The aim of this report is to encourage a wider and more holistic view of drug related deaths (DRD) in Scotland and stimulate actions which can reduce the high death toll among people with a drug problem in Scotland.
Introduction

With an estimated 59,500 problematic drug users Scotland has one of the highest rates of problem drug use per head of population in Europe. The deaths among this group associated with drug overdose have been the focus of significant attention over many years – justifiably so as the trend shows no sign of significant decline. 613 drug-related deaths (DRD) were registered in Scotland in 2014, 257 (72 per cent) higher than in 2004.

The aim of this report is to encourage a wider and more holistic view of drug related deaths (DRD) in Scotland and stimulate actions which can reduce the high death toil among people with a drug problem in Scotland. The report is aimed primarily at the Alcohol and Drug Partnerships across Scotland but will also be of relevance to the Sexual Health Blood Born Virus Managed Care Networks and other local planning groups, and to the Scottish Government.

This report seeks both to reinforce the importance of this focus and to encourage a wider look at other factors causing premature death within this population including blood borne viruses, suicide and bacterial infections. Based on identifying key initiatives currently working at a local level and examining other evidence based solutions, this document will briefly examine the current landscape and set out clear strategies that can ameliorate the current high numbers of deaths.

There has been widespread concern among a range of key stakeholders and within the wider public discourse. This led in August 2014 to a joint Ministerial letter (appendix 4) encouraging Alcohol and Drug Partnerships (ADPs) to work with Scottish Drugs Forum (SDF) to develop evidenced strategic priorities that will decrease the numbers of DRD. Because of their broad memberships ADPs are very well placed to address multi-factorial issues, such as those implicated in DRD, but due to a variety of reasons they may not always make full use of this advantage.

The work to date has consisted of engagement with 14 ADPs exploring what work they are currently undertaking in this area, exploring gaps and potential weaknesses in responses and how approaches can be further developed to impact reducing drug related deaths in Scotland. This initial analysis culminated in a seminar were the issues were further explored and consensus reached on key actions to be progressed. (Appendix 1,2)

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Through this work a toolkit of potential interventions and policies has been developed for further discussion and consultation. These will now be taken forward through a co-ordinated package of support which will include SDF/Hepatitis Scotland’s Death Prevention Project Officer and other resources within SDF who have a crucial role in this area including:

- The Quality Development Team
- The Naloxone Team
- SDF Workforce Development (formerly STRADA)
- Work related to bacterial infections

The summaries below are key areas that have been identified as of critical importance in adequately addressing Scotland’s response to drug-related deaths. They have subsequently informed the compilation of the toolkit.
Summary of key findings

Low threshold services/retention in services

There is recognition that a fundamental aspect of service provision is swift access to help and assistance and that this is not routinely in place across Scotland – particularly in relation to low threshold ORT. 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 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 rates ³⁴.

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 are often not part of local protocols.

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 maintained with this population rather than seeing them as a ‘hard to reach population’. It was recognised that existing service provision made it hard to engage with this group but in most cases they were not hard to find. This may represent lost opportunities for engagement with people at high and multiple risk who may not be in contact with other services. On this basis assertive outreach models should be explored more fully.

Wound-care/bacterial infections

Provision of specialist wound care services is variable. Addiction services staff are not always proficient at diagnostic and intervention procedures related to wound-care. 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. Wound-care assessments allow the opportunity for focussed health behaviour change interventions. Staff should be encouraged to enhance their skills in this area through training.

³ http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446673/
⁴ dx.doi.org/10.1016/j.drugpo.2013.05.005
Responding to people experiencing non-fatal overdose

The sharing of data on non-fatal overdose has been a recurring theme over many years. The value of identifying those who had previously experienced a non-fatal overdose and intervening with this group has been stressed. Protocols have been developed on data sharing between the Scottish Ambulance Service or the Scottish Police and local services and there is agreement that a national protocol is required.

Dual diagnosis and suicide

There was a general recognition and understanding that on occasions it wasn’t clear if a drug overdose was accidental or intentional. This highlighted the need for better working between mental health and addiction services – again a recurring theme over many years. Consistent suicide training and mental health awareness for the specialist addiction service work force is required

BBV testing and treatment

BBV is associated with higher risk of accidental overdose. Co-morbid personality disorder (PD) and co-morbid alcohol use disorder (AUD) are associated with increased all-cause mortality in opiate use. Hepatitis C appears to be under-reported in this high risk cohort and concurrent alcohol use with liver disease heightens mortality risk. In an Australian study liver disease has become the most common cause of mortality in an ageing cohort.

Naloxone provision

With the law change in October, 2015, people employed or engaged in drug services will be able to supply naloxone to any individual who may be on hand at an overdose situation. This broadens the scope for naloxone provision. 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 legislative requirements, this is a very positive opportunity to ensure naloxone is available more widely for emergency use.

5 http://www.ncbi.nlm.nih.gov/pubmed/26118947
6 http://www.ncbi.nlm.nih.gov/pubmed/12375233
Continuity of care

Being in contact with services is protective against DRD 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. Levels of GP engagement is variable and can be poor. GP services may be the primary, or indeed only point of contact with people who are isolated or ‘hard to reach’ Pharmacy NEX are another potential single point of contact and contracts with pharmacy providers should include staff receiving training based on the national IEP guidelines.

Through-care

Through-care for prisoners has received 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 there may not be engagement for the type of assertive support those at highest risk of DRD require.

Information sharing and assessments.

Information sharing protocols across services, organisations and health boards can limit the effectiveness of most interventions. This is a priority need. 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 peoples’ needs. Single shared assessments exist but are often seen as the property of one agency or another and so are often not genuinely ‘shared’

Specific needs of older drug users

Drug-related death risk continues to increase beyond 45 years and there are also age-related increases for specific causes of death (infectious disease, cancer, liver cirrhosis, and homicide). Due to longer years of risk behaviours often there is a greater health impact in areas such as wound infection and other personal health issues e.g. 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 DRD. The ongoing impact of the UK Government welfare reforms are also likely to have both mental and physical impacts on this population.

A lack of planning and provision for older drug users requires the development of an older /vulnerable drug user needs assessment.

Attitude and Stigma

A key theme running through many of the key 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 them. This can lead to discrimination and negative experiences on both sides, leading to briefer and poorer quality of care11.

A greater understanding of user needs can inform training development throughout the substance use sector. 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, such as addressing health issues or providing constructive methods of dealing with lifestyle difficulties.

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’ worker12. 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.


**DRD Template (consultation draft)**

**Introduction:**

This template has incorporated findings and recommendations of the NFDRD, as well as snapshot findings from a questionnaire completed by a pilot group of ADPs and a follow-up seminar. Its purpose is to assist ADPs by providing potential measures which are suitable for adaptation and incorporation in their death reduction strategies. Measures may often form an interlinked matrix, which reflects the interconnectedness of risk and protective factors.

There is an imperative for all working in the field to take full account of their duty of care, and the core principles of human rights and equality, for service users at a risk of harm.

**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.
- Service users and carers are active partners in care as opposed to passive recipients. Ongoing regular peer-led evaluation of service delivery maintains quality assurance. Peers should be actively involved in all local assessments of need and service delivery.
- Peers should be actively involved in treatment staff recruitment
- Evaluation should be built in at start of any new programme/intervention
- Pragmatism helps, some level of service provision is better than none
- Services have a duty of care to vulnerable adults, not unlike child protection responsibilities
- Service working is sometimes more related to good working relationships and ‘history’ than design. Any needs assessments must examine local best practice as regards pragmatic solutions

**National Developments**

Local ADP measures must be supported by national protocols that enable best practice and comparable processes to be developed

- Develop national guidelines for assertive outreach
- Develop needs assessment tool for vulnerable populations
- Development of national information sharing protocols, both with local emergency services, and with voluntary and statutory services
- Develop best practice guide for low threshold service delivery
Measure: Non-Fatal Overdose; Information Sharing

- Non-Fatal Overdose is predictive of subsequent fatal overdose, Local effectiveness assessments of information sharing arrangements between emergency services and health and social care provision should be undertaken immediately.
- Single shared assessments require that they are truly “shared”. Initial work should explore and map how necessary information can be shared across services within the restraints of statutory obligations.
- Explore other local services and systems they use. E.g Edinburgh Homeless Network shares information across voluntary and statutory sectors.

Measure: Risk Assessment/risk management/low threshold services

- Systematic early identification of high-risk individuals across all potential intervention points should be a key part of any DRD reduction strategy.
- Offer targeted harm reduction and overdose interventions and information/advice for all of those assessed as high risk and factual information/advice to all.
- Assess if staff in drug treatment services have a good understanding of high-risk practices (e.g. injecting, poly-substance use, alcohol use), high-risk groups (e.g. users who have previously overdosed, older users, users with certain comorbid health problems) and high-risk stages (e.g. the initial weeks of titration on to opioid substitution treatment, or the weeks following exit from treatment). Does this understanding inform practice on how to reduce the risk of overdose?
- Develop processes for those who have successfully moved through treatment to rapidly re-engage with treatment, ensure this is part of care-planning process.
- Assess need for rapid assessment and access to opioid substitution treatment for those assessed as high risk.
- Include self-harm in risk assessment.
- General rollout of suicide awareness/prevention training to services.

Measure: Active Case Finding and Treatment for HCV and other injection-related infections

- Yearly tests of ALL people currently using and/or joining alcohol AND drug treatment services.
- Active encouragement of BBV treatment for those affected, especially those who use alcohol and have a viral hepatitis diagnosis.
- Provision of safer injecting advice aimed at reducing injection related infections and complications (e.g. DVT, BBV, Streptococcus A).
- Staff are comfortable with providing wound care interventions.
Measure: Assertive Outreach

- Assertive Outreach provides care for those who are “chaotic”; “hard to engage”, and have multiple needs, including co-occurring substance misuse and mental health problems.
- Conduct a local needs assessment for vulnerable, including older populations and link into long-term conditions alliance locally
- Establish a “base level” of service provision required. Older and longer term problematic drug users are at greater risk of drug related death, engagement with services is, of itself, a major protective factor against DRD
- Local assessment of multi-partner or multidisciplinary joint working to allow needs to be matched to those best able to provide services
- Multiple morbidities require cross disciplinary and organisational working. This group are more likely to have a BBV and other multiple morbidities and require more extensive assessment and referral and active follow-up

Measure: Active Retention in services

- Nobody should be excluded from services
- Becomes default position for service delivery, including GP services
- Adopt practices similar to child protection register and training

Measure: Greater engagement with Pharmacy

- 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. Highlights local practice and service developments and can garner up to date intelligence in changes needle exchange provision and support.
- Local ORT practice and IEP service delivery is regularly audited and externally reviewed (including peer review)

Measure: Greater engagement with GP services

- Use tools such as older persons needs assessments to drive engagement
- Link workers into clinics in surgeries
- Link into local GP training, provide joint training with mental health services
Measure: Provision of Naloxone

- Local provision networks and individuals should be promptly assessed with regards to recent legislative change. Current look-back exercises involving recent deaths should include assessments of all opioid-related deaths regarding identification where Naloxone could potentially have been available as an intervention.
- Ensure that staff, services and peers are equipped with the necessary skills and knowledge to deliver training on naloxone to people at risk of opiate overdose and others likely to witness an overdose.
- The provision of take-home naloxone kits should be prioritised to those most at risk and most likely to witness an overdose.
- Services in contact with those at risk of overdose should have access to naloxone for use in an emergency.
- Minimum targets for supplies based on the prevalence of problematic drug use should be met as advised by the National Naloxone Advisory Group and Scottish Government.

Measure: Through-care

- Secure housing is in place upon liberation.
- All prisoners should be assessed prior to liberation regarding potential risk behaviours. High risk individuals should be transferred prior to liberation to community addiction teams. All prisoners should be aware of low threshold services.
- There is proactive support/assertive outreach in place for those who do not engage in formalised through-care programmes.
- All prisoners with a history of substance use leave prison with a supply of Naloxone.

Measure: Communication/Information/Education/Training

- Do services participate in intelligence networks to exchange and disseminate information and advice to other services, service users and staff.
- Make overdose advice realistic and set out risks AND positive outcomes.
- Highlight risks of alcohol and other depressants in increasing DRD risk when using multiple substances.
- Provide advice and support to NPS users who may not be part of “traditional” service users (e.g. students, MSM, sex workers). Advice to include risk factors in mixing sub-types of NPS (e.g. hallucinogen, depressant etc) and also alcohol.
Appendix 1

Pilot ADP Questionnaire and seminar

It was decided to initially work with a smaller number of ADP areas as pilot sites. The use of pilot sites to identify local practice initiatives helps provide an evidence-base of effective interventions that can then be rolled out nationally. A questionnaire was developed which a majority of the pilot ADPs returned.

The subsequent seminar successfully brought together a diverse range of stakeholders from the pilot group of ADPs and permitted an open discussion of issues and initiatives in a pragmatic and realistic way. The commitment of participants was evident. It was designed to give an opportunity for feedback on preliminary findings of the Drug Related Death (DRD) questionnaire to the pilot group of ADPs. There were 14 participants from 8 ADPs in attendance, plus speakers and 7 SDF/Hepatitis Scotland staff.

The programme examined and drew together a variety of key risk and protective factors in respect of Drug Related Death, including non-fatal overdose, unplanned discharge, bacterial risks and blood borne viruses. There was a high level of positive engagement from the participants and a sense that ADPs were happy to work collectively, with support from SDF, to further develop their drug death strategies. There appeared a clear recognition of the benefits of a targeted, nationally guided approach to the reduction of the number of drug related deaths, with local approaches being applied when appropriate.

It is important to highlight that many of the areas are linked to the recommendations previously put forward by the NFDRD (below). This suggests a break between policy and implementation spheres.

From individual discussions with ADPs, the seminar and from the questionnaires received to date, the following themes recurred:

- There is considerable interest in the implementation of protocols with the Scottish Ambulance Service in respect of non-fatal overdose and, indeed, some ADP’s have started to put such protocols in place. This is important as previous non-fatal overdose can be a strong predictor of subsequent fatal overdose. There is a view in various ADPs that it would be beneficial for this to be rolled out as a national initiative.

- Routes into services vary, but low threshold access is not universal. Single shared assessments exist but are often seen as the property of one agency or another and so are often not genuinely ‘shared’

- Demographics for drug related deaths and suicide are similar, a proportion of deaths classified as drug related may be of undetermined intent. There is scope for improving links between services for people who use drugs problematically and suicide prevention services. Deaths determined to be suicide are linked to SMR25 data by the Scottish Suicide...
Information Database (ScotSID) so that previous drug service involvement can be identified. Active engagement of ADPs in suicide prevention should include general rollout of suicide awareness/prevention training to services

- Levels of GP engagement is variable and can be poor. GP services may be the primary, or indeed only point of contact with people who are isolated or ‘hard to reach’

- A lack of planning and provision for older drug users requires the development of an older/vulnerable drug user needs assessment. Differing definitions of ‘older’ in this context may be a factor (for example most social work services define older adults as over 65 whereas ‘older’, in terms of drug users, may be over 50 or even over 35)

- Through-care for prisoners has received much work however protocols do not always work as effectively as desired

- Being in contact with services is protective against DRD 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

- Provision of specialist wound care services is variable. This may represent lost opportunities for engagement with people at high and multiple risk who may not be in contact with other services

- Various ADPs have or have had educational initiatives in place (e.g. lunchtime briefings, seminars) in place to widen awareness of different aspects of DRD

- There is considerable variability in terms of definition across the country in respect of scheduled/unscheduled and disciplinary discharge. There is not clarity regarding where ‘duty of care’ lies, how long it persists and in what form in respect of the person being discharged. There is a potential for legal liability to be tested by families/significant others, a child protection model where it is everyone’s responsibility to consider DRD risk for clearly vulnerable people could be considered to highlight key responsibilities. ‘Assertive retention’ of service users could become the default position nationally. There is probably no other area of medicine or social care where manifesting increased need can lead to decreased service.
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 on SH and Contraception and advanced training from sexual health specialists on implants, condom provision within all teams; Harm Reduction do 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, CJ Services etc.
- Mental health service staff from both health and social work sit on the ADP Board. Managers from Addictions (Health) and Addictions (Social work) also attend mental health service 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.
- Disciplinary discharges are not done. All clients are risk assessed and if they are deemed at higher risk assertive outreach work will be undertaken.
- Aim 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 CPN was funded to improve communication and relationships between Adult Mental Health and SMS.
Appendix 2

National Forum on Drug-related Deaths

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**

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

- 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 inreach. 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 4:

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 14\textsuperscript{th} 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