Public Health Scotland

Guidance on the management of clusters of drug related harms

National Drug Deaths Incident Management Team

Publication Date: 06 November 2024

V1.0

Translations and other formats are available on request at:

phs.otherformats@phs.scot

0131 314 5300

Public Health Scotland is Scotland's national agency for improving and protecting the health and wellbeing of Scotland's people.

www.publichealthscotland.scot

Version history

Version	Date	Summary of changes
1.0	23.09.24	Sign off by National Drug Death Incident Management Team

Contents

1. Introduction

People who use drugs (as classified by the Misuse of Drugs Act 1971 or the Psychoactive Substances Act 2016) may do in differing contexts for a range of purposes. When people find themselves in situations that may cause them harm, they may be able to take action to protect themselves. Sudden and unexpected increases in harm can occur when people are exposed to or at risk of being exposed to highly toxic potent substances with inadequate opportunities to reduce their risk of harm. NHS Boards can use public health incident management frameworks to reduce risk of immediate harm to individuals and communities.

The purpose of this document is to offer a working definition and a framework to consider risk management and risk response in the context of an emergent incident within a local area. A secondary objective is to propose a means by which a cluster or incident can be identified and acted on prior to toxicological information becoming available.

In this response framework, NHS Boards, via the Director of Public Health provide a focal point for a coordinated multiagency response. The Public Health Incident Management Framework sets out the response and resources to enable response. This document should be read in conjunction with **Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams (publichealthscotland.scot)**

2. Background

People who use drugs problematically typically experience mental health problems, other physical long-term conditions and may have experienced significant adversity and trauma during their lifetime. The highest rates of harm are disproportionately experienced in the most disadvantaged communities in Scotland. The criminalised context of drug use and drug dependence presents challenges, including stigma and barriers to accessing care, which specifically increases the risk of harm. This context

must be considered, and approaches adapted accordingly when delivering a public health approach to reducing drugs harms as set out in the Scottish Government's current drug treatment policy.

This document takes a human rights-based approach to increase the ability and accountability of individuals and institutions who are responsible for respecting, protecting and fulfilling rights. The Public Health (Scotland) Act 2008 provides a legal definition of a public health incident identifying the duty bearers central to the protection of health.

If an incident results in major disruption of services or occurs across Scotland or across the UK, local authorities, NHS Boards, Police Scotland, Public Health Scotland and the Scottish Government will be working to plans set out in "Preparing Scotland". Preparing Scotland concerns the implementation of the Civil Contingency Regulations. A localised incident may escalate sufficiently to require the declaration of a major incident. In this situation, the Major Incident Plan, Local Resilience Plan or Regional Resilience plan will need to be activated. This guidance is designed to be used alongside the existing legal frameworks and associated guidance. The aim of this guidance is to provide support to determining what constitutes a potential incident in the context of drug harms.

This relates to the wide range of potential consequences that can be associated with drugs. The health impacts of illicit drug use include drug intoxication, near fatal and fatal overdoses as well as communicable diseases (HIV, hepatitis, infections), injecting-related injuries and impacts on mental and physical health.

In applying this definition and identifying incidents it is necessary to consider the complex interplay of social, cultural and community factors which can both modify or attenuate risk. It is necessary for public health teams involved in incident response to work together with Alcohol and Drug Partnership members including service providers, third sector agencies, people with lived experience and other statutory providers such as Police Scotland, Housing services etc. There is a link between this guidance and the Medication Assisted Treatment Standards, in particular standard 3 anticipatory care for people at the highest risk of drug harm.

The need for and development of local contextual expertise to understand and respond to emerging drug trends is recognised.

Further detail on developing and operating local drug surveillance systems, or early warning systems (LEWS), is set out in the **RADAR Local Guide**. The guidance contains suggested components, contacts, processes and templates that can be adapted to suit local needs, aiming to help areas identify and respond to emerging drug harms

3. Principles governing overdose cluster response.

The priority is to rapidly identify, confirm and respond to a public health incident involving drugs to prevent further morbidity and mortality.

Public health actions should be proportionate to the additional level of risk in any given scenario and based on a risk assessment.

The risk of avoidable harm or negative unintended consequences from acting or not acting should be considered.

A public health response to a cluster requires joint working between statutory and voluntary agencies, clarity and a shared understanding of roles and responsibilities is critical.

Preparedness and response should seek to empower and involve community relationships and actively work to build trust with communities.

The risk of severe adverse consequences following illicit drug use is highest amongst people who have established problematic drug use and amongst those who have multiple complex vulnerabilities (homelessness, poor mental health and other co-morbidities)

Communication between agencies and with the public is required to implement appropriate, acceptable and effective targeted interventions including harm reduction, prevention and recovery support or the provision of healthcare.

Those involved in managing and responding to incidents should evaluate the impact of the response on human rights and whether the approach taken was trauma informed.

The duty to share information for individual care is as important as the duty to protect patient or client confidentiality, there are times when it is essential to share personal information to safeguard individuals or others from harm, and where it is appropriate to do so without consent.

The primary focus of a multiagency response to prevent further drug harms through a focus on harm reduction and heath. To preserve the trust between those providing health and social care and the public it may be necessary to agree the specific details of information sharing with law enforcement agencies.

4. Who is this document for?

This document supports local areas use a **Public Health Incident Management Framework** approach to respond to a suspected cluster.

The Public Health Incident Management Framework sets out the response and resources to enable the NHS board and other statutory agencies to fulfil their remits which are:

- To reduce the number of individuals affected by drug harms by promptly recognising an incident, defining cases and identifying and controlling specific sources of exposure.
- To minimise illness, premature death and disability by ensuring consistent quality harm reduction, treatment and care for those affected.
- To inform people at risk of drug harms, family members, wider public, staff working in treatment, harm reduction and recovery services and the wider media about the risks associated with the incident and how these can be minimised.

- To collect information which will be of use in better understanding how to prevent and manage future incidents.

This document is primarily intended for those involved in recognising and responding to an incident involving drug harms. These include those working in public health departments.

5. Definitions

A case definition is a set of uniform criteria used to define a drug harm for incident identification and response. The purpose of the definitions is to; rapidly identify, validate and respond to a drug related incident, to implement appropriate and acceptable interventions which reduce harm and to support the identification of issues which occur across Scotland, or which extend out with Scotland.

The drug harm case definitions should not be used to make clinical diagnoses or developing a care plan for someone.

Suggested definitions

An increase in the number of intoxication or overdose (fatal or near fatal) presentations during a short period of time (days to weeks) above what is normally expected in a local area.

The occurrence of two or more intoxication or overdose (fatal or near fatal) presentations linked in terms of person, place, and time.

An increase in the number of drug related events in circumstances deemed by local multiagency teams to be unusual e.g. amongst young people, novel clinical presentation (e.g. opioid overdoses amongst people who reported only stimulant or ecstasy use, the presence of unusual features such as skin lesions)

The scope of this definition is limited to short-term harms associated with illicit drug exposures. The rapid identification of an incident is dependent on a high index of clinical suspicion and clinical history. These definitions are based on clinical presentation and do not require confirmatory toxicological testing before action can be taken.

The epidemiological features of drug related harms indicate that most overdose incidents involve more than one substance. Contamination of the illicit drug supply is both common and widespread. The case definition is sensitive enough for the range of toxidromes which may be observed. This may include unusual or unexpected physical or psychological features.

As the incident evolves, and/ or more information becomes available, it will be necessary to adapt the case definition to ensure that further cases are captured and to allow for more detailed descriptive or analytical epidemiology to target control measures. This should be described in terms of time, place and person.

Appendix 1 contains a list of useful information that should be sought to further develop the case definition.

6. Initial reporting and problem assessment group

If concerns about a potential local incident involving an increase in suspected drug harms are identified, they should be reported to the local Consultant in Public Health (Medicine) Hereafter referred to as CPH/ CPHM. Local Public Health teams can be contacted 24 hours a day 7 days a week.

The CPH / CPHM may convene a Problem Assessment Group, this can provide a useful means by with to gather further information to perform a risk assessment. The timescales for convening a Problem Assessment Group will be determined by the CPH / CPHM, factors such as the scale of the incident, availability of partners with appropriate expertise should be considered.

The CPH/ CPHM may or may not have access to background epidemiological information to assist in identifying whether the reported increase represents a true

increase in harms. In situations where background information is available, it may not be applicable to unusual presentations or a situation involving specific population groups or a situation in a specific setting. The role of the problem assessment group is to provide additional information to allow an informed risk assessment to be made.

In situations where the incident involves more than one NHS Board or is considered to have Scotland, UK Wide or International implications, a national Incident Management Team may be convened. Further details on the circumstances in which a National Incident Management Team is stood up and leadership are detailed in **Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams (publichealthscotland.scot).**

6.1. Notification for areas with established drugs early warning systems

Areas with local drug early warning systems may find it helpful to adapt their standard operating procedures as detailed in the **RADAR Local Guide**. This may include identifying a public health consultant (CPM(M)) as a key contact for the early warning system. They would then be alerted to any situations of potential concern during working hours in line with the established local process. The CPH(M) key contact can stand up a problem assessment group if appropriate.

6.2. Notification outside normal working hours

After 5pm and on weekends and public holidays, any urgent notification should first be made to local public health teams as detailed in this guidance. Local public health will determine whether to contact Public Health Scotland in line with should follow the requirements set out in the agreement for joint working between local public health teams and Public Health Scotland. There is limited access to drug specific expertise at a national level outside usual working hours and management would be expected to follow principles of public health incident response with a handover to locally identified leads during working hours. Local leads may include a CPH(M) with

responsibility for drugs or the key contacts identified in the Local Early Warning system. During office hours, details of local leads can also be obtained from the RADAR team in Public Health Scotland **phs.radar@phs.scot**.

6.3. Routine monitoring of drug harm indicators

Public Health Scotland conducts routine monitoring of drug harm indicators. Scottish Ambulance Service and Police Scotland also monitor their routinely collected information. If Public Health Scotland identifies an indicator 10% higher than the previous reporting period, local key contacts will be informed, and data provided. The role of a key contact is described in the **RADAR Local Guide**. The key contacts should consider the implications of these data alongside other local information and determine whether there is evidence of a potential incident. An increase in an indicator may represent an increase in harms, however it may be due to a change in data recording or a change in clinical practice. Early discussion with the CPH/ CPH(M) is advised.

It is expected that participants in a problem assessment group would come from multiple agencies including the public sector, third sector and may also include community groups. Appendix 2 details the suggested membership of a problem assessment group.

Individuals attending a problem assessment group or subsequent incident management team are responsible for contributing to the situational awareness, receiving the operational briefing and receiving tactical assignments to assist with the investigation and management of an incident. Representatives should be chosen who are both able to contribute to the understanding of the incident and undertake interventions to respond to the incident.

A framework agenda for the problem assessment group is provided in appendix 3. The status of members including their role, expectations on confidentiality and conflicts of interest, should be clarified at the start of each meeting in accordance with the steps set out in the **guidance on the management of public health incidents**.

7. Risk assessment

The following framework is proposed to assess impact. The categories identified should be interpreted in the context of the rights as set out by the Charter of Rights produced by the National Collaborative. All the rights set out in the Charter should be considered, in the context of identifying and responding to a drug harm cluster, particular attention should be paid to; the right to life; the right to the highest attainable state of health; the right to healthy environment and freedom from arbitrary detention or arrest.

	Illness severity	Service impact	Exposure	Public concern
Minor	People required limited clinical support. No deaths have been reported	Limited or minor impact on services	Exposure contained and no further reports of harms	Limited interest expected
Moderate	People require urgent care (ambulance or emergency department assistance) Presenting symptoms have the potential to result in serious illness or long-term disability[i] Deaths may be reported	Requiring additional staff or resources to respond to the situation compared to normal	Evidence of ongoing exposure (overdose / poisoning) amongst people in a known at-risk group	Interest within local area anticipated

[i] Eg amputation or liver transplant

	Illness severity	Service impact	Exposure	Public concern
Major	People require intensive clinical support – (ITU/ HDU) Evidence of serious illness or disability[i] Deaths reported	Significant disruption anticipated	Evidence of exposure amongst groups of people not known to be or who would not consider themselves at risk. Evidence of escalating exposure amongst a group of people in a known at-risk group	Substantial interest within and out with area expected

Illness severity relates to the physical impact on the individual. Consideration should be given to the validity and source of this information, with a higher level of confidence for the use of objective criteria and assessment.

Service impact requires consideration of the impact on services. This may present as higher than usual demand within urgent care services, treatment services or may be focused on a particular setting e.g. Prison.

Exposure is about the evidence of and assumptions about illicit substance use. There are broadly three groups of people to consider when making an assessment.

People who have established drug use due to high levels of use or dependence they may require more frequent and higher doses, increasing the risk of exposure.

People with problematic drug use who are not engaged in treatment services are key risk group to consider as they are not benefiting from the protective effects of treatment and may not be accessing harm reduction.

People with established or prior drug problems who are released from settings such as prisons, police custody, discharged from hospital or other care facilities have a high risk of experiencing harm, particularly if planning and aftercare arrangements are not in place. The needs of this group of people should be considered

prospectively during an incident (i.e. considering that people may be returning to communities where a cluster has been identified and is ongoing).

People who do not have established drug use. This group of people can be broad and may vary in age and background. Reasons for using drugs can be varied and may include recreation, self-medication. There can be strong links to social networks and peers both to protect from drug harms and to experiment with drugs. There is likely to be very little intelligence about patterns and trends in this group.

Public concern relates to expected levels of public concern or media interest.

The chairs of problem assessment groups should be mindful that there is no legal requirement to report suspected cases and no recommended timeframe in which to do so. Furthermore, compared to the general population, people who use drugs are marginalised and may experience barriers in accessing services. These barriers include stigma and the criminalised context of drug use. Problem assessment group chairs are recommended to take a proactive approach in seeking information to inform the risk assessment, for example approaching those working in hospital emergency departments, housing crisis services, ambulance call centres etc.

Suggested assessment of risk scoring

Scoring	Suggested response
All minor Three minor and one moderate	The benefits and risks of action need to be considered alongside the benefits and risks of continued monitoring. Continued monitoring and involvement of expert stakeholders and community experts via local drug trend monitoring group and existing groups acting on reducing drug harms. This should be done within locally agreed timescales
2-4 Moderate Any major	Consider escalation. Consider if additional support is required e.g. Local Resilience Partnerships.

Scoring	Suggested response
	Further guidance on this is set out in **Preparing Scotland.** Consider whether business continuity plans need to be activated. Inform Public Health Scotland and consideration whether a national response or a local response is most appropriate. Inform Scottish Government in line with the protocol for informing Scottish Government and Scottish Ministers about significant Public Health incidents and outbreaks.

8. Obtaining rapid toxicological information

During an incident, there is an urgent need for rapid toxicological information. This can help inform details of the alert that is to be communicated and measures which can reduce harms. At the time of writing, rapid drug checking facilities are not available in Scotland. The options for obtaining this information depend on facilities available and in operation at the time of the incident. The absence of toxicological information should not delay action, despite its critical importance to effective action.

It is advisable to consider these options as part of pre-incident planning and ensure that lines of communication for requesting testing and the associated roles and responsibilities are clear.

WEDINOS: WEDINOS is the Wesh drug checking service which accepts samples from Scotland. Samples are sent by post and results available within a short period of time once received.

HOSPITAL TOXICOLOGY: If a person is admitted to a participating hospital and fulfils the criteria for blood sampling, further analysis can be requested from a specialist laboratory. Requests should be discussed with a consultant in Emergency Medicine or Intensive Care as to the availability and suitability of samples. Turnaround time would be expected to be between 2 and 4 days. This pathway is not available in most areas of Scotland.

TESTING OF MATERIAL SEIZED BY POLICE SCOTLAND: If substances are seized from the scene of an incident, it may be possible to have these tested. Requests should be directed via the local Police Scotland Lead and Laboratory Lead who can confirm whether this is possible and timescales for turnaround. It should be noted that these substances may have a different composition to the substances which were ingested and caused harm. Caution is required in interpreting results.

FORENSIC POSTMORTEM TOXICOLOGY RESULTS: If one or more people have died as part of the cluster, it may be possible to request that these toxicological examinations are prioritised. Requests should be discussed with the Forensic Toxicologist and information provided about which individuals are involved. Rapid processing will require 27 days from receipt of sample.

9. Risk communication and risk management.

The purpose of this section is to describe immediate control measures which can be put in place once a cluster has been identified. These interventions can be used before as well as after toxicological confirmation of harms or deaths. The scope of this paper is on the specific actions that can be taken for drugs, it would be expected that overarching frameworks such as the management of public health incidents would be used in conjunction.

This section was developed following a rapid review of the literature focused on Ovid Medline (search strategy and results available on request). Interventions and responses have not all yet been evaluated given the emergency response context of cluster management and so were not fully appraised for effectiveness. The suggestions presented should be considered as examples of emergent practice in

response to dynamically changing drug environments. The effectiveness of any intervention is limited by the marginalisation experienced by and criminalisation of people and communities affected by problematic drug use. To maximise impact of any intervention, availability, acceptability and accessibility should be considered and further discussed during a Problem Assessment Group and interventions adapted accordingly.

There is further detail on communications and alerts in section 4 of the **RADAR local guide**, and an editable alert template.

9.1. Risk communication

RAISE AWARENESS AMONGST THOSE AT RISK

Risk may be increased in situations where a substance is contaminated (e.g. cocaine contaminated with synthetic opioid or street benzodiazepine contaminated with nitazene). People may be unaware of the contamination and may perceive their risk to be lower as they believe the substance to be the same as their purchase intent. Early messages may focus on contamination / toxic contents of substance (even if no toxicological confirmation), overdose awareness, harm reduction advice.

Consideration should be given to the needs of defined population groups and the appropriate means of effective communication. Local commissioned third sector providers as well as Lived and living experience panel representatives provide valuable insights into how to provide information which is both accessible and acceptable to the community at risk of harm.

National commissioned organisations such as SDF and CREW 2000 can provide valuable insight into both framing the alert message for the public and harm reduction messaging.

Appendix 4 contains a template for a press release or media holding statement.

Appendix 5 contains standard harm reduction messages which can be further developed as part of risk communication.

ALERT EMERGENCY SERVICES AND RELAVENT ORGANISATIONS.

Make emergency departments, first responders, assertive outreach and drug treatment services, housing providers etc of the emergent cluster features. The **RADAR Local Guide alert** template provides a framework for alerts that can be used for communication between agencies, organisations or professionals.

Local alert template adapted from the RADAR Local Guide alert template

Title: A descriptive heading of one sentence

Name of the drug: Insert official name of drug plus any street or slang names

Drug appearance: insert photo if available or describe appearance

Effects: a shot description of the effects

Response: What should people do in response, audience specific.

Signposting: To local services

Information and queries on the clinical management of specific substances can be directed TOXBASE. National Poisons Information Service is also available for complex queries.

When using the Public Health Incident Management approach, NHS Boards take the lead in decision making on risk communication. The objectives of communication should be documented.

The chair should work with the problem assessment group members to explicitly determine the purpose of the risk communication, is this for provision of information, support for behaviour change or both. The lead for communications is determined by the framework governing response, in the context of a major incident, roles and responsibilities are set out in Preparing Scotland.

Decisions on risk communication should be recorded. Decisions not to communicate about actual or potential risks to the public health even when these are uncertain should be justified and recorded.

Communication plans should be developed as part of pre-incident preparedness planning.

9.2. Risk management interventions - improving support and care for those affected and at risk.

When reviewing these interventions, consider how their availability, accessibility and acceptability can be improved for the people and communities at risk.

PROVIDE NALOXONE AND SUPPORT FOR HARM REDUCTION.

Regardless of overdose features, ensure that naloxone, harm reduction information (Appendix 7) and support to treatment is provided to people who have experienced drug harms and who are conveyed to hospital or attended by emergency services. Harm reduction information and naloxone should also be provided to families and friends. Ensure that risk is recognised, and access to treatment and support is facilitated, for example by targeted use of assertive outreach services and early intervention pathways between services. Consider how to maximise access out of working hours to harm reduction tools.

EMPLOY TRAUMA INFORMED PRACTICE.

Co-existing mental health conditions are common and can negatively impact psychosocial and cognitive functioning. Social isolation, homelessness, and stigma potentially limiting the opportunities for people to proactively engage. Consider how to make responses trauma informed and appropriate for the needs of individuals. Consider the impact of bereavement or loss and the potential for this incident to re-traumatise individuals, what resources might be available in the wider community that could be directly deployed to communities. Give particular consideration as to whether these resources are accessible and culturally acceptable to the people experiencing harms.

Promote access and engagement with interventions by reaching people at risk via known trusted contacts and social networks.

MOBILISE ANTICIPATORY CARE OR ASSERTIVE OUTREACH SERVICES TO BE VISIBLE IN AFFECTED COMMUNITIES:

Consider if there are other pathways for mobilising assertive outreach and anticipatory care based on features of the cases reported for example housing support officers, public protection, peer groups being able to make direct referrals. Consider how the harms are patterned to inform targeted deployment. Consider whether additional flexibility is required to provide person centred support.

PREVENT RISKS ASSOCIATED WITH INJECTING DRUG USE.

Consider how to maximise access in and out of hours to harm reduction measures such as injecting equipment and promote alternative routes of administration through provision of foil. Consider if there are opportunities to prevent or offer screening and treatment for blood borne viruses. Consider if services for wound care can be extended or deployed on a targeted basis.

PROVIDE ACCESS TO SAFE AND HYGENIC ENVIRONMENTS.

Consider measures to prevent injecting related injuries. People who inject drugs are at risk of a range of (non-BBV) injection-related injuries and diseases, such as abscesses, cellulitis, sepsis, and endocarditis, which can lead to substantial morbidity and mortality. Consider environments that people have access to and opportunities to improve access to safe and hygienic environments.

8.3 Risk management - preventing exposure.

TARGET INTERVENTION TO KNOWN HIGH RISK GROUPS

Consider risks to people re-entering community e.g. people leaving hospital or prison who may be at heightened risk of harm – scale up naloxone, overdose awareness, assertive outreach support and access to treatment and recovery services.

MULTIAGENCY RISK REVIEW IN DRUG TREATMENT SERVICES

Consider using a multiagency group to assess risk of individuals in treatment services and those who may be in contact with other agencies but not drug treatment services. Provision of bereavement support.

Consider the contribution of violence / exploitation e.g. trafficking, cuckooing and whether there are partnership responses which could be deployed to enhance engagement and trust with health and harm reduction interventions.

10. Step down and immediate actions after an incident has occurred

The consultant in public health CPH(M) who chairs the problem assessment group should determine with members of the group when the incident can be considered over, and the group should stand down. Arrangements should be made to ensure continued oversight and delivery of actions if required. A debrief or lessons learned exercise may be useful further guidance on stepping down the response after an incident is declared is contained in **Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams (publichealthscotland.scot)**

11. Pre-incident Planning and Preparedness

The evolving drug market and associated harms are dynamic at a global and local level. This requires surveillance, harm reduction, quality treatment and recovery in communities. Pre-incident planning is about developing locally tailored and relevant interventions which are joined up with other local efforts to reduce drug harms and address the wider social determinants of health.

To mobilise an effective response, both routine surveillance and emergency response structures are needed. Surveillance is the system for understanding and acting on intelligence about harms and trends. Further information on developing

local surveillance systems, also call Local Early Warning Systems (LEWS) is available in the **RADAR Local Guide.**

Consider developing a shared multiagency local incident response plan. This may comprise of a single document, or a series of protocols jointly developed and shared by partner agencies.

The purpose of the plan is to agree who is doing what during an incident. The plan should link to existing emergency preparedness structures. It should help identify the thresholds at which additional assistance will need to be requested. Consider the objectives and the associated activities to respond to an incident in the short and medium term. This may also require explicit consideration of response continuity in and out of hours, exit strategy and debrief strategy.

Other features of a plan include an after-hours response plan, detailing which services are available in the local area during weekends and public holidays and in the evening and overnight. Consider how these services can be notified and mobilised if required.

As part of pre-incident planning, it may be useful to consult with multiple stakeholders and consider a local exercise to understand local systems and gaps. A list of stakeholders who could contribute to a local exercise is contained in Appendix 5. Not all members may be familiar with the format, developing a one-page briefing on expected contribution and responsibilities for each member may be useful. Appendix 6 contains information about roles, responsibilities and links to professional development competency frameworks.

Given the importance and regional variability in access to rapid toxicology, preparedness work should map out what toxicology and checking services people may have access to and how to notify these services of an incident that could result in an increase in demand. In most incidents, specific toxicological information about the substances involved will not be available in the first few hours and days. It may be useful to develop a risk communication template of standard messages for different target audiences. This can also include a template for a press release. Consideration should be given to how these messages can be distributed.

Developing risk communication messages and templates

Engage with stakeholders to ensure that language is non-- stigmatising (in addition to drug use, people who use drugs may experience multiple vulnerabilities; mental health conditions, poverty and experience criminalisation all of which are highly stigmatised)

The perspectives of people who use drugs are important. Including many voices, family members, parents, people from underrepresented groups can help with developing appropriate messaging directly to people who use drugs and to people who support them and may have opportunities to reduce the risk of harm in another.

Specifically consider what words are appropriate and understandable to different people, what are the information or behaviour change needs of the target group and how best to deliver the message. Local commissioned third sector providers as well as Lived and living experience panel representatives provide valuable insights into how to provide information which is both accessible and acceptable to the community at risk of harm.

National commissioned organisations such as SDF and CREW 2000 can provide valuable insight into both framing the alert message for the public and harm reduction messaging.

Key stakeholders for pre-incident planning are listed in appendix 7.

Appendix 1 Requirements for information sharing

To inform the further development of the case definition and identification of further cases it would be necessary to have the following information.

Name	
Date of birth / age	
Gender	
The location where the overdose / intoxication happened	
Information about the drug people thought they were consuming, what was their intention?	
What was the route of drug consumption?	
Was naloxone administered, any information about amount of naloxone administered?	
Picture of drugs found at scene – could be useful for initial communication, however important to note that the drugs found at the scene may not be the same as drugs that the person consumed.	
General description of what happened / is known to have happened to the individual.	

Appendix 2 Suggested membership of a problem assessment group

This list is not exhaustive

Chair - usually a Consultant in Public Health or Consultant in Public Health (Medicine). CPH / CPHM

Administrative Support

Communications lead.

Clinician with expertise in addictions

Emergency department Clinician

Forensic Toxicologist

Lived and living experience groups or representatives of peer naloxone initiatives.

Representative of local drug trend monitoring group / Local Early Warning System (LEWS)

Representative of harm reduction services

Representative of assertive outreach services

Representative of social work with experience in adult and child protection

Scottish Ambulance Service - drug harms team

Substance use specialist pharmacist.

Pathologist

Police Scotland

Others as appropriately identified may include epidemiology specialists, managers of affected areas for example Prison or custody services, housing providers and

homelessness services, clinicians, pharmacists with expertise in substance use, primary care representatives, education and children's services representatives.

National Partners

Public Health Scotland

Specialists with expertise in drug testing or poisons (National Poisons Information Service)

Scottish Drugs Forum: Have expertise in supporting BBV and infection outbreaks amongst people who use drugs and can provide practical support as well as workforce training.

CREW 2000 - have expertise in harm reduction and working with young people

Appendix 3 Template agenda for a problem assessment group

Problem Assessment Group - Date and Location / name of incident

Meeting details (time, location, link if online)

AGENDA

1. Introductions - Reminder of confidentiality and need for accurate records

1.1 Apologies

2. Declarations of conflicts or interests

3. Purpose of meeting: share local intelligence, agree actions.

4. Incident background and situation update

5. Reporting of intelligence from partners.

6. Risk Assessment

7. Risk Communication

Advice to public

Advice to public sector and third sector

Wider communications

8. Risk mitigation - actions to provide care and support to people at risk

9. Review of actions

10. AOCB

11. Date and time of next meeting

Appendix 4 Template for media holding statement.

MEDIA RELEASE

USE:

ISSUE DATE:

CONTACT:

Key messages

Relevant background information

Actions required.

Supports available.

ENDS

Appendix 5 Standard harm reduction messages

These messages are applicable regardless of the substance type and can be communicated before toxicology information is available. These messages should be adapted by the Problem Assessment Group for the scenario and target audience. Shorter statements may be required to use certain communication channels (e.g. social media, public information and advertising boards etc).

For people who use substances.

Don't use drugs alone, have someone around who can help in an emergency.

Call 999 and ask for an ambulance in an emergency.

Dose low to test the effects.

Go slow wait a couple of hours before taking more.

Avoid mixing substances, and if you do, use much less than normal.

Get naloxone, carry naloxone and know how to use naloxone.

For family or community members who may witness an overdose.

Be aware of the signs of an overdose.

Call 999, ask for an ambulance and stay with the person till it arrives.

Get a naloxone kit, carry it and know how to use it.

Avoid home remedies.

Encourage open, non-judgemental communication.

Appendix 6 Roles, responsibilities and links to professional development frameworks

Organisational roles and responsibilities are **detailed in the management of Public Health Incidents**

This section describes common roles and responsibilities for those involved in incident response to a drug harm cluster. It also describes the training needs. The competencies identified originate in the **Public Health Skills and Knowledge Framework** (PHSKF), a UK wide tool to develop the skills of those working in public health The competencies are designed for all individuals taking part in a public health response regardless of professional background or previous experience. Links are also made to the forthcoming workforce capability framework being produced by Scottish Government for people who provide support to those who use substances. These capabilities reflect the values and ways of working which are required in a drug harms incident and reflect the principles of challenging stigma, working in a trauma informed way and promoting human rights. It is expected that the tables below are used by individuals and organisations to identify the level of expertise required, gaps and set out training objectives. Appropriate learning activities can then be identified and undertaken.

Chair of Problem Assessment Group or Incident Management Team

Key activities for the chair	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
Chair Multiagency meeting.	Measure, monitor and report health needs, drug harms and risks and service use across a population.	Function A1 A1.1, A1.2, A1.3, A1.4 A 1.5	Delivering Family-Inclusive Care

Key activities for the chair	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
Maintain situational awareness. Confirm internal and external communication including communication to the public. Provide key information to Director of Public Health, Public Health Scotland or Scottish Government or other response structure as appropriate. Review agreed actions with group members and assign tasks. Monitor action implementation	Reduce risk by including actions which reflect or target the root causes of drug harms including the wider determinants of health, stigma and the contribution of trauma. Protect the public from drug related hazards whilst addressing inequalities in risk exposure and outcomes. Evaluate actions and interventions to improve reduce the risk of drug related harm. Work collaboratively across agencies and boundaries to identify and respond to a drug harm incident. Provide leadership to drive action and improvement.	Function A2 A2.1, A2.3, A2.6 Function A3 A3.1, A3.2, A3.4, A3.5 Function A5 A5.3, A5.4 Function B2 B2.2, B2.4	Tackling Stigma Providing Harm-Reduction Advice. Taking A Human-Rights Based Approach. Practicing Trauma-Informed Care

Key activities for the chair	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
and adjust as necessary. Monitor use of resources and report needs. Observe group members for signs of stress or emotional difficulty; refer for support if required. Brief relief member at handover / end of shift Plan for demobilisation and debrief following incident	Communicate with others about actions required to reduce risk of drug harms.	Function C1 C1.1, C1.2, C1.3, C1.5 Function C2 C2.1, C2.2, C2.5	

Information or data analysts monitoring drug harms - members of local early warning systems, intelligence or analytical teams in Public Health Scotland, Police Scotland, Scottish Prison Service, Scottish Ambulance Service

Key activities for information or data analysts	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
Database management Validation of reports Using routinely collected data to identify changes in trends of drug harms	Measure, monitor and report health needs, drug harms and risks and service use across a population. Protect the public from drug related hazards whilst addressing inequalities in risk exposure and outcomes. Develop information and intelligence systems and provide informed advice. Work collaboratively across agencies and boundaries to identify and respond to a drug harm incident. Communicate with others about actions	Function A1 A1.1, A1.2, A1.3, A1.4, A 1.5 Function A3 A3.1, A3.4 Function A4 A4.2, A4.3 Function A5 A5.2, A5.4 Function B2 B2.2, B2.4 Function C1 C1.1, C1.2, C1.3, Function C2 C2.2, C2.3,	Delivering Family-Inclusive Care Tackling Stigma Taking A Human-Rights Based Approach. Practicing Trauma-Informed Care

Key activities for information or data analysts	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
	required to reduce risk of drug harms.		

Members of invited to take part in Problem Assessment Groups or Incident Management teams - Primary or secondary care clinicians, harm reduction leads, Naloxone leads, Representatives of assertive outreach services, representatives of third sector providers, Police Scotland, Scottish Ambulance Service. Representatives of lived or living experience participation groups, Public Health Scotland, National Poisons Information Service, Pharmacists, Pathologists, Toxicologists

Key activities for members of problem assessment groups	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
Attend Operational Briefing Assess current needs / demands on service. Provide information and about the incident to assist with the risk assessment and actions.	Measure, monitor and report health needs, drug harms and risks and service use across a population. Reduce risk by including actions which reflect or target	Function A1 A1.1, A1.2, A1.3, A1.4 A 1.5	Delivering Family-Inclusive Care Tackling Stigma Providing Harm-Reduction Advice.

Key activities for members of problem assessment groups	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
Support the development of alerts and communication briefings to organisations and the public. Develop the dissemination strategy for key communications. Receive tactical assignment. Monitor use of existing resources and report needs including escalation within their own organisation as appropriate. Maintain situational awareness. Document actions taken. Ensure that services they represent are clear on what actions need to be taken, by whom and where. Brief relief member at end of shift	the root causes of drug harms including the wider determinants of health, stigma and the contribution of trauma. Protect the public from drug related hazards whilst addressing inequalities in risk exposure and outcomes. Evaluate actions and interventions to improve reduce the risk of drug related harm. Work collaboratively across agencies and boundaries to identify and respond to a drug harm incident. Provide leadership to drive action and improvement. Communicate with others about actions required to reduce risk of drug harms	Function A2 A2.1, A2.3, A2.6 Function A3 A3.1, A3.2, A3.4, A3.5 Function A5 A5.3, A5.4 Function B2 B2.2, B2.4 Function C1 C1.1, C1.2, C1.3, C1.5 Function C2	Taking A Human-Rights Based Approach. Practicing Trauma-Informed Care

Key activities for members of problem assessment groups	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
Support transition to longer term change required across services		C2.1, C2.2, C2.5	

Administrative support for Problem Assessment Group or Incident Management Team

Key activities for people providing administrative support	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
Document key decisions and the rationale for the decision, including options considered. Maintain an action log.	Communicate actions required to reduce risk of drug harms.	Function C1 C1.1, C1.2, C1.3 Function C2 C2.2	Practicing Trauma informed care Tackling Stigma

Communications lead.

Key activities for people providing communications support	Suggested technical competencies	Links to PHSKF	Links to Scottish Government Capability framework for people working in substance use
Focal point for communication activities Support Problem Assessment Group Chair in communicating key information. Provide technical expertise on messaging, and appropriate channels to reach target audiences.	Communicate actions required to reduce risk of drug harms.	Function C1 C1.1, C1.2, C1.3 Function C2 C2.2	Practicing Trauma informed care Tackling Stigma

Appendix 7 Key stakeholders for pre-incident planning.

Public health teams should identify and connect with individuals who are likely to be involved in or affected by a drug cluster incident. This list is not exhaustive.

Scottish Ambulance Service

Police Scotland

Emergency Departments

Harm reduction and Drug treatment services. This includes statutory health and social care providers, third sector providers and includes any residential rehabilitation facilities operating locally.

Prisons and custodial settings

Housing providers, including those providing temporary accommodation

Community pharmacy

Peer naloxone providers

People with lived and living experience and family members of people with problematic drug use

Recovery community leaders and peer recovery leaders

Schools, community groups and faith-based settings.

Organisational Communications leads

Local Resilience Partnership leads and Emergency Planning Officers

National Commissioned Organisations including - CREW 2000, Scottish Drugs Forum, Scottish Families Affected by Alcohol and Drugs and Scottish Recovery Consortium (local or regional representatives may be available).

Links to statutory frameworks

The Civil Contingencies Act 2004: The Civil Contingencies Act 2004 and Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Amendment Regulations Scotland 2005 and 2013, delivers a single framework for civil protection in the United Kingdom. The Act is separated into two substantive parts: local arrangements for civil protection (Part 1) and emergency powers (Part 2). Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level.

The Public Health etc (Scotland) Act was passed in 2008 and sets out the public health duties of Scottish Ministers, NHS boards and LAs. Scottish Ministers have a duty to protect public health i.e. to protect the community from infectious disease, contamination and any other hazards that constitute a danger to human health. This includes the prevention of, control of, and provision of a public health response to such disease, contamination or other hazards.

When a Major Incident has been declared), NHS boards (including Scottish Ambulance Service and Public Health Scotland), Police Scotland and the Scottish Government will be working to the local plans based on the principles set out in 'Preparing Scotland'.

An incident that takes place in a single NHS board or LA might also escalate sufficiently to necessitate declaration of a Major Incident and activate the NHS Board Major Incident Plan and/or the Regional Resilience Partnership / Local Resilience Partnership plans including arrangements for a Scientific and Technical Advice Cell (STAC). If the Resilience Partnership request that the Director of Public Health convene a STAC, the investigation and management of the public health dimensions of an incident can be developed in line with this guidance.