

Most deaths caused by illicit drugs can be prevented by swift medical intervention and ongoing treatment.

A&E staff have a vital role to play in reducing drug-related deaths.

DEALING
WITH
DRUGS



Many overdose-related deaths occur in men under the age of 30. There are almost as many life-years lost due to drug-related deaths as road traffic accidents.

Blood-borne viruses, transmitted through shared injecting equipment, will continue to cause serious illness and many deaths in the future.

Providing emergency treatment and encouraging drug misusers to get treatment can save lives.

Fighting on two fronts

Drug-related deaths have to be fought on two fronts. We need to reduce the number of sudden deaths through overdose, while at the same time working to prevent transmission of HIV and hepatitis C, which occurs when drug misusers inject with contaminated equipment.

The cross-government Updated Drug Strategy published in 2002 aims to reduce drug-related deaths in England.



This aim was set by the Department of Health because of the alarming rise in overdose deaths over the last decade. A major cause seems to be the trend towards taking combinations of alcohol and sedatives such as heroin and benzodiazepines.

Overdose

Many deaths occur several hours after the drugs have been taken, which means there is a window of opportunity for intervention to prevent death.

We need to encourage people to call an ambulance if they witness an overdose. Most of those who die have been seen by someone during the time between taking the drug and dying. Often they are just left to 'sleep it off'.

Blood-borne viruses

Because of needle exchange, methadone prescribing and other harm reduction measures, **HIV prevalence among injectors in the UK is less than 1%.**

Hepatitis C, which has been around for much longer, infects 30–40% of injectors and leads to serious illness in at least half, and the premature death of at least 1 in 4, of those with the virus.



About the NTA

The National Treatment Agency is a Special Health Authority that has been operational since autumn 2001.

The NTA was established by the Department of Health and the Home Office with a remit to provide more treatment, better treatment and fairer treatment to drug misusers in England.

Reporting to the Secretary of State for Health, the NTA is funded from the pooled budget for drug treatment. Its role is to ensure that the national drug treatment budget is spent on treatment that really works and meets the needs of local people.

The NTA published *Models of Care* in 2002, which describes how every service in contact with drug users, including A&E departments, has a role to play in helping people access drug treatment. *Models of Care*, according to the Department of Health, has the same status as a National Service Framework.

Reducing drug-related deaths

This information is one of the measures taken to inform key staff of the role they can play in reducing drug-related deaths.

Other projects have targeted information at drug service providers, telephone helpline staff and, of course, drug users themselves.

COVER IMAGE/THIS PAGE: JAMIE BAKER/DEMORI IMAGING



Cause and response

Overdose is usually caused by people taking a combination of drugs such as benzodiazepines and alcohol with opiates than by opiates alone.

While most overdoses are accidental, anecdotal evidence suggests that up to one-third may not be. Everyone involved in the care of drug users should screen patients for anxiety and depression as well as acute, more obvious mental health problems.

According to *Models of Care*, A&E staff should provide tier 1 services to drug users. This means that when contact is made with a drug user, screening should be undertaken to determine their immediate needs, as well as a referral to an appropriate service to meet these needs. Additional interventions may include advice to reduce the harm caused by drug use, such as safer modes of use or how to access sterile injecting equipment. Developing close liaison with drug treatment providers facilitates better access to treatment. The role of tier 1 services such as A&E departments are crucial to improving the quality of service for drug users. Drug user representatives and advocates should be involved in work to reduce drug-related deaths, as should local drug action teams who can help co-ordinate and develop this work.

Messages to drug users should concentrate on specific and credible risks and give clear advice on how best to avoid or limit them (see useful web addresses on back cover). A&E is one of the key venues where this information can be disseminated.

Cocaine

When compared to the depressant drugs (see above), the number of overdose deaths from cocaine use is small. But cocaine use is increasing, both in the form of crack and as a powder. Studies from the United States suggest that up to 25% of heart attacks in people between the ages of 18 and 45 are connected to the use of cocaine. Cocaine use also makes strokes and seizures more likely. It is thought that the risk of having a heart attack is increased by 23 times in the first hour after cocaine use.

When cocaine is used with alcohol, the risk of serious problems is greatly increased because they combine in the body to form a more toxic and longer lasting substance called coca-ethylene.

Combining heroin and cocaine as a 'speedball' can increase the chances of a heroin overdose. This is because the cocaine can mask the depressant effects of heroin, but it stays in the body for a much shorter time (about half an hour for cocaine and about 6 hours for heroin). So as the cocaine wears off the full effects of the heroin can be felt.

Nicola hopes that hearing drug users tell their story might help staff to understand them, and give help and treatment to individuals rather than a 'junkie stereotype'.



"I had stopped using heroin for eight months and then bought it again for the first time. I don't know how much I took, but it wasn't very much. My tolerance levels had obviously gone right down. All I can remember is taking the heroin and then saying 'this is it I'm gone' before I lost consciousness."

Someone who saw her pass out in the crack house that night called an ambulance. "In some places I would have just got shoved in a bin bag or thrown over the balcony. I don't know who it was who dialled 999, a sympathetic person, not a friend – no one has friends in crack houses."

The ambulance staff gave her the opiate antagonist Naloxone and by the time Nicola reached hospital she had started to come round. "I thought I was a gonner," she recalls. "I remember thinking of my mum and thinking that I didn't want to die."

At the time of her overdose Nicola was homeless, but she is now living in a hostel that offers drug treatment, detox and rehabilitation for women left with nowhere to live in the wake of co-ordinated police raids on crack houses in Lambeth.

"GOING TO A&E SAVED MY LIFE"

Feature interview: **Nicola Bell**

Going to Accident & Emergency has saved Nicola Bell's life on more than one occasion: in the last three years she has been to the casualty departments of various London hospitals five times – three times for abscesses, once for an ectopic pregnancy and once for a near fatal overdose.

Not always like this

Nicola's mother was a model and air hostess, but she never knew her father who had finished the brief affair before Nicola was born.

When she was five her mother married a pilot, and the family settled in the Bahamas. She was sent off to boarding school where she was bullied by her stepsister. At the age of nine her mother got divorced and she and Nicola went to live in Majorca. She met another man and remarried and Nicola moved from a termly boarding school to a weekly boarding school when she was in her early teens.

Things started to look up, but she found herself in another awful situation when the family maid began to abuse her. "She forced me to sleep with all kinds of men and threatened to tell my mother what I had been doing if I didn't comply with her demands."

The family left Spain and moved to Belgium just two weeks before Nicola was due to sit her O'Levels.

She was sent to live with relatives in England and found it very hard adjusting to an English school. "I wanted to learn but if you wanted to learn at that school you got beaten up by the other pupils. There were problems with my uniform and I started getting sent home from school so I decided to leave and went to Amsterdam."

She began stripping to earn some money and soon moved on to prostitution. "I remember having sex with a guy and thinking: 'No more, from now on men have got to pay for this.'"

First drugs

Having drunk regularly since her early teens, she began to experiment with drugs. She tried LSD at 15 and hated it but then tried speed (amphetamine) when she was 16, then cocaine and, by the age of 21, was taking heroin regularly.

Family ties

She lived in Germany for a while, moved back to Belgium where her mother was living and then returned to England. She has a daughter of 18, and a son of eight who she sees from time to time.

"I'm very ashamed of myself and I don't like them to see me like this," she says. She is in touch with her mother but feels guilty about some of the things she has put her through. "I love my mother very much, I've put her through hell and she hasn't had an easy life."

Moving so often in her early years means Nicola can speak many languages: Dutch, French, Spanish, German, Italian, Portuguese and some Arabic. She hopes that if she can straighten out her life she will be able to get work as a translator.

"I am finding my feet now thanks to the hostel and the support I'm receiving but every time I reach out to grab at something to help me move on, something seems to happen."

Crack

She started to use crack in 1991.

"The first time I tried crack I didn't feel a thing, but stupidly I carried on. I always put so much effort into the wrong things! I would love to be able to use my brain more. I don't like being seen as an outcast, as lower than the low, but people do see me that way."

She feels that staff make snap judgements about her as soon as they find out that she is a drug user. "A nurse who was taking me into theatre once told me, just before I went under with the general anaesthetic, that I was 'just a dirty junkie'. She was very unforgiving. When medical staff see that you're a drug user they are often more intolerant, more impatient and less compassionate."

"When I arrived in the A&E department after overdosing on heroin I was really fighting for my life. The Naloxone brought me round, but I still felt pretty rough. I was just left in a cubicle, and a few hours later they came back to have a look at me, and said I was OK to go home. But I could hardly walk," she recalls.

"Somehow I managed to get back to Brixton, and bumped into someone I knew, and begged him for some money. He gave me some and I went straight back to the same crack house. I was homeless and I had nowhere else to go. It was grim," she says.

Nicola hopes that hearing drug users tell their story might help staff to understand their needs, and give help and treatment to individuals rather than a 'junkie stereotype'.

She was most recently in an Accident and Emergency department at the end of 2002. She was in agony, and running a temperature because of a huge abscess, when she arrived at a clinic for women who sell sex. The doctor there urged her to go to Accident and Emergency to get the abscess treated.

She eventually agreed to go with drug worker Nicola Pruss, who supports women who have moved from the crack houses to hostel accommodation, and Di Martin, from 'Trust' – an organisation which does outreach work with female street sex workers.

Going to hospital with supportive professionals to act as advocates can be helpful, and in Nicola's case ensured that in addition to the urgent treatment for the abscess, she was prescribed enough methadone to prevent her from suffering opiate withdrawals, which would have led to her walking out of the hospital to score at the first opportunity.

"I was so dependent then, I would have done anything to get out, and get another hit if I'd been withdrawing," she says. The methadone doesn't give a high like heroin, but it prevents withdrawals, and for many heroin users, that is enough to keep them away from illicit opiates.

This time her experience in hospital was a positive one. The infection from the abscess was much worse than she thought, and she was diagnosed with septicaemia, and admitted as an emergency to a medical ward.

"All the staff were lovely, so lovely in fact that I didn't want to come out. But it would be great if some of the A&E staff could be a bit more sensitive, and show a bit more warmth," she says.

Being in hospital, recovering from life-threatening illness, has led Nicola to reappraise her life. Since coming out she has stabilised in methadone treatment, cut her illicit drug use right down, and hopes to go into rehab. "I've been receiving a lot of support. I will straighten out my life, one day," she says.



Heroin

Heroin offers most users an unparalleled state of mind, and unparalleled social problems. Here we explain what this drug is and why people take it.



Most of the illicit heroin imported into Britain is processed from the raw opium sap into a brown powder which is around 70% pure heroin.

Brown heroin is intended for smoking. To smoke heroin, users heat the powder on silver foil with a lighter. As it melts and boils it turns to a sticky tar which flows across the foil, giving off a rising cloud of smoke which is inhaled. This is known as 'chasing the dragon'.

Despite being made for smoking, many users inject brown heroin powder. As it doesn't easily dissolve in water they first have to mix it with an acid (usually ascorbic acid [vitamin C powder] or citric acid) to help it dissolve.

Heroin can't be swallowed because it is largely inactivated by the stomach.

Minimum amounts used usually cost £5–£10. If heroin is taken every day for more than a couple of weeks, the body becomes physically dependent, and will exhibit withdrawal symptoms if the drug is stopped.

Using as little as £10 worth a day can create physical dependence. Regular use also brings tolerance and dependent users either have to take breaks, or gradually increase consumption in order to feel the effects. Some spend in excess of £100 per day and still feel very little effect, other than the absence of withdrawal symptoms.



In contrast to legal drugs such as tobacco and alcohol, heroin does not damage any major organ (including the brain). However, injecting can lead to serious (preventable) health problems, including viral infection and overdose.

Although street purity can vary, the problems of it being cut with dangerous substances, and of 'high purity batches', have been greatly exaggerated by the media.

Putting people in touch with treatment services can help them turn their life around.

There is a strong evidence base that treatment for heroin use really does work. Some people will have tried treatment before and not been successful – this doesn't mean that treatment can't help now.

There are a range of different treatment types and treatment services are working harder to better meet the needs of the people who seek their help. Encouraging people to access treatment could save their life.

You can find your local drug services on the internet using 'Helpfinder' – a database held on the DrugScope website: www.drugscope.co.uk

Why do people take it?

The effects of heroin are powerful. Most people experience a sense of the drug rushing through their body, bringing a, pleasant, relaxing effect, with a sensation of deep inner warmth and complete 'emotional insulation' from all of life's problems.

Not everyone enjoys the sense of detachment, and some first-time users describe a feeling of discomfort and unease. As with opiates used for analgesia, one unpleasant effect of heroin is its tendency to induce sickness. Although people usually become tolerant to this, most dependent heroin users suffer from constipation.

There is no simple answer to the question of why people take, or become dependent on, heroin.

It is probably most helpful to try and understand heroin use on an individual basis, weighing up the relative importance of factors to do with:

the person – their psychological make-up, history, mood, emotional state, self-esteem and expectations of the drug;

the drug – the physical and psychological effects of the drug on the individual and its power to remove withdrawal symptoms; and

society – the ease with which the drug can be bought, the number of people using it, the attitudes of the person's peer group to the drug, etc. The way epidemics of heroin use among young people have swept across the country in clear patterns – spreading out from inner cities into rural towns as supply chains are set up – has clearly demonstrated that availability of the drug is also a key factor.

Unlike the media myth of 'one fix and you're hooked for life', people usually become dependent over a period of time. A pattern of occasional use becomes more frequent, and moves from single doses every now and then to taking it every day for longer and longer periods.

Trying to understand this interplay of psychological, chemical and social factors is probably more helpful than trying to fit people into theories which say that those who take illicit or illegal drugs or become dependent are 'victims of peer pressure' or different because they have an 'addictive personality' or 'the illness of addiction'.

Although many dependent users say that the main thing that drives them to continue using heroin is avoidance of withdrawals, it is important to understand the psychological component of the dependence.

The protection from emotion that heroin affords often fosters a belief that 'normal life' is emotionally even and anxiety free. When people detox and find themselves feeling very emotional they often feel that this isn't normal and that they have to take more heroin to cope. The task of developing coping mechanisms to replace illicit drugs is often the hardest thing for those trying to get off – and stay off – heroin.

Text reprinted with permission from *'What & Why? – Heroin'*, one of a series of booklets explaining drugs and their effects. Available from Exchange Supplies, telephone 01305 262244. www.exchangesupplies.org

“Staff need more education and more support to help them care for this group of people.”



The best possible care

Mary Dawood, Consultant Nurse, St Mary's Hospital A&E Department, Paddington, London.

Mary Dawood has seen many patients come through the A&E department at St Mary's following an overdose. She knows they don't always get enough time and understanding.

“When drug users come into A&E conflicts can arise, because we don't necessarily have that time to spend. Occasionally you do feel that you are giving your very best, but a lot of the time staff are very rushed which is not ideal.”

She feels that it is very important for A&E staff to have as much information as possible to hand to drug users. “Nurses need to know what services are available so that they can pass that information on to the patients,” she says. Contacting local drug services (that can be found on 0800 776600) can provide a wealth of information and referral details.

Most patients are offered psychiatric help, but they should also be referred to drug services.

"If a patient refuses treatment for their drug problem after their initial treatment in A&E there is not a lot that nurses can do about it. It's their choice and we can't force treatment on them, but at least they've got the information for the future, if they change their mind," she says.

Training is an important issue. "I think it's probably fair to say that our training doesn't really address these issues well enough. There is a significant social as well as medical and psychological component in dealing with these patients, especially as it is a group that is not generally viewed in a favourable way."

There are now Drug and Alcohol National Occupational Standards (DANOS) that describe good practice in working with illicit drug and alcohol users. These competency based standards are being used to develop courses which can help nurses gain skills and knowledge to work with patients who use illicit drugs and alcohol.

"If a drug user has overdosed and comes in with a family member they are often understandably despairing. It's a sad, sometimes impossible situation and the relative may also need lots of time. Families do look to nurses and other health professionals to help them out at these times."

"Training is an area where more could be done to prepare nurses when looking after drug users," she says.

Patients who have overdosed on opiates are sometimes treated with Naloxone. Gastric lavage is no longer routine.

"Drug users viewed the gastric lavage as a kind of punishment for what they had done, and as we need to encourage people who have

"There is a significant social as well as medical and psychological component in dealing with these patients, especially as it is a group that is not generally viewed in a favourable way."

overdosed to come in for treatment, it is important to reassure them that gastric lavage is now rarely used."

Patients seeking out the services of A&E because of stimulant overdoses are far fewer in number although St Mary's does still see such patients.

Mary focuses on less critical cases in her department and says that when drug users come into A&E with conditions such as abscesses there is more scope to work with them on issues such as hepatitis B vaccination, using clean needles and doing more to keep themselves properly nourished.

She admits that some staff in A&E can have less than helpful attitudes towards drug users.

"I sometimes feel quite dismayed by the judgemental attitudes towards drug users coming from some medical and nursing professionals.

Such an approach is more likely when the department is very busy and distinctions are made between people who are seen as sick through no fault of their own, and those who have 'contributed to their illness'.

Such attitudes however are not acceptable. As professionals we have a duty of care to all our patients."

She understands how difficult it is when you spend time with someone who has overdosed and then very soon after discharge they are back with the same problem. "Sometimes nurses think: 'what's the point?' But we have to look at the issue in the same way as any other illness and accept that these patients need our help.

It doesn't take any extra time to treat someone with humanity: when someone comes in after an overdose we don't know the whole story, there's often a lot of emotional baggage and it's unfair to make judgements."

"Research shows that if more users could access support and treatment there would be far fewer of them seeking help from A&E following an overdose. We can be more effective earlier on than when they reach crisis point.

At that point they are jeopardising their health much more. But usually when drug users are OK they don't want to come near places like A&E – when they do come in it is important to encourage them to seek treatment, as this will reduce their overdose risk."

"It's their choice – we can't force treatment on them, but at least they've got the information for the future, if they change their mind."

Bringing them in. We talk to Jill Howard about what it is like bringing in a friend who has overdosed.

OVERDOSE IS A HEALTH ISSUE NOT A MORAL ISSUE

Mention the words Accident & Emergency to many drug users, and although they don't quite hold up the cross and garlic, many will give an involuntary shudder.

Many who overdose are left to either come round or die. Those who 'go over' with friends may arrive by ambulance after an anonymous 999 call, or find themselves dumped at the entrance of an A&E department.

Although all are aware that in an overdose situation, taking the victim to A&E can be the difference between life and death, many are wary of doing so through fear of the police and the reception they'll get from the hospital staff.

“A&E departments should talk to drug users or people who work for drug agencies so that they can start to understand the lives of drug users who come into their department.”

The lucky ones are accompanied by someone who is willing to give accurate information about what they have overdosed on, and details of their drug-taking history – which can mean risking being suspected of a drug-related crime and questioning by the police.

Jill Howard (not her real name) has twice brought friends who have overdosed into departments.

She supports the work of the local drug action teams that have negotiated protocols which mean that the police only attend 999 calls in situations when there is need to gain entry, risk to ambulance crews or children. But she knows from experience that attitudes vary from hospital to hospital.

“Generally the reception drug users receive is not good,” she says. She once brought in a friend “who had overdosed on pills”. She had stayed with him, walking him around in the fresh air and plying him with coffee but as he became more drowsy she took him to hospital.

“When I brought him in he had his stomach pumped, and the doctors and nurses said to him: ‘What do you think you’re doing? You have done this to yourself, and you come in here wasting our time when we have emergencies to treat.’”

“The nurses’ attitudes vary between one individual and the next but with the doctors and consultants it’s very rare to find any who are sympathetic towards drug users.”

She condemns a minority of users for the way they behave in hospital, recalling the case of “one girl who had endocarditis from injecting dexedrine” (a pharmaceutical amphetamine that can be ground up into powder and injected). “The hospital put in a tube which was connected to her heart, and she got someone to bring dexedrine in so she could inject it through the tube!” It was a crazy thing to do, but getting

angry wouldn’t stop her, and anyway it is wrong to tar all drug users with the same brush.”

Jill is also concerned that although opiate users have a choice of treatment programmes that offer both detox and stabilisation, these choices are not always made clear to them in A&E.

“You sometimes get the feeling that it’s ‘clean up or nothing’ when actually there are a whole range of things on offer which can enable drug users to live a normal life.”

Methadone maintenance treatment may appear to keep people on drugs, but it is a much safer drug that allows people to get back to a more normal life without the constant treadmill of looking for money and scoring illegal drugs.

Research has shown that patients in methadone treatment commit less crime, are less likely to catch or pass on hepatitis or HIV and are less likely to die from an overdose.

“There’s still so much prejudice from medical staff. We just want to be treated like human beings, but it’s assumed that when we come in we’ll steal anything that’s around.”

“I think that A&E departments should talk to drug users or people who work for drug agencies so that they can start to understand the lives of drug users who come into their department,” says Jill.

“If A&E departments remain as off-putting as they are at the moment, not all the drug users who need help will be brought into hospital, and more of them will die.

Friends who take people to A&E are doing so because they want to help them, and because they want them to live. Saving lives is the most important thing. It’s a health issue, not a moral issue. It would be good if everyone could see that.”

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Cocaine

Cocaine isn't just taken by film stars at parties. It causes serious problems for some of those who take it – and is associated with viral transmission and serious injecting injuries.

Here we explain what it is and why people take it.

Cocaine and crack

Cocaine and crack cocaine are the same drug – just in different forms.

Cocaine hydrochloride powder is snorted up the nose (usually through a tube or rolled-up bank note) or dissolved in water and injected. It is sometimes injected with heroin – a combination known as a 'speedball'.

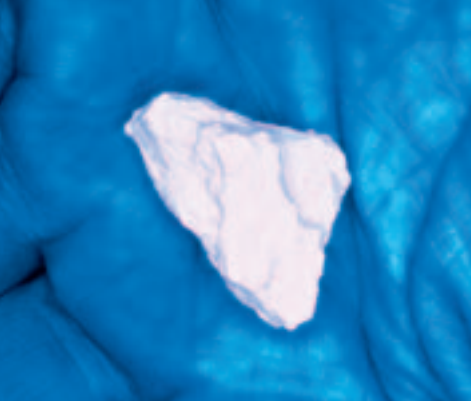
Smoking cocaine powder is inefficient and results in the loss of most of the psychoactive effect. The drug is made smokeable by chemically converting it into the solid freebase form known as crack cocaine.

The process of converting cocaine hydrochloride into crack uses readily available chemicals, including baking powder and ammonia.



The name 'crack' came about because, when smoked, the salt remaining in the mixture sometimes crackles as it burns. Crack cocaine is also known as 'rocks' and 'freebase'.

Crack cocaine is usually smoked through a pipe which can be specially made or improvised out of a drinks can. It can also be rolled into a 'joint' with cannabis or tobacco. Smoking is an extremely efficient way of delivering the drug to the brain quickly.



Treatment

Drug services are responding to the needs of cocaine and crack users who are having problems. Counselling and psychosocial support have been shown to be effective treatments, while complementary therapies can help to retain people in treatment. These services are increasingly available.

Heavy use

As with all stimulants, repeated or heavy use can lead to paranoia and agitation which may develop into a serious mental health problem. The powerful local anaesthetic effect, and the frequency with which people sometimes inject, mean that injecting cocaine often results in considerable vein damage.

Why do people take it?

Cocaine is a powerful central nervous system stimulant and local anaesthetic. Users usually experience a powerful physical and psychological rush of exhilaration, excitement, alertness, strength and confidence within a couple minutes of snorting cocaine, which can last up to 40 minutes.

Injecting cocaine, or smoking crack cocaine, brings on the effects more quickly, in a more intense way, but the effects wear off more quickly too. As with all drugs, the way that this is experienced varies from person to person – some first-time users experience a panicky, nauseating half-hour.

Cocaine has become part of the life and culture of people in groups as diverse as stockbrokers, sex industry workers, ravers and musicians. As with heroin, the reasons why people use it are very different and probably best understood on an individual basis.

One downside of cocaine use is the feeling of exhaustion and depression that many get afterwards – especially after a period of taking it on consecutive days. The problem of dependence can arise when cocaine is used to counteract these (or other) feelings, creating a cycle of use, depression and more use.

Unlike heroin, cocaine is not a drug that lends itself to everyday use. This is partly due to the expense of the drug (binges often cost well in excess of £200 a day) and partly because even 5–10 days of continued use usually create an uncomfortable sense of being 'on edge' and paranoid.

Only a small minority of cocaine users – those with access to lots of money and the drug (mainly rock stars and people dealing in large quantities) – use daily for prolonged periods. This group are more likely to be using crack cocaine, and often suffer from severe depression when they stop.

The usual pattern of use for people who are cocaine dependent is to go through repeated cycles of bingeing, running out of money and/or getting paranoid, stopping for a while and then bingeing again.

Cocaine use is treatable and people attending A&E should be encouraged to access drug treatment services. Although there isn't a pharmacological solution to cocaine use, many psychological interventions have been shown to work, and complementary therapies can help some people too. Motivating people to seek treatment and stay in treatment long enough for it to work seems to be key. Being understanding and sympathetic to difficulties with cocaine use is likely to be effective in helping someone into treatment services.

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Reducing drug-related deaths:

KEY



Images posed by actors

- 1** If they need it, **injectors should be given injecting equipment on discharge**, especially if needle exchanges are closed.
- 2** **Encourage drug users to seek treatment** as this will save lives by reducing overdose and blood-borne infections.
- 3** **Hepatitis B immunisation should be a routine procedure for injectors who attend A&E**, just as tetanus is for those who suffer injury in the garden.
- 4** **Those most at risk of an overdose include those who have lost their tolerance** after a detox, rehab or prison. **Injectors who are homeless and not in touch with services are another high-risk group.**

Images taken from 'Going Over' – an overdose prevention video.
www.goingover.org.uk

POINTS



5 **Long-term users and poly-drug users are at higher risk of overdosing.** Some are complacent about the risks of overdose and may need to be warned that the longer they use, and the more they overdose, the greater the chances of one of the overdoses being fatal.

6 **You can reduce risk of death by providing drug users with information literature on overdose prevention, viral transmission and local drug services.** A number of organisations produce clear, illustrated advice and information – see useful web addresses on back cover.

7 **Establish relationships with local drug agencies and provide training for A&E staff** working with drug users as this can help improve the quality of care.

8 **Ensure that drug users, and those who bring them into A&E departments, are encouraged to do so again** and do not experience hostility from police or hospital staff.

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Name: _____

Job title: _____

Work address: _____

What is your local specialist drug service called? _____

What is their telephone number? _____


Have you found this magazine useful? yes no

Will the information help you in your work with drug users? yes no

Does your department routinely give injecting drug users hepatitis B vaccinations? yes no

What is the prevalence of HIV amongst injecting drug users in the UK? 1% 30% 70%

What is the name of the proxy National Service Framework for drug treatment?

 Please return by 31/12/04 to: Competition, PO Box 2629, Dorchester, Dorset DT1 2DG

Useful web addresses

www.nta.nhs.uk	The National Treatment Agency website – with links to drug-related sites, publications, information and policy documents
www.talktofrank.com	Talk to Frank, 24-hour drug advice and information
www.drugs.gov.uk/Directory	Directory of local drug action teams that help co-ordinate local drug treatment services and new initiatives
www.danos.info	Information and courses on Drug and Alcohol National Occupational Standards
www.exchangesupplies.org	Drug information and resources
www.goingover.org.uk	Information for drug users, including the 'Going Over' od prevention video with drug users telling their own stories
www.drugscope.org.uk	National charity providing drug information and policy advice
www.hit.org.uk	Drug information and resources
www.lifeline.org.uk	Drug information and resources
www.mainliners.org.uk	Information on hepatitis C and HIV from an innovative London drug service

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