BACKGROUND

Taskforce members were asked to consult with others and seek their suggestions for responses on how best to approach or tackle drug deaths in the short term.

The question asked was:

- "What one thing would you recommend that we could do now to stem the rise in Drug Related Deaths we are experiencing in Scotland?

  Prioritise any responses you receive to a maximum of 5 ideas"

SUMMARY

Over 275 suggestions were received via academics (via the Drug Research Network), health and social work professionals, Alcohol and Drugs Partnerships and third sector partners.

The vast majority of suggestions were received through outreach with recovery communities across Scotland via the Scottish Recovery Consortium and others.

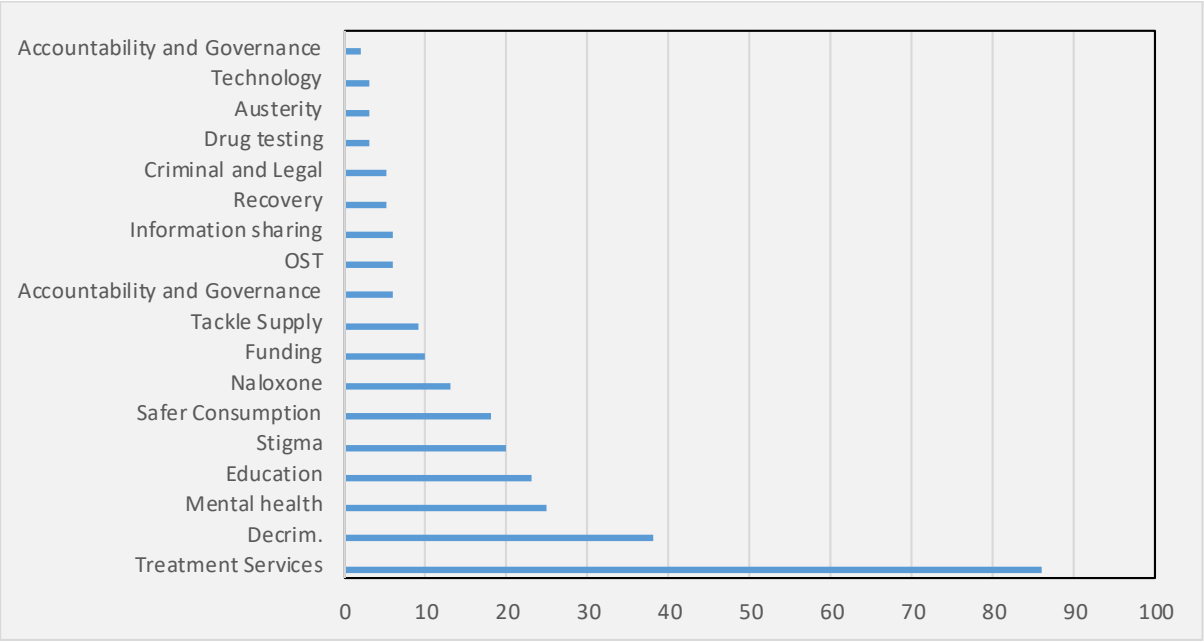
The table below summarises the responses by respondent.

Respondent Group	Responses
Lived Experience (Including families)	240
Health and Social Work Professionals	40
Academics	10
ADP	9
Police	1

Please note there are overlaps between these categories.

The responses were grouped thematically into a number of categories covering areas ranging from the provision of education, decriminalisation, safe consumption rooms, to mental health and addressing stigma:

- **86 responses** focused on the availability of, access to, or need for improvement to current treatment services.
- **38 responses** recommended decriminalisation or legalisation and regulation.
- **25 responses** Called for greater integration or availability of mental health services to be offered to those with addiction issues.
- **23 responses** suggested more should be done to educate school age children of the dangers of drugs or provide more information to current users on the dangers of drugs use. In particular those associated with Street Valium or benzodiazepine use.
- **20 responses** stressed the importance of addressing and reducing the stigma around drug addiction in society and in services.
- **18 responses** supported the implementation of safer consumption rooms.
- **13 responses** recommended the expansion and improvement of Naloxone
- **10 responses** called for funding to be maintained or increased.
- **9 responses** suggested tougher police and legal action on those producing and supplying illicit substances.
- **5 responses** Called for a greater role for the recovery community in tackling addiction.
  6 responses related to information sharing and trend monitoring.
- **6 responses** related to OST.
- **5 responses** address the criminal and legal systems.
- **3 responses** called for drug safety testing facilities.
- **3 responses** highlighted the impact of Austerity with one calling for a concessionary travel scheme for those in treatment/recovery to help them make appointments/meetings.
- **3 responses** suggested technological solutions.
- **2 Responses** sought greater accountability.



A more detailed summary of potentially actionable suggestions follows:

TREATMENT SERVICES

General

- more consistency in treatment options available across services
- social prescribing.

Greater Integration and Collaboration Between Services

- ensure ADPs co-ordinate local implementation of staying alive in Scotland.
- policy requires to be implemented Nationally and examples of good practice across cities shared to other ADP/Local Authorities/ third sector Organisations
- reduce the disconnect between national policy, local implementation and front line services.
- clear leadership and direction required from SG to ensure drug related harm/deaths is prioritised and is seen as a symptom of the causes in relation to poverty, inequality and social isolation.
- great deal of good work taking place across Scotland however there is no systematic way to share that learning and potentially upscale reach and/or provision. Ensure clear lines of accountability and governance between national, local and delivery elements across statutory and third sector partners.
- greater collaboration and communication between services, specifically specialist substance misuse services, pharmacies providing opioid substitution therapies, and hepatitis c (HCV) treatment services.
- more integration between services.

Access to Services

- direct access to services. Pathways too complicated for service users: Every service user has a number of hurdles to overcome to access services. People with multiple complex needs cannot engage in these lengthy processes and are struck off by statutory services stating non engagement.
- if services where direct access then when the service user is requiring intervention at the point they need it the most they could access support immediately.
- service users have to wait on beds being available and many of them continue with chaotic lifestyles until support is made available to which point they may no longer wish to access the service. Asking service users under the influence of substances to keep appointments Monday to Friday is a big ask.
- barriers to people accessing services should be removed wherever possible. This should include: lowering service thresholds where possible (“no wrong door”); providing support for travel; decentralising and making services available locally; accessible 24 hours a day; meaningful engagement with people to understand what they need and the barriers they face

Maximise Opportunities for Engagement Creating Holistic Services

- providing funding to establish or extend “Hubs” and “one stop shops” is a key priority action for reducing drugs deaths. Evidence clearly suggests that

adopting a purely clinical approach to tackling a person's drug use will not be effective without tackling other factors affecting or driving that drug use.

- establishing spaces that are able to adopt a holistic approach to working with people and that link them in to other services would increase the potential for harm reduction approaches as well as improving engagement in recovery services where appropriate.
- key services that should be available include mental health, benefits, money advice, employability, accommodation, legal advice, independent advocacy.
- more generally, we need to ensure that we are connecting people accessing voluntary sector services to all the other services they might want or benefit from.

Rapid Prescribing Service

- a rapid prescribing service that targets people at most risk and provides the medication they need on the day. This might include ORT, Benzos (Alcohol? HAT?)
- not a new service in a fixed premises – this service will be delivered through existing drug services and will integrate with services for people who are homeless, leaving institutions, escaping domestic violence etc. (Mandy's example in Glasgow). It will make use of existing mobile units/outreach services and explore developing more such services
- the medical intervention will be provided alongside clear routes in to ongoing support – we do not want to 'park' people on medication but we do need this service to address the most pressing need

Realign Balance Between Services

- realign the balance between harm reduction, opiate treatment, community based rehabilitation programmes and recovery communities.
- the importance of relationships between workers in Statutory services and the service user. Clearer and more robust links need to be made between statutory and voluntary sector partners to ensure a streamline system can be developed.
- third sector partners can, at times be the conduit and link between the individual and statutory services.

Commissioning

- current commissioning of services was highlighted as a potential barrier to reducing drugs deaths. Decision making powers, particularly statutory domination of commissioning decisions, was identified as a significant problem. This is reinforced by the use of procurement processes and tenders that do not accurately reflect the needs of service users. We need to ensure that voluntary sector and service user voice is included in local and national commissioning processes and that commissioning is based on outcomes, not targets. The voluntary sector can currently see gaps that statutory services are missing.
- this is not just about resources – rehab services were cited as an example where spaces are available and resources are there but we are still seeing high numbers of deaths. The problem is therefore with processes and systems and we need to adopt a fuller understanding of commissioning that

looks at the whole picture, included allocation of resources and assessment of need.

Enhanced Drug Treatment Services

- enhanced Drug Treatment Services involve providing prescribed diamorphine under supervised conditions to people with long-standing heroin addiction and multiple complex needs.
- service users with a long term use of Heroin and who have unsuccessfully managed to remain in treatment for long periods would be identified to use this service. Service users should feel safe and be monitored by nursing staff and other social interventions applied at the point of commencing treatment.

Needle Exchange Provision

- expand Needle Exchange Provision: Out of hours provision (including weekends) is limited across the country and in particular more rural areas.
- procure and introduce a mobile IEP van to operate within the heart of every city centre between the hours of 6-10 pm 7 days per week. Opportunity to engage and build relationships, Increase naloxone provision and Increase access & retention in services. All support providers to promote IEP to ensure as many service users are aware of the support available to them out of hours.

Abstinence Based Rehabilitation Services

- increase investment in the number and availability of residential abstinence based rehabilitation facility beds.
- increase number of abstinence based community services.

Community Services

- re-establish local community drug services lost over the last 20 years to insecure funding.
- each community across Scotland should have a safe space for service users to use a type of hub where all their needs can be addressed in the one place. Statutory services could be based in these hubs where all needs are met.

Rapid access to treatment and support

- As an urgent action we could create ‘crisis protocols’ in willing prescribing services. When people present or are referred to the service a very quick focussed assessment is undertaken to identify those at greatest risk of a drug related death. Those who are not at immediate risk will continue through the usual assessment process. Those who are at high risk will be seen by a prescriber there and then to discuss and agree their ORT programme.
- Importantly, they will also meet with their social care worker on that day so that they can start to build the therapeutic relationship that makes ongoing engagement in the service more likely and can start the psycho-social support that improves the effectiveness of the ORT programme. It is essential that this support is holistic and considers the range of drivers behind that person’s problematic drug use; the medication will only help with one of those drivers.

Increased Treatment Choices

- increased choice of treatment and low threshold support that prioritises access, retention, a 'no unplanned discharges' policy; optimised OST; psychological treatments; assertive outreach; involvement of peers, primary care and shared care models.

Trauma Informed Care

- provide practical support for the implementation of training in trauma-informed care for all staff in all public services in Scotland. This should include backfill for attendance, support for staff whose work with traumatised patients/clients can have an impact on their own mental health and wellbeing, and resources to trauma-informed care to be delivered in practice.

Postcode Lottery

- postcode Lottery in relation to services. Very few local authorities have access to crisis services. Bigger cities to have more crisis beds with direct access. Whilst there is a clear drive to focus on recovery in communities by communities it is clear from partners today there is still a vital need to provide residential care for those who need it.

Lived Experience

- contribution should be sought, at all times, from individuals at a different range of recovery – the third sector have a range of networks across Scotland and can support this process.

Gabapentinoids

- Early identification of users of Gabapentinoids which appear to be present in an increasing number of Drug Related Deaths- within the custody setting, briefing of staff to raise awareness of risk and making appropriate referrals either to Healthcare professionals or third sector agencies;

Vulnerable Individuals

- consider recognition of relevant people that have experienced non-fatal overdose (NFOD) as a vulnerable person to ensure assertive outreach / follow up and multiagency support.
- establish a national non-fatal overdose alert system (based on local experience) in partnership with Scottish Ambulance Service. This could link to a crisis intervention pathway that provides flexible and integrated treatment and support delivered in partnership with primary care, specialist services, third Sector and peer support.
- Practical consideration of child protection issues, bereavement, health diagnosis as heightened risk factors where support requires to be intensified.

DECRIMINALISATION

- though often narrowly assessed in reference to its decriminalization law, Portugal's experience over the last decade and a half speaks as much to its free public health system, extensive treatment programs, and the hard to quantify trickle down effects of the legislation.
- in a society where drugs are less stigmatized, problem users are more likely to seek out care. Today, Portuguese authorities don't arrest anyone found holding what's considered less than a 10-day supply of an illicit drug — a gram of heroin, ecstasy, or amphetamine, two grams of cocaine, or 25 grams of cannabis. Instead, drug offenders receive a citation and are ordered to appear before so- called "dissuasion panels" made up of legal, social, and psychological experts. Most cases are simply suspended. Individuals who repeatedly come before the panels may be prescribed treatment, ranging from motivational counselling to opiate substitution therapy. This is the model that Scotland should approach.

GREATER INTEGRATION OR AVAILABILITY OF MENTAL HEALTH SERVICES

- Full integration of mental health and treatment services with rapid access to crisis intervention including out with Mon-Fri 9-5 services. OOH/Weekend and holiday access required.
- multi-agency crisis intervention / outreach workers / teams that include peer workers as essential to proactively support hardest to reach, vulnerable and isolated individuals/people released from Prison / homeless people with drug and alcohol problems.
- improve access to mental health services to address the root causes of individual drug use.
- ensure non-judgemental services are available 24/7 (or at times of most frequent drug use) in areas of known drug use (city centres etc.) to provide support to drug users including counselling, advice, sharps disposal and clean supplies. This would ensure that there is a safe space available and free advice and support if people wish to access it.
- remove the barriers for service users affected by substance misuse to access mainstream mental health services by absorbing dedicated but resource limited CADS/SMS addiction teams within the wider mental health teams.
- provide emergency crisis management to all non-fatal overdoses including an intervention package of: naloxone, information on high risk drug use (including poly drug use and street benzos), mental health assessment, rapid access to treatment if not already in treatment.
- tackling the underlying causes of drug-taking - improved mental health services and early identification and education of those likely to be at risk in the future; start at primary school and then at secondary, with input from people with 'lived experience' and associated credibility.

EDUCATION AND MEDIA

- make it compulsory to include “if you have been affected by” messages in media articles about drug deaths or substance misuse. linking to helplines and support services.
- support a national programme of drug education for school age children covering the risks of drug abuse.

- Consistent high quality prevention and education in schools and communities that actively involves parents / carers in a whole community approach to preventing and reducing harm. Education in schools requires to be based on evidence of what works and should be fully embedded into personal social education curriculum including sharing support resources for pupils who have parents that use substances. Need to take a family focused / whole family approach to prevention and education. Partnerships between schools, youth workers, parents / carers, leisure providers.
- work to reduce the stigmatisation of drug users in the media.
- experts from education should be included on the reference group and that the development of an education programme for schools might be beneficial
- National anti-stigma and overdose prevention campaign that encourages the public to recognise symptoms, learn basic skills and use intra-nasal or intramuscular naloxone. Naloxone packs could be held in communal sites similar to defibrillators. Local naloxone pop ups in areas with higher levels of drug deaths could support the campaign. Useful to learn from the achievements of See Me campaign. Suggestions for an anti-stigma campaign linked to OD prevention e.g. Your Life Matters, Language Matters, Family Matters, Saving Lives Matters, Inclusion Matters, Compassion Matters, Recovery Matters and son on.

STIGMA

- problematic drug use is a health condition. The causes of problematic drug use often derive from people's experience of poverty and social deprivation.
- People who need support for their drug use deserve the same human rights, respect, dignity and attention as people experiencing any other health condition.
- The best function of the Task Force would be to provide effective leadership to galvanise the sector in Scotland to achieve a consensus.
- lived experience and the voices of those people with lived experience of drug related deaths should be welcomed. It is vital the experiences of bereaved families and loved ones should respected and valued as they
- would be in any other public health crisis. Marginalisation of families affected directly by drug related deaths will serve only to distance the professional sector from population it serves.

SAFER CONSUMPTION ROOMS

- drug consumption rooms should be piloted in an effort to reduce the record number of drug-related deaths in Scotland. DCRs are supervised medical facilities present in seven European countries where drug addicts can take illicitly obtained heroin and cocaine safely, as well as being directed to social, health and recovery services. There have been no recorded deaths in a DCR.
- the government has faced criticism for cutting funding for addiction services while pursuing a criminal justice approach to drug use at a time when other countries are increasingly adopting public health approaches. We need to be brave and support drug addicts and misusers into recovery, but the current approach stifles progress.

NALOXONE

- all IEPs to provide naloxone, all police to carry naloxone and emergency kits to those in need. Large scale pilot to establish the effectiveness and acceptability of nasal naloxone. There are now two licensed take home naloxone products available. Prenoxad Injection and Nyxoid Nasal Spray. All aspects of the naloxone programme currently related to the supply of Prenoxad Injection.
- Nyxoid may be more appealing as a product to use, however individuals being administered nasal spray may experience greater withdrawal and for a longer period of time. Individuals will require education relating to both products.
- people leaving prison in particular identified as key targets for naloxone training and provision given the increased risk of overdose and death in the immediate period following release from prison.
- uptake of naloxone training and use might be facilitated by increasing the use of nasal naloxone over intra-muscular delivery. This delivery method is much simpler and also smaller, so is more portable and potentially less stigmatising. Currently nasal is a bit more expensive that intramuscular but not considerably.
- make mandatory naloxone and naloxone training available anywhere people are accessing OST, in order to maximise opportunities for preventing fatal overdoses.
- staff of HMOs or homelessness services are not required to undergo training in naloxone use – some areas have offered the training but take up as been low. We should also consider making this mandatory.

INFORMATION SHARING AND TREND MONITORING

- create a Scotland wide information sharing agreement with the Scottish ambulance service to share information on non-fatal overdoses with local alcohol and drugs and recovery services to allow assertive outreach.
- the implementation of a comprehensive Scotland-wide early trends monitoring and reporting system of health-related harms. this is linked to improving the timing and notification of post-mortem and toxicology results.
- we need a national drugs database that captures results from NHS toxicology (incl. A&E and drug related deaths), Police Scotland seizures, Scottish prison service seizures and research and drug checking services. this will provide accurate info to inform harm reduction messages for PWUD, drug related deaths responses, and drug trends.
- reluctance to share information and the lack of availability of data and personal information were identified as a consistent problem. Some areas are open and willing to share information but availability of data and personal information is inconsistent. Current GDPR regulations do not prevent sharing of information on those at risk of death and there was a suggestion that the information commissioner has previously stated that this is acceptable. Clarifying the legal position and introducing a briefing to update partners could potentially be a quick solution.
- a key driver for action should be data relating to “near misses”, i.e. using information on non-fatal incidents to drive engagement with people at risk of drugs deaths. An example cited of this was Addaction’s use of search and recovery programmes following reports of disengagement from

services/"disappearing" to attempt to re-engage people in services before they overdose.
- Housing First approaches suggested as a response to non-fatal incidents and could be used as a spur to get people out of high risk environments into supported accommodation.

OST AND THE SOCIAL MODEL OF TREATMENT

- cap methadone treatment with a plan to reduce dosage.
- take a maintenance approach as opposed to a substitution based approach.
- ensure that all pathways are ROSC orientated and focused on stabilisation and reduction of opiate prescriptions rather than long time maintenance plans.
- adopt a social model of treatment and not a medical model: Placing someone on ORT is only one symptom of their addiction. Once on ORT many service users are excluded from society and have no social capital to build on.
- Services users then return to their community of drug use as its all they know. by introducing service users to other service users with past experiences could assist in this.
- resources should be made available at the point of ORT commencing that can deal with a multitude of issues such as housing criminal justice system, trauma counselling, benefits help and assistance.

CRIMINAL AND LEGAL SYSTEMS

Local Policing

- Adopt an assertive outreach model in line with Operation Threshold initiative in Edinburgh.
- Integrate this approach into Recovery Hubs.

Custody Centres

- introduction/Expansion of link-workers in custody centres to engage with substance abusers and assist in introducing them to appropriate support workers following release from custody
- work with healthcare partners to ensure 'Take Home Naloxone' training is provided in every custody centre as appropriate

Leaving Prison

- more money to be placed into follow up care once a client leaves prison or drug services or hospital connecting outreach workers to service users: Using assertive outreach for the most complex and vulnerable service users when they need it the most.
- by having ongoing support once they leave services or prison is likely to reduce re offending, and unsafe drug using practices. Having one positive relationship with outreach workers gives the service user an opportunity to engage in other opportunities and link into community resources.
- outreach should also come from statutory services and instead of the client attending appointments or having to cross cities using public transport why do services not outreach to them. This could increase health interventions both

physical and mental health, housing opportunities and social needs for the individual.
- all prisons to provide naloxone on liberation to prisoners known to have a history of drug taking. The Naloxone kit should be redesigned to be fit for purpose.

Enforcement
- Address the pervasive nature of illicit benzodiazepines. 675 of the recorded deaths in 2018 had such substances present.
- Review classification of benzodiazepines.

IMPACT OF AUSTERITY AND AVAILABLE BENEFITS

Concessionary Travel for Those in Treatment
- concessionary travel would assist those with chaotic lives or suffering financial instability access to services and treatment.

TECHNOLOGY
- a more considered use of technology could provide an opportunity to reduce drugs deaths. Smart living and smart bed technology were identified as potential tools to prevent incidents/overdoses from being fatal.
- current trials underway of smart beds that monitor a person's breathing and heart rate, which could help to prevent overdoses in residential facilities or homeless service accommodation.
- the Good Sam app was identified as a potential opportunity for reducing drugs deaths. This app is available in London and aims to reduce deaths from cardiac arrests by sharing the location of people having heart attacks with registered first responders/first aid trained people in the immediate area so that they can provide CPR while an ambulance is on its way. A version of the app could be developed focusing on drugs overdoses and connecting people with naloxone training.

ACCOUNTABILITY AND GOVERNANCE

Improving Accountability and Governance
- local planning and accountability could be improved by developing local drug death targets.
- Through establishing ambitious local targets, partnerships would be able to rearrange local plans and activities to achieve reductions in drug deaths.
- This could be incentivised through the £20mn additional funding that SG has set aside to tackle the issue and funding could be linked to driving improvements following the publication of a new plan.
- This would need to be underpinned by a focus on evaluation and appropriate indicators would need to be developed.

Review Activity
- consistent and considerable feedback has been received about the inconsistency of approach within local areas after a drug death. Even in areas where good multiagency practice exists there is a common lack of

accountability, a narrow focus which does not always capture the broader mental health or human rights obligations and almost without exception apportions varying degrees of blame to the drug user.

- the appointment of a national figure qualified and mandated to review and publish findings with comments on the efficacy of practice and recommendations for improvement would be an impactful, proportionate and significant response to what is a National public Health Emergency.