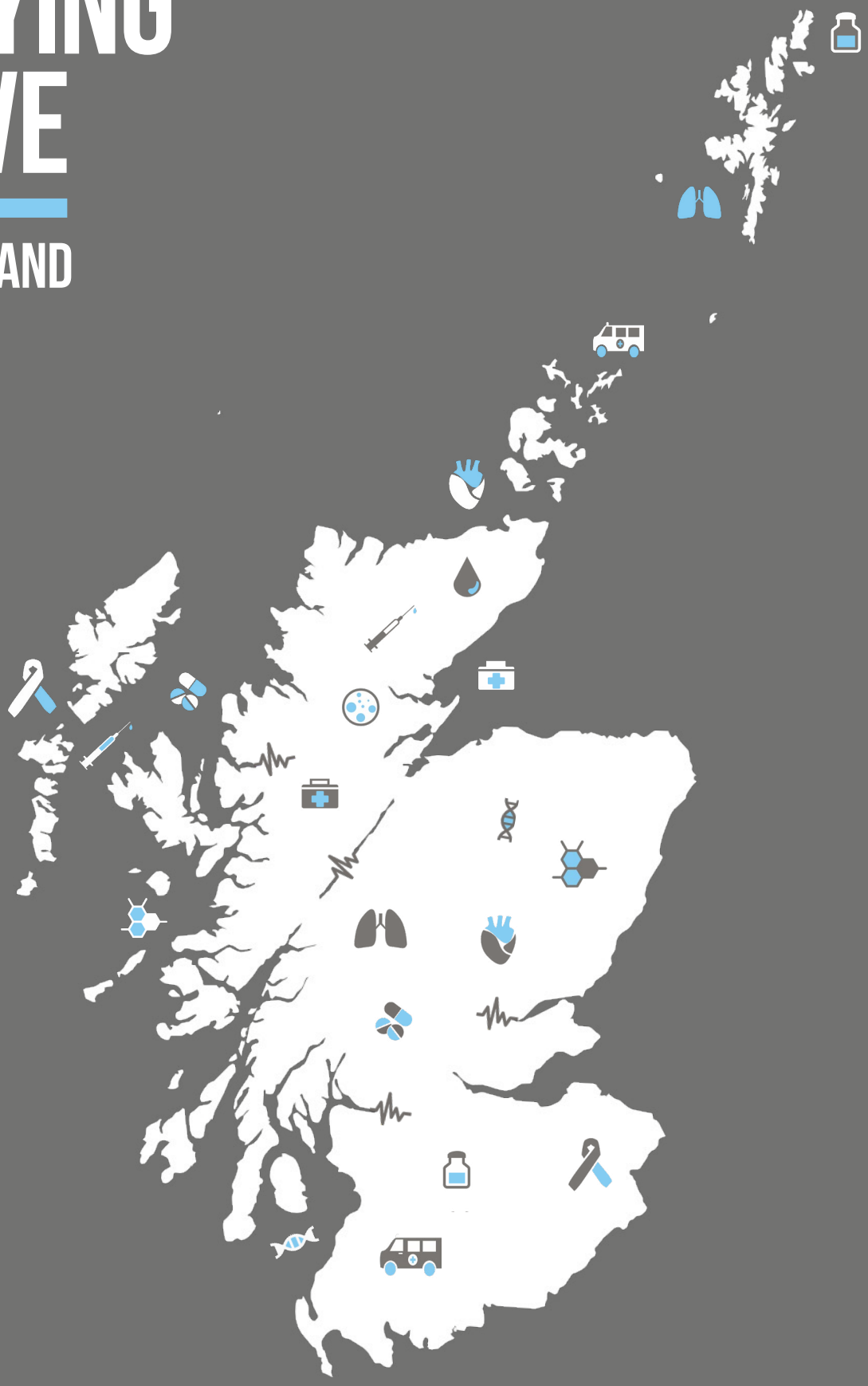
STAYING ALIVE

IN SCOTLAND

STRATEGIES TO PREVENT DRUG DEATHS



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Scottish Drugs Forum

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STRATEGIES TO PREVENT DRUG DEATHS

CONTENTS

Joe FitzPatrick MSP

Minister for Public Health, Sport and Wellbeing

'Staying Alive in Scotland; Strategies to Prevent Drug Deaths' was jointly published by Scottish Drugs Forum and the Scottish Government in 2016. Any loss of life is a tragedy and takes its toll on Scotland's communities and all of us as a nation. In the three years since its publication, we have seen positive change in a number of areas, however, despite our successes, rising drug related deaths continue to be an area of national concern and is one of the most complex challenges to face Scotland.

A key focus of the new Scottish Government alcohol and drug strategy, Rights, Respect and Recovery, is the need for all of us, whether at a local or national or third sector organisation level, to work jointly to deliver change. The vision from that strategy states that everyone has the right to health, to live free from the harms of alcohol and drugs, to be treated with respect and dignity and for their individual recovery journey to be fully supported. I, along with my Ministerial colleagues, remain committed to doing all we can to deliver this vision, recognising that for many people, substance use sits alongside a variety of other issues such as mental health, poverty and inequality, and there is a need for all of us to work together to address these.

The Scottish Drugs Forum has provided us with an easy to use toolkit which can be utilised to support local and national delivery plans and deliver a better response to those harmed by substance use. The updated toolkit offers sound evidence-based steps to prevent drug related deaths. At a local level, it will assist Alcohol and Drug Partnerships and drug services to incorporate good practice in to their drug death prevention plans.

I am pleased that the Scottish Government are able to continue to support the Scottish Drugs Forum and 'Staying Alive In Scotland', an initiative which will continue to save lives.

David Liddell

Chief Executive Officer,
Scottish Drugs Forum

There is widespread concern among stakeholders and within the wider public discourse, about the extent of drug-related mortality in Scotland. Statistics for overdose deaths are released annually by the National Records of Scotland. For each of the years 2014 – 2018 these have set new record highs.

These figures do not include non-overdose deaths related to substance use. The overall extent of drug harms in terms of the health and early death are hinted at in the Burden of Disease study which shows that drug use is one of the most significant causes of years lived with disability and early mortality. Analysis of the causes of the stalling of progress in terms of life expectancy in Scotland heavily implicates drug use.

Bacterial infections, cardiovascular disease, respiratory conditions, liver disease, cancer and other health conditions, including mental health conditions and suicide, all have significant impacts on the lives and deaths of people with a drug problem. Wider considerations including the consequences of social policy such as welfare reform are also of concern.

All of this is partly rooted in and complicated by the stigma that is attached to drug use and particularly people with a drug problem and now represents a significant issue that hinders progress.

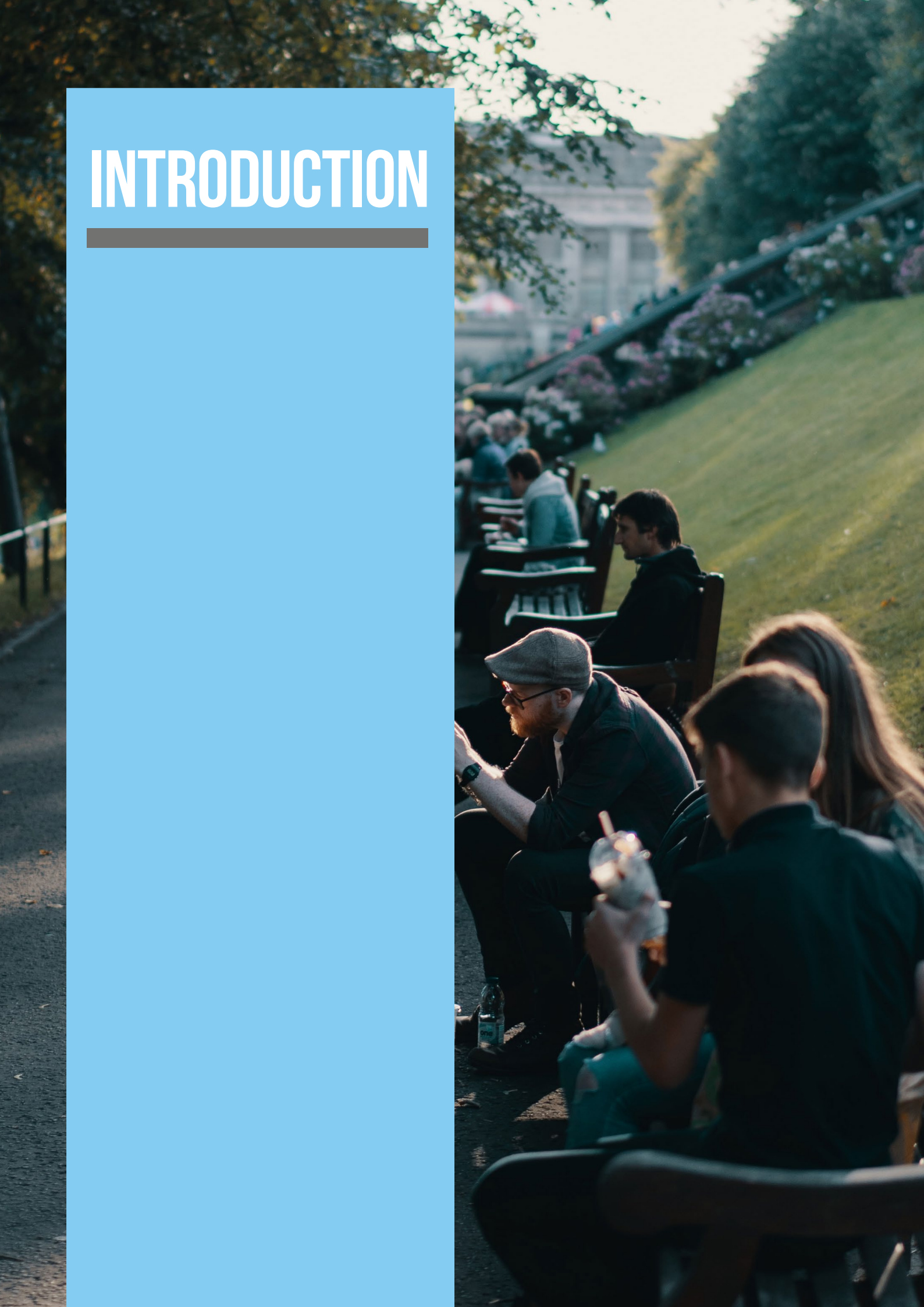
The Scottish Government's new strategy - Rights, Respect and Recovery: Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths - was published in November 2018. It contains an 'Eight-point Plan for Treatment and Recovery' focussing on access to and the quality of treatment and acknowledging the evidence base for treatment interventions. The strategy's plan also acknowledges that 'a comprehensive approach to harm reduction needs to be embedded within recovery-oriented systems of care'.

This document, approved by Scottish Government and which Scottish Drugs Forum developed in consultation with Alcohol and Drug Partnerships and other stakeholders lays out the evidence based measures that will reduce drug-related deaths; supports commissioners, planners and managers in stakeholder organisations to self-audit current provision and practice and to work jointly to improve these.

I welcome the Government's endorsement of the approaches described here and of this publication which was influential in the development of the new strategy. I also welcome the Government's continued support to Scottish Drugs Forum that allows us to work with you to support delivery of this vital work.

I look forward to working with you and other stakeholders in delivering the strategy's aims through the work described here. We all have a responsibility for the current problems and for addressing them – the lives of some of the most vulnerable people are at stake.

INTRODUCTION



Background to Staying Alive in Scotland

The original project that produced Staying Alive in Scotland was funded from SDF resources and by Scottish Government funding. An internal SDF reference group, including a range of staff oversaw and supported the work that resulted in the development of this report. The work was taken forward by the National Development Officer (Harm Reduction and Death Prevention).

This project initially involved direct engagement with all ADPs in Scotland, and a questionnaire was sent to 14 pilot areas that explored current work practices, potential gaps and how approaches can be further developed to reduce drug-related deaths in Scotland. This initial analysis was used to shape a seminar for ADPs 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 were compiled into the consultation draft report.

The consultation report was distributed to all ADPs and other interested parties for comment. The consultation report was also discussed with ADPs at a workshop during the workforce development reference group. 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.

Subsequently the document has been edited to make it easier to use and in the light both of emerging evidence and practice and Scotland's new drug strategy, Rights Respect and Recovery.

SDF would like to thank the ADPs who contributed to this work for their open and direct communication, the Scottish Government for their support and look forward to working with these and other stakeholders to take forward this crucial work.

Why Update Now?

The number of drug-related deaths has risen sharply and Scotland now has the highest rate of reported drug deaths in Europe. There are increased numbers in the over 35 age groups. This could, in part, be because of the poor physical health of people who use drugs. There is a need to incorporate findings from "Older People with Drug Problems in Scotland: A Mixed Methods Study Exploring Health and Social Support Needs" and "Older People with Drug Problems in Scotland: Addressing the Needs of an Ageing Population" in order to address the unmet needs of a population at high risk of drug-related deaths.

Reducing harms reduces the risk of death and providing services which engage and retain individuals is key. Assertive outreach is essential to make contact with those most marginalised and at highest risk. Embedding this within our services has been and is continuing to be a challenge. Providing evidence based healthcare interventions such as low threshold and optimal prescribing, basic medical interventions and working in partnership with the individual are essential.

In this document there is a focus on identifying underlying physical and mental health conditions and supporting people to access treatment with low threshold prescribing and quick access to optimal prescribing. There is an emphasis on providing a range of options to allow individuals to work in partnership with the services that are supporting them. Referral pathways and information sharing,

which allow individuals who need further investigations or support to specialists, are an important part of increasing the physical resilience of people who use drugs.

How to Use this Toolkit

The toolkit is split into fourteen chapters each covering a different area of service. Underpinning these is an awareness of, and commitment to, reducing the stigma experienced by people who use drugs. These chapters are designed utilised independently of each other in order to support the particular aims of the service at that time. When used together, they formulate the basis of a drug death prevention plan. Workforce considerations are integrated within each chapter as a suggestion of how the good practice indicators may be achieved.

It is envisaged that this toolkit would be introduced to staff through development days in which a service may choose to pull out a section or sections relevant to that service. Through workshops and the involvement of all staff, the Good Practice Indicators in this area would be discussed and a plan made of how to achieve these within the service.

The electronic version of the toolkit utilises a traffic light system which allows staff to see at a glance where they have achieved the Good Practice Indicators in any given chapter and the likely timescale, if not yet achieved. There is also the facility to designate “the responsible individual” and attach any supporting policies and procedures, allowing the toolkit to become a larger “one stop” resource which would hold all the tools relating to drug-related deaths in one, easily accessible place. Each Good Practice Indicator is SMART (Specific, Measured, Achievable, Realistic and Timely).

It is envisaged that, with the roll out of the refreshed and updated document, staff in substance use services, and those who work regularly with people who use drugs, will be able to support these individuals utilising evidence based practice in order to improve access and help reduce stigma and drug-related deaths.

Full references are available in the 2016 original report.

Attitudes and Stigma

Much of the stigma and discrimination faced by people experiencing problems with drugs links directly to an increase in the likelihood of drug-related deaths.

The inter-personal communication and relationships developed between staff and the person using the service support positive outcomes. Empathetic, non-judgemental engagement and the quality of interaction between staff and the person using the service are crucial. Consistency of access to the same staff encourages people to engage and should be prioritised in terms of management of the service. These factors are valued by people who use services.

A greater understanding of the needs of people who use drugs can inform training and workforce development throughout substance use and related sectors. People who use drugs have, in a variety of studies, rated positive attitudes towards them as a key outcome indicator for successful engagement. There is a broader need to address the wider stigma in society in relation to people who experience problems related to drugs.

Workforce Considerations

The Scottish Government's 'Rights, Respect and Recovery' strategy highlights the need to build on existing expertise and to ensure that people have the right values, knowledge and experience, as well as access to training and ongoing support, to effectively help and support people experiencing problems with their drug use.

The emerging workforce development framework describes a conceptual shift away from thinking about workforce development primarily at the individual level towards thinking about it in a systemic way.

This broader approach ensures that workforce development activity can effectively respond to organisational, individual, systemic and structural factors that negatively impact on organisational ability to effectively and efficiently deliver services.

The specific areas which a workforce development strategy needs to encompass are:

- Initiatives and strategies which address knowledge, attitudes and skills.
- Supporting strategies for skills and knowledge dissemination – information systems, mentoring and research.
- Workforce structures and policy development/implementation – incentives, performance monitoring, job specification, resource allocation, management, pay and benefits
- Policies, guidelines, management support and supervision and the legitimation of activities through organisational and structural supports
- The needs of people whose drug use is problematic

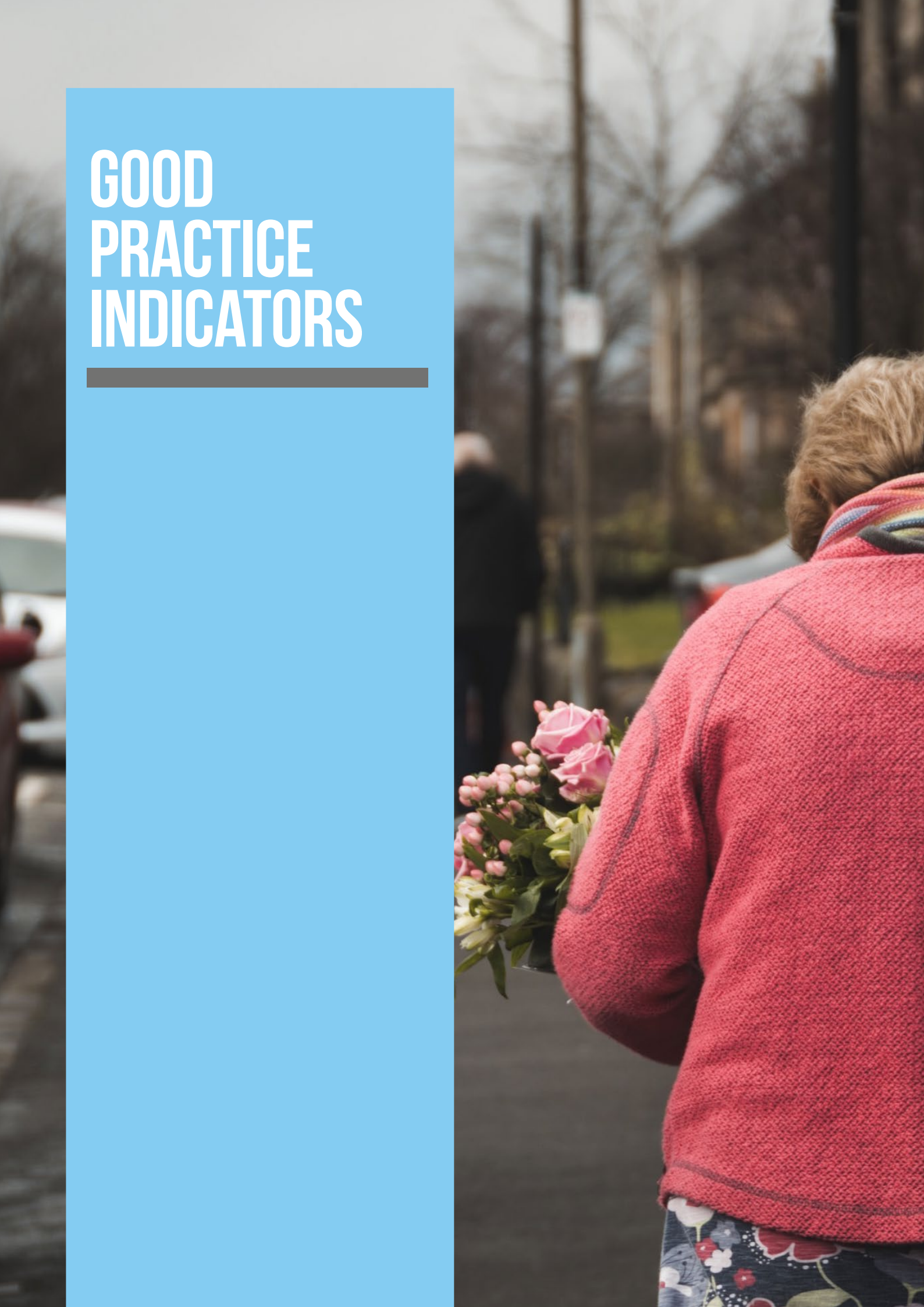
'Rights, Respect and Recovery' focuses on a Recovery Oriented System of Care approach, which fosters the inter-relationships between services to provide a smooth pathway for people who use them. These services include statutory, Third Sector and voluntary services, such as peer supporters. This approach is critical to supporting people with complex needs and enables a person-centred approach to be at the centre of care planning.

The framework will identify skills and competencies that are required at all levels of the workforce and enable ADPs, services and individuals to develop comprehensive learning and development plans to achieve and maintain competence.

Acronyms in this Document

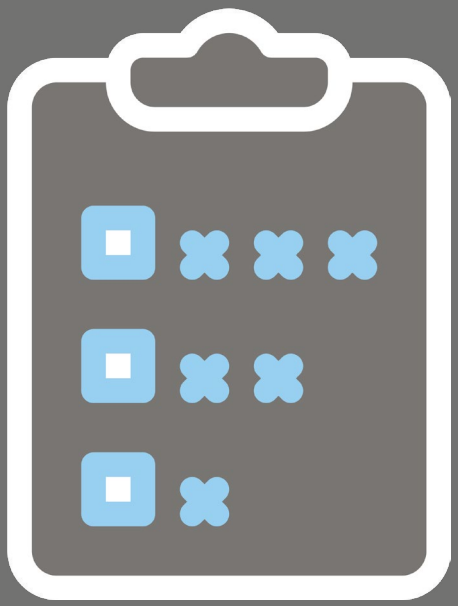
A & E	Accident and Emergency
ADP	Alcohol and Drug Partnership
BBV	Blood Borne Virus
DRD	Drug-Related Death
ECG	Electrocardiogram
GP	General Practitioner
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IEP	Injecting Equipment Provision/Provider
ISP	Information Sharing Protocol
NEX	Needle Exchange
OPDP	Older People with a Drug Problem
OST	Opioid Substitution Therapy
STI	Sexually Transmitted Infection

GOOD PRACTICE INDICATORS



GOOD PRACTICE INDICATOR 1

DRUG-RELATED DEATH MONITORING AND LEARNING



Drug-Related Death Monitoring and Learning

During the scoping for this report it was established that many ADPs have structures to monitor drug-related deaths. There were significant variances in scope and practice by the groups.

It was also found that ADPs often had limited structures for sharing information and learning from these reviews.

A review process can provide an insight into local clinical practice, which may drive further improvements in that area.

As near-fatal overdose is a key indicator of later mortality, this section also recommends that DRD monitoring groups and services examine near-fatal overdose incidents locally.

Good Practice Indicators

Service managers/practitioners across multiple agencies meet and review cases of people who have died. Learning is shared with local partners

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

DRD review includes assessments of all opioid-related deaths with regards to whether naloxone could potentially have been available as an intervention

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	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 near-fatal overdose incidents and apply learning to current practice

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Practitioner learning from discussions with those who have experienced a near-fatal overdose is communicated at the near-fatal overdose review group

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Data regarding female overdose deaths are regularly reviewed and specific factors that may be unique to this group are established to inform service planning

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff are supported in the event of a drug-related death and they are involved in reviews

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ADPs include GPs in DRD reviews for people known to their practice

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ADPs produce an annual drug death prevention report and action plan

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ADPs have regular drug death prevention groups with key partners

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Drug treatment services adopt a no blame culture in the event of a drug-related death

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ADPs engage in regional DRD forums to share learning and good practice

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Staff working in drug services and GPs have joint training

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ADPs facilitate educational events for GPs and staff working in drug services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 2

ACCESS TO SERVICES

Access to Services

Being in treatment is a protective factor against drug-related death. 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 the most vulnerable and marginalised. Services should ensure that they are easily accessible to all and to recognise the individual's right to evidence based healthcare.

Good Practice Indicators

Services adopt an 'all individuals are at high risk' approach

Progress (current practice)			Next Steps (areas for improvement)	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

The use of multiple substances does not exclude people from treatment

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Fast track referral to service and access to OST is in place for those who have experienced a recent, near fatal overdose

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Clear processes are in place for continuation of OST following prison release

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Clear processes are in place for continuation of OST following hospital discharge

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Child protection policies are easily accessed through websites and service literature

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

All initial contacts with individuals who have care of a child should explain the practicalities of how child protection policies operate and what support is available

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Accessible and adequate systems are in place to allow people who use drugs (and where appropriate their families and/or representatives) to be involved in decisions about their care and to appeal when necessary. These processes should be clearly explained

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Accessible, adequate systems are in place for people who use services to make complaints and these should be clearly explained and readily visible in service literature and waiting rooms

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff in drug treatment and support services provide supportive, non-judgemental care for people who use drugs, utilising unconditional positive regard

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff are aware of the impact of previous trauma on an individual and understand this can impact on their engagement with services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Drug treatment services have a good understanding of the risk factors in drug-related deaths among people who use drugs

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

All staff working with people who use drugs receive stigma training

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff have essential skills training

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 3

OPIOID SUBSTITUTION THERAPY AND LOW THRESHOLD PRESCRIBING

Opioid Substitution Therapy (OST)

An independent expert review of OST in Scotland in 2013 reinforced that there is a strong international evidence base for OST as an effective treatment for opioid dependence. A range of evidence based opioid replacement therapies should be available. Assessment should be undertaken to ensure individuals have choice and are advised of the most appropriate treatment. Injectable options, such as diamorphine, should also be considered. Optimal OST is a protective factor against overdose and efforts should continue to be made to increase coverage.

Low Threshold Prescribing

Low threshold services are strongly related to decreased mortality, increased retention rates and are associated with reduced opioid use and lower crime rates. Harm reduction approaches to injecting drug use have emphasised the importance of lowering the threshold for access to OST for people who use drugs. Low threshold programmes aim to reduce negative health outcomes without the expectation that individuals should completely abstain from illicit drug use. There is a wide range of low threshold prescribing and rapid access practice worldwide. Timeframes for accessing OST should be person-centred, with those who are experiencing problematic drug use able to access OST as a matter of urgency.

Good Practice Indicators

Low threshold prescribing (without the expectation that individuals should abstain from illicit drugs) is available

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Information is available about OST, including benefits and side effects, for individuals and their significant others

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Immediate access to OST is available for people experiencing problematic opioid use

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

People who are receiving treatment are active participants in prescribing decisions				
Progress (current practice)			**Next Steps (areas for improvement)**	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

As the risk factors for QTc prolongation increase (such as with daily doses of methadone above 100mg or in the presence of multiple risk factors for QTc prolongation) clinicians will need to consider ECGs, and these may be carried out in some people before an induction onto methadone, and for others before increases in the methadone dose (and then subsequently after stabilisation). (UK guidelines on clinical management)

Electrocardiograms (ECGs) are offered to people who are receiving methadone over 100mg daily, and those who take prescribed medications or substances which have potential cardiac side effects				
Progress (current practice)			**Next Steps (areas for improvement)**	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Regular reviews of OST (dosing, type and suitability of medication) are held with individuals

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Prescribing and pharmacy practices, including dosage of OST, are regularly audited and externally reviewed (every 2-3 years)

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Prescribing and pharmacy practices, including dosage of OST, are regularly reviewed by people who have used their services (every 2-3 years)

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Staff providing drug treatment are aware of clinical guidelines and best practice in OST prescribing

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff in drug treatment services are aware of the stigma of, and barriers to, optimal prescribing for the individual

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 4

RETENTION IN SERVICES, CONTINUITY OF CARE, TRAUMA AND ASSERTIVE OUTREACH

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 are 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.

Assertive Outreach

There is a need to explore ways in which services can better engage with those who are most vulnerable and marginalised.

Assertive outreach is a model which enhances engagement and is responsive to higher levels of need. Assertive outreach models are already in place in some areas and their potential should be further explored. Most people experiencing problems related to drugs in Scotland are from disadvantaged neighbourhoods and are personally disadvantaged. The association between problem drug use and deprivation increases stigmatisation towards people who use drugs

Trauma

Previous research has found that people who use drugs have high rates of trauma. Being more trauma-focussed can involve simply appreciating that many people who use drugs may have been traumatised. Assessment, particularly repeated assessment by different practitioners, may become highly distressing when people are asked to go over past traumas repeatedly.

Continuity of Care

There is a need for a broader view of who can help meet an individual's needs. GP services may be the primary point of contact with people who are isolated. Pharmacy Needle Exchanges (NEX) are another potential single point of contact and contracts should include staff receiving training based on the National Injecting Equipment Provision (IEP) guidelines. Pharmacy staff may often have contact with people who use drugs who are not in structured treatment and they can be a valuable point of communication with individuals.

Good Practice Indicators

Staff work in accordance with duty of care and the principles of human rights and equality

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Assertive outreach principles are embedded in all drug treatment services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Adult Support and Protection enquiries are considered when individuals have multiple morbidities and are deemed to be at high risk of harm

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Increased support mechanisms are available to individuals when they have difficulty in engaging in ways expected of them

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

There is a clear protocol and description of what constitutes planned, unplanned and disciplinary discharges

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Unplanned and disciplinary discharges are reviewed by drug death review groups and audited annually

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Services to adopt a no exclusion policy, and any unplanned discharges are scrutinised

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Attempts made to prevent unplanned and disciplinary discharges are evidenced and recorded

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Referral pathways for GPs to refer into drug treatment services are clear and regularly reviewed and updated at least every three years

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Referral numbers from GPs to drug treatment services are audited annually to ensure the pathway is effective

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Recovery Orientated Systems of Care are in place which include a trauma-informed approach

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Processes are in place for services to rapidly respond if an individual begins to disengage from the service

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Solutions are sought to better engage and retain people in treatment

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Systems are in place for people who use the service to be involved in staff recruitment, training and appraisal and in the evaluation of services particularly in terms of staff engagement

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Staff are supported in the workplace through regular supervision and are encouraged to maintain a healthy approach to their work and work/life balance

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Services consider ways in which staff can be supported in managing clients with complex and challenging needs

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

De-escalation training is available to all staff

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff have training in engagement skills to enable them to effectively work with people

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff are trained in a Recovery Orientated Systems of Care development approach to foster effective partnership working

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff have specialist training in motivational interviewing

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 5

INFORMATION SHARING

Information Sharing

The sharing of data on near-fatal overdose is key to drug death prevention. The value of identifying those who had previously experienced a near-fatal overdose and intervening with this group is essential since a near-fatal overdose can be predictive of a subsequent fatal overdose.

In a few areas protocols have been developed on data sharing between the Scottish Ambulance Service and drug treatment services. Anecdotal evidence from ADPs shows that opt-out models for referral to services have resulted in higher uptake rates than opt-in models. There is potential for this model to be extended to other environments, for example police custody and hospital settings¬

Good Practice Indicators

Information Sharing Protocols (ISPs) are in place between ambulance and drug treatment services

Progress (current practice)			Next Steps (areas for improvement)	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Where ISPs are in place between ambulance and drug treatment services, an opt-out referral model is utilised

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Where ISPs are in place between ambulance and drug treatment services, an assertive outreach model is used

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ISPs are in place between hospital settings and drug treatment services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ISPs between GPs and drug treatment services are in place

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ISPs between pharmacies involved in dispensing OST and drug treatment services are in place

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

ISPs between custodial settings and drug treatment services, particularly in relation to release dates, are in place

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 6

HIGH RISK INJECTING, WOUND CARE, AND BACTERIAL INFECTIONS

High Risk Injecting, Wound Care and Bacterial Infections

Injection site and wound-care assessments should be completed regularly with people who inject drugs.

This allows the opportunity for front line staff to provide basic wound care and to signpost to more specialist health support if appropriate. 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.

During times of infection outbreak, 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. Staff should routinely update their knowledge to enhance their skills in this area through training.

Injecting-related health problems such as blood borne viruses, vein and soft tissue damage and bacterial infections are exacerbated for those who inject outdoors. Public places where people inject are not sterile environments and, as such, people are at a higher risk of bacterial infections, injecting-related complications and also may be more likely to share injecting equipment and related paraphernalia.

Good Practice Indicators

Local information sharing networks are in place when infection outbreaks occur

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Local protocols are in place in each service detailing actions in the case of bacterial infection outbreaks

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Briefings are made available for staff in the event of an outbreak

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

All drug service staff/NEX staff make routine enquiries about injection site health

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

A Practitioners Guide to Injecting Equipment Provision is available in all services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Basic and specialised wound care services are in place

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Referral pathways and protocols are in place for wound care

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Assertive outreach is provided by nursing staff for wound care for those who are not accessing services				
Progress (current practice)			**Next Steps (areas for improvement)**	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

A local assessment of the prevalence of public injecting has been completed every 2-3 years or as required in response to incidents				
Progress (current practice)			**Next Steps (areas for improvement)**	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Public injecting assessment data is used to consider required responses

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Injecting equipment provision training is available to all staff working in treatment and harm reduction services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Safer injecting training is mandatory for all staff providing services to people who use drugs and is updated every 2-3 years

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Basic wound care training is provided to all staff working with people who use drugs

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff receive Bacterial Infection and Drug Use training

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

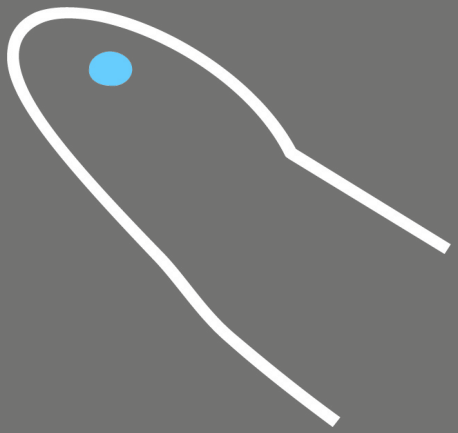
Drug service staff are trained to promote route transition and alternatives to injecting

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 7

BLOOD BORNE VIRUS TESTING AND TREATMENT



Blood Borne Virus Testing (BBV) and Treatment

BBV is associated with a higher risk of accidental overdose. Hepatitis C appears to be under-reported in this high risk cohort and concurrent alcohol use with liver disease heightens mortality risk.

Hepatitis C remains highly prevalent among people who inject drugs in Scotland. 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" 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.

A recent HIV outbreak among people who inject drugs, highlights the issue of the potential spread of HIV. 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 BBVs and have received their diagnosis. Support in understanding treatment regimes, and when treatment is required, is variable and drug treatment service staff are often unsure of HCV and HIV treatment options.

Good Practice Indicators

BBV testing is offered from all Injecting Equipment Providers

Progress (current practice)			Next Steps (areas for improvement)	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

BBV testing and treatment is offered at all drug treatment services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

BBV testing and treatment is offered at all homelessness services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Individuals with a positive BBV result are actively encouraged and supported to access treatment

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

BBV testing is offered at GP practices

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Drug treatment staff are aware of current Hepatitis C Virus treatment options and can discuss these with individuals

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Drug treatment staff are aware of HIV treatment options and can discuss these with individuals

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

BBV training is available to all staff and refreshed every 2-3 years

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 8

NALOXONE

Naloxone

Naloxone is an effective intervention in preventing opioid-related overdose deaths once the overdose has occurred. Scotland was the first country in the world to introduce a national take home naloxone programme in 2011. Since the programme began, naloxone has reportedly been used several thousand times to reverse potentially fatal overdoses. Without naloxone availability in the community, it is likely that drug-related deaths in Scotland would be considerably higher.

The provision of take home naloxone kits sends a clear message that individual staff, services and wider society care about the lives of people who use drugs. To people who are marginalised and may be ambivalent at times about their own survival this is a powerful message. With the law change in October 2015, people employed or engaged in drug services can supply naloxone **to anyone likely to witness an overdose**. 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, this is an important opportunity to ensure naloxone is available more widely for emergency use.

Good Practice Indicators

Assessments have taken place with regards to which services and peer networks will supply naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Coverage of naloxone kits supplied should be assessed based on the local prevalence of problem drug use

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Financial provision has been made for the supply of naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Third sector organisations have naloxone supply frameworks

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Third Sector organisations have volunteer policies in place to allow peer trainers to supply naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Naloxone peer training networks are available in the community and the prison environment. They are inclusive of those who are currently injecting, people with a history of drug use and may also include family members

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

All services in contact with those at risk of overdose have access to naloxone for use in an emergency

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GPs prescribe naloxone to those who may be at risk of, or likely to witness, an overdose

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Family members have access to naloxone training and supply

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Monitoring of naloxone supplies is up to date

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

All staff working in drug services have been trained in overdose prevention, intervention and naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Anyone receiving OST is provided with naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Anyone accessing IEP is provided with naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

People leaving residential rehabs and other detox settings are provided with naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

People leaving hospital settings are provided with naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

People leaving custodial settings are provided with naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Overdose prevention, intervention and naloxone training for trainers is available to all staff working with people who use drugs, their families and significant others

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Drug treatment staff are trained and equipped to deal with overdose emergencies

Progress (current practice)	Next Steps (areas for improvement)

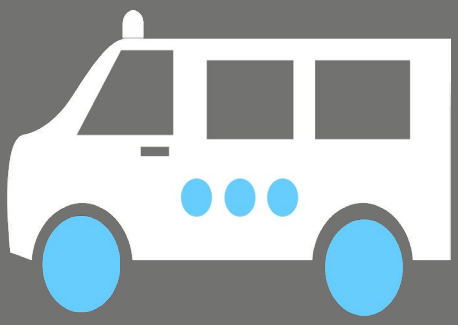
In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Overdose prevention, intervention and naloxone awareness training and e-learning is available to anybody likely to witness an overdose

Progress (current practice)			Next Steps (areas for improvement)	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

GOOD PRACTICE INDICATOR 9

PRISON THROUGHCARE AND POLICE CUSTODY



Thoughcare Support

Throughcare Support is designed to encourage those serving short term sentences to be supported in, and on, leaving prison. It works with people to prepare for, and to successfully make, the transition from custody into the community. It works collaboratively with individual's families, colleagues and partners to develop an asset-based, individualised plan and officers act as advocates on the person's behalf while encouraging the individual to maintain motivation to change through sustained engagement with key services.

Prison Release

Prison throughcare can support prisoners by carrying out a range of interventions that can reduce the risk of death. These include pre-release education about overdose risks and prevention, continuation and initiation of substitution treatment and improved referral to aftercare and community treatment services.

Monitoring of engagement between prisons and throughcare services should be part of local commissioning agreements.

Police Custody

A large number of people who experience problems related to drugs will have spent time in custody. This is an opportunity for engagement and a potential area where various interventions and referral pathways could be initiated.

Good Practice Indicators

Throughcare is in place for all to support re-engagement with services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

There is continuity of care for people on OST on arrival to prison and on release

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Risk assessments are in place prior to release regarding potential drug-related death risks

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Families of prisoners are offered overdose awareness and naloxone training

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Pre-release education on overdose risks and prevention is provided

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Individuals at risk of overdose are referred to prison throughcare services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

All night staff prison officers are trained to identify an overdose and respond with naloxone

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Support is in place on release from prison that ensures benefits are in place for those who are eligible to claim

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Police custody staff are trained on overdose prevention and intervention and naloxone is available to them				
Progress (current practice)			**Next Steps (areas for improvement)**	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Workforce Development Considerations

Scottish Prison Service staff are trained and equipped to deal with overdose emergencies

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Police custody staff are trained and equipped to deal with overdose emergencies

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Throughcare staff training should include being aware of the risks of drug overdose and harm reduction practices				
Progress (current practice)			**Next Steps (areas for improvement)**	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

GOOD PRACTICE INDICATOR 10

PEOPLE OVER THE AGE OF 35 WHO USE DRUGS

People Over the Age of 35 who Use Drugs

From the ministerial forward to rights, respect and recovery.

We live in a changing landscape in which fewer young people are using alcohol and drugs. However, a significant number of the group of people who need our urgent help are older and less healthy older service users are more likely to present with complex multi-morbidities, often having used drugs and alcohol for many years.

While the majority of people who use drugs are male, the recent disproportionate rise in drug-related deaths among women has made us consider further the challenges of supporting this group. Services are also faced with meeting the often complex needs of a growing group of older people

Making sure that services are accessible to people with disabilities is also a key priority. It is widely recognised that many people with problematic substance use have a high incidence of mental and physical health problems as a result of, or concurrent with, their substance use. This is particularly acute among growing numbers of older people with alcohol and drug problems.

The report Older People with Drug Problems in Scotland: Addressing the needs of an ageing population concludes with recommendations to reduce drug deaths in the over 35s.

These highlight the importance of treating underlying health conditions and facilitating access to mainstream health care. Recommendations include embedding assertive outreach into service provision and improving accessibility.

Improving mental health, and increasing trauma awareness is an important area of focus of the research. Addressing the needs of women, advocacy and reducing isolation for all over 35s is also stressed.

Good Practice Indicators

Nurses and other health practitioners working in drug services identify underlying health conditions of people over 35

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Nurses and other health practitioners working with people who use drugs facilitate GP registration for their patients

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Nurses and other health practitioners working in drug services provide screening and advice in BBV, respiratory, cardiac and digestive health and facilitate access to mainstream health care where indicated

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Referral pathways are in place to smoking cessation, pain management clinics, respiratory specialists, cardiac and gastroenterology screening and treatment

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

People over 35 have access to independent advocacy to ensure understanding and exercising of rights with regard to health care and treatment

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Assertive outreach models have been developed to make contact with people over 35 who use drugs and are not currently engaging with services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Liaison with GPs and community organisations is in place to identify individuals at risk

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Meaningful activity programmes are in place, appropriate to over 35s, in order to reduce isolation

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Pilot projects (including small tests of change) are introduced to generate increased evidence and practice models for how to best work with individuals over the age of 35

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff have awareness of the prevalence of trauma, domestic and gender-based violence in women over 35 and referral pathways to appropriate agencies are in place to allow early intervention

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Planning in partnership with providers and local authorities is in place for older people to access full time care settings such as district nursing, home care and nursing homes if and when needed

Progress (current practice)			Next Steps (areas for improvement)	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Workforce Development Considerations

Staff enhance their knowledge and experience of working with individuals over the age of 35 through specialised training and they are aware of this and it is made widely available

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 11

DUAL DIAGNOSIS AND SUICIDE

Dual Diagnosis and Suicide

Many people suffering a drug-related death have had a specific psychiatric disorder recorded in the six months before they died. More generally people with drug problems self-report very high levels of anxiety and depression. Mental health awareness and suicide training should be integral to all workforce development plans for addiction staff and should be central to addiction staff core competencies. There is also a need for better working between mental health and drug treatment services.

Good Practice Indicators

Mental health is represented on Alcohol and Drug Partnerships

Progress (current practice)			Next Steps (areas for improvement)	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Joint working protocols and joint case management takes place between mental health and drug treatment services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

DRD review groups consider and assess the numbers of possible intentional overdoses and potential suicides are monitored

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Active drug use does not exclude a person from accessing mental health services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Mental health interventions, such as psychological therapies, are available within drug treatment services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

When deterioration in mental health is identified, pathways are in place to increase the support available to the individual and staff are aware of these

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Safe plans are developed and reviewed in partnership with people who report suicidal ideation or who have an identified risk of suicide

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

All staff working with people who use drugs are trained in suicide first aid and intervention

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Referral pathways are in place for mental health crisis management and staff are aware of these

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff working in drug treatment services are trauma aware and understand, and can explain, the link between substance use and the experience of trauma in a way that supports people to understand their substance use

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff working in mental health services and acute mental health wards have drug awareness and overdose prevention and intervention training, and are familiar with local services and referral pathways

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Suicide awareness/prevention training is mandatory in drug treatment services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Mental health awareness training is available in drug treatment services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Trauma training is available to drug services staff

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Training is provided in Adverse Childhood Experiences

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff working with young people have access to relevant training such as Multiple Risks and Listening to Children Affected by Parental Substance Use

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Training is provided to staff in order to deliver psychological therapies

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 12

HOMELESSNESS, HOUSING AND ROUGH SLEEPING

Homelessness, Housing and Rough Sleeping

Homelessness can be a contributing factor to drug-related deaths. There may be an under-representation of homelessness at the time of death as it is not always possible to tell if the person was living at a specified address. This is further complicated by "sofa surfing", the use of bed and breakfasts and temporary furnished flats in some areas that are not obviously identified as homeless accommodation.

People who use drugs and who also experience homelessness are vulnerable as a result of multiple exclusion issues. People experiencing homelessness are seven times more likely to die of drug-related issues than the general population. They also experience health conditions typically found in older people in the general population.

It can be difficult to keep track of where vulnerable individuals are living because of the transient nature of experiencing homelessness and, as such, assertive outreach is essential to maintain contact.

Individuals who are actively using substances are entitled to housing and their basic human right to shelter should be met.

Good Practice Indicators

Active drug use does not exclude people from housing and homeless accommodation

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Housing First models are adopted that include mainstream housing, shared housing and cluster housing

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Housing staff and all agencies working with people experiencing homelessness have training in naloxone and it is available for emergency use within services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Housing and homelessness is represented on ADPs and drug death prevention groups and clear links with services are in place

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Measures are in place to prevent and reduce the number of evictions

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Referral pathways are in place between homeless service health staff and drug treatment services, and there is a close working relationship between agencies working with people experiencing homelessness

Progress (current practice)			Next Steps (areas for improvement)	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Workforce Development Considerations

Drug services staff receive training in multiple exclusions and homelessness

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Homeless services staff are trained and equipped to deal with overdose emergencies

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

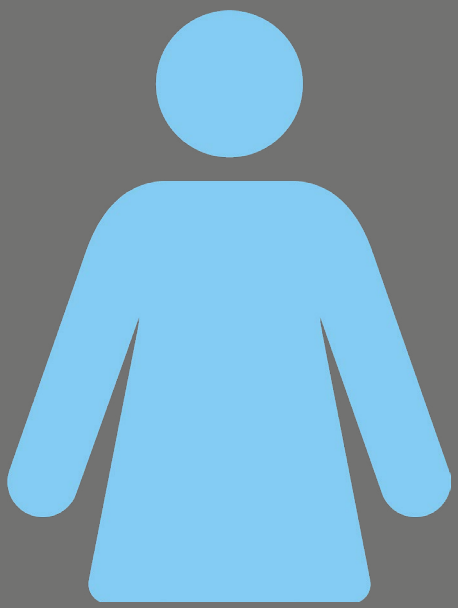
Housing staff receive alcohol and drug awareness training

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 13

WOMEN WHO USE DRUGS



Women Who use Drugs

It is important to understand the treatment and care needs of women in what can be a male dominated environment. While there are some commonalities, there are also marked differences in the motivations and antecedents for alcohol and drug use amongst men and women and differences in their care needs, particularly in relation to parental roles. There have been disproportionate rises in drug-related deaths in women.

Previous experience of violence or abuse, childhood neglect or parental substance use is relatively common among people who use drugs, but is often higher among women. Continuous experiences of intimate partner violence towards women are common and women may also have trauma resulting from experiences of sex work. Both historical and ongoing trauma can sustain or exacerbate drug use, or precipitate relapse. Traumatic experiences, whether predating or occurring during periods of drug use, were common among the women participating in the Older People with Drug Problems project.

Good Practice Indicators

Women are offered a female worker				
Progress (current practice)			**Next Steps (areas for improvement)**	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Female only groups and clinics take place

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff are aware of the many challenges faced by women who use drugs including the stress around being involved with child protection services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Women are offered sexual health screening, advice and access to specialist sexual health services

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Harm reduction services utilise evidence on how to manage drug use during pregnancy. Referral pathways are in place between drug treatment services, specialist midwife services and family nurse partnerships

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Women are asked if they have ever sold sex and are offered support if appropriate. Pathways to specialist services are in place

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Workforce Development Considerations

Staff in pregnancy services provide evidence based care for pregnant women who use drugs

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Staff in Social Work, nurseries and schools should have access to training and evidence based information on parental drug use

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

GOOD PRACTICE INDICATOR 14

POLYDRUG USE AND PRESCRIBED MEDICINES

Polydrug Use and Prescribed Medicines

Although the majority of drug overdose deaths involve opioids – principally heroin - the vast majority have multiple drugs present at time of death.

This is further complicated by the increasing availability of 'street' benzodiazepines - often of unknown content and quality. There is a lack of information about the metabolic and physical effects of such products and the possible effects on short and long-term mental and physical health. Research would allow a better understanding of benzodiazepine type drug use which may support the development of appropriate strategies to reduce drug-related harms.

Substitution of street benzodiazepines with prescribed benzodiazepines should be considered.
Fatal and near-fatal cardiac events attributable to stimulant use are not included in official statistics including drug death figures. This results in significant under-reporting of this type of drug-related harm. The risks of having a possible heart attack are increased by twenty-three times in the hour after cocaine use with risk further increased if alcohol is included.

Many drug overdose deaths involve prescription medications which may or may not have been prescribed to the person. It is important for treatment services to assess the possible risks to the individual arising from interactions between prescribed medication and their possible use of street drugs.

Good Practice Indicators

Drug treatment services offer advice, information and psycho-social support and communicate the risks associated with polydrug use

Progress (current practice)			Next Steps (areas for improvement)	
In Place/ In Development: (within 12 months)	**Goal: (1-2 years)**	**Goal: (2-3 years)**	**No Action: (give reason)**	**Responsible Person/ Job Title**

Healthcare professionals consult with people receiving drug treatment to discuss and monitor the side-effects of prescribed medications, drug use and OST

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Healthcare professionals check blood pressure, pulse and ECGs of people who use drugs

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

Use of substances, including prescribed medications, does not exclude individuals from receiving optimal dose OST

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

A&E staff routinely enquire about stimulant use when a person presents with symptoms of heart problems, strokes and seizures

Progress (current practice)	Next Steps (areas for improvement)

In Place/ In Development: (within 12 months)	Goal: (1-2 years)	Goal: (2-3 years)	No Action: (give reason)	Responsible Person/ Job Title

TOGETHER WE CAN PREVENT DRUG DEATHS IN SCOTLAND

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