

National Forum on Drug Related Deaths in Scotland

Annual Report 2011-12

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The National Forum on Drug-Related Deaths, established in 2005, is an independent expert group which examines trends and disseminates good practice on reducing drug-related deaths in Scotland. The Forum is a multi-disciplinary group which consist of participants from a range of medical, social, community, prison, police, legal and non-statutory agencies.

Introduction

Welcome to the National Forum on Drug-Related Deaths 2011/12 Annual Report. This is the Forum's fifth report and comes at a time when scrutiny of drug policy is intense. As announced at the Forum's media briefing on 17 August 2012, regrettably the number of deaths in Scotland in which controlled drugs were implicated, increased in 2011 for the first time since 2008. The 584 drug-related deaths in 2011 are the highest ever recorded and, for the first time, methadone was implicated in, or contributed to, almost half of the deaths.

In response to concerns expressed by the public about drug-related deaths where methadone was implicated, the Minister for Community Safety and Legal Affairs, Roseanna Cunningham established an Independent Expert Group (announced in October 2012). The purpose of the group is to gather evidence on practice and experience of opiate replacement therapies, like methadone, and community and residential rehabilitation. The Expert Group is led by the Chief Medical Officer in collaboration with the independent Drugs Strategy Delivery Commission and is due to report its findings to the Scottish Government in Spring 2013. The Forum will have an opportunity to work with, and offer evidence, to this independent group. These 2011 drug death figures also generated considerable interest in the Scottish Parliament. A parliamentary debate was held in November 2012, on the national drugs strategy *the Road to Recovery* led by the Minister. Following the debate political consensus for the strategy was re-confirmed.

Despite the disappointment and challenge represented by the figures, the Forum and its members remain committed to understanding and reducing drug-related deaths in Scotland, and the expertise and output of the Forum will, of course, inform the important work of the independent expert group.

Chapter one of this report provides information on the Forum's work and progress during 2011/12. Chapter two highlights key priority areas of work that need to be further progressed to help reduce drug-related deaths. Chapter three focuses on two key recommendations that the Forum recognises as very important interventions in reducing drug-related deaths in Scotland. The Forum's more detailed response to the drug-related deaths statistics for 2011 is included in chapter four and the Forum's insights from the National Drug-Related Deaths Database findings on deaths in 2010 is detailed in chapter five. Scotland's National Naloxone Programme is progressing well across the country and an update on progress is provided in chapter six.

The work of the Forum in 2011/12 has been wide ranging, influential and has required considerable investment of time and resources from the Drugs Policy Unit and the members of the groups. Special appreciation must go to John Somers, Kathleen Glazik and other members of the Scottish Government's Drugs Policy Unit for their commitment, guidance and support, and also to Dr. Lesley Graham and Gordon Bruce from Information Services Division Scotland for their management and reporting on the National Drug Deaths Database. The invaluable work of Drug Deaths Coordinators in all the Alcohol and Drug Partnerships is also acknowledged.

Dr. Roy Robertson and Dr. Saket Priyadarshi
National Forum on Drug-related Deaths in Scotland
February 2013

1. Forum's Work and Progress in 2011/12

- 1.1 Since the Forum's last annual report, published in November 2011, the Forum has considered evidence and has engaged in discussions with a wide range of colleagues and organisations, and has discussed the findings of a number of publications. Among the former has been a selected group of experts including experts on medical and social issues, as well as those close to public health policy, service provision and opinion makers. This report covers the period August 2011 to November 2012 and during that time the Forum has held five one day meetings and an Away Day in May 2012. These meetings all had themes and were individually designed to explore an issue of importance on drug-related deaths. The topics covered and the presenters are listed in Annex A.
- 1.2 Also in the quarterly meetings were opportunities to update the Forum on the work of its subgroups. There is currently a Data Collection Sub Group and a Pathology Sub Group. Regular updates were also received from the National Records of Scotland on collating drug-related deaths statistics, the Scottish Prison Service, the Scottish Crime and Drug Enforcement Agency and the National Naloxone Advisory Group. The Forum would like to thank the Chair and members of the Short-Life Working Group on Family Support who looked at the support available to families following a suspected drug-related death. The Volunteer Forum has not met during 2012 and the Forum is keen to continue engaging with service users. Members of the Forum and its subgroups are listed in Annex B.
- 1.3 The Forum publishes a bi-annual newsletter, Drug Death Matters¹, which provides an update on the group's on-going work. The most recent newsletter was published on-line by Information Services Division (ISD) Scotland in December 2012.
- 1.4 Interventions recommended in previous reports and which have been acknowledged by Ministers, have been pursued this year. Some of these recommendations, such as the national naloxone programme and the drug deaths database, have had results of international significance. In addition, the need to widen the range of opiate substitute prescribing has been recognised as an important part of on-going responses to the problems of mortality and morbidity in this population.
- 1.5 There were also opportunities to present the Forum's views and findings to the Minister for Community Safety and Legal Affairs. The Scottish Government responded to the Forum's 2010/11 recommendations in May 2012 and this is included in Annex C. A number of these recommendations are work in progress but areas to note are:
- The Forum emphasised that prisons remain a crucial part of the naloxone programme, as the published evidence states that prisoners are particularly

¹ [Drug Death Matters Newsletter Issue 14](#)

vulnerable to opioid overdose in the first 12 weeks following liberation. Monitoring data published by ISD Scotland in July 2012 showed progress, with 715 take home naloxone kits being issued by Health Boards in prisons, to prisoners at risk of opioid overdose on their release in Scotland in 2011/12. The National Naloxone Advisory Group is continuing to work nationally and locally to identify and address challenges, build on progress made so far and ensure that on liberation, prisoners are supported in their transition to the community naloxone programme.

- In addition, following the integration of prisoner healthcare services with the NHS on 1 November 2011, the Forum welcomes the establishment of the National Prisoner Healthcare Network (NPHN). The NPHN comprises all 14 territorial NHS Board leads for prisoner healthcare, Scottish Prison Service, NHS National Services Scotland, Healthcare Improvement Scotland, NHS Education Scotland, the State Hospitals Board for Scotland, Scottish Government and Union and third sector representation. This important group will enable stakeholders to participate in a collective where issues regarding prisoner healthcare can be raised and national solutions agreed. The Forum is interested in this group's work as it progresses.
- We understand that work to revise the National Quality Standards for Substance Misuse Services is underway. This work will allow the standards to fully and robustly evidence the performance of recovery-focused local addiction services. This is in line with the Scottish Government's *Road to Recovery* strategy and the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) *Quality Alcohol Treatment and Support* (QATS) report. This work and the findings of the independent expert group on opiate replacement therapies, will help inform thinking on any updates to the Orange Guidelines (Drug Misuse and Dependence UK Guidelines on Clinical Management) in line with recovery, as recommended by the Forum.

1.6 The Forum's Chair also had an opportunity to present the group's work to the independent National Drugs Strategy Delivery Commission. In addition, the Forum was represented by the Chair at an expert group meeting at the European Monitoring Centre for Drugs and Drug Addiction held in Lisbon in November 2012, where the most recent report from the National Drug-Related Deaths Database² was presented (2010 drug deaths).

1.7 It has also been an important year for the publication of evidence and considered opinion. The report from the Department of Health's Recovery Orientated Drug Treatment Group³, chaired by Professor Strang, was an important and authoritative document on the position of treatment services. The UK Drug Policy Commission produced two very useful documents, one on stigma⁴ and the other about legal control of drugs and sentencing policy⁵. These should both influence the perception of drug users and policy in the area of drug control and legislation. The Home Affairs Committee published

² [National Drug-Related Deaths Database](#)

³ [Medications in Recovery Re-orientating Drug Dependence Treatment](#)

⁴ [Getting serious about stigma: the problem with stigmatising drug users](#)

⁵ [A Fresh Approach to Drugs](#)

the report [Drugs: Breaking the Cycle](#)⁶ in December 2012. The Home Affairs Committee took evidence from a wide range of interested experts and presented some recommendations, some of which resonate with our own. On the international stage, the Global Drug Strategy Commission produced a report about the international approach to control of narcotics⁷.

⁶ [Drugs: Breaking the Cycle](#)

⁷ [War on Drugs: Report of the Global Commission on Drugs policy June 2011](#)

2. Forum's Observations on Key Priority Areas of Work

2.1 With reference to the Forum's recommendations from last year (and previous years), and the Scottish Government's response to these, the Forum recognises the challenges in progressing these recommendations. However the Forum would like to re-iterate that the following remain key priority areas of work to reduce drug-related deaths:

- Hepatitis C treatment in community settings has been difficult to develop and further efforts are required to allow shared care models to achieve significant impact. Health Boards should report difficulties encountered and strategies for overcoming these.
- Throughcare for those leaving prison and relocating in communities is slow to develop. This is a central strategy in addressing the risk of death from overdose in the months after leaving custody. Transfer of health care to the NHS is now complete and liaison with community health and social care services needs to be improved and developed.
- Data on drug and alcohol treatment waiting times within prisons has not been published to date. Publishing this information would be valuable in ensuring that there is continuity in the care arrangements of those requiring drug treatment, especially given the increased risk of a drug related death within the first 12 weeks of release from prison.
- Alternatives to methadone remain available to a minority of drug dependent patients. These alternatives are other pharmacotherapies and non-pharmacological interventions such as detoxification and residential rehabilitation. Successful recovery depends upon increased capacity in projects designed to address the longer term problems. One specific example is the possibility of methadone and other opiate substitute therapy maintenance being part of a recovery package in residential recovery agencies.
- Community pharmacies remain vulnerable to criticism and to (lack of) capacity problems. Support and adequate resources are required to maximise the role that optimal pharmaceutical care can play in promoting recovery for individual patients. The Forum recommend that the document *Prevention and Treatment of Substance Misuse-Delivering the Right Medicine: A Strategy for Pharmaceutical Care in Scotland* which was published by the Scottish Executive in 2005, is updated to reflect current strategies to help prevent drug-related deaths.
- The roll out and reach of the national naloxone programme needs to be significantly enhanced. Specialist addiction services need to provide training and provide naloxone to their clients. The Scottish Government should explore how best to deliver this including the possibility of a target for Alcohol and Drug Partnerships (ADPs).

- More work needs to be done by the Scottish Government and ADPs to investigate the specific needs of older drug users (35+years) with a view to improving services for this population.
- In the event of a further prolonged delay by the Home Office including foil in the list of exempted items in section 9a of the Misuse of Drugs Act 1971, the Forum request that the Lord Advocate issue a Letter of Comfort in Scotland, to allow drug treatment services to supply this item of paraphernalia.

3. Forum's 2011/12 Recommendations of High Priority

Drug Treatment as a Core Service in Primary Care

- 3.1 The Scottish Government and Health Boards should develop a clear strategy and commitment to providing support for evidence based interventions. These commitments include ensuring the normalisation of drug treatment in general practice and secondary care, by including work with drug users as core services and the responsibility of all medical and nursing qualified professionals. Despite previous recommendations, health care workers in primary care, secondary care and community pharmacies may still offer a service to drug users which is less sympathetic and supportive than that to other patient groups. This is based on an inappropriate stigma associated with addiction and sometimes erroneous beliefs of the efficacy of treatment.
- 3.2 The opportunity to establish treatments for dependency problems as central to the contract should not be overlooked. Guidelines for all specialist care providers should recognise that addiction problems are increasingly associated with chronic disease. The population of dependent patients with co-morbidity is increasing as time passes and all specialities need a knowledge and expertise in dependency. As previously recommended, training at undergraduate and postgraduate levels is a consequence of these changes.
- 3.3 The recently published document by the British Medical Association (BMA) titled *Drugs of Dependence: The Role of Medical Professionals*⁸ highlights many of the issues which are germane to the views of the Forum and is highly recommended to Ministers and Health Boards as well as those working with drug dependent patients in the NHS (BMA Board of Science 2013).

Recommendation 1

There is a need to encourage all GPs to consider treatment of drug users as essential, rather than optional, work.

Integration of the whole range of requirements of drug users into General Practice and Primary Care is still underdeveloped. This may be due to inadequate guidance, poorly targeted resources and lack of recognition of the central position General Practice has in managing these problems. The BMA Report mentioned above highlights the health issues and suggests that the NHS alter its position and attitude.

Specific examples of how these issues might be addressed might be the inclusion of drug and alcohol services in the current discussions on a separate Scottish Contract for General Medical Practice and Primary Care and updated guidelines for clinical practice.

Action for: Scottish Government and Primary Care Services

⁸ [Drugs of Dependence: The Role of Medical Professionals](#)

Data Analysis of Drug-Related Deaths in Scotland

- 3.4 The Scottish Government is in a strong position to lead discussion on drugs policy and, in many ways, is in a position to recognise the need to change in a direction suggested by various advisory authorities. The European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) and other international groups recognise the investment made on issues such as gathering data on the details of drug related deaths, and scrutinising these data for possible interventions which might prevent deaths in this group.
- 3.5 Significant achievements in recent years have included reducing waiting times for treatment and standardising the post death legal, pathological and toxicological processes. In addition, Scotland's naloxone programme is world leading and is being closely observed by many countries that are now planning similar interventions. The recurring themes of early intervention and engagement in treatment for those most vulnerable and at highest risk of death, together with infrastructural capacity, are more demanding than ever.
- 3.6 Last year's recommendations included the need to develop the data handling capability of the Forum. In addition the recommendation about planning and expanding national and international networks through the EMCDDA and the medium of an international conference or symposium was agreed but not progressed. The agreed position, from the Scottish Government's response, was that work in this area should be agreed and developed through the Data Collection Sub-Group and that, within limits, this would be supported. However, due to other priorities this work has not been progressed. Also, the Data Collection Sub-Group has similarly a limited capacity for initiating and developing suitable projects.
- 3.7 The importance of accurate and dynamic data handling is greater than ever and the Forum requires access to an academic facility to work with ISD and others in determining the basis and correct responses to our drug deaths problem. Developmental work with ISD has been very encouraging with the appointment of an intern to help with the analysis of the dataset for 2011. The following recommendation is based on the need for further development in data collection in a more substantial framework.

Recommendation 2

A three year project should be supported to allow an academic post to work with a university department and to research drug deaths in Scotland. This should be a stage towards establishing a future academic department in a Scottish university which might address the medium to long term clinical and behavioural research interests into Scotland's enduring problem of drug and alcohol misuse.

The project worker should be appointed to work with the Forum and any relevant agency, in order to establish and develop relationships with relevant academic institutions and projects, which might inform the work of the Forum. This person would have suitable academic credentials and capability to work independently but guided by a steering group from the Forum.

Such a project would allow comparisons with published literature, links with relevant academics and production of papers for the Forum, Scottish Government and academic journals. This would allow the work of ISD Scotland, ADPs, the Forum and others to be synchronised and set in the context of the available academic understanding of drug related deaths.

Action for: Scottish Government and Information Services Division Scotland

4. Forum's Response to the National Records of Scotland Drug-Related Deaths in Scotland 2011 Statistics

- 4.1 The National Records of Scotland (NRS) published its annual report, *Drug-Related Deaths in Scotland in 2011*⁹ on 17 August 2012. There were 584 drug-related deaths in 2011. This was the highest number ever recorded since these statistics began in 1996 and was 20% higher than the 485 deaths registered in 2010. Methadone was implicated in, or potentially contributed to, 275 deaths in 2011, which was 47% of all drug-related deaths. The largest percentage increases, over time, have been amongst those aged 35-44 years and 45-54 years. There has been a fall in the proportion of drug-related deaths in those under 25 years.
- 4.2 The rise in drug-related deaths in 2011 is, of course, a source of great disappointment and regret. The Forum has discussed the findings in the NRS report in depth and has had time to reflect on the implications and meaning of the figures. The opportunity to further examine these data will arise when ISD's Drug Related Deaths Database report is published in April 2013. The database report will give more detail and context to the deaths where further information is available from local sources.
- 4.3 The initial response to the headline figure of 584 deaths is that this represents a total in keeping with the underlying long term upward trend. Despite the drop in the total number of deaths over the two preceding years, the trend over a ten year period has been upwards. Looked at more carefully, there is a suggestion that the rate of increase may be slowing down, perhaps even plateauing, because there has been little change recently in the value of the 3-year moving annual average, and this may eventually turn into a downward trend.
- 4.4 In the 2011 figures there is a picture of a rise in age among those dying a drug-related death. This is again in keeping with the expectation that the Scottish problem is, like many other Western European countries, representative of a mature or even ageing cohort of people who have used drugs. The fact that more deaths were in the older age range was not surprising, as was the finding that the majority were men and located in the larger conurbations where there is inevitably a larger number of people who use, or have used drugs, and therefore are at risk of dying. Importantly, when the figures produced by NRS are compared with the estimated numbers of problem drug users, the difference between localities is less noticeable, indicating, that a drug user's risk of death is more or less the same regardless of where they live. As time passes, the cohort of ageing drug users enters an age range when the impact of prolonged drug use is greater. Individuals who have contracted blood borne virus infection, most commonly Hepatitis C, are at an advanced stage of a long term illness, complicated often by problem drinking. The impact of two or three decades of heavy smoking of cigarettes and cannabis is resulting in a compromised respiratory and cardiovascular system.

⁹ [National Records of Scotland Drug-Related Deaths in Scotland in 2011 Report](#)

- 4.5 The NRS then compared the annual average numbers of deaths in 1997-2001 and 2007-2011, in order to reduce the effect of year-to-year fluctuations on the figures. Between the two periods, the percentage increase in deaths was greater for women than men, and greater for the older age-groups (35+) than for the younger ones.
- 4.6 The headlines which attracted most attention were the increase in methadone as the most common drug found at post mortem toxicological analysis and the continued high recording of benzodiazepines. As a percentage, heroin featured less than in previous years. Alcohol was present in a significant number of cases indicating an important, and perhaps an increasingly important risk cofactor. These figures have various possible interpretations. The first is that more than one drug is almost invariably present, and sometimes three or more. When considering the impact of methadone, it is important to note that there were few deaths where methadone was the only drug present (14 drug-related deaths) and could confidently be said to have been the single cause of death. Of the majority, where there were multiple drugs detected, the amounts of methadone were variable and the relative importance of methadone as causal in the death is difficult to assess. The pathologist in many cases felt that it was sufficient to say that the death was caused by an unfortunate combination of drugs which affect the respiratory centre of the brain. The most reasonable and balanced view might be, therefore, that all these drugs are dangerous and potentially lethal if used injudiciously, and this risk is compounded when there is a combination and consequent synergistic effect.
- 4.7 The steep rise in methadone related deaths in 2011 is not yet well understood. It is noticeable, however, that this has coincided with a marked reduction in the purity of heroin seizures, suggesting that heroin users were perhaps taking methadone in place of poor quality heroin. However, further investigations into these deaths are required. Analysis of the Drug-Related Deaths Dataset for 2011 might clarify some of the pressing questions about methadone implicated deaths, such as the number and circumstances of cases where the individual was not receiving methadone on prescription and the sense behind the finding that individuals receiving a prescription for methadone are still, apparently, taking other drugs including heroin. For those in clinical and prescribing practice the reality is that drug-dependent patients and individuals use multiple drugs, and even when considered to be stable on a maintenance prescription, are at risk of death from situational crises causing relapse into illegal drug use, or supplementing their prescribed medication. The well-recognised risk of overdose after a period of loss of tolerance may well account for some of these fatal incidents. Further examination of these data to assess this increased risk is underway. It is recognised that a period of relative reduced tolerance can occur in various situations including custodial sentencing, detoxifications from a therapeutic intervention or even a period in hospital.
- 4.8 The urgency to respond to these figures is tempered by these observations but the need to maximise those services and treatments that are likely to reduce the risk of death remains. Treatment services do not need to be

reminded of the importance of maximising the evidence based interventions and local services should understand that safe expansion in such interventions may well save lives.

4.9 Further clarity is required by the Forum, on behalf of the Drugs Strategy Delivery Commission and the Scottish Government, in understanding the relationship between death and recent hospital or prison experience, the relationship between injecting drug use and deaths and the complex areas of the increased risk of death from various combinations of drugs, including alcohol. The development of our understanding of drug-related deaths is being taken forward by the National Drug-Related Deaths Database group at ISD who have recently appointed a short term researcher to address some of these questions with the support of the Scottish Government.

4.10 A summary of the Forum's main observations from the NRS report:

- Although the increase in numbers is very regrettable, it is in keeping with the overall upward trend shown over the last decade. The last two years had an absolute decrease but the trend remained upwards;
- As in the rest of Europe heroin supplies had been lower in 2011 and this could account for the shift in position of the drugs implicated;
- Methadone, although present in the largest percentage of cases, was in most of these, accompanied by other drugs which clearly combined to cause the fatal incident;
- It is not possible from these figures to say whether the methadone present at death came from a prescription issued to that person or from another source;
- The ageing cohort of drug users in Scotland is represented in these figures and might be expected to continue;
- Policy should remain resolute in the prescribing of opiate substitute treatment, and recommendations made elsewhere in this and previous reports should be considered relevant.

5. Insights from Scotland's Drug-Related Deaths Database: 2010 Deaths

5.1 The Forum's 2010/11 annual report commented on the findings of the first report from the National Drug-Related Deaths Database (Scotland) Report which provided detail on the drug-related deaths which occurred in Scotland in 2009. The information provided gave an invaluable insight into the circumstances of individuals who died from a drug-related death during that time. Although the NRS drug-related deaths statistics provide information on the number of drug-related deaths broken down by age, gender and geographical area, as well as toxicology information on the drugs implicated in the death, in contrast, the National Drug-Related Deaths Database takes this information as its starting point and collects more detailed socio-demographic information and treatment history on each drug-related death.

5.2 The National Drug-Related Deaths Database's second report¹⁰ was published by ISD Scotland in February 2012. The report provided background information on a cohort of 365 drug-related deaths which occurred in Scotland in 2010. These drug-related deaths are a sub-set of the 485 drug-related deaths included in the National Records of Scotland (NRS) Drug-Related Deaths Report 2010 (published in August 2011) and represent cases where substantial further information was available. The report told us that:

- Of the 365 deaths analysed 79% were male, around half lived in the most deprived areas and the highest frequency of deaths occurred amongst the 25-34 and 35-44 year age groups (36% and 32% respectively).
- Access to drug treatment services/ability of services to meet the needs of their clients where known - 59% of the cohort had been in contact with drug treatment services at some point prior to death and 25% had been in contact with services in the month prior to death including addiction services, the patient's GP, an Accident and Emergency Service, a psychiatric service and social work services.
- Use of illicit methadone and supervision of prescribed methadone – one quarter of the cohort were receiving a substitute prescription at the time of death (89 cases) and the majority of these were being prescribed methadone (74 cases). In 64 of the 89 cases, substitute prescribing had been supervised.
- High prevalence of co-occurring psychiatric conditions and problem alcohol use – in the 6 months prior to death, an underlying psychiatric condition was present in 41% of cases (largely depression and anxiety), whilst problem alcohol use was recorded for 35% of the cohort.
- As well as mental health problems, physical comorbid conditions were common with liver, Hepatitis C and Hepatitis B or HIV problems affecting or being present in (38, 72 and 13 cases respectively). Eighty two cases

¹⁰ [National Drug-Related Deaths Database second report: 2010 Deaths](#)

had significant cardiovascular or respiratory conditions and eight had diabetes.

- 5.3 These findings provide a better insight into the complexity of the cases of drug-related deaths. A picture emerges which supports the clinical impression of individuals with multiple problems and conditions which are likely to affect wellbeing and in some cases survival. The ambition of the Forum's Data Collection Sub-Group and the Forum is to progress this project to analyse these results and to answer more detailed questions which might identify special sets of circumstances which may make an individual especially vulnerable to a drug-related death.
- 5.4 Questions about the nature of methadone prescribing and the value and protective effect of supervision are of pressing importance. There are clearly patients who die despite methadone supervision and others where methadone is implicated where the individual was not known to be in receipt of a prescription. Any clarity on the circumstances of these situations and the combination of risk factors which result in death is important.
- 5.5 The National Drug Related Deaths Database has helped not only profile those who die from drug-related deaths in more detail, but has also provided important context for the drug deaths statistics. This in turn should help guide the Forum's future priorities.
- 5.6 The summary above excludes other important findings but confirms that drug deaths occur most often in ageing, male, chronic drug users from our most deprived communities who are out of treatment. This cohort of drug users who are not in structured opiate substitute treatment and have multiple morbidities (which may be additive risks for death) may well be in contact with acute and primary care services. These services have an opportunity to recognise risks and take appropriate actions as they would for any other group of individuals with high risk of poor outcomes. Polysubstance misuse, whether the substance is implicated in the death or not, seems the norm for these individuals, as does a high prevalence of problem drinking and psychiatric co-morbidity (both of which are likely to be even higher than that recorded by the database, as so much is often not recognised). Drug death prevention services should be most targeted for drug users who match this profile.
- 5.7 The fact that only a quarter or less of deaths occur in opiate substitute treatment seems to confirm the international evidence of the protective role of such treatments. However, there is an urgent need to understand not only deaths in opiate substitute treatment but also methadone related deaths in those out of treatment.
- 5.8 With so many individuals who died having contact with services prior to their death, it is imperative that we promote the recognition of drug death risks and an appropriate and co-ordinated response by such service providers.
- 5.9 These are a few, but not exhaustive, range of findings and possible areas for development triggered by the information within the database. Our challenge

is to understand this information as well as possible and to communicate findings and advice.

- 5.10 The third National Drug Related Deaths report is due to be published by ISD in April 2013 and is based on information concerning individuals who died drug related deaths in 2011. As well as providing a similar level of detail concerning the background circumstances of these deaths as the previous two reports have done, this third report will also explore some topics in greater depth. It is expected that the findings from this report will further enhance existing knowledge of the lives of those who die from drug related deaths and will be useful for continuing efforts to prevent such deaths. Following analysis of the 2011 dataset, we will have 3 years' worth of drug deaths data and our immediate priority is to understand deaths involving methadone.

6. Update on Scotland's Naloxone Programme

- 6.1 The National Naloxone Programme has continued to develop and expand across Scotland. Nearly all ADP areas have established a level of local capacity to provide overdose prevention training and naloxone supply to people at risk of opioid overdose. Thousands of sessions have been delivered, either in 1 to 1 or group settings directly training and supplying kits to people who use opiates.
- 6.2 The first annual release of monitoring information on take home naloxone supplies¹¹ was published by ISD Scotland on 31st July 2012. This initial report presents data from the period April 2011 – March 2012. Some key findings were:
- 3445 take home naloxone kits were supplied through Scotland's naloxone programme;
 - Of these, 2730 kits were supplied in a community setting and 715 by the Scottish Prison Service to prisoners at risk of opioid overdose on liberation;
 - 90% of the total number of kits supplied were to people at risk (3085 kits) of a opiate overdose. The remaining kits were supplied to family members and friends (with consent of the individual) and service staff;
 - 145 kits were issued as a 'repeat' supply due to reported use of the previous kit on a person at risk of opioid overdose.
- 6.3 As well as monitoring the supply of 'take-home' naloxone kits in Scotland, ISD were tasked by the National Naloxone Advisory Group to measure the impact of increased naloxone availability on the number of (opioid) drug related deaths in Scotland and, in particular, to monitor the number and percentage of these occurring within four weeks of prison release. ISD have conducted a baseline survey, using calendar years 2007-2009, and the results of this are included in the July 2012 naloxone monitoring report. Performance against this baseline will be measured for calendar years 2010-2013.
- 6.4 A series of innovative radio adverts highlighting how friends, families and people who use drugs can prevent opioid overdose deaths were launched across Central Scotland to mark International Overdose Awareness Day.
- 6.5 Updates and information on the National Naloxone Programme are now available on a variety of social media platforms such as:
- The website www.naloxone.org.uk is live and offers a Scottish focus but also has information from across the UK and internationally.
 - Facebook page – www.facebook.com/naloxoneuk
 - Twitter – www.twitter.com/NaloxoneUK
 - The opiate overdose app from U-turn Training is available free on both android and iPhone platforms.

¹¹ [National Naloxone Programme Scotland Monitoring Report – Naloxone Kits Issued in 2011/12](#)

- 6.6 A Training and Development Officer was recruited to support the National Coordinator at the Scottish Drugs Forum to specifically look at designing, developing and implementing Naloxone Peer Education Networks. This exciting new initiative involves groups of former or stable drug users completing training for trainers and going on to deliver overdose prevention and naloxone intervention to their peers. The involvement of people who use drugs is crucial to extend the reach of the programme further into communities, particularly the hard to reach population.
- 6.7 With support from the National Naloxone Advisory Group, NHS Health Scotland (in collaboration with the Scottish Drugs Forum) led a GP engagement project to support the national naloxone programme. To date, the national programme has mainly been delivered through Statutory Addiction Services or Harm Reduction Teams. GP involvement in the programme has been much more limited. However, GPs have a particularly important role to play in reducing drug-related deaths given that they are the second most common service, after Statutory Addiction Services, which drug-related deaths victims were in contact with prior to their death. A need was therefore identified to strengthen the involvement of GPs in the national programme. With this in mind, the University of Aberdeen Centre of Academic Primary Care was commissioned to conduct a needs assessment in relation to GP engagement with the national naloxone programme. The needs assessment is the first stage of a wider GP naloxone engagement project and will be used to inform the development of a resource and support package to expand access to take-home naloxone among those at-risk of opioid overdose. The study findings published on 12 February 2013 are available on the NHS Health Scotland Website¹². An overdose prevention and naloxone workshop was delivered to GPs for NHS Education Scotland as part of the Continuing Development Professional (CPD) Programme.
- 6.8 The National Coordinator liaised regularly with key stakeholders to support final submissions for the license variation to the Medicines and Health Care products Regulatory Authority (MHRA) with the ultimate aim of ensuring a licensed community pack is available.
- 6.9 A two day event was held for Local Take-Home Naloxone Coordinators from across Scotland. The purpose of the event was to facilitate networking and dialogue between national leads and representatives of National Groups, allowing for the collection of qualitative feedback of their perception and experience of the local programmes. Participants were also encouraged to identify what they saw as priority areas of work for development or further consideration, both at the local and national level.
- 6.10 Scottish Drugs Forum continues to provide support to local areas and has facilitated over 60 'Training for Trainers' sessions to almost 600 participants. A protocol has been devised for basic life support and naloxone administration for emergency call handlers, to ensure that people calling 999 following an opioid overdose are offered the same information in accordance with the National programme.

¹² [General Practitioner Engagement with the Scottish National Naloxone Programme: A Needs Assessment Project](#)

6.11 The key priorities for 2013 are to:

- Continue to develop Peer Education Networks across Scotland;
- Support the work of Health Boards in the delivery of Naloxone in prisons;
- Launch of the rebranded and redesigned national materials;
- Continue work with key strategic partners in order to increase the quality and reach of the naloxone programme;
- Engagement of GPs;
- Continued discussions and engagement with Police, specifically regarding the role of naloxone in custody settings;
- Finalise and launch the naloxone directory.

6.12 The overarching aim for Scotland is to ensure that the provision of naloxone supply to people at risk of opioid overdose is standardised, normalised and prioritised. If someone has a history, or active use, of opioids they should be afforded naloxone without hesitation. The number of naloxone kits being supplied to people in the community must be significantly increased in order to have an impact on the tragic number of drug-related deaths in Scotland.

Summary of Expert Presentations at Forum meetings

Throughout the year, the Forum invited guest speakers who could provide information, reflect upon and stimulate discussion on key issues. The following is a list of presentations received and a brief outline.

On 24 August 2011, Dr Malcolm Bruce, Consultant Psychiatrist in Addiction, NHS Lothian delivered a presentation on alcohol and drug-related deaths.

Also on 24 August **Elaine Park from the National Prisoner Healthcare Programme Team in the Scottish Government** delivered a presentation on the National Programme for Prisoner Healthcare which included an overview of the transfer of responsibility of healthcare from the Scottish Prison Service (SPS) to the NHS on 1 November 2011.

On 16 November 2011 Elaine Lawlor from NHS Forth Valley delivered a presentation on Forth Valley's Narcan Referral Project. This looked at an innovative Forth Valley programme where details of people who received naloxone from the ambulance service were passed to treatment services to improve the care of those in treatment and allow outreach work to those who were not.

Also on **16 November Robin Lawrenson from the Scottish Ambulance Service** delivered a presentation on the Scottish Ambulance Service Information Sharing with Alcohol and Drug Partnerships.

Also on 16 November **Mary Clare Madden, Addiction Pharmacist at Glasgow Addiction Service** delivered a presentation on "Route Transition Interventions – The Foil Pilot" which focused on drug administration, route transition interventions, the legal and health implications surrounding the provision of foil, the Glasgow Addiction Services Foil Pilot and current evidence from the Netherlands, Sheffield and Somerset who are currently providing foil to their service users.

On 22 February 2012 Dr Colin Ramsay, Consultant Epidemiologist from Health Protection Scotland delivered a presentation on the Anthrax Report published by the Outbreak Control Team.

Also on 22 February **Dr Richard Watson from NHS Greater Glasgow and Clyde** delivered a presentation on the effects of methadone and buprenorphine on mortality which focused on the nature of opioid dependence as a chronic relapsing condition and the differing goals and challenges of opioid maintenance and detoxification.

On 22 August 2012, Dr Barbara Broers from the University of Geneva delivered a presentation on the medical complications of drug use and the value of managing this aspect of drug problems with standard drug treatments. Dr Broers presentation focused on two areas; the history, outcomes, facilitating and limiting factors and future directions of the Swiss 4 pillars drug policy and the clinical and organisational aspects relating to older drug users in Switzerland.

On 14 November 2012 Sir Ian Gilmore from the University of Liverpool delivered a presentation on the medical complications of drug and alcohol use.

Also on **14 November Professor Avril Taylor from the University of the West of Scotland** delivered a presentation on the findings of the report published in November 2012 on Hepatitis C Prevalence and Incidence among Scottish Prisoners and Staff Views of its Management. The report is based on findings following a voluntary and anonymous survey carried out in Scotland's 14 closed prisons between June 2010 and March 2011.

National Forum Remit and Membership

Remit

The main aims of the National Forum on Drug-related Deaths are:

- ◆ To make recommendations to Scottish Government Ministers, Alcohol and Drug Partnerships and other joint planning groups as appropriate on action and policy changes;
- ◆ To consider any new research findings from the national and international medical literature and consider policy issues as expressed elsewhere. Appropriate experts are asked to contribute to discussions;
- ◆ To identify areas where examples of good practice are recognised and disseminated to others through the newsletter *Drug Death Matters*, published on the Drug Misuse Information Scotland (DMIS) website; and
- ◆ To report annually to Scottish Ministers with recommendations for further action as required.

FORUM MEMBERSHIP 2011/12

Name	Title
Dr Roy Robertson (Chair)	Roy Robertson, Reader, Centre for Population Health Sciences, University of Edinburgh and Muirhouse Medical Group, Edinburgh
Dr Saket Priyadarshi (Vice Chair)	Senior Medical Officer and Lead Clinician, Greater Glasgow and Clyde Addiction Services
Robert Aldridge	Director, Scottish Council for Single Homeless
Alana Atkinson	Health Improvement Programme Manager (Choose Life) NHS Health Scotland
Mike Bell	Head of Scottish Fatalities Investigation Unit, Crown Office
Gordon Bruce	NHS Services Scotland – Information Services Division
Dr Malcolm Bruce	Consultant Psychiatrist in Addiction, NHS Lothian.
Marina Clayton	Re-Solv Scotland
Tommy Crombie	National Drugs Co-ordinator, Scottish

	Crime and Drug Enforcement Agency
Frank Dixon	National Records of Scotland
Keith Fowler	Perry Fowler Trust
Dr Lesley Graham Lindsey Galbraith	Information Services Division, NHS
Carole Hunter	Lead Pharmacist, Glasgow Addiction Service
Andy Imrie	Substance Misuse Coordinator, Grampian Police
Dave Liddell	Director, Scottish Drugs Forum
Robin Lawrenson	Clinical Performance Manager, NHS
Stephen Malloy	National Training and Development Officer, Scottish Drugs Forum
Dr Julie McAdam	Consultant Forensic Pathologist – University of Glasgow
Andrew McAuley	Public Health Adviser (Substance Misuse) NHS Health Scotland
Dr Claire McIntosh	East Central Scotland MCN Drug Death Group
Ruth Parker	Scottish Prison Service
Dr Samantha Perry	A&E Consultant, Western Infirmary, Glasgow
Eleanor Robertson	Scottish Network for Families Affected by Drugs
Dr Maria Rossi	Consultant in Public Health Medicine, NHS Grampian
Jim Sherval	Specialist in Public Health, NHS Lothian
Ian Smillie	Scottish Association of Drug and Alcohol Action Teams

Scottish Government Official Support and Secretariat

Julie Carr	Scottish Government, Justice Analytical Service
Kathleen Glazik (Secretary)	Scottish Government, Drugs Policy Unit
John Somers	Scottish Government, Drugs Policy Unit
Nicola Thomson (Minutes)	Scottish Government, Drugs Policy Unit

Membership of National Forum Sub-Groups

DATA COLLECTION SUB-GROUP MEMBERSHIP

Name	Title
Dr Roy Robertson (Chair)	Reader, Department of Community Health Studies, Edinburgh University and Muirhouse Medical Group, Edinburgh
Dr Malcolm Bruce	Consultant Psychiatrist in Addiction, NHS Lothian
Dr Lesley Graham	NHS Services Scotland, Information Services Division
Gordon Bruce	NHS Services Scotland, Information Services Division
Jim Sherval	Specialist in Public Health, NHS Lothian
Michael Sibley	NHS Services Scotland, Information Services Division
Ian Smillie	Scottish Association of Drug and Alcohol Action Teams.

Scottish Government Official Support and Secretariat

Julie Carr	Scottish Government, Justice Analytical Service
Nicola Paterson (Secretary)	Scottish Government, Drugs Policy Unit
John Somers	Scottish Government, Drugs Policy Unit

PATHOLOGIST SUB-GROUP MEMBERSHIP

Name	Title
Dr Saket Priyadarshi (Chair)	Senior Medical Officer and Lead Clinician, Greater Glasgow and Clyde Addiction Services
Mike Bell	Head of Scottish Fatalities Investigation Unit, Crown Office
Sunella Brahma	Scottish Police Services Authority, Forensic Services, Edinburgh
Dr Ralph Bouhaidar	University of Edinburgh
Linda Cockburn	Crown Office
Frank Dixon	National Records of Scotland
Dr James Grieve	Consultant – University of Aberdeen
Dr Julie McAdam	Consultant Forensic Pathologist– University of Glasgow
Professor Derrick Pounder	University of Dundee
Rosslyn Rankin	Pathologist - NHS Highland
Duncan Stephen	Aberdeen Royal Infirmary
Hazel Torrance	Forensic Toxicology, Glasgow University
Dr Marjorie Turner	Consultant – University of Glasgow

Scottish Government Official Support and Secretariat

Kathleen Glazik (Secretary)	Scottish Government, Drugs Policy Unit
Nicola Thomson (Minutes)	Scottish Government, Drugs Policy Unit

VOLUNTEER FORUM

Name	Location
Stephen Malloy (Facilitator)	Scottish Drugs Forum
Karen	Edinburgh
Charlene	Edinburgh
Michael	Edinburgh
Jason	Glasgow
Ronald	Renfrewshire
John	Renfrewshire
Gavin	Renfrewshire

Scottish Government Official Support and Secretariat

Kathleen Glazik (Secretary)
Nicola Thomson (Minutes)

Scottish Government, Drugs Policy Unit
Scottish Government, Drugs Policy Unit

FAMILY SUPPORT SHORT LIFE WORKING GROUP

Name	Title
Keith Fowler (Chair)	Perry Fowler Trust
Elaine MacLennan	Scottish Crime and Drug Enforcement Agency
Dr Julie McAdam	Forensic Pathologist, Glasgow University
Deborah McLaughlin	Forensic Pathology Technician
Eleanor Robertson	Chair, SFAD
Austin Smith	Scottish Drugs Forum

Scottish Government Official Support and Secretariat

Kathleen Glazik (Secretary)
Nicola Thomson (Minutes)

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<p>SCOTTISH GOVERNMENT RESPONSE IN MAY 2012 TO RECOMMENDATIONS MADE IN THE NATIONAL FORUM ON DRUG-RELATED DEATHS 2010/11 ANNUAL REPORT</p>

Recommendation 1

All prisoners believed to be a high risk of drug overdose should now be offered naloxone training and a take home kit on release from prison. Take up numbers are available but not the total number offered. The Forum would request that this information should be collected as it is essential to the understanding of the success of the programme.

Response: The Scottish Government recognises that individuals with a history of opiate use released from custody are at an acute risk of opiate overdose. As in 2011/12 the Scottish Government will continue to provide funding to all NHS Boards to provide naloxone kits to their prisons throughout 2012/13. We will also continue, through the Information Services Division (ISD) naloxone monitoring programme, to collect as much data as possible on prisoner uptake, and assess any potential barriers that may prevent an individual from taking a naloxone kit with them on release.

The Drugs Policy Unit (DPU) will work in partnership with the national naloxone co-ordinator and with the Scottish Prison Service (SPS) to ensure that all prisoners identified at risk, are offered a kit pre-release from custody.

We are pleased that all Scottish Prisons are fully engaged with the national naloxone programme. The programme launched in June 2011 is still new and this may explain the reason for some unavoidable gaps in our data, just five months into the programme when this recommendation was published. There may be a number of logistical and personal issues that result in an individual not taking a kit with them on release. The 2012/13 programme will carry out some targeted work with SPS to identify and address these issues and we will report back to the Forum on progress and for further advice.

Recommendation 2

The Scottish Government Research Evidence Group should be refreshed and reconstituted. A drug “attributable fraction” study should be commissioned.

Response: The National Evidence Group was consulted early in 2011 as to the future remit of the group. It was agreed that moving forward, a standing group was no longer necessary and that the DPU would seek to organise a national research conference in 2012/13.

This event is now in the project planning stage and the Chairs of both the National Forum on Drug-Related Deaths and the Drugs Strategy Delivery Commission have been (and will continue to be) consulted on its planning and delivery. The DPU has also met with the Scottish Government Chief Scientist for advice on current

academic activity on drug related research across Scotland. The feedback from this advice will shape the planned national conference.

The DPU is pleased to discuss further with the Forum its views on ways in which Scotland might position itself as a leader in addiction research for drug-related deaths and in the broader themes of care, treatment and recovery.

The drug-related deaths database is a product of the Forum's recommendation to the Government. If the Forum wished to expand that work to include work on attributable fractions then we are happy to scope that work out with the Data Collection sub group and ISD. If the policy rationale is clear and resource is available then the Scottish Government will consider this work.

Recommendation 3

Drug Misuse and Dependence: UK Guidelines on Clinical Management 2007 (Orange Guidelines) should be updated by Departments of Health and/or NICE/SIGN in order to renew the management of drug users in line with the recovery agenda. Community and Primary Care services need to be better integrated to increase their capacity for collaboration on joint areas of responsibility.

Response: The Scottish Government agrees that Community and Primary Care services need to be well integrated to ensure their capacity for collaboration on joint areas of responsibility, and that the Orange Guidelines for healthcare professionals should be updated, in line with the recovery agenda in Scotland. The Drugs Strategy Delivery Commission has also made a similar recommendation regarding the Orange Guidelines.

Bearing in mind that this is a UK wide document, the DPU will keep informed on relevant work of NICE in this area and will look, with advice from members of the Forum and the Commission, to see how this recommendation should best be taken forward. Priorities for 2012-15 have been already agreed with Ministers; however, we will look at this again when work to revise the National Care Standards has been completed. The new national quality standards for drugs will replace the National Quality Standards for Substance Misuse Services published in September 2006 and will be recovery focused. The work to redevelop the quality standards will also help inform thinking on the Orange Guidelines.

Recommendation 4

Hepatitis C treatment in the community should be developed in order to increase the uptake of curative therapy for this condition and to substantially alter the course of the epidemic in Scotland. In the longer term this might have a greater impact on preventing drug-related deaths than almost any other initiative. Specific resources should be directed towards those infected patients currently outside treatment services, as treating this group might have a disproportionately high benefit in slowing down transmission.

Response: The Sexual Health and Blood Borne Virus Framework was published in August 2011 and will build on the foundations established by the Hepatitis C Action Plan for Scotland. In this respect, NHS Boards continue to initiate increasing numbers of people onto anti-viral treatment for hepatitis C in line with the national treatment target (1100 in 2011-12) which increases on a year by year basis. This includes the provision of anti-viral treatment in specialist treatment centres and approximately 23 community settings across Scotland in large and medium sized NHS Boards, with further shared care arrangements with affiliated island NHS Boards. In the community, these are a mix of nurse or consultant led clinics, primarily operating out of addiction or harm reduction services, community hospitals and health centres. Anti-viral treatment for hepatitis C is similarly provided in almost all prisons across Scotland.

Recommendation 5

The practice of instructing, investigating and reporting suspected drug-related deaths should be standardised across Scotland. The final cause of death should be reported within reasonable timeframes.

Response: While this recommendation is an action for the Crown Office the Scottish Government fully supports this recommendation as families should not have to wait an unacceptable length of time to hear the cause of death of a loved one. The DPU will continue to work with the Forum's Pathology sub-group in its discussions to standardise the timescales for toxicology reports in Scotland. The Forum has written to the Lord Advocate highlighting their concerns in this area and once a response is received the DPU will work with the Forum to progress this.

Recommendation 6

Following the transition of prison health care to the NHS, we would expect better continuity and planning of care between different sectors, particularly prisons and NHS acute services. Links with primary care, social work, local drug services and recovery support in the community on discharge from prison, must be prioritised.

Response: This recommendation is for Health Improvement Scotland (HIS) who has established a Network Team to develop and lead on the National Prisoner Healthcare Work plan. This recommendation will be shared with HIS via the Forum's secretariat who may wish to respond directly to the Forum.

The Scottish Government Drugs Policy Unit chairs a Prisoner Health Group attended by policy leads in drugs, alcohol, mental health and community justice. This policy group also has representation from the Scottish Prison Service and ISD. The aim of the Scottish Government group is to ensure continuity and collaboration at a national policy level and to work closely with, and offer support to HIS.

There are several Scottish Government officials on the HIS Network Team, including the Drug Policy Unit's Head of Strategy.

Recommendation 7

Treatment services need to address the under prescribing of alternatives to methadone, and where this is attributed to causes not related to evidence based best practice, must strive to correct this omission. Buprenorphine is effective in maintenance treatment of opiate dependency and should be offered more frequently to patients who might benefit from this alternative to methadone. Its efficacy in detoxification is less clear. The Forum suggests that the Scottish Medicines Consortium might provide a briefing on the effectiveness and cost effectiveness of Buprenorphine which might be given to Health Boards to assist them in incorporating this in the first line of their formularies. Community pharmacies should be offered a joint contract to support supervision of medications such as methadone or buprenorphine rather than a single methadone or multiple contracts.

Response: While we recognise the Buprenorphine can and does have an important role to play in recovery from drug addiction, it is not for Scottish Ministers to promote or recommend one treatment over another. It is the responsibility of the prescriber to determine the appropriate course of treatment for an individual patient with an opiate dependency and this should be done in line with good practice, the *Drug Misuse and Dependence UK guidelines on Clinical Management (Orange Guidelines)* and in line with their local drug formulary.

It would not be for the Scottish Medicines Consortium (SMC) to provide a briefing on the (clinical) effectiveness and cost effectiveness of buprenorphine products to NHS Boards. Each NHS Board has an Area Drug and Therapeutics Committee (ADTC) and one of their functions is to consider the effectiveness, safety and economic use of medicines. It would, therefore, be more appropriate for NHS Boards, via their ADTCs, to review buprenorphine in the context of other existing medicines available within their respective Board formularies to treat the opiate dependency and make a decision regarding whether or not to include buprenorphine products in their formulary.

The dispensing and supervision of opiate substitute therapy is a locally negotiated service. A small number of NHS Boards have contracts to support supervision of buprenorphine in addition to existing methadone arrangements, however in some cases this is under detoxification arrangements as opposed to maintenance. It is worth noting that the supervision of solid dosage forms takes longer and consideration would need to be given to the service provision implications in the community pharmacy. It would be for the NHS Board to determine whether these contracts should be single or multiple contracts. Finally NHS Boards would require to make additional funding available (presumably from local funding for drug and alcohol budgets) to pay for the additional supervision arrangements service.

DPU will be happy to share this recommendation with Alcohol and Drug Partnerships in the Forum's name.

Recommendation 8

The development of specific pharmacy support in the management of dual addiction problems in the form of supervised disulfiram along with supervised opiate substitute drugs should continue to be funded and developed. Alcohol services should assess and advice of the risks of concomitant drug use, especially opiates, in problem drinkers; and drug services should be aware of the risks of co-dependency with alcohol in problem drug users and have appropriate interventions to minimise risks. The merging of specialist alcohol and drug services can only help in the better management of poly-substance use.

Response: It is the responsibility of the prescriber to determine the appropriate course of treatment for an individual patient with addiction problems, including dual treatment where appropriate, and this includes the option to request supervised administration of the treatment concerned. Where a prescribed dose is supervised in the pharmacy it is undertaken by the pharmacist or a member of their support staff and occurs in a discrete or quiet area of the pharmacy to ensure a degree of patient confidentiality. The dispensing and supervision of opiate substitute therapy is a locally negotiated service and NHS Boards would need to consider the additional resources required to support the provision of dual supervision and then agree the terms and conditions and funding arrangements with their local community pharmacy contractor committees.

The DPU will share this recommendation with NHS Boards and ADPs.

Recommendation 9

To look for examples of good practice (countries with lower drug prevalence and lower drug-related deaths), a National/International meeting should be convened to compare experiences with other centres with similar problems.

Response: This is, in part, already being progressed through our work with the British-Irish Council and our reporting to the United Nations Office on Drugs and Crime (UNODC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The Scottish Government is a member of the 8 administration (England, Scotland, Ireland, Wales, Northern Ireland, Jersey, Guernsey and Isle of Man) British-Irish Council, which has a sub group that specifically focuses on the misuse of drugs. The purpose of the group is to share best practice and look at potential areas of policy collaboration. It is recognised within the Council that Scotland has developed a strong policy response to its high prevalence and drug-related deaths, and it is noted that both these trends are higher in Scotland than in any of the other members.

Scotland also regularly responds to the UNODC and EMCDDA. These offer valuable centre-points of both quantitative and qualitative international and global data. Where we sometimes find limitations in this reporting is with the binary comparison of countries, without considering a country's investment in data

collection, quality assurance and frequency of reporting – in all of which Scotland is a world leader.

As with recommendation 2 the DPU will discuss with the Forum and other stakeholders, ways in which Scotland might position itself as a leader in addiction research, including the broader themes of care, treatment and recovery and learn from countries who have made early progress, in tackling drug prevalence and drug-related deaths.

Recommendation 10

Older drug users should be drawn into national campaigns such as Keep Well. Addiction services should be more active in other health related areas such as smoking cessation, weight management, dietary advice and the importance of exercise. Suicide prevention training should be prioritised. Mental Health First Aid and other interventions to prevent suicide should be highlighted given that this may account for around 25–30% of all drug-related deaths. A significant number of drug service staff (and others) have received this kind of training, which has been positively evaluated in Scotland.

Response: Through the Scottish Government's Keep Well Programme of targeted health checks, as from April 2012, individuals over the age of 35 on an identified support programme including substitute prescribing; will be offered a health check. This is in recognition of their vulnerability to cardiovascular disease (CVD) and the need to target services at adults. Part of this health check will assess the risk factors associated with CVD and where appropriate, refer individuals for support in changing their behaviour – this will include smoking cessation, weight management, health coaching, employment support and mental health services. All of this work has been built on learning to date including the successful engagement of community pharmacy with those on substitute prescribing programmes. Those leading on local Keep Well programmes and ADP co-ordinators have been encouraged to link up so local responses to those at risk of CVD can be maximised.

On suicide prevention training, the HEAT 5 target for 50% of NHS frontline, primary care, accident and emergency, and substance misuse staff to undertake suicide prevention awareness training by the end of 2010 was achieved. From engagement with NHS Boards, we know they are still investing in this activity. It is intended that this will be further considered within the development of the successor to the Choose Life Strategy which runs to 2013.

Work is currently being undertaken with NHS Tayside to test an assertive approach to improving access to treatment for people, especially young men, with a drug or alcohol problem that have presented in crisis at A&E. Learning from this and targeted work on how mental health and drug and alcohol services work better together will feature in the Scottish Government's Mental Health Strategy.

Scottish Government
May 2012



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