Scottish Government
Riaghaltas na h-Alba
gov.scot

Scotland's Alcohol and Drugs Workforce: A Compendium of Mixed-Methods Research

HEALTH AND SOCIAL CARE

social research

Scotland's Alcohol and Drugs Workforce: A Rapid Evidence Review

Key findings

The key findings from this rapid evidence review were that:

- There is limited literature relating to the tier 3 (specialist drug and alcohol assessment and intervention services) workforce in Scotland. The literature which does exist does not relate to the numbers of workers, or what they do in their roles. Instead it examines the impact of funding reductions on services, staff numbers, the skills and experience of staff and some of the challenges staff can encounter through the nature of their work.
- Some professions in the wider health and care workforce working with people who use drugs do not feel they have adequate skills or knowledge to do so effectively. In contrast, pharmacists have developed their knowledge and skills in working with people who use drugs and lessons from the approaches which they have utilised could be beneficial for other professions.
- The majority of the literature about the workforce relates to people who use drugs. The exception is literature which focuses on tier 1 and tier 2 professionals talking to people about their alcohol use. Some professionals accept this is their role and feel confident in doing this, while others do not. It is a common theme that professionals in tier 1 and tier 2 are concerned that talking about alcohol use with people may damage their relationship.
- Stigma exists in the workforce and has negative consequences for service delivery to people who use drugs and alcohol. Stigma is something that people who use drugs and alcohol are aware of, and it can stop them engaging with care and treatment services. Training should be given to all tiers of the workforce regarding stigma.
- People who use drugs and alcohol want a workforce which is empathetic, non-judgemental and positive that change is possible. Staff should have a good knowledge of substance, and be aware of specific issues which can affect some people who use drugs and alcohol, for example co-morbidity with mental health issues, trauma and abuse for women, specialist support needs for older people, and barriers to accessing services for LGBT people. Services themselves should be flexible, non-punitive and involve people who use drugs and alcohol in setting goals and care planning.
- International good practice around workforce initiatives which have reduced drugs-related deaths are scant. One initiative which the Scottish Government could examine in more depth is the embedding of training on drugs and addictions on core training courses for nurses, doctors and psychologists, which has been done in Portugal.

1. Overview and policy background

Scotland currently faces a challenging and complex situation related to drug use and drugs-related deaths. The most recent figures for the prevalence of people whose drug use is problematic is estimated to be between 55,800 to 58,000[1]. The number of drugs-related deaths in Scotland was 1,339 in 2020 - the highest figure to date for the 7th year running, and the highest rate in Europe[2]. Poverty and deprivation have been identified as key drivers, with the likelihood of dying from a drugs-related death being 18 times higher for those from the most deprived areas than the least deprived areas in Scotland[3]. These figures are located in the context of a changing landscape of the drugs being used in Scotland, with an increase in polydrug use and new synthetic psychoactives becoming increasingly prevalent. Alongside this the population of problem drug users is aging, and consequently more likely to present with more complex health and social needs. These changes are posing new challenges for policy and treatment services. There were 1,190 alcohol-specific deaths in Scotland in 2020, an increase of 16% from 2019, with the rate of alcohol specific deaths being 4.3 times higher in the most deprived areas of Scotland than in the least deprived[4].

The Scottish Government is committed to reducing drug-related deaths, and harm, for people who use drugs, and also for their families and communities. The Scottish Government has published a number of policies relating to drugs and alcohol with the most recent being 'Rights, Respect and Recovery' (2018)[1], which complemented the Alcohol Framework (2018)[5]. These set out the Scottish Government's strategy to reduce drug and alcohol use, harms and deaths. The First Minister announced a National Mission to reduce drugs-related deaths in January 2021[6]. This Mission includes a commitment to the implementation of Medication Assisted Treatment (MAT) Standards, residential rehabilitation and the development of a target in relation to treatment and is underpinned by additional investment of £250 million over five years.

In order to deliver these policies services need to have sufficient staff with the appropriate skills and training. This is a complex, multi-level workforce and there are several tiers of services in Scotland which work with people who use drugs and alcohol.

- Tier 1 services provide drug and alcohol related information and advice, and signposting, and are typically agencies whose primary focus is on providing another service, for example the Scottish Ambulance Service, A & E Departments, Housing Officers etc.
- Tier 2 services have more structured input for people who use drugs and alcohol, and provide drug and alcohol related advice and information, harm reduction interventions, triage assessments and referral on to specialist services. Tier 2 services are provided by GPs, outreach services, pharmacies and criminal justice settings where people who use drugs are detained or on programmes such as a Drug Treatment and Testing Orders (DTTOs).
- Tier 3 services are specialist drug and alcohol assessment and intervention services.
- Tier 4 services are residential services[7].

All tiers provide an important aspect of support and treatment for people who use drugs and alcohol. At present the make-up of the drugs and alcohol workforce in Scotland, and its training needs, are unclear. In order to ensure that treatment and support services can provide the best, and most appropriate care, more needs to be known about the workforce and the challenges which the system currently faces. Therefore, the Scottish Government is undertaking a suite of research to better understand the workforce. This rapid evidence review is part of this suite of research.

2. Aim of the rapid evidence review

This rapid evidence review will examine the existing literature relating to the tier 1, 2 and 3 drug and alcohol workforce in Scotland to ascertain what is known about the workforce and identify challenges which it currently faces[8]. This complements ongoing research which includes mapping qualifications for the drug and alcohol workforce, a survey of the tier 3 workforce to gauge staff numbers, professions, vacancies and recruitment issues, and qualitative reference groups to examine the challenges faced by the tier 3 drug and alcohol workforce. This tranche of research aims to provide evidence of the state of the current drugs and alcohol workforce in Scotland, which can inform the Scottish Government on how to support services in order to meet policy objectives.

3. Methodology

A focused search using academic databases, government documents and reports and grey literature has been undertaken using key terms to ascertain what has been published relating specifically to the drugs and alcohol workforce in Scotland. A search was also conducted for countries where high drug-related deaths have been reduced through workforce initiatives. This was with a view to identifying good international practice which could be replicated in Scotland.

The high levels of drug-related deaths and short time frames for fully embedding the MAT Standards requires research around the workforce to be undertaken quickly. A rapid evidence review of the existing literature is therefore an appropriate approach. This does however mean that a systematic review of the evidence has not been possible. It must therefore be acknowledged that some studies may not have been identified and included.

4. Key Themes

A number of themes have been identified in the literature and these are examined below.

4.1 Challenges facing the specialist drug and alcohol workforce

The literature which related to the workforce in specialist drug and alcohol services (tier 3) was limited but it primarily focused on the challenges the workforce faced and the impact this had on their ability to do their work.

The literature highlighted the reduction in funding for drug and alcohol services. Audit Scotland[9] noted that funding was transferred from the Scottish Government's Justice Directorate to its Health Directorate in 2015. Combined drug and alcohol funding fell from £69.2 million in 2015/16 to £53.8 million in 2016/17, with NHS Health Boards expected to make up the short fall from health budgets. However, over half the NHS Health Boards cut their drug and alcohol funding in 2016. While additional funding was allocated by the Scottish Government from 2018 and the National Mission introduces further funding the literature consistently identified that the reduction in funding over this period had a number of negative consequences for drug and alcohol services and its workforce.

Research suggested that funding cuts had led to some third sector organisations reducing in size, becoming more centralised and consequently less accessible to service users. Some had closed completely. This research also found that there was a growing reliance on volunteers to deliver recovery cafes and communities, noting that,

> "as superb as many of these are, they may be unable to match the expertise

> and training that was lost when funding cuts closed independent community-based services." [10]

Funding reductions meant that services had capacity for fewer service users, which in turn meant that access to support was more limited and thresholds for entry to services became higher[11]. Qualitative research found professional stakeholders reported that reductions in funding had led to lower levels of pay for staff, and to reduced skills and experience across the workforce[12]. To put this into context the average salary of a drugs worker was cited by researchers to have fallen from £25,000 to £20,000[13]. However, no source was provided for this estimate and it is not supported by wider health workforce pay statistics.

One report focussing on older drug users found that some services had high caseloads and found it difficult to manage these, especially if they had lower staff levels. This meant that services operated with a narrower remit, and had longer waiting times. Higher caseloads also resulted in some services prioritising their recording practices to certain higher risk areas, such as child protection, at the expense of other areas like housing and benefits information. The report found that:

> "these are serious concerns as services are losing an accurate up-to-date picture of clients' situations and missing opportunities to make effective interventions to help and support clients."[14]

The Scottish Social Services Council (SSSC) publishes data from the Care Inspectorate and local authorities which details the social services workforce in Scotland. One element of this dataset concerns employment in care homes for adults by service type. These data show that the number of people employed in 'alcohol and drug misuse' services over the last few years has remained broadly stable: 350 in 2018[15], 340 in 2019[16] and 350 again in 2020[17]. However, this data only captures private and voluntary sector services. The lack of representation from public sector services (e.g. the NHS) makes it difficult to assess employment trends, and how the aforementioned funding fluctuations have impacted capacity at the service level.

A report undertaken by the Care Inspectorate into Alcohol and Drug Partnerships (ADPs) found that staff recognised the importance of offering good quality support, but some reported that they did not have the time or the training to offer psychologically focused support. Some staff also reported that they felt they needed more training around trauma, specifically around the disclosure of trauma by service users[18]. This has implications for the delivery of the MAT Standards. Standard 6 relates to Psychological Support and sets out that services will "ensure the service culture and environment is psychologically-informed"[19]. While tier 3 workers may not be delivering structured psychological interventions they do need to ensure staff have training in psychological-informed care. Standard 10 relates to Trauma Informed Care and sets out that understanding and working with trauma needs to be embedded in drug and alcohol services.

Qualitative research carried out which related specifically to Dundee[20] found challenges around recruiting staff – especially in more specialised posts such as medical, psychological and nursing positions – which had a negative impact on the level of service which could be provided. Interventions were limited to focusing on prescribing which consequently meant clients had relatively little access to other treatment options. The report also highlighted the fact there was a lack of services for clients to move on to when they were ready to do so. This meant some services were becoming increasingly stretched. While the researchers only spoke to a small number of staff they found that they felt pressurised by high levels of drug-related deaths in Dundee and the media attention which accompanied this.

Finally, the wellbeing of workers was discussed in a small section of the literature. There was a recognition that staff themselves needed to have regular, good quality supervision[21] and access to specialist psychological support when appropriate[22]. Research undertaken in Lanarkshire found that substance misuse staff experienced sadness, anger and grief following the drugs-related death of one of their clients. They concluded that the need to support staff, who are often impacted by the nature of their work, is something which services need to be mindful of[23].

4.2 Mixed views from professionals regarding their skills and knowledge around drugs

The literature evidenced mixed views among wider health professionals in Scotland about their knowledge and skills when it comes to working with people who use drugs. Alongside more specialist staff in tier 3 and tier 4 services staff from numerous professions working across tier 1 and 2 services also come into contact with people who use drugs. These can include police officers, ambulance staff, health visitors, social workers, GPs, pharmacists and housing officers. The literature related to these professionals demonstrated that some, primarily medical and social work professionals, did not feel sufficiently skilled to work effectively with people who use drugs. This in part appeared to be because drugs and addiction training was not embedded in core training for these professions, so they often did not feel confident of their knowledge or skills around working with people who use drugs.

Qualitative research examining GPs attitudes to people who use drugs found that the majority did not feel they had sufficient knowledge about drug use. The researchers reported that:

> "The lack of knowledge was put down to a lack of training or a lack of contact and experience with misusers. Those who felt they did have enough knowledge admitted that this was in a limited field, and being asked to exceed this would cause them problems."[24]

In research which focused on drug treatment in primary care the views of GPs in the North East of Scotland towards their understanding and management of psychostimulant drug misuse (PSDM) among their patients were examined. Psychostimulant drugs include cocaine, crack cocaine and amphetamines, and as previously noted the use of these drugs, and their use alongside other drugs (polydrug use), is increasing in Scotland. Although the research was limited to one geographical area its findings were clear that while GPs thought PSDM was an important issue the majority were uncertain that they had the adequate knowledge to identify PSDM use in their patients, and over half were not personally prepared to manage a patient with PSDM[25].

In relation to medical students at the University of Glasgow Medical School, qualitative research exploring their views on the teaching they had received and the awareness this had engendered around illicit recreational drugs was undertaken [26]. The limitations of this research must be noted: it relates to only one medical school, the number of students who participated in the research is not recorded so the representativeness of their views is not clear, and the use of terminology is unclear at times in the article. The research was undertaken in response to increasing numbers of people being admitted to hospital due to drug use. The research therefore explored how prepared junior doctors felt in relation to discussing drug use with patients. It found that students did not feel they had a good knowledge about the effects of drugs on people, or how to measure if a person's usage was problematic or not (in contrast to smoking and alcohol use where there are clearly defined criteria to judge this). Students reported that they had limited teaching on drugs and also that clinical placements where they could learn about recreational drug use were mainly in acute medical settings; however:

> "issues related to recreational drugs can arise in a large variety of clinical settings, so it is important that this be emphasised more when teaching staff construct clinical placement experiences."[27]

The research concluded that more needs to be done to educate medical students about the impact drugs may be having on their patients, and to equip them with the skills and confidence to discuss drugs with their patients.

There was a recognition in the literature that social work training lacks sufficient input in relation to substance use. This is in spite of the fact that social workers often have clients for whom substance use is an issue[28]. Research found that as a result social workers who did not work in specialist drug and alcohol services did not feel confident in talking with their clients about their substance use. Where substance use was not the main focus of their service's interventions researchers noted that this could mean constraints were created:

> "These include not enough time to engage with the issues, lack of departmental policy to support this work, and lack of clarity about whether or not engaging with substance use is part of their job." [29]

However, this was not the case in services where their focus was substance use, with staff reportedly feeling more positive about their skills and knowledge[30]. Although the literature identified related to medical and social work professionals it is difficult to ascertain if other professions have similar issues, as a lack of identified literature related to them cannot be assumed to mean they either do or do not feel adequately skilled and knowledgeable.

In contrast pharmacists, as a profession, appeared to feel both confident and skilled in working with people who use drugs. Over the last 20 years the role of pharmacists working with people who use drugs has increased. The literature attributes this to the facts that there has been a broadening of the role of community pharmacists in Scotland generally[31] and that specific funding has been targeted at ensuring pharmacists were available as non-medical prescribers in the treatment of substance use[32]. Pharmacists were highlighted as playing a positive bridging role between primary care services and specialist services, which can be particularly effective for service users for ensuring their wider health needs are met at the same time as providing them with specific specialist substance use treatment[33]. Research found that there had been an increase in the number of pharmacists undertaking training around substance use and also an increase in levels of positive attitudes among pharmacists towards working with people who use drugs. An example of this training included a specialist distance learning resource which was developed by NHS Education for Scotland (NES): 'Pharmaceutical Care in Substance Misuse'. Researchers argue that an increase in positive attitude among pharmacists will continue to lead to an increased willingness to work with people who use drugs[34]. The initiatives utilised by pharmacists could be considered by other professions and the Scottish Government to assist them to become more skilled, knowledgeable and confident in working with people who use drugs.

4.3 Talking about alcohol use

The majority of literature about the drugs and alcohol workforce in Scotland relates specifically to drugs. However, an exception to this is literature which focuses on professionals talking with people about their alcohol use. In some of the literature this was discussed in relation to Alcohol Brief Interventions (ABIs), but in other literature it was described simply as talking about alcohol use. Overall, this literature showed that there are differences in the levels of confidence and knowledge that professionals in tier 1 and 2 level services have around discussing alcohol with people.

ABIs are time limited interventions which seek to reduce harmful or hazardous drinking behaviours, and refer people who need it on to specialist services. An NHS performance target (HEAT target) for delivering ABIs was introduced in Scotland in 2008[35]. ABIs take place across a range of health, social care and justice settings. A wide range of professions have been trained to provide ABIs and there is evidence that they can be effective in reducing drinking behaviours in primary care settings[36]. Qualitative research undertaken in the evaluation of the implementation of NHS delivered ABIs found that the majority of GPs they interviewed were comfortable talking to their patients about alcohol consumption, and agreed it was part of their role[37]. However, the researchers found that in other health settings (non-primary care) the extent to which professionals and wider services accepted their role in undertaking ABIs was very variable. In A&E settings for example, barriers were identified to the implementation of ABIs, including the belief that staff should focus on the reason for the acute presentation in A&E, that patients under the influence of alcohol were unlikely to be receptive to ABIs and that there had been a lack of time to train staff to deliver ABIs[38].

Qualitative research with a small number of midwives found that they recognised the relevance of delivering ABIs in their role, and that they felt confident in delivering ABIs because they had been given the relevant training. However, they also reported that they did not think it was a priority in their busy workloads[39]. In research undertaken in youth work settings it was found that staff had varying levels of training and confidence in carrying out ABIs, although they were generally viewed as useful. Staff reported that they viewed them as more valuable if they were able to use ABIs in a flexible way (not always as a structured/formal tool) and if they had first built up a relationship of trust with the young person[40].

Research undertaken among medical and allied health professional students at a number of Scottish HEIs found that they recognised the benefits of talking about alcohol with patients and that the majority would not be embarrassed to do so (the exception to this were dieticians)[41]. Interestingly, in contrast to the evidence relating to their work with people who use drugs, qualitative researchers found that community pharmacists in general did not feel that it was their role to discuss alcohol use with clients, nor did they feel confident in doing so[42].

Finally, a theme emerged from this area of research which showed a common concern among professionals that attempting to discuss alcohol use with clients had the potential to damage their relationships, and this made many reluctant to do so[43].

4.4 Workforce Stigma

The issue of stigma among the workforce was another factor present in the literature. This was more commonly noted in relation to staff in tier 1 and tier 2 services but was also noted in relation to staff in tier 3 specialised services. Stigma was conceptualised variously as the perception that people who use drugs and alcohol were viewed negatively[44], or were to blame for their substance use and its consequences[45]. Stigma, as discussed in the literature, was not necessarily expressed verbally, although this could be the case, but was present in the way services were designed and operated and in the way in which staff viewed and treated people who use drugs and alcohol.

An international review, which included research within Scotland, demonstrated that staff regard among health care professionals towards people who use drugs was found to be more negative than towards other patient groups such as people with depression or diabetes. Staff not only reported feeling negative attitudes towards service users but "moreover, health professionals often report that caring for substance users can be unrewarding and unpleasant."[46] Staff who worked in more specialist settings with people who use drugs were found to have a more positive regard, with the researchers attributing this to more specialised training among this group, and to a younger workforce which had

undergone this training more recently. This research was undertaken across a number of countries in Europe, including Scotland, so it is fair to conclude this is an issue which is not unique to Scotland[47].

As well as being present among professionals the literature highlighted that, in Scotland, people who use drugs recognised that they were being negatively perceived and treated. Researchers found that people who use drugs and alcohol experienced stigma from staff in primary health care settings including acute hospital settings[48], pharmacies[49], GPs and Consultants and also in other services such as housing.[50] One report noted that older people who use drugs experienced additional stigma because there was not only a negative view among staff regarding their drug use, but also a perception that they should not continue to do so at their age. The researcher gave the following example of this: "One service user was told by medical staff 'You should know better at this age'"[51] Some older people who use drugs also believed that specialist services were geared towards younger people, and were more willing to work with and help them because they had a longer future ahead of them. One participant stated that:

> "Aye, we're older, so basically they don't care about us, know what I mean…they're lookin at us going "Waste of space", they won't come off it now"[52]

Researchers found that the impact of stigma included people who use drugs being given inadequate treatment for issues such as pain[53], barriers (perceived or actual) being put up for people who use drugs to access services[54] and that people who use drugs could be reluctant to engage with services because of being stigmatised[55]. Training for the workforce on stigma was recommended in the literature[56].

4.5 Views of people who use drugs and alcohol and their expectations of the workforce

The views of people who use drugs and alcohol was another theme which came out of the literature. Qualitative research consistently found that people who use drugs and alcohol want a workforce which is empathetic, non-judgemental and which motivated service users to believe that change was possible[57]. People who use drugs and alcohol valued good quality, consistent relationships with staff and this was identified in the literature as one factor which helped people engage with services and treatment[58]. People who use drugs wanted staff in services to have a good knowledge around drugs (including their effects, and the potential risks of their combination with other drugs and/or alcohol)[59].

Participants also suggested that staff should be aware of the fact that different groups of people may have different issues. For example women who use drugs are more likely to have experienced issues around abuse, trauma and having children taken into care[60]. Older people who use drugs also have specialist support needs[61]. This call for greater awareness was likewise the case with alcohol. For example, LGBT people reported a number of barriers when accessing alcohol services, and outlined concerns that "…health professionals would make incorrect assumptions if they knew about their sexual orientation or gender identity."[62] In addition, service users felt staff needed more training in more specialised areas, such as those mentioned above and co-morbidity with mental health issues[63].

Finally, people who use drugs and alcohol wanted services which were flexible, and could respond at short notice[64], and which were not punitive or did not always require people to have stopped using drugs before they started to work with them[65]. Services which were flexible in the length of time they would see service users were valued[66], as were services where abstinence was not the only treatment objective[67], and where people who use drugs and alcohol were involved in setting their own goals and were involved in their own care planning[68].

4.6 International Good Practice

This rapid evidence review also set out to identify examples of international good practice where workforce initiatives had positively reduced drugs-related deaths. This was with a view to considering if these initiatives could be replicated in Scotland. While some interventions have successfully reduced drug-related deaths in other countries these were not identified as being related to workforce changes. The exception to this is Portugal, which has successfully reduced drug-related deaths through a number of initiatives, including a number relating to the workforce. These included embedding training on drugs and addiction at a core level for all nurses, doctors and psychologists. In addition treatment centres work with social re-integration teams who advise people who use drugs on education and employment[69]. However, these workforce changes were only part of a whole system overhaul, which saw Portugal decriminalise drugs. The embedding of core training for health professions on drugs and addiction is well supported by findings from literature and could be considered further by the Scottish Government.

5. Conclusion

This rapid evidence review has presented findings from the literature on the drugs and alcohol workforce in Scotland. Although these findings allow us to understand to a greater extent the challenges which face the current workforce, they also highlight that much remains unknown about the drugs and alcohol workforce in Scotland. For example, the size and scale of the workforce, as well as the composition of the tier 3 workforce and the roles they undertake, are not well understood. Moreover, the long-term impacts of the COVID-19 pandemic and associated lockdowns on frontline service delivery remain to be seen.

The evidence presented here will therefore play a key role informing forthcoming aspects of this project, including a survey of drug and alcohol services, as well as reference group sessions with key stakeholders. In doing so it will help identify areas where the Scottish Government can take action to better support and train those who work with people who use drugs and alcohol.

[1] Information Services Division (2019). 'Prevalence of Problem Drug Use in Scotland: 2015/16 Estimates', NHS National Services Scotland. Available at: Prevalence of Problem Drug Use in Scotland (isdscotland.org)
[2] National Records of Scotland (2021). 'Drug-related deaths in Scotland in 2020', Scottish Government, Edinburgh. Available at: Drug-related deaths in Scotland in 2020, Report (nrscotland.gov.uk)
[3] National Records of Scotland (2021). 'Drug-related deaths in Scotland in 2020', Scottish Government, Edinburgh. Available at: Drug-related deaths in Scotland in 2020, Report (nrscotland.gov.uk)
[4] National Records of Scotland (2021). 'Alcohol specific deaths 2020', Scottish Government, Edinburgh. Available at: Alcohol-specific deaths, 2020, Report (nrscotland.gov.uk)
[5] Population Health Directorate (2018) 'Alcohol Framework 2018: Preventing Harm – next steps on changing our relationship with alcohol', Scottish Government, Edinburgh. Available at: Alcohol Framework 2018 - gov.scot (www.gov.scot)
[6] Nicola Sturgeon MSP Drugs policy - update: statement by the First Minister - 20 January 2021 - gov.scot (www.gov.scot)
[7] ISD Scotland (2010) 'HEAT A11: Updated Drug and Alcohol Treatment Types', NHS Scotland, Edinburgh. Available at: HEAT A11: Updated Drug and Alcohol Treatment Types (isdscotland.org); Clark, I. *et al.* (2014) 'Assessing the availability of and need for specialist alcohol treatment services in Scotland', NHS Health Scotland, Edinburgh. Available at: 24408-AssessingTheAvailabilityOfAndNeedForSpecialistAlcoholTreatment.pdf (healthscotland.com)
[8] Residential rehabilitation services (tier 4) are being researched separately and so their workforce are not included in this literature review.
[9] AUDIT Scotland (2019). Report: 'Drug and Alcohol Services: an update'
[10] McPhee, I. and Sheridan, B. (2020). AUDIT Scotland ten years on: explaining how funding decisions link to increased risk of drug related deaths among the poor. *Drugs and Alcohol Today,* **20** (4).: 12.
[11] McPhee, I. *et al*. (2019). Time to look beyond ageing as a factor? Alternative explanations for the continuing rise in drug related deaths in Scotland. *Drugs and Alcohol Today,* **19** (2).
[12] Tweed, E. *et al.* (2018). Report: Why are Drugs-Related Deaths among women increasing in Scotland? Edinburgh, Scottish Government.
[13] McPhee, I. and Sheridan, B. (2020). AUDIT Scotland ten years on: explaining how funding decisions link to increased risk of drug related deaths among the poor. *Drugs and Alcohol Today,* **20** (4).
[14] Brand, B. (2016). Report: Older Drug Users in Scotland: professionals' views. Scottish Drug Forum, Glasgow.
[15] Scottish Social Services Council (2020). Report: Scottish Social Service Sector: Report on 2018 Workforce Data. Scottish Social Services Council, Dundee. Available at: https://data.sssc.uk.com/data-publications/28-adults-services-workforce/225-adults-services-workforce-in-scotland-tables
[16] Scottish Social Services Council (2020). Report: Scottish Social Service Sector: Report on 2019 Workforce Data. Scottish Social Services Council, Dundee. Available at: https://data.sssc.uk.com/data-publications/28-adults-services-workforce/248-adults-services-workforce-in-scotland-tables-2019
[17] Scottish Social Services Council (2021). Report: Scottish Social Service Sector: Report on 2020 Workforce Data. Scottish Social Services Council, Dundee. Available at: https://data.sssc.uk.com/data-publications/28-adults-services-workforce/267-the-adults-services-workforce-tables-2020
[18] Care Inspectorate (2017). Report: Alcohol and Drug Partnerships: A report on the use and impact of the Quality Principles through validated self-assessment. Care Inspectorate, Dundee.
[19] Public Health Scotland (2021). 'Medication Assisted Treatment (MAT) Standards for Scotland: Access, Choice, Support' Scottish Government, Edinburgh.: 25.
[20] Figure 8 Consultancy Services Ltd (2019). Report: Responding to drug use with Kindness, Compassion and Hope: A report from the Dundee Drugs Commission. Part three – supporting evidence – fieldwork. Figure 8 Consultancy Limited, Dundee.
[21] Scottish Drugs Forum (2019). Report: Staying Alive in Scotland: Strategies to prevent drug deaths. Scottish Drugs Forum, Glasgow.

[22] Scottish Government (2018). Report: The delivery of psychological interventions in substance misuse services in Scotland: A guide for commissioners, managers, trainers and practitioners. Scottish Government, Edinburgh.
[23] McAuley, A. and Forsyth, A. J. (2011). The impact of drug-related deaths on staff who have experienced it as part of their caseload: an exploratory study. *Journal of Substance Use*, **15** (1).
[24] McKeown, A. *et al.* (2003). A qualitative study of GPs' attitudes to drug misusers and drug misuse services in primary care. *Family Practice*, **20** (2).: 124.
[25] Alkhamis, A. *et al.* (2009) General Practitioners' management of psychostimulant drug misuse: Implications for education and practice. *Drugs: Education, Prevention and Policy*, **16** (4).
[26] Sebag, A. (2020). Discussing illicit recreational drug use with patients: How prepared do medical students feel? *[X]position* **5**.
[27] Ibid, : 3.
[28] Galvani, S. and Forrester, D. (2011). Report: Social Work Services and Recovery from Substance Misuse: A review of the evidence. Association of Directors of Social Work, Edinburgh.;
Hillen, P. (2018). 'Social work and substance misuse' *Social work in a changing Scotland*, Routledge, London.;
Johnston, L. and Burton, G. (2017). What is this thing called workforce development? A Scottish perspective. *Drugs: Education, Prevention and Policy*, **24** (6).
[29] Galvani, S. and Forrester, D. (2011). Report: Social Work Services and Recovery from Substance Misuse: A review of the evidence. Association of Directors of Social Work, Edinburgh.: 8.
[30] Ibid.
[31] Wilson, H. and Barber, N. (2013). Report: Review of NHS Pharmaceutical Care of Patients in the Community in Scotland. Scottish Government, Edinburgh.
[32] Mundt-Leach, R. and Hill, D. (2013). Non-medical prescribers in substance misuse services in England and Scotland: a mapping exercise. *Mental Health Practice*, **17** (9).
[33] Ibid.
[34] Matheson, C. *et al.* (2016). Community pharmacy services for people with drug problems over two decades in Scotland: Implications for future development. *International Journal of Drug Policy*, 27.
[35] NHS Health Scotland (2015) Report: 'Monitoring and Evaluating Scotland's Alcohol Strategy: 5th annual report', NHS Health Scotland, Edinburgh.
[36] Stead, M. *et al.* (2017) Delivery of alcohol brief interventions in community-based youth work settings: exploring feasibility and acceptability in a qualitative study. *MBC Public Health*, **17**.
[37] NHS Health Scotland (2015) Report: 'Monitoring and Evaluating Scotland's Alcohol Strategy: 5th annual report', NHS Health Scotland, Edinburgh.
[38] Ibid.
[39] Doi, L. *et al.* (2014) Alcohol brief interventions in Scottish antenatal care: a qualitative study of midwives' attitudes and practices, *BMC Pregnancy and Childbirth*, **14**.
[40] Stead, M. *et al*. (2017) Delivery of alcohol brief interventions in community-based youth work settings: exploring feasibility and acceptability in a qualitative study. *MBC Public Health*, **17**.
[41] Gill, J. and O'May, F. (2011) Is it my job? Alcohol brief interventions: Knowledge and attitudes among future health-care professionals in Scotland. *Alcohol and Addiction*, **46** (4).
[42] McCaig, D. *et al*. (2011) Provision of advice on alcohol use in community pharmacy: a cross-sectional survey of pharmacists' practice, knowledge, views and confidence. *International Journal of Pharmacy Practice*, **19**.
[43] Doi, L. *et al.* (2014) Alcohol brief interventions in Scottish antenatal care: a qualitative study of midwives' attitudes and practices, *BMC Pregnancy and Childbirth* **14**.;
Stead, M. *et al.* (2017) Delivery of alcohol brief interventions in community-based youth work settings: exploring feasibility and acceptability in a qualitative study. *MBC Public Health*, **17**.;
McCaig, D. *et al*. (2011) Provision of advice on alcohol use in community pharmacy: a cross-sectional survey of pharmacists' practice, knowledge, views and confidence. *International Journal of Pharmacy Practice*, **19**.;
NHS Health Scotland (2015) Report: 'Monitoring and Evaluating Scotland's Alcohol Strategy: 5th annual report', NHS Health Scotland, Edinburgh.;
Millard, A. and McAuley, A. (2008) Alcohol and the Over 65s: Service gaps seen from Home Care in Scotland. *Journal of Social Work Practice in Addictions*, **8** (3).
[44] Clark, I. *et al.* (2014) 'Assessing the availability of and need for specialist alcohol treatment services in Scotland', NHS Health Scotland, Edinburgh. Available at: 24408-AssessingTheAvailabilityOfAndNeedForSpecialistAlcoholTreatment.pdf (healthscotland.com)
[45] Holleran, J. *et al.* (2020). A Strategy to Address the Stigmatisation of People and Communities Affected by Drug Use – we all have a part to play. Scottish Drug Deaths Taskforce.

https://drugdeathstaskforce.scot/news-information/publications/policy-and-strategy/stigma-policy-and-strategy/

[46] Gilchrist, G. *et al.* (2011). Staff regard towards working with substance users: a European multi-centre study. *Addiction*, **106**.: 1114.

[47] Ibid.

[48] Brand, Biba (2016). Report: Older Drug Users in Scotland: professionals views. Scottish Drugs Forum, Glasgow;
Roe, L. (2020) Echoes of endlessness: Time, memory, and experience for heroin users in Scotland. Thesis. University of St Andrews. https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.813978;
Clark, I. et al (2014) 'Assessing the availability of and need for specialist alcohol treatment services in Scotland', NHS Health Scotland, Edinburgh. Available at: 24408-AssessingTheAvailabilityOfAndNeedForSpecialistAlcoholTreatment.pdf (healthscotland.com)

[49] Matheson, C. *et al*. (2017). Report: Older People with Drug Problems in Scotland: A mixed methods study exploring Health and Social support needs. Scottish Drugs Forum, Glasgow

[50] Care Inspectorate (2017). Report: Alcohol and Drug Partnerships: A report on the use and impact of the Quality Principles through validated self-assessment. Care Inspectorate, Dundee.;
Singleton, N. (2011) Report: Getting serious about stigma in Scotland: The problem with stigmatising drug users. UK Drug Policy Commission, London.

[51] Brand, Biba (2016). Report: Older Drug Users in Scotland: professionals views. Scottish Drugs Forum, Glasgow.: 10.

[52] Matheson, C. *et al.* (2017). Report: Older People with Drug Problems in Scotland: A mixed methods study exploring Health and Social support needs. Scottish Drugs Forum, Glasgow.: 20.

[53] Ibid.
Singleton, N. (2011) Report: Getting serious about stigma in Scotland: The problem with stigmatising drug users. UK Drug Policy Commission, London.

[54] Gilchrist, G. *et al*. (2011). Staff regard towards working with substance users: a European multi-centre study. *Addiction*, **106**.;
Neale, J. and Kennedy, C. (2002). Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community*, **10** (3).;

[55] Matheson, C. *et al.* (2017). Report: Older People with Drug Problems in Scotland: A mixed methods study exploring Health and Social support needs. Scottish Drugs Forum, Glasgow;

[56] Scottish Drugs Forum (2019). Report: Staying Alive in Scotland: Strategies to prevent drug deaths. Scottish Drugs Forum, Glasgow.;
Matheson, C. *et al.* (2017). Report: Older People with Drug Problems in Scotland: A mixed methods study exploring Health and Social support needs. Scottish Drugs Forum, Glasgow

[57] Wylie, L. W. J. (2010). Assessing user perceptions of staff training requirements in the substance use workforce: A review of literature. *Drugs: Education, Prevention and Policy*, **17** (5).;
Neale, J. and Kennedy, C. (2002). Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community*, **10** (3).;
Morris, Z. and Gannon, M. (2008). Drug misuse treatment services in Scotland: predicting outcomes. *International Journal for Quality in Health Care*, **20** (4).;
Scottish Drugs Forum (2019). Report*: Staying Alive in Scotland: Strategies to prevent drug deaths.* Scottish Drugs Forum, Glasgow.;
Matheson, C. *et al*. (2017). Report: Older People with Drug Problems in Scotland: A mixed methods study exploring Health and Social support needs. Scottish Drugs Forum, Glasgow

[58] Hillen, P. *et al*. (2014). Facilitating recovery from drug and alcohol problems – reflections on interviews with service users in Scotland. *Practice,* 26 (5).;
Scottish Drugs Forum (2019). Report: Staying Alive in Scotland: Strategies to prevent drug deaths. Scottish Drugs Forum, Glasgow.

[59] Wylie, L. W. J. (2010). Assessing user perceptions of staff training requirements in the substance use workforce: A review of literature. *Drugs: Education, Prevention and Policy*, **17** (5).

[60] Tweed, E. *et al*. (2018). Report: Why are Drugs-Related Deaths among women increasing in Scotland? Edinburgh, Scottish Government.

[61] Matheson, C. *et al.* (2017). Report: Older People with Drug Problems in Scotland: A mixed methods study exploring Health and Social support needs. Scottish Drugs Forum, Glasgow

[62] Emslie. C. *et al.* (2022). Report: The Social Context of LGBT People's Drinking in Scotland. Scottish Health Action on Alcohol Problems. Available at: https://www.shaap.org.uk/images/shaap-glass-report-web.pdf

[63] Wylie, L. W. J. (2010). Assessing user perceptions of staff training requirements in the substance use workforce: A review of literature. *Drugs: Education, Prevention and Policy*, **17** (5).

[64] Neale, J. and Kennedy, C. (2002). Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community*, **10** (3).
[65] Matheson, C. et al (2017). Report: Older People with Drug Problems in Scotland: A mixed methods study exploring Health and Social support needs. Scottish Drugs Forum, Glasgow
[66] Morris, Z. and Gannon, M. (2008). Drug misuse treatment services in Scotland: predicting outcomes. *International Journal for Quality in Health Care*, **20** (4).;
Hillen, P. *et al.* (2014). Facilitating recovery from drug and alcohol problems – reflections on interviews with service users in Scotland. *Practice,* 26 (5).
[67] Neale, J. and Kennedy, C. (2002). Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community*, **10** (3).
[68] Kelly, Claire (2019). Report: Substance Misuse and Young People in Scotland: A Practitioner Research Report. Includem, Glasgow;
Brand, Biba (2016). Report: Older Drug Users in Scotland: professionals views. Scottish Drugs Forum, Glasgow
[69] Drug Policy Alliance (2018). Report: Drug Decrimilization in Portugal: Learning from Health and Human-Centered Approach. Drug Policy Alliance, New York.

Bibliography

Alkhamis, A. *et al.* (2009) General Practitioners' management of psychostimulant drug misuse: Implications for education and practice. *Drugs: Education, Prevention and Policy*, **16** (4).

Audit Scotland (2019) 'Drug and Alcohol Services: an update'.

Brand, Biba (2016) *Older Drug Users in Scotland: professionals views*. Scottish Drugs Forum, Glasgow.

Care Inspectorate (2017) *Alcohol and Drug Partnerships: A report on the use and impact of the Quality Principles through validated self-assessment*. Care Inspectorate, Dundee.

Clark, I. *et al.* (2014) 'Assessing the availability of and need for specialist alcohol treatment services in Scotland', NHS Health Scotland, Edinburgh.

Doi, L. *et al*. (2014) Alcohol brief interventions in Scottish antenatal care: a qualitative study of midwives' attitudes and practices, *BMC Pregnancy and Childbirth* **14**.

Drug Policy Alliance (2018) Drug Decrimilization in Portugal: Learning from Health and Human-Centered Approach', Drug Policy Alliance, New York.

Emslie, C., Lennox J. C., and Ireland, L. (2022) The social context of LGBT people's drinking in Scotland. Scottish Health Action on Alcohol Problems, Glasgow.

Figure 8 Consultancy Services Ltd (2019). Report: Responding to drug use with Kindness, Compassion and Hope: A report from the Dundee Drugs Commission. Part three – supporting evidence – fieldwork. Figure 8 Consultancy Limited, Dundee.

Galvani, S. and Forrester, D. (2011) Social Work Services and Recovery from Substance Misuse: A review of the evidence. Association of Directors of Social Work, Edinburgh.

Gilchrist, G. *et al.* (2011) Staff regard towards working with substance users: a European multi-centre study, *Addiction*, **106**.

Gill, J. and O'May, F. (2011) Is it my job? Alcohol brief interventions: Knowledge and attitudes among future health-care professionals in Scotland. *Alcohol and Addiction*, **46** (4).

Hillen, P. *et al*. (2014) Facilitating recovery from drug and alcohol problems – reflections on interviews with service users in Scotland, *Practice*, **26** (5).

Hillen, P. (2018) 'Social work and substance misuse' *Social work in a changing Scotland*, Routledge, London.

Holleran, J. *et al.* (2020). A Strategy to Address the Stigmatisation of People and Communities Affected by Drug Use – we all have a part to play. Scottish Drug Deaths Taskforce.

Information Services Division (2010) 'HEAT A11: Updated Drug and Alcohol Treatment Types', NHS Scotland, Edinburgh.

Information Services Division (2019) 'Prevalence of Problem Drug Use in Scotland: 2015/16 Estimates', NHS National Services Scotland.

Johnston, L. and Burton, G. (2017) What is this thing called workforce development? A Scottish perspective *Drugs: Education, Prevention and Policy*, **24** (6).

Kelly, Claire (2019) 'Substance Misuse and Young People in Scotland: A Practitioner Research Report', Includem, Glasgow.

Matheson, C. *et al.* (2016). Community pharmacy services for people with drug problems over two decades in Scotland: Implications for future development. *International Journal of Drug Policy*, 27.

Matheson, C. *et al.* (2017) *Older People with Drug Problems in Scotland: A mixed methods study exploring Health and Social support needs*. Scottish Drugs Forum, Glasgow.

McAuley, A. and Forsyth, A. J. (2011) The impact of drug-related deaths on staff who have experienced it as part of their caseload: an exploratory study'. *Journal of Substance Use*, **15** (1).

McCaig, D. *et al.* (2011) Provision of advice on alcohol use in community pharmacy: a cross-sectional survey of pharmacists' practice, knowledge, views and confidence. *International Journal of Pharmacy Practice*, **19**.

McKeown, A. *et al.* (2003) A qualitative study of GPs' attitudes to drug misusers and drug misuse services in primary care. *Family Practice*, **20** (2).

McPhee, I. *et al.* (2019) Time to look beyond ageing as a factor? Alternative explanations for the continuing rise in drug related deaths in Scotland. *Drugs and Alcohol Today* **19** (2).

McPhee, I. and Sheridan, B. (2020) AUDIT Scotland ten years on: explaining how funding decisions link to increased risk of drug related deaths among the poor. *Drugs and Alcohol Today* **20** (4).

Millard, A. and McAuley, A. (2008) Alcohol and the Over 65s: Service gaps seen from Home Care in Scotland. *Journal of Social Work Practice in Addictions*, **8** (3).

Morris, Z. and Gannon, M. (2008) Drug misuse treatment services in Scotland: predicting outcomes. *International Journal for Quality in Health Care*, **20** (4).

Mundt-Leach, R. and Hill, D. (2013) Non-medical prescribers in substance misuse services in England and Scotland: a mapping exercise. *Mental Health Practice*, **17** (9).

NHS Health Scotland (2015) 'Monitoring and Evaluating Scotland's Alcohol Strategy: 5th annual report', NHS Health Scotland, Edinburgh.

National Records of Scotland (2021). 'Alcohol specific deaths 2020', Scottish Government, Edinburgh.

National Records of Scotland (2021) 'Drug-related deaths in Scotland in 2020', Scottish Government, Edinburgh.

Neale, J. and Kennedy, C. (2002) Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community*, **10** (3).

Population Health Directorate (2018) 'Alcohol Framework 2018: Preventing Harm – next steps on changing our relationship with alcohol', Scottish Government, Edinburgh.

Population Health Directorate (2021) ‘Medication Assisted Treatment (MAT) standards: access, choice, support’, Scottish Government, Edinburgh.

Roe, L. (2020) Echoes of endlessness: Time, memory, and experience for heroin users in Scotland. Thesis. University of St Andrews.

Scottish Drugs Forum (2019) *Staying Alive in Scotland: Strategies to prevent drug deaths*. Scottish Drugs Forum, Glasgow.

Scottish Government (2018) ‘The delivery of psychological interventions in substance misuse services in Scotland: A guide for commissioners, managers, trainers and practitioners’ Scottish Government, Edinburgh.

Scottish Social Services Council (2020a). Report: Scottish Social Service Sector: Report on 2018 Workforce Data. Scottish Social Services Council, Dundee.

Scottish Social Services Council (2020b). Report: Scottish Social Service Sector: Report on 2019 Workforce Data. Scottish Social Services Council, Dundee.

Scottish Social Services Council (2021). Report: Scottish Social Service Sector: Report on 2020 Workforce Data. Scottish Social Services Council, Dundee

Sebag, A. (2020) Discussing illicit recreational drug use with patients: How prepared do medical students feel?. *[X]position* **5**.

Singleton, N. (2011) *Getting serious about stigma in Scotland: The problem with stigmatising drug users*. UK Drug Policy Commission, London.

Stead, M. *et al*. (2017) Delivery of alcohol brief interventions in community-based youth work settings: exploring feasibility and acceptability in a qualitative study. *MBC Public Health* **17**.

Tweed, E. *et al.* (2018). Report: Why are Drugs-Related Deaths among women increasing in Scotland? Edinburgh, Scottish Government.

Wilson, H. and Barber, N. (2013) *Review of NHS Pharmaceutical Care of Patients in the Community in Scotland*. Scottish Government, Edinburgh.

Wylie, L. W. J. (2010) Assessing user perceptions of staff training requirements in the substance use workforce: A review of literature. *Drugs: Education, Prevention and Policy*, **17** (5).