

STAYING ALIVE IN SCOTLAND

*Strategies to
Combat Drug
Related Deaths*

The aim of this report is to stimulate actions which can reduce the high mortality rate amongst people with drug problems in Scotland by encouraging a wider and more holistic view of drug related deaths.

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Contents

Introduction and Methods	6
Introduction.....	6
Methods	7
Section 1: Key Principles.....	8
Section 2: Key Findings and Good Practice Indicators	10
Key Finding 1: Drug Related Death Monitoring and Learning in ADPs is variable across the country.....	11
Key Finding 2: Being in treatment is a protective factor against death	12
Key Finding 3: ORT is a protective factor and Low Threshold services decrease mortality.....	13
Key Finding 4: Retention in Services is a protective factor against Drug Related Death	15
Key Finding 5: Information Sharing across ADP area can be strengthened.....	17
Key Finding 6: Injecting drugs can result in a range of injecting related health problems.	19
Key Finding 7: Blood Borne Virus testing and treatment should be increased.....	20
Key Finding 8: Naloxone is an effective intervention in preventing Opioid Overdose Deaths	22
Key finding 9: Release from prison/police custody are risks for overdose death.....	24
Key finding 10: Ageing drug users bring new challenges to services.	26
Key Finding 11: Correlates with an individual’s mental health	27
Key Finding 12: Drug users experiencing Homelessness have an increased risk of DRD.....	28
Key Finding 13: Recent percentage increases in DRD are higher for females	29
Key Finding 14: Prescription drugs and non-opiate illicit substances	30
Key Finding 15: Attitude of workforce key to engagement	31
Section 3: Good Practice Baseline Tool	32
Reference List	48

Appendix 1 -ADP DRD Questionnaire	51
Appendix 2 -National Forum on Drug-related Deaths Recommendations 2014	54
Appendix 3 -Seminar Programme	55
Appendix 4 -Presentation summaries	56
Appendix 5 -ADP Good Practice Examples	60
Appendix 6 -Ministerial Letter	61
Appendix 7 –Consultation Document	63
Appendix 8 –Workshop Notes ADP Reference Group Death Prevention	64
Appendix 9 -ISD Definition of a Drug Related Death.....	66

Overview

There is widespread concern among key stakeholders, and within the wider public discourse, about the extent of drug-related mortality in Scotland. 613 drug related deaths were registered in Scotland in 2014, 16% more than in 2013. This was the largest number ever recorded, 72% higher than in 2004¹. But these deaths, as defined by Information Service Scotland (ISD), sadly are only part of a wider picture of health-related impacts of problematic drug use that have led to increases in deaths among people who use or have used drugs problematically.

Bacterial infections, deaths from cardio-vascular disease, suicide, liver disease, cancer and other health conditions^{2 3} may all have significantly increased due to the negative impact of substance use on people's health and wellbeing. Systemic disease, most prominently liver disease, is common in this group and can influence the dynamics and age demographics of wider drug-related death.

Wider considerations including the consequences of social policy such as welfare reform are also of concern. This partly evolves from and is exacerbated by the stigma that historically increases as society becomes more unequal⁴⁵. Many of those at highest risk of death express ambivalence towards living or dying thus bringing a challenge when delivering harm reduction measures.⁶

It is estimated that the ageing process among older people with a longer term drug problem is accelerated by at least 15 years and at the age of 40, drug users may need a level of care corresponding to that required by an elderly person in the general population⁷. The Scottish government are currently commissioning a piece of work to support the development of strategic and operational responses are developed to meet the health care needs and increased risk of death. The interim report⁸ shows that there are currently approximately 30,000 individuals with a drug problem who are between 35 and 65 years old. Comparing drug death averages for 2000-2004 and 2010-14 shows large increases in the number of deaths in the 35-65 year old age group⁹. Many of the key findings of this report are also applicable to these older drug using groups.

¹ <http://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/drd14/drugs-related-deaths-2014-revised.pdf>

² <http://onlinelibrary.wiley.com/doi/10.1046/j.1360-0443.1998.9357016.x/abstract>

³ <http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2006.01495.x/abstract>

⁴ Wilkinson, R., & Pickett, K. (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London: Allen Lane.

⁵ <https://www.jrf.org.uk/report/does-income-inequality-cause-health-and-social-problems>

⁶ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724503/>

⁷ Vogt I. Life Situations and Health of Older Drug Addicts: A Literature Report. *Suchttherapie*.2009;10 (1):17–24.

⁸ Scottish Drug Forum Older People with drug problems in Scotland Interim Report June 2016

⁹ <http://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/drd14/drugs-related-deaths-2014-revised.pdf>

At the time of writing this report significant changes to the health and social care landscape in Scotland are taking place. A new drugs advisory landscape in Scotland has recently been established¹⁰. The Partnership for Action on Drugs in Scotland (PADS group) met for the first time in January 2016 and brings together leaders from the fields of addiction, mental health, inequality, social work and health and social care. The group has a dynamic and action orientated approach and includes a sub group on drug related deaths, harm and quality improvement.

Legislation to implement health and social care integration, passed by the Scottish Parliament in February 2014, came into force on April 1, 2016¹¹. This brings together NHS and local council care services under one partnership arrangement for each area. Working together, NHS and local council care services will be jointly responsible for the health and care needs, to ensure that those who use services get the right care and support whatever their needs, at any point in their care journey. This integration should support the work of ADP's and assist in the implementation of this report's key findings.

The on-going development of a Recovery Oriented System of Care (ROSC) in each ADP area is critical in helping ensure that locality-based specialist and non-specialist services work in partnership to meet the needs of service users timeously, comprehensively and effectively. As ROSC is an outcome-driven concept, each ADP has responsibility for establishing systems to monitor and measure performance of the local ROSC and the services within it, thereby informing a cycle of continuous improvement.

The publication of the Quality Principles (Standard Expectations of Care and Support in Drug and Alcohol Services) followed directly from the 2013 Review of Opiate Replacement Therapy in Scotland. These provide a foundation for the commissioning, planning, delivery and review of recovery-focused services, with the ultimate aim of ensuring consistency in service quality across the range of services in each ADP area.

For policy makers, service planners, commissioners, managers and staff, responding to a more vulnerable and unstable group who are at greater risk of overdose and other health and social issues that increase mortality, who have a history of moving frequently in and out of services and have sometimes relatively short periods of treatment, requires due consideration.

¹⁰<http://news.scotland.gov.uk/News/Tackling-problem-drug-use-2202.aspx>

¹¹<http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration>

Introduction and Methods

Introduction

With an estimated 61,500¹² problem drug users, Scotland has one of the highest rates of problem drug use per head of population in Europe. 613 drug-related deaths (DRD) associated with drug overdose were registered in Scotland in 2014, a 72 per cent increase since in 2004¹³. These deaths as defined by Information Services Division (ISD) Scotland (appendix 9) and are mainly attributed to direct correlation with drug use, mainly overdose. The wider numbers that could be related to drug use are likely much higher.

Significant efforts have been made in Scotland to understand the deaths, which have included a National Forum on Drug Related Death and the establishment of a National Drug Related Deaths Database (Scotland (NDRD). ADP's coordinate annual data on the nature, health and social circumstances of individuals who have died a drug related death to be analysed by the NDRD.

This report aims to stimulate actions to prevent or minimise the number of deaths whether as a direct or indirect consequence of an individual's drug use.

In August 2014 a joint Ministerial letter (appendix 6) encouraged ADPs to work with Scottish Drugs Forum (SDF) to develop evidenced strategic priorities that will decrease the numbers of drug related deaths. Because of their broad memberships ADPs are well placed to address multi-factorial issues, such as those often implicated in drug related death. This report identifies key initiatives that are being undertaken at a local level and examines other evidence-based solutions in order to set out clear strategies that can reduce the number of drug related deaths in Scotland.

The creation of a national post and the commissioning of this paper are supportive measures that assist with this complex and multifaceted work. The work of the National Forum on Drug Related Deaths (NFDRD) will now be incorporated to the new Partnership for Action on Drugs Scotland (PADS) group. The past work, including annual reports and recommendations, informs this document and many of the recommendations have now been incorporated into the actions to be taken forward by ADPs.

¹² <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2014-10-28/2014-10-28-Drug-Prevalence-Report.pdf>

¹³ <http://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/drd14/drugs-related-deaths-2014.pdf>

Methods

The increase in DRD numbers has highlighted the need for this project and it has been funded from SDF resources. An internal Scottish Drug Forum reference group, which included the SDF CEO, Hepatitis Scotland, National Naloxone Program, National Quality Development, Operations, Harm Reduction and Emergency response Policy Officer, Communications and Workforce Development, oversaw and supported the work that resulted in the development in this report. The work was taken forward by the National Development Officer (Harm Reduction and Death Prevention). The recommendations from the National Forum Drug Related Deaths were consulted and used as a reference throughout the work (appendix 2).

This project initially involved direct engagement with all ADPs in Scotland, and a questionnaire was sent to 14 pilot sites that explored current work practices, potential gaps and how approaches can be further developed to reduce drug related deaths in Scotland (appendix 1). This initial analysis was used to shape a seminar (appendices 3, 4) for ADP's to explore the issues further.

An interim report was then presented to the internal reference group. This report identified key work areas and a list of potential Good Practice Indicators which were then compiled into the consultation draft report.

The consultation report (appendix 7) was distributed to all ADPs, the NFDRD, NVFDRD and other interested parties (i.e. SFAD) for comment. The consultation report was also discussed with ADP's at a workshop during the workforce development reference group (appendix 8). The feedback and subsequent follow up meetings were then used to refine the document and include a measurement tool for ADPs to use to assess their current work in this area which would help to identify a list of strategic and operational priorities for the coming years.

SDF would like to thank the ADPs who contributed to this work for their open and direct communication and look forward to working with all ADPs to take forward this crucial work.

Section 1: Key Principles

Drug related deaths in Scotland can be reduced and change is possible.

This document can assist ADPs through identifying Good Practice Indicators suitable for adaptation and incorporation in local death reduction strategies.

During the scoping and consultation work, key themes emerged that resulted in the development of a set of common principles. These principles can underpin drug death prevention work and be applied throughout all the Key Findings and Good Practice Indicators in this report.

Common principles:

- The aim of treatment is to assist the person to make choices that enable them to achieve an optimum quality of life based on their abilities and strengths while taking into account the realities of their situation.
- Incorporating local needs into all service level agreements (SLA) will improve service delivery. All commissioned organisations should have an SLA with the strategic lead (ADP). In terms of implementation, some practical decisions need to be made, particularly as to which aspects are best carried forward at local, sub – national and national levels.
- Commissioning, review and development of services should ensure that death prevention is given priority. This must include a review of recovery services protocols in response to times when service users recommence substance use.
- Services should be reviewed regularly using the Quality Principles Standard Expectations of Care and Support in Drug and Alcohol Services. Ongoing regular peer-led evaluation of service delivery maintains quality assurance and peers should be actively involved in all local assessments of need and service delivery.
- Service users and carers are active partners in care as opposed to passive recipients. Users of services should be actively involved in the recruitment of substance misuse staff.
- Service models should be evidence-based and research and evaluation integral to all services being commissioned, ensuring they remain evidence based and develop in-line with changes in policy and best practice.
- All services should meet their duty of care to vulnerable adults (Adult Support and Protection, Scotland Act 2007), not unlike child protection responsibilities and this duty of care should have the same priority.
- Partnership working is key in meeting the holistic needs of individuals and all services should foster good working relationships. This can be strengthened by joint training and work shadowing and the commissioning of Public Social Partnerships and consortium's.

Workforce Development

To meet the challenges posed to ADPs and services in this document, it will be important to make demonstrable links between strategic responses and how they link to the workforce across both specialist drug services and universal services. An appropriately trained and supported “frontline” worker in either setting is well-placed to identify and respond to people at risk, however they must be supported by suitable systems at service level to allow them to recognise, assess and respond appropriately. Conversely, a well-designed system can be ineffective if not implemented as planned, therefore the commitment of those charged with the implementation of that strategy i.e. the workforce, is fundamental.

There are two strands to consider – the first is how to ensure that the current workforce is enabled to build on and augment their practice to respond to the challenges which have been set out. In the current economic climate where services budgets may be tightly scrutinized, any changes are construed as making additional demands upon the workforce must be perceived as a) worthwhile and b) of a sufficiently high priority to warrant the required level of regard in an environment of competing priorities. This may require a re-visiting across the workforce of some of the fundamentals of harm reduction and the rights of all people, regardless of their use of substances to access the appropriate support. To reduce the operational pressures associated with releasing staff to attend face-to-face training, blended learning approaches may be appropriate where activities and reading can be completed online both pre- and post-attendance at short face-to-face training events.

The second strand is to consider how building the aspiration of reducing the mortality rate amongst people who use or have used drugs will be introduced to new members of the workforce as they enter their respective jobs. Planning the workforce in this manner may require a review of the current skill sets, job description and person specifications of a variety of job roles to ensure that the challenges set out here are “built-in” and not merely seen as an “add-on” to existing roles. ADPs should consider how Service Level Agreements with their providers can accommodate this. Cultures of practice which are or have become significantly appointment-driven at service locations should be challenged to drive a reinvigorated approach to outreach work. It is acknowledged that to do this will require some services to adapt their current policies.

In Scotland some ADP’s have already started work in this area and many ADP’s have workforce development blueprints in place, these reflect local and national priorities and set out core competencies for the workforce. These local plans are informed by the Scottish Government’s Alcohol and Drug workforce development statement.

Section 2: Key Findings and Good Practice Indicators

Below are summaries of the key findings of the scoping work and consultation. Accompanying each finding is a list of associated Good Practice Indicators (GPI) to assist in self-assessment of current practice and to aid in the planning for future developments. The GPI have been developed from practices seen within Scotland, consultation with ADP's and from further scoping from international and national literature. Individual ADP's will already have in place a number of the indicators recommended but these will vary from one area to another. It is not expected that any one ADP will have all in place. The measurement tool in section 3 will support individual ADP's to identify the indicators already in place and to select priorities from the others, determining their own timeframes dependant on local need. This section also identifies potential workforce development considerations inherently related to the key findings.

Key Finding 1: Drug Related Death Monitoring and Learning in ADPs is variable across the country

A recent Australian study posited that 90% of all DRD were potentially preventable¹⁴. During the scoping for this report it was established that many ADP's have structures to monitor drug related deaths however there were significant variances in scope and practice by the groups. It was also found that ADP's often had limited structures for sharing information learning from these reviews and solutions implemented with other areas. A review process can also provide an insight into local clinical practice, which may drive further improvements in that area¹⁵. As non-fatal overdose is a key indicator of later mortality¹⁶ this section also recommends that DRD death and monitoring group(s) and services examines non-fatal overdose statistics and cases locally.

Good Practice Indicators

- Service managers/practitioners across multiple agencies meet and review cases of people who have died. This learning is shared across area.
- DRD review of recent deaths includes assessments of all opioid-related deaths in regards to whether Naloxone could potentially have been available as an intervention.
- Service managers/practitioners across multiple agencies meet and review non-fatal overdose cases and apply learning to current practice.
- 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.
- Data regarding woman's overdose deaths is regularly reviewed and profiles created to establish any factors that are unique to this group and this information is used in service planning.
- ADP's facilitate DRD review/feedback for GP's.
- ADP's produce annual death prevention report and action plan.
- ADP's death prevention steering groups include all key stakeholders which should include Police Scotland, Procurator Fiscal, Scottish Ambulance service, Scottish Prison Service, ADP, NHS, Voluntary sector, Homelessness and Mental Health.
- Regional DRD good practice forums take place and share learning across ADP areas. This includes ADP's from outwith NHS board area.

¹⁴ <http://onlinelibrary.wiley.com/doi/10.1111/add.12337/abstract?systemMessage=Wiley+Online+Library+will+be+unavailable+on+Saturday+14th+May+11%3A00-14%3A00+BST+%2F+06%3A00-09%3A00+EDT+%2F+18%3A00-21%3A00+SGT+for+essential+maintenance.Apologies+for+the+inconvenience.>

¹⁵ http://www.nta.nhs.uk/uploads/drug_related_deaths_setting_up_a_local_review_process.pdf

¹⁶ <http://onlinelibrary.wiley.com/doi/10.1111/j.1465-3362.2009.00057.x/abstract;jsessionid=E1273CF69AE9721913933044B83EE324.f04t01?systemMessage=Wiley+Online+Library+will+be+unavailable+on+Saturday+14th+May+11%3A00-14%3A00+BST+%2F+06%3A00-09%3A00+EDT+%2F+18%3A00-21%3A00+SGT+for+essential+maintenance.Apologies+for+the+inconvenience>

Key Finding 2: Being in treatment is a protective factor against death

In 2014 47% of people were not in contact with addiction services at the time of their death. 68% of DRD's¹⁷ had been in contact with addiction services at some point in their life. Being in treatment is a protective factor against both overdose and non-overdose deaths¹⁸.

The more difficult it is for people to access a service, the less likely they are to engage. This applies especially to people who are most vulnerable to drug-related death – e.g. people who 'have chaotic lifestyles', are homeless, have mental health problems, have learning difficulties etc. They are often described as a 'hard to reach population'. This group are not necessarily hard to reach as they can often engage with other types of services (i.e. homelessness, criminal justice) and may be highly visible within communities.

There is recognition that waiting times have decreased in Scotland but many individuals still struggle to access services through the current system. Structure, organisation and delivery of services can be barriers for individuals alongside service characteristics such as location and opening times¹⁹. Individuals may not contact services as they are concerned that there are potential consequences related to their responsibility for their children. There are also groups who don't access services as what they want is not on offer.

Care should also be taken to assess the waiting room and welcome at services as this first impression is a major influence whether people continue to engage with services.

Good Practice Indicators

- Individuals are triaged upon first presentation.
- Services adopt 'all individuals are high risk' approach until risk assessments are undertaken.
- Processes are in place for those who have successfully moved through treatment to rapidly re-engage with treatment if needed.
- Standard Operating Procedures include processes that allow rapid re-engagement for individuals who have disengaged from services.
- Fast track assessment and access to ORT is in place for those experiencing non-fatal overdose.
- Risk management plans of individuals with a history of limited engagement outlines solutions to encourage engagement.
- Clear processes are in place for continuation of ORT following prison.
- Clear processes are in place for continuation of ORT following hospital discharge.
- Services assess access by high risk groups every 3 years.
- Child protection policies are easily accessed via websites and service literature.
- All initial contacts with individuals who are parents explains the practicality of how child protection policies operate.

¹⁷ <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-03-22/2016-03-22-NDRDD-Report.pdf>

¹⁸ <http://www.ncbi.nlm.nih.gov/pubmed/21054613>

¹⁹ <https://www.nice.org.uk/advice/lgb14/chapter/Why-are-some-people-not-accessing-services>

Key Finding 3: ORT is a protective factor and Low Threshold services decrease mortality.

Opiate Replacement Therapy (ORT)

In 2014 one third of DRD's in Scotland were prescribed ORT at time of death²⁰ while opioids were found in 87% of all deaths. 39% of those prescribed ORT were below the recommended dose²¹. An independent expert review of ORT in Scotland in 2013²² found that there is a strong international evidence base for its use and it is an effective treatment for opioid use. A range of evidence based opiate replacement therapies should be available²³. Assessment should be undertaken to ensure individuals are matched to the most appropriate treatment, potentially including prescribing heroin²⁴. ORT is a protective factor and efforts should continue to be made to increase coverage²⁵.

Low Threshold Prescribing

Low threshold services are strongly related to decreased mortality from natural causes and from overdoses, increased retention rates and are associated with reduced opioid use and lower crime rates²⁶. Harm reduction approaches to injecting drug use have emphasised the importance of lowering the threshold for access to methadone, in order to enable drug users to avoid drug injecting and associated risk behaviours and negative health and social outcomes. Low-threshold programs aim to reduce negative health outcomes while not requiring individuals to completely abstain from illicit drug use^{27,28}. There is a wide range of low threshold prescribing and rapid access practice worldwide.

Timeframes for accessing ORT should be person-centered and based on risk assessment, with those who are at high risk of DRD being able to access ORT as a matter of urgency.

²⁰ <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-03-22/2016-03-22-NDRDD-Report.pdf>

²¹ http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

²² <http://www.gov.scot/Publications/2013/08/9760>

²³ <http://www.emcdda.europa.eu/best-practice/treatment/opioid-users>

²⁴ <http://onlinelibrary.wiley.com/doi/10.1111/add.12748/abstract;jsessionid=8E4C981C8AADE48889C8F877B55313D6.f02t04?userIsAuthenticated=false&deniedAccessCustomisedMessage=>

²⁵ <https://www.opensocietyfoundations.org/sites/default/files/lowering-the-threshold-20100311.pdf>

²⁶ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446673/>

²⁷ [http://www.ijdp.org/article/S0955-3959\(13\)00034-0/abstract](http://www.ijdp.org/article/S0955-3959(13)00034-0/abstract)

²⁸ <http://www.ncbi.nlm.nih.gov/pubmed/23743178>

Good Practice Indicators

- Triage risk assessments determine timeframe for commencing on ORT.
- Triage risk assessments determine if rapid access and low threshold prescribing is required.
- Rapid titration protocols are in place for high risk individuals.
- Individuals assessed as at a high risk of DRD are prescribed ORT within 48 hours of assessment (those assessed on the day a service closes should be prescribed within two working days).
- Absence from all drugs is not a condition of entry or a requirement throughout course of treatment.
- Service users are an active partner in prescribing decisions and choice of ORT.
- Regular reviews of ORT are held with individuals.
- A range of ORT are offered when appropriate.
- Information is available about ORT including benefits and side effects for individuals and their families.
- Pharmacy ORT practices are regularly audited and externally reviewed (every 5 years).
- Pharmacy ORT practices are regularly reviewed by service users and/or people who have used services (every 5 years).

Workforce Development Considerations

- Addiction staff and GP's have joint training.
- ADP's facilitate learning and sharing events for GP's and addiction staff.

Key Finding 4: Retention in Services is a protective factor against Drug Related Death

Retention in Services

There would appear to be significant differences in retention rates across the country although the data is limited in terms of providing an accurate picture. There would also appear to be significant variations in the recording of discharges from services i.e. planned, unplanned and disciplinary. Duty of care considerations to highly vulnerable clients should be a key part of all local protocols. If a high-risk individual is to be discharged from a prescribing service then other harm reduction services should be made available to them.

Assertive Outreach

Many of the most chaotic and therefore highest at risk, service users are unable to engage with the existing configuration of services. There is a need to explore ways in which contact can be sought and maintained with this population. Assertive outreach is a model taken from the mental health field which has enhanced engagement for service users and been responsive to higher levels of need during illness.²⁹ Assertive outreach models are already in place in some areas and their potential should be further explored.

Most problematic drug users in Scotland are from disadvantaged neighbourhoods and are personally disadvantaged³⁰. This association between problem drug use and deprivation may worsen stigmatisation, as drug injecting can be used as the cause, focus and explanation of all the drug user's difficulties in life.

Trauma

Much previous research has found that substance users may have high rates of trauma, often before drug dependence and also as a consequence of it. The drug use is not used to medicate against a specific problem per se but rather as a means to avoid remembering distressing events, feel anxiety, pain or fear and to "insulate" against complex life issues.

Being more trauma-focussed can involve simply appreciating that many drug users may have been traumatised³¹. Clients may exhibit a range of dysfunctional behaviours when engaging with practitioners, these are learned means of protecting themselves from further trauma. They can include violence, verbal aggression, insincere charm or compliance, withdrawal or shutting down, and detachment or disassociation from their problems. Assessment, particularly repeated assessment by different practitioners, may become highly distressing as clients are asked to go over past traumas repeatedly.

²⁹ [http://www.journalofnursingstudies.com/article/S0020-7489\(03\)00109-3/fulltext](http://www.journalofnursingstudies.com/article/S0020-7489(03)00109-3/fulltext)

³⁰ <http://www.ncbi.nlm.nih.gov/pubmed/25251885>

³¹ www.sdf.org.uk/index.php/download_file/view/596

Continuity of care

Being in contact with services is protective against DRD³² and there is, overall, a need for a broader view of who can help meet an individual's needs, either directly or by signposting, 'hand holding' or referral. GP services may be the primary, or indeed only point of contact with people who are isolated or 'hard to reach'.

Pharmacy Needle Exchange (NEX) are another potential single point of contact and contracts with pharmacy providers should include staff receiving training based on the National Injecting Equipment Provision (IEP) guidelines. Pharmacy staff may often have contact with drug users who are not in structured treatment and can be a valuable point of 2-way communication with high risk individuals.

Good Practice Indicators

- No exclusion policy is the default position for addiction services. Standard operating procedures should reflect this and be embedded across services.
- Staff take full account of their duty of care, and the principles of human rights and equality.
- Assertive Outreach principles are embedded across all substance misuse services.
- Adult Support and Protection enquiries are made when individuals have multiple morbidities and are engaged in high risk behaviours.
- Increased support mechanisms are available when individuals have difficulty in engaging in ways expected of them.
- There is a clear protocol and description of what constitutes unplanned and disciplinary discharges.
- Audits of unplanned and disciplinary discharge are reviewed by senior strategic groups (5 years).
- Attempts made to prevent unplanned discharges are evidenced and recorded.
- Referral pathways for GP's into addiction services are clear and regularly reviewed and updated
- Referral numbers from GP to addiction services are audited annually to ensure pathway is effective.
- Flowcharts are in place for frontline staff that highlights when assertive outreach models should be adopted.
- Outreach and assertive outreach models are clearly defined and the terms are used appropriately when commissioning services, to avoid confusion between the two.
- ROSC has elements of psychosocial supports that facilitate personal change.
- Previous information in assessments around trauma informs future assessments to prevent repeated questioning of individuals which can cause distress.

Workforce Development Considerations

- Staff are aware of the impact of previous trauma on an individual's behaviour towards authority/services/individual workers.
- Services should consider ways in which staff can be supported in managing clients with complex and challenging needs

³² <http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2010.03140.x/abstract?systemMessage=Wiley+Online+Library+will+be+unavailable+on+Saturday+14th+May+11%3A00-14%3A00+BST+%2F+06%3A00-09%3A00+EDT+%2F+18%3A00-21%3A00+SGT+for+essential+maintenance.Apologies+for+the+inconvenience.>

Key Finding 5: Information Sharing across ADP area can be strengthened.

Information sharing protocols across services, organisations and health boards can limit the effectiveness of most interventions. Even in the presence of protocols, there is recognition that services' working effectively together is sometimes more related to good working relationships and 'history' rather than design. Differing cultures, systems and infrastructure incompatibilities (e.g. with IT) can impede joint working and a holistic approach to people's needs. Single shared assessments exist but are often seen as the property of one agency over another and so are often not genuinely 'shared'.

Commissioning is one potential lever to improve this area. ADPs have some control in this regard. Improving relationships between service teams is another means of making information sharing more likely. Joint events, including joint training and work shadowing may help improve cultures and provide networking opportunities.

The sharing of data on non-fatal overdose is key to drug death prevention. The value³³ of identifying those who had previously experienced a non-fatal overdose and intervening with this group is stressed as non-fatal overdose can be predictive of subsequent fatal overdose³⁴. In a few areas protocols have been developed on data sharing between the Scottish Ambulance Service and addiction services. Anecdotal evidence from ADP's shows that opt out services for referral to services has resulted in higher uptake rates than opt in systems. There has been some work in using similar procedures in accident and emergency departments of hospitals however these were not fully implemented.

³³ <http://www.ncbi.nlm.nih.gov/pubmed/26118947>

³⁴ [http://onlinelibrary.wiley.com/doi/10.1111/j.1465-3362.2009.00057.x/abstract;jsessionid=E1273CF69AE9721913933044B83EE324.f04t01?systemMessage=Wiley+Online+Library+will+be+unavailable+on+Saturday+14th+May+11%3A00-14%3A00+BST+%2F+06%3A00-09%3A00+EDT+%2F+18%3A00-21%3A00+SGT+for+essential+maintenance.Apologies+for+the+inconvenience.](http://onlinelibrary.wiley.com/doi/10.1111/j.1465-3362.2009.00057.x/abstract;jsessionid=E1273CF69AE9721913933044B83EE324.f04t01?systemMessage= Wiley+Online+Library+will+be+unavailable+on+Saturday+14th+May+11%3A00-14%3A00+BST+%2F+06%3A00-09%3A00+EDT+%2F+18%3A00-21%3A00+SGT+for+essential+maintenance.Apologies+for+the+inconvenience.)

Good Practice Indicators

- Information sharing protocols are in place between ambulance services and addiction services. Opt out service referral systems are in place.
- Information sharing protocols are in place between accident and emergency departments and addiction services in non-fatal overdose situations and for continuation of ORT on discharge.
- Communication policies between GP's and addiction services are in place.
- Information sharing protocols are in place between pharmacy's involved in dispensing ORT and addiction services.
- Information sharing protocols are in place between pharmacy and addiction services.
- Information sharing protocols allow for pharmacy staff to share information about any concerns they have about individuals with addiction services.

Workforce Development Considerations

- Drug treatment services have a good understanding of high-risk groups (e.g. individuals who have previously overdosed, have multi morbidities, older drug users).
- Drug treatment services have a good understanding of high-risk practices (e.g. injecting, poly-substance use, alcohol use).

Key Finding 6: Injecting drugs can result in a range of injecting related health problems.

Basic wound-care assessments should be completed regularly with those at risk and allow the opportunity for front line staff to sign post to more specialist health support if appropriate. It was found that the provision of specialist wound management and infection control services in Scotland is variable. Referral pathways to specialist wound management services are not always available or fully utilised. Service planners should consider the points of contact individuals have and ensure that wound care provision is available and is of the necessary capacity.

During times of outbreak, and in some areas at times of general infection, there are gaps in the dissemination of information to frontline staff and those at risk. Areas should ensure a wide coverage of information dissemination including all services that people at risk may access such as homelessness accommodation, mental health services, criminal justice services, GP's and pharmacies. A local protocol detailing the service response to bacterial infections and bacterial infection outbreaks for each service will encourage the right level of information dissemination as well as a coordinated front line approach to supporting people at risk. Staff should be encouraged to enhance their skills in this area through training.

Injecting related health problems such as blood borne virus, vein and soft tissue damage and bacterial infection are exacerbated for those who inject outside. Those who inject in 'public' usually inject in unsterile environments and as such are at a higher risk of bacterial infections, injecting related complications and also have a higher risk of sharing injecting equipment and related paraphernalia.

Good Practice Indicators:

- Local information sharing networks are in place when infection outbreaks occur.
- Local protocols are in place in each service detailing actions in the case of bacterial infection and bacterial infection outbreak.
- Briefings are made for staff in event of an outbreak.
- All addiction staff/NEX staff make routine enquiries about injection site wounds.
- A Practitioners Guide to Injecting Equipment Provision is available in all services.
- Specialised wound care services are in place.
- Referral pathways and protocols are in place for referrals for wound care.
- Assertive outreach is provided by nursing staff for wound care for those who are harder to reach.
- A local assessment of public injecting including prevalence, age, gender, locations has taken place.
- Public Injecting Assessment data is used to consider responses needed.

Workforce Development Considerations

- Safer injecting training includes advice aimed at reducing injection related infections and complications (e.g. DVT, BBV, Streptococcus A).
- Wound awareness training - All addiction staff/NEX staff are aware of the main signs of complications with injecting wounds and sign post to wound care or if appropriate accident and emergency services.
- Staff receive Bacterial Infection and Drug Use training.

Key Finding 7: Blood Borne Virus testing and treatment should be increased.

BBV is associated with higher risk of accidental overdose³⁵. Hepatitis C appears to be under-reported in this high risk cohort and concurrent alcohol use with liver disease heightens mortality risk³⁶. In an Australian study liver disease has become the most common cause of mortality in an ageing cohort^{37,38}.

In 2014, 21,200 of the estimated 36,700 HCV chronically infected individuals in Scotland had been diagnosed. While just over 40% of all infections remain undiagnosed, the proportion identified has increased since the launch of the Hepatitis C Action Plan Phase II and its continuation through the Sexual Health and Blood Borne Virus Framework. This increase, evident throughout Scotland, has been fuelled in part by the implementation of finger-prick sampling and dried blood spot (DBS) testing of active PWID attending drug treatment and harm reduction settings. In the context of the new highly effective and easy to administer antiviral therapies, the identification of the thousands of individuals who remain undiagnosed or require to be “re-diagnosed” because of loss to follow-up is more critical than ever. Not only is treatment so much better in terms of cure rates but even people with fairly advanced disease can benefit greatly from therapy. BBV testing is available to the group however in some areas opportunities to test are missed. It was also observed that DBS testing in a number of settings was not always carried out in accordance with procedural requirements, potentially contaminating samples and therefore subsequent results.

A recent HIV outbreak in Glasgow affecting 47 injecting drug users in 2015, highlights the issue of potential spread of HIV within this group. A lack of frontline staff awareness and a delay in testing, monitoring and treatment of individuals could result in serious medical issues which will limit their lives.

There is a need to ensure that all people who have injected drugs, whether they are in drug treatment or not, have been tested for BBV's and have received their diagnosis. Support in understanding treatment regimes and when treatment is required is variable due to recent changes in treatments. We found that addiction service staff were often unsure of HCV and HIV treatment options.

³⁵ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3271367/>

³⁶ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2715970/>

³⁶ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2715970/>

³⁷ <http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2011.03575.x/abstract>

³⁷ <http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2011.03575.x/abstract>

³⁸ <http://www.ncbi.nlm.nih.gov/pubmed/21749525>

³⁸ <http://www.ncbi.nlm.nih.gov/pubmed/21749525>

Good Practice Indicators

- BBV Finger-prick sampling and dried blood spot testing should be used.
- BBV testing is offered at all Needle Exchanges.
- BBV testing is offered at all addiction services.
- BBV testing is offered at low threshold homelessness services.
- All individual's known to addiction services are offered BBV testing.
- Individuals with a positive BBV result are actively encouraged and supported to access treatment.
- BBV testing is offered at GP practices.
- BBV treatment is offered at GP practices.

Workforce Development Considerations

- Addiction staff are aware of current HCV treatment options and can discuss these with individuals.
- Addiction staff are aware of HIV treatment options and can discuss these with individuals.
- Addiction/NEX staff receive safer injecting training.
- All staff are trained in DBS testing and best practice regularly reviewed.
- Safer injecting competency checklists are used following training.
- Safer injecting training is refreshed every 3 years.
- Addiction staff are trained and confident to actively promote alternatives to injecting such as smoking, UTB.

Key Finding 8: Naloxone is an effective intervention in preventing Opioid Overdose Deaths

Naloxone is an effective intervention in preventing overdose deaths³⁹. Scotland was the first country in the world to introduce a National take home Naloxone program in 2011. A total of 21,140 kits were issued over the four years 2011/12 to 2014/15 in Scotland. The percentage of all opioid-related deaths that occurred within four weeks of prison release fell steadily from 9.8% during 2006-10 (before the programme) to 3.1% in 2014⁴⁰. This substantial fall reflects both increasing total opiate-related deaths and falls in the relatively small number of deaths within four weeks of prison release.

There have been a reported 1500+ overdose reversals with take-home Naloxone in the community since the programme began.

Naloxone also has the potential to help engagement with people who are not in services and is a potential instrument of cultural change as it sends a clear message that individual staff, services and wider society care about the lives of drug users. To people who are marginalised and may be ambivalent at times about their own survival this is a powerful message. A clear message that drug deaths are a priority for investment of resources and training, needs to be consistently pushed to support staff to understand this.

With the law change in October, 2015, people employed or **engaged** in drug services can supply Naloxone to **any individual who may be on hand at an overdose situation**. This broadens the scope for Naloxone provision as supply is no longer restricted to nursing and medical staff. Local analysis should be undertaken to assess where targeted distribution can most benefit those at risk. With training available to set up peer distribution networks that ensure concordance with legal requirements, this is a very positive opportunity to ensure Naloxone is available more widely for emergency use.

³⁹ <http://www.gov.scot/Resource/0045/00451251.pdf>

⁴⁰ <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-10-27/2015-10-27-Naloxone-Report.pdf>

Good Practice Indicators

Staff need to be supported to understand the importance of harm reduction and death prevention. ADPs have a clear role in identifying and promoting this priority in workforce development plans.

- Assessments have taken place with regards to recent legal changes (October 2015) assessing which services and peer networks will supply Naloxone.
- The number of Naloxone kits that should be made available following the legal changes has been assessed.
- Financial provision has been made for these extra supplies of Naloxone.
- Third sector organisations have operational procedures that allow non nursing staff to supply Naloxone.
- Third sector organisations have procedures to allow peer Naloxone trainers to be granted volunteer status thus allowing them to supply Naloxone.
- Naloxone peer training networks include those who are currently injecting and prisoners.
- Services in contact with those at risk of overdose have access to Naloxone for use in an emergency i.e. homelessness services, criminal justice services.
- Minimum targets for supplies are based on the prevalence of problematic drug use in area.
- GP practices prescribe licensed Naloxone community pack (Prenoxad) to those who are not in contact with addiction services who may be at risk of overdose.
- Naloxone training and supplies are made to families.
- Demographics of those provided Naloxone are reviewed at regular intervals i.e. gender, age, engaged in a service and plans are in place for those not getting access to Naloxone.

Workforce Development Considerations

- Workforce development plans include training and competency checks for addiction and homelessness staff and peers trainers in opiate overdose and delivery of Naloxone training to people at risk of opiate overdose and others likely to witness an overdose.
- Organisations, services and staff should know where to get access to Naloxone information and training.

Key finding 9: Release from prison/police custody are risks for overdose death

Key finding 8 shows that Naloxone is as effective tool in reducing drug related deaths amongst individuals released from prison however other interventions should also be used.

Components of the care provided in prison and police custody are informed by the needs of individuals who use substances. All such services have the potential to detect/address problem drug use and to promote overdose awareness and deliver harm reduction interventions⁴¹.

Prison Release

Where known, one in ten individuals (11%) had been in prison in the six months prior to death in 2014. Prison through-care can support prisoners by carrying out a range of interventions that can reduce risk of death. These include pre-release education on overdose risks and prevention, continuation and initiation of substitution treatment and improved referral to aftercare and community treatment services⁴².

EMCDDA state that improving through-care between prison and community can prevent overdose deaths⁴³ Through-care for prisoners has been the focus of much work however protocols do not always work as effectively as desired. Monitoring of engagement between prisons and through-care services should be part of any local commissioning agreement.

SPS are currently rolling out a service model based on prison officers engaging pre-release and following through in the community. As this is an opt-in service it may not be as effective with chaotic drug users whose engagement with services is limited. Models that involve assertive linkage and outreach may be necessary for this group. This type of through-care model is currently being piloted in Low Moss prison with short term prisoners and an evaluation report is available⁴⁴.

Police Custody

Where known, one in four individuals (26%) in 2014 had been in police custody in the six months prior to death. This figure is potentially an under-representation, as 15% of data was missing as Glasgow data was not included⁴⁵.

⁴¹ <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-03-22/2016-03-22-NDRDD-Report.pdf?>

⁴² http://www.rsat-tta.com/Files/Prison_Mortality.pdf

⁴³ http://www.emcdda.europa.eu/attachements.cfm/att_212359_EN EMCDDA POD 2013 Preventing%20overdose%20deaths.pdf

⁴⁴ <http://www.turningpointscotland.com/wp-content/uploads/2016/03/Evaluation-Report-FINAL.pdf>

⁴⁵ <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-03-22/2016-03-22-NDRDD-Report.pdf?>

Good Practice Indicators

- Support is in place at liberation that ensures benefits are in place for those eligible to claim.
- Peer support networks are made available in prison and on liberation to support reintegration into community i.e. Smart recovery, NA, ORT and me.
- All prisoners are assessed prior to liberation regarding potential drug related risk behaviours.
- Pre-release education on overdose risks and prevention is available at release from prison.
- Addiction services are informed of high risk individuals prison liberation dates. Provision is in place for continuation/initiation of ORT in the community including weekend release.
- Individuals at risk of opiate overdose are referred to prison through-care services.
- All prisoners with a history of opiate use are offered a supply of Naloxone on liberation.
- Families of prisoner's are offered overdose awareness and Naloxone training in preparation for the prisoner's release. People released from Police Custody receive a supply of Naloxone.

Workforce Development Considerations

- Local Scottish Prison Service staff are trained and equipped to deal with opiate overdose emergencies.
- Police custody suite staff are trained and equipped to deal with overdose emergencies.
- Through-care staff training should include risks of drug overdose and harm reduction practices.

Key finding 10: Ageing drug users bring new challenges to services.

In Scotland there are currently approximately 30,000 individuals with a drug problem who are between 35 and 65 years old. They have often had a long history of drug use including injecting. Due to longer years of risk behaviours there is often a greater health impact in areas such as wound infection and other personal health issues e.g. Chronic Obstructive Pulmonary Disease (COPD). This includes a longer term impact of years of illicit drug use on mental health e.g. a sense of fatalism and inevitability regarding Hepatitis C and DRD⁴⁶.

Comparing drug death averages for 2000-2004 and 2010-14 shows 207 more deaths in the 35-65 year old age group with 86 more individuals dying in the 45-54 year age range⁴⁷. Alongside the higher risk of DRD, age-related increases for specific causes of death (infectious disease, cancer, liver cirrhosis, and homicide) are also factors that affect this group⁴⁸ making their risk of death even higher. It is estimated that the ageing process among older people with a drug problem is accelerated by at least 15 years. At the age of 40, drug users may need a level of care corresponding to that required by an elderly person in the general population⁴⁹. The ongoing impacts of the UK Government's welfare reforms are also likely to have both mental and physical impacts on this population.

A report on the needs of older drug users in Scotland will be published by Robert Gordon University and SDF in 2016 and may form the basis for local action planning for this group. This report should be consulted by death prevention groups when it becomes available. The interim report will be available in June 2016 and consultation with ADP's will take place during the summer months.

⁴⁶ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724503/>

⁴⁷ <http://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/drd14/drugs-related-deaths-2014-revised.pdf>

⁴⁸ <http://www.ncbi.nlm.nih.gov/pubmed/25454405>

⁴⁹ [https://www.thieme-connect.com/products/ejournals/abstract/10.1055/s-0028-1128135I.](https://www.thieme-connect.com/products/ejournals/abstract/10.1055/s-0028-1128135I)

Key Finding 11: Correlates with an individual's mental health

There was a general recognition and understanding that there can be a lack of final clarity on whether a drug overdose was accidental or intentional, anecdotal evidence from frontline staff is that some overdose deaths may well involve, at the least, people who have been ambivalent about whether they live or die⁵⁰. As 60% of DRD in 2014⁵¹ had a specific psychiatric disorder recorded in the 6 months before they died (a 20% increase from 2009) mental health awareness and suicide training should be integral to all workforce development plans for addiction staff⁵ and should be core to addiction staff core competencies. It was found that there is also a need for better working between mental health and addiction services and that mental health services are not always represented in ADPs.

Good Practice Indicators

- Mental Health services are represented on the ADP.
- Joint working protocols and joint case management takes place between mental health and substance misuse services.
- DRD review groups have protocols to assess the numbers of potential suicides amongst DRD.
- ADP DRD reports show changes over time in numbers of potential suicides.

Workforce Development Considerations

- Suicide awareness/prevention training is mandatory in substance misuse services.
- Mental health awareness training is mandatory in substance misuse services.

⁵⁰<http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2011.03575.x/abstract>

⁵¹<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2715970/>

Key Finding 12: Drug users experiencing Homelessness have an increased risk of DRD

Homelessness can be a contributing factor to drug related death (1 in 20 DRD's in 2014 were individuals who were experiencing homelessness)⁵². It was found during the scoping work that homelessness in NRS DRD figures may be an under-representation as it was assessed by registered address at time of death. It is not always possible to tell if the person was actually living at that address at time of death, further complicated by the use of bed and breakfast and temporary furnished flats in some areas that are not obviously identified as homeless accommodation. Drug users who are homeless are the most vulnerable⁵³ as a result of multiple exclusion issues such as substance misuse, institutional care, street culture, adverse life effects and the extent and complexity of their experience of homelessness. They have an increased risk of DRD. People experiencing homelessness are 7 times more likely to die of drug related issue than the general population⁵⁴. They experience health conditions typically found in older people in the general population. Individuals who are actively using substances are entitled to housing, their basic human right to shelter should be met. There are currently limited housing models used in Scotland with this group. Many individuals do not have secure housing options and some rough sleep following a period of abstinence in treatment, hospital, and prison and police custody.

The health and homeless strategy and steering groups⁵⁵ are taking forward a number of recommendations that include closer working with other sectors such as substance misuse, criminal justice. This provides opportunities to work with this group to help improve the health and mortality of individuals experiencing homelessness who use substances.

Good Practice Indicators

- Active drug use does not exclude people from housing.
- Statutory temporary/homeless accommodation does not exclude Individuals as a result of their drug use.
- Housing first models are adopted that include mainstream housing, shared housing and cluster housing models.
- Housing and homelessness services are represented on ADP and Drug death prevention group.
- Links are in place between ADP and homelessness planning structures.
- Temporary/homeless accommodation that supports active drug users is in place.

Workforce Development Considerations

- Addiction staff receive training in multiple exclusion homelessness.
- Housing staff receive alcohol and drug training.

⁵² <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-04-28/2015-04-28-NDRDD-Report.pdf>

⁵³ <http://www.ncbi.nlm.nih.gov/pubmed/17962008>

⁵⁴ <http://www.scotphn.net/wp-content/uploads/2015/10/Restoring-the-Public-Health-response-to-Homelessness-in-Scotland-May-2015.pdf>

⁵⁵ <http://www.gov.scot/Publications/2005/03/20774/53766>

Key Finding 13: Recent percentage increases in DRD are higher for females

The number of deaths of female is consistent with the ratio of woman and men accessing services, however the percentage increase in the number of drug related deaths was greater for females by 91% than for males when comparing annual average for 2010-2014 with that of 2000-2004⁵⁶. Inadequate access to information, education and counselling can also cause women who use opiates or cocaine (both of which can impact on the menstrual cycle) to be unaware of the continued possibility of pregnancy and the need for contraception and/or may delay accessing antenatal care if pregnancy occurs.

Good Practice Indicators

- Assessments include woman's views around family planning and support suitable contraception or clear planning around family planning and need of unborn children.
- Harm reduction services are supportive of pregnant women who use drugs and they include access to evidence-based information on how to manage drug use during pregnancy.
- Women are offered a female case worker where practical.
- Female only groups take place.

Workforce Development Considerations

- Staff in pregnancy related services complete training and have access to evidence-based information on how to manage drug use during pregnancy and the challenges for those using substances in accessing antenatal care, support during labour and birth, advice on breastfeeding and postnatal support.

⁵⁶ <http://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/drd14/drugs-related-deaths-2014-revised.pdf>

Key Finding 14: Prescription drugs and non-opiate illicit substances

The vast majority of DRD had multiple drugs present at time of death (96% in 2014). Benzodiazepines were present in 70% of post-mortem toxicology. This is further complicated with the increasing availability of benzodiazepine-type NPS of unknown content and quality. Excessive doses of these substances are used. There is a lack of information about the metabolic and physical effects of such doses and the effects on short term and long term mental health⁵⁷. Research is needed to allow a better understanding of benzodiazepine-type drug use which would allow for the development of appropriate strategies to reduce drug related harms.

The number of people who die of stimulant induced heart failure is not included in drug death figures leading to a potentially significant under-reporting of numbers. The risks of having a possible heart attack are increased 23 times in the hour after cocaine use with risk further increased if alcohol is included.

Novel psychoactive substances were present in 112 deaths in 2014, with these were dominated by benzodiazepine type NPS.

Good Practice Indicators

- Drug services offer advice and information on all drug groups and how to reduce these risks, this should include risks of poly drug use.
- A&E staff should screen for stimulant use when a person presents with heart problems, strokes and seizures.

Workforce Development Considerations

- Staff of drug services should be competent to offer advice and information on the risks of different drug groups and how to reduce these risks; this should include risks of poly drug use.

⁵⁷ <http://www.scotpho.org.uk/publications/reports-and-papers/1803-investigating-the-role-of-benzodiazepines-in-drug-related-mortality>

Key Finding 15: Attitude of workforce key to engagement

A key theme running through many of the findings above can be linked to the attitude and engagement of staff with service users. The group of individuals most at risk of DRD are often quite chaotic and hard to engage with. Staff members with low levels of knowledge and skill levels are more likely to show a low regard for substance users and may feel unable to cope with regular contact with them⁵⁸. This can lead to discrimination and negative experiences on both sides, leading to briefer and poorer quality of care.

A greater understanding of user needs can inform training and workforce development throughout the substance use and related sectors. Substance users in a variety of studies rate positive attitudes towards them as a key outcome indicator for an interaction. Therapeutic technique is not judged to be as important as manner and attitude by some users. Interpersonal skills such as empathy, being non-judgemental, quality of interaction and staff availability are seen as important enablers for positive outcomes. These factors are valued by people who use substance use services and may be even more valued by particularly vulnerable users including older users.

As the staff that come into contact with users are many and varied, it may be more efficacious to teach the tools and attitude of acquiring knowledge rather than the many strands necessary to be the 'complete' worker⁵⁹.

Exploring organizational and staff attitudes to gain an indicative baseline could be an initial starting point. Prioritising the recruitment of staff who display a positive attitude towards clients may present a cost-effective route towards increasing general service attitude. There are a number of ways of ensuring positive recruitment outcomes but a key method is involving service users in the recruitment process.

Good Practice Indicators

- Confidential systems are in place for users of services to make complaints and these should be readily visible in service literature and waiting rooms.
- Systems are in place for Users of services to be involved in staff recruitment, training and appraisals.
- Systems are in place to allow drug users and families/representatives to appeal decisions about their care i.e. increases/decreases in ORT, funding for rehab and these processes should be clearly displayed in waiting rooms, service leaflets etc.
- Bereavement training is available to staff.

Workforce Development Considerations

- Workforce development plans include work on values and attitudes.
- Values and attitudes work is integral to all workforce development opportunities.
- Programmes to increase staff resilience and promote well-being should be available to increase the likelihood of embedding the right values and attitudes amongst staff.

⁵⁸ http://findings.org.uk/PHP/dl.php?file=hot_workforce.hot&s=

⁵⁹ <http://www.tandfonline.com/doi/abs/10.3109/09687631003705538?mobileUi=0&journalCode=idep20>

Section 3: Good Practice Baseline Tool

The Good Practice Indicators described in section 2 have been developed into a good practise baseline tool for ADP's to measure their work against and help prioritise actions for implementation. This is followed by tables with the Workforce Development Considerations.

This will allow ADP's to stock check on the existing good practise in place and identify priorities for the next few years. These actions will support ADP's with their current work with Care Inspectorate on the Quality Principles Standards of Expectations of Care and Support in Drug and Alcohol Services. It can also be used by individual services to assist with actions for development plans.

Guidance for use of tool

- A tick should be put in either in place, in development, or not in place.
- If not in place is ticked then please select goal 1-2 years, goal 2-3 years or no action.
- If no action is chosen please give reason.
- Actions selected as goals should form part of planning process for ADP and death prevention groups.

Explanation of Options on the tool

Option	Explanation
In Place/ In Development (complete within 12 months)	Is in place across entire ADP area/ Work has already started to put this indicator in place and is due to complete within 12 months of this assessment.
Not in place	Is not in place across entire ADP area or in development. If this box is chosen then one of the next boxes must be completed.
Goal (1-2 Years)	Item will be made a goal to be completed within 1-2 years or less.
Goal (2-3 years)	Item will be made a goal to be completed within 2-3 years.
No action	This should be used if implementation of the indicator is not practical or needed in the area. A reason must be given to why no action will be taken.
Person Responsible/Job Title	Name and job title of the person responsible for taking forward the action in this indicator.

Staying Alive in Scotland Good Practice Baseline Tool

ADP: _____

Date: _____

Good Practice Indicator 1: DRD Monitoring and Learning	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Service managers/practitioners across multiple agencies meet and review cases of people who have died. This learning is shared across area.						
DRD review involving recent deaths includes assessments of all opioid-related deaths regarding identification where Naloxone could potentially have been available as an intervention.						
Service managers/practitioners across multiple agencies meet and review non-fatal overdose cases and apply learning to current practice.						
Services hold reviews with individuals who have experienced a non-fatal overdose and relevant supports to review support plan and harm reduction processes including ORT.						
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.						
Data regarding woman's overdose deaths is regularly reviewed and profiles created to establish if any factors that are unique to group and this information is used in service planning.						
ADP's facilitate DRD review by GP's for individuals in their practice.						
ADP's produce annual death prevention report and action plan and report.						
ADP's have regular death prevention steering groups with key stakeholders.						
Regional DRD good practice forums take place and share learning across ADP areas. This includes ADP's from outwith NHS board area.						

Good Practice Indicator 2: Access to services	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Individuals are triaged upon first presentation.						
Services adopt 'all individuals are high risk' approach until risk assessments are complete.						
Processes are in place for those who have successfully moved through treatment to rapidly re-engage with treatment if needed.						
Processes are in place for individuals who have disengaged from services to allow rapid reengagement.						
Fast track assessment and access to ORT is in place for those experiencing non fatal overdose.						
Risk management plans of individuals with a history of limited engagement outlines solutions to encourage engagement.						
Clear processes are in place for continuation of ORT following prison.						
Clear processes are in place for continuation of ORT following hospital discharge.						
Services assess access by high risk groups every 3 years.						
Child protection policies are easily accessed via websites and service literature.						
All initial contacts with individuals who are parents explain the practicality of how child protection policies operate and the support available.						

Good Practice Indicator 3: ORT and Low threshold prescribing	In Place/ In Development (complete within 12 months)	Not in place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Triage assessments determine timeframe for commencing on ORT.						
Triage assessments determine if low threshold prescribing is required.						
Rapid titration protocols are in place for high risk individuals.						
Individuals assessed as high risk of DRD are prescribed ORT within 48 hours of assessment.						
Absence from all drugs is not a condition of entry or a requirement throughout course of treatment.						
Service users are active partner in prescribing decisions.						
Regular reviews of ORT are held with individuals.						
A range of ORT is offered when appropriate.						
Information is available about ORT including benefits and side effects for individuals and their families.						
Pharmacy ORT practices are regularly audited and externally reviewed (every 5 years).						
Pharmacy ORT practices are regularly reviewed by service users and/or people who have used services (every 5 years).						

Good Practice Indicator 4: Retention in services, continuity of care, trauma and assertive outreach	In Place/ In Development (complete within 12 months)	Not in Place (Give reason)	Goal 1-2 yrs	Goal 2-3 yrs	No Action Give reason	Responsible Person/Job Title
No exclusion policy is default position of addiction services.						
Staff take full account of their duty of care, and the principles of human rights and equality.						
Assertive Outreach principles are embedded in all substance misuse services.						
Adult Support and Protection enquiries are made when individuals have multi morbidities and are engaged in high risk behaviours.						
Increased support mechanisms are available to individuals when they have difficulty in engaging in ways expected of them.						
There is a clear protocol and description of what constitutes unplanned and disciplinary discharges.						
Regular audits of unplanned and disciplinary discharge are reviewed by senior strategic groups (5 years).						
Attempts made to prevent unplanned discharges are evidenced and recorded.						
Referral pathways for GP's to refer into addiction services are clear and regularly reviewed and updated every 3 years.						
Referral numbers from GP to addiction services are audited annually to ensure pathway is effective.						
Flowcharts are in place for frontline staff that highlights when assertive outreach models should be adopted.						
Outreach and assertive outreach models are clearly defined and the terms are used appropriately when commissioning services, to avoid confusion between the two.						
ROSC has elements of psychosocial supports that facilitates personal change.						
Previous information in assessments around trauma informs future assessments to prevent repeated questioning of individuals which can cause distress.						

Good Practice Indicator 5: Information Sharing	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Information sharing protocols are in place between ambulance and addiction services. *Opt out referral systems are place. *Assertive Outreach is used.						
Information sharing protocols are in place between accident and emergency departments and addiction services in non-fatal overdose situations and for continuation of ORT on discharge. *Opt out referral systems are place. *Assertive Outreach is used.						
Communication policies between GP's and addiction services are in place.						
Information sharing protocols are in place between pharmacy's involved in dispensing ORT and addiction services.						
Information sharing protocols are in place between pharmacy and addiction services.						
Information sharing protocols allow for pharmacy staff to share information about any concerns they have about individuals with addiction services.						
Addiction services are informed of high risk individuals liberation dates. Provision is in place for continuation of ORT in community including weekend release.						

Good Practice Indicator 6: High Risk Injecting/Wound care/Bacterial Infections	In Place/ In Development (complete within 12 months)		Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Local information sharing networks are in place when infection outbreaks occur.						
Local protocols are in place in each service detailing actions in the case of bacterial infection and bacterial infection outbreak.						
Briefings are made for staff in event of an outbreak.						
All addiction staff/NEX staff make routine enquiries about injection site wounds.						
A Practitioners Guide to injecting Equipment Provision is available in all services.						
Specialized wound care services are in place.						
Referral pathways and protocols are in place for referrals for wound care.						
Assertive outreach is provided by nursing staff for wound care for those who are harder to reach.						
A local assessment of public injecting including prevalence, age, gender, locations has taken place.						
Public Injecting Assessment data is used to consider responses needed.						

Good Practice Indicator 7: BBV testing and treatment.	In Place/ In Development (complete within 12 months)	In Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
BBV testing is offered at all Needle Exchanges.						
BBV testing is offered at all addiction services.						
BBV testing is offered at low threshold homelessness services.						
All individual's known to addiction services are offered BBV testing.						
Individuals with a positive BBV result are actively encouraged and supported to access treatment.						
BBV testing is offered at GP practices.						
BBV treatment is offered at GP practices.						

Good Practice Indicator 8: Naloxone	In Place/ In Development (complete within 12 months)	Not in place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Assessments have taken place with regards to recent legal changes (October 2015) assessing which services and peer networks will supply Naloxone.						
The number of Naloxone kits that should be made available following the legal changes has been assessed.						
Financial provision has been made for these extra supplies of Naloxone.						
Third sector organisations have operational procedures that allow non nursing staff to supply Naloxone.						
Third sector organisations have procedures are in place to allow peer Naloxone trainers to be granted volunteer status thus allowing them to supply Naloxone.						
Naloxone peer training networks include those who are currently injecting and prisoners.						
Services in contact with those at risk of overdose have access to Naloxone for use in an emergency i.e. homelessness services, criminal justice services.						
Minimum targets for supplies are based on the prevalence of problematic drug use in area.						
GP's prescribe licensed Naloxone community pack (Prenoxad) to those not in contact with addiction services who may be at risk of overdose.						
Naloxone training and supplies are made to families.						
Demographics of those provided Naloxone are reviewed at regular intervals i.e. gender, age, engaged in a service and plans are in place for those not getting access to Naloxone.						

Good Practice Indicator 9: Prison Throughcare/Police Custody	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Support is in place at liberation that ensures benefits are in place for those who are eligible to claim.						
Peer support networks are made available in prison and on liberation to support reintegration into community i.e. Smart recovery, NA, ORT and me.						
All prisoners are assessed prior to liberation regarding potential drug related risk behaviours.						
Families of prisoner's are offered overdose awareness and Naloxone training in preparation for the prisoner's release.						
All prisoners with a history of opiate use are offered a supply of Naloxone on liberation.						
Pre-release education on overdose risks and prevention is available at release from prison.						
Support is in place for continuation or initiation on ORT at release.						
Individuals at risk of opiate overdose are referred to prison through-care services.						
People released from Police Custody receive a supply of Naloxone.						

Good Practice Indicator 11: Dual diagnosis and suicide.	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Mental Health services are represented on the ADP.						
Joint working protocols and joint case management takes place between mental health and substance misuse services.						
DRD review groups have protocols to assess the numbers of potential suicides amongst DRD.						
ADP DRD reports show changes over time in numbers of potential suicides.						

Good Practice Indicator 12: Homelessness/rough sleeping/housing	In Place/ In Development (complete within 12 months)	Not in place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Active drug use does not exclude people from housing.						
Statutory temporary/homeless accommodation does not exclude Individuals as a result of their drug use.						
Housing first models are adopted that include mainstream housing, shared housing and cluster housing models.						
Housing and homelessness services are represented on ADP and Drug death prevention group.						
Links are in place between ADP and homelessness planning structures.						
Temporary/homeless accommodation that supports active drug users is in place.						

Good Practice Indicator 13: Female drug users	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Assessments include woman's views around family planning and support suitable contraception or clear planning around family planning and need of unborn children.						
Harm reduction services are supportive of pregnant women who use drugs and they include access to evidence-based information on how to manage drug use during pregnancy.						
Woman are offered a female case worker						
Female only groups take place.						

Good Practice Indicator 14: Prescription drugs and non-opiate illicit substances.	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Drug services offer advice and information on all drug groups and how to reduce these risks, this should include risks of poly drug use.						
A&E staff should screen for stimulant use when a person presents with heart problems, strokes and seizures.						

Good Practice Indicator 15: Attitude and Stigma	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Confidential systems are in place for users of services to make complaints and these should be readily visible in service literature and waiting rooms.						
Systems are in place for Users of services to be involved in staff recruitment, training and appraisals.						
Systems are in place to allow drug users and families/representatives to appeal decisions about their care i.e. increases/decreases in ORT, funding for rehab and these processes should be clearly displayed in waiting rooms, service leaflets etc.						
Bereavement training is available to staff.						

Workforce Development Considerations	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Addiction staff and GP's have joint training.						
ADP's facilitate learning and sharing events for GP's and addiction staff.						
Staff are aware of the impact of previous trauma on an individual's behavior and understand this can impact on their approach towards authority/individual workers.						
Services should consider ways in which staff can be supported in managing clients with complex and challenging needs.						
Drug treatment services have a good understanding of high-risk groups (e.g. individuals who have previously overdosed, have multi morbidities, older drug users).						
Drug treatment services have a good understanding of high-risk practices (e.g. injecting, poly-substance use, alcohol use).						
Safer injecting training includes advice aimed at reducing injection related infections and complications (e.g. DVT, BBV, Streptococcus A).						
Wound awareness training - All addiction staff/NEX staff are aware of the main signs of complications with injecting wounds and sign post to wound care or if appropriate accident and emergency services.						
Staff receive Bacterial Infection and Drug Use training.						
Addiction staff are aware of current HCV treatment options and can discuss these with individuals.						
Addiction staff are aware of HIV treatment options and can discuss these with individuals.						

Workforce Development Considerations	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Addiction/NEX staff receive safer injecting training.						
Safer injecting competency checklists are used following training.						
Safer injecting training is refreshed every 3 years.						
Addiction staff are trained and confident to actively promote alternatives to injecting such as smoking, UTB.						
Workforce development plans include training and competency checks for addiction and homelessness staff and peers trainers in opiate overdose and delivery of Naloxone training to people at risk of opiate overdose and others likely to witness an overdose.						
Local Scottish Prison Service staff are trained and equipped to deal with opiate overdose emergencies.						
Police custody suite staff are trained and equipped to deal with overdose emergencies.						
Through-care staff training should include risks of drug overdose and harm reduction practices.						
Suicide awareness/prevention training is mandatory in substance misuse services.						
Mental health awareness training is mandatory in substance misuse services.						
Addiction staff receive training in multiple exclusion homelessness.						
Housing staff receive alcohol and drug training.						

Workforce Development Considerations	In Place/ In Development (complete within 12 months)	Not in Place	Goal (1-2 years)	Goal (2-3 years)	No Action Give Reason	Responsible Person/Job title
Staff in pregnancy services complete training and have access to evidence-based information on how to manage drug use during pregnancy and the challenges for those using substances in accessing antenatal care, support during labour and birth, advice on breastfeeding and postnatal support.						
Staff of drug services should be competent to offer advice and information on the risks of different drug groups and how to reduce these risks; this should include risks of poly drug use.						
Staff of drug services should be competent to offer advice and information on the risks of different drug groups and how to reduce these risks; this should include risks of poly drug use.						
Workforce development plans include work on values and attitudes.						
Values and attitudes work is integral to all workforce development opportunities.						
Programmes to increase staff resilience and promote well-being should be available to increase the likelihood of embedding the right values and attitudes amongst staff.						

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Appendix 1 -ADP DRD Questionnaire

Scottish Drugs Forum/Hepatitis Scotland

Drug Related Death Questionnaire for ADPs

1) Overdose

- a. What is the coverage of naloxone locally in relation to the number of people who use drugs problematically?
- b. How many kits have been supplied? How many of these have been first supplies?
- c. Are there plans in place to increase this?
- d. Do you have a protocol with emergency services for notification of 'near misses? Is there a system for tracking non-fatal overdoses or other 'near misses'?
- e. If so, how are these people followed up?
- f. How is learning from fatal and non-fatal overdoses used to develop policy and practice?

2) Addiction services

- a. What proportion of the drug using population in your area is in treatment?
- b. How many of these are on ORT?
- c. What is the average length of time in treatment?
- d. What are the rates of unplanned or disciplinary discharge/drop-out and how are these terms defined in your area?
- e. What strategies are in place to audit/manage this?
- f. What is the process for the individual surrounding unplanned discharge (e.g. onward referral pathway, risk assessments)?
- g. Is there a local protocol regarding the ongoing duty of care following planned or unplanned discharge from a service?
- h. What is the availability of wound care clinics in your area?

3) Mental Health

- a. How effectively do mental health and addiction services interface and work together?
- b. Are psychiatric assessments available to people within addiction services and are substance use assessments available to people within mental health services? Are there issues with waiting times for these assessments?

- c. What referral and treatment protocols are in place for people with a dual diagnosis?
- d. Are any initiatives in place or in development to improve joint working?
- e. What arrangements are in place for follow up/liaison in respect of hospital admission/discharge (acute liaison nurses etc)?
- f. What are the links between the ADP and mental health services planning structures?

4) Homeless/roofless/no fixed abode populations

- a. In your opinion how effectively do services for homeless/roofless/no fixed abode populations and addiction services work together?
- b. Are any initiatives in place or in development to improve joint working?
- c. Are there any Housing First (a housing led strategy out of homelessness for individuals who still have an active drug problem) type services in operation locally?
- d. Are housing services represented on the ADP?
- e. What are the links between the ADP and the housing/homelessness planning structures?

5) Older problem drug users

- a. Have you mapped the numbers of older problem drug users in your ADP area?
- b. Are any initiatives/services in place or in development to meet the needs of older drug users?
- c. Is there awareness among services for older people of the needs of the increasing number older drug users?
- d. What are the links between services for older people and addiction services?

6) Prison through care/follow up

- a. What arrangements are in place for prison throughcare/continuity of care (including continuity of prescription)? Are these currently effective?
- b. Is naloxone/injecting equipment/foil provided on liberation? Are prisons represented on the ADP?

7) Sexual Health and BBV

- a. How close are links between the ADP(s) and the BBV MCN?
- b. What joint working takes place between ADPs and MCN regarding prevention and treatment?
- c. What testing/provision is available in respect of sexual health and BBVs within addiction services?
- d. What proportion of the population diagnosed with HCV is/have been in treatment?

- e. Are there any plans/moves locally towards community based HCV treatment? Is there any involvement of addiction services/community pharmacy in this?
- f. What plans are in place locally to roll out new HCV treatments and what stage are these at?
- g. What HCV Testing strategy is in place in local addiction services? (For example, is there regular testing of all clients with an opiate using background and at least one-off testing for alcohol using clients?)

8) Bacterial infections

- a. Are outbreaks of infection monitored by the ADP?
- b. Is there a system in place for responding to outbreaks of bacterial infection among problem drug users?

9) Stimulant drug use

- a. Does the ADP monitor problems arising from psycho-stimulant drug use?
- b. Have any needs assessments been undertaken with regard to this population?

10) Screening for Drug Related Death risk

- a. Is there a DRD risk screening system in operation and, if so, how does it operate? Is an individual's DRD risk regularly reviewed?
- b. Is a DRD risk assessment incorporated in the drug treatment assessment process?
- c. Which stakeholders have access to this system and are able to:
 - i. Input information?
 - ii. Extract information?
 - iii. Make/receive referrals?

Appendix 2 -National Forum on Drug-related Deaths Recommendations 2014

Recent reports of the forum reiterate previous recommendations in regards service delivery and preventative interventions. These include:

- More work needs to be done by the Scottish Government and ADPs to investigate the specific needs of older drug users (35+years) with a view to improving services for this population. All ADPs should ensure local strategies and work plans prioritise drug-death prevention strategies to vulnerable groups, particularly those not in contact with treatment services. All ADPs should conduct a needs assessment for such vulnerable groups in their localities and assess the need for interventions. More should be done to engage such populations with recovery opportunities. Potential means of achieving this are the availability of assertive outreach by harm reductions services, low threshold treatment services, Heroin Assisted Treatment and Drug Consumption Rooms and assertive links to the recovery communities
- Hepatitis C treatment in community settings has been difficult to develop and further efforts are required to allow shared care models to achieve significant impact
- Through-care for those leaving prison and relocating in communities is slow to develop. This is a central strategy in addressing the risk of death from overdose in the months after leaving custody. Community health and social care services links to be improved/developed
- Alternatives to methadone remain available to a minority of drug dependent patients. These alternatives are other pharmacotherapies and non-pharmacological interventions such as detoxification and residential rehabilitation. Successful recovery depends upon increased capacity in projects designed to address the longer term problems. One specific example is the possibility of methadone and other opiate substitute therapy maintenance being part of a recovery package in residential recovery agencies
- Community pharmacies remain vulnerable to criticism and to (lack of) capacity problems. Support and adequate resources are required to maximise the role that optimal pharmaceutical care can play in promoting recovery for individual patients
- Roll out and reach of the national naloxone programme needs to be significantly enhanced. Specialist addiction services need to provide training and provide naloxone to their clients.

Appendix 3 -Seminar Programme

DRD Seminar 5th March 2015

Programme

10:00	Registration and refreshments
10:30	Welcome and introduction to day – Dave Liddell, Director, SDF
10:40	Setting the scene – Dr Roy Robertson, Chair of the National Forum on Drug Related Deaths
11:25	Coffee
	Service factors
11:45	Findings from pilot ADP questionnaire – Ian Robertson National Officer (Death Prevention) SDF/Hepatitis Scotland
12:05	Unplanned discharge from services - Austin Smith, Policy and Practice Officer, SDF
12:15	Non-fatal overdose – information sharing protocols - Sandy Kelman, ADP Co-ordinator for Aberdeen City
12:25	Discussion – service factors
12:45	Lunch
	Physical and mental health
13:30	Blood borne viruses – Leon Wylie, Lead Officer, Hepatitis Scotland
13:40	Bacterial risks - Emma Hamilton, National Training and Development Officer (Harm Reduction and Emergency Responses), SDF
13:50	Mental Health and suicide
14:00	Discussion – physical and mental health
14:30	Refreshment Break
	Access to services
14:50	Low threshold services – Andrew O'Donnell, Trainer, NHS Lothian Harm Reduction Team
15:00	Harm reduction - assertive outreach
15:10	Discussion – Access to services
15:45	Next steps - Dave Liddell, Director, SDF
16:00	Close

Appendix 4 -Presentation summaries

Session 1: Setting the Scene

Dave Liddell, Director, Scottish Drugs Forum

- introduced the context of the seminar, referring to the especially high rates of drug related deaths in Scotland
- emphasised the importance of partnership working in this as per Ministerial letter from August 2014

Roy Robertson, Chair of the National Forum on Drug Related Deaths

- gave a comprehensive overview of factors associated with DRD and various protective factors, noting the steady increase over many years in the numbers of people dying as a result of drug /use in Scotland and the possible levelling off of this since 2011.
- presented the point of view that much problematic substance use may relate to people self – medicating and evidenced the high level of correlation with childhood adversity and trauma.
- highlighted key protective factors against DRD, such as being engaged with services (the majority of people are not engaged with treatment services at the time of their death, in 2012 60% of people who died were within six months of leaving treatment.
- identified service factors that can impact positively on rates of DRD such as treating mental health and problematic substance use together and substituting respectful, person centred systems of care for punitive approaches.

Session 2: Service Factors

Ian Robertson, National Officer (Death Prevention), SDF and Hepatitis Scotland

- Delivered a qualitative overview of the findings from the DRD questionnaire (appendix 3) for pilot ADPs. The presentation looked at responses to each questionnaire section followed by Good Practice Examples of initiatives or policies in place in individual areas of Scotland. These good practice examples have been incorporated into the Strategy toolkit. Key examples included information sharing protocols for cases of non – fatal overdose (NFO), NFO being reviewed alongside Fatal Overdoses to help inform future practice, provision of dual diagnosis nurses and suicide prevention training for addictions staff. Participants were very keen to look at a spread of approaches to the problem of DRD with a consensus view that some Good Practice Indicators require to be developed nationally whilst others are best developed locally, taking more account of local circumstances.

Austin Smith, Policy and Practice Officer, SDF

- presented on the key topic of **Unplanned Discharge from Services** and the impact of this on rates of DRD
- highlighted that not being engaged with services increases the risk of DRD and although a large proportion of people who die have recently been in services, there is no consensus definition of unplanned discharge. This matters because a) being in treatment is protective b) services have a moral/legal duty of care to people leaving the service and c) discharges are a barometer of service efficacy.
- put forward the argument that discharges are complicated and often relate to a number of different factors but that a duty of care still applies, for example, where someone fails to attend, drops out, has dependent children, or is clearly struggling in treatment. In following discussion it was suggested that duty of care provisions having been highlighted as key issues by some Procurators Fiscal and FAI may cause future issues.

Sandy Kelman, ADP Co-ordinator, Aberdeen City

- delivered a presentation covering Aberdeen's local experience of developing **Information Sharing Protocols**.
- protocol developed in discussion with the Scottish Ambulance Service, in line with protocol being operated within NHS Forth Valley. The Aberdeen protocol has been formulated in such a way that information sharing/opt in is the default position and service users have to actively opt out for information not to be shared. The most recent stats show that, out of 113 cases where people were not in treatment. 14 of these individuals subsequently came into treatment. In the follow up discussion, there was general agreement that negotiating a Scotland wide protocol might be an effective way to proceed and should be investigated.

Session 3: Physical and Mental Health

Leon Wylie, Lead Officer, Hepatitis Scotland

- presented on the topic of **blood borne viruses** which are not necessarily always recognised as a significant cause of deaths in individuals who have injected drugs.
- stressed the interconnectedness of problematic drug use and BBVs and noted that the various harms associated with both tend to be cumulative e.g. if someone's liver is compromised by hepatitis c, their 'risk envelope' for overdose will be of longer duration. Hepatitis C does not have to have caused significant liver damage for it to be linked to multiple morbidities of physical and mental health issues.

Emma Hamilton, National Training and Development Officer (Harm Reduction and Emergency Responses), SDF

- looked at the range of **Bacterial Risks** affecting drug users.
- bacterial infections are widespread among PWID with 28% having experienced abscesses or sores and around 10% being hospitalised every year. Recently a range of bacteria have been implicated in various outbreaks among PWID including Clostridium Botulinum (causing wound botulism and implicated in a current outbreak in Scotland), Group A Streptococcus (implicated in a current outbreak in Scotland via injection of NPS), Bacillus Anthracis and Clostridium Novyii.
- suggested that ADPs are already active in overdose and naloxone provision and perhaps should all be active in planning for and involvement in bacterial outbreaks.

Leon Wylie, Lead Officer, Hepatitis Scotland

- noted that substance and mental health problems are associated and often develop concurrently (in 2012 56% of DRD had a psychiatric condition) while withdrawal from substance use often leads to or indeed unmasks mental health problems.
- studies show around 40% of PWID having made at least one suicide attempt and heroin users being 14 times more likely to die due to suicide than the general population. Noted that the average age of people dying by suicide is some 10 years greater than the average for the main DRD cohort.
- evidenced a need for early interventions which are broad based and person centred and which cover substance use as well as social, educational, employment and mental health dimensions. Integrated services, planning, management and thinking are crucial as well as joint training on suicide prevention, overdose awareness and naloxone.
- emphasised that recognition of the risks of isolation and the role of assertive outreach is crucial. It is important that active learning from reviews of DRDs and non – fatal O/Ds takes place.

Session 4: Access to Services

Andrew O'Donnell, Trainer, NHS Lothian Harm Reduction Team

- presented on the **history of the Low Threshold Harm Reduction Service** in the NHS Lothian area.
- presented his thoughts and experiences of being involved in the development and delivery of Low Threshold services over some 20 years.
- noted the recent increase in the use of various NPS and the difficulties experienced by some staff in keeping up to date with these trends.
- this can be associated with a tendency for frontline staff to view those further up the hierarchy as doing nothing which can be seen as similar to how harm reduction and DRD prevention are sometimes viewed.

- in terms of access to services, harm reduction should be a constant with person centred and outreach approaches aiming for transition to in reach. Services should be diverse but with flexibility as a common factor, evidence based but taking account of changing patterns of drug use. Services should be flexible enough to address the barriers people may create or use to postpone or avoid support.

Emma Hamilton, SDF

- delivered a further presentation looking at **Harm reduction – assertive outreach.**, defined as “an approach that offers flexibility in terms of when, where and how individuals are supported” and gave Housing First and the Harm Reduction Needle Exchange Outreach Service and the Harm Reduction Team – Outreach Needle Exchange van as examples. In Glasgow, Community Safety, Homelessness and Treatment service are working in partnership to identify and support street injectors
- some of the strengths of assertive outreach include:
 - meeting with people who may not typically engage with services or have had bad experiences of services
 - being based on long term relationships with users of the service
 - being informal and thus tending to build trust
 - not being time limited and not discharging service users
 - being needs focused
- outlined some of the benefits of an assertive outreach service including:
 - reduction of hospital inpatient frequency and duration
 - improved engagement, increased service contact and higher levels of user satisfaction
 - improved reported quality of life
 - improved adherence to medication and treatment
 - regaining or establishing social relationships with improvement in social functioning
 - better overall ability to manage the tasks of everyday life

The organisers would like to thank all who attended for their invaluable contribution to the further development of this work.

Appendix 5 -ADP Good Practice Examples

- Joint drug death working groups across multiple regional ADPs.
- Strategic representation of ADP networks with BBV networks and vice versa.
- Addiction staff trained in Sexual Health and Contraception and advanced training from sexual health specialists on implants, condom provision within substance misuse teams. Harm Reduction services completing opportunistic sexual health screening.
- Bacterial outbreaks, if confirmed to involve PWID, a rapid alert is sent out to all areas with specific emphasis put on IEP services, Addiction Services, A & E Department, Homeless units, Criminal Justice Services etc.
- Mental health service staff from both health and social work representatives on the ADP. Health and Social work Addictions managers attend mental health service managers meetings and work jointly in planning with mental health services.
- The Acute Substance Misuse nursing liaison service has a robust pathway of referral from and into community based services. If there is a continued identified need and a perceived gap in service the liaison service will continue to support the individual.
- Physical health assessments or 'Keep Well' assessments are integral on Opiate Replacement programs.
- Disciplinary discharges are not undertaken; instead risk assessments are completed and if an individual is deemed at higher risk assertive outreach work is undertaken.
- Service aims to offer BBV test on initial referral then 6 monthly in local addiction services. In services seeing opiate and alcohol using clients - test offered on initial referral.
- All cases discussed at clinical meeting prior to discharge or closure. Two workers employed at 'front-door' service to follow up service users who disengage from initial referral.
- Dual diagnosis liaison Community Psychiatric Nurse funded by ADP to improve communication and relationships between Adult Mental Health and Substance Misuse Services.
- Information sharing protocols are in place between Scottish Ambulance and Substance misuse services with opt out referrals made by ambulance service at non-fatal overdose to substance misuse service

Appendix 6 -Ministerial Letter

To: ADP Chairs

Drug Death Prevention Strategies

6 August 2014

Dear ADP Chair,

As you will be aware, Scotland has a legacy of drug misuse that stretches back decades, creating an upward trend in drug related deaths. Drug related deaths continue to be a significant challenge for the recovery agenda. The National Records of Scotland (NRS) will publish their 2013 Drug Related Deaths Report on Thursday 14th August 2014.

Alcohol and Drug Partnerships (ADPs) play a crucial role in bringing together strategies to tackle this at a local level. In response to the recommendations made by the National Forum on Drug Related Deaths, we are writing to you to encourage all ADPs to develop coordinated responses that cover key issues contributing to premature deaths among problematic drug users.

Over recent years there has been much focus on opiate overdose and the provision of Naloxone. It is crucial that this important work continues. Alongside this we also need to consider other causes of drug related deaths including blood borne viruses (particularly but not exclusively Hepatitis C), suicide, bacterial infections and new psychoactive substances.

We support the Scottish Drugs Forum (SDF) to assist and coordinate the roll-out and delivery of Scotland's National Naloxone Programme. SDF host Hepatitis Scotland who support a wide range of work around effective prevention and treatment approaches to Hepatitis C. Hepatitis Scotland also has a new post focusing on bacterial infections among drug users and ensuring that preparations are in place for future outbreaks of infection.

We have asked SDF to undertake specific work with ADPs to assist them in progressing the development of death prevention strategies. This will initially consist of the development of death prevention strategy guidelines followed by support to ADPs to develop these strategies locally.

This work is crucial in ensuring that our responses are well co-ordinated and very much linked to the third phase of the *Road to Recovery* strategy which focuses on improving the quality of service delivery. The number of deaths associated with drug use is unacceptably high in Scotland and I ask that your ADP participates fully in supporting this initiative.

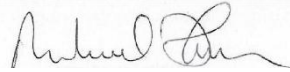
Yours faithfully

Roseanna Cunningham



Minister for Community Safety and Legal Affairs

Michael Matheson



Minister for Public Health

Appendix 7 –Consultation Document

<http://www.hepatitisscotland.org.uk/harm-reduction/>

Appendix 8 –Workshop Notes ADP Reference Group Death Prevention

ADP Reference Group Workforce Development

Death prevention Workshop Notes

08/12/15

Patricia Tracey introduced her role with SDF/Hepatitis Scotland as Harm Reduction and Death prevention. To provide ADP's support with Drug Death strategies that look at both overdose and other causes of mortality as result of drug use. A consultation event was held with a selection of ADP's in May 2015 and this was followed by a draft paper 'Staying Alive in Scotland; Strategies to combat Drug related deaths. Patricia will distribute the paper to the group and is looking for feedback by 30th January 2016. The aim is for the paper to be finalized and distributed by April 2016. Patricia can work with ADP's in their local area to formulate drug death prevention strategies using the toolkit in the paper and will action the national guidelines and best practise guides detailed in the report.

The group were keen that national guidance was published that included:

- Information Sharing protocols in particular in relation to responses to non-fatal overdose i.e. ambulance referrals to services. Also in relation to ORT pharmacists sharing concerns re clients (involve in care plan?).
- How to reach those not in services this should also look at what was is on offer and whether services are offering what these groups want.
- Outreach services.
- Low threshold ORT prescribing, how to overcome barriers (Already in place in Fife).
- GP prescribing guidance of addictive substances perhaps (pain management) with audits of inappropriate prescribing and a cost benefits analysis.
- Children affected by drug deaths (Angus has a pathway that could perhaps be adapted nationally).
- Role of adult support and Protection.

Discussions also resulted in a consensus that support was needed for ADP's to share best practise and learn from each other. This should extend beyond sharing what's happening to include how it happens and results. Trish suggested a survey monkey on what is in happening in relation to death prevention areas and she could compile information and share nationally. There were a few examples discussed but the following highlights this;

Several areas had ambulance referral schemes for non-fatal overdose. However how the referral took place was different. There was more take up of services that were opt out and that involved home visits with appointment times given in a letter (Angus gave an example of 75% take up).

There also discussion was also mindful of these examples being explicit about the demographics of the areas this could be a factor in how practical it is for an area to duplicate.

Other areas to include

- Loneliness/isolation.
- Needs assessments of public injecting (currently happening in Glasgow city centre).
- Attitudes/values of A&E staff (include in workforce development).
- Environmental effects, media, communities, stigma and attitudes (Aberdeenshire gave examples of stigma work with local press). Discussed melting the iceberg paper (LJ to send copy to Trish). Citizen's survey could assess public attitudes to drug users.
- Public Health input.
- Ageing drug users understanding the issues.
- Role of children and family services, workforce development for teachers and nursery nurses on awareness of overdose.
- Peer group/social circumstances analysis of survivors who may also be at risk of death and build supports around them.

Appendix 9 -ISD Definition of a Drug Related Death

The 'baseline' definition for the NDRDD is derived from the UK Drugs Strategy and covers the following cause of death categories (ICD10 codes are given in brackets):

a) Deaths where the underlying cause of death has been coded to the following sub-categories of 'mental and behavioural disorders due to psychoactive substance use':

- i. opioids (F11);
- ii. cannabinoids (F12);
- iii. sedatives or hypnotics (F13);
- iv. cocaine (F14);
- v. other stimulants, including caffeine (F15);
- vi. hallucinogens (F16);
- vii. multiple drug use and use of other psychoactive substances (F19).

b) Deaths coded to the following categories and where a drug listed under the Misuse of Drugs Act (1971) was known to be present in the body at the time of death:

- i. accidental poisoning (X40 - X44);
- ii. intentional self-poisoning by drugs, medicaments and biological substances (X60 - X64);
- iii. assault by drugs, medicaments and biological substances (X85);
- iv. event of undetermined intent, poisoning (Y10 - Y14).

Prior to 2012, deaths covered by point b (ii) were included in the NRS data; however they were not included in the deaths recorded in the NDRDD. The NDRDD report for deaths occurring in 2012 was the first report that included deaths under this category.

A number of categories that may be regarded as 'drug-related' deaths are excluded from the definition because the underlying cause of death was not coded to one of the ICD10 codes listed above. Examples of deaths which are not counted for this reason are:

- deaths coded to mental and behavioural disorders due to the use of alcohol (F10), tobacco (F17) and volatile substances (F18);
- deaths from AIDS where the risk factor was believed to be the sharing of needles;
- deaths from drowning, falls, road traffic and other accidents (except the inhalation of gastric contents, or choking on food) which occurred under the influence of drugs;
- deaths due to assault by a person who was under the influence of drugs, or as a result of being involved in drug-related criminal activities;
- deaths due to infections from contaminated drugs, such as *Clostridium novyi* or anthrax.

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

