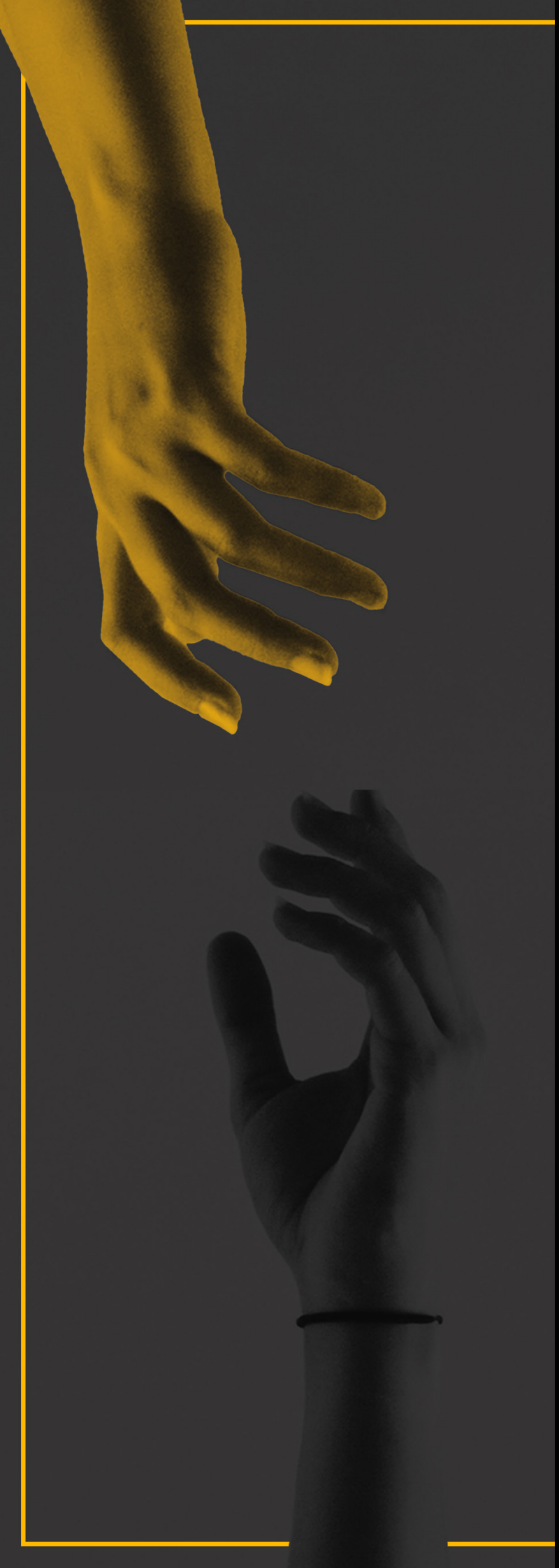

PROVIDING EMERGENCY HELP TO SOMEONE HAVING AN OVERDOSE:

YOUR EXPERIENCES

SCOTTISH DRUGS FORUM
MAY 2022

#STOP THE DEATHS

SDF Scottish Drugs Forum

Contents

Acknowledgements

We would like to thank all survey participants for taking part, and acknowledge the commitment involved in sharing experiences that may have involved trauma.

1. Introduction

1.1 - Background

Scotland has the highest reported rate of drug-related deaths in Europe, per head of population, with the vast majority of fatal overdoses involving opioids in combination with other substances (National Records of Scotland, 2021). A National Mission to Reduce Drug-related Deaths was announced in January 2021.

An important part of the strategy to reduce overdose mortality is the provision, free of charge, of naloxone kits and training in their use to people most likely to be at the scene of an overdose (https://www.sdf.org.uk/what-we-do/reducing-harm/take-home-naloxone/).

1.2 - Aim

The project's key aims were:

1. To investigate the experiences of people who have provided emergency help to someone who presented as having an overdose (not necessarily involving naloxone administration).

2. To find out more about who is providing this emergency help, their relationship to the person experiencing an overdose, and the settings and circumstances of the overdose situation.

3. To assess the interactions of the people providing this emergency help with emergency services, particularly police and ambulance services.

4. To explore the subsequent support needs of people who have provided this emergency help to someone having an overdose.

2. Methodology

The project involved asking respondents who had provided emergency help to answer a series of fixed and open response questions about their demographics, details of the overdose situation(s), interactions with emergency services, and general questions about their experiences with naloxone and naloxone training. The questions were developed by Scottish Drugs Forum (SDF) and circulated for feedback and refinement to members of the Scottish Naloxone Network (ScoNN), a practitioner forum for local naloxone coordinators, chaired by SDF.

2.1 - Methods

2.1.1 Data collection

The survey questions were compiled in SurveyMonkey, allowing participants to complete the survey online by following a SurveyMonkey link. After the survey was closed, SurveyMonkey data was exported for analysis.

2.1.2 Recruitment and sampling of participants

The SurveyMonkey link was shared through the Scottish Naloxone Network (ScoNN) email list; through the SDF website; through SDF and other related social media accounts; and via a link on stopthedeaths.com website, host to the 'How to Save a Life' campaign, from August 2021.

The first question asked whether the respondents had ever provided emergency help to someone experiencing an overdose, with a negative response to this question screening the respondent out for the rest of the survey. Participants outside of Scotland were also screened out at the follow up question on demographics.

At the beginning of the survey, respondents were cautioned about the potentially traumatic nature of the content. At the end, a link was provided to the Scottish Families Affected by Alcohol and Drugs (SFAD) support line for people who have lost someone to an overdose. A link to stopthedeaths.com was also provided for links to other support services or to learn more about how to help someone experiencing an overdose.

2.2 - Analysis

Analysis was undertaken by the project team and involved presenting descriptive statistics from the survey, mainly the proportion of respondents who responded to specific categorical variables (e.g., proportion who answered 'yes' and 'no' to whether the person experiencing an overdose survived). The survey also contained opportunities to leave open-ended responses. Qualitative data in these sections was thematically analysed and used to illustrate the quantitative findings, providing insight into the experiences behind the statistics.

3. Findings

3.1- Demographics

There were 385 survey respondents, 285 (74.3%) of whom had provided emergency help to someone who had witnessed an overdose. This figure was made up of 193 (50.1%) who had helped someone more than once and 92 (23.9%) who had helped someone once. People who answered 'no' were screened out of the rest of the survey. All data presented below is based on this sample of 285 respondents.

Of the 285 respondents who had provided emergency help to someone who had witnessed an overdose and were therefore eligible for the full survey, 253 answered all the questions (a completion rate of 88.8%).

Survey respondents consisted of support workers (40%), healthcare professionals (20%), friends or family members (12.4%), emergency services workers (10.6%), persons who used drugs (3.3%), and peer workers or volunteers (1.8%) (Table 1).

Role	Proportion (count)
Support Worker	40.0% (110)
Healthcare Professional	20.0% (55)
Friend or Family Member	12.4% (34)
Emergency Services Worker	10.6% (29)
Member of the Public	6.6% (18)
Person Who Uses Drugs	3.3% (9)
Peer Worker/Volunteer	1.8% (5)
Other	5.5% (15)

Table 1 – person providing emergency help

Around three-quarters of respondents had ever completed a training course on the signs and symptoms of overdose and how to use naloxone. There was a fairly even split of those who had been trained within the last year (36.6%) and those who had been trained more than a year ago (39.6%). Those who said that they had never been trained accounted for 24.0% of the respondents.

Geographically, most people last helped someone who was experiencing an overdose did so in Greater Glasgow and Clyde (36.4%), Lanarkshire (16.7%), Lothian (13.8%), and Ayrshire and Arran (9.1%). Small numbers of respondents had helped somebody in the rest of the areas (Table 2).

People who answered 'not in Scotland' were screened out of the rest of the survey.

Health Board Area	Proportion (count)
Greater Glasgow & Clyde	36.4% (100)
Lanarkshire	16.7% (46)
Lothian	13.8% (38)
Ayrshire and Arran	9.1% (25)
Tayside	5.5% (15)
Fife	3.3% (9)
Grampian	2.9% (8)
Dumfries and Galloway	2.6% (7)
Forth Valley	1.8% (5)
Highland	1.5% (4)
Borders	1.5% (4)
Orkney	1.1% (3)
Shetland	0.7% (2)
Western Isles	0.4% (1)
Not in Scotland	2.9% (8)

Table 2 – health board area

Over half (51.0%) of respondents indicated that the person experiencing an overdose was a client of the service they worked in. Around a quarter (26.9%) did not know the person at all. After that, smaller numbers involved a family member (8.3%), friend (3.6%), partner or spouse (3.2%), or a person they did not know well but were using drugs with (1.6%).

3.2 – Details of the overdose situation

The overdoses most frequently occurred in an outdoor environment (26.5%), a hostel or supported accommodation (24.5%), or in the person's home (19.8%). Some also occurred within a drug or other support service (12.3%). Very few occurred in public places such as public transport, bus/train stations, or in public buildings such as restaurants or public toilets (<1.0%). The free text responses included other locations including prisons, police stations, homelessness services, hotels, community hubs and community health settings.

There were usually people other than the survey respondent present at the scene of the overdose. Most commonly, there were two to four other people there (37.2%) or one other person there (32.4%). It was rarer for five or more people to be present (7.1%). In just under a quarter of incidents, the respondent was the only person there with the person who had overdosed (23.3%)

3.3 – Actions taken to provide help

Responses show that the most common actions taken were to check their breathing (85.8%), check for a response (84.6%), call 999 (81.4%), and stay with them until an ambulance arrived

(81.0%).

Fewer respondents also put the individual in the recovery position (64.8%), this could potentially be a lower number than expected due to ambulance call handlers' standard advice to keep the person on their back. Just over half the respondents (51.8%) administered their own naloxone, in comparison to naloxone carried by the person (4.0%) or somebody else's naloxone (4.7%). CPR was administered by 15.8%. It was uncommon to call their family or friends (9.1%) (Table 3).

Actions Taken	Proportion (count)
Checked their breathing	85.8% (217)
Checked for a response	84.6% (214)
Called 999	81.4% (206)
Stayed until ambulance arrived	81.0% (205)
Put them in recovery position	64.8% (164)
Administered own naloxone	51.8% (131)
Provided CPR	15.8% (40)
Called someone else (e.g., friend/family)	9.1% (23)
Administered someone else's naloxone	4.7% (12)
Administered their naloxone	4.0% (10)
Other	18.2% (46)

Table 3 – Actions taken

The free text responses introduced several themes that were not covered by the survey options. For example, one form of support described was to protect the person experiencing an overdose from other members of the public:

"Stopped passer-by's from throwing water on him and kicking him."

Responses provided an insight into the difficult circumstances involved. For example, there were reports of some people being revived and leaving the scene before medical assistance:

"The person came to quite quickly and ran away before the ambulance could arrive on one occasion."

Several comments described occasions when the individual had died, such as the following comment:

"Stayed with them in the room while they died."

An understanding of the signs of overdose and the need for intervention had been vital at times, with one person commenting that their response had been:

"CPR. Hardest thing ever and pulling him off the bed after my mate put him in thinking he'd sleep it off but could see signs before that and said NO IM GETTING

999."

The value of naloxone training was apparent when one participant described delaying calling medical help due to a lack of knowledge:

"Did all the wrong things as had not been trained - so didn't call ambulance for ages and ages as everyone was not thinking straight have now been trained."

3.4 – Interactions with emergency services

Respondents were asked to rate their interactions with 999 call handlers, ambulances, and police, using a scale of 'very helpful' to 'very unhelpful'. Responses of 'not applicable' have been excluded so that the proportions only include respondents who interacted with emergency services.

3.4.1 – Ambulance call handlers

The majority of interactions with ambulance call handlers were rated as very helpful (30.2%) or helpful (37.7%). A minority of participants rated their interactions as unhelpful (6.3%) or very unhelpful (9.4%) (Table 4).

Rating	Proportion (count)
Very Helpful	30.2% (48)
Helpful	37.7% (60)
Neutral	16.4% (26)
Unhelpful	6.3% (10)
Very Unhelpful	9.4% (15)

Table 4 – Ambulance call handler interactions

The free text comments left in response to this question provided insight into why interactions were felt to be helpful or unhelpful. Helpful interactions included those where the call handler was calm, empathetic, and provided useful instructions on how to best help the person experiencing an overdose:

"Call handler stayed on the phone until the ambulance paramedics arrived, checking that I had followed procedures, reassuring me I was doing great, and that the ambulance would be with me shortly."

Unhelpful interactions often involved being given unclear or contradictory advice about whether to administer naloxone. Respondents who had witnessed several overdoses indicated that the quality of information could be variable, either advising to administer naloxone when it was not needed or:

"Occasionally berate us for administering naloxone 'unnecessarily', even when given contrary indications and observations. Can't win."

Another complaint was the call handlers did not log the incident at a sufficient level of emergency, meaning it took a long time for an ambulance to arrive. There was also felt to be a lack of urgency, asking lots of irrelevant questions (such as patient weight) rather than sending an ambulance immediately.

"Had to call twice first time was told a health professional would call back, after an hour called back and was told it wasn't high priority, I had to explain this was happening in a very public place and scaring children and that I wasn't able to cope with the medical emergency before I was listened to. A health professional phoned me 15 minutes later and sent a single paramedic to assess who then had to call for a fully manned ambulance to take the man to hospital."

"I was told by the call handler not to administer naloxone despite explaining that I was trained to do so and that all signs point to an overdose. I also explained that the person's breathing was very shallow, and I would rather administer naloxone than wait and perform CPR. I had to administer naloxone with someone continuing to tell me not to which made the situation more stressful than it already was."

"Was advised it would take about 4 hours to arrive, despite being a 999 call."

3.4.2 – Ambulance crews

The majority of respondents rated their interaction with the ambulance staff as very helpful (43.3%) or helpful (28.6%). A minority of respondents rated their interaction as unhelpful (3.6%) or very unhelpful (7.6%) (Table 5).

Ambulances attended at around three-quarters of the reported overdoses (77.1%). It was uncommon for ambulance crews to discuss with or offer naloxone to anybody present at the scene. Only 8.7% of respondents who interacted with an ambulance crew indicated they discussed or offered to provide take home naloxone (THN) to anybody present. No THN was discussed or offered to 91.3% of respondents. However, some of the overdose situations being described may have occurred before the Scottish Ambulance Service (SAS) were providing THN.

Rating	Proportion (count)
Very Helpful	43.3% (97)
Helpful	28.6% (64)
Neutral	17.0% (38)
Unhelpful	3.6% (8)
Very Unhelpful	7.6% (17)

Table 5 – Ambulance crew interactions

From free-text responses, the key themes in helpful interactions with ambulances were being

efficient, reassuring, and having a good attitude towards the patient and the situation.

"They stayed until the person was stable and were very kind and helpful and importantly non-judgemental."

"14 mins CPR done by a young female paramedic who didn't want to give up. She was amazing…"

Key themes in unhelpful interactions usually related to stigmatising attitudes towards the person who had overdosed as well as other people present at the scene.

"I feel that as a nurse within the prison environment that the paramedics have no time for us and criticise our care. I also feel that the attitude of them towards the prisoners is very negative."

"When you tell a medical worker that you are an IV user, they put on gloves and mostly treat you like a leper, there are exceptions I admit."

There were occasions where ambulance crews questioned why the respondent was carrying naloxone or criticised them for administering it.

"They seemed more concerned about why we had a naloxone kit than about helping the person who had overdosed. It was the first question they asked when they attended the scene."

"Ambulance crew advised we should not have administered naloxone as a SU had advised she had only had Valium … it had brought her out of overdose, so it was likely she had some opioid in her system."

3.4.3 – Interactions with police

Police attended in just over a third of overdose situations (37.5%). Around half of the respondents found police to be very helpful (30.5%) or helpful (20.0%). Just under a quarter found police to be unhelpful (10.5%) or very unhelpful (12.6%) (Table 6). Take-home naloxone was said to be carried by police officers on few occasions (4.4%). Most respondents indicated police were not carrying naloxone (43.9%) or they did not know if the police were carrying naloxone (51.8%). Some of the situations may have occurred prior to the police carriage of naloxone or when this was only at a pilot stage.

Rating	Proportion (count)
Very Helpful	30.5% (29)
Helpful	20.0% (19)
Neutral	26.3% (25)
Unhelpful	10.5% (10)

Very Unhelpful	12.6% (12)

Table 6 – Police interactions

The free text comments that described helpful interactions with police made reference to them being friendly, non-judgemental, kind, and restricting their role in the situation to making sure that everyone was safe.

"Police arrived as the address was known. Police did not interfere with proceedings and were friendly. They did not attempt to pursue any issues with people on site and made it clear they were there purely to ensure safety of those in attendance not to make arrests etc."

Unhelpful interactions with police involved the situation being treated as a crime scene, being more interested in the use of illegal drugs and finding out who had supplied them than the medical emergency, e.g.:

"They were only interested in where drugs came from and treated us all like suspects."

A feeling from respondents of being criminalised was closely related to a feeling of being stigmatised, due to being suspected of using or supplying drugs, as well as further stigma towards the areas they live in etc.

"The Police were accusatory and antagonising in relation to my role in my partner's overdose - despite the details of the other person involved being printed on the label on the bottle of methadone my partner had consumed. I was held and questioned for several hours in my bathroom while my young daughter was being observed in the lounge by a female CID officer. The uniformed officers were judgemental, I felt, because of the area I live in. One officer in particular was notably surprised when I told him I worked full time for a large charity. The female CID officer was more empathetic; however, an already extremely traumatic experience was made 100% worse by the treatment I received from the Police. It was totally unnecessary."

3.5 – Outcomes of the situation

Following the most recent time the respondents had provided help to someone experiencing an overdose, most of the time the person survived (86.6%). In around one in twenty of the instances, the person did not survive (5.5%). Another 7.9% of respondents did not know the outcome, so the rate of mortality was potentially slightly higher (Table 7, Figure 1).

Survival	Proportion (count)
Yes	86.6% (219)
No	5.5% (14)
Don't Know	7.9% (20)

Table 7 – Overdose outcomes

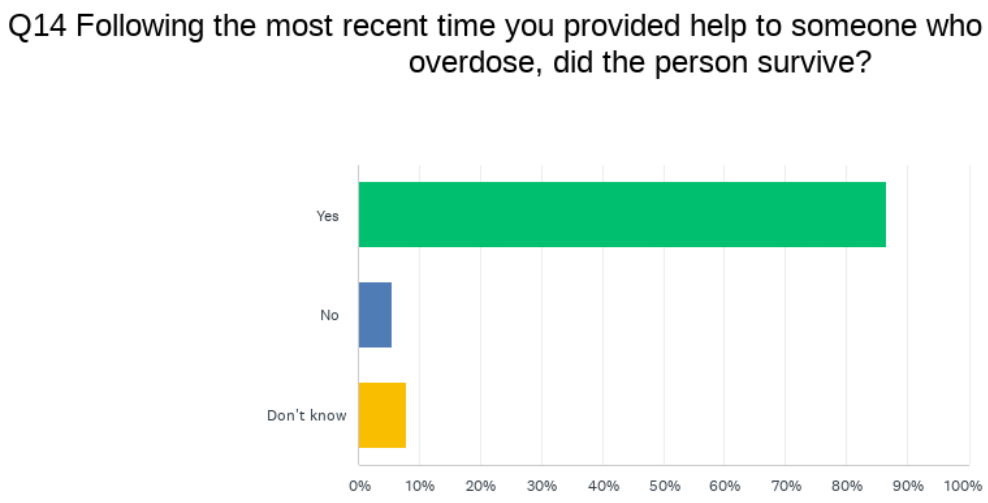

Figure 1 – Overdose outcomes

Free-text comments illustrated that the use of naloxone had saved many people who otherwise would have died.

"The administration of naloxone was a success reversing the overdose and I stayed with the person for the period of time that was needed, I was thanked by the person the next day."

"Was just a relief to get him breathing again."

In some cases, naloxone had been administered but it was too late, and the person died, one respondent commenting:

"Too late for naloxone."

There were several comments indicating that the individual survived the overdose at that time, but died of an overdose later, e.g.:

"A month later died of overdose."

"The person did survive. However, at home, within a few weeks, patient was found overdosed at home."

"Person refused to go in the ambulance and declined medical treatment. She was given a supply of naloxone. I later found out that this person was found dead the following day, assumption that [she] had died during the night."

One respondent reported that surviving an overdose had led to the individual using more than before:

"Coma for 3 days came out and started using heavier."

Family members experienced serious trauma from witnessing overdoses in their partners and children:

"It was my son he did and has had various periods of recovery. Currently in NA. Me on the other hand have PTSD."

"My partner was pronounced dead soon after the paramedics arrived."

Respondents also described serious harms from overdose other than death. For example:

"The boy had suffered a brain haemorrhage and has been declared brain dead and his family are with him in hospital just now."

3.6 – Availability of naloxone

Just over three-quarters of respondents (77.6%) said they knew where they could get a supply of take-home naloxone. Just under a quarter (22.4%) did not know where to get a naloxone kit. Amongst those who knew where to get a kit, just over half of the naloxone kits were sourced from NHS (38.9%) or non-NHS (14.0%) drug services. Nearly a quarter (24.0%) were supplied by a homeless service. Pharmacies supplied 17.7% of the take home naloxone kits. The Scottish Families Affected by Alcohol and Drugs (SFAD) click and deliver service was the source of 12.7% of the kits. 7.7% were distributed through a peer naloxone service. Finally, 1.4% came directly from a GP (Table 8, Figure 2).

Source of THN kit	Proportion (count)
Drug Service (NHS)	38.9% (86)
Homeless Service	24.0% (53)
Pharmacy	17.7% (39)
Drug Service (Non-NHS)	14.0% (31)
SFAD Click-and-Deliver	12.7% (28)
Peer Naloxone Service	7.7% (17)
GP	1.4% (3)
Other	14.0% (31)

Table 8 – Source of naloxone kits

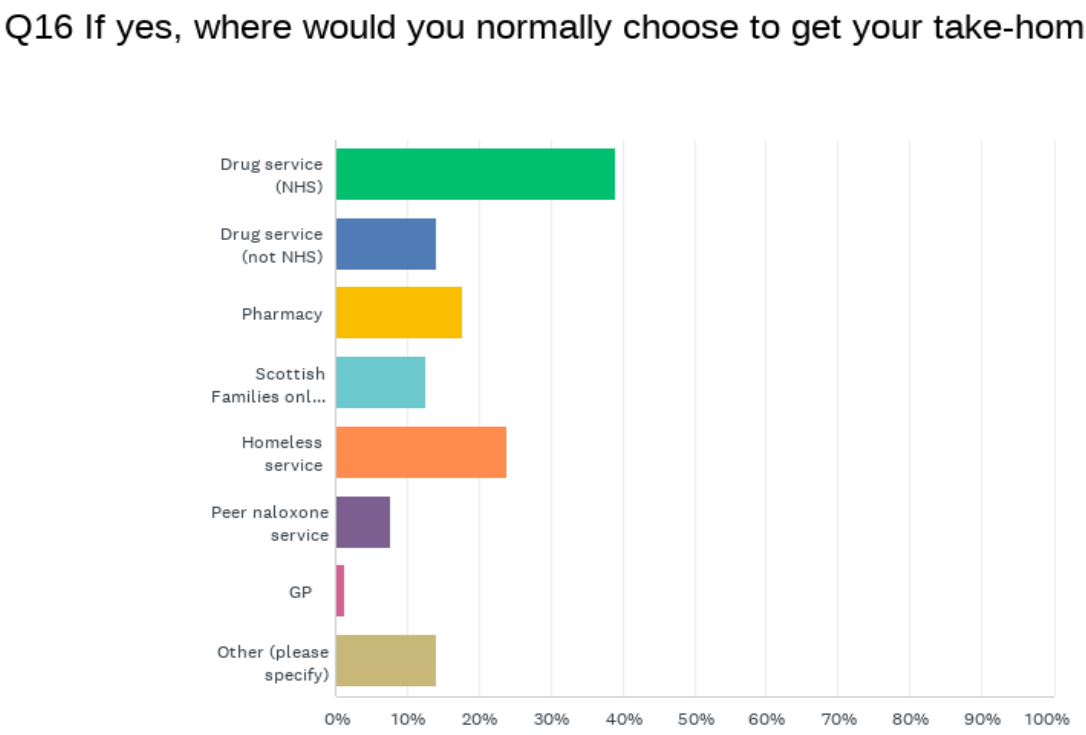

Figure 2 – Source of naloxone kits

3.7 – Naloxone use

A majority of respondents had administered naloxone to a person (60%). Approximately a fifth (21.6%) had used it on someone once, while roughly two-fifths (38.4%) had used it more than once.

Nearly a third (30.2%) of the respondents had administered naloxone to a person more than five times, suggesting they were frequently in contact with people experiencing overdoses. Slightly over a third had administered naloxone once (36.9%). The other third had used it 2-4 times (32.9%).

Most of the naloxone administrations were on different people. Slightly over a third of respondents had administered naloxone to only one person (36.9%). The rest had used naloxone on two people (20.1%), three people (8.7%), four people (4.0%), or more than five people (30.2%).

Most of the naloxone used by survey respondents was injectable Prenoxad, which accounted for 94.6% of the kits used. Another 5.4% used Nyxoid, a nasal spray. The 2.7% 'other' responses included one who couldn't remember and two who had used naloxone ampules (Table 9). Public Health Scotland (PHS) monitoring indicates these figures are generally consistent with the types of naloxone product distributed in Scotland (e.g., the Q2 report for 2021/22 shows that 91% of kits distributed were injectable Prenoxad).

Naloxone Product	Proportion (count)
Prenoxad (injectable naloxone)	94.6% (141)
Nyxoid (naloxone nasal spray)	5.4% (8)
Other	2.7%

Table 9 – Naloxone product used

Only a fifth of respondents used a single dose of Prenoxad (20.3%). The remained four-fifths who used multiple doses used two doses (26.2%), three doses (21.3%), four doses (14.9%), five doses (10.6%), or six or more doses (14.2%). The significance of dosing is that it is desirable to administer enough naloxone to restore breathing and consciousness, but not so much that it puts the individual into opioid withdrawal.

With the Nyxoid spray, it was more common to use a single dose (41.6%) than with the Prenoxad. However, many people who used Nyxoid administered either two doses (33.3%) or three doses (25.0%).

Most of the respondents who had to use multiple doses (88.6%) timed their naloxone doses 2-3 minutes apart, as recommended in training, the last time they used naloxone. Around one-tenth (11.4%) did not time their doses 2-3 minutes apart.

Free-text responses mainly related to the reasons why respondents did not time the doses 2-3 minutes apart. Often, the reason was that they had been advised by the 999 operators to give the full syringe in one go:

"Although I had had training that indicated the need for spacing out the doses, the 999-operator advised I give the full syringe in one go. This resulted in the individual immediately going into serious withdrawal."

"The ambulance operator told me to give her the full 5 doses at once. I had 2 different naloxone kits, both were used at separate times."

On other occasions, the doses had been given with a shorter space of time between them, due to the individual not regaining consciousness after an initial dose.

"The first person — I injected them and my colleague assisted. They came round without the full syringe.... The second person my colleague injected and timed the first two doses, but they were not rousing so put all of the rest of it in."

3.8 – Support

Respondents were asked whether they talked to anyone about their experience of helping someone who was having an overdose. Having someone available to speak to, to reflect on and process the experience is referred to here as 'support'. The most common response was to speak to a colleague, which slightly over half of the respondents did (54.9%). Another two-fifths (40.8%) discussed it in a supervision or with their work supervisor. Just over a quarter (26.6%)

spoke to a friend of family member. Around a quarter of the respondents did not speak to anyone (12.5%) or feel the need to speak to anyone (12.0%) (Table 10, Figure 3).

Person spoken to	Proportion (count)
Colleague	54.9% (128)
Supervision / Work Supervisor	40.8% (95)
Friend / Family Member	26.6% (62)
Didn't speak to anyone	12.5% (29)
Didn't feel the need to speak to anyone	12.0 (28)
Other	6.9% (16)
Mental Health Professional	6.0% (14)

Table 10 – Person spoken to about overdose situation

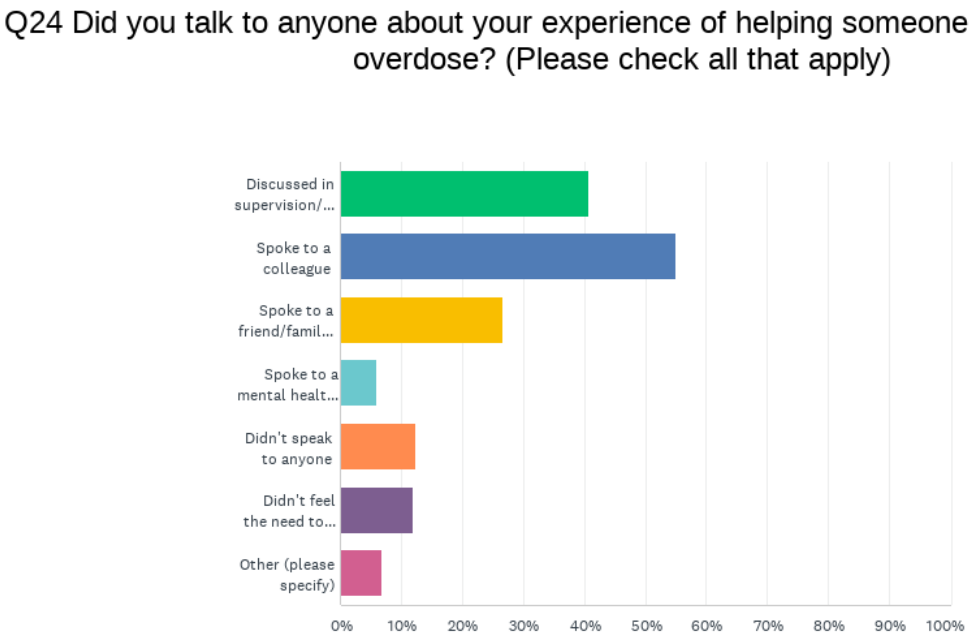

Figure 3 – Person spoken to about overdose situation

Other answers in the free-text response included family support services, private therapy and grief counselling, and their drug worker. One respondent spoke to the person to whom they had administered naloxone:

"Once met the guy I administered naloxone to the next day, and it was emotional. I know that 2 people I gave naloxone to are attending support groups now."

Just under two-thirds (64.4%) of respondents felt there was adequate support available to them. Slightly over one-third (35.6%) felt there was not adequate support available to them (Table 11, Figure 4).

Was there adequate support available?	Proportion (count)
Yes	64.4% (150)
No	35.6% (83)

Table 11 – Was there adequate support available

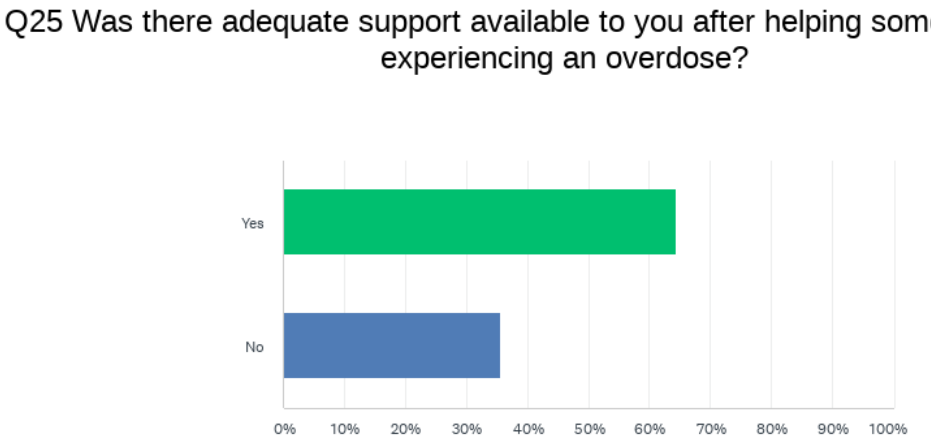

Figure 4 – Was there adequate support available

3.8.1 – What support would be helpful

Respondents were asked whether they would find a range of potential support options helpful: a national telephone helpline, a local telephone helpline, a webchat facility, an online support session, peer group support, and management support.

The two options that were most indicated as likely to be very helpful were management support (27.5%) and peer group support (22.8%). There were also indications that it would be very helpful to have a local telephone support line (16.3%), online support session (14.6%), national telephone line (13.3%), or a webchat facility (12.5%).

The two options that were most indicated as likely to be helpful were also management support (34.3%) and peer group support (33.9%). Respondents also indicated it would be helpful to have a local telephone line (27.0%), a webchat facility (27.0%), a national telephone line (26.6%), an online support session (25.3%).

Only a small minority of the respondents (<10%) indicated that any of these options would be unhelpful or very unhelpful.

The comments reinforced the need for high quality support, because of the high levels of trauma involved in providing support to somebody experiencing an overdose. The need for support was particularly apparent in situations involving family members.

"I have seen a lot of life threatening situations with my son... the non-fatal overdoses are I am aware a step closer each time to fatal… i am not sure if that is something you can cope with.. i am in a state of uncertainty which is distressing and outwith my

control."

Particularly when family members had died, there was a level of trauma involved that it was not possible to fully recover from.

"This happened many years ago. I have never got over it despite being a trained therapist. I saw my child dead for a time."

There was also a general sense that the person dying made the incident far more traumatic in general than if they survived.

"It depends on the outcome of the situation. If the person survives and is ok , you feel you managed to help them and might feel ok, but if they did not survive more help is needed as that will be very traumatic."

Lay persons who had supported family members or members of the public often reported support from psychological services. The quality of support was described in mixed terms, with some positive and some negative experiences.

"There would need to be proper training to offer support online. I used [a confidential phoneline for mental health support] and it was very distressing, the original handler was clueless but phoned back and second person was very good. This shouldn't be down to luck."

Comments highlighted that for professionals, dealing with overdose is a traumatic experience and the importance of not losing sight of the individual.

"Witnessing an overdose is a traumatic experience. Whilst we normalise naloxone, an overdose should not be considered 'just another overdose' or 'just part of the job'. It is a near death experience for someone, who has hopes and aspirations."

People would benefit from a debriefing with a professional to reassure them they had done the right thing.

"After experiencing this kind of emergency, you are left with a high adrenalin rush, it's good to talk to a trained professional to help bring you down and reassure you [that] you did everything correctly."

The importance of peer support groups was that people could talk, offer and receive support from each other, and share their stories and experiences. It seems like this would allow their experiences to be validated.

"I think any support would be helpful for people administering naloxone either webchat, online support or peer groups for people to talk and offer and receive support from each other I would believe would be a very powerful tool for people to

share their story's, experiences of using naloxone."

Drugs workers tended to mention that they had support from managers and colleagues, which suggests that the helplines and online resources would be more useful for members of the public.

"As a drugs worker I feel supported when dealing with these situations and to discuss with colleagues after but if more and more of the public are trained which is obvs a great thing it maybe they would benefit from the ability to speak to someone after, especially if it was a traumatic experience."

"I did not need support, it is part of my job, the issue was discussed with my line manager and had a debriefing, but I was fine, I had also discussed the issue with my colleague afterwards."

"My manager offered emotional support."

"Debriefing with management always helps."

However, not everybody felt they had support from their managers, indicating that the additional support options such as telephone and online options may help professionals who lack management support.

"If my manager cared it would be helpful."

"No debriefing no support given."

Despite the trauma of overdose situations and the variability of access to follow up support, the vast majority of respondents (98.7%) said they would help someone who was experiencing an overdose again.

Responses emphasised the value of human life and that everybody deserves a chance to be saved. People who had lost family members to overdoses indicated they were highly motivated to make sure it didn't happen to other people. People who had saved lives with naloxone felt a sense of accomplishment from saving a life.

"Everybody deserves not to die prematurely through drugs or alcohol."

"Life is precious, she was OK, and I'd do it again."

"It is within my duty of care as a support worker to assist. If I was not in work I would also help as it is my duty to help individuals who need it just out of basic care to another human in need. I always carry a naloxone kit on me outside of work."

"It was too late for my son but I would like to prevent another parent from going through what I did."

"Without a doubt. I've lost my son to drugs; no mother should ever feel this pain."

"Perhaps I could have saved my partner's life if I had had access to naloxone. My experience of overdose and drug-related death is the most painful and traumatic thing that has ever happened to me. I would not wish it on my worst enemy. If I can stop someone else from dying of an overdose, it would be some consolation to me, even though I couldn't save my partner."

"It was a privilege to give air to someone and see them come back to life."

There was a sense of passion and pride amongst people who had saved a life and then seen the individual make steps towards changing their lives afterwards.

"100%, my own son is a heroin addict in recovery of 9 years, he had his heart started 3 times during his time of addiction. My passion comes from being his mum and someone else helping him and I vowed I would help someone else's son (daughter, granny, aunt, etc) Drug deaths are far too high and with ambulance call out times like what I witnessed, no wonder. What if I didn't know the person who called, I would've possibly sent the ambulance expecting them to get there on time, had I done that she would not be here to tell the tale. Good news is she went home from hospital and threw out her beer, tablets and weed, and now attends my smart group every week. Since then, she has had one joint, nothing else."

Amongst the many professionals responding to the survey, there was a sense that it was both a professional and personal responsibility to intervene, whether they witnessed an overdose in their work role or as a member of the public.

"I feel it is my responsibility to do so if I can, in or out of work — if someone is in a position to save a life they should do so. I felt very positive about having administered naloxone and potentially saving a life and having done it once would feel more confident next time."

On one occasion, a respondent administered naloxone even when they were not supposed to in their professional capacity, because saving a life was the most important thing.

"On a nightshift there was myself and an agency worker. I was 20 weeks pregnant and we witnessed an overdose. The agency worker refused to administer naloxone. It was within my risk assessment that I should not administer naloxone. However, at that point in time I could not do nothing. I knew the girl well and had a really good relationship with her. I was aware of how she would react etc as I had administered naloxone on her previously. Therefore, I done it as the other option was to wait on the ambulance and she may well have died in that space of time. When the ambulance did arrive she had come round."

3.8.2 - Further Information

Respondents were given a free text box to offer any other information about their experience of helping people who have been experiencing an overdose. These included comments that the prevalence of street benzos was making overdoses more difficult to deal with:

"In terms of folk who may be new to this, judging a straight opiate overdose isn't particularly contentious or difficult. But those are now the minority of cases we see. We're having to teach folk how to see opiate involvement when clouded by varying strengths of benzos. I believe that training now needs to focus on this area, both because of the prevalence of those cases, and in how hard they can be to work out for folk without experience. While "if in doubt, administer naloxone" sounds good, newer volunteers are naturally more hesitant about an administering an invasive intervention when the signs and symptoms are less than clear to them when compared with their training of pure-opiate ODs."

Additional to providing support to the person who was experiencing an overdose, there were examples where further ongoing support was provided to prevent any potential future overdoses. There could be a lack of follow up support for the person who experienced the overdose meaning this responsibility fell onto their informal supports.

"Scary time. The person was released from hospital the same day and told to make a doctor's appointment which then took 2 weeks. Surely there should have been more help available. Resulted in me being with the person 24/7 for around 2 months."

The lack of follow up support from treatment services (such as psychological and rehabilitation support) was identified as a reason that people stay in a cycle of abstinence and relapse, suggesting that more could be done to link people who have overdosed into specialist services to help them make their lives more manageable.

"I feel incredibly sad that the funds allocated bring a person round, are medically treated, discharged "medically fit" within the shortest time frame possible. They might return soon afterwards as the intense psychological therapy and rehabilitation if the person seeking that is patchy… it is government under funding and a lack of fully addressing the total person, a broken person needs a lot of help and 24/7 … a person who is drugging on benzos wants to be numb … life without drugs is too hard and they cannot see a future. The cycle continues…"

"Drug related deaths are just wrong. My son relapsed during the lockdown. He was beaten and stabbed, and his home destroyed by dealers. I fought hard to get him a safe place despite his risks and mental health. Cost of rehabilitation 10000 pounds. Trauma counselling 40 pounds a session."

There were signs that awareness raising messages are useful in helping people to recognise an overdose and take the necessary action:

"The man who overdosed was mistaken by us all as being drunk, as he had been seen wandering about with a can previously. I had called the police but wasn't getting through. He was "sleeping" on the pavement when someone said, "aw listen to him snoring!" I remembered this as a symptom of overdose from a leaflet I had picked up from the local chemist … and called the ambulance."

Stigma was identified as still being a major barrier to progress, amongst the public and even a small minority of survey respondents. One respondent described a scenario when they experienced stigma from the public.

"One occasion was in a mainland town where a young lad was slumped in a doorway with youngsters taking pics and kicking him. when I assessed he was not breathing I asked passing public to call 999. the response was "leave him to die, they are scum" The lack of human compassion still haunts me."

Although stigmatising views were rare amongst survey respondents, there were a small minority of comments that demonstrated the presence if stigma, such as one calling overdose a self-inflicted problem.

"These people are self-inflicting this upon themselves. We seem to be blaming everyone other than the people taking the drugs who are ultimately responsible for their own actions and are well-aware of the consequences."

4. Conclusion and recommendations

4.1 - Summary of findings

Most respondents had provided emergency help to someone experiencing an overdose more than once. A majority of respondents had provided emergency help in their professional roles as support workers, healthcare workers, or emergency services roles. There were also a substantial number of friends, family members, and peers of the person who overdosed, along with some members of the public. Most participants had received training on the signs and symptoms of overdose and how to use naloxone, but around a quarter had not. The person experiencing the overdose was commonly a client of the service the respondent worked in, someone they did not know, or a family member or partner/spouse. Overdoses occurred in a range of settings, including outdoor spaces, people's homes, and hostels. The number of people present varied, it was most common for there to be 2-4 other people but in many of the cases there was nobody else there.

The most usual support provided was to check for a response, check breathing, call 999, and stay with the person until an ambulance arrived. It was less common to also place the individual in the recovery position, provide CPR, or administer naloxone. Respondents described challenging scenes which involved managing interference from bystanders, dealing with behaviour they had not anticipated from the person they revived (e.g., irritability or immediately

leaving the scene), and having to assess whether the person was overdosing and make a fast decision to act (perhaps against the advice of others present). Naloxone training helped people navigate these situations effectively. This would suggest that as many people as possible should be trained and training should emphasise the recovery position, administering naloxone, and how to manage the various other situational challenges.

Most interactions with 999 call handlers were felt to have been helpful, with helpful interactions characterised by clear information and an empathetic approach. There were a minority of respondents who felt that 999 call handlers were unhelpful, by giving unclear advice, advising to use naloxone when it was not necessary, advising against using naloxone when it was necessary, or not treating the incident with the necessary urgency (leading to slow ambulance response times). To avoid these scenarios, there should be appropriate training for call handlers to ensure consistently helpful responses and more focus on training to callers regarding the provision of correct and concise information to get the best response.

Interactions with ambulance crews were also mostly helpful with a minority being unhelpful. A key difference in helpful versus unhelpful interactions was whether they demonstrated a caring or judgemental attitude. Some respondents reported being criticised for administering naloxone, despite the national campaign to encourage lay person intervention. Only a small minority said the ambulance crew discussed or offered them a take-home naloxone kit. Interactions with police were similar to those with ambulances, with most described as helpful but a minority that were unhelpful. However, more respondents found police unhelpful than ambulances (around a quarter, compared to one tenth). This was because police were less likely to provide useful medical intervention (only a small proportion were known to be carrying naloxone) but sometimes added additional problems by treating the situation as a criminal incident rather than a medical emergency (e.g., enquiring about drug sources).

In most cases, the person experiencing an overdose did survive. Often it was reported that administering naloxone had saved their lives. However, a minority did die and there were other cases when the outcome was unknown. Some survived but went on to die due to another overdose in a separate incident. There were reports of people who did not die but suffered life changing injuries due to their near-fatal overdose. There was clearly a great deal of trauma involved in becoming involved in these fatal and near-fatal situations and dealing with the aftermath.

Most respondents knew where they could get take-home naloxone but over one-fifth did not. Raising awareness of naloxone supply or increasing the supply routes could reduce this number. Around three-quarters of the respondents got their naloxone from either drug services or homeless services, making these the most common supply routes. Community pharmacies and the Scottish Families Affected by Alcohol and Drugs (SFAD) ‘Click and Deliver’ service also made a substantial contribution to supplies, although given the role of community pharmacies in other harm reduction measures (such as opioid replacement therapy) there is scope for distribution via this route to be expanded. Only a tiny number of supplies were from GPs, another community route that could be higher. The Medication Assisted Treatment Standards may prompt an increase in GP supplies, as they state that harm reduction services should be available via GPs who provide medication assisted treatment. Peer naloxone services played a small but important role, likely extending the reach of distribution to demographics who do not engage with other services.

Most respondents had used naloxone on somebody, but two-fifths had not. This would indicate that there is scope for increasing the proportion of helpers who administer naloxone. Most

people who used naloxone had done so on more than one occasion and on numerous different individuals.

Almost all of the naloxone used was injectable Prenoxad, which has been the main product provided over the course of the National Naloxone Programme. Four-fifths of respondents indicated they had to use more than one dose and most spaced the doses 2-3 minutes apart. The need for multiple doses was due to advice from emergency operators or due to the difficulties in bringing people back to consciousness with single doses.

Most people spoke to somebody about their experience. Most commonly this was with work supervisors and colleagues, likely because of the large proportion of support workers and healthcare professionals who responded. A significant number also spoke to friends and family members, while only a small minority (one in twenty) spoke to a mental health professional. Two thirds found the support they received adequate, but one third did not. This suggests that a wider range of support services may be beneficial for a number of respondents. The forms of support most valued as being helpful were management support and peer group support, and responses indicated it would also be helpful to have telephone and webchat options available. Very few respondents felt that any of these support options would be unhelpful. Whether or not they had adequate support, the vast majority of respondents would provide emergency help to someone experiencing an overdose again. There was a strong belief in the responsibility to intervene and the value of saving a life.

4.2 – Recommendations

Ensure more people are trained in use of naloxone and overdose responses

There should be more efforts to increase the proportion of the population who are naloxone trained and carry naloxone, as findings show that training was crucial in identifying and responding to overdoses. Greater emphasis in training could be given to the maintenance of an airway using the recovery position. People should be encouraged to administer naloxone routinely as part of their emergency help.

Increased availability of naloxone

As many people as possible should be made aware of where they can get take-home naloxone. Increased participation of pharmacies, hospitals and GPs in the distribution of naloxone would help increase availability. Ambulance crews need to have increased awareness of take-home naloxone and to routinely offer naloxone to people present at the scene of an overdose.

Near fatal overdose pathways should be available in all areas

There should also be clear, near-fatal overdose pathways in place in all localities to enable quick access to treatment options for people who have experienced a near-fatal overdose.

Better training for call handlers

Emergency call handlers should be routinely trained in naloxone protocols and training for people carrying naloxone should have a greater emphasis on the clear/concise information to pass to

call handlers, to ensure a timely response.

Reduce stigma

There is a need to reduce stigma towards people who use drugs by ambulance crews and police, specifically to encourage them to view and engage with people who have overdosed as vulnerable people requiring immediate support.

Awareness of trauma

There should be recognition of the trauma involved in witnessing and intervening at an overdose and an adequate provision of support options. For professionals, management support is valued but not always provided so more formal support procedures could be developed. Telephone and online peer group support would also be beneficial, to help people process their experiences and receive validation and understanding.

4.3 – Recommendations for future research

- People who use (or have used) drugs were underrepresented in comparison to support/ healthcare workers – future research could engage more with these groups.
- The emotive aspects could be captured better through in-person methods such as interviews and focus groups.
- More research on the harms caused by near-fatal overdose, such as traumatic injury and brain damage.
- Research on emergency service naloxone carriage.

#STOP THE DEATHS

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