Evidence-Based Strategies for Preventing Drug-Related Deaths in Scotland

Our Emergency Response

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EVIDENCE-BASED STRATEGIES FOR PREVENTING DRUG-RELATED DEATHS IN SCOTLAND:

OUR EMERGENCY RESPONSE

A paper by Scotland’s Drug Deaths Taskforce for Integration Authorities and their Alcohol and Drug Partnerships and other local partners, including those working in: general and specialist treatment/recovery settings; wider health and social care settings; and justice settings.

INTRODUCTION

1. Scotland faces a crisis from the continued rise in drug-related deaths. We are not alone in this, but the scale of the rise each year in Scotland is almost unparalleled elsewhere. This steep rise in numbers each year means that it is everybody’s responsibility to tackle this problem head on as a national and local priority.

2. The primary role of the Drug Deaths Taskforce is to co-ordinate and drive action to improve the health and wellbeing outcomes for people who use drugs, reducing the risk of harm and death. The Taskforce members are also involved in monitoring, supporting and facilitating the delivery of key commitments and actions set out in Rights, Respect and Recovery and the related Action Plan 2019-21.

3. This work is underway, and Integration Authorities, ADPs and other organisations have already started making plans for short-to-medium term local strategies in advance of many of the recommendations that the Taskforce will be making. This paper provides direction from the Taskforce on the strategies which are known to help avoid drug deaths, and so we think it is vital that partners consider how far these are already being reflected in local planning for 2020/21.

4. How we care for the most vulnerable and most at risk in our society is a measure of our compassion as a nation. We need to be innovative and ambitious in our response to this emergency.

5. This paper draws on evidence of what works to summarise what our emergency response to this crisis must be. The evidence, crucially, comes from three equally important perspectives. Similarly our responses must be shaped and continuously informed by each of these perspectives:

   a) High-quality, research and evidence;
   b) The professional opinions and experiences of clinical, public health and other practitioners; and
   c) The preferences, priorities and values of the people who are most at risk and their families.

6. The Drug Deaths Taskforce is taking great care to ensure a balance is struck between these perspectives. It is unlikely that recommendations made based only on research or practitioner experience, but which do not take account of lived or
living experience, would be as successful as recommendations made based on all three perspectives.

7. The evidence-based strategies set out in this paper focus on the local initiatives and changes required to tackle drug deaths, for which, with the exception of in justice settings in a few parts of the country, Integration Authorities are responsible. However, where appropriate there will be national and regional initiatives and changes required as well. These will need a more coordinated response, which the Scottish Government must be geared up to support and facilitate.

**Context: Rights, Respect and Recovery**

8. The starting point for developing and implementing *Our Emergency Response* is that we already have a national strategy to reduce the use of and harms from alcohol and drugs: *Rights, Respect and Recovery*. That strategy was published in November 2018, and the first detailed, three-year action plan for implementing it was published in October 2019.

9. The strategy provides a vision and a set of guiding principles based on everyone having the rights: to health, free from harms; to be treated with dignity and respect; and to be fully supported to find their own type of recovery. It aims to make improvements so that: fewer people develop problematic drug use; more people benefit from effective, integrated, person-centred support; children and families will be safe, healthy, included and supported; and vulnerable people are diverted from the justice system where appropriate and those within justice settings are fully supported. The strategy set out commitments to help achieve these aims and the action plan sets out actions and milestones for completion by the end of 2021.

10. The creation of the Drug Deaths Taskforce is one of the key milestones in the action plan, along with milestones on developing assertive outreach and reviewing the need for residential services. The members of the Taskforce are now ensuring that these are being made high priorities within their own respective organisations. This paper is being made available to all national and local organisations as a summary of what is needed from them to help tackle the increasing rate of drug deaths in Scotland.

**Context: Staying Alive in Scotland**

11. In 2016 the Scottish Drugs Forum, with support from the Scottish Government, published *Staying Alive in Scotland*. This report was produced from engagement with Alcohol and Drug Partnerships. It identified Good Practice Indicators. The indicators were refreshed in a new edition of Staying Alive, published in November 2019, to provide a self-assessment tool for ADPs to develop strategies to tackle the growth in drug deaths.

12. Staying Alive 2019 sets out fourteen topic areas which ADPs should consider as forming part of their on-going local strategies:

- Drug-Related Death Monitoring and Learning
• Access to Services
• Opioid Substitution Therapy and Low Threshold Prescribing
• Retention in Services, Continuity of Care, Trauma and Assertive Outreach
• Information Sharing
• High Risk Injecting, Wound Care and Bacterial Infections
• Blood Borne Virus Testing and Treatment
• Naloxone
• Prison Throughcare and Police Custody
• People Aged 35 and Over Who Use Drugs
• Dual Diagnosis and Suicide
• Homelessness, Housing and Rough Sleeping
• Women Who Use Drugs
• Poly-drug Use and Prescribed Medications

Context: Keeping People Safe

13. The most recent evidence review carried out in Scotland into drug-related deaths was carried out by NHS Health Scotland (Dickie et al 2017). Keeping people safe was published in 2017 and remains relevant. This rapid evidence review raised the following key points:

• There is review-level evidence that the health of individuals with opioid dependence is safeguarded while in substitution treatment.

• It is important to consider which medications work for whom.

• The first 4 weeks of treatment and the first 4 weeks after leaving treatment are critical intervention points to reduce mortality risk.

• One size does not fit all. Treatment approaches and services need to be tailored to the individual to support them to stay in treatment.

• Psychosocial interventions in conjunction with medication-assisted treatment have been shown to contribute to improving outcomes for people with opioid dependence.

• Complex psychological and social barriers must be addressed to support individuals to access services.

• A holistic approach, designed and tailored to the health and social needs of individuals, will improve the effectiveness of interventions, help increase motivation and prevent drop out.

• Treatment and harm-reduction services are effective in reducing the transmission of blood-borne viruses.

• Take-home naloxone programmes have been demonstrated to increase the odds of recovery from overdose and improve knowledge of overdose recognition and management in the community.
Context: Drug Death Statistics for 2018

14. The most up-to-date statistics published on drug deaths are as follows:

- There were **1,187 drug-related deaths** in 2018 (up 27% from 2017 and more than double the total in 2008);

- In 2018 Scotland’s rate of drug-related drugs per 100,000 of population was the highest in Europe and around **3 times** the rate of the **UK as a whole**;

- **Three quarters (74%)** of decedents were over 35 years;

- **Opiates or opioids** were implicated in, or potentially contributed to **86%** of deaths – nearly always alongside other drugs and/or alcohol;

- There has been a **significant increase** in illicit **benzodiazepines, gabapentinoids** and **cocaine** being implicated in deaths last year.

- **94%** of deaths involved **more than one drug**.

15. We also know from recent data from 2016\(^1\) that:

- Three quarters of decedents were known to have used drugs for at least ten years and over half were known to have used for 20 years or more;

- **63%** were known to inject drugs;

- Over half (54%) had previously experienced a non-fatal overdose.

Context: Definition of “Drug-Related Death”

16. The definition of a ‘drug-related death’ is not straightforward. For the work of the Taskforce we are using the classification as reported on by National Records of Scotland since 2008. The definition here of a drug-related death is **where any drugs were implicated in, or potentially contributed to, the cause of a death registered in Scotland**.

\(^1\) Data from NDRDD, 2016
EVIDENCE-BASED STRATEGIES

17. The Drug Deaths Taskforce believes the following evidence-based strategies must be central to all responses to the drug death crisis. There will be other strategies which will be developed or which will emerge to meet new challenges, but these strategies here should form the basis of national and local responses as quickly as possible.

18. The strategies below each set out:
   a) What the outcome of the strategy should be, as a contribution to reducing drug deaths;
   b) A summary of why the strategy works; and
   c) Some key evidence for the strategy.

1 – Targeted Distribution of Naloxone

19. The outcome of this strategy would be that naloxone is available to those who need it.

20. Naloxone is an opioid antagonist that can quickly and safely reverse the potentially fatal effects of an opioid overdose. Ensuring that naloxone is available to those who need it will involve the training and equipping of individuals who are most likely to encounter or witness an overdose – especially people who use drugs, first responders and care providers. These individuals should be equipped with naloxone kits, which they can use in an emergency to save a life.

Why this strategy works

21. Naloxone has no effect on individuals who do not already have opioids in their system. It does not generate physical dependency. It produces no neurological or psychological effects or euphoria and it poses negligible risk if misused. Training and equipping individuals with naloxone reduces the potential delay between the onset of an overdose and the delivery of life-saving care. Ready access to naloxone in the community and with first responders is key for saving lives.

22. Targeting the distribution of naloxone works best when:
   • Naloxone is provided to people at high risk of experiencing or witnessing overdose;
   • Outreach workers, health staff and clinicians are properly trained and comfortable distributing naloxone kits (including take-home naloxone kits) to those at most risk of overdose;
   • People who use drugs are well informed about the potential benefits of naloxone.
Evidence

23. NHS Health Scotland’s evidence review on *Keeping people safe* concluded there is robust evidence that take-home naloxone programmes reduce heroin-related overdose fatalities. Education and training of users, families and peers is an effective and safe proactive approach to equip witnesses to overdose events with the ability to intervene and save a life. [see Giglio et al 2015; McDonald & Strang 2016; ACMD 2016; SDF 2016]

24. Robust evidence of effectiveness to support take-home naloxone programmes reducing heroin-related fatalities was provided by two systematic reviews (see Giglio et al, 2015; A McDonald and Strang, 2016). In a robust systematic review and meta-analysis, Giglio et al summarised the effectiveness of bystander naloxone administration and overdose education programmes from 12 high-quality studies. The findings conclude that lay naloxone administration and overdose education programmes are associated with increased odds of recovery and improved knowledge of overdose recognition and management in non-clinical settings for heroin users, their families and peers.

25. In a similarly robust review of take-home naloxone programmes for opioid users, McAuley et al (2015) estimated that nine percent of naloxone kits distributed are likely to be used for administration by peers within the first three months of supply for every 100 people who use drugs (PWUD) trained to use the kits. This review concluded that maximising the distribution of naloxone kits to PWUD is a sensible strategy.

26. The outcome of this strategy would be that people are supported following a non-fatal overdose to help reduce the risk of subsequent fatal overdose.

27. There is strong evidence to show that fatal overdoses often follow non-fatal ones, and so there is a need to intervene and provide support as quickly as possible after a non-fatal overdose as a clear way of avoiding or reducing the risk of a fatal overdose. There is currently a lack of any consistent focus on this at-risk group across Scotland. The Scottish Drugs Forum (SDF) publication *Staying Alive* (2016) made some recommendations which the Taskforce endorses:

   a) Service managers/practitioners across multiple agencies meet and review non-fatal overdose cases and apply learning to current practice.

   b) Practitioner learning from work with those who have experienced a non-fatal overdose is gathered and informs the work of the non-fatal overdose review group.

   c) Fast track assessment and access to MAT is in place for those experiencing non-fatal overdose.
d) Information sharing protocols are in place between Accident and Emergency departments and addiction services in non-fatal overdose situations and for continuation of prescribed medication (including MAT) on discharge.

28. There are other partners such as the Police and service providers in justice settings for which IAs are not responsible, where information-sharing protocols must be set up quickly.

29. In hospital settings, a key action will be to ensure drug liaison service or response pathway is in place as quickly as possible.

**Why this strategy works**

30. Taking immediate reaction to a non-fatal overdose should be relatively straightforward to arrange. It might require some re-configuration to services such as introducing out-of-hours and weekend response services. With better information sharing and some coordinated effort it should be possible to take protective action which could save lives.

31. This strategy will work best where multi-agency reviews include learning from experience and where access to MAT has been optimised.

**Evidence**

32. Non-fatal overdose is a key indicator of later mortality (Stoove et al, 2009; Olfson 2018). In 2016, over half of people who had a DRD had previously experienced a non-fatal overdose (440, 54%). This was a similar percentage to previous years. Among those who had previously overdosed, 70 (16%) were known to have overdosed at least five times prior to their death. In 2016, where known, the mean number of previous overdoses among DRDs was 2.8 (yearly averages over the time series ranged from 2.7 to 3.6). In 2016, of those who had experienced a previous overdose, 24% (105) had overdosed within six months of death (15% (67) had overdosed in the three months prior to death) [NDRDD, 2018]

33. Non-fatal overdose which results in hospital admission is also an opportunity for intervention. The latest drug related hospital statistics show a sharp increase in hospital stays for drug overdose.
3 – Optimise the use of Medication-Assisted Treatment

34. The outcome of this strategy would be that optimal Medication-Assisted Treatment is available for everyone who needs it.

35. Medication-Assisted Treatment (MAT) is a proven pharmacological treatment for opioid use disorder. This treatment is recognised and approved by medical authorities, and forms part of Scotland’s eight-point treatment plan. Agonist drugs such as methadone and buprenorphine are licenced for medical use and activate opioid receptors in the brain, preventing painful opioid withdrawal symptoms without causing euphoria. Naltrexone is a drug which blocks the effects of opioids. MAT is effective at reducing illicit use and is less impactful on the daily lives compared to sourcing illicit drugs. This will help people avoid the risk of drug-related death.

36. New formulations of buprenorphine in depot injecting form show promise and should be considered. This is being tested already in Glasgow and although the test includes small numbers, early outcomes are positive. While moving to a new treatment modality will likely require changes to local formularies, this may be an effective way forward and should be considered as a priority.

Why this strategy works

37. The World Health Organization has called MAT “one of the most effective types of pharmacological therapy of opioid dependence”. Numerous studies have shown that MAT contributes to significant reductions in opioid use, criminal activity and overdose. MAT quells cravings and allows patients to stabilise their physical dependency. This stabilisation allows MAT patients to achieve healthy social, psychological and lifestyle changes. Decades of research support the efficacy of opioid agonist medications (methadone and buprenorphine) in preventing
overdose. Injectable long-lasting naltrexone also appears to prevent overdose, but may be harder to initiate in some patients.

38. MAT works best when:

- It is combined with other treatment strategies such as counselling and social support with fixed, safe and predictable doses;
- Public awareness of MAT as an effective medical intervention is promoted by local leadership. This helps to reduce stigma that discourages people from seeking this form of care;
- Entry into MAT is voluntary. Compulsory treatment programmes through legal and social welfare systems are less effective than voluntary treatment;
- Patients have access to a variety of medication options. All patients are different and treatment is best when it is individualised. Some patients need to try several treatment options before discovering what works best for them;
- The challenges some people face in accessing MAT are recognised and mitigated. Many people face hurdles in accessing MAT, such as inconvenient locations, appointment times, prescription delays and reluctance to review dosages. Treatment is more successful when these obstacles are removed.

Evidence

39. NHS Health Scotland’s evidence review on Keeping people safe concluded: There is high-quality review-level evidence that substitution treatment reduces the mortality risk of people with opioid dependence (see Sordo et al 2017). Time spent in treatment is protective – the largest number of available cohort studies included in the review related to methadone treatment participants and this body of evidence demonstrated a reduced mortality rate of less than a third compared to those out of treatment, with the greatest difference in the number of deaths from overdose. Preliminary evidence from the more limited numbers of buprenorphine cohort studies also suggests a reduced mortality rate for those in treatment.

40. There is review-level evidence that the health of individuals with opioid dependence is safeguarded while in substitution treatment. Optimum dose is critical and retention in treatment essential to achieving positive outcomes. [see Sordo et al 2017; ACMD 2016; SDF 2016; ACMD 2015]

41. Evidence from both the systematic reviews and grey literature suggests that it is important to consider which medications work for whom, particularly for vulnerable older users. Additionally, in order to provide support to entrenched heroin users, emerging evidence suggests that heroin-assisted approaches may be appropriate where previous treatment has not been successful. [see Timko et al 2016; ACMD 2016]

42. There is emerging evidence that in order to keep people in treatment and see treatment gains, it is important to assess which treatment approaches (methadone,
buprenorphine, heroin-assisted) will benefit whom. The grey literature also suggests that just like any other medication, not everyone will respond effectively to every drug, so choice in treatment options is important, with care plans reviewed and updated according to needs. Strategies and processes to engage and maintain continuity of care for individuals at high risk are also identified against good practice indicators. [see Timko et al 2016; ACMD 2016; SDF 2016 ACMD 2015]

4 – Target the People Most at Risk

43. The outcome of this approach would be that the most at risk are supported, informed and empowered to help decide on the recovery pathway which will offer the best outcome for them. Targeting the most at risk will also help tackle health inequalities by focusing activities around the people who are often hardest to reach.

44. Intelligence from the ISD Drug Related Deaths Database report has identified a number of risk factors for some of the groups of people most at risk. These groups need to be the focus of evidence-based interventions to mitigate risks and protect them from harm. We know a lot about the risk factors and those who are most at risk of drug related death [see ISD DRD Database Report].

45. Risk factors include:

- A correlation between deprivation (and associated unemployment and homelessness) and drug related death.

- Being male, although deaths among older females has increased in disproportionately in recent years.

- Older age (and associated complex health and social care needs, isolation, mental health problems, chronic pain).

- Poly-drug use (particularly involving drugs with a sedative effect) and other risky behaviours (including smoking, chronic alcohol use, poor diet and lack of exercise). Injecting drug use, which carries a higher risk of death from overdose, as well as a high prevalence of BBV infection.

- Release from prison or discharge from hospital. Drug related deaths are a major cause of death among ex-prisoners particularly immediately after release. [see Graham et al, 2015]

46. Elevated risks are also associated with frequent entrance and exit from treatment. This demonstrates the importance of good recovery oriented practice which enables access to, and retention in, services – with a focus on assertive outreach and no unplanned discharges.

47. Many people live with multiple complex needs – these are the people impacted by a number of the above inter-related characteristics. We must improve our understanding of what type of interventions will best meet their needs.
48. Anticipatory care initiatives and assertive outreach are examples of initiatives which could be implemented quickly to have the best outcomes for people with multiple complex needs or people living with adversity.

49. One of the most effective ways of ensuring people benefit from the protection of being in services is to ensure that they are supported through information and empowerment to choose to be in the service which they believe will be best for them and their circumstances.

50. We need to ensure that people most at risk are well enough supported and informed to help decide on their own recovery pathway in collaboration with services. The therapeutic relationship with service staff is a powerful means to secure the protective benefit of treatment and support.

Why this strategy works

51. There is an ageing population of drug users who are most at risk of harm and death. Most of the increase in drug related deaths, and drug related hospital admissions is accounted for by the increase in the over 35 age group – many of whom have been using drugs for over a decade (NDRDD). The older people with drug problems report (SDF, 2017) shone light on the complex comorbidities (mental health, pain, respiratory and circulatory disease) experienced by these individuals and their specific needs.

52. Over 80% of drug deaths in 2018 involved opiates or opioids, but almost always alongside other drugs. The steep rise in the number of deaths involving opiates or opioids alongside ‘street’ benzodiazepines (specifically etizolam) and/or gabapentinoids is of particular concern. In addition injecting drug use, and specifically street injecting, and using drugs alone are placing people at greater risk.

53. This strategy works best where people are engaged in a co-ordinated way. Intensive actions focusing on disadvantage should be some of the most effective – actions such as assertive outreach require co-ordinated actions from services to be most effective. There are a number of geographic outreach initiatives in place or being planned.

Evidence

54. Professor Sally Macintyre articulated a set of guiding principles for effective policies and interventions to address health inequalities in society for the 2008 Ministerial Task Force on Inequalities. The guiding principles included prioritising disadvantage and offering intensive support [see Macintyre, 2007].

55. NHS Health Scotland’s evidence review on Keeping people safe concluded: Barriers to seeking support and accessing services were highlighted in relation to stigma, loneliness and isolation among older people with drug problems, preventing individuals from addressing the harms they experience. The literature emphasises a need to specifically tailor or adapt, as well as design services to meet the distinct medical, psychological and social needs of this group and recognise the role of the therapeutic relationship in this regard. [see Atkinson (2016) Matheson et al (2018)]
Complex physical and mental health issues resulting from long-term drug use were highlighted in the literature on service responses for older high-risk drug users. Overall poorer levels of health were reported, with greater risks of disease progression and chronic problems in this vulnerable group. Together with personal, social and financial circumstances restricting opportunities for change, as well as intense feelings of shame and negative perceptions of services, these unmet needs demonstrate greater holistic support requirements for interventions to be effective and to increase motivation and prevent drop out. [see Atkinson 2016; Matheson et al, 2018]

5 – Optimise Public Health Surveillance

The outcome of this strategy would be that services would be more responsive to trends and changes in patterns of harm or in drug types found to be in supply – using better information and intelligence to shape their responses.

This outcome will depend on everyone improving how we collect, communicate and share data more quickly. Good quality data at the national and local level are essential for monitoring and surveillance purposes. Appropriate information sharing protocols, coordination and collaboration between services (Police, A&E departments and other front line services) are critical to reducing harm and preventing premature deaths.

We need to be set up to be able to use better surveillance data, but first we must implement a system which makes data available in a more timely way and which is more responsive to need. We also need at national and local level to improve communication channels to ensure we are able to support people quickly and appropriately. Partnership working is going to be key to success in this strategy.

Why this strategy works

The World Health Organisation define a public health surveillance as the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice.

Such surveillance can:

- Serve as an early warning system for impending public health emergencies;
- Document the impact of an intervention, or track progress towards specified goals; and
- Monitor and clarify the epidemiology of health problems, to allow priorities to be set and to inform public health policy and strategies.

The right data, information and evidence being in the right place at the right time is completely essential to improving outcomes for people. In the digital age and with the need and desire to improve co-operation and co-ordination of effort
improved public health surveillance is not just possible, it will be crucial to be able to predict and track trends, interventions and outcomes.

63. This will help services be more rapidly responsive to real-world needs.

**Evidence**

64. A monitoring and risk communication system allows better detection, assessment, prioritisation, and response to associated public health and social threats. Assessment is based on an analysis of the nature, number, scale, and timing of serious adverse health events or social problems, as well as risk assessment procedures. Surveillance enables early detection of emerging harms or trends to facilitate a rapid response.

6 – Ensure Equivalence of Support for People in the Criminal Justice System

65. This outcome of this strategy is that people who use drugs have access to equivalent support through the most appropriate MAT and that naloxone provision is available in the criminal justice system as they would elsewhere.

66. People in custody must have an equivalence of care with people in other communities. There is duty on services to provide this equivalence and any barriers to this must be removed.

67. A key aspect of this equivalence is ensuring that release from custody happens at a time when services are immediately available. This is particularly important for Friday releases. Services also need to be flexible in ensuring, as part of their anticipatory care planning, that people being released from custody can be provided with support as quickly as possible. Anticipatory care also extends to ensuring appropriate, person-centred throughcare is available to cover the transition from justice settings back into the community.

68. Local planning should take account of existing good practice guidance for substance misuse in justice settings as well as the Orange Guidelines\(^2\). Good practice guidelines for services in prisons\(^3\) and in Police settings\(^4\) are already in place. The national Police Care Network and Prison Health Care Network provide co-ordination and support in partnership with Police Scotland and the Scottish Prison Service. Local planning should include transparent monitoring and reporting on how well services are using existing guidance and the national Guidelines.

69. These actions will help protect some of the most vulnerable people in our communities from the risks of harm and death associated with drugs through a transition for which we know there is significant risk.


70. Given the link between drug-related death and recent contact with the criminal justice system, a public health approach to these deaths means trying to find ways to help people avoid, or be diverted from the system. Specialist treatment may be offered as part of the judicial process (e.g. Drug Treatment and Testing Orders or Drug Treatment Requirements as part of a Community Payback Order).

**Why this strategy works**

71. There is a high prevalence of problem drug use in those coming into contact with the criminal justice system e.g. in 2018/19, 71% of those entering prison tested positive for illegal drugs with 29% testing positive for opiates [see SPS Addiction Prevalence Testing, ScotPHO, 2019].

72. Many people who have died a drug related death have been in recent (within six months) contact with the criminal justice system e.g. in 2016, where known, 12% had been in prison and 28% had been in police custody [see NDRDD 2016]. The criminal justice system therefore provides an opportunity to detect, intervene or signpost people into treatment and support.

73. There is also the opportunity to mitigate against the known elevated risk of drug deaths at transition points such as release from custody such as ensuring naloxone provision and continuity of care on release [see Graham et al, 2015]. The timing of release from custody should be organised for times when services are available. Across the UK there is a potential increase in deaths associated with Friday release from prison [see ACMD Report, 2019]. There are more releases on Friday than any other day. Releases from custody after services have closed for the weekend may have a link to increased risk of death.

**Evidence**

74. Release from prison is identified as a risk factor for drug-related death (Merral et al, 2010). The importance of understanding poly-drug use and the role of benzodiazepines in particular to reduce drug-related harms is also highlighted. The importance of staff attitudes on users’ experience of services, particularly engagement is also emphasised.

75. There is robust evidence that take-home naloxone programmes reduce heroin-related overdose fatalities. Education and training of users, families and peers is an effective and safe proactive approach to equip witnesses to overdose events with the ability to intervene and save a life. A focus on prison through-care to reduce drug-related deaths on liberation is also offered in good practice indicators within the grey literature. [Giglio et al, 2015; McDonald & Strang, 2016; ACMD, 2016; SDF, 2016]
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