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Pharmacy's role in reducing harm and preventing drug deaths

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Background

Drug deaths have been rising year-on-year in Scotland, and in the UK, and work is ongoing looking at preventing drug deaths, identifying good practice examples to learn from and researching barriers to treatment.

Pharmacists, and pharmacy teams, already play a big role in supporting and providing treatment to people who use drugs, as well as offering harm reduction services and advice. Their work has been especially valued as the Covid-19 pandemic has impacted services and patient access across the country.

The Royal Pharmaceutical Society wants to build on this fantastic work by enabling pharmacists, and pharmacy teams, to do even more to reduce harm from drugs.

The recommendations made in this report are based on engagement with stakeholders. We used a survey to gather views on priority areas, and held focus group discussions and engagement meetings to fully understand the specifics of what pharmacy teams can offer.

What has been apparent throughout the process is that pharmacy teams have the opportunity, with the right support, to do even more to reduce harm from drugs and improve the health of people who use drugs. To achieve this, we are making 14 recommendations, which cover the detail of what we propose is needed. This will require significant resource, expertise and finance. To provide this, we are calling on Scottish Government, pharmacy organisations, contractors and teams to work together to implement these recommendations to reduce harm and prevent drug deaths.

Recommendations: Harm Reduction

RECOMMENDATION 1

Naloxone must be available from every community pharmacy and staff trained to use it. Naloxone should also be kept in first aid boxes for emergency use in any clinical setting where people who use drugs attend, and pharmacy teams in those locations be among the staff trained to use it.

RECOMMENDATION 2

Pharmacy teams in all settings should have the tools to prevent and identify possible dependence on prescribed or over the counter (OTC) medicines and carry out brief interventions where appropriate.

RECOMMENDATION 3

Community pharmacy teams should have a method of recording over the counter medication purchases to help identify overuse or misuse, and enable action to prevent harm.

RECOMMENDATION 4

The expansion of the existing new medication/high risk medication tools in community pharmacy should include medicines with a risk of dependence to encourage and enable education to start at the point of prescribing and dispensing.

RECOMMENDATION 5

Community pharmacies are ideally placed to host targeted public health campaigns around dependence on prescribed, illicit, and over the counter meds. Pharmacy teams in any setting can highlight and reinforce these messages.

Improved multidisciplinary working

RECOMMENDATION 6

All pharmacists should have access to shared patient records and clear communication pathways with other health care professionals involved in the care of people who use drugs.

RECOMMENDATION 7

Some community pharmacies could be set up to act as hubs where patients could access services from other agencies, available for all but particularly to reach those patients not currently engaged with services.

Prescribing, treatment and review

RECOMMENDATION 8

As part of the multi-disciplinary team (MDT) and when appropriate for patients, pharmacists could undertake polypharmacy reviews and carry out health checks to improve the health and wellbeing of people who are dependent on drugs.

RECOMMENDATION 9

Pharmacists and pharmacy teams in all settings could be used to widen patient treatment options and location of treatment supply e.g. Depot buprenorphine injection clinics, independent prescribing and deprescribing.

RECOMMENDATION 10

A new structured service with clear referral pathways should be established to enable prisons and hospitals to refer, to an appropriately trained and resourced community or primary care based pharmacist, people who are at risk and require medication at a time when addiction services are not available.

Education and training

RECOMMENDATION 11

Pharmacy teams should be trained in psychologically informed care and should identify and change areas of their practice to reduce the stigma on this patient group.

RECOMMENDATION 12

All pharmacy teams involved in caring for people who use drugs should undertake mandatory basic training on addiction and harm reduction, plus further training if offering enhanced services in response to local need.

RECOMMENDATION 13

Undergraduate courses should have learning and teaching about addiction that is comparable in scope and depth to other clinical areas, teaching the basics of addiction, harm reduction and extensive training on treatment options, pharmacological and non-pharmacological.

Future developments

RECOMMENDATION 14

Regulated Supervised Drug Consumption Rooms (SDCRs) should be introduced and use of Heroin Assisted Treatment (HAT) should be expanded as treatment options with pharmacy input from the start.

Harm reduction

RECOMMENDATION 1

Naloxone must be available from every community pharmacy and staff trained to use it. Naloxone should also be kept in first aid boxes for emergency use in any clinical setting where people who use drugs attend, and pharmacy teams in those locations be among the staff trained to use it.

A recent study into take home naloxone programmes found that ownership and carriage of the medicine were lower than desired⁽¹⁾. Supplying patients with naloxone and impressing upon them the importance of carrying it is fundamental to the success of the programme.

Community pharmacy teams are ideally placed to make these vital interventions. The *Drug Misuse and Dependence: UK Guidelines on Clinical Management* state that "it is good practice for the pharmacist to engage the patient in a discussion regarding risk management to ensure all harm reduction options have been addressed (such as overdose awareness and provision of naloxone where available)".⁽²⁾ Every community pharmacy team should be able to offer naloxone to anyone they believe to be at risk of an overdose or to anyone who may witness an overdose. This should be offered as part of a package of care which promotes not only the safe use of naloxone but also the importance of carrying it and of naloxone being accessible.

Pharmacists based in other settings, e.g. specialist services, GP practices, should also be engaging patients in conversations about harm reduction. They should be offering education around naloxone and ensuring patients have a supply.

The guidelines also recommend that "opportunistic interventions (such as hepatitis interventions, injecting equipment, and overdose and naloxone training) can be crucial to maximise engagement in potentially life-saving interventions." Community pharmacists are the most accessible healthcare professionals which makes these interventions possible on a regular, sometimes daily, basis. This is true

for not only patients but also family members, friends and those in the community. Interventions can also be offered at times when patients are particularly vulnerable to overdose, for example, during the initial stages of treatment or upon release from prison or hospital.

This accessibility also makes community pharmacy ideally placed to hold a stock of naloxone for use in the event of an emergency in the immediate vicinity. However, we also believe that naloxone should be included in the emergency boxes in any clinical setting where people who use drugs may attend and first aid staff trained to use it, including pharmacy teams.

RECOMMENDATION 2

Pharmacy teams in all settings should have the tools to prevent and identify possible dependence on prescribed or over the counter medicines (OTC) and carry out brief interventions where appropriate.

The principles of brief interventions⁽³⁾ could be applied to prescribed or over the counter (OTC) medicines allowing trained pharmacy staff to engage patients in a non-confrontational way. Brief interventions are a tool to motivate and support patients to think about their medicine use and identify if a change may be required to reduce harm. They can be a way to identify any additional needs and signpost accordingly.

The *Drug Misuse and Dependence: UK Guidelines on Clinical Management*⁽²⁾ make reference throughout to brief interventions and suggest they are beneficial for young people, those at initial assessment of drug misuse or where the person is perhaps not at the threshold of requiring more structured help, which is often the case with prescribed or OTC dependence. The guidelines also recognise the invaluable resource that pharmacists can be in identifying problems, harm reduction and the provision of brief interventions, particularly for the ageing drug treatment population with complex comorbidities.

Pharmacists, and pharmacy teams, are ideally placed to make an impact on patient care through brief interventions. Interventions can take place in any setting the patient may attend, do not require any formal arrangements to be made and are quick, making them ideal for patients presenting at a community pharmacy, general practice surgery, custodial setting, or even when receiving their discharge medication from hospital.

Use of brief interventions would ensure that every contact the pharmacy team has counts. To achieve this, carefully developed tools will be required with clear, distinct messages to educate and support patients in a way that means these interventions are meaningful and effective. Previous campaigns have used communication bundles ⁽⁴⁾ to ensure that safety messages are delivered specific to that medicine every time it is dispensed/sold. This model which would work well with prescribed and OTC medicines susceptible to dependence. The whole pharmacy team must be involved and trained to deliver a consistent and professional message to patients, with aide memoirs supplied to reinforce the message.

RECOMMENDATION 3

Community pharmacy teams should have a method of recording over the counter medication purchases to help identify over or misuse, and enable action to prevent harm.

Sales of OTC products, particularly pain relief and sleeping aids, are continuing to increase.

⁽⁵⁾ Pharmacists and pharmacy teams could provide much needed interventions and education on the dependent nature of some of these medicines.

⁽⁶⁾ Public health campaigns such as those mentioned below would be a starting point to get these messages across but, with patients still able to make multiple purchases from different community pharmacies with no way of this being monitored or recorded, the risks of harm are still high.

A method of recording OTC sales of medicines liable to abuse or dependence would help address this issue. Patients registering with one pharmacy could facilitate this. The records would need to be accessible to others, where appropriate, and relate to a particular patient. A shared patient record would enable this to be done in a quick and unobtrusive manner while recording what could be valuable and potentially lifesaving information (see Recommendation 6).

RECOMMENDATION 4

The expansion of the existing new medication/high risk medication tools in community pharmacy should include medicines with a risk of dependence to encourage and enable education to start at the point of prescribing and dispensing.

High risk medicines are defined as medicines that have a high risk of causing injury or harm if they are misused or used in error, ⁽⁷⁾ Medicines with a risk of dependence come under this definition. Pharmacy teams can use existing high risk medicine tools to identify harm or deterioration in patients taking these medicines. They can intervene to prevent harm and to structure a timely response if harm occurs.

Extension of the current community pharmacy new medicine tool to include the classes of medication with a risk of dependence would allow community pharmacy teams to educate patients at the point of dispensing, building on information provided during the consultation with the prescriber (who may be a pharmacist or another professional). This will encourage person centred working with realistic expectations from the outset, as well as patient awareness of the risks and limitations of treatment. It also allows an opportunity for discussion on non-pharmacological treatments which may be of benefit and ensure a holistic approach to care.

RECOMMENDATION 5

Community pharmacies are ideally placed to host targeted public health campaigns around dependence on prescribed, illicit, and over the counter meds. Pharmacy teams in any setting can highlight and reinforce these messages.

Public health is an intrinsic part of pharmacy practice. Pharmacists and pharmacy teams, working in all settings, can support people with dependence on medicines and/or drugs and prevent dependence from happening by promoting public health messaging. Teams can educate patients on the importance of adhering to maximum treatment times and dosing, self-management and seeking help with concerns about personal use.

For campaigns to be successful all pharmacy team staff must be trained and involved. Public health campaigns around smoking cessation have been very successful in the past. Organisations enhance their impact by working together and utilising visual aids, posters, leaflets, and training. Trained staff can then engage patients and get the important messages across.

Campaigns are needed to raise public awareness of a growing issue of prescribing⁽⁸⁾ and dependence on certain groups of medicines. It would also work well in targeting those purchasing medication over the counter and online. There is also a role in educating the general public on drug treatment options as a way to try to de-stigmatise seeking drug treatment.⁽⁹⁾ As the most accessible healthcare professionals, community pharmacy teams are ideally placed to deliver a campaign's key messages. These messages could be reinforced across healthcare settings with posters and materials. Pharmacy teams in all settings can also raise awareness of risks while ensuring patients do not stop medication abruptly or inappropriately.

Improved multidisciplinary working

RECOMMENDATION 6

All pharmacists should have access to shared patient records and clear communication pathways with other healthcare professionals involved in the care of people who use drugs.

Achieving Excellence in Pharmaceutical Care called for a digital infrastructure capable of allowing pharmacists and their teams to increase their clinical role.⁽¹⁰⁾ Key to this are shared patient records and better communication. People with dependence or addiction issues would benefit from the extended range of interventions this would allow.

Access to shared patient records would mean independent prescribing services would be possible from a variety of settings to increase patient choice. Clinics for the administration of long acting preparations of Opioid Substitution Therapy (OST) could be provided in the community as communication and reporting would be improved. Monitoring and interventions in prescribing or purchasing of medicines liable to abuse would be easily tracked and recorded.

Most importantly, shared patient records would have a potentially significant impact on drug deaths with the ability to share more quickly, easily, and accurately relevant and potentially lifesaving information with other healthcare providers. For example, for patients receiving OST or antiretroviral medication, this improved infrastructure would allow reporting of missed or refused doses. This helps identify patterns of attendance which may give cause for concern. It would be possible to align all a patient's medication and the information could be used to increase concordance by linking the supply of other medicines to OST in the community where appropriate. Shared records could also provide information relating to high-risk times for patients e.g. bereavement, recent non-fatal overdose, when support from the community pharmacy team would be important.

The recently published *Medication Assisted Treatment (MAT) Standards*⁽¹¹⁾ call for "information sharing agreements that enable multiagency partnerships to deliver timely, high-quality and equitable care. These should allow for shared record keeping between the multiagency team providing care including social care, housing, community pharmacy, GPs, Police Scotland, Scottish Ambulance Service (SAS), primary and secondary care and third sector providers." We believe that a shared patient record would help achieve this. People who use drugs can interact with multiple agencies, with very limited joined up working. A shared patient record would allow a truly holistic approach to be taken to their care without the need to remove any of the support network that is in place.

The responses to our survey highlighted communication between healthcare professionals involved in a patient's care as one of the major barriers pharmacists and pharmacy teams must overcome to provide effective treatment. Not only would a shared record allow access to clinical notes and treatment plans, where appropriate, it would allow improved communication between healthcare providers. Pharmacy teams would be able to see who was involved in the patient's care. The record would contain direct contact details allowing quicker reporting of issues and concerns which would facilitate better patient outcomes.

RECOMMENDATION 7

Some community pharmacies could be set up to act as hubs where patients could access services from other agencies available for all but particularly to reach those patients not currently engaged with services.

Some community pharmacies could become primary care public health and holistic care hubs if resourced accordingly. They could improve access, engagement, and onward referral to other NHS and third sector services. The availability of community pharmacy situated hubs, and the services they would offer, would be based on local need.

Research has shown that patients value a range of services when choosing where to access care.⁽¹²⁾ This, coupled with good relationships with the pharmacy team, make community pharmacies the ideal sites from which to offer enhanced services. Access in this way builds on the existing stable and supportive environment patients respond to.

Consultation rooms in some community pharmacies should be used to their full advantage and where possible developed. Private areas and rooms could be used to allow the most vulnerable, the homeless population or those not engaged with services, access to digital technology. The groups of patients would have facilitated access to other NHS professionals and other agencies involved in their care e.g. housing, etc. This helps address inequalities of access while allowing the consultation to take place in a venue with professional support from the pharmacy team.

Community pharmacies could be the base from which outreach services are provided, either by staff or third-party providers. This maintains the relationship many patients value from their pharmacy teams whilst taking the care required to the patient. For patients who are not currently in treatment, this gives them a location with healthcare professionals on hand. From there they can access help and advice until they are ready to enter treatment.

Prescribing and Treatment

RECOMMENDATION 8

As part of the multi-disciplinary team (MDT) and when appropriate for patients, pharmacists could undertake polypharmacy reviews and carry out health checks to improve patients' health and wellbeing.

Scotland has an ageing drug using population with the average age of those having a drug related death rising from 30 in 2000 to 42 in 2019.⁽¹³⁾ For these people, the risks associated with their drug use have increased as they have aged and they are faced with complex additional health problems. Polypharmacy is a key challenge in complex health care situations and pharmacists in all settings are ideally placed to undertake polypharmacy reviews. This could directly target patients who are most at risk of health harms but who are least likely to engage at a time which is appropriate for the patient. Reviews could be carried out at locations to suit the patient. This type of assertive outreach has been shown to increase access to medicines for patients who would otherwise remain forgotten.⁽¹⁴⁾ It is vital this is done as part of the patient's MDT and with the necessary IT infrastructure in place to ensure the patient's medical history is available. This would also ensure any interventions can be recorded and reported back to the wider team, as well as the patient's GP or homeless GP team. There must also be in place referral pathways to enable the team to refer on if further care or assessment is needed e.g. mental health assessment.

Pharmacists could offer physical health monitoring, support, and reviews of other long-term conditions. The *Scottish Government "Keep Well" Programme* was rolled out in 2006 and used pharmacy teams to help to tackle health inequalities. One of the major actions was the anticipatory care model which targeted areas of greatest need in the hope of identifying health issues before they became problematic. This would work to reduce harms in people who use drugs by engaging them in a setting they are already comfortable in. It would give them access to basic health checks they miss out on and identify issues.

RECOMMENDATION 9

Pharmacists and pharmacy teams in all settings could be used to widen patient treatment options and location of treatment supply e.g. Depot buprenorphine injection clinics, independent prescribing and deprescribing.

The recently published *MAT standards* have been developed to ensure that patients are offered a person-centred, holistic treatment plan delivered in a way that suits them.⁽¹¹⁾ Standard 2 of the *MAT standards* calls for patients to be supported to make informed medication choices. Pharmacists and pharmacy teams can help deliver that support as an integral part of the multi-disciplinary team. As experts in medicines, pharmacists are ideally placed, at the start of treatment, to provide guidance and information on the treatment options for patients to help them make informed decisions about their care ensuring a *Realistic Medicine*⁽¹⁵⁾ approach to treatment, the team can then work with the patient over time to evaluate the treatment, dose, and instalment schedule. The team can then work with the patient to adapt their treatment to meet their current needs.

With the correct IT infrastructure, support and training, pharmacy teams can offer clinics in the community and in GP practices for prescribing of OST and long-acting buprenorphine. Community pharmacies can also offer administration of long-acting buprenorphine. These options would be particularly beneficial to patients in rural settings where access to specialist services is a barrier to treatment. Pharmacists can also offer deprescribing of addictive medication in primary care, specialist, or community settings. This allows patients the choice of treatment location and at times that suit them. It is hoped that enabling this flexibility would increase retention in treatment, increase engagement, improve the patient experience, and reduce drug deaths.

RECOMMENDATION 10

A new structured service with clear referral pathways should be established to enable prisons and hospitals to refer, to an appropriately trained and resourced community or primary care based pharmacist, people who are at risk and require medication at a time when addiction services are not available.

The following are recognised times when people who use drugs are more at risk of overdose and subsequent drug death -

- On release from prison
- On leaving residential rehabilitation or hospital
- When recently detoxed
- During relapse
- When in poor physical or mental health
- After a recent life event, such as bereavement, relationship breakdown or loss of custody of children
- During Festive periods, weekends, or holidays.

Some of these events can be unplanned, such as release from prison, leaving hospital or a rehabilitation facility. This can lead to a breakdown in the normal throughcare pathways that are followed, leaving people vulnerable. Other times are out of hours or at times when services are typically closed such as festive periods or weekends. The normal emergency supply routes for obtaining medicines cannot be offered safely in these circumstances often due to a lack of communication or the nature of the medication, and therefore a new structured service is required.

Achieving Excellence in Pharmaceutical Care calls for “high quality seamless care at all points of the persons journey across the healthcare system” ⁽¹⁰⁾. In the absence of 24-hour addiction services, a structured service is required to enable prisons and hospitals to refer patients directly to an appropriate community or primary-care based pharmacist when the normal throughcare channels are unavailable. This must be a clear referral pathway underpinned by appropriate IT infrastructure, information sharing and governance. If developed, it could result in pharmacists being able to ensure no patient is left without medication when their usual prescriber is unavailable, which may be especially useful since community pharmacies are open extended hours and at weekends, times when other services are typically closed. Alongside this, consideration should be given to extending the availability of addiction services into out of hours periods.

Education and training

RECOMMENDATION 11

Pharmacy teams should be trained in psychologically informed care and should identify and change areas of their practice to reduce the stigma on this patient group.

The Scottish Government Paper *Substance Misuse Services: Delivery of Psychosocial Interventions* ⁽¹⁶⁾ and the newly published *MAT standards* ⁽¹¹⁾ both stress the importance of psychologically informed care. Pharmacy teams can build on their current skills to offer a more psychologically informed approach.

With some additional training, pharmacy staff should offer trauma awareness and motivational interviewing to build a non-judgemental therapeutic relationship with the patient. In areas of need, pharmacy teams could then undergo further training and move up to a more enhanced level of service where interventions are more structured. Once established as health hubs, community pharmacy teams could offer remote treatment options e.g. computerised Cognitive Behavioural Therapy (CBT) with a professional pharmacy team on-site to offer support.

As healthcare professionals it is important that pharmacists and pharmacy teams reflect on their own practice and identify areas they could change to help reduce stigma e.g. restricted opening times, language they use. ⁽¹⁷⁾ Teams must ensure all patients who access their services are treated fairly and consistently.

It is happening already

Training for whole pharmacy teams has been piloted in Scotland. ⁽¹⁸⁾ This very successful pilot indicates the willingness and potential for such training. Staff undertook a facilitated review of their practice to identify where it could be potentially stigmatising, albeit unintentionally. It also highlighted the importance of communication skills to support people appropriately. We recommend expansion and evaluation of psychologically informed environments (PIE).

RECOMMENDATION 12

All pharmacy teams involved in caring for people who use drugs should undertake mandatory basic training on addiction and harm reduction, plus further training if offering enhanced services in response to local need.

Pharmacists and their teams are at the front line of patient care wherever they are practising. With accessibility comes sensitive and challenging situations, and staff need to be equipped with the correct training to support patients. Our recent survey, undertaken to inform the development of this policy, showed that 92% of respondents believe that mandatory training on several topics should be undertaken by pharmacists to allow them to provide OST and harm reduction services.

Mandatory training is not unusual. It is required for the provision of several services already, including injecting equipment provision in many locations. Mandatory training would ensure a basic level of knowledge and skills, and enable the pharmacy team to better provide a full holistic service for this patient group.

Therefore, mandatory training is recommended on naloxone, OST, safer injecting techniques, suicide awareness, domestic abuse/violence and child protection.

Training, specifically in OST, has been shown to increase both the confidence and skills of the workforce with regards to treating this patient group as well as significantly changing attitudes for the better. ^(19,20) These outcomes encourage a more person-centred approach to treatment and therapy.

Mental health first aid and suicide awareness are essential skills when dealing with people who use drugs. In 2019/20, 60% of patients assessed for specialist drug treatment reported they suffered from mental health issues. ⁽²¹⁾ These patients may have frequent contact with pharmacists, and pharmacy teams, and will present at times of risk and vulnerability. Pharmacy teams, regardless of setting, can support these patients. There must also be in place robust onward referral processes. This would also support Scotland's suicide prevention action plan which calls for access to skilled staff and well-co-ordinated support. ⁽²²⁾

Pharmacists routinely undertake training to provide enhanced services, but the training usually focusses on the specifics of the service i.e. eligibility, how to run the service, payment, etc. Instead, pharmacists should have access to training which will give them the knowledge to provide enhanced services. This will also give them the confidence and skills to make each contact count which it is agreed leads to better outcomes, health, and wellbeing for the patient, as well as improved confidence and motivation among staff.⁽²³⁾ Enhanced training covers several areas including challenging discussions, motivational interviewing, trauma training and training on psychologically informed environments. More than 80% of respondents to our survey felt training on handling challenging discussions should be mandatory. Two thirds of respondents also felt that training in trauma should be undertaken by those offering any enhanced addiction service. We believe that training such as the *NES National Trauma Training Programme*,⁽²⁴⁾ or similar, should be undertaken by members of pharmacy teams, in any setting. Teams can then recognise where someone has been affected by trauma and respond in a way that can reduce harm. Training programmes undertaken should be informed by people with lived experience, as the NES programme is, to embed person centred care from the outset. t

RECOMMENDATION 13

Undergraduate courses should have learning and teaching about addiction that is comparable in scope and depth to other clinical areas, teaching the basics of addiction, harm reduction and extensive training on treatment options, pharmacological and non-pharmacological.

Most pharmacists, regardless of sector or role, will at some point provide care for people who use drugs. To fully prepare the pharmacists of the future, all undergraduate courses should have learning and teaching about addiction that is comparable in scope and depth to other clinical areas such as cardiovascular disease or diabetes. We believe this is best achieved through the integration of addiction teaching within a coherent teaching and learning strategy that meets the requirements of the General Pharmaceutical Council's *Standards for the Initial Education and Training of Pharmacists (2021)* ⁽²⁵⁾ and decisions about how this is best delivered are made by the course team.

This recognises that modular structures differ between universities and calling for a “stand-alone” module would not address the disparity in depth and scope of this area that currently exists. Regardless of how this teaching is delivered, key competencies which students must achieve in this area should be detailed. The course should include every aspect of addiction from the basics i.e. why some people become addicted and others don't, underpinning trauma and harm reduction to the treatments available, including pharmacological and non-pharmacological options. Undergraduate teaching on addiction currently varies greatly. It can range from workshops scattered over the undergraduate years to full modules touching on every aspect of addiction with experiential learning visits to treatment centres and patients with lived experience coming in to share their knowledge with students. A consistent approach would furnish all new pharmacists with an understanding of the deeper issues facing those with addiction including trauma and co-morbidities. It would also address the stigma that is associated with this patient group.

Practical experience of working with this patient group should also be undertaken by students within the initial education and training of pharmacists first five years. They should be encouraged and supported to challenge inequalities in service (e.g. restricted access) and to pass on their education to those with stigmatising views. The foundation pharmacists' first aid course should include how to administer naloxone in an emergency. Normalising the administration of this life saving medication will also go some way to addressing stigma.

The Scottish Government *Rights, Respect, and Recovery: Alcohol and Drug Treatment Strategy* highlights the importance of people with lived and living experience being involved in the design, development and delivery of services. ⁽²⁶⁾ This approach is also vital when teaching about a particular patient group. People who use drugs face challenges at every stage of their healthcare journey and raising awareness of this with students is essential. The experiences of people who use drugs can shed light on inequalities and stigma. It also allows them to share their positive stories and views on good practice on all aspects of their care. It is important people are drawn from a range of appropriate backgrounds. This avoids training only in one particular ideology which can be detrimental. Students are then exposed to a variety of experiences and are trained with a balanced view. This teaching reinforces for students the value of a person-centred approach to their practice, regardless of sector.

Future developments

RECOMMENDATION 14

Regulated Supervised Drug Consumption Rooms (SDCRs) should be introduced and use of Heroin Assisted Treatment (HAT) should be expanded as treatment options with pharmacy input from the start.

As we consider new ways of engaging with patients in a bid to reduce drug deaths it would be remiss of us not to consider ways of working and engagement which have proved very successful in other countries. There are now around 100 supervised drug consumption facilities across the world, primarily in Europe, which have provided over thirty years of evidence of their effectiveness.

The RPS, as the leader in safe and effective use of medicines, supports the establishment of regulated drug consumption facilities, and the necessary changes in legislation to enable this, as part of a focus on reducing drug deaths. Pharmacist and pharmacy teams are ideally placed to advise on the appropriate governance structures required to operate a regulated facility of this nature.

Providing a clean safe place for injecting users brings them closer to mainstream health and addiction support services. It provides the opportunity for health professionals to engage in treatment and prevention. Once the regulated consumption room is established, pharmacy team input may not be directly required for the long term running of the facility. However, there is an opportunity for outreach work to be carried out by pharmacy teams, and for health and medication checks to be undertaken in a population who may not be engaged with services.

The First Minister of Scotland announced in January 2021 that additional funding will be made available for heroin assisted treatment services to allow this treatment option to be more widely available.⁽²⁷⁾ The RPS advocates that it is vital that pharmacists, and their teams, are involved in the process from the start. A pharmacist's knowledge of the legal, ethical, and practical implications of dealing with Controlled Drugs (CDs) and their expert medicinal knowledge is essential for the safe and effective running of these services. Pharmacists and their teams can ensure the legal operation of all aspects of the service including product procurement, CD destruction, CD governance and compliance checks for CD stock as well as, in some cases, drug reconstitution and dose preparation. The RPS would also like to see the current restrictive legislation changed to open the eligibility for schedule 1 CD prescribing licences to other healthcare professionals, including pharmacists, to increase access to care for patients.

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