PREVENTION AND TREATMENT OF SUBSTANCE MISUSE
Delivering the Right Medicine:
A Strategy for Pharmaceutical Care in Scotland

A REPORT OF A JOINT WORKING GROUP
OF THE NATIONAL PHARMACEUTICAL FORUM /
SCOTTISH MEDICAL AND SCIENTIFIC ADVISORY COMMITTEE
TERMS OF REFERENCE

The Group was set up to explore ways to maximise the contribution of pharmacists to services for substance misusers in Scotland and to report on the findings to the Chief Pharmaceutical Officer.
EXECUTIVE SUMMARY

This report, which has been prepared for the Chief Pharmaceutical Officer by a Joint Working Group of the National Pharmaceutical Forum (NPF) and the Scottish Medical and Scientific Advisory Committee (SMASAC), sets out the present and future role of pharmacy in the provision of services to substance misusers. It does so within the context of current policy and covers health promotion, health education and harm reduction in relation to the misuse of illegal drugs, prescribed and over-the-counter medicines, volatile substances, smoking and alcohol.

Pharmacists, as part of a team of healthcare professionals, have a key role to play in providing services to substance misusers. They also act as a signpost to other relevant services. For some years now, pharmacists in Scotland have been engaged in the provision of smoking cessation services, the supervised self-administration and ingestion of methadone, and pharmacy-based needle exchange schemes. These areas of activity are the most well-known and the most publicised areas of involvement. There are many other areas in which pharmacists can, and do, contribute to the wider field of preventing and treating substance misuse. Some of these areas have been made possible as a result of changes in legislation and the changing context in which healthcare is being delivered to the Scottish population.

Key drivers for change include:
- publication of *The Right Medicine* – Scotland’s strategy for pharmaceutical care
- the extension of prescribing rights and the introduction of supplementary prescribing
- the new community pharmacy contract
- publication of the consultation paper on *Modernising NHS Community Pharmacy in Scotland*
- the establishment of ePharmacy to oversee the development of information technology
- UK-wide developments such as the recommendations flowing from the Shipman Inquiry.

This report encourages NHSScotland and other agencies to take advantage of the opportunities to engage pharmacy more fully in the planning, provision, delivery and extension of services for substance misusers. These areas of activity include:
- The adoption of a more proactive approach to health promotion, health education and harm reduction.
- Engagement with local communities, especially schools.
- Engagement with the general public to challenge perceptions about substance misusers.
- The need to recognise leading partnership practice.
- The need to explore new ways of delivering services [e.g. outreach via non-traditional pharmacy premises such as hostels for the homeless].
- The need to identify patients who are ready to move on from the daily supervision of self-administration of methadone to some other type of arrangement.
- The need to encourage improved provision of pharmacy-based needle exchange schemes.
- Increased participation in multi-agency, multi-professional education and training.

Two of the main recommendations relate to the inclusion of senior pharmacy representation on Drug and Alcohol Action Teams and access to specialist pharmacist advice on all areas of substance misuse. Pharmacy makes a considerable contribution to the prevention of substance misuse and the care and treatment of misusers, but there are significant opportunities to improve and develop these services. It is, however, essential that pharmacists are involved in strategic and operational planning, and that implementation is supported by
pharmacists with specialist knowledge of substance misuse and its treatment.

The emphasis is very much on partnership working, that is, the pharmacist working in tandem with other relevant agencies to deliver a consistent, high standard of service which recognises state-of-the-art leading practice and utilises to the full the particular knowledge and skills that pharmacists and other members of the healthcare team can bring to this vital area of work.

As a first step, it is recommended that the Scottish Executive Health Department should establish a series of integrated care pilots, based on the principles of the pharmaceutical care model schemes, to encourage these activities and to accommodate the different needs of substance misusers within local populations.

The exact nature of these pilot schemes and the mechanism by which they will be set up and funded will be subject to further discussion within the Scottish Executive Health Department.

Lyndon Braddick
Chairman of the Working Group

June 2005
SUMMARY OF MAIN RECOMMENDATIONS

DEVELOPMENT OF NATIONAL AND LOCAL POLICY
1. The Scottish Executive Health Department and other relevant agencies should ensure that the profession of pharmacy is fully engaged in the development and review of national policies relating to substance misuse.

2. NHS Boards, in conjunction with their local Drug & Alcohol Action Teams (DAATs) should ensure that the profession of pharmacy is fully engaged in the development of policy and the planning of services through representation at a senior level on every DAAT.

3. NHS Boards and pharmacy contractors should have access to specialist pharmacist advice in relation to formulating and implementing national and local policy on pharmaceutical services for substance misusers.

SERVICES TO SUBSTANCE MISUSERS
4. The concept of a patient-specific “multi-agency agreement” incorporating a pharmaceutical care plan should be developed for use in NHSScotland and incorporated into all integrated pharmaceutical care services for substance misusers.

5. NHSScotland and other agencies should take advantage of opportunities offered by pharmacist prescribers and the new community pharmacy contract to engage pharmacy more fully in the planning, provision, delivery and extension of services for substance misusers.

6. Pharmacists should adopt a proactive approach to health promotion, health education and harm reduction. Support should be provided to ensure that pharmacists have access to accurate information which is up to date and consistent.

7. NHS Boards should consider building on the success of supervised self-administration of methadone by extending the concept to other treatments and areas of substance misuse.

8. NHS Boards should ensure equitable access to pharmacy services for substance misusers, particularly for the homeless and for ethnic minorities.

COMMUNICATION
9. National and local networks of pharmacists providing services for substance misusers should be established. These networks should be facilitated by specialist pharmacists in substance misuse.

10. All members of healthcare teams should ensure a regular exchange of information both of a clinical and a “street” nature. This information should reflect local practice and trends.

11. NHSScotland and the Scottish Prison Service (SPS) should explore arrangements for the integrated and consistent pharmaceutical care of substance misusers.

EDUCATION AND TRAINING
12. Education and training in substance misuse should be conducted on a multidisciplinary, multi-agency basis. Pharmacists should be afforded every opportunity to attend meetings/seminars in order to develop and promote a team approach to patient care.

13. NHS Boards, with the support of Local Authorities and police services, should organise public education campaigns advocating the benefits to the community of providing pharmacy-based services to substance misusers.
14. Engagement with local communities, especially schools, should be encouraged and facilitated.

**RESEARCH AND DEVELOPMENT**

15. Pharmacists should be encouraged to engage in research to improve the range of treatments available for substance misuse. They should also be encouraged to engage in multi-disciplinary practice research aimed at increasing the effectiveness of service delivery.

**FURTHER WORK**

16. Consideration should be given to exploring the issues surrounding the misuse of prescribed and purchased medicines.
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CHAPTER ONE:
INTRODUCTION
INTRODUCTION

1. Since July 1999, Scotland’s health has been a matter for the Scottish Parliament. Devolution has brought about many changes, including the way in which the National Health Service functions in Scotland. Patients are already benefiting from the publication of *The Right Medicine*¹, the Scottish Executive Health Department’s (SEHD’s) strategy for pharmaceutical care. This document, which contains 60 actions in five main areas, has opened the way for pharmacists and their staff to be more integrated within the healthcare team and to offer a greater and more extensive range of services than ever before.

2. The five main areas in *The Right Medicine* are concerned with improving health, improving access, helping patients to make better use of their medicines, service re-design and workforce planning. These areas will form the basis for the new pharmacy contract in Scotland which, in turn, will help to deliver strategy by focusing on the nature and quality of pharmaceutical care.

3. A separate document, *Pharmacy for Health: The Way Forward for Pharmaceutical Public Health in Scotland*, (December 2002)² builds on and complements *The Right Medicine*, taking forward the development of the profession to benefit the people of Scotland. It explores the numerous opportunities to develop and enhance the profession’s involvement in delivering the health improvement agenda through the efforts of pharmacists working in the community and in hospitals, and of specialists who work within multidisciplinary public health teams. Several references to services for substance misusers are contained in the report.

4. The consultation document, *Modernising NHS Community Pharmacy in Scotland*,³ issued in April 2004, outlines the Executive’s proposals for legislation that will allow the NHS in Scotland to deliver a number of the community pharmacy objectives set out in *The Right Medicine*¹ and, in particular, to support the future implementation of the new community pharmacy contract. Among other things, it will help to ensure that service provision is based on locally identified care needs and that patients have convenient access to a full range of services. It also clarifies and extends the current pharmaceutical list and control arrangements to allow for innovative ways of providing dispensing and supply services giving patients and pharmacy contractors greater flexibility in the way that pharmaceutical care services can be accessed and delivered.

BACKGROUND

5. Scotland has had a considerable drug problem for several decades. Recent data has revealed that:
   - Between 4% - 6% of all children under 16 have a problem drug-using parent⁴
   - 19% of 15 year olds and 6% of 13 year olds take illegal drugs (mainly cannabis)⁵
   - Approximately 51,582 individuals take opiates and benzodiazepines⁶
   - Half of all recorded crime is said to be drug-related⁷
   - An average of 8 people die each year in Scotland from volatile substance abuse. Many of them are under 18 years of age⁸
   - 33% of adult men and 15% of adult women exceed the recommended weekly alcohol consumption limits⁹
   - One in four Scottish women admit that they binge drink⁹
   - 20% of 13 year olds (boys and girls), 46% of 15 year old girls and 40% of 15 year old boys reported drinking alcohol at some time during the past week prior to a survey that was conducted in 2004⁵
   - At least 20-25% of deaths in Scotland are due to smoking: 11,600 to 14,500 in 2002¹⁰
   - Around 1.2 million people smoke – 30% of the adult population¹¹
   - About 25% of girls and 16% of boys are regular smokers by the time they are 16¹¹
   - A quarter of women smoke during pregnancy with serious consequences for their children’s health¹¹
6. These statistics suggest that substance misuse has a significant effect on the nation’s health. For example, more than half of Hepatitis C cases are estimated to be directly attributable to drug misuse; a significant number of short-term admissions to hospital are alcohol-related and smoking is a major cause of coronary heart disease (CHD), stroke, several types of cancer, chronic obstructive pulmonary disease and premature death. It is well known that there is also a link between alcohol and accidents (including road traffic accidents) and violence (including domestic violence).

7. The misuse of drugs is pervasive. It affects all sectors of society. Numerous factors, which may be genetic, environmental, psychological, neurochemical and pharmacological, are said to influence risk of addiction to legal and illegal drugs. In the case of some illicit drugs, (e.g. cocaine), the nature of the drug or substance has changed rapidly which makes it very difficult to predict what will happen in the future. Pharmacists play an important part in controlling the availability of medicines and other substances liable to misuse through the implementation of legislation such as the Misuse of Drugs Act and the Medicines Act.

8. Pharmacists provide general information and advice about substances liable to misuse and the associated risks to children and young people, parents and adults. Substance misusers are advised on harm reduction, including safer injecting, alternatives to injecting, safer sex and wound treatment. Pharmacists also refer people to other services and to sources of information and advice.

**REMIT**

9. The present multidisciplinary Group was established by the National Pharmaceutical Forum (NPF) and the Scottish Medical and Scientific Advisory Committee (SMASAC) as part of the process to drive forward the pharmaceutical strategy with the intention that its deliberations and recommendations would embrace the Joint Future Agenda.

10. The remit of the Group originates directly from one of the action points contained in *The Right Medicine* namely to explore ways to maximise the contribution of pharmacists to services for substance misusers in Scotland and to report on the findings to the Chief Pharmaceutical Officer. In particular, the Group was asked to:

- review current service provision
- explore opportunities for new services
- consider strategic and practical issues, and
- advise on an integrated pharmaceutical care model for substance misusers.

11. The term “substance misuse” encompasses a wide variety of behaviours with different characteristics and relates chiefly to the misuse of illicit drugs [mainly opiates and psychostimulants], prescribed medicines, over the counter (OTC) medicines, volatile substances, alcohol and nicotine.

**METHODOLOGY**

12. The Working Group met on seven occasions between March 2003 and June 2004. The Group, which was multidisciplinary in composition, included representation from the medical, pharmacy and nursing professions as well as representatives from Social Work Services, the Drug Action Team Association, Scottish Drugs Forum (SDF), the police, the Scottish Prison Service (SPS) and the Scottish Executive Health Department (SEHD).

13. Contributions were invited from a number of individuals and organisations in order to inform the work of the Group. A list of acknowledgements is given in Appendix II. Attempts were made to take on board user participation via the Scottish Drugs Forum and other user groups but it was not possible to undertake a fully representative Scotland-wide survey given the timescale and the resources. The Group did, however, take account of previous research identifying the barriers that substance misusers experienced in accessing services when making its recommendations.

14. The Group would also wish to thank Professor Christine Bond, (Consultant in Pharmaceutical Public Health, NHS Grampian) and colleagues for permission to make use of material from a report entitled *Drug Misuse*.
and Community Pharmacy: Issues for Pharmaceutical Care. This report, which was prepared for the Scottish Specialists in Pharmaceutical Public Health (SSiPPHs), focuses specifically on illicit drug use. It is more restricted in scope (but also more detailed) than the present report. To a certain extent it covers similar ground and should be read in conjunction with the present report in order to give the reader a fuller understanding of the issues involved.

**KEY AIMS OF THE REPORT**

**KEY AIMS**

To improve patient care and the quality of pharmaceutical services to substance misusers in line with the principles contained in *The Right Medicine*.

To emphasise the contribution of pharmacy, as a team player, in tackling substance misuse.

To give examples of agencies working in partnership.

To highlight areas for future development.
INTRODUCTION
15. Over the years, there has been a growing recognition that the energies, commitment and professionalism of all agencies concerned with substance misuse have to be harnessed in order for all the issues to be effectively addressed. A Ministerial Task Force report identified the roles that statutory and non-statutory bodies can play in the prevention of substance misuse and the provision of services for substance misusers. Its recommendations place particular emphasis on the delivery of a co-ordinated, multi-agency approach involving local communities. This approach is very much in line with the current Joint Future agenda and will help to provide more effective services.

SUMMARY OF NATIONAL POLICY
16. This chapter summarises current policy in relation to drug misuse, alcohol and smoking. Although all three areas are covered in separate sections, each subject is seen as part of a single spectrum of substance misuse which requires a co-ordinated multidisciplinary response.

DRUG MISUSE
17. The first National Prevalence Study into Drug Misuse estimated that in the year 2000 there were 55,800 individuals in Scotland using opiates and benzodiazepines (heroin, temazepam, methadone, etc). Out of that figure, 22,805 were injecting drug users and 10,000 were infected with Hepatitis C. A follow-up study which estimated the prevalence of problem drug use in Scotland in 2003 found a small but statistically significant fall in numbers to 51,582 individuals. The overall figure for the number injecting opiates in 2003 was 18,737. Around 24% of schoolchildren have misused drugs at least once, with about half of these having been offered illegal drugs. Estimates suggest that a third of all recorded crime is drug-related and that more than 3 out of 4 of those entering prison show signs of problematic drug misuse at the point of entry.

18. Current policy for drug misuse is set out in Tackling Drugs in Scotland: Action in Partnership and its subsequent Action Plan Protecting Our Future. These documents were published in 1999 and 2000 respectively. In March 2002, the Scottish Executive launched its Drug Communications Strategy using the “Know the Score” (KTS) logo. Around £6m over 3 years is being invested on national campaigns to raise public awareness (via a website and information line) and improve media relations. The Summary and Action Plan from a Review of Drug Treatment and Rehabilitation Services, published in October 2004, set out a package of measures to improve the quality and consistency of drug treatment services across the country.

19. The Scottish Executive works in partnership with 22 Drug and Alcohol Action Teams (DAATs), and statutory and voluntary organisations to tackle Scotland’s drug problems in a co-ordinated way. DAATs contain representation from local drug treatment agencies, local authorities, NHS Boards, the police, prisons and voluntary sector organisations, which act as the focal point for local action to implement the national strategy. These arrangements allow for services to be designed and delivered to meet local needs and priorities.

20. National targets, some subject to local target setting, were announced in December 2000. Key national targets include:
- Increasing the number of drug misusers in contact with drug treatment and care services in the community, by at least 10% every year until 2005
- Reversing the upward trend in drug-related deaths and reducing the total number, by at least 25% by 2005
- Reducing the proportion of drug misusers who inject, by 20% by 2005.

21. Parental substance misuse can, and does, cause serious harm to children at every age from conception to
adulthood. A range of initiatives across the Scottish Executive aims to ensure better and integrated services for vulnerable young people and practice guidelines have been issued for working with children and families affected by substance misuse.

22. In response to the need to tackle drug misuse among schoolchildren, the Scottish Executive, in conjunction with NHS Health Scotland, the Scottish Drugs Forum and Scotland Against Drugs, has produced a guide entitled *Drugs: What Every Parent Should Know* to help parents discuss the dangers of substance misuse with their children. This guide, which is available from the KTS advice line [see Appendix XI] has been distributed to a range of outlets including GP practices, pharmacies and Social Work Departments.

**SMOKING**

23. Smoking is the single greatest cause of preventable ill-health and premature death in Scotland. It results in 13,000 (1 in 5 deaths) each year. Some 35,000 hospital admissions are due to smoking-related diseases at a cost to NHSScotland of £200m per year in hospital care. More than a quarter of women in Scotland still smoke during pregnancy. This means that about 13,500 babies born in Scotland each year are exposed to toxic chemicals with potentially damaging consequences for their health.

24. The annual cost of employee smoking in Scotland is estimated to be around £500m, £450m for lost productivity (smoking breaks), £40m for higher absenteeism among smokers and £4m as a result of fire damage.

25. Since devolution, the Scottish Executive has been driving forward in a Scottish context the comprehensive tobacco control programme set out in the UK White Paper *Smoking Kills*. Working with partners, the Scottish Executive has delivered new and expanding cessation services, high quality communications campaigns, Nicotine Replacement Therapy (NRT) on prescription, a ban on tobacco advertising, enhanced health warnings on cigarette packets and tobacco test purchasing pilots.

26. In January 2004, the Scottish Executive published the first ever action plan on tobacco control designed specifically for Scotland. At the same time, a related report, entitled *Reducing Smoking and Tobacco-related Harm: A Key to Transforming Scotland’s Health* – a joint venture between NHS Health Scotland and Action on Smoking and Health Scotland (ASH) – provides a platform for the implementation of the Action Plan.

27. These two documents examine current smoking trends in Scotland, summarise the most up to date evidence about smoking and tobacco-related harm and how it can be reduced. They also consider current prevention, control and treatment policies and services in Scotland and make recommendations about what further action should be taken.

28. Actions are set out in the following four broad categories:

- **Prevention** – action to accelerate reductions in smoking prevalence including a major review of prevention, education and communications efforts
- **Provision of Services** – action to further extend and improve cessation services
- **Second-hand Smoke [Passive smoking]** – action to reduce the health risks from second-hand smoke
- **Protection and Controls** – legislative and other action to reduce the attractiveness and availability of cigarettes.

29. A consultation document, *Smoking in Public Places*, was issued in June 2004. This has helped to facilitate an open national debate on the dangers involved in passive smoking and how to reduce exposure.

30. In the context of pharmaceutical services, the Action Plan will assess the success of current communication and education programmes and establish a new, integrated, long-term strategy aimed at young people to raise awareness of tobacco addiction. It will also allocate additional funding to smoking cessation programmes, particularly those which are targeted at the most disadvantaged communities, and agree annual cessation targets with each NHS Board.
31. Current targets, set by the Scottish Executive in *Towards a Healthier Scotland*[^13], aim to reduce adult smoking from 35% to 33% by 2005, and to 31% by 2010, and to reduce smoking among young people from 14% to 12% by 2005, and to 11% by 2010. These targets will be reviewed and consideration will be given to setting new targets or milestones to drive change in key groups. The Scottish Executive has already announced in its Tobacco Control Plan that it proposes to adjust the adult target to 29% by 2010. In many ways, pharmacists have led the way with pharmacies being designated as smoke-free zones more than 20 years ago.

32. NHS Boards and their partners in health improvement will be required to set and monitor local targets to underpin achievement of the national targets. The *Smoking Atlas of Scotland*[^due in 2005], a source of guidance to NHS Boards and local authorities on the level of smoking and related harm in their area, will help to inform this process.

### ALCOHOL

33. Alcohol is widely used and enjoyed but carries serious consequences if, and when, it is misused. It is a known fact that problem drinking is on the increase in Scotland. The level of binge drinking is rising rapidly and young people, especially women, are drinking more than ever before[^9]. There is also a sharp upward trend in alcohol-related illness and death, particularly in alcoholic liver disease in women, which is being seen at younger ages[^9]. Current figures estimate that problems relating to alcohol cost £1bn per year, including £96m to NHSScotland[^34].

34. The national policy on alcohol is contained in the *Plan for Action on Alcohol Problems* (January 2002)[^34] and its accompanying framework document entitled *Alcohol Problems Support and Treatment Services Framework* (August 2002)[^35].

35. The *Plan for Action on Alcohol Problems*[^34] sets out a comprehensive package of measures to reduce alcohol-related harm in Scotland (*not* alcohol per se). This includes action to develop support and treatment services. The *Plan* has both short- and long-term aims. These aims centre around the need to promote a change in attitude towards the consumption of alcohol and to develop local strategies to reduce harmful patterns of drinking among young people. The *Plan* acknowledges the need to look at issues such as prevention and education and the need to find alternatives to, the “drink culture” (e.g. the establishment of Youth Cafés). The *Plan* aims to adopt a positive, non-judgmental attitude which embraces both the context and the causes of alcohol problems, and is generally considered to have led the way in the UK.

36. The *Framework* which supports the *Plan* sets out a four-pronged approach to help local alcohol action teams, NHS Boards and local authority departments to assess local needs, identify gaps in service provision, clarify referral processes and develop plans for the provision of integrated support and treatment services for people with alcohol problems. The two key priorities are to reduce binge drinking and to reduce harmful drinking by children and young people. With regard to the latter, the Scottish Executive, in conjunction with NHS Health Scotland and Alcohol Focus Scotland, has produced a guide entitled *Alcohol: What Every Parent Should Know*[^26] to help parents discuss the dangers of alcohol misuse with their children. This guide, which is available from the Drinkline advice line [see Appendix XI] has been distributed to a range of outlets including GP practices, pharmacies and Social Work Departments.

37. The *Framework* is not intended to be prescriptive nor to set out minimum service levels or standards. It does, however, identify service elements of proven effectiveness that should form the basis of all services across NHSScotland.

38. To date, a total of 22 Local Alcohol Action Teams are working in consort with Drug Action Teams (DATs) and most of the action points within the *Plan* have been delivered.

39. Current priorities, which have been set by the Partnership Agreement[^37], include a commitment to expand alcohol-free environments and examine the scale and costs of alcohol misuse across Scotland. Advertising
campaigns will place a far stronger focus on young people, especially young women. There is also a commitment to strengthen links between the Scottish Executive and those who have responsibility for delivering the programmes at local level.

**CONCLUSION**

40. Policy to tackle substance misuse cannot operate in isolation from other strategies. There is therefore a need to link with other national strategies [e.g. the Mental Health Strategy, the Sexual Health Strategy and the Information Management and Technology Strategy (IM&T)] and key players within the Scottish Executive Health Department, the Scottish Prison Service, the Community Justice Service Division, Drug Treatment and Testing Orders (DTTOs) and Drug Court Teams in order to ensure that there is a full and informed contribution towards the treatment and care of the substance misuser. There is also a need to link in with other partnership agencies in relation to the formulation and delivery of policies.
This chapter provides a summary of existing services provided by pharmacists for the treatment and care of substance misusers.

INTRODUCTION
41. Pharmacists in Scotland are currently involved in dispensing medication for the treatment of substance misuse, providing needle and syringe exchange schemes, nicotine replacement therapy, and the provision of advice on better health to substance misusers. These services are part of a multidisciplinary approach to prevent the spread of diseases such as HIV infection and Hepatitis B and C, to stabilise and normalise the lives of misusers, improve their health and integrate them back into the community.

42. This chapter gives a brief description of each of these services and summarises the main areas where pharmacists contribute to the treatment and care of substance misusers.

43. Examples of agencies working in partnership are included in Appendix X. Not all of the examples are necessarily unique and their widespread adoption would be beneficial to patients and other members of the healthcare team.

SUMMARY OF SERVICES PROVIDED BY PHARMACISTS TO SUBSTANCE MISUSERS

Health Promotion and Health Education
44. Community pharmacists provide advice to the public on healthy lifestyles. They are ideally placed to support national and local community projects aimed to disseminate information about the misuse of a range of substances, including drugs, prescription and “over-the-counter” (OTC) medicines, volatile substances, alcohol and tobacco. They are uniquely placed to prevent the misuse of both “over the counter” (OTC) and prescription medicines.

45. Pharmacists are involved in activities that encourage the safe use of medicines. These take the form of advice at the point of sale or dispensing, as well as talks or lectures to parents’ groups in schools and community groups. Specially trained pharmacists offer advice to parents on signs and symptoms of drug misuse, as well as advice to young people on the risks of drug misuse. This advice is in line with national and local policies.

46. Community pharmacists make available to the public a wide range of educational booklets and leaflets produced by the Scottish Executive. These include:

- a new parents’ guide to drugs
- a club owner’s guide to drugs
- new material on psychostimulants, such as cocaine and crack
- a cannabis guide for young people
- a guide to reducing risks from drug-related sexual assault
- Know the Score (KTS) booklets on drink and drugs (including volatile substance abuse, overdose and Hepatitis C).

Copies are available to the public through a number of outlets including GP surgeries and community pharmacies.

Prescription Monitoring
47. Community Pharmacists and Pharmaceutical Prescribing Advisers undertake an important role by identifying excessive prescribing by individual prescribers. They must also be prepared to challenge inappropriate prescribing. Recommendations from the Fourth and Fifth Reports of the Shipman Inquiry will doubtless have an impact on future practice with regard to the monitoring of prescribing patterns of Controlled Drugs (CDs)38,39.

Medication Review
48. Community Pharmacists and Primary Care Pharmacists working within general practice also monitor prescribing and how patients use their medications when
undertaking medication reviews. The pharmacist assesses the patient’s use of prescribed medications when taking a patient’s medication history, and gives appropriate advice to prevent the inappropriate use of products containing ingredients with the potential for misuse.

**Substitute Medication and Detoxification**

49. Substitute medications can be prescribed to substance misusers for a variety of reasons. These include stabilization, maintenance, detoxification and harm reduction.

50. Pharmacists have led the way in expanding the supervised self-administration of methadone\(^{40,41,42}\). Participation is not obligatory but the large majority of pharmacists provide this service, [see Appendix VI]. There are well recognized procedures for the supply of multidose medication before weekends and public holidays when pharmacies are closed, but an increasing number of pharmacists are now able to offer late evening and weekend services.

51. The benefits of supervised self-administration or ingestion of methadone are now well documented\(^{40,43,44}\) and include:

- Frequent contact with a health care professional
- Opportunity for contact with other appropriate services
- Adherence to the prescribed dosage
- Reduced risk (to the individual and/or other people, including children) of accidental poisoning
- Stabilization of chaotic lifestyles
- Continuity of treatment
- Reducing an individual’s contact with drug dealers
- Removing the need for individuals to support a drug habit through crime.

52. Methadone is addictive but it is less addictive than heroin and certain other opiates. Some substance misusers may only ever use methadone maintenance as a form of harm reduction and be unable to move to abstinence, but others, with support, are able to make adjustments in their lives towards a more organised existence that eventually leads to abstinence. This goal is manageable if it is backed up by the provision of advice and counselling and if there is a willingness on both sides to achieve abstinence. This provides the prescribing doctor and the pharmacist with an opportunity to build up a professional relationship with the substance misuser and to monitor changes in attitude or behaviour. It is a major challenge for substance misusers to maintain an opiate-free life and appropriate support is essential. This may include the use of antagonist drugs, such as Naltrexone, and counselling.

53. The definition of “success” should not, however, be confined to abstinence. A broader definition should be applied that encompasses those elements which lead to stabilisation, a reduction in problems related to drug use and a reduction in drug intake.

54. In addition to methadone, there is the potential for pharmacists to become involved in the dispensing and supervised consumption of other substitute medications for the treatment of opiate dependence, such as dihydrocodeine and buprenorphine (Subutex).

55. Some pharmacists have been involved in supervising the consumption of other medications that have been prescribed for patients with drug misuse problems, including doses of benzodiazepines such as diazepam.

56. Hospital pharmacists are also involved in the care of drug misusing patients. As the number of patients on substitute prescribing programmes increases it is inevitable that some will be admitted to the secondary care sector for non-drug related reasons. Such patients should have their treatment continued and be provided with adequate pain relief.

57. Hospital-based Medicines Information Pharmacists play an important role in advising both community and secondary care colleagues on treatment regimens, as well as assisting in the identification of tablets following accidental poisoning.
Care Management

58. Hospital and community Pharmacists are involved in the development of integrated care plans and pathways which take cognisance of the pharmaceutical needs of the patient. Monitoring the implementation of care pathways should always include an assessment of the pharmaceutical needs of the patient and it is crucial that compliance with medication regimens is taken into account when assessing the patient’s condition. In the absence of pharmaceutical involvement at this stage the patient’s adherence to his/her medication regimen, or inappropriate use of OTC medications, may be missed. Pharmacists dispensing daily medication are ideally placed to monitor the patient’s physical condition.

Drug Testing

59. Pharmacists have a valuable role to play in the provision of advice on the increasing range of “near-patient” drug testing now on the market. However, it is important that they do this in collaboration with biochemistry departments that have specific expertise in the identification of drugs in urine, saliva, or buccal fluid. There is an opportunity for these new technologies to be used in community pharmacies, providing a convenient and effective means of monitoring patient compliance with the care programme.

Needle and Syringe Exchange Schemes

60. A needle and syringe exchange scheme is a facility that enables an injecting drug user to obtain clean needles and syringes and return used ones for safe disposal and destruction. They serve to limit the spread of blood-borne infections, such as HIV and Hepatitis B and C, which can be transmitted by the sharing of injecting equipment. They can also provide an opportunity for clients to gain access to mainstream drug services for longer term help. Depending upon where the exchange is located, additional services such as advice and counselling may also be provided.

61. The first needle exchanges began in Britain in 1986 but only one of these was pharmacy-based. Different models of service were developed following a pilot scheme in 1987. These were established alongside existing schemes based within hospitals or drug agencies. Pharmacy-based schemes emerged as a result of the pilot and in recognition of the fact that there was considerable potential for more injectors (such as young people and women) to be reached. The Royal Pharmaceutical Society of Great Britain issued guidelines for pharmacists taking part in needle exchange schemes in 1987. Further, more detailed, guidance was issued in 1989, 1991 and 1993 and a comprehensive resource pack was produced by the National Pharmaceutical Association (NPA) in 1998.

62. The involvement of Scottish community pharmacies in the provision of needle exchange is at a much lower level than that in England or Wales. This is due to the fact that, prior to their official, funded introduction in Scotland in 1992, most Scottish pharmacies that were selling clean injecting equipment to injecting substance misusers did not remove contaminated syringes from circulation and did not therefore fulfil the true definition of an “exchange”. Some of the used equipment was returned to “fixed” nurse-led exchanges instead. Nevertheless, those pharmacies that are involved in needle exchange schemes have demonstrated that they are capable of providing a valuable and attractive low-threshold service to drug injectors.

63. Two Scottish documents have highlighted the need for the expansion of needle exchange provision: the Scottish Needs Assessment Programme (SNAP) report on Hepatitis C and the Health Promotion Strategy Review Group Report on HIV. Recent Scottish Executive advice to Drug and Alcohol Action Teams requires an increase in the number of outlets for needle exchange in order to reduce sharing of injecting equipment. An increase in the provision of clean injecting equipment and its safe return for disposal is essential if the prevalence of the viruses HIV, Hepatitis B and C, are to be contained and reduced.

64. Pharmacists who participate in needle exchange schemes may well be asked to sell citric acid. Citric acid is used by heroin injectors to help dissolve some types of
street heroin in water. Until recently, Section 9A of the Misuse of Drugs Act made it an offence for anyone to supply anything that could be used for the preparation and administration of a “controlled substance”. The Home Office has recently agreed to a change in the law and, with effect from 1 August 2003, it is no longer an offence for doctors, pharmacists and drug workers to supply swabs, filters, sterile water, certain mixing utensils (e.g. spoons, bowls, cups and dishes) and citric acid to drug users who have obtained controlled drugs such as heroin and cocaine without prescription.

**Treatment of Overdose**

65. Naloxone is the specific antidote for opiate poisoning, yet it is not presently included in the list of Prescription Only Medicines [POMs] that anyone can administer in an emergency to save lives.

66. Several publications have addressed the issue of the distribution of naloxone to substance misusers and a survey of substance misusers shows extensive support for the provision of supplies to take away. Preliminary results of two pilot schemes in Germany and the Channel Islands are encouraging and a study of the wider distribution of take home naloxone is now required. Home treatment by an acquaintance is a controversial programme that is being tried out in a number of countries outwith the UK but research is needed to measure its effectiveness and safety.

67. Naloxone can be administered safely to people who have taken overdoses of opiates and without harm to those who have not. At present, the only way to provide naloxone for administration in an emergency, other than on the prescription of a doctor, is by way of a Patient Group Direction (PGD).

68. PGDs can be used for the supply and administration of medicines to a patient that cannot be previously identified, provided the following conditions are met:

- The multidisciplinary team that draws up a PGD must include a pharmacist and a doctor.
- The PGD must include the following:
  - specification of the drug and its dose,
  - the conditions under which it can be supplied and/or administered,
  - the professionals to whom the PGD applies,
  - the circumstances in which it can be used.

- The relevant Operating Division or authorising body must approve its use.
- There must be training for all concerned and a clear audit trail.
- The PGD’s use must be documented and reviewed.

69. Three such Directions have been developed for use in Glasgow and since their introduction at least one life has been saved. Surveys of pharmacists undertaken in Glasgow, Aberdeen, and Edinburgh have indicated the willingness of pharmacists in those cities to supply and be trained to administer naloxone in the case of an emergency.

**Detection/Management of Solvent Misuse**

70. At present, the pharmacist’s role in the detection and management of solvent misuse and the misuse of volatile substances is limited. This is because the effects of solvents wear off quickly, within 30 minutes or so, and are therefore difficult to detect. Furthermore, symptoms such as nausea, headaches and dilated pupils can be misleading as they may have many causes unrelated to the misuse of volatile substances. Pharmacists are, however, alert to certain signs and symptoms such as a chemical smell on clothing, hair or breath; or “drunken” behaviour, such as a lack of co-ordination and coherence. They have established useful links in certain areas for the reporting of suspected cases of solvent abuse. NHS Boards should seize the opportunity to make use of the skills and aptitudes of pharmacists so that they can join forces with Local Authority Education Departments to warn parents and schools about the dangers of solvent abuse. Pharmacists also have a duty to prevent the inappropriate sale of solvent-based products from their premises.

**Misuse of Over-The-Counter (OTC) Medicines**

71. The RPSGB Code of Ethics states that pharmacy services are concerned with ensuring the safe, effective and appropriate use of medicines. However, there is
potential for the misuse of all medicines including those bought over the counter at a community pharmacy. Although clear guidance on the use of OTC medicines is given with the medicine, patients may inadvertently or deliberately take more than the recommended dose or use the medicine for longer than recommended. Most people who misuse OTC medicines are unlikely to view themselves as “substance misusers”.

72. Surveys of community pharmacies in Scotland have found a consistently high rate of suspected misuse of OTC medicines with 67.8% in 1995 and 69% in 2000 believing OTC medicines were misused in their area\textsuperscript{61}. The most widely suspected products of misuse were those containing antihistamines, opiates or mild stimulants, and laxatives. Although most OTC medicines that are misused fall into one of these categories, it is important to remember that almost any drug has the potential to be misused. Often these are only documented by a few case reports or are generally acknowledged as current “street” trends\textsuperscript{62}.

73. Pharmacists take this matter seriously and work to a variety of protocols to maximize benefit and minimize harm to patients. These include the control of particular products using registers of sales, refusing sales (in line with the RPSGB Code of Ethics), and ceasing to stock certain products where misuse is suspected\textsuperscript{61,63}.

74. An increased awareness of OTC medicines and their potential for misuse would help all health workers to be more alert to, and able to spot, patients with these problems. This will be of even greater importance as Internet sales may increase the supply of both OTC medicines and POMs beyond the current network of providers. Pharmacy referrals on to support groups, community-based drug teams or other health professionals could be a key aspect of supporting a patient suspected of misusing non-prescription medicines.

**Smoking Cessation Schemes (SCS)**

75. Nicotine Replacement Therapy (NRT) is regarded as the pharmacological treatment of choice in the management of smoking cessation. The term NRT is used to refer to a number of products such as nicotine patches, high strength chewing gum, nicotine inhalation devices, tablets, lozenges and nasal sprays. It supplies the body with nicotine at a level that controls withdrawal symptoms, leaving the person free to concentrate on breaking their addiction.

76. Since April 2001, all forms of NRT are now available on prescription under the NHS\textsuperscript{64}. This will benefit less affluent people who wish to give up smoking. Most are now available on general retail sale or over-the-counter in community pharmacies. Its enhanced profile as a medical treatment should also encourage those able to afford it to buy it from their pharmacist.

77. However, there is good evidence that NRT by itself is not sufficient to make a large difference in the numbers of people who successfully give up smoking each year. To succeed, smokers need education, support and motivation\textsuperscript{65}. This type of intervention ranges from low intensity support such as self-help materials and telephone helplines to more intensive interventions including individual and group counselling. In general, the more intensive the intervention, the greater the success rate.

78. Bupropion (Amfebutamone or Zyban) was licensed for use as an aid to smoking cessation in June 2000. NICE guidance states that bupropion is not recommended for smokers under 18 years or those who are pregnant or breastfeeding and that there is currently not enough evidence to recommend the use of NRT and bupropion together\textsuperscript{66}.

79. Most community pharmacists provide some form of smoking cessation service. These range from the locally funded supply of NRT under a PGD with structured counselling and motivational support to opportunistic interventions associated with the sale of NRT or other products to aid smoking cessation\textsuperscript{67}. This type of service has the potential to reduce nurse/GP workload. Learning resources on smoking cessation are available for pharmacists from NHS Education for Scotland.
80. Pilot evaluations have demonstrated the benefits of hospital initiation of NRT in selected high risk patients\(^6\). However, these developments have typically been small scale and short term. The emphasis here is on continuity of treatment/motivation after discharge. A further pilot, referred to as the *Breathe* Project, has just been launched throughout Greater Glasgow as a means to help pregnant women to give up smoking. The project, which is being led by two specialist midwives, will forge links with pharmacies participating in the *Starting Fresh* stop smoking scheme across Glasgow. The results of the pilot will be evaluated in due course.

*Alcohol Counselling*

81. With the recent emphasis on the spread of illegal drugs there has been a greater tendency to play down alcohol which, when misused through heavy and binge drinking, can lead to addiction and have a detrimental effect on health. Pharmacists can, however, play an important part in the management of alcohol problems\(^6\)\(^9\).\(^{70}\)

82. The main role that pharmacists currently play in relation to alcohol is one of education and advice. Many people drink alcohol but forget that it is a drug. When it is combined with certain types of medicine, such as anti-depressants, antihistamines, drugs used to treat epilepsy, etc., it can be dangerous. As well as asking patients about their drinking habits and encouraging them to reduce their consumption, pharmacists are alert to the signs of alcohol-related disease, counsel on the appropriate use of medicines in known alcohol misusers, and act as a signpost to services for specialist help.

83. Pharmacological interventions used in alcohol dependence for prevention of relapse include deterrent medication such as disulfiram (Antabuse), acamprosate (Campral) and naltrexone (Revia) although the latter is currently unlicensed for this indication in the UK.

84. A Health Technology Assessment by NHS Quality Improvement Scotland has found evidence in favour of the efficacy of supervised disulfiram and acamprosate in the prevention of relapse\(^71\).

85. All NHS Specialist Alcohol Services in Scotland use disulfiram or acamprosate and a few use named patient/off license prescribing of naltrexone. For example, in NHS Lothian, the Area Drug and Therapeutics Committee has approved the use of acamprosate on a shared care basis with Primary Care. NHS Lothian has also produced a protocol for prescribing oral naltrexone for alcohol dependence. NHS Greater Glasgow has a shared care protocol in place for acamprosate.
CHAPTER FOUR:
CHALLENGES TO EFFECTIVE SERVICE PROVISION
AND WAYS TO ADDRESS THEM
INTRODUCTION

86. Historically, the degree to which pharmacists and, in particular, community pharmacists, have been involved in services to substance misusers has, to a large extent, been determined by changes in drugs legislation as well as by changes in the manner in which healthcare in the United Kingdom is provided and funded. The legal and ethical restrictions to which pharmacists are subjected can, on occasion, cause frustration and lack of understanding on the part of clients and other members of the healthcare professions. This chapter examines the main challenges that are posed by legal, professional, educational and other issues and suggests ways in which these issues might be overcome.

LEGAL AND ETHICAL CHALLENGES

The Sale and Supply of Medicines

87. The Medicines Act (1968)\(^7\) and the Misuse of Drugs Regulations (2001)\(^7\) (and amendments) govern the sale and supply of medicines. The pharmacist has an obligation to abide by the very precise requirements of the Act and the Regulations and incurs an absolute liability for any failure to do so. There can often be tensions between the pharmacist’s legal and ethical responsibilities for patient care. It is illegal, for example, for a pharmacist to supply Controlled Drugs (CDs) such as methadone other than by way of a legally written prescription. Telephoned or verbal alterations or orders are not allowed.

88. It is likely that the Regulations will be tightened as a result of the Shipman Inquiry\(^7\), particularly in relation to CDs and this could serve to exacerbate the problems even further. It is important that other healthcare professionals (and patients) understand and comply with the legal requirements, that Regulations do not become more restrictive and that those that are already in place are amended to reflect clinical need (e.g. to allow for supplementary prescribing and extended nurse prescribing of CDs).

89. On 21 November 2002, the Minister for Health and Community Care announced new powers to allow pharmacists and nurses in Scotland to prescribe a wide range of drugs, following diagnosis by a doctor and within an individual clinical management plan. The introduction of these prescribing rights is already helping pharmacists to optimise therapy, improve response to clinical need and adherence to treatment.

Patient Confidentiality and the Sharing of Information

90. The Data Protection Act (1998)\(^7\) places a legal duty on data controllers to process data fairly and lawfully, to use no more data than is necessary for the task and to retain it for only as long as it is needed. The Human Rights Act (1998)\(^7\) guarantees respect for a person’s private and family life. Under the terms of this Act, this right to privacy may be overridden, but only when there is a lawful reason to do so. The common law reinforces the need to obtain patient consent before sharing information. Professional guidelines require healthcare workers to ensure that patients are informed about how information about them is used and that consent requirements are met. Decisions should be taken on a case by case basis in the light of the best available information, which may include advice from the local Data Protection Officer or Caldicott or Information Guardian.

91. The RPSGB’s Code of Ethics\(^6\) requires pharmacists to respect the confidentiality of information acquired about patients and their families in the course of their professional practice. There are occasions when, in the best interests of the patient, information needs to be shared between health professionals and drug users. This is particularly so in the case of substance misuse where the emphasis is very much on multidisciplinary
team working. This calls for a culture of openness and trust between agencies and agreement on the core elements of information that need to be transferred.

92. The findings of the Bichard Inquiry will doubtless have an impact on current practice in terms of the effectiveness of record keeping and information sharing with other agencies.

93. In all cases, sharing of information should take place within an environment of informed client consent. Any written or verbal agreement or contract between the patient and the pharmacist should make it clear that these situations may occur and should describe the action that would be taken.

94. Access to records for individuals who are homeless is particularly problematic. In addition, for many individuals, the period immediately following release from prison is a vulnerable time, especially if they have not voluntarily agreed to participate in the Transitional Care Programme available to short-term and remand prisoners in the Scottish Prison Service (SPS). Most parts of Scotland are far from achieving this level of access at the present time. This situation should improve dramatically with the advent of electronic patient records although agreement urgently needs to be reached for records to be shared between the SPS and NHSScotland.

Patient Access to Health Records

95. Patients, or their legally appointed representatives, have the right to see and obtain a copy of personal health information held about them. Pharmacists should facilitate this right of access. Exceptions to this rule would apply if access to the record could cause serious harm to the patient’s or someone else’s physical or mental health; could identify someone else; or be subject to legal restrictions.

Duty of Care

96. Pharmacists owe a duty of care to their patients and customers. A duty of care arises when the pharmacist can reasonably foresee that the patient is likely to suffer harm from his/her conduct, e.g. liability for professional services such as dispensing, misleading or deficient advice, etc. The pharmacist also has a duty of care to ensure that prescriptions are not inadvertently supplied to the wrong person. The mandatory introduction of Standard Operating Procedures (SOPs) by the RPSGB should assist pharmacists to provide the necessary levels of care and act as a safeguard against error. The duty of care obligation also extends to the safety and security of customers and other staff while they are on the premises (occupiers’ liability).

The Care of Young People Under 16

97. The Children (Scotland) Act 1995, the UN Convention on the Rights of the Child (1989), and the Age of Legal Capacity (Scotland) Act 1991, are the main pieces of legislation that deal with the care and welfare of children in Scotland. The framework of the Scottish legislation respects the privacy and dignity of young people, their right to make certain decisions for themselves and the right to a say in who should and should not be involved in their care. When deciding on the best way forward, pharmacists should bear in mind the legal rights of the child concerned. However, pharmacists also need to recognise the rights of the parents and to balance this against the right of the child to confidentiality.

98. An increasing number of publications on substance misuse now include references to young people under the age of 16. For example, the Effective Interventions Unit (EIU) and Lloyds TSB Foundation for Scotland’s Partnership Drugs Initiative has collaborated to produce a guide to inform and support the design and delivery of services for children and young people under the age of 16 who have had problems with drugs and/or substance misuse. More recently, the EIU has produced a guide to inform the design and delivery of effective assessment for young people with problematic substance misuse. Furthermore, The Scottish Executive has issued revised guidance on needle and syringe exchange schemes in HDL (2002) which includes a reference to the particular needs of this age group. The Scottish Drugs Forum, in recognition of the fact that a small number of
young children might be exposed to very serious risk through intravenous drug use, has produced a leaflet for children under the age of 16.

99. The care of young people should also include the care of babies/young children of drug-using parents. Pregnancy is often an event which prompts women to want to stop using drugs. There is an opportunity here for pharmacists to advise on appropriate nutrition and folic acid intake during pregnancy, as well as try to ensure that the mother-to-be makes contact with relevant services and is in receipt of ante-natal care. After the birth, mother and baby are sometimes separated in hospital and the mother is often discharged home with her baby whilst still withdrawing from her drug. Post-natal support is essential for the maintenance of health and well-being in both mother and child. More places for special care are required in hospital.

100. Some parents/guardians bring their children into the pharmacy when they come to receive their daily dose of methadone. The pharmacist is then faced with the dilemma of either leaving the children unattended in the shop or bringing them through into a separate area where they would be exposed to seeing their parent taking methadone. Taken in context, seeing a parent or guardian receive their daily dose of methadone is probably the least harmful thing that could happen to the child.

PROFESSIONAL CHALLENGES

Service Capacity

101. Around 600,000 people in Scotland visit their pharmacist every day for a range of advice on healthcare and medicines.

102. Prescription volumes have increased from 40.1 million in 1987/88 to 69.5 million items in 2002/03. This represents an average year-on-year growth of 3.7%. The increase reflects not only the availability of new or more effective medicines, but also increasing patient expectation and, more recently, the implementation of clinical guidelines and recommendations.

103. Prescriptions for methadone have increased sharply over the past 5 years. In 1998/99 there were 214,921 prescriptions or 42 per 1,000 population and in 2002/03 there were 358,389 prescriptions or 71 per 1,000 population. It should be noted, however, that “prescriptions” or the “rate of prescriptions” per area do not allow for comparison between areas due to differences in prescribing practice. These figures are shown by NHS Board in Appendix VII.

104. In 1999/00 there were 2,185,109 instalment and 32,473 single dispensings of methadone mixture. In 2003/04 there were 4,050,783 instalment and 55,311 single dispensings of methadone mixture. These figures should, however, be treated with caution. In July 2000 there was a major change in the way prescriptions were claimed, as well as in the method of recording information at Information Services Division (ISD). This means that direct comparison between these two sets of figures is therefore inadvisable because they are derived from different methods of data collection.

105. There is clearly a limit to the number of services that can be provided by pharmacists working within existing resources. Desire to meet demand should be tempered by the need to uphold patient safety and quality of care. Any additional services should therefore be developed on a selective basis in the first instance.

Team Working

106. It is often difficult for pharmacists to become integrated into the shared care team. Their ability to attend daytime meetings, case conferences, training events, etc., is adversely affected because of the legal requirement to be present in the pharmacy at all times during opening hours in order to supervise the dispensing of prescriptions and the sale of Pharmacy Medicines (P). There is therefore a legal obligation for the owner or manager to ensure that a pharmacist is present during his/her absence. In practice this usually means for the minimum of half a day. In Greater Glasgow, a “peripatetic pharmacist” was appointed on a trial basis to provide, among other things, locum cover to enable individual community pharmacists to attend case
conferences, assessment meetings, etc., relating to individual patients and/or GP practice multi-professional/disciplinary training sessions.

107. Studies should be made of how staff from other professions (e.g. general medical and dental practitioners) manage to provide cover without the need for a qualified full-time professional presence on the premises. If and when workable alternatives can be found, the law should be challenged in order to free-up valuable pharmacist time. In addition to cover, there is also the question of funding. Without adequate compensation it is often impossible for pharmacists to participate fully in professional activities which take place off the premises.

108. The pharmacist should be seen as being one member of a team of equals. In practice, the pharmacist and the other members of the core team (the General Practitioner, the community psychiatric nurse, the drugs worker, etc) do not appear to operate in tandem. An unwillingness to share information because of a perceived need to maintain patient confidentiality can result in a sense of professional isolation and frustration. Such an approach inevitably impacts upon the treatment plan and the overall quality of patient care.

109. A multi-agency agreement needs to be put in place so that all members of the team and, most importantly, the patient, know what information is being shared and why and the extent of the responsibility for each of the parties involved.

**Provision of Pharmaceutical Advice**

110. All NHS Boards and all pharmacy contractors should have access to, and receive professional support from, a Specialist Pharmacist in Substance Misuse (SPiSM). Essentially, the role of the SPiSM is to provide a professional lead for the pharmaceutical aspects of substance misuse services whilst developing and improving the quality of pharmaceutical aspects of patient care in the provision of substance misuse services. These posts already exist in some NHS Boards and other Boards are in the process of making such appointments (see Appendix IX). The remits of the existing posts are not identical. Some are specifically drug-orientated whilst others cover a wider remit (e.g. alcohol misuse). There are historical and geographical differences to the posts which define the involvement of the individual post holders within primary and secondary care and the wider health and social care environment.

111. Key functions include:

- monitoring and evaluating the supervised consumption of methadone programmes and pharmacy-based needle exchange schemes in terms of cost and quality of service
- providing support and advice to community pharmacists involved in the continuing care of substance misusers
- providing education and training to pharmacists and other health professionals on the pharmaceutical aspects of substance misuse
- undertaking and encouraging clinical audit and practice research in aspects of substance misuse
- liaising with other professionals including social work, police, and
- providing support for the planning and implementation of services through DAATS.

112. Given the increased involvement of pharmacy in this expanding field it is appropriate for DAATS, NHS Boards and their Operating Divisions to consider the employment of Specialist Pharmacists in Substance Misuse, (SPiSMs). In addition, there is an increasing recognition by drug services that they require access to specialist pharmaceutical advice.

**EDUCATIONAL CHALLENGES**

113. At present, not all pharmacists regard substance misuse as being an area in which to gain additional knowledge and expertise. Effort has been expended on other “clinical priority” areas such as coronary heart disease, diabetes and asthma. Steps need to be put in place to redress the balance in order to ensure that more pharmacists are well placed to provide services to substance misusers as part of a multidisciplinary team.
Undergraduate education at the two Scottish Schools of Pharmacy already includes substance misuse as part of the curriculum. However, following graduation, the subject should also become an integral element of pharmaceutical care modules within and beyond the pre-registration year.

NHS Education for Scotland (Pharmacy) has produced two training packages available for pharmacists involved in the pharmaceutical care of substance misusers. The profession needs to build on this initiative in order to ensure the development of a sustained and integrated approach to education and training. These are currently being updated.

The Scottish Training in Drugs and Alcohol (STRADA) initiative, which is a partnership between the University of Glasgow and DrugScope, has a central role to play in ensuring that the competence of professional staff delivering services to substance misusers is raised throughout Scotland and that interventions to address substance misuse are evidence-based. Working in parallel with STRADA, Healthwork UK, on behalf of all the UK Health Departments, developed a set of competencies for staff working in drug and alcohol services. STRADA and the Royal College of General Practitioners have been commissioned by the Scottish Executive to develop a multidisciplinary drug misuse training programme for Scotland.

A wide range of professionals from both within and outwith NHSScotland are involved in contributing to services for substance misusers. Many facets of education and training will have a common thread that will be pertinent to all service providers. It is important that all professionals keep abreast of the latest developments, establish a mutual understanding of each other’s roles and adopt a consistent approach to service delivery and patient care. The potential for shared learning and networking is considerable and a multidisciplinary approach should lead to enhanced team working. Much of the success of this approach will be dependent upon pharmacists and other professional staff having the necessary resources to attend daytime meetings in order to participate in these events.

Pharmacists have a role to play in the education and training of front-line staff (e.g. receptionists in GP surgeries and pharmacy support staff in community pharmacies). Community pharmacists also act as a point of contact to enable other professionals and workers, such as Social Work Staff, Local Authority Staff, Drug Workers, etc., to reach patients and clients utilising, for example, a multi-agency agreement.

OTHER CHALLENGES

Information Technology

Significant progress is likely to be made within the next two years in terms of the delivery of new e-systems and e-applications within pharmacy practice. For example, the latest version of GPASS includes the electronic transfer of prescriptions (ETP) module as standard. Non-GPASS system suppliers have been provided with a description of the ETP system and will now be provided with a detailed specification. The connection of all community pharmacies to the NHSnet is another vital infrastructure development.

A connection programme was commenced in October 2003 and will run through to the end of 2005. For community pharmacists connection to the NHSnet, and through it, access to NHSmail, will be pivotal to their ability to deliver on The Right Medicine and the new community pharmacy contract. The benefits of computer-generated scripts, records and registers will be invaluable for service delivery, especially in terms of services to substance misusers which are heavily reliant upon partnership working at a multi-agency level.

Access

Current access to pharmacy services out of hours is variable. Some areas rely on individual pharmacies choosing to open, while others have a rota service covering Sundays and public holidays. Problems often occur on Bank Holidays or when ancillary services have closed for the weekend. There is the related issue of pharmacists’ inability to contact prescribers when there are problems, particularly at weekends. In some of these
instances, it would be helpful if a pharmacist could reactivate a prescription and endorse the fact that a dose had been changed.

122. Extending opening hours would improve the service to those who are receiving treatment for problem drug use, especially for those who have found employment or are attending a course of training. On the positive side, one of the action points in *The Right Medicine* commits NHS Boards to review their Out of Hours Services to improve public access and the Scottish Specialists in Pharmaceutical Public Health Group have recently published an Out of Hours needs assessment toolkit.

**Social Inclusion**

123. Poverty and deprivation are significant and persistent problems in both urban and rural areas of Scotland. As well as geographical pockets of deprivation, some groups face particular forms of disadvantage. These include people from minority ethnic groups, asylum seekers, “travelling people”, the homeless and groups vulnerable to poverty. They also include people with chaotic lifestyles.

124. The Scottish Executive’s report *Drug Misuse and Deprived Communities* published in December 2000 by the Social Inclusion, Housing and Voluntary Sector Committee, is relevant to this issue.

125. Consideration should be given to the provision of a service that is sensitive to the social as well as the clinical needs of the patient. In the context of pharmaceutical care, this means that services need to be developed as part of the broader spectrum to engage people from disadvantaged backgrounds, especially the homeless and those who might not choose to enter a pharmacy of their own accord.

**The Homeless**

126. Many substance misusers are homeless or living at the margins of homelessness in insecure or temporary accommodation. In 2001, a review of the Rough Sleepers Initiative (RSI) in Glasgow suggested that about half of rough sleepers between the age of 25-34 years and about one third of rough sleepers between the ages of 16-24 years were dependent on heroin. Similarly, a study of 200 substance misusers in Glasgow and Dundee showed that one third were homeless and two-thirds had experienced homelessness at some stage. The chaos in which these people live means that they fail to stay engaged with services which makes it very difficult to retain them on a course of treatment for any length of time. Cross-agency working (health, social work, police and prisons) needs to be greatly improved if there is to be any semblance of continuity of service provision.

127. Homeless people experience great difficulty in accessing health care. For example, many are not registered with a general practitioner and many general practitioners are unwilling to prescribe for them because of the potential for overdose and problems associated with the safe storage of substitute medication.

128. Apart from providing advice on harm minimisation/safer injecting practices, vein damage, wound management and hepatitis, etc., pharmacists are well placed to act as the “gateway” to other services. This access to care could be improved if there were clear pathways and referral systems to other places such as hostels or voluntary agencies for the homeless. There is also a need to explore new ways of delivering services [e.g. outreach via non-traditional pharmacy premises] to encourage greater uptake.

**Street Workers**

129. Many street workers have drug problems. Again, pharmacists are well-placed to offer advice on safer sex, provide condoms and other OTC contraceptive products and offer emergency hormonal contraception (EHC). Pharmacists may also offer advice on access to other services for this group of clients. Again, there is a need to consider new ways in which these services can be developed and delivered [e.g. the use of a mobile service] to encourage greater uptake.
Privacy

130. In recent years there has been a move to provide a private area where questions can be asked and advice given in private. The need for such an area is particularly relevant in the case of substance misuse (e.g. supervised administration of methadone and the supply of clean injecting equipment), when clients need to have the opportunity to discuss matters privately with the pharmacist away from the open counter.

131. Some existing premises will be capable of adaptation to provide consultation areas and a recent estimate suggests that as many as 50% of pharmacies already have private areas for consultation purposes. For many community pharmacy owners, providing a quiet area could involve a significant redesign, or re-location, of the premises. Scotland has led the way in providing funding for the adaptation of private areas for consultation and the Scottish Executive and NHS Boards should be congratulated on this initiative.

Proof of Identity

132. In 1997 a pharmacist was referred to the Statutory Committee for allegedly supplying a prescription to the wrong patient and failing to take remedial action\textsuperscript{92}. A reported incident in Glasgow underlines the need for pharmacists to ensure that the person presenting a prescription for methadone (whether supervised or not) is the person to whom the prescription belongs\textsuperscript{93}. The advent of e-pharmacy will help the pharmacist to check more fully that the person presenting the prescription is not already in receipt of a prescription from another source.

133. Pharmacists should consider establishing a method of patient identification (patient record or photo-card). In general terms, proof of identity is not so much an issue with service users as with staff. Whatever strategy is adopted it must be acceptable from the point of view of civil liberties and is likely to vary from client to client and area to area.

Security

134. The RPSGB's multidisciplinary Working Party Report on Pharmaceutical Services to Drug Misusers\textsuperscript{94} recognised that the safety and security of the public, pharmacists and their staff is of paramount importance.

135. Theft from pharmacies and attacks on staff are increasing problems. These are not necessarily related to substance misusers \textit{per se} nor are they confined to pharmacies since they are also being experienced across the whole of the retail sector. Safety issues can be discussed with the local police and community safety. Some Operating Divisions have provided funding for appropriate safety precautions such as CCTV and/or the installation of panic buttons linked to the police in those pharmacies that provide a needle and syringe exchange facility and/or a supervised methadone service.

Public Perceptions

136. There can be local opposition to pharmacy-based services for substance misusers. This is particularly the case in relation to needle exchange schemes because local residents assume that they will bring “drug addicts” into the area. NHS Boards should actively obtain the support of Local Authorities and police services when organising public education campaigns advocating the benefits of these services to the community.
CHAPTER FIVE: THE WAY FORWARD
This chapter introduces the concept of integrated care and advocates the establishment of an integrated care pilot based on the principles of the pharmaceutical care model schemes. The pilot could apply to prevention and treatment in relation to the misuse of illicit drugs, prescribed and over-the-counter medicines, alcohol and nicotine.

INTRODUCTION

137. Pharmacists are already involved in many aspects of the planning and implementation of services for substance misusers but such involvement is patchy, and the profession’s contribution is constrained because it is often not included at the early stages of development. The adoption of an integrated approach, that seeks to combine and co-ordinate all the services required to meet the needs of an individual, will enable pharmacists, as equal members of a team of providers, to become fully engaged in the development and provision of services for substance misusers according to local need. This will result in decisions about the provision of pharmaceutical services to substance misusers being made with informed consideration of all the issues involved.

138. Service response needs to be patient-focused addressing the wider needs of the patient and his/her family and not limited by organisational or administrative practice. Support should be made available for the whole extent of the patient’s journey including rehabilitation and reintegration into the community. Many informal local arrangements are already in place but these are not recognised centrally and do not operate within a clearly defined system.

THE CONCEPT OF INTEGRATED CARE

139. “Integrated” as opposed to “shared” care is now the accepted and recognised term to describe a process that seeks to combine and co-ordinate all the services that are required to meet the needs of an individual. The change in terminology has come about because of the existence of different definitions for medical and social care.

140. Evidence shows that substance misusers do, in many cases, need help from a wide range of service providers [see box below]95,96. No single agency can tackle the diverse needs of this sector of the population on its own.

Range of Potential Service Providers for Substance Misusers

- General Practitioners and Primary Care Teams
- Community and Hospital Pharmacists
- Scottish Prison Service (SPS)
- Providers of SPS transitional care arrangements
- Housing services
- Employment and training providers
- Health specialties [A&E Departments, peri-natal and hepatology services]
- Religious organizations
- Addiction services
- Social Inclusion partnership initiatives
- Social Work community care, children and families services, criminal justice social work
- Criminal Justice Services (Drug Courts, DTTOs, Arrest Referral Schemes, the Police)
- Providers of residential detoxification or rehabilitation services
- Acute Services
- After-care services


141. In order to further this development and ensure the adoption of a consistent approach throughout the whole of Scotland:

- Formal links should be established between pharmacists and other agencies, such as Social Services staff
- The profession of pharmacy should be fully represented on all Drug Action Teams
- All NHS Boards should have access to advice provided by a Specialist Pharmacist in Substance Misuse (SPiSM)
An integrated care model, which would identify and standardise existing best practice and involve the pharmacist and other relevant healthcare professionals, should be constructed to address the needs of all clients and specific client groups (e.g. pregnant women, the homeless, those wishing to withdraw from methadone, employed and chaotic drug users, etc.).

AN INTEGRATED PHARMACEUTICAL CARE MODEL FOR SUBSTANCE MISUSERS

142. Pharmaceutical care was first described in 1990 as the process required to ensure that all the patient’s drug therapy is appropriately indicated, effective, safe, and convenient and achieving a defined outcome. In 1999, The Clinical Resource and Audit Group (CRAG) Framework for Clinical Pharmacy Practice in Primary Care recommended that pharmaceutical care needs should include:

- needs for a pharmaceutical product: a medicine, a formulation, and a “compliance aid”
- needs for a pharmaceutical service: advice, simplified regimens, a medication review, monitoring of drug therapy and health promotion.

143. Pharmacists can help to address an individual patient’s needs by working in collaboration with the patient, and/or carer, other healthcare professionals, social work services staff and the acute sector to provide integrated care.

144. MEL (1999) 78, entitled Model Schemes for Pharmaceutical Care provides an opportunity for community pharmacists to develop services for frail elderly patients, people with palliative care needs and people with severe and enduring mental illness through implementation of evidence-based practice, national guidelines and policy.

145. There is a commitment in The Right Medicine to develop similar models for chronic disease management including epilepsy, asthma, diabetes and coronary heart disease by the end of 2005.

EXAMPLE OF STEPWISE APPROACH

Step 1 Preparing your Practice

Step 1 would standardise best practice and improve access to information relating to medication, condition, local support agencies and integrated care through discharge planning, improved documented communications and teamwork. Subjects covered would include:

- Potential side-effects and how to manage them (e.g. drowsiness and the implications for driving/operating machinery)
- Advice on action to be taken if a dose was missed
- Stocking of self-help leaflets
- Health improvement and harm reduction information including topics such as safe sex, diet and smoking cessation
- Multi-agency agreement and sign-posting to other agencies
- Wound management advice and referral.

Step 2: Appropriateness and Safety: Targeted Intervention

Working in collaboration with their colleagues in primary care the pharmacist would carry out an assessment of the appropriateness of drug therapy in relation to whether or not the dose was optimal and assess if the patient was experiencing any preventable or manageable side effects or reduction
in risk associated with specific phases of a drug misusers “journey”. The latter might include specific support for pregnant women, chaotic drug users, those wanting to withdraw from methadone or those where a relaxation of daily supervision would be advantageous (i.e. employment or study opportunity). Oral testing, etc would also be a component.

**Step 3: Holistic Medication Review**

To ensure that all of the patient’s drug therapy was appropriately indicated, safe, effective, and convenient and that health promotion needs were being met.

148. The steps could be provided as packages of care or as individual components. The principles of the pharmaceutical care model schemes could be applied to substance misuse as part of an integrated care model.

149. The goals of care should be as outlined in the box below.

![Goals of Care](image)

150. An integrated care model for substance misuse should:

- Contribute to the planning, design and delivery of services
- Reserve sufficient time and resource for forging and maintaining links with other relevant agencies
- Allow adequate training for all members (including, wherever possible, multidisciplinary and multi-agency training to promote a mutual understanding of the roles of different partner agencies)
- Establish an atmosphere where organizational and cultural barriers can be explored
- Establish components of the pharmaceutical care plan that would contribute to the single shared assessment and/or existing multi-disciplinary care plans
- Establish and agree systems and protocols for referral, the sharing of information and joint working between agencies
- Promote evidence-based practice
- Develop systems for clinical effectiveness
- Work with patients to support them through the provision of pharmaceutical care.

**Goals of Care**

CHAPTER SIX: CONCLUSION
CONCLUSION

151. Substance misuse is a chronic relapsing condition and should be treated as such even though it is acknowledged that not all clients will meet the “chronic disease” model. Chronic disease management is one of the cornerstones of The Right Medicine. It is built on the concept of repeat dispensing with medication review and is part of the process of helping clients to monitor their condition. It is also about clients taking ownership of their condition as a partner in their care.

152. This report has reviewed the role of the pharmacist, as an essential member of a multidisciplinary team, in the provision of services to substance misusers. This has been set in the context of current policy on drugs, smoking and alcohol. The report reaffirms the message that pharmacists have a key role to play in providing a range of services to substance misusers and that this is best achieved within the context of integrated care.

The report recommends the establishment of a series of integrated care pilots for substance misuse based on the principles of the pharmaceutical care model schemes. These pilots, which would be designed to accommodate the different needs of substance misusers, would both inform and call upon the professionalism and expertise of a wide range of statutory and voluntary agencies across Scotland.

153. When designing these pilots, care should be taken not to lose sight of the role of hospital pharmacists in providing pharmaceutical care to substance misusers who require secondary or tertiary care for reasons that may or may not be related to their substance misuse. There is also a need to recognise that substance misusers often have other health problems that require treatment.

154. The “core” services provided by pharmacists in relation to substance misuse are summarised in the box below.

<table>
<thead>
<tr>
<th>CORE SERVICES TO SUBSTANCE MISUSERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensing of medication for the treatment of substance misuse and in some instances supervising the self-administration of these medicines</td>
</tr>
<tr>
<td>Health promotion/education and awareness raising activities in hospitals, community pharmacies and the wider local community</td>
</tr>
<tr>
<td>Smoking Cessation Schemes (SCS)</td>
</tr>
<tr>
<td>Needle and syringe exchange schemes</td>
</tr>
<tr>
<td>Advice on the secure handling and storage of medicines and their disposal and safe destruction</td>
</tr>
<tr>
<td>Referral to appropriate agencies</td>
</tr>
<tr>
<td>Undertaking audit and research and implementing evidence-based practice</td>
</tr>
</tbody>
</table>

OVERVIEW OF RECOMMENDATIONS

155. The recommendations originating from this report relate to:

- Pharmacist involvement in national and local policy development
- Pharmacist involvement in service planning
- The establishment of national and local networks of pharmacists engaged in the treatment of substance misuse, led by specialists
- Accessible multi-disciplinary and multi-agency education and training
Pharmacist contribution to developing the evidence-base

Support for pharmacists’ health education/promotion/harm reduction activities

Engagement of pharmacists with local communities, especially schools

Opportunities afforded by the extension of prescribing rights and the new community pharmacy contract

The establishment of a series of integrated care pilots to accommodate the different needs of substance misusers

Ensuring that legislation designed to protect the public and patients does not damage the ability to provide effective care.

A summary of the recommendations is given at the front of this report.


38. Shipman Inquiry [Fourth report]. The Regulation of Controlled Drugs in the Community. Command Paper Cm 6249 [July 2004].


52. Misuse of Drugs (Amendment) (No 2) Regulations 2003.


59. Roberts, K. – Personal communication.


83. Scottish Drugs Forum – Personal communication.

84. Information and Statistics Division (now Information Services) – Prescribing Information System.


98. Clinical Resources and Audit Group (CRAG). Framework for Clinical Pharmacy Practice in Primary Care.

GLOSSARY OF ACRONYMS AND ABBREVIATIONS

AAT  Alcohol Action Team
ACMD  Advisory Council on the Misuse of Drugs
AIDS  Acquired Immunodeficiency Syndrome
ASH  Action on Smoking and Health
BBV  Blood Borne Virus
CAHRU  Child and Adolescent Health Research Unit
CCTV  Closed Circuit Television
CD  Controlled Drugs
CDPS  Community Drug Problem Service
CHD  Coronary Heart Disease
CHP  Community Health Partnership
CNS  Central Nervous System
CRAG  Clinical Resources and Audit Group
DAAT  Drug and Alcohol Action Team, often commonly referred to as Drug Action Teams (DATs), Alcohol and Drug Action Teams (ADATs) and Substance Action Teams (SATs).
DTTO  Drug Treatment and Testing Orders
EHC  Emergency Hormonal Contraception
EIU  Effective Interventions Unit, SEHD.
GDPS  Glasgow Drug Problem Service
HAT  Homeless Addiction Team
HIV  Human Immunodeficiency Virus
KTS  Know The Score
MAP  Methadone Activities Programme
NES  NHS Education for Scotland
NPA  National Pharmaceutical Association
NPF  National Pharmaceutical Forum
NRT  Nicotine Replacement Therapy
OTC  Over the Counter (Medicines)
PGD  Patient Group Direction
RSI  Rough Sleepers Initiative
SALSUS  Schools Adolescent Lifestyle and Substance Use Survey
SCPPE  Scottish Centre for Post Qualification Pharmaceutical Education
SDF  Scottish Drugs Forum
SDMD  Scottish Drugs Misuse Database
SEHD  Scottish Executive Health Department
SNAP  Scottish Needs Assessment Programme
SNEW  Scottish Needle Exchange Workers’ Forum
SOPs  Standard Operating Procedures
SPISM  Specialist Pharmacist in Substance Misuse
SPS  Scottish Prison Service
SSiPPHs  Scottish Specialists in Pharmaceutical Public Health
STRADA  Scottish Training on Drugs and Alcohol
Street Worker  An individual whose profession is street-based prostitution
TDM  Therapeutic Drug Monitoring
TDPS  Tayside Drug Problem Service
VSA  Volatile Substance Abuse
MEMBERSHIP OF THE WORKING GROUP

Chairman:
Mr Lyndon Braddick
Acting Head of Health Care/Pharmacy Adviser SPS Rehabilitation & Care Directorate, SEHD.

Mr John Duffy
(from August 2003)
Strathclyde Police

Ms June Grant
Pharmacist
Princess Royal Maternity Hospital, Glasgow

Members:
Ms Annemargaret Black
Operational and Clinical Team Leader North East Community Addiction Service, Greater Glasgow Primary Care NHS Trust

Ms Dawn Griesbach
(from May 2003)
Effective Interventions Unit, SEHD

Mr Andrew McDonald
Community Pharmacist, Alva.

Professor Christine Bond
Consultant in Pharmaceutical Public Health NHL Grampian
(from August 2003)

Mr Stephen McGill
Scottish Drugs Forum
(from October 2003)

Dr Malcolm Bruce
Consultant Psychiatrist in Addiction, Community Drug Problem Service, Lothian Primary Care NHS Trust

Ms Annamarie McGregor
Director (Pharmaceutical Care Model Schemes) Royal Pharmaceutical Society of Great Britain (Scottish Department)

Mr Robert Dolan
Addiction Co-ordinator Social Work Services – South Addiction Service Glasgow City Council
(from October 2003)

Ms Karen Melville
Principal Pharmacist (Drug Misuse and BBV Prevention)
Carseview Centre, Dundee.

Dr David Dorward
General Practitioner West Gate Health Centre, Dundee.

Mr Stuart Notman
Community Pharmacist, Aberdeen

Mr George Downie
Director of Pharmacy and Medicines Management NHS Grampian

Mr Hugh Purves
Community Pharmacist, Cupar
Mrs Kay Roberts  Co-ordinator: Pharmacy
Needle Exchange
NHS Greater Glasgow

Mr Andy Rome  Effective Interventions Unit,
(until April 2003)  SEHD

Mr Austin Smith  Scottish Drugs Forum
(until September 2003)

Ms Justine Walker  National Officer
Association of Drug and
Alcohol Action Teams

Officers:
Mr Neil Leadbeater  Health Planning & Quality
Division, SEHD.

Ms Cheryl Paris  Health Planning & Quality
Division, SEHD.
LIST OF CONTRIBUTORS

Mr Colin Cook                      Substance Misuse Division, SEHD

Dr Laurence Gruer, OBE            Consultant in Public Health Medicine/Director, NHS Health Scotland

Mrs Karen Norrie                   Addictions Contract Manager, Scottish Prison Service

Dr Kennedy Roberts                Glasgow Homeless Addiction Team

D.S. Kenny Simpson                Drug Squad, Strathclyde Police
DRUG MISUSE IN SCOTLAND: SOME FACTS

Illicit Drugs

Opiates

Opiates continue to be the most common drug type used illicitly by those reported to the Scottish Drugs Misuse Database (SDMD) as entering drug treatment services. Of the 10,311 new clients attending such services in 2002/03 who reported illicit drug use in the past month, more than four out of five had taken opiates. The three main forms of opiates used illicitly were heroin (76%), dihydrocodeine (12%) and methadone (8%). A rise in reported heroin use has been seen in the past five years (69% in 1998/99 to 76% in 2002/03). By contrast, the use of dihydrocodeine and methadone has fallen.

Similarly, for hospital discharges involving a diagnosis of drugs misuse, the drug type most often identified was opiates. Half of the 4,840 drug-related discharges from acute general hospitals, and nearly a third of the 1,768 drug-related psychiatric hospital discharges specifically mentioned opiates.

In May 2003, two-thirds of tests carried out at reception into prison from courts were positive for the use of drugs. In a quarter of all the tests administered opiates were found to be present.

Benzodiazepines

In recent years, diazepam and temazepam were the two main benzodiazepines reported as having been used illicitly by those entering drug treatment services. During 2002/03, more than one in three new clients reported the illicit use of diazepam, making it the second most common drug after heroin. The proportion of new clients reporting the use of diazepam has remained broadly similar over the past five years. In contrast, reports of temazepam use have fallen from 14% in 1998/99 to just 4% in 2002/03. This is perhaps a reflection of the withdrawal of the gel capsule formulation.

Psychostimulants

The number of cocaine and crack cocaine users who come into contact with drug treatment services, or who present at health services with problems attributable to cocaine use, remains low in comparison with heroin. In 2002/03, 739 new clients attending a drug treatment service reported taking cocaine, and 308 taking crack cocaine. Steady increases in the use of these drugs have, however, been seen over the past five years. The percentage of individuals reporting use of cocaine has increased from 2% in 1998/99 to 7% in 2002/03. The use of crack cocaine has increased from 1% to 3%. The number of discharges from an acute hospital involving cocaine more than doubled from 41 (1%) in 1998/99 to 118 (2%) in 2002/03.

Reported use of ecstasy among new people entering drug treatment services has remained broadly constant at around 5% over recent years (434 individuals in 2002/03). Statistics are not available regarding discharges from general acute hospitals with a diagnosis relating to the misuse of ecstasy. However, the number of discharges involving stimulants other than cocaine (of
which ecstasy is one) has fallen slightly from 264 (7%) to 240 (5%) between 1998/99 and 2002/03.

Use of other drugs with opiates

Among those who take opiates, use of other drugs is also common. In 2002/03, over a third of new individuals coming into contact with drug treatment services reported illicit use of diazepam, as well as opiates, in the past month. This does not imply that both drugs were taken at the same time. The main other drug reported by opiate users was cannabis (23%).

Source: Scottish Drug Misuse Database.
ISD Scotland.
DRUG MISUSE IN PREGNANCY

Overview of Drug Misuse in Pregnancy

• In 2001/02, of an estimated total of 49,790 maternities recorded, there were 238 cases where the mother had a diagnosis of drug misuse (4.8 per 1,000 maternities).

• Of the 238 cases where a diagnosis of drug misuse was recorded the majority (155 or 65%) were aged between 20 and 29 years and 30 were aged under 20 years.

• Of the 242 births where a diagnosis of drug misuse was recorded, the majority (161 or 67%) were full-term normal birthweight. This compares to the all-births figure of 90% of births (45,370), which were recorded as full-term normal birthweight.

• In 2001/02, there were a total of 14,185 neonatal discharges in Scotland, of which 257 included a diagnosis of drug misuse (18.1 per 1,000 discharges). It should be noted that neonatal discharge information is only recorded for babies who require medical care or who have a congenital anomaly.

• The rate of maternities where the mother had a diagnosis of drug misuse has increased from 2.4 per 1,000 maternities in 1997/98 to 4.8 per 1,000 maternities in 2001/02.

• The number of neonatal discharges recording drug misuse has increased from 217 in 1997/98 to 257 in 2001/02. As with the maternity discharges, this conflicts with the decreasing trend in all neonatal discharges (17,269 in 1997/98 to 14,185 in 2001/02).

• The rate of neonatal discharges recording drug misuse diagnoses (per 1,000 discharges) was 18.1 in 2001/02. This has increased from 1997/98 (12.6 per 1,000 discharges).

Drugs Recorded

• The most commonly reported drug type for maternities recording drug misuse was opioids. Of the 238 cases, 138 (58%) recorded opioids.

Source: Scottish Drug Misuse Database. Information Services, NHS National Services Scotland.
**APPENDIX FIVE**

**DRUG-RELATED DEATHS IN SCOTLAND**

This section is based on the General Register Office for Scotland’s Short Paper published on 26 August 2004. The paper, and those for previous years, can be found at www.gro-scotland.gov.uk

**Overview of Drug-related Deaths**

In 2003, there were 317 drug-related deaths, 65 (17%) fewer than in 2002. Within these totals, the number of deaths of known or suspected habitual substance misusers fell substantially, from 280 in 2002 to 216 in 2003. However, the number of deaths in this category is 23% higher than in 1996.

**Drugs Recorded**

Of the 317 deaths, heroin/morphine was involved in 175 (55%) of the deaths; diazepam was involved in 153 (48%) of deaths; and methadone was involved in 87 (27%) of the deaths. A wide range of drug combinations was recorded. Of particular note was the fact that diazepam was also mentioned in 95 (54%) of the 175 deaths involving heroin/morphine. The presence of alcohol was mentioned for 128 of the 317 drug-related deaths in 2003. The blood-alcohol level was not given for all cases but, where mentioned, it was often at a relatively low level.

There have been significant increases in the involvement of heroin/morphine and, to a slightly lesser extent, diazepam, though the figures for 2003 both show a fall from the peaks recorded in 2002. Since 1996, there have also been marked increases in the smaller numbers involving cocaine and ecstasy. However, the number of deaths involving cocaine decreased slightly from 31 to 29 between 2002 and 2003, and the number involving ecstasy fell from 20 to 14. Between 1996 and 2000 there was a downward trend in the number of deaths involving methadone, but there has been a substantial increase since then, almost back to the 1996 level (100).

**Age and Gender Profile**

Most deaths (89%) were to persons aged under 45, with a quarter (25%) aged under 25. Of the 36 cases aged 45 and over, only 10 were known, or suspected, to be drug-dependent. Men accounted for 81% of the 317 drug-related deaths in 2003. Almost three-quarters (74%) of the male deaths were of known or suspected misusers compared to only 43% of the female deaths.

**Geographical Profile**

Of the 317 deaths in 2003, 107 (34%) occurred in the Greater Glasgow Health Board area. Lothian with 40 (13%), and Grampian with 37 (12%), had the next highest totals. The Greater Glasgow total showed a large decrease, down from 126 in 2002 to 107 in 2003, that for Grampian fell from 47 to 37, while Lothian’s total increased by 1 to 40. Of the other areas, there were sizeable decreases for Ayrshire & Arran (down from 33 to 19), Forth Valley (down from 24 to 12) and Lanarkshire (down from 37 to 25).

There are some geographical differences in the reported involvement of certain drugs. For example, heroin/morphine was mentioned in a much larger proportion of the deaths in Greater Glasgow (60 out of 107) and Grampian (27 out of 37) than in Lothian (9 out of 40). However, the pattern is reversed for methadone – only 40 out of 107 deaths in Greater Glasgow and 5 out of 37 in Grampian, compared to 19 out of 40 in Lothian. Diazepam was involved in almost two-thirds (72 out of 107) of the deaths in Greater Glasgow.
Notes

1. Care should be taken when assessing these trends because of the possibility that more complete information has been reported in recent years.

2. The definition of a “drug-related death” is not straightforward. A useful discussion on the definitional problems may be found in an article in the Office of National Statistics publication Population Trends†. Further information may be obtained from the following website www.gro-scotland.gov.uk


Source: Scottish Drug Misuse Database. Information Services, NHS National Services Scotland based on information provided by the General Register Office for Scotland.
## NUMBER OF PHARMACIES INVOLVED IN THE SUPERVISED SELF-ADMINISTRATION OF METHADONE [BY NHS BOARD AREA]

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>No. of Pharmacies involved in the Supervised Self-administration of Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Clyde</td>
<td>78</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>66</td>
</tr>
<tr>
<td>Borders</td>
<td>9</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>27</td>
</tr>
<tr>
<td>Fife</td>
<td>59</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>48</td>
</tr>
<tr>
<td>Grampian</td>
<td>92</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>173</td>
</tr>
<tr>
<td>Highland</td>
<td>37</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>84</td>
</tr>
<tr>
<td>Lothian</td>
<td>96</td>
</tr>
<tr>
<td>Orkney</td>
<td>2</td>
</tr>
<tr>
<td>Shetland</td>
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</tr>
<tr>
<td>Tayside</td>
<td>52</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
</tr>
</tbody>
</table>
### Table B2.3: Prescriptions for Methadone Mixture: 1998/99 - 2002/03

<table>
<thead>
<tr>
<th>NHS board of prescription, number and rate per 1000 population¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>Scotland</td>
</tr>
<tr>
<td>Argyll &amp; Clyde</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
</tr>
<tr>
<td>Borders</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>Fife</td>
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<tr>
<td>Forth Valley</td>
</tr>
<tr>
<td>Grampian</td>
</tr>
<tr>
<td>Greater Glasgow</td>
</tr>
<tr>
<td>Highland</td>
</tr>
<tr>
<td>Lanarkshire</td>
</tr>
<tr>
<td>Lothian</td>
</tr>
<tr>
<td>Orkney</td>
</tr>
<tr>
<td>Shetland</td>
</tr>
<tr>
<td>Tayside</td>
</tr>
<tr>
<td>Western Isles</td>
</tr>
</tbody>
</table>

¹ Data is expressed as per 1,000 population, based on GRO mid year estimates.

- (zero); 0 (>0.0 & <0.5)

Source: Information Services - Prescribing Information System (PIS).
**APPENDIX EIGHT**

**NUMBER OF PHARMACY-BASED NEEDLE EXCHANGES**  
**[BY NHS BOARD AREA]**

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>No. of Pharmacy-based Needle Exchanges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Clyde</td>
<td>4</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>7</td>
</tr>
<tr>
<td>Borders</td>
<td>2</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>4</td>
</tr>
<tr>
<td>Fife</td>
<td>9</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>2</td>
</tr>
<tr>
<td>Grampian</td>
<td>11</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>22</td>
</tr>
<tr>
<td>Highland</td>
<td>5</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>18</td>
</tr>
<tr>
<td>Lothian</td>
<td>19</td>
</tr>
<tr>
<td>Orkney</td>
<td>2</td>
</tr>
<tr>
<td>Shetland</td>
<td>1</td>
</tr>
<tr>
<td>Tayside</td>
<td>12</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
</tr>
</tbody>
</table>
## SPECIALIST PHARMACISTS IN SUBSTANCE MISUSE (SPISMs)

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Name</th>
<th>Address</th>
<th>Telephone and E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Clyde</td>
<td>Sarah Harris</td>
<td>Co-ordinated Addictions Network Joint Hospital Cardross Road DUMBARTON G82 5JA</td>
<td>Tel: 01389 604 100 E-mail: <a href="mailto:Sarah.Harris@vol.scot.nhs.uk">Sarah.Harris@vol.scot.nhs.uk</a></td>
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<tr>
<td>Ayrshire &amp; Arran</td>
<td>Frances Donachie</td>
<td>Dundonald Health Centre 2 Newfield Drive DUNDONALD KA2 9EW</td>
<td>Tel: 01563 851 338 E-mail: <a href="mailto:Frances.donachie@aapct.scot.nhs.uk">Frances.donachie@aapct.scot.nhs.uk</a></td>
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<tr>
<td>Grampian</td>
<td>Lucy Eagles</td>
<td>Medicines Unit Westholme Woodend Hospital ABERDEEN AB9 2YS</td>
<td>Tel: 01224 556 621 E-mail: <a href="mailto:Lucy.eagles@gpct.grampian.scot.nhs.uk">Lucy.eagles@gpct.grampian.scot.nhs.uk</a></td>
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<tr>
<td>Greater Glasgow</td>
<td>Carole Hunter</td>
<td>Top Floor New Trust HQ Gartnavel Royal Hospital 1055 Great Western Road GLASGOW G12 0XN</td>
<td>Tel: 0141 211 0315 E-mail: <a href="mailto:carole.hunter@gartnavel.glacomen.scot.nhs.uk">carole.hunter@gartnavel.glacomen.scot.nhs.uk</a></td>
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<tr>
<td>Greater Glasgow [Pharmacy-based Needle Exchange only]</td>
<td>Kay Roberts</td>
<td>Pharmacy Department Leverndale Hospital 510 Crookston Road GLASGOW G53 7TU</td>
<td>Tel: 0141 211 6478 E-mail: <a href="mailto:Kay.Roberts@glacomen.scot.nhs.uk">Kay.Roberts@glacomen.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Lothian</td>
<td>Amanda Hart</td>
<td>CDPS The Spittal Street Centre 22-24 Spittal Street EDINBURGH EH3 9DU</td>
<td>Tel: 0131 537 8345 E-mail: <a href="mailto:ajhart@lpct.scot.nhs.uk">ajhart@lpct.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Tayside</td>
<td>Karen Melville</td>
<td>Carseview Centre Medipark DUNDEE DD2 1NH</td>
<td>Tel: 01382 878 723 E-mail: <a href="mailto:Karen.melville@tpct.scot.nhs.uk">Karen.melville@tpct.scot.nhs.uk</a></td>
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### Examples of Agencies Working in Partnership

<table>
<thead>
<tr>
<th>Brief Description</th>
<th>Contact</th>
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| **Drug Problem Clinic, Dundee** | Ms Dina Ajeda  
Integrated, primary care based service, involving GPs, key workers from the Drug Problem Clinic (DPC) and community pharmacists. Pharmacists return forms to the DPC to provide feedback on clients. Information in ring binder for pharmacists involved.  
Tel: 01382 424 544  
Fax: 01382 424 532 |
| **The Breathe Project** | Ms Shirley Hamilton  
The Breathe Project, launched throughout Greater Glasgow in 2004, is designed to help pregnant women to give up smoking. The project is being led by two specialist midwives and is linked with pharmacies participating in the Starting Fresh stop smoking scheme. The results of the pilot will be evaluated in due course.  
Tel: 0141 201 9804  
Fax: 0141 201 9829 |
| **Information for Prisoners** | Ms Karen Norrie  
The Scottish Prison Service has collaborated with Know The Score to produce information on drugs in the form of magazines and posters for young offenders, women and long-term prisoners. Prisoners have had a direct input into the preparation of the information.  
Tel: 0131 244 8636  
Fax: 0131 244 6996 |
| **Drugs Awareness Training Package** | Mrs Karen Norrie  
STRADA in conjunction with the Scottish Executive Health Department has prepared a drugs awareness training pack aimed at all new recruits to the SPS.  
Tel: 0131 244 8636  
Fax: 0131 244 6996 |
| **NHS Grampian Shared Care Scheme** | Professor Christine Bond  
Action plan for GPs and Community Pharmacists when prescribing “substitute” medication for drug misusers.  
Tel: 01224 558 411  
Fax: 01224 558 609 |
**Shared Care Scheme for Supervised Self-administration of Methadone, Aberdeen**
Development of a shared care scheme for supervised self-administration of methadone, with regular multi-disciplinary training, capitation fee paid to GPs and community pharmacists, supported by a Specialist Pharmacist.

Gillian McLaughlin
Tel: 01224 557 288
Fax: 01224 840 975

**Four-Way Agreement (Berkshire)**
Development of ‘four-way agreement’ for methadone prescribing between pharmacists, GPs, local drug team and patients.

Ms Marion Walker
Tel: 0118 977 4310
USEFUL ADDRESSES

Action on Smoking and Health (ASH)
8 Frederick Street
EDINBURGH
EH2 2HB

Tel: 0131 225 4725
Fax: 0131 220 6604

E-mail: ashscotland@ashscotland.org.uk

ASH Scotland is the leading voluntary organisation campaigning for effective tobacco control legislation. It works to raise awareness about the impacts of tobacco and the activities of the tobacco industry. It also provides help and advice to people who want to give up smoking.

Alcoholics Anonymous:

Tel: 0845 7697555

Website: www.alcoholics-anonymous.org.uk

Alcohol Focus Scotland

2nd Floor
166 Buchanan Street
GLASGOW
G1 2LW

Tel: 0141 572 6700
Fax: 0141 333 1606

The Alliance [formerly known as The Methadone Alliance]
PO Box 32168
LONDON
N4 1XP

Helpline:
Tel: 0208 374 4395

E-mail: methadone.alliance@blueyonder.co.uk

The Alliance supports people who receive prescribed drugs for the treatment of their drug dependency. Service users and professionals work together as equals in a unique initiative to give drug users a real voice in the drug policy debate.

Drinkline Advice Line:

Tel: 0800 917 8282

Drug Action Team Association

Pitteuchar Resource Centre
211 Tantallon Avenue
GLENROTHES
Fife
KY7 4QA

Tel: 01592 412 033
Fax: 01592 412 040
DrugScope
32-36 Loman Street
LONDON
SE1 0EE

Tel: 020 7928 1211
Fax: 020 7928 1771
E-mail: services@drugscope.org.uk

Website: www.drugscope.org.uk

DrugScope is the UK’s leading independent centre of expertise on drugs. It aims to inform policy development and reduce drug-related risk through the provision of drug information, the promotion of effective responses to drug taking and a programme of research at local, national and international levels.

Effective Interventions Unit (EIU)
Substance Misuse Division
Scottish Executive Health Department
St. Andrew’s House
Regent Road
EDINBURGH
EH1 3DG

Tel: 0131 244 5117
Fax: 0131 244 2689

Website: www.drugmisuse.isdscotland.org.eiu/eiu.htm

The Scottish Executive’s Effective Interventions Unit carries out a range of research and evidence gathering to identify effective practice in addressing the problems of drug misuse. The Unit actively disseminates its findings through regional and local seminars and aims to support local teams in implementing evidence-based practice.

Eshara
187 Old Rutherglen Road
GLASGOW
G5 0RE

Tel: 0141 420 8100
Fax: 0141 420 8041

This service is for people from black and minority ethnic communities who are affected by drug/alcohol use. The service offers information, advice and practical help to such people.

e-smokeline

Website: www.hebs.scot.nhs.uk/topics/smoking/e-smoke.cfm

e-smokeline is an electronic helpline which offers advice and support for people who want to give up smoking.

Know the Score (KTS) Advice Line:

Tel: 0800 587 5879

Narcotics Anonymous Helpline:

Tel: 020 7730 0009

National Alcohol Information Resource
Information Services
NHS National Services Scotland
Gyle Square
1 South Gyle Crescent
EDINBURGH
EH12 9EB

Tel: 0131 275 6000
Fax: 0131 275 7500
The NTA, which is a Special Health Authority, aims to increase the availability, capacity and effectiveness of treatment for drug misuse in England. It prepares publications and guidance for professionals working in the drug treatment sector and sets minimum standards for drug treatment under the auspices of the Department of Health, the Home Office and the Anti-Drugs Co-ordination Unit.

Re-Solv

The Society for the Prevention of Solvent and Volatile Substance Abuse
Scottish Regional Office
135b Main Street
East Calder
LIVINGSTON
EH53 0EP

Tel: 01506 881 498
Fax: 01506 881 498
Web: www.re-solv.org

Royal Pharmaceutical Society of Great Britain
Scottish Department
36 York Place
EDINBURGH
EH1 3HU

Tel: 0131 556 4386
Fax: 0131 558 8850
E-mail: info@rpsis.com

Scotland Against Drugs
120 Bath Street
GLASGOW
G2 2EN

Tel: 0141 331 6150
Fax: 0141 331 6151
Website: www.scotlandagainstdrugs.org.uk

NHS 24 [24 hour help and advice from nurses]:

Tel: 08454 24 24 24
Scottish Council on Alcoholism
2nd Floor
166 Buchanan Street
GLASGOW
G1 2NH

Tel: 0141 333 9677
Fax: 0141 333 1606

Scottish Drugs Forum
Shaftesbury House
5 Waterloo Street
GLASGOW
G2 6EY

Tel: 0141 221 1175
Fax: 0141 248 6414

Scottish Drug Misuse Database
Information Services
NHS National Services Scotland
Gyle Square
1 South Gyle Crescent
EDINBURGH
EH12 9EB

Tel: 0131 275 6000
Fax: 0131 275 7500

Smokeline (12 Noon – 12 Midnight):

Tel: 0800 84 84 84