of the Forum.

- The Forum must continue to highlight the dangers of injecting drugs and of poly-drug use, especially when combined with alcohol. The increased use of cocaine and in particular its combination with alcohol is also of great concern.
- A key concern of the group is the number of deaths among older drug users. The SDF European project will help the group identify key issues needing to be addressed in order to reduce the number of deaths among this population.
- There is a need for an information leaflet to be developed for the ambulance service for those who refuse treatment.
- There is a need for better first-aid training for the police to include information about drug overdoses and the factors that discourage early contact with emergency services.
- Specific advertising campaigns would be useful to reinforce the fact the police are primarily interested in the preservation of life.
- Two research projects have been funded in 2008 and their recommendations are important and will be considered by the Forum in future work. In particular the Forum will focus on the recommendations made by Figure 8 Consultancy in their report on *Reducing Drug Users Risk of Overdose*.
- Non-fatal overdoses should be recorded and monitored as lives may be saved by learning what prevented the death.

DEATHS INVOLVING OR RESULTING FROM ABUSE OF CONTROLLED SUBSTANCES

Please return to: Vital Events Branch, GROS, Ladywell House, Ladywell Road, Edinburgh EH12 7TF

Name of deceased: .....

Date of birth (dd/mm/yyyy):

Date of death: (dd/mm/yyyy):

1. Was the deceased a known or suspected habitual drug/solvent abuser? Yes [ ] No [ ]

2. Was the death the result of overdose / intoxication? Yes [ ] No [ ]

3. Was the death due to a complication of drug abuse? Yes [ ] No [ ]

(e.g. acute infection or cocaine-related cardiac arrhythmia - but not chronic infections or diseases, such as Hepatitis C or HIV )

If 'Yes', please specify:.....

4(i) Based on the available evidence, what were the main drugs or solvents you believe were implicated in, or which potentially contributed to, the cause of death? (If possible, list in descending order of importance in relation to the cause of death):

- a..... d.....
b..... e.....
c..... f.....

4(ii) Please specify any other drug(s)/solvent(s) which were present, but which were not considered to have had any direct contribution to this death:

- a..... c.....
b..... d.....

5. Was alcohol present at the time of death? Yes [ ] No [ ]

If 'Yes', was it implicated in the cause of death Yes [ ] No [ ]

6. Pathologist's view of cause of death (full details - as would appear on a medical certificate of cause of death):

- I (a) .....
(b) .....
(c) .....
(d) .....

II .....

7. Any other comments or information which may help in coding this death?

.....
.....
.....

## **Form ME4: Deaths involving or resulting from the abuse of controlled substances**

### **Notes for completion:**

#### **General:**

The information collected by this form is essential for the correct coding and monitoring of drug-related deaths in Scotland. If you have any queries about the form or its completion, please contact Frank Dixon (GROS), telephone 0131 314 4229.

#### ***Completed forms should be returned to:***

Vital Events Branch  
General Register Office for Scotland  
Ladywell House  
Ladywell Road  
Edinburgh  
EH12 7TF

#### **Coverage:**

A form should be completed, by a pathologist following post-mortem/toxicological examinations, for all deaths in Scotland involving or resulting from the abuse of drugs/solvents which are controlled under the Misuse of Drugs legislation.

#### **Drugs to be recorded:**

All drugs/solvents involved should be recorded, not just 'illicit' or 'controlled' drugs. However, it is not necessary to record additional metabolic by-products found by the toxicology.

#### **Complications of drug/solvent:**

As well as acute infections, please include causes such as cocaine-related cardiac arrhythmia. Do ***not*** include chronic infections or diseases (e.g. hepatitis C or HIV) or road traffic accidents where a driver had been under the influence of drugs.

#### **Cause of death:**

Please record the full details as they would appear on a medical certificate of cause of death (Form 11).

#### **Controlled substances under the Misuse of Drugs legislation**

A detailed list is available from the Home Office Website (<http://www.homeoffice.gov.uk/documents/cdlist.pdf>). Examples are:

- Class A drugs - include Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (whether prepared or fresh), methylamphetamine (crystal meth), other amphetamines if prepared for injection;
- Class B drugs - include Amphetamines, Methylphenidate (Ritalin), Pholcodine;
- Class C drugs - include Cannabis, tranquillisers, some painkillers, GHB (Gamma hydroxybutyrate), ketamine

## **Estimates of 'life expectancy' for postcode sector 'G40 2' – the Calton area of Glasgow**

*This Annex describes work carried out for the Forum by Frank Dixon, GROS Vital Events Statistician.*

### **Summary**

1. The male life expectancy for the Calton area of Glasgow was estimated to be about 54 years, compared with around 73 years for Scotland as a whole – but the effect of factors such as hostel accommodation, population movement and future changes in health mean that one should not regard such an estimate as the expected number of years of life for a child who is born in that area.
2. A relatively high percentage of the male deaths in Calton were drug-related or suicides. Excluding the drug-related deaths might raise the estimate to around 58 years; and excluding the suicides as well would raise it to about 59 years.
3. The other main causes of deaths of males aged up to 74 in Calton at that time were ischaemic (coronary) heart diseases, alcohol dependence and chronic liver disease etc, malignant neoplasms (cancers) and diseases of the respiratory system. For females, life expectancies were estimated as being about 75 years for Calton and around 79 years for Scotland as a whole. In the relevant period, there was only one female drug-related death, and no suicides, so excluding them would raise the estimated life expectancy only slightly.

### **Background**

4. In August 2008, a WHO report was published which included estimates of life expectancy for different parts of Scotland. Considerable publicity was given to the estimated life expectancy of about 54 years for males in the Calton area of Glasgow and the contrast with the figure of 82 years for Lenzie in East Dunbartonshire. The estimate of life expectancy for males for Scotland as a whole was around 73 years. For females, life expectancies were estimated as being about 75 years for Calton and around 79 years for Scotland as a whole.
5. On 3 September 2008, at a meeting of the Forum, members suggested that the Calton area might have a figure which was more like those of other areas if its drug-related deaths and suicides were excluded. Frank Dixon (GROS) agreed to look into the matter. This note sets out his findings.
6. It must be remembered that estimates of life expectancy are based on information about the size of the population and the number of deaths in recent years. Strictly speaking, therefore, one should not regard the

estimates of life expectancy for an area as representing the expected number of years of life for a child who is born in that area because e.g. they are based on data for a population whose members may move, or be changed by inward migration and the calculations use past mortality rates, which may not apply in the future.

### **The basis of the figures**

7. The estimates of life expectancy in the WHO report were originally produced by NHS Health Scotland, based on methodology used by the Office for National Statistics (ONS). NHS Health Scotland estimated the life expectancies, separately for males and females, for Scotland as a whole and for each of 837 different parts of Scotland (which were defined in terms of postcode sectors). The calculations for each area used:

- the annual average number of deaths registered from 1998 to 2002, inclusive (these excluded registrations for which a geographic reference could not be assigned - deaths of non-Scottish residents);
- the population according to the 2001 Census (including people in communal establishments); and
- broken down by sex and age (5-year groups, apart from 'under 1', '1-4' and '85+').

8. The 2001 Census population of postcode sector 'G40 2' (i.e. Calton) was only 2,529 (1,245 males and 1,284 females), so it was likely to be markedly smaller than most of the parts of Scotland for which NHS Health Scotland estimated life expectancies (their average population was over 6,000: Scotland's 5.06 million people divided by the 837 parts).

9. In general, the smaller an area, the easier it is for its figures to be skewed by unusual circumstances. Statistical 'confidence limits' provide an indication of the variation that could arise due to 'random' factors, whose effect would be expected to be proportionately larger in areas with smaller populations and fewer deaths (in such areas, the fates of a few people with, say, '50:50' chances of survival will have a proportionately greater effect on the resulting estimates).

10. On the basis of statistical theory, one would expect random chance to lead to about one area in 20 having '95% confidence limits' that do not include the (unknown) true value of the quantity being estimated.

11. The original workbook calculates such limits for the estimates of life expectancy. In the case of Calton, these were:

- males - between 46.2 years and 61.6 years, so the estimate can be described as 53.9 years +/- about 7.7 years; and
- females - between 70.0 years and 79.5 years, so the estimate can be described as 74.8 years +/- about 4.8 years.

12. The estimates may also be affected by other factors, the likely scale of whose influence cannot be quantified statistically. For example, if an

area's population changes rapidly (e.g. declines due to the demolition of housing, in preparation for redevelopment), its figures for deaths over a 5-year period might be inconsistent with the population recorded in a Census conducted towards the end of the period, because many of the deaths might have occurred in years when the population was much larger than on the census date.

13. In the case of Calton, the area apparently had a number of hostels for people with particular types of problems, who may well not have been born in the area, might not have been in the best of health, and so might have resulted in Calton having rather more deaths than just those which occur among its 'long-term' residents. Because such factors are not 'random', the likely scale of their effects cannot be quantified using statistical theory; and much more detailed data (e.g. on the year-by-year populations of the hostels and of the rest of Calton) than is available would be needed to determine the scale of their effect on the estimates.

### **Estimating life expectancies excluding certain kinds of deaths**

14. Extracts of the numbers of deaths between 1998 and 2002 in the 'G40 2' postcode sector were taken from the GROS database. After checking that the program produced the same numbers as the original workbook used, it was amended in order to split the numbers of deaths between the following categories:

- drug-related deaths (as defined for *Drug-related deaths in Scotland*);
- other drug-related deaths (on the basis of the ONS 'wide' definition);
- suicides and deaths as a result of 'events of undetermined intent', unless they are 'drug-related'. (NB: it is thought likely that most 'undetermined intent' deaths are suicides, but some could be due to accidents or murders, etc - these are the cases for which GROS does not know if the person killed him/herself); and
- all other deaths.

15. The results may be summarised as follows:

**Table 1: Total deaths in postcode sector 'G40 2' - 1998 to 2002, inclusive**

	<b>Males</b>	<b>Females</b>
Drug-related (on the basis of the standard definition used for ' <i>Drug-related Deaths in Scotland</i> ')	12	0
Other drug-related (on the basis of the ONS 'wide' definition)	2	1
Suicides and 'undetermined intent' deaths (excluding any which are 'drug-related')	5	0
All other deaths	196	151
<b>Total deaths</b>	<b>215</b>	<b>152</b>



2.20 All the drug-related deaths were of people who were aged between 20 and 54, and all but one of the suicides were of people aged between 20 and 44, so one would expect that excluding those deaths would increase the estimated life expectancy.

16. Estimates were made of the following life expectancies, generally for males and females separately:

- Scotland as a whole, was looked at to check that the calculations were correct. The results were the same as the original ones;
- Calton (i.e. postcode sector 'G40 2'), was looked at and again, the results were the same as the original ones;
- Calton, this time after excluding all 'drug-related' deaths (whether counted as 'drug-related' by the standard definition or by the ONS definition); and
- Calton, for males only, this time after also excluding all deaths from suicides and events of undetermined intent. (There was no need to estimate this for females, because there were no female suicides or 'undetermined intent' deaths.)

17. Estimating life expectancy by excluding certain types of death assumes that the people concerned would not have died of any other cause in the period concerned. As almost all the drug-related deaths and suicides were aged under 50, it seems likely that they would not have died from 'normal' causes by 2002 (although some of them might have been living in ways that involved significant risks of premature death from other causes).

18. It could be argued that, for the purposes of this work, they should have been counted as having died at a 'more normal' age (e.g. some at 60, some at 65), but that would complicate the methodology (e.g. one would have to establish how to decide, for the purpose of the calculations, at what ages they should be assumed to die), and was thought unlikely to change greatly the revised estimates of life expectancies.

19. The results of these calculations may be summarised as follows:

**Table 2: Estimated life expectancy (years)**

	<b>Males</b>	<b>Females</b>
Scotland as a whole (*)	73.29	78.69
Calton (*)	53.87	74.76
Calton, excluding all drug-related deaths	57.77	75.13
Calton, excluding all drug-related deaths and all deaths from suicide or events of undetermined intent	59.14	75.13

(\*) these agree with the estimates produced originally

20. Clearly, excluding drug-related deaths and suicides does raise the estimates of life expectancy for Calton, but not by much when compared

with the gap between the original estimates and the overall figures for Scotland.

### **Deaths of males in Calton between 1998 and 2002 – some further information**

21. The figures for deaths of males in Calton were examined in a more detail because the estimated male life expectancy for Calton was much lower than the figure for Scotland as a whole. (This was not done for females because their estimated life expectancy in Calton was 'only' four years below the Scottish average.)

22. Between 1998 and 2002, there were 215 male deaths in postcode sector 'G40 2' (Calton) – more than double the number that one would have expected if the overall Scottish death rate for each age-group had applied to Calton's population at the time of the 2001 Census. The numbers of 'extra' deaths by age-group included:

- 20-24, 25-29, 30-34 - 3, 4 and 5 respectively;
- 35-39, 40-44 - 8 each;
- 45-49, 50-54, 55-59 - 13 or 14 each; and
- 60-64, 65-69 - 16 and 13 respectively.

23. Summarising the causes of Calton's male deaths between 1998 and 2002 is complicated due to the version of the International Classification of Diseases (ICD) which GROS uses to classify the causes of deaths changing from ICD9 (up to 1999) to ICD10 (2000 onwards)<sup>19</sup>.

24. However, the main causes of Calton's 165 deaths of males at ages who were aged up to 74 included:

- ischaemic (coronary) heart diseases – 33 deaths;
- alcohol dependence, chronic liver disease – 23 deaths;
- malignant neoplasms (cancers) – 21 deaths;
- diseases of the respiratory system – 17 deaths; and
- plus the 14 drug-related deaths and 5 suicides mentioned earlier.

There were also small numbers for each of many other causes of death.

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<sup>19</sup> ICD9 and ICD10 – Frequently Asked Questions explains the differences between the two.  
<http://www.acep.org/practres.aspx?id=30476>

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## GLOSSARY

Term	Meaning
A & E	Accident and Emergency
ADAT	Alcohol and Drug Action Team
ASIST	Applied Suicide Intervention Skills Training
AUDIT	Alcohol Use Disorders Identification Test - developed by the World Health Organisation as a simple screening tool to pick up the early signs of hazardous and harmful drinking and identify mild dependence.
BAT	Buprenorphine Assisted Treatment
Bi-polar Disorder	A mood disorder sometimes called manic-depressive illness or manic-depression that characteristically involves cycles of depression and elation or mania.
BMJ	British Medical Journal
Caldicott Recommendations	<p>In 1997 a committee was established under Dame Fiona Caldicott to review patient identifiable information. Her subsequent report made a series of recommendations with regard to confidentiality that all healthcare organisations should take on board within local information governance. A key recommendation of the 1997 Caldicott report was the establishment of the Caldicott Guardian across the NHS to safeguard access to patient-identifiable information. The Caldicott Guardian is responsible for agreeing and reviewing policies governing the protection of patient-identifiable information</p> <p>The Caldicott principles include:</p> <ul style="list-style-type: none"> <li>_ justify the purpose</li> <li>_ do not use patient identifiable information unless it is absolutely necessary</li> <li>_ use the minimum necessary patient identifiable information</li> <li>_ access to patient identifiable information should be on a strict need to know basis</li> <li>_ everyone should be aware of their responsibilities</li> <li>_ understand and comply with the law.</li> </ul>
CARES	Centre for Addiction Research and Education Scotland
Chi-Square test/analysis	A statistical test to determine the probability that an observed deviation from the expected event or outcome occurs solely by chance.

<b>Term</b>	<b>Meaning</b>
Choose Life	Choose Life is the Scottish Government's 10 year national strategy and action plan aimed at reducing suicides in Scotland by 20% by 2013
CMO	Chief Medical Officer
CoSLA	Convention of Scottish Local Authorities
CVS	Council for Voluntary Service
DORIS	Drug Outcome Research in Scotland
ePRF	Electronic Patient Report Form
ESCR	Emergency Service Control Room
EU	European Union
GP	General Practitioner
GPwSI	General Practitioners with Special Interest
GROS	General Register Office for Scotland
HCV	Hepatitis C Virus
HEAT	Health, Efficiency, Access and Treatment
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prison
HRAS	Harm Reduction Awareness Sessions
ICD Codes	International Statistical Classification of Diseases and Related Health Problems
IDU	Injecting Drug User
ISD	Information Services Division
JRF	Joseph Rowntree Foundation
MAT	Methadone Assisted Treatment
MOU	Memorandum of Understanding
N-ALIVE	Naloxone Investigation
Naloxone	a drug used to counteract the effects of narcotic overdoses
NHS	National Health Service
NTORS	National Treatment Outcomes Research Study
Orange Guidelines (or Book)	Drug Misuse and Dependence – UK Guidelines on Clinical Management
ONS	Office of National Statistics
PGD	Patient Group Directive
POM	Prescription Only Medicine
PRF	Patient Report Form
RCGP	Royal College of General Practitioners
SAADAT	Scottish Association of Alcohol and Drug Action Teams
SACDM	Scottish Advisory Committee on Drug Misuse
SAS	Scottish Ambulance Service
SCDEA	Scottish Crime and Drugs Enforcement Agency
SDDCare	Senior Drug Dependents and Care Structures
SDF	Scottish Drugs Forum

<b>Term</b>	<b>Meaning</b>
SMACAP	Scottish Ministerial Advisory Committee on Alcohol Problems
SMR01	Data source for Hospital Discharges
SMR04	Data source for Psychiatric Discharges
SMR25	Data source for Scottish Drug Misuse Database
SNFAD	Scottish Network for Families Affected by Drugs
SPS	Scottish Prison Service
STRADA	Scottish Training on Drugs and Alcohol
UK	United Kingdom
WHO	World Health Organisation



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