

A decorative graphic on the right side of the page. It features a large pink hexagon at the top, a smaller solid pink hexagon below it, and a large solid pink hexagon at the bottom right. Thin pink lines connect the top-left corner of the top hexagon to the top-left corner of the middle hexagon, and the top-right corner of the middle hexagon to the top-left corner of the bottom hexagon. A thin pink line also extends from the top-left corner of the top hexagon towards the bottom-left corner of the page.

NATIONAL FORUM ON DRUG- RELATED DEATHS IN SCOTLAND

ANNUAL REPORT 2014

PUBLISHED MAY 2015

SUMMARY

The National Forum on Drug-related Deaths (NFDRD/The Forum) was established by the Scottish Advisory Committee on Drug Misuse Drug-related Deaths Working Group in 2005 as an independent expert advisory group of professionals and representatives working to reduce drug-related deaths in Scotland. The Forum provides expertise, constructive challenge and evidence based advice with a remit to report to Ministers annually and advises Alcohol and Drug Partnerships (ADPs) and other joint planning groups, as appropriate, on trends and causes of drug-related deaths in Scotland and actions and policy changes. The Forum does this by considering any new research findings from national and international literature and policy issues as expressed elsewhere. Appropriate experts are asked to contribute to these discussions. Very few groups with a national remit have the reputation that the Forum has acquired for delivering on priorities and actually effecting change. The Forum is a multi-agency and multi-disciplinary group and includes individuals with lived experience and family representatives affected by another's substance misuse.

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CONTACT US

We are always interested to hear from anyone wanting to know more about the Forum's work. You can email the Forum [here](#)¹.

¹ Email: susie@sfad.org.uk

THE WORK OF THE FORUM

The Forum meets four times a year, inviting experts both from within the Forum membership and from outside the Forum. As well as making formal recommendations to Scottish Government and others, the Forum impacts on drug death prevention by regularly gathering this group of key stakeholders, inviting expert opinion and facilitating discussions, thereby immediately influencing, shaping and streamlining current practice across the disciplines. Many members of the Forum are also actively involved with other expert groups within Scotland, the UK and Europe.

The Forum has four resident working groups: the Research & Data Monitoring Subgroup (formerly the Data Collection Subgroup), the Pathology Subgroup, the National Naloxone Advisory Group and the Volunteer Forum.

The Data Collection Subgroup has been renamed to better reflect the remit of the group going forward: now titled **THE RESEARCH & DATA MONITORING SUBGROUP**. This subgroup has continued to work closely with Information Services Division (ISD) and local Data Collection Coordinators to manage the Drug Deaths database. Following detailed work to streamline data from 2009 – 2012, the group have contributed to shaping new linkage work that the database is now capable of achieving. This has enabled the research agenda to progress and given opportunity to consider topics such as benzodiazepines and the ageing cohort of drug users in more depth.

The latest National Drug-related Deaths Database (NDRDD) Report² has just been published³ and we have shared the key points at page 13 in this report. The emerging picture and evidence base from this report is crucial in helping us identify factors that might be addressed in reducing drug-related deaths in Scotland. The Research & Data Monitoring Subgroup have a unique opportunity going forward to ensure that the findings are developed into an evidence base that influences practice and saves lives in Scotland, with the added potential of influencing and impacting practice in this area further afield.

² National Drug-related Deaths Database (Scotland) Report

³ <https://isdscotland.scot.nhs.uk/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-04-28/2015-04-28-NDRDD-Report.pdf?1838320494>

The membership of **THE PATHOLOGY SUBGROUP** grew in 2014 and now has members from all four Scottish University Forensic Departments, consequently improving information sharing and impacting practice more consistently across Scotland. An update from the Pathology Subgroup follows at page 17 of this report.

An update from **THE NATIONAL NALOXONE ADVISORY GROUP** on the National Naloxone Programme is provided at page 17 of this report.

THE VOLUNTEER FORUM, an NFD RD subgroup re-established in 2013 and made up of Naloxone peer trainers, has provided key anecdotal evidence for Forum discussions exemplifying its value in broadening expert understanding in relation to the drug scene in Scotland from the perspective of the service user. An update from the Volunteer Forum follows at page 18 in this report.

The Forum produces a newsletter, **DRUG DEATH MATTERS**, published [here](#)⁴ bi-annually. The newsletter describes the Forum's ongoing work, shares important findings, highlighting academic research as well as identifying examples of good practice and disseminating to a wide readership of professionals in the public and third sector.

Each year the Forum presents a **REPORT** to Scottish Government, key stakeholders and colleagues in the field. This might be the final report of the Forum in its current format. Discussions are actively broadening the remit of this group to include a wider range of 'harms' arising from drug taking. This new challenge is welcome and we have responded by beginning with a review of the Forum remit, which will take place in the coming months.

A WORD FROM THE CHAIRS

Welcome to the National Forum on Drug-related Deaths 2014 Annual Report. This is the seventh report of the Forum and a fresh opportunity to reflect on the impact of the work since the Forum began.

The NFD RD produces a unique, multidisciplinary understanding of the complex issues that affect drug-related deaths, which has and continues

⁴ <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Drugs-Misuse/Drug-Related-Deaths-Database/drug-death-newsletter.asp>

to inform and influence policy making in Scotland, supporting Scottish Government to be innovative in its approach to harm reduction and pioneering in promoting recovery.

In its first annual report in 2007, the NFDRD proposed that a new system for data collection on drug-related deaths should be established: the National Drug-related Deaths Database (NDRDD). The development of the NDRDD and collection of drug-related death data was led by Information Services Division (ISD), working in close collaboration with ADPs and local drug-related death monitoring groups under the auspices of the NFDRD's Research and Data Monitoring sub-group. The fifth NDRDD report was published by ISD on 28th April 2015⁵. The data for this report is gathered by ADP drug coordinators and analysed by statisticians at ISD with the help of Forum members. This expanding longitudinal database is now being merged with other National datasets to provide the most comprehensive picture available anywhere in the field.

Members of the Forum are regularly invited to participate in meetings in Europe and beyond. In September and October 2014 several Forum Members attended the European Monitoring Centre for Drugs and Drug Addiction presenting and contributing to discussions on high risk drug use and drug treatment⁶, considering topics such as opioid replacement therapy, ageing drug users, vulnerable populations and high risk benzodiazepine use. Members participated in the Naloxone meetings⁷ by looking at regulations, experiences, achievements and challenges for the take home naloxone programmes across Europe. The drug-related deaths (DRD) and drug-related infectious diseases (DRID) key epidemiological indicators expert meetings⁸ focused on evidence from overdose and toxicology, mortality cohort studies, cannabis-related emergencies, HCV infections and treatment, HIV outbreaks among drug users, changing and new groups of injectors and emerging risks. The Forum and its members are committed to an ongoing relationship with European counterparts as essential to developing a considered, evidence-based approach to reducing drug-related deaths here in Scotland.

Forum Members have also taken part in Scottish consultations for the revision of the Clinical Guidelines on Drug Misuse and Dependence

⁵ <https://isdscotland.scot.nhs.uk/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-04-28/2015-04-28-NDRDD-Report.pdf?1838320494>

⁶ <http://www.emcdda.europa.eu/activities/expert-meetings/2014/ki-event>

⁷ <http://www.emcdda.europa.eu/events/2014/meetings/naloxone>

⁸ <http://www.emcdda.europa.eu/expert-meetings/2014/drd-drid>

(Orange Guidelines) and some of our members are also part of the steering group, who have been meeting in London periodically since October 2014.

The Independent Expert Review of Opioid Replacement Therapy (ORT) in 2013 set out to gather and explore evidence on opioid replacement therapies used to treat people with drug addictions⁹. As the review reported, the role of ORT as an option in treatment is crucial. Being retained in treatment has been strongly linked to clinical improvements and ORT has consistently been found to be associated with better retention. The Forum agrees with the Independent Expert Review that these benefits should be defended from criticism and built upon with improved governance, research and recovery orientation to maximise benefit to problem drug users in Scotland.

However, ISD Scotland has reported¹⁰ that ‘for the third successive year (2013/14) there has been a decrease in the dispensing of opioid replacement therapy (including methadone)’ despite there being no evidence of reducing prevalence of problem drug users. The Forum considers that it is important to address concerns around the use of ORT. Evidence strongly suggests that time limiting ORT or early discharge from treatment will result in the majority relapsing into heroin use and may have two significant unintended consequences, increasing heroin overdose death rates and the spread of blood borne viruses, including hepatitis and HIV. The recent report to UK Ministers from the Advisory Council on the Misuse of Drugs make a strong statement to this effect and additionally suggests that time limiting methadone or other ORT treatment could result in a legal challenge. The Forum would agree and emphasise the increased risk of death through inappropriate or coercive reduction in medical treatment in any setting. In Scotland there are also issues of stigma and a perceived lack of recovery orientation, which are also barriers to increasing protective treatment coverage.

The Forum believes that for those who need ORT, access should not be limited, but rather enhanced. It is also crucial that we explore further why people drop out of ORT, particularly where their discharge is unplanned. The Forum will take this forward in 2015.

⁹ <http://www.gov.scot/Resource/0043/00431023.pdf>

¹⁰ <https://isdscotland.scot.nhs.uk/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2014-10-14/2014-10-14-ScotPHO-drugs-October-Summary.pdf?82642763854>

THE FORUM'S IMPACT AND THE FUTURE

This report reviews the impact of the Forum during 2014 and looks ahead by setting out recommendations that seek to reduce the numbers at risk.

This year, we have restricted our recommendations to only four priorities. This does not mean that previous recommendations are no longer relevant. Indeed, the Scottish Government's response to recommendations from last year not only demonstrates that the Forum's advice is taken seriously, but, such as with take home naloxone, has long lasting resonance. If there is a theme to our recommendations this year, then it seems to be engagement with high risk populations who are not engaged in treatment, care and support with their GPs or specialist drug and alcohol services. As well as utilising the contact we know this group makes with prisons and acute hospitals, we strongly recommend the continued roll out of naloxone in a broad range of relevant settings and the research and development of new services. Whilst it is still not possible for family members to receive kits in their own right, Scottish Families Affected by Alcohol and Drugs (SFAD) are running sessions for family members on overdose prevention, overdose awareness and naloxone administration. SFAD Family Support Development Officers are also attending local drug-related death prevention groups to promote and encourage the role of family and friends in increasing distribution, particularly for individuals who are not currently accessing services.

The Scottish drugs advisory landscape is currently being reviewed by the Scottish Government, partners and stakeholders. Members of the Forum continue to participate and support this process and hope the changes that result will be an opportunity to develop the vital work we do and the extraordinary influence and capacity we have accumulated.

Further to the revision of the drugs advisory landscape and the development of a research sub-group and research strategy, additional research capacity could be used in partnership with Health Protection Scotland, Information Services Division, a nationally commissioned agency or one of the many interested University departments. The reality of death due to drug use is often that they occur at the end of a chain of events. Sometimes these events begin with a genetic predisposition to dependency or as a result of intergenerational influences. In childhood, problems may lay the ground for future problems and disadvantages. In adolescence and young adulthood poor

choices or peer distractions may precipitate addiction problems. Unfolding and cumulative consequences of lifestyle choices accumulate in later life. The Forum's vision is to look for ways of interrupting or intervening at one or many stages in this chain.

THANKS

We are grateful to all Forum and Subgroup Members for making time to attend and contribute to Forum and Subgroup meetings. We would like to also offer our thanks to those who kindly accepted our invitation to present at the Forum in 2014.

Our thanks to:

- ▲ Isabelle Giraudon, Scientific Analyst at ECMDDA¹¹;
- ▲ Professor Sheila Bird, Programme Leader, MRS Biostatistics Unit at University of Cambridge;
- ▲ Dr Claire McIntosh, Consultant Addiction Psychiatrist at NHS Forth Valley;
- ▲ Kirsten Horsburgh, National Naloxone Coordinator at Scottish Drugs Forum (SDF);
- ▲ Jason Wallace, Naloxone Training-Support Officer at SDF;
- ▲ Professor Alison McCallum, Director of Public Health in Lothian;
- ▲ Dr Linda de Caestecker, Director of Public Health in Greater Glasgow and Clyde;
- ▲ Dr Stephen Conroy, Lanarkshire Drug Treatment and Testing Order Team;
- ▲ Kenny Simpson, STOP Coordinator at Police Scotland;
- ▲ Dr Julie McAdam, Forensic Pathologist at University of Glasgow;
- ▲ Andrew McAuley, Public Health Information Manager, Observatory Division at NHS Health Scotland; and
- ▲ Dr Grace Campbell, Chair of the Expert Advisory Group for the National Prisoners Healthcare Network and Lead Clinician, NHS GG&C Prison Healthcare.

We also wish to express our thanks to the Scottish Government Officials in the Drugs Policy Unit, namely Beverley Francis and her team, for their support and partnership in 2014.

¹¹ European Monitoring Centre for Drugs and Drug Addiction - <http://www.emcdda.europa.eu/>

Thanks to those who have contributed to analysis of the drug death figures, including our colleagues at ISD and Scottish Public Health Observatory (ScotPHO). The invaluable work of Drug Death Coordinators in all the Alcohol and Drug Partnerships is also acknowledged. Without this resource there would be no dataset and without the extensive work involved in gathering and interpreting information relating to drug deaths there would be equally little quality to these responses. The Forum recognises the special effort made at a time when resources are stretched to the limit.



Gratitude is also extended to Scottish Families Affected by Alcohol and Drugs for providing the Secretariat to the Forum. This has been a particular strength during this year and has allowed development of extended areas of work for the Forum.

PROF ROY ROBERTSON (CHAIR)
PROFESSOR OF ADDICTION MEDICINE
CENTRE FOR POPULATION HEALTH SCIENCES
UNIVERSITY OF EDINBURGH AND
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DR SAKET PRIYADARSHI (VICE-CHAIR)
ASSOCIATE MEDICAL DIRECTOR, GREATER GLASGOW & CLYDE
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FORUM'S 2014 RECOMMENDATIONS

RECOMMENDATION ONE: PRESCRIBING IN PRISON

We consider that current policy for treatment of people with drug, alcohol and mental health problems in custodial settings is inconsistent in its lack of a clear commitment to provide the best opioid replacement therapy in optimal and therapeutic doses over the period when risks are at their highest. Underpinning this recommendation are the principles of reducing harms associated with illicit drug use and increasing wellbeing and engagement with recovery opportunities.

In formulating and publishing National Policy and/or guidelines there must be clarity and authority. Without this the present random drug use in custody and the associated risks after discharge will continue. Clear directions should be available to those caring for prisoners and opioid replacement therapy should be continued at optimal dosage throughout periods of custody for those who want it and are considered to benefit from it. This should be seamlessly available during the transition and Throughcare periods.

Buprenorphine should be available as an alternative to methadone where appropriate. Mental health problems and dual dependencies have to be recognised as ongoing problems and treated with a view to longer term outcomes rather than short term goals. For those with an opioid problem revealed for the first time on reception methadone or buprenorphine should be available with the usual supporting framework. Naloxone should be supplied to all those leaving these settings at risk of opioid overdose.

The Forum suggests that guidelines for ORT in custodial settings should be developed, implemented and audited by the National Prisoner Healthcare Network in consultation with NHS Medical Directors. There should also be advice developed for NHS Health Boards about how to monitor prescribing in local prisons.

See Appendix Part B for the full statement.

RECOMMENDATION TWO: BROADENING OUT PREVENTION & THE NALOXONE PROGRAMME

Sudden, potentially preventable, drug-related deaths occur in all settings. The Forum recognises that there are still missed opportunities to save lives following hospital discharge, liberation from prison and for those not currently accessing services.

Naloxone saves lives. Now that a licensed product is available Health Boards should ensure every possible avenue should continue to be explored and expanded, in addition to the Patient Group Direction (PGD) supply route. Areas for expansion include acute and mental health hospital discharges, GP prescribing and supplies from police custody suites. Following initial funding from Scottish Government, naloxone supplies should now be well embedded within local services.

It is still the view of the Forum that supplies of take home naloxone should be made available to non health staff in services such as homeless hostels, supported accommodation, outreach services and other non-NHS sites and agencies where staff routinely have contact with large groups of individuals at high risk of overdose.

The Forum also urges consideration of a broadening of supplies of naloxone to family members whose loved ones may be at risk. The Forum supports extending access to naloxone supplies for families and others by extending the Lord Advocate's Guidance and/or an amendment of the legal status of naloxone from a Prescription Only Medicine (POM) to Pharmacy (P) status.

RECOMMENDATION THREE: RESEARCH

The recent report from ISD highlights the findings of this year's analysis. Ongoing efforts to widen our scope in data handling should allow merging datasets. This will allow an accumulation of information currently stored electronically. Primary care information, hospital discharge details, psychiatric and mental health data and follow up from specialist services will all allow a broader view of the complexities of drug problems. This should also make possible insights into areas well beyond drug-related deaths.

Discussions with colleagues in the Drug Policy Unit at Scottish Government should be focussed on developing and supporting this electronic mine of useful information.

RECOMMENDATION FOUR: HEROIN ASSISTED TREATMENT AND DRUG CONSUMPTION ROOMS

In previous reports the Forum has made recommendations promoting the development of local services to include heroin prescribing and safe injecting facilities where necessary. The Forum notes that injecting drug use, particularly opioids, remains a significant risk factor for drug deaths as does being out of structured treatment or poor response to ORT. In addition, the Forum notes recent national outbreaks of anthrax and Botulism in Scottish injecting drug users. The Forum has discussed the format and structure of such a facility and considers that along with the well understood functions of delivering heroin assisted treatment the project could act as a coordinating centre for services for injectors, a harm reduction agency to intervene in cases under severe stress and to provide reactive data in a rapidly changing drug taking environment.

Therefore, the Forum repeats this recommendation but further recommends that the scoping, establishment and evaluation of pilot services in one or two ADPs where the need is most, is seen as a national priority and supported by government and national agencies.

FORUM'S RESPONSE TO 2013 DRUG DEATH FIGURES IN SCOTLAND

NFDRD RESPONSE TO THE NRS OFFICIAL FIGURES FOR DRUG-RELATED DEATHS IN 2013 (RELEASED 14TH AUGUST 2014), WHICH REPORTED THAT THERE WERE 526 DRUG-RELATED DEATHS IN SCOTLAND IN 2013, A 9% REDUCTION FROM THE PREVIOUS YEAR.

'Today's figures are a familiar representation of a complex problem. The welcomed reduction in total numbers of drug-related deaths is in line with fluctuations seen over a long time period but, hopefully, shows an improving situation.

There are clearly variations between geographical regions in these trends as well as differences in percentages succumbing to different drugs or drug combinations.

In addition the pattern of multiple drug ingestion leading to a fatality is continued from previous years. It is interesting that the cases involving novel psychoactive substances are almost all included in the main totals indicating that for those dying after taking an NPS, other drugs are also ingested.

The complex nature of drug problems and the many reasons why they can sometimes lead to a fatal event makes it difficult to attribute a single reason for change. It may be, however, that the many interventions implemented by treatment services and prevention initiatives have had an effect. In particular the Forum is keen to stress the importance of the Government's naloxone programme and the urgency to continue to enlarge the scope of this potentially lifesaving treatment.

The Forum would also reiterate the importance of engaging drug users in treatment and support services and reminding all involved of the risks associated with multiple drug use, injecting drugs and the dangers of associated mental health problems in increasing the risk of death. Older drug users seem particularly vulnerable, as are those who have recently been abstinent from drug taking.

Expansion of opportunities to engage drug users in support should continue to be explored. It is known that, for those most at risk, opioid replacement therapy is preventive of overdose death. The Forum also supports promoting recovery for those most at risk of drug overdoses through new service developments such as safe injecting rooms and heroin assisted treatment where needed.'

This response was given on behalf of the NFDRD by Chair Roy Robertson and Vice-Chair Saket Priyadarshi.

NATIONAL DRUG-RELATED DEATHS DATABASE REPORT FOR 2013

INTRODUCTION

Identifying the number of drug deaths in Scotland is problematic but is recorded and analysed with great precision by the office of the National Records of Scotland (NRS). The National Drug-Related Death Database (NDRDD), subsequently collected and analysed by Information Services Division (ISD), is extraordinary in its comprehensive detail. Few other countries have moved to the next logical stage of analysing these deaths further and pursuing a wider range of information to explore a greater level of detail on each death. Often referred to as a psychological autopsy, the NDRDD receives a wide range of further information which allows a detailed examination of each case and a collective analysis of causes of death in the group. This is a unique resource. This year's report is the fifth in the series and, for the first time, researchers at ISD and Health Scotland have scrutinised the trends in this time series. The key points provided below were published within the full report¹².

KEY POINTS FROM THE NATIONAL DRUG-RELATED DEATHS DATABASE REPORT FOR 2013 (PUBLISHED APRIL 2015)

This report provides information on the nature and social circumstances of individuals who died from a drug-related death in Scotland in 2013. The 448 cases analysed in this report are largely a subset of the 526 drug-related deaths, on which National Statistics were published by National Records Scotland (NRS) in August 2014.

Profile of Individuals

- As in previous years, over three quarters (76%) of those who died were male and half (50%) lived in the most deprived areas of Scotland.
- The mean age of individuals suffering a drug-related death increased from 34.4 in 2009 to 39.1 in 2013.
- The percentage of deaths among individuals aged 35 and over has increased from half of deaths (50%) in 2009 to two-thirds (66%) of deaths in 2013.

¹² The full report was published on Tuesday 28th April 2015 and can be accessed here: <https://isdscotland.scot.nhs.uk/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-04-28/2015-04-28-NDRDD-Report.pdf?1838320494>

- More than half of the cohort lived on their own all of the time (232, 53%) – a known risk factor for drug-related death.
- Nine out of ten (88%) of individuals were known to be using drugs prior to death and, of these, almost two-thirds (64%) also had a history of intravenous (IV) drug use.
- In 2013, almost one third (31%) were prescribed an Opioid Replacement Therapy (ORT) drug at the time of death (an increase since 2009 (21%)), while over half (51%) had been prescribed an ORT at some point since 2009.
- Over one third of the 2013 cohort (37%) had been prescribed an anti-depressant in the 30 days before death (the most commonly prescribed substance being mirtazapine). Diazepam was recently prescribed to one-fifth (21%) and gabapentin to one-tenth (10%) of the cohort. Anti-depressant and gabapentin prescriptions have both increased since NDRDD started in 2009.
- Almost three quarters (72%) had a medical condition recorded in the six months prior to death, while almost two thirds (63%) had a psychiatric condition recorded (higher than in any previous cohort).
- The average number of medical conditions in relation to which individuals were admitted to an acute hospital increased from 1.0 in 2009 to 1.4 in 2013, suggesting that multiple morbidity in the cohort may be increasing over time.
- Over a third of those who died (36%), were a parent or parental figure. 273 Children lost a parent or parental figure to a drug-related death in 2013.

Contact with Services

- Over half of individuals (53%) had been in contact with a drug treatment service in the six months before death. Half of individuals (50%) were in contact with services for reasons other than management of a drug misuse problem in the six months before death.
- Ten per cent had been discharged from an acute or psychiatric hospital within four weeks of death, rising to 28% discharged within the past six months.
- The percentage of the cohort with experience of an acute or psychiatric inpatient stay (93%) increased over time (2009: 86%).
- Around one third (31%) had been in police custody and around one in ten (13%) had been in prison in the six months prior to death.
- Collectively, seven in ten individuals (71%) who died a drug-related death in 2013 had been in contact with a service (drug treatment, hospital, police or prison) which may have identified them as being at risk of drug-related death.

Drugs Present and Implicated in Death

- As in previous years, in almost all cases (97%) there was more than one drug *present* in the body at death and in 68% of cases more than one drug was *implicated* in death, indicating the presence of polydrug use amongst this cohort.
- The drug most frequently found to be *present* in the body at death was diazepam (66%), followed by heroin/morphine (50%), methadone (47%), alcohol (42%) and anti-depressants (39%). Opioids (methadone, heroin, morphine or buprenorphine) were *present* in 82% of cases.

- The percentage of deaths with diazepam *present* declined from 77% in 2009 to 66% in 2013. The decrease in diazepam presence among females was particularly marked (from 80% in 2012 to 61% in 2013). For the first time, diazepam was not the substance most likely to be found present in female drug-related deaths (antidepressants were found in 62% of female deaths).
- The percentage of deaths with heroin-morphine *present* was similar to the past two years, while the percentage with methadone *present* decreased from a peak of 56% in 2011 to 47% in 2013.
- The drug most frequently found to be *implicated* in death in 2013 was heroin/morphine (44%), followed by methadone (42%), diazepam (19%) and alcohol (18%). Opioids (methadone, heroin, morphine or buprenorphine) were *implicated* in 76% of cases.

Novel Psychoactive Substances

- Between 2009 and 2013, there were 203 cases with a 'Novel' Psychoactive Substance (NPS) present in the body at time of death. 2013 had the highest number of cases to date (108), an increase of 129% from the previous high of 47 in 2011.
- Deaths with NPS present in the body at time of death could be broadly categorised into two types: mainly those featuring Benzodiazepine-type NPS (e.g. Phenazepam, Etizolam) and to a lesser extent Stimulant-type NPS (e.g. PMA/PMMA, BZP, Mephedrone).
- Almost all deaths with NPS present in the body at time of death had co-presence of other drugs; typically combinations of NPS, opioids, alcohol and benzodiazepines.

Deaths by Suicide

- In addition to the 448 non-intentional deaths in the 2013 NDRDD, 37 deaths by suicide were recorded. Again, these were largely a subset of the 526 drug-related deaths (including suicide statistics) already published by National Records Scotland (NRS) in August 2014.
- Almost two-thirds (65%) of deaths by suicide recorded by NDRDD were among males. The mean age of deaths by suicide (45.3) was six years higher than the main NDRDD cohort (39.1).

FURTHER REMARKS FROM FORUM CHAIR, PROFESSOR ROY ROBERTSON

Progression from a genetic predisposition to early childhood trauma, neglect, initiation and dependent drug use through to death from the damage caused by drug taking can be seen as a chain of events. These events may not necessarily result in an unstoppable and relentless outcome. Understanding of causes at each of these stages is increasing as is the implied potential for interrupting these risk factors at each

stage. This database is intended and is likely to lead to a more intelligent approach to prevention.

Cases continue to be dominated by men in deprived areas of Scotland and the trend towards an older age range is seen. Injecting drug use, longstanding problems and multi-morbidity issues draw attention to the medical and mental health nature of these cases and their dependency on ongoing treatment services.

The role and benefits of opioid replacement therapy has to be interpreted in association with other research information on its benefits, which cannot be directly derived from these data. If we believe the international research literature, however, then we must conclude that if death could have been prevented more of these cases should perhaps have been in continuous sustained treatment.

The human misery and tragedy of the deaths represented in this dataset is apparent from the records of family and children associated with the cases and the predominance of direct and indirect indicators of mental health distress. The latter is increasing over the time series. Scottish Families Affected by Alcohol and Drugs (SFAD) has received funding to develop a bereavement counselling programme for those impacted by a drug-related death.

The drugs found at toxicology also require interpretation. The decrease in diazepam presence may be a reflection of prescribing policies but the collateral increase in antidepressant drugs found at autopsy show the continued need for these medical supports and the emerging use of novel substances demonstrates the ongoing self-medication present in Scottish drug users.

There is little comfort from these data to suggest that the problems giving rise to the unacceptable rate of drug-related deaths are diminishing. They are changing however and the need for vigilance is greater than ever. This dataset should be further expanded to include and refine the variables collected to monitor and report on a changing landscape. Interventions clearly should change to reflect this moving target with new and perhaps more appropriate treatment policies and a more targeted treatment capacity. Suggestions as to how these might be improved are included in our 2014 recommendations in *this* report.

Thanks should be extended to the dedicated work of drug death coordinators in ADPs across the country and especially to the work of Lee

Barnsdale, Ruth Gordon and the rest of the team at ISD and Andrew McAuley of Health Scotland.

PATHOLOGY SUBGROUP UPDATE

During 2014, the Pathology Subgroup made progress in establishing better networks and communication around Novel Psychoactive Substances (NPS) nationally. A letter was sent to Scottish Government Ministers from two of the subgroup's resident toxicologists, Dr Hazel Torrance and Dr Duncan Stephen, asking for assistance in NPS investigation and data collection. As a result, they were invited to discuss their letter further and the Scottish Government are now taking forward some of the suggested actions around standardisation of NPS and information sharing. The Pathology Subgroup will continue to monitor and consider NPS developments as well as monitoring developments in this area and in the rest of the UK and Europe.

The group have also contributed to a renewed effort to review the recording of drug-related deaths, particularly in view of the ageing cohort of drug users in Scotland, helping to give a more accurate national picture, which will make a positive impact toward the reduction of drug-related deaths.

Going forward the group hope to look in more detail at the particular differences in reporting of benzodiazepines and how these are reported, due to current variation in reporting practice.

NATIONAL NALOXONE PROGRAMME

Previously, in 2013, expert advice received from Scotland's National Naloxone Advisory Group suggested that a minimum of 15% of people with problem opioid use, based on the latest available estimates of the prevalence of problem drug use for 2009/10, should be supplied with take home naloxone kits. All health boards achieved this minimum and the recommended cumulative target was subsequently increased to 25% for community supplies during 2014/15. NHS Prison Health Teams have been given a separate target to supply 25% of eligible prisoners at liberation annually.

The Scottish Government's funding allocation letter to Alcohol and Drug Partnerships included the above advice with a Ministerial priority which highlighted the importance of increasing the reach and coverage of the National

Naloxone Programme by increasing the number of kits supplied to people at risk of opioid overdose.

- There were 6,472 THN kits issued in Scotland in 2013/14, through the National Naloxone Programme. This compares with 3,878 kits issued in 2012/13, an increase of 2,594 THN kits (66.9%).
- A total of 13,808 kits (includes kits issued in the community and from prison) were issued in Scotland between 1st April 2011 – 31st March 2014.
- There were 5,395 kits issued in the community (an increase of 72% compared to 2012/13) and 1,077 kits issued by prisons (an increase of 44%).
- Ten NHS Boards increased their distribution of kits issued in the community between 2012/13 and 2013/14, distribution decreased in three and one NHS Board is not currently participating in the programme. Six NHS Prison Health Teams increased their distribution of kits at liberation in 2013/14 compared to 2012/13, and ten decreased their distribution of kits.
- The percentage of opioid-related deaths occurring within four weeks of prison release was 9.8% during 2006-10 (baseline period), compared to 8.4% in 2011, 5.5% in 2012 and 4.7% in 2013. This reduction coincides with the introduction of the National Naloxone Programme and distribution of kits to 'at risk' prisoners on liberation.

The percentage of opioid-related deaths occurring within four weeks of a drug-related hospital discharge was 9.7% during 2006-10 (baseline). This figure fluctuated around the same level in 2011 (10%), 2012 (7%) and 2013 (10%). Currently the National Naloxone Programme is not implemented within the hospital setting, but there would be potential benefits to co-ordinated naloxone distribution from hospitals, especially for older and female high-risk opioid users.

VOLUNTEER FORUM

During 2014 the newly re-formed National Volunteer Forum on Drug-Related Deaths (NVFDRD) discussed various topics which had been presented to the NFDRD. The volunteer membership is made up of naloxone peer trainers. They also viewed presentations which had been delivered at the main Forum meetings and any questions or comments that the volunteers had were then conveyed back to Forum members.

The volunteers undertook the task of looking at unplanned discharges from treatment and Jason Wallace, Volunteer Forum Coordinator, spent several months gathering information from various volunteers throughout Scotland.

Upon obtaining information on unplanned discharges from ISD and other sources and following discussion at the National Forum, Kirsten Horsburgh, SDF, then gave a short overview of some of the figures obtained by the Volunteer Forum.

Following discussion at the National Forum on how to engage people better in treatment the Volunteer Forum gave a list of questions to the volunteers to answer both from their own experience and the experience of others who would be engaging in treatment.

The results of this questionnaire are in Appendix Part C.

POLICE SCOTLAND

On 1 April 2013, Scotland's eight police forces, the Scottish Crime and Drug Enforcement Agency (SCDEA) and the Association of Chief Police Officers in Scotland (ACPOS), merged to form Police Scotland. Police Scotland is now responsible for policing across the length and breadth of Scotland.

The Service is led by Chief Constable Sir Stephen House and comprises of police officers, police staff and special constables who are working together to deliver the best possible policing service for the people of Scotland. Reducing the number of drug deaths and the harm caused by the availability and use of illicit substances such as controlled drugs and New Psychoactive Substances is a key element of "Keeping People Safe".

Police Scotland recognises the importance of The National Forum on Drug-Related Deaths in the examination of trends and the dissemination of good practice to reduce drug-related deaths in Scotland. As a committed member of the independent expert group, Police Scotland will continue to support, enhance and develop its important work.

SCOTTISH PRISON SERVICE

Staff and Prisoners at HMP Edinburgh have been trained in awareness of New Psychoactive Substances (NPS) / Legal Highs. This was delivered as 'training for trainers' and provided staff with the skills to deliver awareness sessions to colleagues and prisoners on NPS and also enables Peer Supporters to provide wider awareness around NPS to the prisoner population. Learning from this 'test site' will be used to inform future roll out across the prison estate.

In order to ensure a consistent Naloxone Peer Support Service within HMP Edinburgh, senior prison management are working collaboratively with the Scottish Drugs Forum to deliver training locally to prison staff in order to provide an internal resource to support the training of naloxone supporters. This will enable HMP Edinburgh to become self-sufficient in training naloxone peer supporters.

SCOTTISH PRISON SERVICE RESPONSE TO RECOMMENDATION FOUR OF THE FORUM 2013 ANNUAL REPORT¹³

SPS are working collaboratively with HMP Inverness, NHS Highland and Highland ADP to deliver Naloxone Training to Operational Prison Staff to provide them with the competence and confidence to administer intra-muscular naloxone to prisoners in emergency 'first on the scene' situations. Lessons learned from this 'test site' will be used to inform future roll out across the prison estate. SPS will work in partnership with the Scottish Drugs Forum National Naloxone Co-ordinator to take forward this national training initiative.

¹³ **Recommendation Four:** The National Forum believes drug death prevention strategies could be significantly strengthened in prison settings. Best practice as demonstrated and described in the recent Chief Medical Officer's Independent Expert Review of Opiate Replacement Therapy includes optimising Opiate Replacement Therapy in such settings, ensuring continuity and initiation, high uptake of Naloxone on release and recognition and treatment of comorbidities. **Recommendation:** NHS boards which have responsibility for healthcare in prisons should embed such drug deaths prevention strategies in prison care. SPS should work in collaboration with the Scottish Government, Alcohol & Drug Partnerships and the Scottish Drugs Forum to develop a corporate Naloxone training package for operation prison staff. **Action for:** NHS boards and Scottish Prison Service
See p.9, National Forum on Drug Related Deaths Annual Report 2014, found at http://sfad.org.uk/media_centre/news/56/National_Forum_on_Drug_Related_Deaths_Annual_Report_2013

SCOTTISH GOVERNMENT RESPONSE TO FORUM'S RECOMMENDATIONS FOR 2013

The Scottish Government's Drug and Alcohol Quality Improvement Framework (QIF) underpins our on-going commitment to ensuring that quality is embedded and evidenced in services across Scotland and that Alcohol and Drug Partnerships (ADPs) are enabled to progress local strategy development, delivery planning and associated service improvement.

The ADP National Support Team work collaboratively with commissioned organisations to support ADPs' implementation of the QIF. The detail of this work and its contribution to reducing drugs-related deaths is woven into our response to the NFDRD recommendations.

Recommendation One

All ADPs should ensure local strategies and work plans prioritise drug-death prevention strategies to vulnerable groups, particularly those not in contact with treatment services. All ADPs should conduct a needs assessment for such vulnerable groups in their localities and assess the need for interventions identified above. The Scottish Government should consider how this might be best supported by government.

Action for: All ADPs

Scottish Government Response

There is evidence from ADP Annual Reports and our national support work that ADPs are prioritising the prevention of drug-related deaths, with many of them including this in their annual reports, and we would expect to see this reflected again in their Delivery Plans (due for submission in June 2015). Appropriate sections of delivery plans could be shared with the Forum once published. Going forward, the Forum could be involved in the evaluation of these plans to identify good practice.

The Scottish Government is funding the Scottish Drugs Forum to work specifically with a pilot group of 14 ADPs to progress the development of death prevention strategies. This has involved working with ADPs to develop prevention strategy guidelines followed by support to ADPs to develop these strategies locally. This offer of support went out to all ADPs in a letter from the then Minister for Community Safety and Legal Affairs in August 2014.

The Scottish Government's ADP National Support Team have also been leading improvement events with ADPs for the past year focused primarily on a newly developed Drug & Alcohol system Improvement Game (DAIG) which explores how patients and service users access, move

through and exit drug and alcohol care pathways. Improvement theory is a key aspect of these improvement events, covering capacity and demand in services, bottlenecks, mistakes which can occur and the Scottish Government's Three Step Improvement Model for small tests of change. 16 DAIGs have taken place, covering 12 ADP areas, as well as 2 service specific DAIGs in the same period, since November 2013 with the issue of drug-related deaths regularly coming up in discussions and follow-up action plans.

The National Support Team has also been supporting ADPs in effectively using data to improve the quality of service provision in ADP areas. All 30 ADPs now receive data at ADP level on Did Not Attend (DNA) and (un)planned discharges through Scottish Government national support. In March 2015 Integrate Resource Framework patient tracking NHS data has been made available to all ADPs through SG National Support. The latter has still to be used by ADPs, though Glasgow gained access in December 2014, through National Support. In addition, to assess the impact of quality improvement work we are currently conducting an impact assessment for those who undertook a DAIG event or quality principles event.

An example of where data is being used to improve service provision through the use of the Quality and Efficiency Support Team's (QuEST's) DCAQ Tool which focuses on Demand, Capacity, Activity and Queue. To date, 3 ADPs and drug and alcohol services have used this tool to analyse their own existing data and improve how resources are allocated, these are Borders ADP, Edinburgh Substance Misuse NHS Team and Highlands ADP. Borders ADP have produced a report jointly with Scottish Government on this work, which illustrates how services in the area have used the tool to target DNAs or missed appointments and to balance staff resources to meet the level of presenting demand from service user referrals. In exploring DNAs and queues, services can ensure that appointment systems are effective, that service users are followed up when they miss a meeting and ultimately avoid service users leaving services in an unplanned way, deteriorating and potentially overdosing.¹⁴

A further example of effective use of data has come through ADPs now receiving information on unplanned discharge and DNAs. This information has enabled work to take place in ADPs to improve recording, discharge policies and procedures in drug and alcohol services, particularly for unplanned discharge, and improvement work to take place to reduce DNAs. Some of the ADP areas and services seeking to address these issues are Fife and Borders ADPs. More information on this work can be found through the Scottish Government's ADP National Support Team: Alcohol_and_Drug_Partnerships@scotland.gsi.gov.uk.

¹⁴ <http://www.knowledge.scot.nhs.uk/media/7689721/borders%20adp%20dcaq%20final%20-%2009%2001%2014.pdf>

Recommendation Two

Injecting drug use remains one of the highest risk factors from drug deaths. Route transition from injecting to smoking heroin is likely to significantly reduce risk of fatal overdose and may be the first step on an individual's recovery journey. Despite the Ministerial statement last year on the changes to allow supplies of foil we are still waiting on details of the supply and monitoring restrictions that will be put in place.

Action: *The National Forum on Drug-Related deaths recommend that a Scottish solution is sought that would provide a "letter of comfort" or an equivalent of the Lord Advocate's guidance on Naloxone supply to allow this and other harm minimisation initiatives to proceed in Scotland.*

Scottish Government Response

Legislation was put in place on 5th September 2014 allowing for the lawful provision of foil. This combination of legislation and guidance was in line with advice to the UK Government from the Advisory Council for the Misuse of Drugs (ACMD) in order to maximise the benefits of the provision of foil.

The provision of injecting equipment is a public health priority in terms of prevention of blood-borne viruses and engagement of injectors with services and is complementary to Scotland's national drug policy. The provision of clean injecting equipment seeks to minimise the risk of transmission of Hepatitis C and HIV amongst those who inject.

Recommendation Three

National work should be initiated to inform health boards and ADPs on best practice and models of care to reduce the disease burden in older drug users. This will clearly involve optimised recovery orientated systems of care, but should also include how to deliver health improvement and chronic disease management to this vulnerable group. The absence of national guidelines on prescribing and clinical management remains an outstanding problem which needs to be addressed.

Action for: *Scottish Government*

Scottish Government Response

The problems associated with the older drug taking cohort are being taken up by a specific working group, chaired by SDF but including members of Scottish Government, healthcare clinicians and ADPs. We anticipate this will be a continuing priority for the sector going forward.

This group will look to address the issues highlighted, explore the specific needs of this population in terms of physical and mental health and social problems and identify effective service responses, including existing better practice. The group intend to provide guidance on effective practice by early 2016. The Scottish Government is also giving consideration to testing new models of service delivery for this group.

Recommendation Four

NHS boards which have responsibility for healthcare in prisons should embed such drug deaths prevention strategies in prison care. SPS should work in collaboration with the Scottish Government, Alcohol & Drug Partnerships and the Scottish Drugs Forum to develop a corporate Naloxone training package for operation prison staff.

Action for: NHS Boards and Scottish Prison Service

Scottish Government Response

ADPs have been working alongside SPS to take forward death prevention strategies within prisons. This will include the first delivery of a DAIG (Drug and Alcohol Improvement Game) in a prison setting. As part of this we will be working with ADPs to establish and implement recovery pathways for offenders at point of incarceration and liberation to ensure appropriate supports are in place to assist community reintegration and sustained recovery.

A pilot of training for prison staff in intra-muscular Naloxone administration, and the awareness raising training that goes alongside it, has been discussed between NHS Highland and HMP Inverness. *See Scottish Prison Service section on page 19 for further information*

The national Naloxone programme target of issuing kits to 25% of identified 'at-risk' individuals following release from prison is continuing with an increase in the number of kits being distributed, 686 across all of Scotland's prisons to the end of December 2014. 40% of all the NHS Health Boards responsible for the delivery of healthcare services in prisons are expected to have met the 25% target by end of March 2015.

Recommendation Five

The Scottish Government should continue to support the Forum's research capacity, particularly in gaining deeper understanding from the drug deaths database with future priorities being the role of mental health, multi-morbidity, benzodiazepine misuse and methadone overdoses in drug deaths. A robust and secure method of supporting this research capacity needs to be developed which will last for a realistic period. Research needs support for several years to prosper. The Scottish Government should encourage close coordination between national information departments and institutions to support drug deaths research. The Scottish Government and the Drugs Delivery Strategy Commission should ensure drug deaths prevention research is embedded within the research outputs of an action plan related to the Independent Expert review of ORT.

Action for: *Scottish Government*

Scottish Government Response

Work is being taken forward by the Scottish Government, alongside academics and professionals from the sector, to identify where research evidence gaps exist, and to develop an overarching drugs research strategy for Scotland.

Drug-related deaths will undoubtedly be included within this work and as part of this process the research group will take advice from members of the NFD RD as to where research in this area would be best targeted. If the Forum has a specific data and evidence gap, then it should develop a specific proposition for this group to consider.

With the current review of the advisory landscape, we will be developing a more consistent and robust way of monitoring progress. A dedicated evidence and data group would be established.

Recommendation Six

Although Novel Psychoactive Substances feature in only a small minority of drug deaths in Scotland, the numbers seem to have risen in recent years. The Forum would like to see NPS awareness and training embedded into health and social care services as well as criminal justice settings (custody suites and prisons) and will also support and collaborate with ISD on any research into the size and nature of NPS use in Scotland.

Action for: ADPs and Scottish Government

Scottish Government Response

The Scottish Government published the NPS Expert Review Group Report on Thursday 26 February. The group was established last year to consider the powers currently available in Scotland to tackle the sale and supply of these substances. The report makes a number of recommendations which the Minister for Community Safety and Legal Affairs is minded to accept.

One of the recommendations was for the Scottish Government to work in partnership with the Home Office to create new legislation to tackle the sale and supply of NPS. Legislation on the restriction and classification of drugs is reserved to the UK Government, however the Scottish Government is in early discussions with the Home Office on how we will work together to create new legislation to control both the sale and supply of NPS here in Scotland and also around the rest of the UK.

There is evidence that the absence of a consistent and effective definition of NPS is impacting on enforcement agencies, healthcare and wider sectors. The Expert Review Group made a recommendation to address this gap. This is being taken forward through the Scottish Government NPS Evidence Group. We are working with a range of stakeholders from a range of fields to develop a definition that can be used across all areas in Scotland.

The Scottish Government is at the early stages of developing a Centre for Excellence in forensic testing for NPS. This will develop much needed standards for NPS and provide a national centre for information to be collated and shared in relation to NPS. This will assist the police, Crown Office and Procurator Fiscal Service (COPFS), trading standards, health service and those working in the front line by better identifying substances and providing information on the effects and how to treat more effectively.

The Scottish Government recently commissioned research to address some of the most important gaps in our knowledge about NPS use in Scotland. The aim of the research is to provide data on the prevalence, motivations and harms of NPS use amongst the following groups: vulnerable young people, users in contact with or identified by mental health services, homeless adults, new/existing injecting drug users, and men who have sex with men. The three key questions the research will address are around patterns of NPS use within the these subgroups, what the motivations, triggers, barriers and facilitators for NPS use and the short

and long terms harms associated with NPS use. It is expected the research will take nine months and will be completed by March 2016.

NPS remains a Ministerial priority for the Scottish Government and, as such, ADPs are also to continue to treat NPS as a priority in their areas. Following the review of the ADP Annual Reports a number of ADPs are taking a proactive approach to raising awareness of NPS and the dangers they pose by ensuring information and advice is available to the public. It is key that the partnership working with Drug Trend Monitoring Groups and other partners continues and that appropriate information is shared between agencies to better inform partners of what to expect in their respective fields and also to assist the Scottish Government in building the evidence base on NPS.

In 2015/16 the Scottish Government will be looking to work with local services to fund small tests of change. This will be to improve service design and look at new and innovative ways of reaching the NPS client group. An application process is currently being developed and further information on this will be provided shortly.

The Scottish Prison Service has been working in collaboration with CREW to develop 'training for trainers' training package on New Psychoactive Substances (NPS) for prison managers and staff. The training is designed to provide prison managers and operational staff with the knowledge and understanding of the emerging drug trends and their impact on prisoner management, and also to provide them with the skills to deliver NPS awareness training to prison colleagues and prisoners.

HMP Edinburgh has recently acted as a 'test site' for this training and lessons learned will be used to inform future roll out across the prison estate during 2015/16. Initial focus will be the training of prison staff and then thereafter training for prisoners, as training for trainers to enable Peer supporters to provide wider awareness of NPS to the prisoner population.

In addition to this national training package Prison Governors continue to liaise and work collaboratively with local community partners in relation to NPS.

These responses were submitted by the Drugs Policy Unit, Scottish Government, in April 2015.

APPENDIX PART A: NATIONAL FORUM MEMBERSHIP 2014/5

Chair

Dr Roy Robertson Professor of Addiction Medicine, Centre for Population Health Sciences, University of Edinburgh and Muirhouse Medical Group, Edinburgh

Vice-Chair

Dr Saket Priyadarshi Associate Medical Director, Greater Glasgow and Clyde Addiction Services

Members

Robert Aldridge	Director, Scottish Council for Single Homeless
Alana Atkinson	Health Improvement Programme Manager, NHS Health Scotland
Dr Alex Baldacchino	Lead Clinician & Consultant in Addiction Psychiatry, NHS Fife and Senior Lecturer at University of Dundee
Lee Barnsdale	Principal Information Analyst, ISD, NHS National Services Scotland
Garry Burns	National Policy & Practice Coordinator (Housing), Homeless Action Scotland
Tom Byrne	National Prisons Pharmacy Adviser, Healthcare Improvement Scotland
Emma Christie	Scottish Prison Service
Marina Clayton	Re-Solve Development Manager, Scotland
Dr Stephen Conroy	Lanarkshire Drug Treatment and Testing Order Team
Frank Dixon	Statistician, National Records of Scotland
Christine Duncan	CEO, Scottish Families Affected by Alcohol & Drugs
David Early	Data Manager, ISD Scotland
Wayne Gault	Team Leader & Strategy Manager, Aberdeenshire ADP
Ruth Gordon	Senior Information Analyst, ISD, NHS National Services Scotland
David Green	Head of Scottish Fatalities Investigation Unit, Crown Office
Kirsten Horsburgh	National Naloxone Coordinator, Scottish Drugs Forum
Dr Carole Hunter	Lead Pharmacist, Glasgow Addiction Service, NHS Greater Glasgow & Clyde And Chair of National Naloxone Advisory Group
Alexander Kelman	ADP Support Team Lead, Aberdeen City ADP
Robin Lawrenson	Clinical Performance Manager, Scottish Ambulance Service
Dave Liddell	Director, Scottish Drugs Forum
Chris Littlejohn	Consultant in Public Health Medicine, NHS Grampian
Dr Tony Martin	Drugs Death Research Associate, Glasgow Drug and Alcohol Partnership
Dr Julie McAdam	Forensic Pathologist, University of Glasgow
Andrew McAuley	Public Health Information Manager, NHS Health Scotland
Dr Claire McIntosh	Consultant Addiction Psychiatrist, NHS Forth Valley
D.I. Michael Miller	National Drug Co-ordinator, Police Scotland
Ruth Parker	Head of Health & Wellbeing, Scottish Prison Service HQ
Dr Samantha Perry	A&E Consultant, Western Infirmary, Glasgow

Angela	Prentice	Information Manager, ISD, NHS National Services Scotland
Carolyn	Rixon	Data Management Officer, ISD, NHS National Services Scotland
Eleanor	Robertson	Board Member, Scottish Families Affected by Alcohol & Drugs
Dr Maria	Rossi	Consultant in Public Health Medicine & Bloodborne Virus Co-ordinator, NHS Grampian
Jim	Sherval	Specialist in Public Health, NHS Lothian
Lynn	Sutherland	Public Health Officer, NHS Grampian
Jason	Wallace	Naloxone Training-Support Officer, Scottish Drugs Forum and National Volunteer Forum on Drug-related Deaths Coordinator

Scottish Government Official Support (Drugs Policy Unit)

Beverley Francis, Hilary Scott, Biba Brand, Scott McEwen and Vicky MacDougall

Secretariat (Scottish Families Affected by Alcohol & Drugs)

Susie McClue

Thanks to: Tommy Crombie, Garry Hecht, Catherine Thomson, John Campbell, Julie Carr and Gillian McKenzie who are now in new posts and have left the Forum.

SUBGROUP MEMBERSHIP 2014/5

NATIONAL NALOXONE ADVISORY GROUP

Chair

Dr Carole Hunter Lead Pharmacist, Glasgow Addiction Service,
NHS Greater Glasgow & Clyde

Members

Lee	Barnsdale	Principal Information Analyst, ISD, NHS National Services Scotland
Prof Sheila	Bird	Programme Leader, MRS Biostatistics Unit, University of Cambridge
Tom	Byrne	National Prisons Pharmacy Adviser, Healthcare Improvement Scotland
Emma	Christie	Scottish Prison Service
Elinor	Dickie	Public Health Adviser, Evidence for Action, NHS Health Scotland
Christine	Duncan	CEO, Scottish Families Affected by Alcohol and Drugs
Kirsten	Horsburgh	National Naloxone Coordinator, Scottish Drugs Forum
Dave	Liddell	Director, Scottish Drugs Forum
Christine	Lyall	Community Resuscitation Development Officer, Scottish Ambulance Service
Andrew	McAuley	Public Health Information Manager, NHS Health Scotland
Ruth	Parker	Head of Health & Wellbeing, Scottish Prison Service HQ
Dr Samantha	Perry	A&E Consultant, Western Infirmary, Glasgow
Jim	Sherval	Specialist in Public Health, NHS Lothian
Jason	Wallace	Naloxone Training-Support Officer, Scottish Drugs Forum

Papers only

Dr Saket Priyadarshi Associate Medical Director, Greater Glasgow and Clyde Addiction Services And Vice-Chair National Forum on Drug-related Deaths

Scottish Government Official Support and Secretariat (Drugs Policy Unit)

Malcolm Cowie, Frances Warren, Fiona Fraser, Hilary Scott, Michael Crook, Rachel Tatler and Andrew McKie.

Thanks to Dr Parveen Chishti and D.I. Tommy Crombie who left the group in 2014.

PATHOLOGY SUBGROUP

Chair

Dr Saket Priyadarshi Associate Medical Director, Greater Glasgow and Clyde Addiction Services and Vice-Chair National Forum on Drug-related Deaths

Members

Jim	Allison	Service Clinical Director – Biochemistry, Consultant Clinical Scientist, Aberdeen Royal Infirmary
Lee	Barnsdale	Principal Information Analyst, ISD, NHS National Services Scotland
Dr Ralph	Bouhaidar	Honorary staff Member, Pathology Department, University of Edinburgh
Frank	Dixon	Statistician, National Records of Scotland
Prof		Professor of Cellular and Molecular Pathology and Director of the
Stewart	Fleming	Centre for Forensic and Legal Medicine, University of Dundee
David	Green	Head of Scottish Fatalities Investigation Unit, Crown Office
Dr Julie	McAdam	Forensic Pathologist, University of Glasgow
Dr		
Rosslyn	Rankin	Consultant Pathologist, Raigmore Hospital, Inverness
Dr David	Sadler	Forensic Pathologist, University of Dundee
Dr		
Duncan	Stephen	Consultant Clinical Biochemist & Forensic Toxicologist, NHS Grampian
Dr Hazel	Torrance	Manager of Forensic Toxicologist Service, University of Glasgow
Marjorie	Turner	Consultant Forensic Pathologist, University of Glasgow
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Secretariat (Scottish Families Affected by Alcohol & Drugs)

Susie McClue

Thanks to Dr James Grieve, D.I. Tommy Crombie and Gillian McKenzie who left the group in 2014.

RESEARCH & DATA MONITORING SUBGROUP

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Dr Roy Robertson Professor of Addiction Medicine, Centre for Population Health Sciences,
University of Edinburgh and Muirhouse Medical Group, Edinburgh

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Lee	Barnsdale	Principal Information Analyst, ISD Scotland
David	Early	Data Manager, ISD Scotland
Peter	Fairbrother	Drug Death Review Co-ordinator, NHS Lothian
Ruth	Gordon	Senior Information Analyst, ISD Scotland
Dr Lesley	Graham	Associate Specialist, Public Health, Health Improvement Team
Robin	Lawrenson	Clinical Performance Manager, Scottish Ambulance Service
Dr Tony	Martin	Drugs Death Research Associate, Glasgow Drug and Alcohol Partnership
Andrew	McAuley	Public Health Information Manager, NHS Health Scotland
Dr Claire	McIntosh	Consultant Addiction Psychiatrist, NHS Forth Valley
Angela	Prentice	Information Manager, ISD Scotland
Carolyn	Rixon	Data Management Officer, ISD Scotland
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Fiona Fraser and Michael Crook

Secretariat (Scottish Families Affected by Alcohol & Drugs)

Susie McClue

Thanks to Julie Carr, Garry Hecht, Gillian McKenzie and D.I. Tommy Crombie who left the group in 2014.

APPENDIX PART B: JOINT STATEMENT FROM NFDRD AND EXPERT ADVISORY GROUP

Dear Colleagues,

Within the National Forum on Drug-related Deaths and the Expert Advisory Group we represent a large group of professional organisations whose work impacts on drug use and drug users. Our joint interests are to prevent morbidity, ongoing drug taking and mortality in those experiencing periods of custody. We would like to express a view on the urgency of developing and supporting a robust and evidenced based policy for treatment of people with drug, alcohol and mental health problems in custodial settings. This clearly includes the SPS estate and NHS prisons, but also requires cooperative and collaborative involvement of police custody suites and recognition of the essential continuity of management of drug and alcohol related problems before and after periods of confinement.

We recognise that providing high quality health and recovery services in these settings are challenging and complex tasks. We also recognise the extraordinary work done by many colleagues in these settings but we think that a clear and unambiguous policy is necessary to maximize the efficacy of evidence based treatments for individuals with drug and alcohol dependency problems, often major factors in bringing them into prison.

Problems are visible to all health and social care professionals involved with the transition from the community to custody and back to the community. These, we believe, could be helped by a treatment policy and facility that recognised the following essential elements. Offenders are often using a range of opioid and psychoactive drugs prior to admission to prison sometimes in a disorganised and non addictive pattern. For many reasons they have frequently been outside recognised treatment services. Most custodial periods are relatively short and therefore are an opportunity for change but unlikely to be little more than a period of stabilisation rather than a serious and prolonged recovery time. The best available evidence suggests that treatment in these situations should be using the appropriate substitute drug and maintaining this for a prolonged (often at least 2 years) time. Treatment should continue, therefore, until and after discharge from custody with no interruption. Maximum use of the opportunity to treat and engage with offenders offers the most important way we know of to reduce drug-related deaths. We believe that adequate treatment will result in

harm reduction benefits that are well established and that engagement in custodial settings may well be the beginning of an individual's recovery journey. Partnerships working together in the interests of this population are essential to reduce not only the consequences of continued drug use but also recidivism. There is compelling evidence that a restrictive approach to availability of drugs in prison has failed to stop injecting and other non-prescribed and hence dangerous drug taking. It is well known and accepted that prevention of drug-related harms is best served by the widest possible availability of alternative measures, in this context prescribed opioid replacement therapy. Considering the evidence from many studies the restriction of opioid replacement therapy is with holding a potentially lifesaving therapy.

In conclusion, clear directions should be available to those caring for prisoners that opioid replacement therapy should be continued at optimal dosage throughout periods of custody for those who want it and are considered to benefit from it. This should be seamlessly available during the transition and Throughcare periods. Buprenorphine should be available as an alternative to methadone where appropriate. Mental health problems and dual dependencies have to be recognised as ongoing problems and treated with a view to longer term outcomes rather than short term goals. For those with an opioid problem revealed for the first time on reception methadone or buprenorphine should be available with the usual supporting framework. Naloxone should be supplied to all those leaving these settings at risk of opioid overdose. Underpinning these recommendations are the principles of reducing harms associated with illicit drug use and increasing wellbeing and engagement with recovery opportunities.

We are under no illusion that the treatment of offenders in and after custody is complicated and that skilled clinical judgement is required to manage difficult and varied situations. The risks are high and there are many circumstances which need to be considered before effective and compassionate treatment can be tailored to individual needs. We do, however, consider that current policy is inconsistent in its lack of a clear commitment to provide the best opioid replacement therapy in optimal and therapeutic doses over the period when risks are at their highest. Lack of resources is not an adequate excuse and every attempt needs to be made to comply with the best available guidance. In formulating and publishing National Policy there must be clarity and authority. Without this the present random drug use in custody and the associated risks after discharge will continue.

The following extract from a European document seems a useful summary:

“A systematic review of the effectiveness of opioid maintenance treatment in prison (Hedrich et al., 2012) analysed data from 21 studies, including six experimental studies. The authors concluded that the benefits of the treatment in prison are similar to benefits in community settings; namely, it presents an opportunity to recruit problem opioid users into treatment, to reduce illicit opioid use and risk behaviours in prison and potentially minimise overdose risks on release. Positive outcomes depended on the quality of treatment. The review highlights the importance of establishing a liaison between prison and community-based programmes in order to achieve continuity of treatment and longer-term benefits. The data also show that disruptions in the continuity of treatment, especially owing to short periods of detention, are associated with very significant increases in hepatitis C incidence.”¹⁵

Dr Grace Campbell

Dr Saket Priyadarshi

Prof Roy Robertson

February 2015

This letter was shared with NHS Medical Directors for appropriate action following the National Prisoner Healthcare Network Advisory Board Substance Misuse Workstream meeting in March 2015.

¹⁵ Source: *Prisons and drugs in Europe: the problem and responses* EMCDDA, Lisbon, November 2012 Pages 22-23

APPENDIX PART C: Feedback from NVFDRD

Encouraging Better Engagement

1. What type of support would help you engage better with health services?
 - Access to faster appointments
 - Better Throughcare
 - Peer educators in services doing the job
 - Breaking down information into layperson's terms.
 - No threat of removal or reduction from prescription
 - If service was known to be approachable and didn't have such stringent methods of control
 - More flexibility in available times for people who work maybe night time or evening appointments
2. What would have improved your experience of health services?
 - To be treated with respect mental health and drug issues to be treated together
 - Less stigmatisation and doctors adhering to person centred care plan
 - Not tarring every patient with the same brush
3. How do you decide if a health service is meeting your needs?
 - Feel that you can approach them without fear of reprimand
 - Improvement of physical and mental health
 - Less criminality and more stable
 - When you get past the receptionist trying to get an appointment and being told you need to wait 2 weeks when you are due your prescription in 4 days
 - When you know you can tell your drug worker anything without fear of being judged or feeling embarrassed
 - Full involvement My decision what route I was taking as I know myself better than anyone being able to decide what happens and at what time
4. What involvement did you have in your Care/Support Plan?
 - WHAT care plan?
 - Having to sign a contract you know you can't stick to
 - Staff tend to write your care plan then ask questions of you when you come back in 2wks/month you maybe don't even remember what was asked at last appointment
 - Threat of being sanctioned if you didn't attend appointment at specified time

5. What recommendations do you think would improve services?

- Self-directed support
- Person centred care plan
- Menu of choices
- A more understanding caring worker
- Not getting a different worker every month or 3 month
- Continuity with staff building up trust and respect then that staff member leaves and you need to start all over again with someone new
- Everyone is different and issues should be treated individually
- More flexibility
- Less sanctions
- Unplanned discharges should be banned
- There should be some kind of safety net if you have an unplanned discharge as you're at high risk of death homelessness or losing job

Unplanned Discharges

Do you have any examples of being discharged from a service? Please explain

We discussed Unplanned discharges from treatment and some of the reasons for this the peers discussed some of the reason they had heard from service users like being late for appointments, using illicit drugs on top of substitute prescription, not being able to meet the requirements of the service.

- Discharged from residential rehab for refusing to give information on other residents
- Giving a dirty urine sample then being discharged
- Presenting groggy in morning then being stuck off script (in Prison)

