

2019

Responding to Drug Use with Kindness, Compassion and Hope

A report from the Dundee Drugs Commission

PART TWO – SUPPORTING EVIDENCE – BACKGROUND

Presented to the Dundee Partnership

**FOR FURTHER INFORMATION
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<p>The Chair of the Commission (Robert Peat) and the Commission Facilitator (Andy Perkins) were assisted by a small steering group (below), who provided guidance and support. This group met on six occasions. The Commission are grateful for the advice and support they provided.</p>	
<p>Peter Allan (Community Planning Manager, Dundee City Council)</p>	<p>Vered Hopkins (Protecting People Lead Officer, Dundee Protecting People Team)</p>

NOTE: Simon Little was a member of the Drugs Commission until January 2019 when he resigned his position to take up the role of independent Chair for the Dundee Alcohol and Drugs Partnership.

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Reports

This **Part 2** report is the first of two 'Supporting Evidence' Appendix reports of the Dundee Drugs Commission and provides nine background and contextual evidence documents (**Appendices I – IX**). The other 'Supporting Evidence' Appendix report provides records of the thirteen 'fieldwork' evidence gathering activities (**Appendices X – XXII**) conducted by the Commission during its tenure. These two documents document the evidence to support the findings and recommendations in the Commission's main 'Part 1' report.

Disclaimer

This report contains the views of members of the Dundee Drugs Commission who also took into account data, intelligence, evidence and views from invited participants and experts as well as over a thousand people who have responded to the Commission's calls for evidence. The members do not speak on behalf of any organisation but rather express their own conclusions following evidence from these and many other sources. The report is not intended to reflect the entire breadth of the discussions that have taken place over the last year but, instead, is a distillation of the many and varied contributions that have been made.

It is not the intention of this report to cast aspersions on any individual, but rather to help identify where systems and services aren't working as they should in order to help identify realistic and workable solutions.

For details of the Commission members (see **Appendix I** in this report), as well as those who attended and contributed to the discussions (see **Appendices XI, XIII-XXIII** in the **Part 3 – Supporting Evidence – Fieldwork** report).

Acknowledgments

The Commission would like to place on record its grateful thanks to all the individuals and organisations who have given evidence to the Commission – often requiring great courage to recount difficult and painful experiences.

The Commission would also like to express its thanks to the wide variety of speakers who gave up their time to prepare and present to the public meetings of the Commission. These sessions provided a wealth of valuable information and insight – without which the Commission's report would be incomplete.

Finally, the Commission would like to acknowledge the time and input from the team (Christian Cole, Emma Corrie, Harry Gray and Joyce Klu) at the Leverhulme Research Centre for Forensic Science (University of Dundee) who have produced the primary analysis of the 'deeper dive of Drug Related Death data' which was commissioned from ISD Scotland (see **Appendix XII** in the **Part 3** report).

APPENDIX I: COMMISSIONER MEMBERS – BIOGRAPHIES

This appendix provides short biographies/profiles of all the professional members of the Dundee Drugs Commission. These professional members were also joined by three members with lived experience and/or family experience of a person who experiences problems with drugs.

Dr Robert Peat (Chair)

Robert graduated from the University of Strathclyde in 1980 with a BA in Sociology and Administration. He obtained his PhD from the University of Aberdeen in 1984.

Retired from the Scottish Care Inspectorate (May 2016) where he had worked for 3 years. Robert was the Director of Inspection and latterly the Executive Adviser to the Board of the Inspectorate.

A social worker for over 30 years Robert's main career was in Local Government in the Tayside area of Scotland. He became Director of Social Work and Health with Angus Council in 2003 and from 2006 was also the Depute Chief Executive of the Council, a role he fulfilled alongside his duties as Director of Social Work and Health. Robert left Angus Council in 2013 at a point when the Council was undertaking a major reorganisation.

Robert was Chair of the Angus Alcohol and Drug Partnership for ten years from 2003 until 2013.

Robert was appointed as a Non- Executive Member of NHS Tayside Board and took up this position on 1st January 2017. This is a 4year appointment.

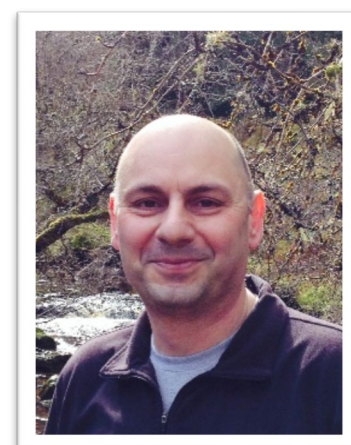
Robert has recently worked as a consultant with Support in Mind Scotland and is also a member of an Expert Panel with the Commissioner for Older People (Northern Ireland).



Prof Alex Baldacchino

Professor Baldacchino is Professor in Medicine, Psychiatry and Addictions at the St Andrews University, Scotland, UK. He was awarded membership with the UK Royal College of Psychiatrists (MRCPsych) in 1994, Fellowship with the UK Royal College of Psychiatrists (FRCPsych) in 2007 and Fellow with the Royal College of Physicians (Edinburgh) (FRCPE) in 2017.

Since 2001 he has, along his academic career, also worked with NHS Scotland as a Senior Consultant Psychiatrists and Clinical Director in



Addiction Medicine and in 2015 NHS Fife Research and Development (R&D) Director. He is President Elect and Executive Board Member for the International Society of Addiction Medicine (ISAM). His research portfolio have a common thread of understanding the comorbid conditions (physical and psychological) arising as a result of chronic abuse of pharmacological agents with dependence potential especially opioids, nicotine and alcohol. He has around 150 peer reviewed publications. He is also Honorary Professor with the University of Dundee and City of Dundee Ambassador.

Sharon Brand

Sharon Brand is co-founder and the main organiser of 'Recovery Dundee' and is in long-term recovery from drug use. 'Recovery Dundee' is an independent community of people in recovery, who have come together to support the development of recovery in Dundee. They have social events that are substance free providing a safe place to go, such as: open mic nights, peer support groups, health, fitness, nutrition and alternative therapies. They work in partnership with the Albert Street community hub and support people to maintain and sustain their own recovery.



Dr Andrew Fraser

Andrew Fraser is Director of Public Health Science with NHS Health Scotland. He was Director of Public Health in NHS Highland from 1994-97, Deputy Chief Medical Officer in the Health Department of the Scottish Office, then Scottish Executive from 1997-2003. He was responsible for advice on Public Health Policy. From 2003-2012, he worked in the Scottish Prison Service as Director of Health and Care, where he also worked with WHO to improve prisoner's health. His current focus is on public health reform, and ways to tackle health inequalities in Scotland.



Prof Eilish Gilvarry FRCPsych MRCGP FRCPI DCh DObs

Eilish Gilvarry is a Consultant Psychiatrist in Addictions at Newcastle Addictions Service, Professor of Addiction Psychiatry at the University of Newcastle upon Tyne and has been involved with UK addictions services over many years. She has been Clinical Director of Specialist Services and Forensic Services until 2016 at Northumberland Tyne and Wear NHS Foundation Trust (NTW) and currently is Deputy Medical Director for Appraisal and Revalidation at NTW.

She chaired the Executive Committee of the Royal College of Psychiatrists Addictions Faculty (2004-08) and was involved with a number of working parties: member of the National Institute for Clinical Excellence (NICE) guidelines on opiate detoxification (2007), NICE guidelines on clinical management of alcohol related physical complications (2010-11), NICE guidelines on management of alcohol harm and dependence (2011), member of the review of 'Orange' clinical management guidelines with the Department of Health and



Public Health England (PHE) published 2017. She is Chair of the review of the "Blue Book" - Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management (2017-2018). In 2010 she chaired a review of injectable treatment for people experiencing drug problems. She also reviewed deaths in prison (2011-13), this review of practice standards in prisons informed the review of the section on custodial care included in "Orange" guidelines. She has a particular interest in young people and use of substances and has been involved in research and lecturing on this subject.

Chair of the Secretary of State for Transport's Advisory Committee on drugs and alcohol and a member of the expert panel which produced the report "Driving Under The Influence Of Drugs" (2013), Eilish continues to advise on this issue. She has edited several books, published widely in scientific journals and is currently involved in research particularly with young people and brief interventions for alcohol misusers. She is also an Assessor and Medical Supervisor with the General Medical Council and other regulatory authorities.

John Goldie

John Goldie qualified as a Registered Mental Health Nurse in 1988, working in Glasgow until retiring in 2017. During this time John set up needle exchange services in Gorbals and Pollok areas of Glasgow in the early 1990's. He started in the newly commission Glasgow Drug Problem Service in 1995, Offering the first Opiate Replacement Therapy service across the Glasgow City.



In the 1999 John joined the Homeless Addiction Team in Glasgow as service manager as part of the cities hostel closure and re-provision programme. In the early 2000's John became Community Addiction Manager in the newly formed integrated Glasgow Addiction Service working in Easterhouse and later becoming Head of Addiction services for South Glasgow in 2005 until his retirement. During this time, he was Glasgow City strategic lead for Recovery and Employability and along with colleagues was central to reviewing of Glasgow services and their move to creating recovery-oriented systems of care. John's clear and committed to the requirement that recovery needs to be central to all care and treatment and has promoted asset-

based care for the last 10 years. Introducing lived experience into service delivery as an essential component alongside integrated health and social care professionals.

John was the Chair of the Scottish Recovery Consortium from 2014 to 2017 and is still the Chair of the South Glasgow Recovery Network.

John is also an advisor on the board of FASS Glasgow family support group.

Most recently John has just completed an independent review of Renfrewshire Alcohol Drugs Services commissioned by Renfrewshire Health and Social Care Partnership and Renfrewshire Alcohol and Drug Partnership.

Cllr Kevin Keenan

Kevin Keenan is currently Leader of the Labour Group on Dundee City Council, Chair of the Scrutiny Committee.

Kevin's background is in engineering and for over 30 years his employment involved him in the manufacturing, supply and installation of power equipment within the electricity supply industry.

He is now the Manager of ATM RC Limited, a growing Arbroath based company that is involved in the upgrade and refurbishment of ATMs and their component parts. Supplying and supporting customers from the worldwide financial industry

Kevin was first elected to Dundee City Council in May 1997. He was re-elected for a second term in 2003 to present representing the multi-member Ward of Strathmartine.



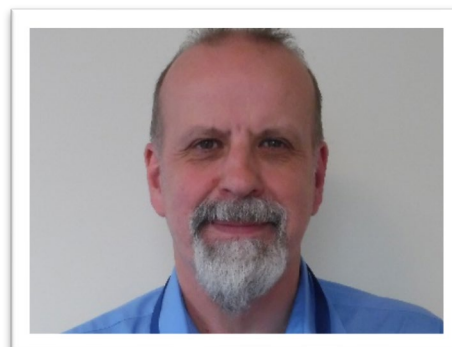
During his time on Dundee City Council and in Local Government he has held various positions including:

- Leader of the Council
- Chair of the Waterfront Board
- Chair of the Dundee Partnership
- Member of Scottish Enterprise Tayside Advisory Board
- Convener of Education
- Convener of Communities
- Chair of CoSLA Audit Committee
- Former CoSLA Capacity & Resources spokesperson

Kevin has a keen interest in partnership working to improve health outcomes and address life and health inequalities.

Eric Knox

Eric is currently the CEO of Volunteer Dundee taking up the role in May 2017. Prior to this he spent 30 years with Tayside Police working in a variety of roles mainly within the Criminal Investigation Department. In the early 2000's he was seconded to the newly formed Scottish Drug Enforcement Agency (SDEA) responsible for the Drug Strategy Unit. He oversaw the production of two National Drugs Death Reports and 4 strategic assessments for the Association of Chief Police Officers (ACPOS) on drug use in Scotland working closely with Glasgow University. Latterly he was the Director of Crime Policy within Tayside Police HQ Crime and responsible for the implementation of the Scottish Governments Community Disclosure for Sex Offenders across Scotland. On retirement in 2011 he took up the role of Director of Tayside Council on Alcohol (TCA) the leading third sector organisation across Tayside in supporting individuals who have issues with alcohol. He led the organisation for 6 years. He was heavily involved in creating mentoring and peer support for individuals in recovery who are also involved in the criminal justice system across Tayside. During this period, he was the third sector representative on two of the three ADPs across Tayside and chaired the Angus ADP for three years until he took up his current role.



Dave Liddle OBE

David leads the SDF staff team. He has worked for Scottish Drugs Forum since its inception in 1986 and in the field of drugs, alcohol and homelessness for over 35 years in England, Ireland and Scotland. He served on the UK Government's Advisory Council on the Misuse of Drugs from 2008 until 2017. He is a Board Member of the national anti-poverty network in Scotland, The Poverty Alliance.

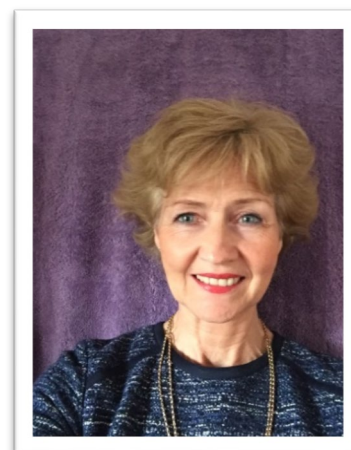
He was a key player in the development of harm reduction services in Scotland, advocating the introduction of needle exchanges and substitute prescribing programmes. Since the creation of the Scottish Parliament in 1999, he has been a Secretary to the Cross-Party Group on Alcohol and Drug Misuse. He pioneered approaches to the involvement of people with experience of drug problems in influencing the planning and delivery of services – particularly through SDF's peer research approach. An active member of the European Civil Society Forum on Drugs, David is a regular media commentator on issues relating to problematic drugs use in Scotland. He has contributed to a number of publications on drug use in Scotland. David was made Officer of Order of the British Empire (OBE) in the Queen's 2012 Birthday Honours for services to disadvantaged people in Scotland.



Jean Logan

Jean Logan is Associate Director of Pharmacy, Community Care, NHS Forth Valley. She has a broad range of pharmacy experience with expertise in substance misuse and mental health.

Her pharmacy degree was obtained from Heriot Watt University and Masters in Psychiatric Pharmacy at De Montford University. She is a previous chair of the Scottish Specialist Pharmacists in Substance Misuse and member of the Scottish Mental Health Pharmacy Strategy Group.



Cllr Ken Lynn

Ken Lynn has been a councillor since 2007 and is the current vice-chair of the Dundee IJB. He has lived in the city for over 20 years and has had a long career working with homeless people, many of whom have issues with drugs and alcohol. The damage he has witnessed caused by substance use is his primary motivation for involvement in the commission and he wants to see better outcomes in terms of prevention, recovery and harm reduction. He has been vocal in his desire to see changes which will make a difference to Dundee's drug deaths toll.



Susie Mertes

Suzie Mertes was born and raised in Forfar. She studied at Dundee University and holds 2 degrees, an MA (Hons) in English and Political Science and an LLB and has completed the Diploma in Legal Practice.

Suzie Mertes joined Tayside Police in 1995 and early in her probation joined the Accelerated Career Development Programme, when she was promoted to Operational Sergeant in 1998. Postings to the Control Room, CID and the Scottish Police College followed.



She worked as an Operational Inspector at Forfar before joining the G8 Summit planning team and undertaking key planning and Operational Command of key elements of the G8 Summit held at Gleneagles in 2005.

She undertook the role of the Staff Officer to the Assistant and Deputy Chief Constables and on temporary promotion to Chief Inspector headed up the Business Support Department, responsible for all ICT projects in Tayside. While a Chief Inspector she established the Forensic Gateway in

Dundee Drugs Commission

Dundee and oversaw the transition of ICT and forensic services to the SPSA. In 2009 she was appointed as the Chief Inspector responsible for operational policing in Dundee, a post she held for 3 years. Immediately prior to the creation of Police Scotland Suzie led on the internal and external engagement strands to decide the new force's Visions and Values.

In 2014, she was Operational Commander for the fourth time at the T in the Park music festival and Deputy Lead Planner and Operational Commander for the Ryder Cup. She is a trained and accredited as a Public Order Silver Commander, a role she undertakes frequently across Scotland.

In 2015 she was appointed as Superintendent Support in Tayside Division, responsible for all corporate and personnel functions.

For the last year has been the Superintendent responsible for Partnerships and Performance and is a member of the Police Scotland Tayside Division Command Team.

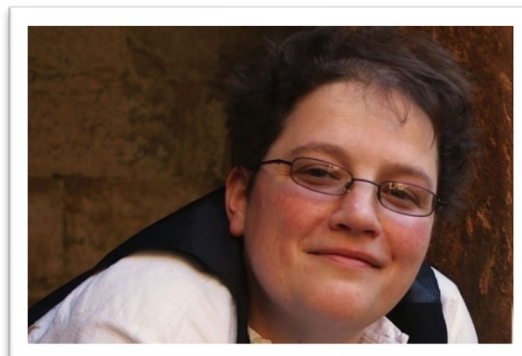
Justina Murray

Justina joined Scottish Families Affected by Alcohol and Drugs as CEO in June 2017. This followed seven years as Chief Officer of South West Scotland Community Justice Authority (CJA), a formal partnership aiming to reduce reoffending across Ayrshire and Dumfries and Galloway. This included holding the national CJA portfolio for children and families affected by the justice system. Prior to this Justina was the Coordinator of North Ayrshire Community Planning Partnership, following on from roles in public policy, equal employment opportunities and research in Scotland and New Zealand.



Professor Niamh Nic Daeid BSc BA PhD FRSE FRSC CChem FICI FCSFS

Professor Niamh Nic Daeid is Director of the Leverhulme Research Centre for Forensic Science at the University of Dundee. She has over 25 years of experience in research, training, education and practice as a forensic chemist specialising in the clandestine manufacture and characterisation of drugs of abuse as well as other areas of forensic chemistry. She is a Fellow of the Royal Society of Edinburgh, and holds Fellowships with the Royal Society of Chemistry, the Institute of Chemistry of Ireland, the Royal Statistical Society and the Chartered Society for Forensic Science. She is a Chartered Chemist, is authorised as a Forensic Chemist to provide expert evidence to the courts and is registered as a forensic expert with the National Crime Agency.



She has held leadership positions with the European Network of Forensic Science Institutes (ENFSI) and has been the technical coordinator for forensic chemistry for the INTERPOL forensic science symposium, chairing the symposium in 2016. She sits on the scientific advisory board of the International Criminal Court and has acted as a consultant to the United Nations Office of Drugs and Crime on aspects of New Psychoactive Substances.

John Owens

John Owens has over 40 years' experience in public service in both the statutory and voluntary sector. Educated to degree level with Diploma in Social Work from Moray House and MSc in Criminal Justice from Edinburgh University, he has worked in North Lanarkshire, Glasgow, East Dunbartonshire and Argyll and Bute. Following a grounding in generic social work in North Lanarkshire he moved to Glasgow where he spent the majority of his career working in the Drumchapel and Govan areas of Glasgow as Area Manager and ultimately as Head of Health and Community Care in South West Glasgow. He was employed by East Dunbartonshire as Head of Children's Services and Criminal Justice prior to early retirement.



In the early 90s, he managed the Social Work Unit in HMP Barlinnie and led the introduction of the Drug Unit for those working to reduce their use of drugs as part of their rehabilitation. Collaboration and partnership working have been a constant feature of his philosophy and approach throughout his career. This initiative sat alongside the award-winning Open Doors Project supporting those with mental health problems. His partnership approaches were recognised by CoSLA and SSSC with awards in 1998 and 2011 for a community regeneration/development project and a Prevention of Homelessness Service.

Justice and Equalities have been key values in his practice and following early retirement he accepted voluntary directorships with Govan Law Centre and Deafblind Scotland which provided a valuable insight into Third Sector organisations. For the last three years he has enjoyed the role of Independent Chair of Argyll and Bute's Alcohol and Drug Partnership bringing together partners from the Statutory and Third Sector alongside those in recovery and with lived experience of the impact of alcohol and drugs on individuals, families and communities. He remains passionate about community development and continues to describe himself as a Community Social Worker.

Dr Tessa Parkes

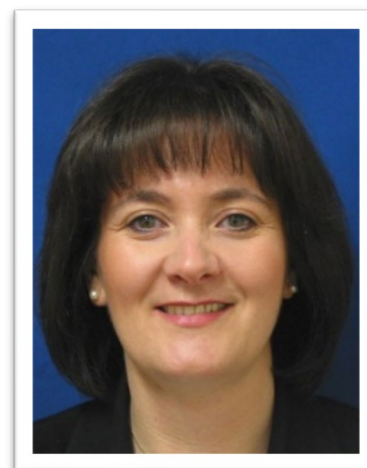
Tessa has experience in the statutory and non-statutory health, social care and housing/homelessness sectors as a front-line support worker, team leader and mental health nurse, and has provided consultancy and training to a wide variety of organisations focused on service

improvement to better meet the needs of healthcare users. Tessa has a track record of creating positive impact on policy and practice through research. For 20 years her research activity has centred on enhancing the experience of people who use health/social care services, with a clear commitment to social justice, health equity and advocacy for poorly serviced groups, with a specialism in mental health and substance use. Moving research evidence into action is a central focus for her, including use of participatory film-making. She is Research Director for the new Salvation Army Centre for Addiction Services and Research in the Faculty of Social Sciences, University of Stirling. She sits on the Partnership for Action on Drugs in Scotland Executive Group and is Deputy Convenor for the Drugs Research Network for Scotland hosted at the University of Stirling.



Hazel Robertson

Hazel Robertson has been employed as a social worker within a local authority setting since 1986. In 1990, she was appointed to a specialist post focusing on Drugs and HIV. From 1992, as Senior Social Worker, she managed the Tayside Social Work HIV/AIDS service and latterly, (from 1999) also managed the Social Work Drug and Alcohol services in Dundee City Council. In 2004, she was appointed as Principal Officer for Community Care within Angus Council where she had responsibility for the strategic planning and development of Community Care services and had a lead role for Drugs and Alcohol services. From 2008 she also managed Children and Families Intake services in Angus. In 2011 she was invited to become a member of the Drugs Strategy Delivery Commission CAPSM task group. Hazel has been a Board Member of Scottish Drugs Forum since 2011 and has had a career long interest in the needs of children affected by substance misuse. She is currently employed as Head of Services for Children, Young People and Families in Perth and Kinross Council in Services for Children, Young People and Families.



Jardine Simpson

Jardin has been in recovery for 10 years from problematic substance use. In that decade he has worked as Scottish National Coordinator form SMART Recovery, a service and community based mutual aid organisation. During his five years with SMART he worked with most of the Scottish ADPs and the services within these localities to build the National SMART Recovery Meeting Network. From 2015 to 2018 he worked across Forth Valley ADPs to develop then manage Forth Valley Recovery Community (FVRC). FVRC is a peer-led and delivered



Visible Recovery Community working in parallel and close collaboration with locality service providers. In October of 2018 he took up the post of Chief Executive of The Scottish Recovery Consortium. SRC supports, advocates on behalf of and represents people with lived and living experience of problematic substance use and service engagement. He is passionate about making recovery more accessible to more people across Scotland. A significant part of this journey for many people is through treatment and support.

Pat Tyrie – family member



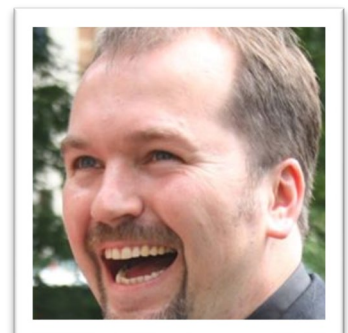
Maureen Walker – family member



The Drugs Commission has been supported by Figure 8 Consultancy. The Director of Figure 8 (Andy Perkins) has been responsible for setting up and facilitating the work of the Commission, including the provision of support to the Chair of the Commission and Commission members, and collation of evidence gathering activities.

Andy Perkins

Andy has 24 years' experience in the alcohol and drug field and is an expert in the evaluation and review of a wide range of policies, services and systems. As the Director of Figure 8 Consultancy, Andy has project managed over 120 contracts in the last twelve years for a range of clients including health, social care and criminal justice providers (with timescales from one month to four years, including several national contracts). Andy is currently co-leading (with the University of Sheffield) an evaluation of the impact of MUP of alcohol on Scotland's harmful



drinkers. He is concluding (in partnership with the University of South Wales and Glyndwr University, Wrexham) a review for Welsh Government on the potential for drinkers to switch substances as a result of minimum pricing for alcohol. With the same partners, Andy is starting work on three (5-year) research projects for Welsh Government to help evaluate their forthcoming Minimum Pricing of Alcohol legislation. In 2017, Andy led a review of the Welsh Government's national alcohol and drug strategy in partnership with Glyndwr University in Wrexham. Andy is involved in two current Peer Research projects and has recently co-authored a journal article which has been published in a special edition of the *Drugs and Alcohol Today* journal on Co-Production issues¹. A further co-authored article has just been published in *Drugs, Education, Prevention and Policy* ('The potential of Contribution Analysis to alcohol and drug policy strategy evaluation: an applied example from Wales')².

He has been responsible for a diverse range of research and evaluation projects including needs assessments, scoping exercises, process evaluations, and feasibility studies. Andy is a co-author of the Scottish Government 'Research for Recovery: A Review of the Drugs Evidence Base' study (2010). He is an experienced qualitative interviewer and is used to seeking the views of a broad range of stakeholders. As a practitioner, Andy spent 10 years managing residential and in-prison alcohol and drug treatment programmes, including registered residential services for men, women and children, and in-prison services for young offenders.

¹ Livingston, W. and **Perkins, A.** (2017) *Participatory action research (PAR) research: critical methodological considerations*, *Drugs and Alcohol Today*, <https://doi.org/10.1108/DAT-08-2017-0035>

² Wulf Livingston, Iolo Madoc-Jones & **Andrew Perkins** (2019): The potential of contribution analysis to alcohol and drug policy strategy evaluation: an applied example from Wales, *Drugs: Education, Prevention and Policy*, DOI:

10.1080/09687637.2019.1645093

<https://www.tandfonline.com/eprint/2AQK9K6H2XWFT3TQSCGY/full?target=10.1080/09687637.2019.1645093>

APPENDIX II: SOURCES OF EVIDENCE

A wide variety of quantitative (data and statistics) and qualitative (expressed views) activities have been used to capture as broad and balanced set of evidence as possible over the last year. In total, we have grouped these activities into eighteen different categories of evidence, as detailed below. The following table identifies the key messages of the study and which of the sixteen activities have contributed to those key messages. The relative strength of each key message is also identified using a traffic light system.

No.	Evidence source	Notes	Appendix
1	Literature and evidence review and bibliography	Throughout the course of the Commission we have identified relevant reports, documents, articles, policies, strategies, etc. The Figure 8 team have selected and reviewed the most relevant of these to its work and have written these up in summary form for consideration by Commission members. These 76 documents have provided a whole library of evidence that are directly linked to our report recommendations. A wider set of evidence sources (n=181) have been considered throughout the Commission process and are included as a full Bibliography.	Appendix III
2	Rapid review of literature in relation to Low Threshold Methadone prescribing	One of the foremost gaps identified by the Commission in the provision of drug treatment services in Dundee is that of Low Threshold Methadone Maintenance Treatment (MMT). With this in mind, a rapid review of key literature in relation to Low Threshold MMT has been conducted to provide the supporting evidence for recommending a swift move to developing such service provision in Dundee.	Appendix IV
3	International research evidence case studies (Canada, Iceland, Portugal)	The Commission were asked to consider evidence of what has worked elsewhere to combat drug use and drug-related deaths including approaches to achieve prevention and recovery. After due consideration, the Commission requested that Figure 8 look at evidence from Canada (in relation to Harm Reduction approaches), Iceland (in terms of a	Appendix V

		prevention approach for young people), and Portugal (in terms of their approach to decriminalisation).	
4	Related Conferences – materials	Across the lifespan of the Drugs Commission, members of the Commission and the Figure 8 support team have attended a number of conferences in Scotland that have had significant relevance to the issues that have been considered by the Commission. A summary of the conferences attended is provided below. The conference materials obtained have been included in our full review of evidence.	Appendix VI
5	Rapid inequalities review (Dundee)	Problem drug use has strong links to poverty and deprivation, with individuals from deprived areas more likely to have experienced psychological trauma and mental health issues, which can result in the use of high-risk drugs to escape psychological stress and trauma. That is not to say, however, that deprivation causes addiction, given the links between poverty and drug misuse are multifaceted. Recent local data suggest that 73% of individuals who died as a result of the presumed non-intentional overdose of illicit (or illicitly obtained controlled) substances in Tayside in 2017 lived in areas that were classified in the two most deprived SIMD quintiles. This suggests an inequality incline associated with drug-related deaths, with more than half of drug-related deaths occurring in areas of greatest socioeconomic deprivation.	Appendix VII
6	Scottish Affairs Committee Inquiry into Problem Drug Use in Scotland – summary of relevant written submissions	The Scottish Affairs Select Committee has been receiving evidence as part of its inquiry into the use and misuse of drugs in Scotland and is due to report in the autumn (2019). All responses to the Scottish Affairs Select Committee have timely relevance to the Dundee Drugs Commission. A rapid review of submissions responding to the questions 'What are the unique drivers of drugs abuse in Scotland?', 'How is drugs misuse in Scotland different from the rest of the UK?' and 'recommendations' has highlighted themes of significant relevance.	Appendix VIII

APPENDIX III: LITERATURE AND EVIDENCE REVIEW AND BIBLIOGRAPHY

Literature and Evidence Review – Introduction

This paper presents summaries of a series of key local and national papers, resources, strategies etc. that provide relevant context for the Dundee Drugs Commission. It has been a work-in-progress over the last 12 months and now represents an extensive resource library of evidence against the issues and themes that the Commission have been exploring. Each report/article/document included in our review has a clear link to the recommendation(s) that it helps to evidence (at the bottom of each table).

The summaries provided include links to online versions of reports and articles where available, and they are collated into the following categories:

Local Landscape

Wider Context

Recovery

Reducing Drug-Related Deaths - opportunities

Local Landscape

Capturing Experiences of Mental Health Services in Tayside

Source		Capturing Experiences of Mental Health Services in Tayside
Author(s)		Independent Inquiry into Mental Health Services in Tayside
Year		2019
Retrieved from		https://independentinquiry.org/
Key findings		<ul style="list-style-type: none">• The report is based on feedback from over 200 people and it suggests several areas of improvements in the provision of mental health support in Tayside. These include improvements to preventative services, access, building a therapeutic environment and a more recovery-focussed approach.• The Inquiry heard many examples of good quality care and high-level professional practices across mental health services in Tayside.• Analysis revealed key themes where the quality and care are not good. The Key Themes arising from the evidence submitted to the inquiry are as follows: Patient Access to Mental Health Services; Patient Sense of Safety; Quality of Care; Organisational Learning; Leadership; and Governance.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none">• Patients presenting to mental health services following alcohol or drug consumption, report rejection from crisis assessment.• People with addiction to alcohol and/or illegal drugs may be refused access to mental health services.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none">• The report notes that third sector services with a responsibility for substance misuse report that clients complain they are only receiving treatment for their substance misuse issues and are not receiving any treatment for their mental health problems, either because they are on a long waiting list or have been rejected from mental health services due to their substance misuse issues.
Link to Commission Recommendation(s)		<ul style="list-style-type: none">• RECOMMENDATIONS: 1, 7, 9 and 13

About Dundee 2018

Source About Dundee 2018	
Author(s)	Dundee Partnership, Dundee City Council
Year	2019
Retrieved from	https://www.dundee.gov.uk/sites/default/files/publications/about_dundee_2018.pdf
Key findings	<ul style="list-style-type: none"> • The most recent estimate of Dundee's population is 148,710 (National Records of Scotland (NRS) 2017 Mid-year population estimate). • The Dundee City Council area covers 60 square kilometres and is, geographically, the smallest local authority area in Scotland. It is bordered by Perth and Kinross Council to the west and Angus Council to the north and east. • Dundee City has 55 data zones which are in the 15% most deprived in Scotland according to the Scottish Index of Multiple Deprivation, 29% of the Dundee City population live within these areas. • 65% of the Dundee City population within the 15% most deprived areas are of working age. • Dundee City has 21 data zones which are in the 5% most deprived in Scotland according to the Scottish Index of Multiple Deprivation, 11% of the Dundee City population live within these areas. <p>65% of the Dundee City population who live within the 5% most deprived areas are of working age.</p>
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Although complex, there are strong links between poverty, deprivation, widening inequalities and problem drug use. • People who live in the most deprived areas are most likely to experience conditions which limit their opportunities in life.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Poverty, deprivation and inequalities, are important factors which need to be considered in terms of service provision and local strategies.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 9 and 14

Dundee Fighting for Fairness

Source Dundee Fighting for Fairness	
Author(s)	Dundee Partnership
Year	2018
Retrieved from	https://www.dundeefightingforfairness.co.uk/
Key findings	<ul style="list-style-type: none"> • The Fairness Commission for Dundee brings together 12 people with lived experience of poverty and 12 people with influence in the city – building relationships, listening to stories of Commissioners personal experiences and drawing key issues together from these stories. • The Commissioners focused on three key themes: Mental Health through the Lens of Poverty; People and Money; and Stigma.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • In terms of mental health provision, one recommendation is that the Dundee Health and Social Care Partnership develops a 24/7 drop-in (self-referral) service in collaboration with beneficiaries and offering clinical, non-clinical, therapeutic and peer support. • Another recommendation relating to mental health is that the Dundee Drug Commission and the Dundee Alcohol & Drug Partnership utilise the Fairness Commission's mental health research findings to ensure that people with substance misuse issues are offered and can access appropriate mental health support. • In terms of stigma, a recommendation is that the Dundee Partnership produces guidance and materials to enable all service providers to attract, recruit, train and support staff with the right values and attitudes towards people who are experiencing poverty or who are in recovery.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Poverty, stigma and a general lack of mental health support for those with drug use issues in Dundee have been highlighted during the commission's research.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 2, 3, 9, 13 and 14

Drug Deaths in Tayside, Scotland, 2017

Source Drug Deaths in Tayside, Scotland, 2017	
Author(s)	Tayside Drug Death Review Group
Year	2018
Retrieved from	https://www.angus.gov.uk/social_care_and_health/protect_someone_from_harm
Key findings	<ul style="list-style-type: none"> • In 2017 there were 73 drug deaths in Tayside, compared to 56 in 2016, with the greatest number of deaths occurring in Dundee City (51, compared to 38 in 2016). • Of the 2017 drug death casualties, 27 are recorded as having experienced at least one adverse childhood event, with 15 experiencing two or more. • Over half (56%) of drug deaths involved an opioid (heroin or methadone) plus a gabapentinoid (pregabalin or gabapentin) plus a benzodiazepine (typical or atypical). • 73% of individuals who died as a direct consequence of drug use in Tayside in 2017 lived in areas that were classified in the two most deprived SIMD quintiles.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • There is a need to design and scale up interventions to reduce overdose risk. • Opportunity to make naloxone more widely available to people at high risk of opioid overdose and to their peers, partners and family to enable them to intervene while waiting for emergency services to arrive.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The report suggests an inequality incline associated with drug deaths, with more than half of drug deaths occurring in areas of greatest socioeconomic deprivation. • Provides local evidence of drug-related deaths which could provide the commission with a baseline of where to target any future provision.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 2, 6, 7, 14 and 16

Substance Misuse Strategic & Commissioning Plan for Dundee, 2018-2021

Source		Substance Misuse Strategic & Commissioning Plan for Dundee, 2018-2021
Author(s)		Dundee Partnership, Dundee Health and Social Care Partnership.
Year		2018
Retrieved from		https://www.dundeehsc.com/publications/substance-misuse-strategic-and-commissioning-plan-dundee-2018-2021
Key findings		<ul style="list-style-type: none"> • Presents a way forward for developing and improving the responses to the impact of substance misuse on communities in Dundee. • The plan is underpinned by the following key themes / principles: Strengthening Governance, Delivering Service Improvements, Improving Service User / Carers' Involvement and opportunities for Community Activism, Value for Money, Integrating Services, Co-producing Developments, Promoting Best Practice and Improving Quality, Increased Focus on Prevention.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • The principles above have been adopted because they are either derived from local needs and national policy identified through the process of consulting stakeholders or through fact-finding exercises. • Outcomes in the plan are set against the national outcomes for substance misuse. These include health, accessibility, prevalence, recovery, families and children, quality, community safety and local environment.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • Outlines the vision, key priorities and actions to improve the lives of individuals and families in Dundee affected by substance misuse.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 4, 6 and 12

Profile of the Substance Misusing Population Dundee City

Source		Profile of the Substance Misusing Population Dundee City
Author(s)		Goldsmith, R.
Year		2017
Key findings		<ul style="list-style-type: none"> • Substance misuse can affect the health of an individual resulting in a demand for health services and although the number of hospital admissions has decreased recently, the rate of substance related mortality has increased over time. • Substance misuse also affects those around them including the neighbourhoods in which they live and can be a contributory factor in criminal activity. • Data regarding recovery is under development, with outcome data not available. However, the development and collection of performance and outcomes information is ongoing. • Substance use can have harmful and wide-reaching consequences for not only the individuals using the substances but also their families.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • The report states that NHS Tayside is performing well towards national targets relating to substance misuse set by Scottish Government and this has resulted in an increase in the number of individuals engaging with local substance misuse services.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • Problem drug use prevalence in Tayside is higher than the national average but varies widely across the three council areas with Dundee City estimated to have the highest prevalence rate.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 6 and 16

Tayside Plan for Young Children, Young People and Families 2017-2020

Source	
Tayside Plan for Young Children, Young People and Families 2017-2020	
Author(s)	Angus Council, Perth and Kinross Community Planning Partnership, Dundee Partnership.
Year	2017
Retrieved from	https://www.pkc.gov.uk/article/17744/Tayside-plan-for-children-young-people-and-families
Key findings	<p>Sets out five priorities which are underpinned by key policies, such as GIRFEC and the consistent implementation of the Named Person.</p> <ol style="list-style-type: none"> 1. Our children will have the best start in life, they will be cared for and supported to learn in nurturing environments; 2. Our children, young people and their families will be meaningfully engaged with learning and combined with high quality learning experiences, all children and young people will extend their potential; 3. Our children and young people will be physically, mentally and emotionally healthy; 4. Our children and young people who experience inequalities and disadvantage will achieve health, wellbeing and educational outcomes comparable with all other children and young people; 5. Our children and young people will be safe and protected from harm at home, school and in the community.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Priority three aims to improve the mental health, wellbeing and resilience of children and young people and reduce their involvement in risk taking or harmful behaviours such as substance use.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • To promote good physical, mental and emotional health for children, the strategy aims to develop and implement a Tayside multi-agency framework to prevent and address early initiation into substance misuse.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 13 and 16

Stop People Starting and Supporting People to Recover: A strategy for preventing substance misuse and embedding recovery in Dundee [2017-2027]

Source	
Stop People Starting and Supporting People to Recover: A strategy for Preventing Substance Misuse and Embedding Recovery in Dundee [2017-2027]	
Author(s)	Perkins, A. et al.
Year	2017
Key findings	<p>This strategy addresses five key questions, with a chapter for each.</p> <ol style="list-style-type: none"> 1. Where are we, in respect of prevention? 2. Where do we want to get to? 3. What changes must be made? 4. How should changes be made? 5. How shall we measure progress? <p>The strategy is framed within a set of guiding principles; providing a reference point for the overall approach and articulating key responsibilities and their assignment.</p>
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • There is a need for an overarching strategy in Dundee to prevent substance misuse and to enhance Recovery-orientated Systems of Care across the city. • The Community Planning Partnership) has set preventing substance misuse as a key outcome of its Strategic Outcome Agreement (SOA) and the forthcoming Local Outcome Improvement Plan (LOIP).
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • This document is intended for existing and potential providers who will be able to use the information presented to identify the role they can play and to help develop their business plans. The hope is that the strategy will enable provider partners to respond to the identified prevention approach, identify potential opportunities for collaborative working, as well as bring forward new and innovative ways of working.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1 and 9

Defining and Improving Prevention and Recovery Through Better Substance Misuse Outcomes

Source	
Defining and Improving Prevention and Recovery Through Better Substance Misuse Outcomes	
Author(s)	Perkins, A. et al.
Year	2016
Key findings	<ul style="list-style-type: none"> • For maximum preventative impact services should: (1) operate within a coherent strategic framework; (2) be effectively operationalised; and (3) be capable of constantly learning and adapting. • Historically, the ADP had struggled to fulfil its strategic role in respect of prevention and, if progress is to be made, it will require to be empowered by The Dundee Partnership to hold partners accountable for delivery. • That to achieve a decisive shift towards prevention, as advocated by The Christie Commission, will require a fundamental review of the allocation of resources and a managed process for achieving such a shift.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<p>Recommendations include:</p> <ul style="list-style-type: none"> • A local definition: priority should be to develop and agree a local definition of 'prevention and early intervention' for the ADP to reflect the breadth of necessary prevention activity across the life course; • Ongoing needs assessment: consideration be given to needs assessments across a key set of areas, such as: school-based interventions; parental support; and generic and targeted youth work.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The Christie Commission on the Future Delivery of Public Services (2010) argued for a fundamental shift towards prevention as a guiding principle of public service delivery.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1 and 9

Dundee Alcohol & Drugs Partnership Alcohol & Drugs Review (2013-2015)

Source		Dundee Alcohol & Drugs Partnership Alcohol & Drugs Review (2013-2015)	
Author(s)		Hopkins, V.	
Year		2015	
Key findings		<ul style="list-style-type: none"> Provides the ADP with an agreed structure (multi-agency Hubs) and an approach (Lead Professional) on which to base future strategic planning and delivery of care to individuals and families affected by substance misuse. The process of recovery from substance misuse requires individuals to access a range of different specialist and mainstream / generic services, skills and approaches. The multi-agency Hubs and the Lead Professional approach were identified as an effective structure for providing individuals the care and support they need to progress with their recovery. There has been a marked improvement in the partnership-working between organisations. However, although this is a positive improvement, a persistent element of mistrust between services has remained. 	
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> Two multi-agency Hubs have been operating (each in a slightly different environment) for over a year, and much learning and experience have been gathered by both. However, the teams of both Hubs still struggle to systematically demonstrate the effectiveness of their work and every effort is currently being made to develop robust outcomes-reporting frameworks. 	
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> Information on the extent and nature of community Hubs to tackle the harms experienced by the wider community and their impact is limited. The review has highlighted that, provided in isolation and in a non-coordinated structure, services are often ineffective, duplicative and difficult to access. 	
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> RECOMMENDATIONS: 1, 5 and 9 	

Dundee Alcohol & Drugs Review Questionnaire for Individuals Who Use Services

Source		Dundee Alcohol & Drugs Review Questionnaire for Individuals Who Use Services
Author(s)		Dundee Alcohol and Drug Partnership
Year		2014
Key findings		<ul style="list-style-type: none"> • More generally, women tend to access a bigger range of services • Most men reported to be using TSMS (either now or in the past) but are less likely than women to access other services. • Individuals under the age of 25 are less likely to engage with specialist substance misuse services. • The biggest age group to access services are those between the ages of 26 and 46 years old. By comparison, those age 46 and over are again less likely to use services. • Those under the age of 25 are the least likely to engage with specialist substance misuse services.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • There is an opportunity to design services to improve access and keep high-risk individuals engaged. • Older people are a vulnerable, ageing cohort, at high risk of premature mortality if multi-morbidity is not addressed.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • It is estimated that the ageing process among older people with a longer-term drug problem is accelerated by at least 15 years and at the age of 40, people experiencing drug problems may need a level of care corresponding to that required by an elderly person in the general population.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 15 and 16

Wider Context

Drug-related Deaths in Scotland in 2018

Source	Drug-related Deaths in Scotland in 2018
Author(s)	National Records of Scotland
Year	2019
Retrieved	https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland
Key findings	<ul style="list-style-type: none"> • In 2018, 1,187 drug-related deaths were registered in Scotland, and increase of 27% on 2017 figures. This is the largest number of drug-related deaths in Scotland since records began in 1996. • 72% of deaths were male, 28% were female. • 76% (n=905) of deaths were in the 'over 35' age range • One or more opiates were implicated in 1,021 (86%) of deaths. • The main substances which contributed to the 1,187 deaths were: Heroin and or Morphine- 537 (45%) deaths; Benzodiazepines- 792 (67%) deaths; Methadone- 560 (47%) deaths.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Scotland's drug-death rate (per head of population) is nearly three times that of the UK as a whole.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • In 2018, 66 drug-related deaths were registered in Dundee. • Opiates were implicated in 58 of the 66 deaths in Dundee
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 5, 6 and 16

Source		European Drug Report 2019
Author(s)	European Monitoring Centre for Drugs and Drug Addiction	
Year	2019	
Retrieved from	http://www.emcdda.europa.eu/publications/edr/trends-developments/2019	
Key findings	<ul style="list-style-type: none"> • The UK's drug-related public expenditure is more focused on supply reduction (including the policing of people for drug possession), compared to demand reduction (treatment and education). • Drug-induced mortality rate among adults in the UK reached 74 per million in 2016. This is three times the EU average of 22.6 per million. • In 2017, there were 115 new HIV diagnoses associated with injecting drug use in the United Kingdom, 32 of which were registered in Scotland. This is a reduction from the 51 new diagnoses in Scotland in 2015, when an outbreak of HIV was detected among people who inject drugs (PWID) in Glasgow, but the same number as in 2016. • Drug use prevalence among young people in Scotland has declined since 2004 but remained stable between 2013 and 2015. 	
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Opioids (primarily heroin, but also methadone) were involved in the majority of deaths (almost 9 in 10) in the UK, which echoes findings from drug-related deaths in Scotland where one or more opiates or opioids (including Heroin/Morphine and Methadone) were implicated in, or potentially contributed to, 815 deaths (87%). 	
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The drug-induced mortality rate among adults in the United Kingdom (aged 15-64 years) was 74 deaths per million in 2016, however in Scotland, the drug-related death rate is considerably higher than the UK. 	
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1 and 9 • NATIONAL CONSIDERATION: 1 	

Drug-related Hospital Statistics Scotland 2017/18

Source Drug-related Hospital Statistics Scotland 2017/18	
Author(s)	Information Services Division Scotland
Year	2019
Retrieved from	https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/
Key findings	<ul style="list-style-type: none"> • Over the past 20 years, there was a fourfold increase in the rate of drug-related general acute hospital stays (from 51 to 199 stays per 100,000 population). • In 2017/18, approximately half of the patients with a drug-related general acute or psychiatric hospital stay lived in the most deprived areas in Scotland. • Individuals aged under 15 years and 15-24 years (both 97%) had the highest percentages of general acute stays following emergency admission, while individuals aged 55-64 years and 65 years or over had the lowest percentages (both 91%). • Drug-related general acute/psychiatric patient rates for 15-24-year olds decreased consistently to 126 in 2012/13 but have since increased to 190 in 2017/18. • Cannabinoid-related patient rates among 15-24-year olds increased from 30 patients per 100,000 population (2012/13) to 53 (2017/18). Relatedly, Cocaine increased from 24 patients per 100,000 population (2012/13) to 49 (2017/18). • Cocaine-related general acute stay rates more than doubled from 8 to 21 per 100,000 population between 2010/11 and 2017/18.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The figures also show changes in the drug using behaviour of young people, and findings point to an emerging trend of increasing drug-related patient rates among individuals aged 15-24 years.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Highlights the need for better and directed interventions, both within the hospital and community settings.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 6, 7 and 10

Rising Opioid-Related Deaths in England and Scotland Must be Recognised as a Public Health Crisis

Source		Rising Opioid-Related Deaths in England and Scotland Must be Recognised as A Public Health Crisis
Author(s)		Kimber, J., Hickman, M., Strang, J., Thomas, K., and Hutchinson, S.
Year		2019
Retrieved from		https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30209-3/fulltext
Key findings		<ul style="list-style-type: none"> • In England and Scotland, the number of drug-related poisonings in 2017 was the highest ever recorded. • Opioid-related deaths are the biggest contributor to drug-related deaths and have driven the recent increase in such deaths. In 2017, 815 opioid-related deaths were recorded in Scotland (double the number recorded in 2007) and 1829 were recorded in England (a 40% increase since 2007). • This marked increase in avoidable mortality must be recognised as a public health crisis.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • The authors suggest that this marked increase in avoidable mortality must be recognised as a public health crisis.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • In 2017, 57 drug-related deaths were registered in Dundee, this is 19 (50%) more than in 2016, and 34 (147%) higher than the figure for 2007, which was 23. • There have been calls for the Scottish Government to declare a public health emergency to tackle the country's drug crisis in recent years.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • NATIONAL CONSIDERATION: 3

Rights Based Advocacy as Intervention: A Mixed Methods Study of Reach Advocacy: A Recovery-Oriented Advocacy Service Based in North Lanarkshire

Source	
Rights Based Advocacy as Intervention: A Mixed Methods Study of Reach Advocacy: A Recovery-Oriented Advocacy Service Based in North Lanarkshire	
Author(s)	McPhee, I., Sheridan, B., and O’Rawe, S.
Year	2019
Retrieved from	https://www.reachadvocacy.net/
Key findings	<ul style="list-style-type: none"> • This research study evaluates an independent rights-based advocacy service, Reach Advocacy. • An inclusive rights-based approach to advocacy in the context of recovery is innovative and markedly different from existing needs and issues-based service provision for people experiencing drug problems and dual diagnosed individuals.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The report suggests that a rights-based person-centred approach to problem alcohol and /or drug (AOD) use and dual diagnosed individuals requires a new way to understand how to commission services. This means a move from needs-based approaches that focus on one issue such as drug and alcohol consumption, mental health, treatment compliance, or on housing that create eligibility criteria, which can also be perceived as barriers to recovery. • A rights-based approach to problematic AOD use and dual diagnosis services requires universal services and commissioners to have as their starting point, the understanding that vulnerable and marginalised AOD users and dual diagnosed individuals present with complex and concurrent issues whilst experiencing the effects of marginalisation and discrimination.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The authors recommend that service purchasers and providers acknowledge that problematic AOD users, and dually diagnosed individuals are rights bearers, and existing services as duty bearers should fully embrace Rights Based Advocacy (RBA).
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 3 and 5

No Wrong Door: Capability Framework for Co-Occurring Mental Health and Alcohol/Drug Conditions

Source	
Author(s)	Revolving Doors
Year	2019
Retrieved from	http://www.revolving-doors.org.uk/blog/no-wrong-door-capability-framework-co-occurring-mental-health-and-alcoholdrug-conditions-0
Key findings	<ul style="list-style-type: none"> • The framework aims to better equip services to meet the needs of people with co-occurring mental health and alcohol/drug use conditions. • The capability framework supports the implementation of Public Health England's Better Care guide on the ground. It describes the values, knowledge, and skills required for effective care of people with co-occurring conditions.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The aim of the framework is to describe the values, knowledge and skills required to work with people who have co-occurring mental health and alcohol/drug use conditions. • It is designed to be relevant to workers in mental and physical health settings, alcohol/drug misuse services, social services and the criminal justice system.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The capability framework and the e-learning toolkit have been informed by people with lived experience of co-occurring conditions. • The framework is designed as an individual development tool, but it can also be used and modified by any service provider for workforce development.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 3, 5 and 13

Drug and Alcohol Services an Update

Source Drug and Alcohol Services: An Update	
Author(s)	Audit Scotland
Year	2019
Retrieved from	https://www.audit-scotland.gov.uk/report/drug-and-alcohol-services-an-update
Key findings	<ul style="list-style-type: none"> • This paper provides an overview of the current position of drug and alcohol services in Scotland and summarises the progress against recommendations made in AUDIT Scotland's 2009 report. • Drug and alcohol-related deaths and morbidity remain high in Scotland compared to the rest of the UK and many other European countries. • Drug problems are increasing in people aged 35 and over, with 76 per cent of drug-related deaths occurring in this age group in 2017. Of this group, the most significant increase was seen in people aged 45 and over. This figure has increased from 20 per cent in 2009 to 37 per cent in 2017. • Stigma remains a significant barrier to treatment and support.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The Scottish Government's new 2018 drug and alcohol strategy recognises problem drug and alcohol use as a public health issue. It commits to focus on a holistic, human rights-based approach and a reduction in avoidable deaths related to problem drug and alcohol use. • The Scottish Government announced an additional £20 million per year for drug and alcohol services, for the next three years in 2018, taking the annual funding to £73.8 million.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Any new strategies developed by the commission to tackle problem drug use in Dundee, can be shared across Scotland.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 2, 3 and 8

Human Rights Based Approach: A Self-Assessment Tool

Source		Human Rights Based Approach: A Self-Assessment Tool
Author(s)	Scottish Human Rights Commission	
Year	2018	
Retrieved from	http://www.scottishhumanrights.com/media/1814/shrc_panel_self-assessment_tool_vfinal.pdf	
Key findings	<ul style="list-style-type: none">• This tool is based on the PANEL principles (Participation, Accountability, Non-discrimination, Empowerment and Legality) which form the basis of a human rights-based approach.• It is intended to help organisations assess their work and identify priorities for improvement towards embedding a human rights-based approach.	
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none">• This tool has been designed to be used flexibly. It can support people in organisations tasked with (or, often, having tasked themselves with) embedding a human rights-based approach.	
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none">• This tool can be used to develop a new policy, organisational structure, an individual developing a policy or a board reviewing the workings of an organisation.	
Link to Commission Recommendation(s)	<ul style="list-style-type: none">• RECOMMENDATIONS: 1, 2 and 8	

Rights, Respect and Recovery: Scotland's Strategy to Improve Health by Preventing and Reducing Alcohol and Drug Use, Harm and Related Deaths

Source	
Author(s)	Scottish Government
Year	2018
Retrieved	https://www2.gov.scot/Resource/0054/00543437.pdf
Key findings	<ul style="list-style-type: none"> • The updated strategy sets out a variety of approaches, including: <ul style="list-style-type: none"> ○ Support people to find "their own" type of recovery; ○ Public health ought to be evidence-led - that means supporting responses that might be controversial or initially unpopular (such as drug consumption rooms); ○ A focus on prevention and early intervention in education, housing and justice; ○ Diverting people with problematic alcohol and drug use away from the justice system and into treatment support; ○ Families now have the right to support, and the right to be involved in their loved one's treatment and support.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The strategy, Rights, Respect and Recovery, states that it supports well-evidenced approaches to reduce harm, even among people who feel unready for treatment. • It is the first time that Scotland's drug and alcohol strategies have been combined, a decision made due to commonalities between those predominantly affected by both substances and the potential solutions.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The new strategy includes a key focus on drug-related deaths, an area where Dundee has seen increasingly high rates in recent years.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 4, 6, 7, 12 and 15

Drug-related Deaths in Scotland in 2017

Source Drug-related Deaths in Scotland in 2017	
Author(s)	National Records of Scotland
Year	2018
Retrieved	https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland
Key findings	<ul style="list-style-type: none"> In 2017, 934 drug-related deaths were registered in Scotland, 66 (8%) more than in 2016, and 479 (105%) higher than the figure for 2007, which was 455. This is the largest number of drug-related deaths in Scotland since records began in 1996, and more than double the figure for 2007 (455 deaths). <p>Of the 934 drug-related deaths in 2017:</p> <ul style="list-style-type: none"> Heroin and/or Morphine were implicated in, or potentially contributed to, the cause of 470 deaths (50% of the total); Methadone was implicated in, or potentially contributed to, 439 deaths (47%); One or more opiates or opioids (including Heroin/Morphine and Methadone) were implicated in, or potentially contributed to, 815 deaths (87%).
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> Opportunity to further develop take-home naloxone programmes to make naloxone widely available to people at high risk of opioid overdose and to their peers, partners and family to enable them to intervene while waiting for emergency services to arrive.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> In 2017, 57 drug-related deaths were registered in Dundee, this is 19 (50%) more than in 2016, and 34 (147%) higher than the figure for 2007, which was 23. Heroin and/or Morphine were implicated in, or potentially contributed to, the cause of 42 deaths (74% of the total).
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> RECOMMENDATIONS: 1 and 6

Source National Naloxone Programme Scotland Monitoring Report 2017/18	
Author(s)	Information Services Division Scotland
Year	2018
Retrieved	http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/
Key findings	<ul style="list-style-type: none"> • Data shows that 8,397 naloxone kits were issued in 2017/18, an increase of 3% on the previous year. • Since 2011/12 46,037 kits have been supplied in Scotland. It is estimated that 23,096 people 'at risk of opioid overdose' have been supplied with a kit. • There is some evidence of greater reach – last year, 2,458 kits were issued as a first supply to an individual at risk of opioid overdose. • There is also evidence that naloxone is being used and potentially saving lives. Of the supplies made, 53% (3,996) were repeat supplies – to people who had previously been issued with a kit. 25% of these were made because the previous kit was reported as having been used to treat an opioid overdose. That data suggests that around 1000 potentially fatal overdoses have been reversed using the kits.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Opportunity to further develop take-home naloxone programmes to make naloxone widely available to people at high risk of opioid overdose and to their peers, partners and family to enable them to intervene while waiting for emergency services to arrive.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • There has been an upward trend in the number of Drug-Related Deaths in Dundee in recent years, whereas the National Naloxone Programme is associated with a reduction in the proportion of opioid-related deaths.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 6 and 10

Why are Drug-related Deaths Among Women Increasing in Scotland? - Research Findings

Source		Why are Drug-related Deaths Among Women Increasing in Scotland? - Research Findings
Author(s)		Scottish Government
Year		2018
Retrieved from		https://www.gov.scot/publications/drug-related-deaths-women-increasing-scotland/are-drug-related-deaths-among-women-increasing-in-scotland-research-findings
Key findings		<ul style="list-style-type: none"> The study found that the disproportionate rise in drug-related deaths among women is likely to have a complex answer, involving many interacting factors. Key themes include: ageing among the cohort of women who use drugs; increasing prevalence of physical and mental health problems; changes to treatment services and wider health and social care; changes in the welfare benefits system; changes in patterns of substance use; changes in relationships and parenting roles; ongoing risk among women engaged with drug treatment; previous experiences of trauma and adversity.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> While there are many commonalities between men and women who use drugs, there are several key areas where women's experience of substance use and treatment services may differ from men. Highlights the need to involve women with lived experience in design and delivery of services and policies.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> Treatment and support services in Dundee may need to adopt gender mainstreaming practices to ensure the needs of women are fully addressed.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> RECOMMENDATIONS: 3, 5, 15 and 16

National Naloxone Programme Scotland Monitoring Report 2016/17

Source National Naloxone Programme Scotland Monitoring Report 2016/17	
Author(s)	Information Services Division Scotland
Year	2017
Retrieved from	https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2017-11-07/2017-11-07-Naloxone-Summary.pdf?2718752623
Key findings	<ul style="list-style-type: none"> • Accidental overdose is a common cause of death among users of Heroin, Morphine and similar drugs, which are referred to as opioids. Naloxone is a drug which reverses the effects of a potentially fatal overdose with these drugs. • A total of 8,159 take-home naloxone kits were issued in Scotland in 2016/17, a decrease of 1% on the previous year. A total of 37,609 take-home naloxone kits were supplied in Scotland between 2011/12 and 2016/17. • In 2016/17, 6,497 kits were issued in the community, 700 kits were issued in prisons upon release and 962 kits were dispensed via community prescription. • In 2016/17, 3,471 (48%) take-home naloxone kits distributed in the community and prisons were repeat supplies. • In 2016, 9.4% of people whose death was opioid-related had been discharged from hospital in the previous four weeks.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Opportunity to further develop take-home naloxone programmes to make naloxone widely available to people at high risk of opioid overdose and to their peers, partners and family to enable them to intervene while waiting for emergency services to arrive. • The National Naloxone Programme is associated with a reduction in the proportion of opioid-related deaths in Scotland.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • In 2017, 57 drug-related deaths were registered in Dundee. Heroin and/or Morphine were implicated in, or potentially contributed to, the cause of 42 deaths (74% of the total).
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 6 and 10

Adverse Childhood Experiences (ACEs)

Source	Adverse Childhood Experiences (ACEs)
Author(s)	NHS Health Scotland
Year	2018
Retrieved from	http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces
Key findings	<p>Adverse Childhood Experiences (ACEs) are stressful events occurring in childhood including:</p> <ul style="list-style-type: none">• Domestic violence;• Parental abandonment through separation or divorce;• A parent with a mental health condition;• Being the victim of abuse (physical, sexual and/or emotional);• Being the victim of neglect (physical and emotional);• A member of the household being in prison;• Growing up in a household in which there are adults experiencing alcohol and drug use problems.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none">• An ACE survey with adults in Wales found that compared to people with no ACEs, those with 4 or more ACEs are more likely to have been in prison, have committed violence in the last 12 months, and have health-harming behaviours such as high-risk drinking and drug use.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none">• Evidence shows that adversity suffered in childhood significantly impacts future adult health and health harming behaviours.• While ACEs are found across the population, there is more risk of experiencing ACEs in areas of higher deprivation.
Link to Commission Recommendation(s)	<ul style="list-style-type: none">• RECOMMENDATIONS: 5, 6 and 14

Evaluability Assessment of the Distress Brief Intervention programme in Scotland

Source		Evaluability Assessment of the Distress Brief Intervention Programme in Scotland	
Author(s)		NHS Health Scotland	
Year		2017	
Retrieved from		http://www.healthscotland.scot/media/1316/evaluability-assessment-of-the-distress-brief-intervention-programme-in-scotland_mar2016_english.pdf	
Key findings		<ul style="list-style-type: none"> • A Distress Brief Intervention (DBI) is a time-limited and supportive problem-solving contact with an individual in distress. • It is a two-level approach. DBI level 1 is delivered by front-line staff and involves a compassionate response, signposting and offer of referral to a DBI level 2 service. DBI level 2 is provided by specially trained staff who would see the person within 24 hours of referral and provide community problem-solving, support and signposting for a period of up to 14 days. 	
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • The overarching aim of the DBI programme is to provide a framework for improved inter-agency coordination, collaboration and cooperation across a wide range of care, settings, interventions and community supports. 	
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • Distress Brief Interventions (DBIs) are an innovative way for supporting people in distress. The DBI approach emerged from the Scottish Government's work on the Suicide Prevention and Mental Health strategies. • The need to improve the response to people presenting in distress has been strongly advocated by service users and front-line service providers. 	
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATION: 13 	

The National Drug-Related Deaths Database (Scotland) Report: Analysis of Deaths Occurring in 2015 and 2016

Source	The National Drug-Related Deaths Database (Scotland) Report: Analysis of Deaths Occurring in 2015 and 2016
Author(s)	Information Services Division Scotland
Year	2018
Retrieved from	http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2018-06-12/2018-06-12-NDRDD-Summary.pdf
Key findings	<ul style="list-style-type: none"> • The NDRDD includes 865 deaths which occurred in 2016, of which 818 were classed as nonintentional (in 2015, 643 of 695 deaths were non-intentional). • The percentage of drug-related deaths which occurred among women increased from 2009 (21%) to 2016 (29%). • In 2016, heroin or morphine (61%), alcohol (49%) and anti-depressants (47%) were the most common substances present at post-mortem. • The percentage of deaths where etizolam (a benzodiazepine type 'Novel' Psychoactive Substance) was present increased from 9% in 2015 to 33% in 2016, while the presence of diazepam (a prescribed benzodiazepine) decreased from 66% to 46%. • Opioids (heroin/morphine, methadone or buprenorphine) were implicated in 77% of deaths in 2016.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Drug-Related Deaths in Dundee and Scotland are at an all-time high, therefore strategies to assist in the reduction of drug related deaths should be prioritised.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Opioids (heroin/morphine, methadone or buprenorphine) were implicated in 77% of deaths in 2016, therefore services must ensure that Naloxone is readily provided to people likely to witness an overdose.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 6, 7 and 10

The Delivery of Psychological Interventions in Substance Misuse Services in Scotland: A Guide for Commissioners, Managers, Trainers and Practitioners

Source	
Author(s)	Scottish Government
Year	2018
Retrieved from	http://www.gov.scot/Publications/2018/06/1568
Key findings	<ul style="list-style-type: none"> • Psychosocial interventions are key components of effective substance misuse treatment. In some cases, where no pharmacological interventions are available, they offer the only evidence-based treatment. • Sets out a strategy for best practice, following an identified need outlining the delivery of psychological interventions for Substance Misuse Services in Scotland. • It has evolved from strategic work carried out by the Lead Psychologists in Addiction Services Scotland (LPASS group), in collaboration with NHS Education for Scotland (NES) and the Ministerial led Partnership for Action on Drugs in Scotland (PADS). • The report indicates that evidence based, psychologically informed support, delivered by a well-trained and supervised practitioner at any level of the treatment system, can be effective as part of an early intervention model.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • This guide is designed primarily to support commissioners and providers in developing effective recovery-oriented systems of care, with psychological and psychosocial interventions at their heart.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Although the guide focuses primarily on delivering psychological interventions in specialist substance misuse services, many of its recommendations are equally relevant to delivery for people with substance misuse problems in other settings, such as primary care, mental health and prisons/forensic settings.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 7, 8 and 9

Shooting Up: Infections among People Who Inject Drugs in the UK, 2017

Source	Shooting Up: Infections Among People Who Inject Drugs in the UK, 2017
Author(s)	Public Health England
Year	2018
Retrieved	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756502/Shooting_up_2018.pdf
Key findings	<ul style="list-style-type: none"> • People who inject drugs are vulnerable to a wide range of viral and bacterial infections, which can result in high levels of illness and death. • Hepatitis C remains the most common blood borne infection among people who inject drugs, and there are significant levels of transmission among this group in the UK. • Overall UK HIV levels remain low, but risks continue. In the UK, around 1 in 100 people who inject drugs are living with HIV. Most have been diagnosed and will be accessing HIV care. However, HIV is often diagnosed at a late stage among people who inject drugs. There is still an ongoing HIV outbreak in Glasgow. • Hepatitis B remains rare, but vaccine uptake needs to be sustained, particularly in younger age groups.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • HIV infection in people who inject drugs is often diagnosed late and there are still AIDS cases reported among this group. Enhanced HIV testing, immediate initiation of HIV treatment after diagnosis and improved retention in care are necessary.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Scotland has seen a sustained increase of people who inject drugs who report uptake of voluntary confidential testing for hepatitis C. • During 2015, there was a substantial increase in new cases of HIV among people who inject drugs in Glasgow city. In 2015 there was a dramatic increase to 48 cases, whereas 140 diagnoses were reported in up to April 2019.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 10

Reducing Crime and Preventing Harm: West Midlands Drug Policy Recommendations

Source		Reducing Crime and Preventing Harm: West Midlands Drug Policy Recommendations
Author(s)		West Midlands Police
Year		2018
Retrieved from		https://www.westmidlands-pcc.gov.uk/media/477434/West-Midlands-Drug-Policy-Recommendations.pdf
Key findings		<ul style="list-style-type: none"> • Prescribing heroin in a medical setting to people suffering from addiction who have not responded to other forms of treatment will take the market away from organised criminals and stop people stealing to fund their addiction. Work with the Home Office, who have championed the benefits of Heroin Assisted Treatment. • Equipping and training police officers in the application of naloxone – a medication that can be used to help those overdosing. • Establishing a Drug Early Warning Programme, to make the public, outreach workers and medical professionals aware of the impact of emerging drugs and to reduce the number of deaths. • Considering the benefits of Drug Consumption Rooms to assess if they would add value to current services in the West Midlands.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • The Commissioner's proposals outline ways to tackle the cost of drugs to public services, reduce drug related crime and the number of deaths. • Joining-up police, community safety and public health funding streams could increase efficiency and improve outcomes for those suffering from addiction.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • The First Minister believes that there should be cross-party collaboration to implement 'bold and new' initiatives to tackle drug-related deaths in Scotland.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATIONS: 7 and 10

Deaths Related to Drug Poisoning in England and Wales: 2016 Registrations

Source Deaths Related to Drug Poisoning in England And Wales: 2016 Registrations	
Author(s)	Office for National Statistics
Year	2017
Retrieved from	https://www.ons.gov.uk/
Key findings	<ul style="list-style-type: none"> • There were 3,744 drug poisoning deaths involving both legal and illegal drugs in England and Wales registered in 2016; this is 70 higher than 2015 (an increase of 2%) and the highest number since comparable statistics began in 1993. • Of these 3,744 deaths, 69% (2,593) were drug misuse deaths. • In line with previous years, most of the drug-related deaths registered in 2016 in England and Wales were males (2,572 male deaths and 1,172 female deaths). • People aged 40 to 49 years had the highest rate of drug misuse deaths in 2016, overtaking those aged 30 to 39 years. • Over half (54%) of all deaths related to drug poisoning in 2016 involved an opiate (mainly heroin and/or morphine). • The highest mortality rate from drug misuse was in the North East with 77.4 deaths per 1 million population, a 13% increase from 2015; the lowest rate (29.1 deaths per 1 million population) was in the East Midlands, which remained stable.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Over half (54%) of all deaths related to drug poisoning in 2016 involved an opiate (mainly heroin and/or morphine), therefore services must ensure that Naloxone is readily provided to people likely to witness an overdose.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • See above.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 10

Older People with Drug Problems in Scotland: A Mixed Methods Study Exploring Health and Social Support Needs

Source	
Author(s)	Scottish Drugs Forum
Year	2017
Retrieved from	http://www.sdf.org.uk/wp-content/uploads/2017/06/OPDP-mixed-methods-research-report-PDF.pdf
Key findings	<ul style="list-style-type: none"> • This study aimed to identify healthcare and social support needs of older people with a drug problem (OPDP) in Scotland. • Older people are a vulnerable, ageing cohort, at high risk of premature mortality if multi-morbidity is not addressed. • The report suggests that the working group consider actions in the following areas: Isolation and Loneliness, Mental Health, General Health, Pain Management, Retention, Stigma, Gender, Welfare Reform, Advocacy and Vulnerability.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • It is estimated that the ageing process among older people with a longer-term drug problem is accelerated by at least 15 years and at the age of 40, people experiencing drug problems may need a level of care corresponding to that required by an elderly person in the general population.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • See above. • The report highlights the issues facing those aged thirty-five and over with a drug problem.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 5, 9 and 14

Older People with Drug Problems in Scotland: Addressing the Needs of an Ageing Population

Source	
Author(s)	Scottish Drugs Forum
Year	2017
Retrieved from	http://www.sdf.org.uk/wp-content/uploads/2017/06/Working-group-report-OPDPs-in-2017.pdf
Key findings	<ul style="list-style-type: none"> • Older people with drug problems will increasingly become the norm within services and services need to adapt to better meet the needs of this population – both specialist and non- specialist. • This group have a range of complex needs, including being isolated and experience significant underlying physical and mental health problems. • They are not engaging well with existing services and tend to drop out of services on a regular basis. • This group is at high risk of fatal overdose and dying of other causes if they are not retained in care. • There is significant and increasing cost to the health service.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The growing population of older people experiencing drug problems will require a tailored support package to seek, treat and keep them.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • See above. • There is an opportunity to design services to improve access for older people and to keep this ageing cohort engaged.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 5, 6, 9 and 14

Realising Realistic Medicine: Chief Medical Officer's Annual Report 2015-2016

Source	
Realising Realistic Medicine: Chief Medical Officer's Annual Report 2015-2016	
Author(s)	NHS Scotland
Year	2017
Retrieved	https://www.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/
Key findings	<ul style="list-style-type: none"> Realistic Medicine puts the person receiving health and care at the centre of decision-making and creates a personalised approach to their care. It aims to reduce harm, waste and unwarranted variation, all while managing risks and innovating to improve. These concepts will be essential to a well-functioning and sustainable NHS for the future. The term 'medicine' does not solely apply to the work carried out by doctors. It is a broad concept which involves utilising skills and knowledge to maintain health and to prevent, identify and treat illness.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> Realistic medicine encourages shared decision making about an individual's care and progressing from a "doctor knows best" culture. Individuals are encouraged to ask questions about their health and what support they are offered. When 'Realistic Medicine' was published in January 2016, the social media footprint alone demonstrated that in this digital age, sharing a message was incredibly quick and effective. By January 2017, Realistic Medicine had reached almost ten million Twitter feeds and new networks for learning and collaboration were forming.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> It is impossible to achieve Realistic Medicine without a truly multidisciplinary approach, appreciating the varied skills and experience of the health and social care workforce in Dundee, and Scotland as a whole.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> RECOMMENDATIONS: 1, 7 and 8

Realistic Medicine: Chief Medical Officer's Annual Report 2014-15

Source		Realistic Medicine: Chief Medical Officer's Annual Report 2014-15
Author(s)		NHS Scotland
Year		2016
Retrieved		https://www2.gov.scot/resource/0049/00492520.pdf
Key findings		<ul style="list-style-type: none">• The Chief Medical Officer's annual report Realistic Medicine sets out a challenge to those involved in delivery of health and healthcare in Scotland.• Current models of healthcare services are stretched and do not always suit patients, their carers or the aspirations of the workforce.• In striving to provide relief from disability, illness and death, modern medicine may have overreached itself and is now causing hidden harm – or at best providing some care that is of lesser value.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none">• The report acknowledges that the traditional "doctor knows best" approach to decision-making has proved inadequate and there is now a cultural and legal expectation on both professionals and people to collaborate in partnership decisions. This sets a challenge as to how to design and develop health and care services so that it brings out the best of the expertise of people and their professionals.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none">• There is great potential to harness the support of local and online communities to help inform decisions. It will also be required to make healthcare simpler and more engaging so that it is responsive, particularly to those with the greatest health literacy needs and those with the least support.
Link to Commission Recommendation(s)		<ul style="list-style-type: none">• RECOMMENDATIONS: 1, 7 and 8

Peer Engagement Principles and Best Practices: A Guide for BC Health Authorities and Other Providers

Source	
Author(s)	Greer, A.M., Amlani, A.A., Buxton, J.A. & the PEEP team.
Year	2017
Retrieved from	http://www.bccdc.ca/resource-gallery/Documents/PEEP%20Best%20Practice%20Guidelines.pdf
Key findings	<ul style="list-style-type: none"> • Peer engagement practices are not limited to one-on-one participation processes; they include certain considerations in the preparation, engagement, support, and conclusion stages of peer engagement. • Promoting peer engagement within Health Authorities can improve the involvement and uptake of peers' voices in health service planning and policy making in BC. • Individuals who work in Health Authorities can use these peer engagement principles and best practice guidelines to foster meaningful engagement, which can in turn promote positive relationship and capacity building for everyone involved.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Collaborating with peers could potentially maximise the utility and benefits of harm-reduction policies and practice. • Giving agencies the tools to efficiently work with peers could improve peer-provider relations and service delivery.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Opportunity to further develop peer engagement practices across the city.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 3 and 5

An Evidence Review of the Outcomes That Can Be Expected of Drug Misuse Treatment in England

Source	
Author(s)	Burkinshaw, P., et al.
Retrieved from	https://www.gov.uk/government/publications/drug-misuse-treatment-in-england-evidence-review-of-outcomes
Year	2017
Key findings	<ul style="list-style-type: none"> • The number of drug misuse deaths has increased over the past 20 years. • Opioid substitution treatment (OST) is associated with a marked reduction in heroin use (66% abstinence) and substantially reduces the risk of fatal opioid poisoning (overdose) and the risk of blood borne viral infection. • The proportion of opiate users, both in and out of treatment, aged 45 and over is increasing. • Continuing (after) care is associated with a positive effect on substance use. • There is evidence that housing insecurity may contribute to an increased risk of relapse.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Drug treatment will need to respond to a range of age-related, long-term health conditions and actively support referrals for primary and specialist care.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The evidence supports co-ordinated approaches to employment support and approaches to meeting housing and other needs which are integrated with treatment services. Such approaches are more likely to enable navigation through the system of housing, treatment, health care and social care.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 6, 10 and 12

Drugs-related Deaths Rapid Evidence Review: Keeping People Safe

Source	Drugs-related Deaths Rapid Evidence Review: Keeping People Safe		
Author(s)	Dickie, E., Arnot, J., and Reid, G.		
Year	2017		
Retrieved from	http://www.healthscotland.scot/media/1609/drugs-related-deaths-rapid-evidence-review.pdf		
Key findings	<ul style="list-style-type: none">Findings from this rapid evidence review are divided into three categories for ease of reference: • Seek – engagement and access to services • Keep – characteristics of treatment and support • Treat – benefits of treatment.There is review-level evidence that the health of individuals with opioid dependence are safeguarded while in substitution treatment.The first 4 weeks of treatment and the first 4 weeks after leaving treatment are critical intervention points to reduce mortality risk.One size does not fit all. Treatment approaches and services need to be tailored to the individual to support them to stay in treatment.Treatment and harm-reduction services are effective in reducing the transmission of blood-borne viruses.		
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none">Older people experiencing drug problems make up a high number of drug-related deaths in Dundee in 2017.Complex psychological and social barriers must be addressed to support individuals to access services.		
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none">There is a need to develop a clearer picture of the extent and nature of polydrug use among different groups of people experiencing drug problems to support the development of appropriate responses.		
Link to Commission Recommendation(s)	<ul style="list-style-type: none">RECOMMENDATIONS: 1, 6, 9, 10 and 12		

United Kingdom Drug Situation: Focal Point Annual Report 2017

United Kingdom Drug Situation: Focal Point Annual Report 2017	
Source	
Author(s)	UK Focal Point on Drugs
Year	2017
Retrieved from	https://www.gov.uk/government/publications/united-kingdom-drug-situation-focal-point-annual-report
Key findings	<ul style="list-style-type: none"> • Two-fifths (42%) of treatment presentations in the UK were for primary heroin use. • Using the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) definition, the total number of drug-related deaths (DRDs) that occurred in the UK during 2015 was 3,070, a 13% increase from 2014 and the highest number reported to date. • There was a substantial increase in the number of deaths registered in Scotland in 2016 that involved a benzodiazepine. • Over the last decade the average age at death has increased from 37.6 years in 2004 to 42.1 in 2015, with males being younger than females (41.3 years and 44.5 years respectively). • National take-home Naloxone programmes continue to supply naloxone to those exiting prison in Scotland and Wales: there were 720 kits issued by NHS staff in prisons in Scotland, and 655 in Wales, in 2016/17.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Benzodiazepines were cited by a much larger proportion of treatment entrants in Scotland and Northern Ireland than in the rest of the UK.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • See above. • The report details the national landscape which to situate the local context within.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 14

Drug Misuse and Dependence UK Guidelines on Clinical Management

Source Drug Misuse and Dependence UK Guidelines on Clinical Management	
Author(s)	Department of Health
Year	2017
Retrieved from	https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
Key findings	<ul style="list-style-type: none"> Engaging service users in treatment and building a therapeutic alliance are key steps towards facilitating recovery in treatment settings. Many factors determine the nature and degree of engagement, including service user factors, therapist factors, service and organisational factors.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<p>Two simple measures act as markers of service engagement:</p> <ol style="list-style-type: none"> Attendance at appointments is an obvious marker of effective engagement. A tailored plan using simple strategy to encourage attendance (e.g. texting in advance or scheduling to coincide with another appointment) should be used. Level of therapeutic alliance is usually determined by clinical judgement (although can be measured using brief measures such as the Session Rating Scale). Practitioners, and their supervisors, should actively consider therapeutic alliance and plan actions to improve it if required. Consideration should be given to low threshold (e.g. flexible drop-in times for attendance) as well as assertive techniques (e.g. in-reach to hostels) to keep service users with complex needs engaged.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> For individuals in Dundee with opioid dependence and other associated problems, access to medication is one of the key drivers of early engagement. However, the process of developing a strong therapeutic alliance may be more important in promoting recovery in the longer term.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> RECOMMENDATIONS: 1, 7, 8 and 10

Taking Away the Chaos: A Health Needs Assessment for People who Inject Drugs in Public Places in Glasgow, Scotland

Source	
Author(s)	Tweed, E. and Rodgers, M.
Year	2016
Retrieved from	https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf
Key findings	<ul style="list-style-type: none"> • This report investigates the characteristics and health needs of people involved in public injecting practices. • 2015 saw a significant HIV outbreak among people who inject drugs in Glasgow, with 47 new diagnoses compared to a previous annual average of 10. Initial investigations suggested a link between the outbreak and injecting in public places in the city centre, with most cases interviewed reporting this risk factor.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The report recommendations include: • Support the development of a peer network for harm reduction aimed at current people who inject drugs, similar to – and linked with – successful local peer-led recovery initiatives. • Maximise the capacity of the existing Assertive Outreach service to provide injecting equipment during evenings and shift existing contracts with city-centre outlets to sites with extended opening hours. • Introduce and evaluate a pilot service for heroin-assisted treatment in Glasgow City ADP, for people who continue to use street heroin despite optimal opioid substitution therapy.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The recommendations above could be useful when discussing any new strategies to reduce the increasing drug-related deaths in Dundee.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 5 and 12

Reducing Opioid-Related Deaths in the UK

Source		Reducing Opioid-Related Deaths in the UK
Author(s)		Advisory Council on the Misuse of Drugs
Year		2016
Retrieved from		https://www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk
Key findings		<ul style="list-style-type: none"> • Possible causes of recent increases in opioid-related deaths include greater availability of heroin at street level, deepening socio-economic deprivation, drug treatment and commissioning practices changes, and lack of access to mainstream mental and physical health services. • Other treatment options could be further developed in order to reduce the risk of death including broader provision of Naloxone, heroin-assisted treatment for those for whom other forms of OST are not effective, medically supervised drug consumption clinics, treatment for alcohol problems, and assertive outreach to engage heroin users who are not in treatment into OST (especially for those who are homeless and/or have mental health problems).
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • Governments should continue to invest in high-quality OST of optimal dosage and duration delivered together with interventions to help people achieve wider recovery outcomes. • Drug treatment services should follow national clinical guidelines on OST and provide tailored treatment for individuals for as long as required; • Concerns are raised in that many patients experience quite short durations of treatment. As entry to and exit from OST are times of heightened risk, this may increase their vulnerability.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • The ACMD recommend that central and local governments provide an integrated approach for people experiencing drug problems at risk of DRD and prioritise funding and access to physical and mental health and social care services.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 7 and 10

Staying Alive in Scotland: Strategies to Combat Drug Related Deaths

Source		Staying Alive in Scotland: Strategies to Combat Drug Related Deaths
Author(s)		Scottish Drugs Forum, Hepatitis Scotland
Year		2016
Retrieved from		http://www.sdf.org.uk/what-we-do/reducing-harm/reducing-drug-related-deaths/drug-related-deaths-reports-resources/
Key findings		<ul style="list-style-type: none"> Identifies key areas that have been identified as of critical importance in adequately addressing Scotland's response to drug-related deaths. Details summaries of the key findings of the scoping work and consultation. Key findings include drug-related deaths monitoring and learning, access to services, ORT and low threshold prescribing, retention in services, continuity of care, trauma and outreach, information sharing, high risk injecting/wound care/bacterial infections, BBV testing and treatment, Naloxone, prison throughcare/police custody, older people experiencing drug problems, dual diagnosis and suicide, homelessness, females, prescription drugs and non-opiates, attitude and stigma.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> Accompanying each key finding is a list of associated Good Practice Indicators (GPI) to assist in self-assessment of current practice and to aid in the planning for future developments. The Good Practice Indicators have been developed into a good practice baseline tool for ADP's to measure their work against and help prioritise actions for implementation. These actions can support the ADP with their current work with Care Inspectorate on the Quality Principles Standards of Expectations of Care and Support in Drug and Alcohol Services. It can also be used by individual services to assist with actions for development plans.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> Sets out clear strategies that can help reduce the current high number of deaths in Dundee and Scotland as a whole.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> RECOMMENDATIONS: 2, 3, 8 and 9

The National Drug Related Deaths Database (Scotland) Report: Analysis of Deaths Occurring in 2014

Source	The National Drug Related Deaths Database (Scotland) Report: Analysis of Deaths Occurring in 2014
Author(s)	Barnsdale, L., Gordon, R., Graham, L., Walker, D., Elliot, V., and Graham, B.
Year	2016
Retrieved	http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-03-22/2016-03-22-NDRDD-Report.pdf
Key findings	<p>This report provides detailed information on the nature, health and social circumstances of those who have died a drug-related death. Information includes:</p> <ul style="list-style-type: none"> • Profiles of individuals (e.g. age, socio-economic status, gender etc.); • Whether individuals were in contact with services that had the potential to help individuals address drug problems or deliver interventions; • Drugs present and implicated in deaths; • Involvement of Novel Psycho-active substances in deaths; • Female Drug-related deaths; • Death by suicide.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Evidence shows that a large proportion of individuals that experienced a drug-related death were in contact with support service near the time of their overdose.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Over half of DRDs (54%) occurred when others were present at the scene of the overdose (46% of individuals died alone), which highlights the need to upscale naloxone provision.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 7

How Can Opioid Substitution Therapy (and Drug Treatment and Recovery Systems) be Optimised to Maximise Recovery Outcomes for Service Users?

Source	
Author(s)	Advisory Council on the Misuse of Drugs.
Year	2015
Retrieved from	https://www.gov.uk/health-and-social-care/health-improvement
Key findings	<ul style="list-style-type: none"> • There is strong evidence that several key components of OST are critical to OST treatment outcomes of stopping injecting and spread of blood-borne viruses, cessation of heroin use, and cessation of crime. • Many recovery outcomes for people who use drugs are dependent on input from wider health and social welfare providers and the wider society, including mental healthcare; physical healthcare; housing; education and training; employment; and social integration. • There is evidence that people who use drugs including those in medication-assisted recovery may be stigmatised by mainstream providers.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Key factors that drive variations in outcomes for those with heroin dependence include: the quality and effectiveness of the local treatment and recovery service including management and staff competence; the local treatment and recovery system, including the commissioning of the system; wider local community services and assets to support wider recovery outcomes and reintegration.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The ACMD recommends that balanced systems of OST plus abstinence pathways and ongoing recovery support are commissioned for those with heroin dependence based on the needs of local populations and should include a 'segmented' and 'phased and layered' approach that takes into account the different needs of groups.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 2, 7 and 8

Reducing Preventable Deaths Among People Who Use Drugs

Source		Reducing Preventable Deaths Among People Who Use Drugs
Author(s)		Horsburgh, K.
Year		2015
Retrieved from		https://www.wcmt.org.uk/fellows/reports/reducing-preventable-deaths-among-people-who-use-drugs
Key findings		<ul style="list-style-type: none"> • SUPERVISED INJECTING FACILITIES: Wherever there are significant numbers of people injecting in public, there is a clear need for supervised injecting facilities. • TAKE-HOME NALOXONE: Take-Home Naloxone should be available free of charge, and promoted widely, to those most likely to witness an overdose. • ACTIVE ENGAGEMENT AND RETENTION IN TREATMENT SERVICES: Low threshold services should be widely available across the country.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • There is a need for organisations to be using every single measure available in order to prevent further preventable deaths. • There is an imperative for all working in the field to take full account of their duty of care towards people using drugs problematically at very high risk of harm.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • Drug-Related Deaths in Dundee and Scotland are at an all-time high, therefore strategies to assist in the reduction of drug related deaths should be prioritised and implemented as soon as possible. • See above.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATION: 8

Optimising Opioid Substitution Treatment: Turning Evidence into Practice

Source		Optimising Opioid Substitution Treatment: Turning Evidence into Practice
Author(s)		Public Health England
Year		2014
Retrieved from		https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice
Key findings		<ul style="list-style-type: none"> Although opioid substitution treatment (OST) is the most effective intervention for heroin use and dependence, the medication itself, and accompanying psychosocial/recovery interventions, need to be optimised to give the user the best chance of recovery and sustained abstinence. The recommended higher doses of OST are associated with positive treatment outcomes (including longer-term recovery with sustained abstinence). The recommended average effective doses are 60 to 120mg/day of methadone, and 12 to 16mg/day (or up to 32mg in some cases) of buprenorphine.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> OST may be most effective in supporting recovery within a broad evidence-based framework of care. Arbitrarily curtailing or limiting the use of OST does not achieve sustainable recovery and is not in the interests of people in treatment or the wider community. For those who have not stopped using heroin and who are less stable, safe prescribing and dispensing systems (including access to supervised consumption) can help limit the risk of diversion.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> This briefing focuses on elements that can be optimised and provides key messages to help achieve this. The content is drawn from authoritative guidance, published evidence and service provider feedback.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> RECOMMENDATIONS: 8 and 9

Medications in Recovery: Best Practice in Reviewing Treatment

Source		Medications in Recovery: Best Practice in Reviewing Treatment
Author(s)		Public Health England
Year		2013
Retrieved from		https://www.gov.uk/government/news/medications-in-recovery-best-practice-in-reviewing-treatment
Key findings		<ul style="list-style-type: none"> • The group's advice makes clear that: • care planning, with its ongoing and planned reviews of specific goals and actions, should be part of a phased and layered treatment programme; • A strategic review of the client's recovery pathway will normally be necessary within three months (and no later than six months) of treatment entry, and will then usually be repeated at six-monthly intervals • A strategic review should always revisit recovery goals and pathways (to support clients to move towards a drug-free lifestyle) • Drug treatment should be reviewed based on an assessment of improvement (or preservation of benefit) across the core domains of successful recovery.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • To enable this clinical advice to be followed locally, commissioners will want to ensure their services: have the resources (sufficient staff, with appropriate competences and the time) to conduct ongoing, specific and strategic reviews as specified; monitor a range of recovery outcomes to understand and demonstrate the benefits being derived from treatment; and have access to a diverse range of interventions, intensities and settings (including residential) to optimise treatment and care.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • This supplementary report from the RODT expert group describes the nature of the different review processes that should take place during drug treatment to ensure that patients are deriving the most benefit possible from the available interventions.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATIONS: 8 and 9

Medications in Recovery Re-Orientating Drug Dependence Treatment

Source Medications in Recovery Re-Orientating Drug Dependence Treatment	
Author(s)	National Treatment Agency for Substance Misuse
Year	2012
Retrieved from	https://www.drugsandalcohol.ie/18123/
Key findings	<ul style="list-style-type: none"> • Entering and staying in treatment, coming off opioid substitution treatment (OST) and exiting structured treatment are all important indicators of an individual's recovery progress, but they do not in themselves constitute recovery. • Coming off OST or exiting treatment prematurely can harm individuals, especially if it leads to relapse, which is also harmful to society. • Well-delivered OST provides a platform of stability and safety that protects people and creates the time and space for them to move forward in their personal recovery journeys. • Treatment must be supportive and aspirational, realistic and protective.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • OST will improve because of changes at a system, service and individual level. These include treatment systems and services having a clear and coherent vision and framework for recovery visible to people in treatment, owned by all staff and maintained by strong leadership; purposeful treatment interventions that are properly assessed, planned, measured, reviewed and adapted.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The report supports a drive to place prescribing within a fully recovery-orientated system of care, with changes at system, service and individual levels. The report makes clear that this involves treatment services continuing to re-orient their delivery of care to provide active and visible support for recovery.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 8 and 9

Commission on the Future Delivery of Public Services

Source	
Author(s)	Scottish Government
Year	2011
Retrieved from	https://www2.gov.scot/Resource/Doc/352649/0118638.pdf
Key findings	<ul style="list-style-type: none"> • The Christie Commission on the Future Delivery of Public Services (2010) was established at the request of the Scottish Government in November 2010, with the report published in 2011. • It argued for a fundamental shift towards prevention as a guiding principle of public service delivery, saying: "A cycle of deprivation and low aspiration has been allowed to persist because preventative measures have not been prioritised...tackling these fundamental inequalities and focussing resources on preventative measures must be a key objective of public service reform." • Several reforms were suggested to ensure sustainable public services, centred on people, focused on clear outcomes.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • In 2011, the Scottish Government announced their priorities for reform in public services drawing heavily on Christie's recommendations. They proposed four pillars for reform, the first of which was 'prevention' and identified £500m of public spending over three years reserved for funding a shift towards preventative approaches in early years policy, efforts to reduce reoffending, and care for older people.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • A key message from the report was that tackling fundamental inequalities and focussing resources on preventative measures must be a key objective of public service reform. • The report recommended that addressing systemic failings will require a fundamental overhaul of the relationships within and between institutions and agencies, public, third sector and private, responsible for designing and delivering public services.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • NATIONAL CONSIDERATION: 2

Recovery

Let's Celebrate Recovery. Inclusive Cities Working Together to Support Social Cohesion

Source	
Author(s)	Best, D., and Colman, C.
Year	2018
Retrieved from	https://www.tandfonline.com/doi/full/10.1080/16066359.2018.1520223
Key findings	<ul style="list-style-type: none">• Recovery from illicit drug and alcohol use takes place over time and is characterised by a dynamic interaction between internal and external components.• The concept of an Inclusive City is founded on an empirical evidence base, consisting of recovery models such as CHIME (Leamy et al. 2011) and Recovery Oriented Systems of Care, ROSC (White 2008).• An Inclusive City promotes participation, inclusion, full and equal citizenship to all her citizens, including those in recovery, based on the idea of community capital.• The aim of building recovery capital at a community level through connections and 'linking social capital' to challenge stigmatisation and exclusion, is seen as central to this idea.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none">• Sustaining recovery could be about social and community processes and factors, and that accessing supportive and visible role models may play a vital role in persuading individuals that the struggle to attempt recovery is worthwhile.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none">• The central idea of an Inclusive City is that no one should walk the recovery path alone. Several members in a city, including the city council, public and private organisations, employers, landlords and neighbours, should be encouraged to work together with the recovering individuals to promote their recovery process.
Link to Commission Recommendation(s)	<ul style="list-style-type: none">• RECOMMENDATIONS: 2, 3 and 5

Dundee Recovery Roadmap

Source	Dundee Recovery Roadmap
Author(s)	McReady, R., Parish Nursing UK., The Queen's Nursing Institute
Year	2018
Retrieved from	https://www.thecourier.co.uk/fp/news/local/dundee/694289/outreach-nurses-create-roadmap-to-recovery-for-dundee-addicts/
Key findings	<ul style="list-style-type: none">• The Dundee Recovery Roadmap is a pocket guide for people who are struggling with complex health needs to help them navigate support services in Dundee. It's a visual aid which sets out all the services available across the city, including addiction support, family carers support and health and wellbeing information.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none">• The aim of the map is to make the recovery journey more connected for people.• The road map contains a colour-coded guide pinpointing where services are available across Dundee.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none">• The road map was established to bring together voluntary and statutory services who work with individuals struggling with complex health and social needs, including addiction, homelessness, adverse childhood experiences, poor mental health and wellbeing.
Link to Commission Recommendation(s)	<ul style="list-style-type: none">• RECOMMENDATION: 7

Source	
Author(s)	Turning Point
Year	2018
Retrieved from	https://www.turning-point.co.uk/
Key findings	<ul style="list-style-type: none"> • The UK All-Party Parliamentary Group (APPG) on complex needs and dual diagnosis was established in 2007 in recognition of the fact that people seeking help often have several over-lapping needs including problems around access to housing, social care, unemployment services, mental health provision or substance misuse support. • Sets out the findings from a call for evidence on how social action can improve outcomes and develop more responsive services for people with complex needs or a dual diagnosis. • Explores the benefits of social action initiatives working with people with complex needs or a dual diagnosis. We have seen how it can support recovery. • Social action is about people coming together to tackle an issue, support others or improve their local area, by sharing their time and expertise through volunteering, peer-led groups and community projects.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The report provides examples of how social action can support recovery, self-worth and confidence, boost employment prospects and skills, reduce stigma, better shape services to meet people's needs, contribute to better health and wellbeing and save money.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The report analyses how to overcome some of the challenges and barriers to developing social action focused around complex needs. These include resources, stigma, procedural issues, leadership, commissioning structures and demonstrating benefits.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 2, 3 and 7

Changing Lives: Using Peer Support to Promote Access to Services for Family Members Affected by Someone Else's Drug or Alcohol Use

Source	
Changing Lives: Using Peer Support to Promote Access to Services for Family Members Affected By Someone Else's Drug or Alcohol Use	
Author(s)	Adfam
Year	2018
Retrieved from	http://adfam.org.uk/professionals/latest information and events/news/838
Key findings	<ul style="list-style-type: none"> Family support should include: One-to-one practitioner support (e.g. listening, signposting and advice); Information (e.g. on drugs and alcohol, self-care, communication, boundaries, keeping safe, enabling and other important topics); Peer support (e.g. often, but not exclusively, delivered in a group setting). Suggests that the key characteristics of family support are: Recognising the need to support family members in their own right and not simply as a source of 'recovery capital' for those who use substances; inculcating a warm, supportive, 'client-centred' ethos which is responsive to individual circumstances (rather than adopting a 'one size fits all' approach); Enabling the close involvement of family members in service design.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> Adfam have empowered families to develop, deliver and evaluate sustainable services for themselves and for other families. They have become visible Family Recovery Champions, inspiring others to make positive changes in their lives and redress the negative impact of drug and alcohol use in their families and communities.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> Opportunity to further develop family support across the city.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> RECOMMENDATION: 5

Understanding Recovery from a Family Perspective: A Survey of Life in Recovery for Families

Source	Understanding Recovery from a Family Perspective: A Survey of Life in Recovery for Families
Author(s)	Andersson, C., Best, D., Irving, J., Edwards, M., Banks, J., Mama-Rudd, A., and Hamer, R.
Year	2017
Retrieved from	http://alcoholresearchuk.org/alcohol-insights/understanding-recovery-from-a-family-perspective-a-survey-of-life-in-recovery-for-families/
Key findings	<ul style="list-style-type: none"> • Family members are both a resource to support recovery, and people whose own lives can be transformed through recovery, and who will benefit from their family member's recovery journey. • 'Recovery' journeys are experienced by families as a period of positive change, but also emotional challenge, and starting on this journey does not mean full or immediate reversal of the damage done. • Where recovery is successful, family members can experience significant improvements to quality of life and wellbeing, including reduced domestic conflict, less use of healthcare, and improved personal finances.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Emphasises the importance of family members to support individuals in their recovery journey.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Highlights the importance of family members to support individuals in their recovery journey and provides an opportunity to further develop family support across the city.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 5

Overcoming Alcohol and Other Drug Addiction as a Process of Social Identity Transition: The Social Identity Model of Recovery (SIMOR)

Source	
Overcoming Alcohol and Other Drug Addiction as A Process of Social Identity Transition: The Social Identity Model of Recovery (SIMOR)	
Author(s)	Best, D. et al.
Year	2015
Retrieved from	http://shura.shu.ac.uk/10842/
Key findings	<ul style="list-style-type: none"> • Explains how the transition to recovery can occur, together with the social and psychological dynamics that underpin it. • Introduces a new and key aspect of recovery, involving social identity change and outlines how this is implicated in both the initiation and the maintenance of recovery pathways. • Proposes that (a) identity change in recovery is socially negotiated, (b) recovery emerges through socially mediated processes of social learning and social control. • Builds on evidence which suggests that belonging to one or more social groups or networks is supportive for recovery (Best et al., 2010). • Peers linked to specialist treatment providers acted as “connectors” between socially isolated clients and pro-social groups, resulting in both increased engagement in group activity and better substance use outcomes.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Highlights the important role of social groups in recovery. • Demonstrates the positive effect of peers in helping people to recover.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Improving peer engagement in recovery initiatives in Dundee could potentially build community capacity so that peers could make and/or promote safer decision-making regarding substance use and promoting recovery.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 5 and 7

Research for Recovery: A Review of the Drugs Evidence Base

Source		Research for Recovery: A Review of the Drugs Evidence Base
Author(s)		Best, D., et al.
Year		2010
Retrieved from		http://www.gov.scot/resource/doc/321958/0103435.pdf
Key findings		<ul style="list-style-type: none"> • The best predictor of the likelihood of sustained recovery is the extent of 'recovery capital' a person has, the social supports that are available to them and the basic foundations of quality of life (i.e. a safe place to live, meaningful activities and a role in their community, however they define this). • There is little UK-based research on recovery and the international evidence base is limited by three factors – much of it is quite dated, much of it is based on alcohol or mental health rather than illicit drugs, and almost all the evidence originates from the United States. • Barriers to recovery include psychological problems (mental illnesses and the absence of strengths, such as self-esteem), significant physical morbidities (including blood borne viruses), social isolation and ongoing chaotic substance use.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • Findings from this review emphasise: 1) the importance of providing ongoing support to individuals following structured treatment; 2) the positive outcomes associated with mutual aid and peer support in the community; and 3) the importance of assertive follow-up support as aftercare.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • The evidence base on recovery is growing, demonstrating that recovery-focused approaches can augment and enhance treatment interventions, and maximise wider benefits to families and communities.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATIONS: 1, 5 and 14

Reducing drug-related Deaths- Opportunities

National Overdose Strategy 2014-2017 "Sure You Can Quit Drugs – But First You Have to Survive"

Source	
Author(s)	Norwegian Directorate of Health.
Year	2014
Retrieved from	https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/145/National-overdose-strategy-2014-2017-IS-0418EN.pdf
Key findings	<ul style="list-style-type: none"> • Aims to facilitate a transition from intake of drugs by injection to less harmful means of intake. • Assists in the formulation of local authority action plans to combat overdose via a learning network. • Makes Naloxone nasal spray, a life-saving antidote, available to people experiencing drug problems and others. • Strengthens the overdose prevention focus. • Aims for stricter control of prescription of addictive medicines.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The national overdose strategy calls for the scaling-up of activities to prevent overdose risks and promotes emergency assistance and treatment for people experiencing drug problems. • In Norway, the municipalities are responsible for the organisation of harm reduction measures based on local needs and challenges.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Prevention of drug-related overdoses is among current Norwegian national priorities. The objective of National Overdose Strategy is an annual reduction in the number of overdose fatalities and, ultimately a Vision Zero. Thus, there is an opportunity to develop a similar strategy in Scotland.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • NATIONAL CONSIDERATION: 2

Proposal for a Trauma-informed, Low-threshold Opiate Replacement Therapy (ORT) Service

Source		Proposal for a Trauma-informed, Low-threshold Opiate Replacement Therapy (ORT) Service.
Author(s)	Tay, J.	
Year	2018	
Retrieved		
Key findings	<ul style="list-style-type: none"> • This document is a proposal for a trauma-informed, low threshold Opiate Replacement Therapy (ORT) service. • Trauma informed services are based on the principles of safety; transparency and trustworthiness; choice; collaboration, respect and empowerment. • Low threshold refers to the removal of barriers that limit or delay access to ORT. • The referral process is open so clients can be referred from any source, including self-referral. • Intake assessments are minimised, focussing on addressing immediate risks (including driving & child protection), harm reduction and safe ORT initiation with other aspects of assessment occurring later. 	
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • ORT can reduce fatal opioid overdose rates, reduce illicit drug use, and increase treatment retention. • Traditional treatment programs for addiction often have long waiting times and assessments all of which can increase the risk for continued harmful illicit drug use, criminal activity, infectious disease spread, overdose and mortality. • Addiction treatment services which are perceived to be punitive, judgmental or obstructive runs the risk of re-traumatisation and consequently high levels of disengagement. 	
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • See above. 	
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 8 and 10 	

Naloxone Peer Educators

Source	Naloxone Peer Educators
Author(s)	The Scottish Drugs Forum
Year	2018
Retrieved from	http://www.sdf.org.uk/wp-content/uploads/2018/06/SDF-Annual-Review-2017-18-Digital.pdf
Key findings	<ul style="list-style-type: none"> In the first six months, SDF-supported peers trained more than 650 people and supplied nearly 800 naloxone kits.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> Provides a plan and offers an opportunity for this to be replicated which could potentially engage 'hard to reach' individuals given the peer approach. This model has shown one of the strengths of using peer educators to deliver an initiative like this in the community.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> Opiates were implicated in 87% of the drug-related deaths in Scotland in 2017. Of the 57 drug-related deaths in Dundee during 2017, Heroin and/or Morphine were implicated in, or potentially contributed to, the cause of 42 deaths (74% of the total).
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> RECOMMENDATIONS: 5 and 12

County Durham and Darlington Unveil Plans for Police in Custody Suites to Administer Naloxone

Source		County Durham and Darlington Unveil Plans for Police in Custody Suites to Administer Naloxone
Author(s)		The Scottish Drugs Forum
Year		2018
Retrieved from		http://www.sdf.org.uk/county-durham-and-darlington-unveil-plans-for-police-in-custody-suites-to-administer-naloxone/
Key findings		<ul style="list-style-type: none"> Police in custody suites in County Durham and Darlington will be able to administer naloxone to people who are experiencing an opiate overdose from later this year under new plans. Currently, people employed or engaged in the provision of drug treatment services can, as part of their role, supply naloxone if it is supplied for the purpose of being available to save life in emergencies. Officers are being trained to enable its introduction later this year, and the guidelines for when naloxone should be used are currently being finalised.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> If the plan goes ahead, Durham will be one of the first police forces in the country to introduce it into custody suites.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> Opiates were implicated in 87% of the drug-related deaths in Scotland in 2017. Of the 57 drug-related deaths in Dundee during 2017, Heroin and/or Morphine were implicated in, or potentially contributed to, the cause of 42 deaths (74% of the total).
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> RECOMMENDATION: 5 NATIONAL CONSIDERATION: 2

Supervised Injection services: What Has Been Demonstrated? A Systematic Literature Review

Source		Supervised Injection Services: What Has Been Demonstrated? A Systematic Literature Review
Author(s)		Potier, C., Lapr�v�te, V., Dubois-Arber, F., Cottencin, O. and Rolland, B.
Year		2014
Retrieved from		https://www.sciencedirect.com/science/article/pii/S0376871614018754
Key findings		<p>Evidence from Vancouver and Sydney where supervised injecting sites (SISs) are shows reductions in:</p> <ul style="list-style-type: none"> • Overdoses, injecting risk behaviours, BBV transmission, drug-related litter, and ambulance callouts and deaths in the immediate vicinity. • There is no evidence of increases in crime or drug use.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> • The implementation of new SISs in places with high rates of injecting drug use and associated harms appears to be supported by evidence. • Scotland has the highest level of drug deaths in Europe. • The First Minister believes that there should be cross-party collaboration to implement 'bold and new' initiatives to tackle drug-related deaths in Scotland.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> • See above. • Facilities such as supervised injecting sites appear to be a credible intervention that contribute to preventing overdoses.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> • RECOMMENDATION: 12 • NATIONAL CONSIDERATION: 3

Non-fatal Overdose Pathway

Non-fatal Overdose Pathway	
Name	
Author(s)	Amir Kirolos, Claire Glen and Duncan McCormick
Year	2017
Retrieved	https://www.nhslothian.scot.nhs.uk/Services/A-Z/HarmReductionTeam/Pages/default.aspx
Key findings	<ul style="list-style-type: none"> • In Edinburgh, the Scottish Ambulance Service provides information on cases of suspected opiate overdose to the substance misuse directorate (SMD). This initiative was started in May 2015. • In 2016 there were 431 cases of non-fatal overdose attended to by the Scottish Ambulance Service (cases of suspected opiate overdose). Of these 278 (64%) were male, 145 (34%) female and 8 unknown gender. Age is known in 316 cases and 37% were under 35 versus 28% under 35 in cases of DRD.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Non-fatal overdose information is screened to identify whether the patient is already in treatment. If they are, the patient's practitioner is informed of the overdose. If they're not, case information is referred to third sector agencies who undertake assertive outreach. • Opportunity to develop a non-fatal overdose further in Dundee.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Non-fatal overdoses are a major risk factor for a drug-related death.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 9 and 10

Perspectives on Drugs Consumption Rooms: An Overview of Provision and Evidence

Source Perspectives on Drugs Consumption Rooms: An Overview of Provision and Evidence	
Author(s)	European Drug Monitoring Centre for Drugs and Drug Addiction
Year	2018
Retrieved	http://www.emcdda.europa.eu/publications/pods/drug-consumption-rooms_en
Key findings	<ul style="list-style-type: none"> • Provides an overview of the 'history' of drug consumption room in Europe and basic facts and statistics in relation to consumption rooms in Europe. • There is data/research for effectiveness of consumption rooms with one of the outcomes showing a reduced risk of overdosing. • Research has also shown that the use of supervised drug consumption facilities is associated with self-reported reductions in injecting risk behaviour such as syringe sharing. This reduces behaviours that increase the risk of HIV transmission and overdose death.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • The use of consumption facilities is associated with increased uptake both of detoxification and drug dependence treatment, including opioid substitution. • Some studies suggest that, where coverage is adequate, drug consumption rooms may contribute to reducing drug-related deaths at city level.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • See above.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 10 • NATIONAL CONSIDERATION: 3

Naloxone Training Website

Source		Naloxone Training Website
Author(s)		St Paul's Foundation, Toward the Heart
Year		2018
Retrieved		http://www.naloxonetraining.com/
Key findings		<ul style="list-style-type: none">• The app uses information from Toward the Heart, a service of the BC Centre for Disease Control that administers the provincial Take Home Naloxone program.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none">• Healthcare workers around the province now have access to a simple online training app to teach people how to use naloxone - www.NaloxoneTraining.com.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none">• Opiates were implicated in 87% of the drug-related deaths in Scotland in 2017.• Of the 57 drug-related deaths in Dundee during 2017, Heroin and/or Morphine were implicated in, or potentially contributed to, the cause of 42 deaths (74% of the total).• Naloxone must be readily available to people likely to witness an overdose.
Link to Commission Recommendation(s)		<ul style="list-style-type: none">• RECOMMENDATION: 8

Facility Overdose Response Box

Source Facility Overdose Response Box	
Author(s)	Toward the Heart
Year	2018
Retrieved	https://towardtheheart.com/forb
Key findings	<ul style="list-style-type: none"> • The FORB program provides overdose response boxes with the opioid antidote naloxone for employees at community-based organisations. • The response boxes include 3, 5, 10 or 20 doses of naloxone and other OD response supplies which are supplied at no charge by the British Columbia Centre for Disease Control to sites registered in the program.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Services must ensure that Naloxone is readily provided to people likely to witness an overdose.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Opiates were implicated in 87% of the drug-related deaths in Scotland in 2017. • Of the 57 drug-related deaths in Dundee during 2017, Heroin and/or Morphine were implicated in, or potentially contributed to, the cause of 42 deaths (74% of the total).
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 8

Low Threshold Methadone Programme

Name Low Threshold Methadone Programme	
Author(s)	Kirolas, A., Glen, C., McCormick, D.
Year	2017
Retrieved	https://www.nhslothian.scot.nhs.uk/Services/A-Z/HarmReductionTeam/Pages/default.aspx
Key findings	<ul style="list-style-type: none"> • Low Threshold Methadone Programme (LTMP) is delivered by the Harm Reduction Team at the Spittal Street Centre in Edinburgh. It treats high-risk injectors who self-present or who are referred by the community Hubs. • There is daily contact with the therapeutic team (weekday medication is collected and consumed on the premises) and twice weekly contact with a non-medical prescriber to initiate Opioid Substitution Therapy (OST). • There is good access to initial and ongoing care with good retention and continuity of care. • High intensity intervention including weekday contact with therapeutic staff. • Safe rapid titration with twice weekly increases, close observation of mental and physical state, easy to resume OST following missed doses.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • LTMP offers the most intensive supervision and support for people initiating OST. • Clients can opportunistically engage with the other psychosocial, and clinical interventions available at Spittal Street Centre. These include routine contact with people with lived experience and a recent qualitative study found that peer support enables service user engagement with treatment.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Opportunity for the LTMP to be discussed and potentially introduced across the city to facilitate quicker access to OST.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • 5, 8, 10.

The Edinburgh Access Practice

Name	The Edinburgh Access Practice
Author(s)	Kirolos, A., Glen, C., McCormick, D.
Year	2017
Retrieved	https://www.nhslothian.scot.nhs.uk/Services/A-Z/HarmReductionTeam/Pages/default.aspx
Key findings	<ul style="list-style-type: none"> • The Edinburgh Access practice provides Opioid Substitution Therapy (OST) at the Spittal Street clinic. Unlike other General Practices, Edinburgh Access Practice routinely initiates prescribing with nursing non-medical prescribers (NMPs). • Good access with a single assessment process and practitioner relationship in a single location Safe.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • This pathway is the shortest and simplest route to OST requiring a minimum of two appointments with the nurse and with weekday dispensing supervised in pharmacies. It is available only for those who are homeless or not registered with another GP. • Rapid titration with 1-2 increases per week. • Pharmacy medication pick up is flexible on location and time. • Very close linkage to general medical interventions in primary care.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Opportunity for this pathway to be discussed and potentially introduced across the city to facilitate quicker access to OST.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATIONS: 8, 9, 10 and 15

Insite Supervised Injection Site

Source	Insite Supervised Injection Site
Author(s)	City of Vancouver
Year	2018
Retrieved	https://vancouver.ca/people-programs/safe-injection-site-and-needle-exchange.aspx
Key findings	<p>The benefits to offering supervised injection sites include:</p> <ul style="list-style-type: none"> • Reduces number of overdose deaths. • Provide a safe, clean, and secure place for people experiencing drug problems to inject while reducing the visibility of drug consumption on the street. • Needle exchange programs. • Vancouver Coastal Health offers needle exchange services where people can dispose of used needles in a safe and legal way. They also provide clean needles, sterile water, alcohol wipes and health information to encourage safer injecting practices.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • International research on supervised consumption services has found that these sites are beneficial to people who use substances as well as the surrounding community. • Provides an opportunity for multiple contacts with health care staff, social workers, and other individuals who can help people experiencing drug problems move toward healthier choices, such as drug treatment programs, primary health care, and other social services. • Reduces HIV and hepatitis C transmission and ensures that injecting equipment remains inside and is not discarded in the community.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Evidence has also shown that supervised consumption services: save lives; reduce sharing of needles that cause HIV and hepatitis C; increase use of detox and addiction treatment services; and provide opportunities to connect people to health care services.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 12

Overdose Prevention Sites

Source	Overdose Prevention Sites
Author(s)	Government of British Columbia
Year	2018
Retrieved	https://www2.gov.bc.ca/gov/content/overdose/what-you-need-to-know/overdose-prevention
Key findings	<ul style="list-style-type: none"> • Each site provides various levels of services, including overdose prevention education and Take-Home Naloxone training and distribution. • Some sites may also distribute harm reduction supplies (such as sterile needles, filters, cookers, condoms, etc.) offer safe disposal options, and facilitate referrals to mental health and substance use services. Currently, each British Columbia overdose prevention site offers drug-checking services.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • While supervised consumption services require municipalities (within Canada) to seek an exemption from federal drug laws, the same process is not required to establish an overdose prevention site. • Reduces HIV and hepatitis C transmission and ensures that injecting equipment remains inside and is not discarded in the community. • Reduces risks to the community as the open consumption of drugs can be more easily discouraged.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • Overdose prevention services are uniquely positioned as a 'low threshold' point of introduction to health and/or social services for people with substance use issues. • Opportunity for the implementation of overdose prevention sites to be discussed within the broader DRD context.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 12 • NATIONAL CONSIDERATION: 3

The Uniting Medically Supervised Injecting Centre (MSIC)

Source The Uniting Medically Supervised Injecting Centre (MSIC)	
Author(s)	Uniting
Year	2018
Retrieved	https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre
Key findings	<ul style="list-style-type: none"> • The Uniting Medically Supervised Injecting Centre (MSIC) Kings Cross is a compassionate and practical health service that seeks to connect with people who inject drugs and welcome them in a non-judgmental, person-centred way. • Approximate number of clients since Uniting MSIC opened: 15,400. • About 70% of the people registered with Uniting MSIC have never accessed any local health service before coming to them. • Since opening the service has supervised more than 965,000 injections. • Number of overdoses successfully managed: More than 6000. • Number of fatalities: 0. • More than 12,000 referrals have been accepted by our clients, connecting them to health, drug treatment and social welfare services. Among our frequently attending clients, 80% have ultimately accepted a referral for addiction treatment.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • Key learning points suggest that Uniting MSIC provides a unique and important entry point for access to health and social welfare services in Kings Cross. • Number of fatalities: 0.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • See above.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 12 • NATIONAL CONSIDERATION: 3

Glasgow Drug Crisis Centre

Source	Glasgow Drug Crisis Centre
Author(s)	Turning Point Scotland
Year	2018
Retrieved	http://www.turningpointscotland.com/what-we-do/substance-misuse/glasgow-drug-crisis-centre/
Key findings	<ul style="list-style-type: none"> • The Glasgow Drug Crisis Centre offers a safe, confidential service which supports and encourages people to find ways of making their substance misuse less problematic and to achieve a better quality of life. • Assessments are carried out on a 24-hour basis and an abscess and ulcer clinic is also provided by Glasgow's Physical Health Team. • The Naloxone Programme educates people on what to do in the event of an overdose. Training in basic first aid skills is provided along with training to administer naloxone, which reduces the risk of fatality in the event of an overdose. • The needle exchange is open 24 hours a day. Used injecting equipment can be brought in to be disposed of safely and exchanged for new equipment. Those who come to the needle exchange for the first time will also be given a brief initial screening. It is expected that those who use the service may want to access other services offered or be put in touch with relevant local agencies.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> • There are no waiting lists or appointment times at the Glasgow Drug Crisis Centre. • The centre offers a range of support services 24 hours a day.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> • The crisis centre is a 'One Stop Service'. The One Stop service provides 24-hour advice, information and support on substance misuse and related issues.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> • RECOMMENDATION: 7 and 11

#StoptheDeaths Campaign

Source	#StoptheDeaths Campaign
Author(s)	Scottish Drugs Forum
Year	2018
Retrieved from	http://www.sdf.org.uk/stopthedeaths/
Key findings	<ul style="list-style-type: none">• #StopTheDeaths is an initiative to ensure that all stakeholders in Scotland – people who use drugs, their families, services and wider society understand their role in the prevention of drug deaths.• It calls for a national focus on drug-related deaths in Scotland.• The campaign was launched at the Scottish Drug Forum's annual conference marking International Overdose Awareness Day.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none">• #StopTheDeaths acts to raise awareness of the rising toll of drug overdose deaths in Scotland and to focus efforts to prevent these tragedies. The initiative will also focus on other drug-related deaths – for example, those caused by adverse health effects of drug use.• By using social media, SDF aim to spread the #StopTheDeaths campaign and bring a wider focus on the rise of drug-related deaths across Scotland.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none">• Opportunity to develop local social media campaign to raise awareness of the rising number of drug overdose deaths in Dundee.
Link to Commission Recommendation(s)	<ul style="list-style-type: none">• RECOMMENDATIONS: 2, 3 and 5

Naloxone-On-Release: Guidelines for Naloxone Provision upon Release from Prison and Other Custodial Settings

Source	
Author(s)	Kirsten Horsburgh, Scottish Drug Forum
Year	2018
Retrieved from	http://www.sdf.org.uk/wp-content/uploads/2018/07/My-first-48-hours-out-Guidelines-for-naloxone-provision-upon-release-from-prison-and-other-custodial-settings.pdf
Key findings	<ul style="list-style-type: none"> The hands-on toolkit explains how to set up and run naloxone programmes for overdose prevention upon release from prison and other custodial settings.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none"> The guidelines are aimed at providing hands-on recommendations for policymakers and practitioners from prison health services on how to promote, initiate and manage interventions related to overdose prevention through naloxone programs and how to organise related training and capacity building.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none"> See above.
Link to Commission Recommendation(s)	<ul style="list-style-type: none"> RECOMMENDATION: 1 NATIONAL CONSIDERATION: 2

Norway to be 7th European Country to Offer Heroin Assisted-Treatment

Source		Norway to be 7th European Country to Offer Heroin Assisted-Treatment
Author(s)		Lucy Faber
Year		2018
Retrieved from		https://www.talkingdrugs.org/norway-to-be-7th-european-country-to-offer-heroin-assisted-treatment
Key findings		<ul style="list-style-type: none"> Norway will offer free heroin prescriptions through a Heroin-assisted treatment (HAT) programme by 2020 to improve the living conditions of people dependent on the drug. HAT typically allows people who use heroin, for whom other treatment options such as methadone have proved insufficient, to be provided and administered the drug in a clinical environment. The Norwegian scheme sets out to provide the drug to up to 400 people, although details on quantities are unclear while authorities formulate specific plans.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none"> HAT delivers the health benefits of prescribed supply - heroin of known strength, free from contaminants and adulterants, used with clean injecting equipment - but combined with the benefits of supervised use in a safe and hygienic venue. The Glasgow Needs Assessment report suggests implementing evidence-based supports and services such as HAT as a response to the high numbers of individuals injecting drugs in public places.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none"> The evidence from trials in several countries shows that this form of treatment can be effective in reducing illicit drug use and improving retention in treatment among people deeply entrenched in opiate dependency, for whom other forms of substitution treatment have been ineffective.
Link to Commission Recommendation(s)		<ul style="list-style-type: none"> RECOMMENDATIONS: 7 and 12 NATIONAL CONSIDERATION: 3

The Harm Reduction Nurses Association

Source		The Harm Reduction Nurses Association
Author(s)		The Harm Reduction Nurses Association
Year		2018
Retrieved from		http://www.hrna-aiirm.ca/
Key findings		<ul style="list-style-type: none">• The Harm Reduction Nurses Association is a Canadian national organisation with a mission to advance harm reduction nursing through practice, education, research, and advocacy.
Practice implications/gaps (i.e. relevance to Dundee drug services)		<ul style="list-style-type: none">• The HRNA strives to achieve its mission through the following actions:• Serving as a national voice for harm reduction and related nursing issues;• Promoting education and continuous learning opportunities for nurses;• Encouraging evidence-based harm reduction nursing practices;• Creating a dynamic network to support and mentor nurses across the country.
Relevance to Dundee Drugs Commission		<ul style="list-style-type: none">• Providing opportunities to share nursing knowledge, expertise and practices;• The HRNA advocate for the rights and dignity of people who use drugs and their families.
Link to Commission Recommendation(s)		<ul style="list-style-type: none">• RECOMMENDATION: 5

Public Health Emergency Declaration

Source Public Health Emergency Declaration	
Author(s)	British Columbia Government News
Year	2018
Retrieved from	https://news.gov.bc.ca/releases/2016HLTH0026-000568?WT.mc_id=NEWS&WT.cg_n=HootSuite
Key findings	<ul style="list-style-type: none">• In 2016 British Columbia Provincial Health Officer Dr. Perry Kendall declared a Public Health Emergency under section 52 of the Public Health Act in response to the rise in opioid overdoses.
Practice implications/gaps (i.e. relevance to Dundee drug services)	<ul style="list-style-type: none">• This was the first time the provincial health officer has served notice under the Public Health Act to exercise emergency powers.• B.C. is the first province to take this kind of action in response to the current public health crisis from drug overdoses.• The new powers enacted by the provincial health officer provide one more tool in the robust provincial strategy to address this public health crisis. Currently information on overdoses is only reported if someone dies, and there is some delay in the information.
Relevance to Dundee Drugs Commission	<ul style="list-style-type: none">• The action allows medical health officers throughout the province to collect more robust, real-time information on overdoses in order to identify immediately where risks are arising and take proactive action to warn and protect people who use drugs.• Language change was apparent within the context of the implementation of a public health emergency strategy which proved critical to opening the way for responses to the increasing drug-related deaths.
Link to Commission Recommendation(s)	<ul style="list-style-type: none">• RECOMMENDATION: 3• NATIONAL CONSIDERATION: 3

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In addition to the extensive range of documents formally reviewed by the Commission in the literature and evidence review above, a wide range of other relevant papers, reports, resources were identified by the team at Figure 8 and provide a secondary, broader layer of evidence upon which the Commission's findings are based. These documents are recorded below.

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APPENDIX IV: RAPID REVIEW OF LITERATURE IN RELATION TO LOW THRESHOLD METHADONE PRESCRIBING

Low-threshold definitions

Methadone maintenance treatment (MMT) was designed by Dole and Nywssander (1965) to manage opioid dependence. To block cravings and stabilise this deficiency, they advocated for long-term maintenance of the client and provision of ancillary services.³ From the 1980s, a new approach was conceptualised, with redefined objectives, introducing Methadone Maintenance in low-threshold programmes. The development of such programmes aimed to eliminate access barriers for people experiencing drug problems who did not intend to abstain from all drugs but who wished to benefit from methadone support services.⁴ Furthermore, the justification for introduction of low-threshold practices was to offer easy access to services and engage marginalised clients, to motivate them to seek help and to assist them whilst engaging with the health and welfare system. In some European countries, low-threshold is used as an umbrella term to describe different services such as needle-exchange programmes (NSP), opioid substitution treatment (OST), and health services.⁵

‘Low-threshold’ has been described within the larger harm reduction field, with aspects being reducing barriers by engaging clients in places where they are willing to meet. Another descriptor is that low threshold indicates both minimal requirements for entry into a service or programme and a minimal requirement for retention. Thus, low-threshold services are those which try to reduce barriers to attendance or retention, by implementing less stringent eligibility criteria.

Mofizul-Islam and colleagues⁶ suggest three indispensable criteria that define a service as low-threshold. Firstly, people experiencing drug problems should be the crucial (but not the only) target population. Secondly, abstinence from drug use should not be required, which is vital in terms of de-marginalising individuals and creating a positive environment. Thirdly, to facilitate service entry, other barriers to service access must be reduced as much as possible. This may include outreach programmes or an inviting atmosphere and effective client engagement.

Evidence

Strike and Rufo (2010)⁷ offer two different types of methadone maintenance orientated programmes; high and low threshold. They suggest the goal of high threshold programmes is to eliminate the use

³ Strike, C. J., Millson, M., Hopkins, S., and Smith, C. 2013. What is low threshold methadone maintenance treatment? *International Journal of Drug Policy*, 24(6), e51–e56.

⁴ Lopes, P., Trigo, H., Coutinho, R., Leitão, E., Miguel, N, and Oliveira, J. 2016. Low threshold methadone program: 13 years of experience in Portugal. In Smith, C., and Marshall, Z. (eds.) *Critical approaches to harm reduction*. New York, PP. 23-40.

⁵ Mofizul-Islam, M., Topp, L., Conigrave, K. and Day, C. 2013. Defining a service for people who use drugs as ‘low-threshold’: what should be the criteria? *International Journal of Drug Policy*, 24: pp. 220-222.

⁶ Ibid.

⁷ Strike C., and Rufo, C. 2010. Embarrassing, degrading, or beneficial: Patient and staff perspectives on urine drug testing in methadone maintenance treatment. *Journal of Substance Use*, 15(5), 303-312.

of all illegal drugs (i.e. opiates and others) but maintain clients on methadone. These programmes have strict policies that control entrance and expulsion from the programmes. High threshold programmes are not always user-friendly and often eject clients for using illegal drugs or otherwise violating programme requirements. In comparison, the programmes Strike and Rufo studied were labelled as low-threshold and had few treatment entry and retention criteria. These programmes did require regular attendance, expected on-going but diminishing use of other illegal drugs, and did not tolerate on-site violence or drug trafficking.

Exploring the types of thresholds people with drug problems and mental health disorders at a low-threshold facility encounter, Edland and colleagues⁸ found that three thresholds were significant: the registration threshold, the competence threshold, and the threshold of effectiveness. In addition to these, the authors suggest that a fourth threshold is significant for this group: the threshold of trust. In the low-threshold centre studied they observed that, for the clients, crossing the threshold of trust seemed to be an essential precondition for subsequently being able to cross other thresholds in order to receive the help they need. The authors further add that the threshold of trust seems to be particularly important for people experiencing drug problems and mental health issues. The results have implications both for practice and policy because if taken seriously into consideration, the authors suggest that more clients could access the services they need.

Strike and colleagues⁹, citing empirical evidence of comparisons to higher threshold methadone treatment programmes (i.e. programmes with rigorous policies governing continued use of any illicit drug during treatment), demonstrate that low-threshold methadone programmes attract different types of clients, have higher retention rates, and are associated with reductions in heroin use, injection-related Human Immunodeficiency Virus (HIV) risk behaviours, injection-related mortality, criminal charges, and mortality. Similarly, introducing low-threshold methadone services has been associated with reduced injecting and the sharing of injecting equipment, with Millson and colleagues¹⁰ suggesting that low-threshold methadone programmes can help reduce the risk of HIV without the enforcement of abstinence-based policies.

In a recent study to increase initiation of eligible patients, a buprenorphine programme implemented changes to lower treatment thresholds which included the elimination of a requirement that patients demonstrate abstinence from stimulants prior to initiating buprenorphine. The authors conclude that lower-threshold policies may increase buprenorphine treatment initiation for patients with co-occurring stimulant use. However, patients using stimulants may require additional supports to remain engaged.¹¹

⁸ Edland-Gryt, M., and Skatvedt, A. H. 2013. Thresholds in a low-threshold setting: an empirical study of barriers in a centre for people with drug problems and mental health disorders. *International Journal of Drug Policy*, 24(3): 257-64.

⁹ Strike, C. J., Millson, M., Hopkins, S., and Smith, C. 2013. Op. Cit.

¹⁰ Millson, P., Challacombe, L., Villeneuve, P. J., Strike, C. J., Fischer, B., Myers, T., et al. 2007. Reduction in injection-related HIV risk after 6 months in a low-threshold methadone treatment program. *AIDS Education and Prevention*, 19(2), 124-136.

¹¹ Payne, B. E., Klein, J. W., Simon, C. B., James, J. R., Jackson, S. L., and O'Merrill, J., et al. 2019. Effect of lowering initiation thresholds in a primary care-based buprenorphine treatment program. *Drug and Alcohol Dependence*, 200: 71-77.

Low-threshold methadone treatment programme participation has also been found to be associated with improved health-related quality of life among opiate users in the first 6 months upon entering a low-threshold methadone treatment programme, particularly in the mental health domains during the first 6 months of treatment.¹²

Participation in a low-threshold methadone programme has also been found to be associated with a reduction in mortality amongst two long-standing Canadian cohorts of people who inject drugs. The authors, Nolan and colleagues (2015, p.60)¹³ conclude that 'given the evidence regarding the benefits of low-threshold MMT programmes, these findings further expand upon the known benefits of MMT for reducing the harms associated with injection drug use and support the need for universal and unrestricted access to low-threshold MMT for the treatment of opioid use disorder'.

A review by Kourounis and colleagues¹⁴ suggests that there are generally better treatment outcomes for low treatment-threshold compared with high treatment-threshold designs. The authors found that treatment thresholds were defined as barriers individuals could face prior to and during treatment. The variables of these barriers were classified into treatment accessibility barriers and treatment design barriers. The authors conclude that clinical characteristics of low-threshold treatments that were identified to increase the effectiveness of a methadone programme intervention include: increasing accessibility so as to avoid waiting lists; using personalised treatment options regarding medication choice and dose titration; flexible treatment duration; and a treatment design that focuses on maintenance and harm reduction with emphasis on the retention of low adherence patients.

Lopes and colleagues¹⁵, utilising data collected over the course of 13 years of intervention (2001-2013) in Portugal, found low-threshold methadone programmes (LTMP-Lx) to be a fundamental support programme to the marginalised population, with positive impacts evident in terms of personal and public health. For example, the authors provide data on comparisons between the percentages of positive results found in the LTMP-Lx population in 2002 and in 2013, which shows that HIV decreased from 23.8% to 18.8%, (compared to around 0.5-0.9% in the general population), and that Hepatitis C Virus (HCV) decreased from 64.3% to 61.6% (in the general population it is around \pm 1%). Tuberculosis (TB) decreased from 4.2% to 1.1% (general population).

¹² Villeneuve, P. J., Challacombe, L., Strike, C. J., Myers, T., Fischer, B., Shore, R., et al. 2006. Change in health-related quality of life of opioid users in low-threshold methadone programs. *Journal of Substance Use*, 11(2), 137–149.

¹³ Nolan, S., Hyashia, K., Milloy, M. J., Kerr, T., Dong, H., Lima, V. D., et al. 2015. The impact of low-threshold methadone maintenance treatment on mortality in a Canadian setting. *Drug and Alcohol Dependence*, 156: 57–61.

¹⁴ Kourounis, G., Richards, B.D., Kyprianou, E., Symeonidou, E., Malliori, M.M., and Samartzis, L., 2016. Opioid substitution therapy: Lowering the treatment thresholds. *Drug and Alcohol Dependence*, 161: 1-8.

¹⁵ Lopes, P., Trigo, H., Coutinho, R., Leitão, E., Miguel, N., and Oliveira, J. 2016. Op. Cit.

APPENDIX V: INTERNATIONAL RESEARCH EVIDENCE CASE STUDIES (CANADA, ICELAND, PORTUGAL)

Introduction

The following papers present a snapshot of interventions by the Governments, local health authorities, peers and frontline workers in Canada, Iceland and Portugal. This should not be regarded as a thorough review of interventions; rather, it should be viewed as a snapshot of interventions available in these countries which can potentially offer lessons from their experience of problematic substance use which could be useful in terms of avoiding drug-related deaths, learning from non-fatal overdoses, and achieving reduced levels of drug use within the population in Dundee.

Overdose Prevention: What Can Be Learned From Canada?

Summary

- Canada is currently experiencing an opioid crisis. Across the country, the crisis is having overwhelming effects on the health and lives of many individuals;
- In response to the overdose crisis, health authorities, peers, frontline workers and the Government have been collaborating to implement different interventions;
- British Columbia (BC), Canada is experiencing a public health emergency due to overdoses resulting from consumption of street drugs contaminated with fentanyl.
- Over 9,000 individuals died in Canada between January 2016 and June 2018 related to opioids.
- A public health emergency under the Public Health Act was declared in 2016 in B.C in response to increasing overdoses and overdose deaths in the province. The public health emergency gave health officials in the Canadian province additional control to collect real-time data and take proactive steps to help protect people taking drugs.
- Responding to the rising overdose deaths and emergence of unsanctioned Overdose Prevention sites (OPS), the province's Minister of Health moved to enact a Ministerial Order as part of the declared public health emergency to hastily sanction OPSs as an extraordinary measure to respond to the overdose crisis in December 2016.
- There are several OPSs operating across Canada, which have reversed thousands of overdoses. Within a year of being implemented, there were approximately 550,000 visits, 2500 non-fatal overdoses, and no overdose deaths recorded at OPSs in BC.
- Supervised Injecting Facilities (SIFs) aim to diminish the social and public health impacts of drug use. SIFs in Canada consist of facilities where people who take drugs can bring illicitly purchased drugs, for consumption under supervision. These 'drug consumption rooms' have emerged as a response to the public health risks associated with public areas where people who take drugs congregate in large numbers to purchase and inject or smoke drugs.

The Canadian Experience

Over 9,000 individuals died in Canada between January 2016 and June 2018 related to opioids. Recent available data shows there were 2,066 apparent opioid-related deaths in Canada between January and June 2018; 94% were accidental. Most accidental apparent opioid-related deaths occurred among males (76%); however, this varied by province or territory. Age group patterns also vary by region; however, most deaths were among young and middle-aged adults. Data also indicates that fentanyl and other fentanyl-related substances continue to be a major driver of this crisis. From January to June 2018, 72% of accidental apparent opioid-related deaths involved fentanyl or fentanyl analogues.

- In 2016 there were 3005 apparent opioid-related deaths, which is a death rate of 8.3 per 100,000 population.
- In 2017 there were 3998 apparent opioid-related deaths, which is death rate of 10.9 per 100,000 population.
- From January to June 2018 there were 2,066 apparent opioid-related deaths, which is a death rate of 11.2 per 100,000 population.¹⁶

The province of British Columbia (BC) in Canada has experienced the greatest number of overdoses, instigating the need for inventive harm reduction and public health measures. In April 2016, BC's provincial health officer declared drug-related overdoses to be a public health emergency, and by the end of that year approximately 930 overdose deaths occurred, a rate of 20.7 deaths per 100,000 persons, with many of the street drugs contaminated with fentanyl.¹⁷ The current overdose crisis has been named a 'fentanyl crisis' with fentanyl detected in 72% of illicit drugs, according to post-mortem toxicology tests.¹⁸ Recent data from the BC Coroners Service shows that in December 2018, there were 112 overdose deaths across BC. In January 2019, there were 537 overdoses seen at nine VCH Emergency Departments. Most overdoses occurred in males (70%) and in people aged 19 to 39 years (58%).¹⁹

Fentanyl is an opioid analgesic that is prescribed medicinally to treat pain. The province of BC has been one of the most severely impacted areas by fentanyl overdoses and is currently experiencing a public health emergency related to opioid overdoses driven by consumption of street drugs contaminated with illicitly manufactured fentanyl.²⁰

Until 2013, fentanyl in the illicit drug marketplace was primarily diverted prescription-grade fentanyl in the form of transdermal patches. However, in May 2013, members of CCENDU and related partner

¹⁶ Government of Canada. 2019. *Opioid-related harms and deaths in Canada*. Available at: <https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/data-surveillance-research/harms-deaths.html>

¹⁷ Notta, D., Black, B., Chu, T., Joe, R., and Lysyshyn, M. 2019. Changing risk and presentation of overdose associated with consumption of street drugs at a supervised injection site in Vancouver, Canada. *Drug and Alcohol Dependence*, 196(1): 46-50.

¹⁸ Wallace, B., Pagan, F., and Pauly, B. B. 2019. The implementation of overdose prevention sites as a novel and nimble response during an illegal drug overdose public health emergency. *International Journal of Drug Policy*, 66: 64-72.

¹⁹ Vancouver Coastal Health. 2019. *Overdose statistics January 2019*. Available at: <http://www.vch.ca/about-us/news/overdose-statistics-january-2019>

²⁰ Karamouzian, M., Dohoo, C., Forsting, S., McNeil, R., Kerr, T., and Lysyshyn, M. 2018. Evaluation of a fentanyl drug checking service for clients of a supervised injection facility, Vancouver, Canada. *Harm Reduction Journal*, 15(1): 46. doi: 10.1186/s12954-018-0252-8

organisations began sharing anecdotal reports regarding the availability of fentanyl in powder and tablet form (i.e., illicit fentanyl). Although misuse of pharmaceutical grade fentanyl can result in overdose or other health complications, illicit fentanyl poses an even greater health threat.²¹

Actions to Prevent Overdoses in Canada

In response to the overdose crisis in Canada, health authorities, people who use drugs or 'peers', frontline staff, concerned residents and the Government have been collaborating to implement different interventions.

Public Health Emergency Declaration

In April 2016, the Provincial Medical Health Officer in British Columbia (BC), Dr. Perry Kendall, declared a public health emergency under the Public Health Act in response to increasing overdoses and overdose deaths in the province. BC was the first province to take this kind of action in response to drug overdoses.²²

The declaration of a public health emergency related to overdose deaths allowed the authorisation of a Ministerial Order to rapidly establish overdose prevention sites (OPSs) with more than 20 OPSs operational within weeks. This emergency response was enacted by a provincial authority, within the context of protracted federal processes for implementing sanctioned supervised consumption services (SCSs) and the federal criminalisation of drugs, which stalled implementation of a SCS in the city for more than a decade. Drug user and harm reduction activism led the government response in BC as unsanctioned sites were implemented as acts of defiance to raise awareness of the need as well as defining the emerging services.²³

In September 2017, the provincial government allocated \$322 million over the next three years to save lives, help to tackle stigma and improve access to services for people struggling with addiction. Directed by the Ministry of Mental Health and Addictions, the government is taking an all-province approach to combat the overdose crisis that includes crucial additional investments and improvements to mental health and addictions services. In December 2017, to escalate its response across all sectors and lead urgent, life-saving action, the Province launched the Overdose Emergency Response Centre. The centre works to mobilise resources within communities to intervene quickly to save lives and deliver hands-on treatment and support on the ground to proactively identify and support people at risk from overdose.²⁴

²¹ Young, M. M. Pirie, T., Buxton, J. A., and Hosein, S. F. 2015. The Rise of Overdose Deaths Involving Fentanyl and the Value of Early Warning. *The Canadian Journal of Addiction*, 6(3): 13-17

²² BC Centre for Disease Control (BCCDC). 2017. *The BC Public Health Opioid Overdose Emergency March 2017 Update*. Available at: http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/Public%20Surveillance%20Report%202017_03_17.pdf

²³ Wallace, B., Pagan, F., and Pauly, B. B. 2019. The implementation of overdose prevention sites as a novel and nimble response during an illegal drug overdose public health emergency. *International Journal of Drug Policy*, 66: 64-72.

²⁴ Government of British Columbia. 2018. *How the province is responding*. Available at: <https://www2.gov.bc.ca/gov/content/overdose/how-the-province-is-responding>

Community Overdose Response Plan

The Public Health Guide to Developing a Community Overdose Response Plan²⁵ is a guide providing tools which could be utilised in the community to develop a community overdose response plan. The guide contains four key elements required to produce an overdose response plan, as well as strategies for implementation.

The four vital elements of a community overdose response plan are:

to strengthen system resilience and community capacity for responding to and preventing overdoses;

recognise and disrupt social and personal stigma and discrimination associated with substance use and addiction;

implement a broad range of health promotion and harm reduction interventions to prevent overdoses; and

assess and strengthen pathways to substance use services and supports.

Essential to overdose responses is the vital role that peers (people with lived experience and past or current substance use) have in contributing to the design, expansion and delivery of overdose response strategies and harm reduction services. Peer engagement and peer-led services are a critical feature of an effective and efficient response.

Changes in Opiate Replacement Treatments

Another action to prevent overdose was that barriers to physician prescribing of buprenorphine (Suboxone) were reduced enabling physicians the ability to prescribe the drug. Before this, there was limited prescribing as only physicians who prescribed methadone could prescribe buprenorphine. However, since July 2016, physicians in British Columbia no longer have to hold a federal Section 56 exemption from the Controlled Drugs and Substances Act in order to prescribe buprenorphine.^{26, 27, 28} Buprenorphine, due to the partial agonist properties, is said to be preferable in terms of reduced overdose potential. Research suggests that buprenorphine is six times safer than methadone in terms of overdose risk, whereas studies have also found that methadone has a four-fold higher risk of fatal overdose compared to buprenorphine.²⁹

²⁵ Pauly, B., Hasselback, P., and Reist, D. 2017. *A public health guide to developing a community overdose response plan*. Available at: <https://www.uvic.ca/research/centres/cisur/assets/docs/resource-community-overdose-response-plan.pdf>

²⁶ CBC News. 2016. B.C. College of Physicians and Surgeons lifts 'outdated' restriction on Suboxone to help overdose crisis. Available at: <https://www.cbc.ca/news/canada/british-columbia/suboxone-bc-college-physicians-surgeons-1.3665744>

²⁷ CBC News. 2016. 'Outdated' restrictions on Suboxone making B.C.'s overdose crisis worse. Available at: <https://www.cbc.ca/news/canada/british-columbia/outdated-restrictions-on-suboxone-making-b-c-s-overdose-crisis-worse-report-1.3609422>

²⁸ British Columbia Centre on Substance Use and B.C. Ministry of Health. 2017. *A guideline for the clinical management of opioid use disorder*. Available at: <http://www.bccsu.ca/care-guidance-publications/>

²⁹ British Columbia Centre on Substance Use and B.C. Ministry of Health. 2017. Op. Cit.

Recent guidelines on the clinical management of opioid use disorders published by the British Columbia Centre on Substance Use and B.C. Ministry of Health strongly endorse the use of buprenorphine/naloxone as the preferred first-line treatment when opioid agonist therapy is being considered for the treatment of opioid use disorder. The recommendation echoes research which suggests that buprenorphine has a safety profile six times greater than methadone in terms of overdose risk.³⁰

In February 2018, the practice scope of nurse practitioners (NPs) was extended to include prescribing opioid agonist treatment drugs such as methadone and buprenorphine. This change is part of province-wide efforts to address the opioid overdose crisis and builds on NPs' existing authority to prescribe controlled drugs and substances.³¹ The standards, limits, requirements and conditions for prescribing are set out in the recently released Scope of Practice Nurse Practitioners guide.³²

New Opioid Agonist Treatment training requirements came into effect In January 2019. The Opioid Agonist Treatment Compliance and Management Program (OAT-CAMPP) for community pharmacy was developed aimed at reducing stigma and expanding pharmacists' knowledge about methadone, buprenorphine/naloxone and slow-release oral morphine. The program addresses gaps in the College's current methadone maintenance training program by providing additional education for pharmacists and pharmacy technicians involved in delivering care to patients with opioid use disorder. The training program aims to improve the experience and of people receiving treatment. It includes a patient-centred approach, discussing lived experiences of patients and communication strategies to reduce stigma and increase patient engagement.³³

Take-Home Naloxone (THN) Programmes in Canada

Responding to increasing numbers of fatal and non-fatal opioid overdoses in Canada, there has been a great deal of effort invested in increasing the availability of naloxone, a drug that temporarily reverses the effects of opioids and can save lives in opioid overdose situations. In March 2016, Health Canada made naloxone available without a prescription. Efforts to increase the availability of naloxone have followed, including:

- Establishing THN programmes to increase access to naloxone among people who use opioids and their friends or family;
- Encouraging or permitting accessibility and use of naloxone by first responders (e.g., paramedics, firefighters, law enforcement, etc.); and

³⁰ Ibid.

³¹ College of Pharmacists of British Columbia. 2019. *Guest Post: Nurse practitioner scope expanded to include opioid agonist treatment prescribing*. Available at: <https://www.bcpharmacists.org/readlinks/guest-post-nurse-practitioner-scope-expanded-include-opioid-agonist-treatment-prescribing>

³² BC College of Nursing Professionals. 2019. *Scope of practice for nurse practitioners*. https://www.bccnp.ca/Standards/RN_NP/StandardResources/NP_ScopeofPractice.pdf

³³ College of Pharmacists of British Columbia. 2019. *New opioid agonist treatment training requirements now in effect*. Available at: <https://www.bcpharmacists.org/news/new-opioid-agonist-treatment-training-requirements-now-effect>

- Encouraging authorities to change the prescription-only status of naloxone to increase availability and encouraging reimbursement of naloxone through publicly funded drug plans across Canada, particularly for people with low incomes.

There are THN programmes in seven of the 13 provinces and territories in Canada. Increased access to naloxone is only one part of a comprehensive overdose prevention strategy that also includes improved overdose prevention education, training and services, and enhanced surveillance and utilisation of overdose data.³⁴

Irvine and Colleagues (2018), in the first study to estimate the impact of a Take-home Naloxone programme on the number of overdose deaths during an epidemic of Fentanyl use, estimate that the BC THN programme averted 226 deaths from Jan 1 to Oct 31, 2016.³⁵ This estimate represents 33% of the deaths that occurred over that time period. The authors state that, in comparison, if the programme had achieved scale-up earlier and all kits that were distributed in 2016 had been distributed by the beginning of the year, 344 deaths would have been averted, which represents 53% of all deaths over that time period.

Schweitzer and colleagues (2017) report that several school districts in BC and higher education institutions, including the University of British Columbia, have already implemented or begun planning to make naloxone kits publicly available.³⁶

Use of Naloxone by First Responders

All ambulance paramedics throughout BC can carry and administer naloxone. Firefighters, after completing training and updating licences, can also carry and administer naloxone. In Alberta, all classifications of paramedics can administer naloxone. Since early 2017, police, firefighters, and Public Security Peace Officers are also authorised to administer naloxone by injection for emergency use in an opioid overdose outside a hospital setting, through a Ministerial Order.

Naloxone can be carried and administered by emergency medical responders, emergency medical technicians, primary care paramedics, intermediate care paramedics, and advanced care paramedics in Saskatchewan, whereas, in some regions, firefighters can now carry and administer naloxone (Saskatoon Health Region, Regina Qu'Appelle Health Region). In Manitoba, paramedics, the Winnipeg Police Service, the Royal Canadian Mounted Police (RCMP), and firefighters with the Winnipeg Fire Paramedic Service can carry and administer naloxone.

All advanced care paramedics and all primary care paramedics in Ontario can administer naloxone under a physician's orders. In some cities in Ontario, firefighters and police are being trained to

³⁴ The Canadian Community Epidemiology Network on Drug Use. 2016. *CCENDU Bulletin the Availability of take-Home Naloxone in Canada*. Available at: <http://www.ccdus.ca/Resource%20Library/CCSA-CCENDU-Take-Home-Naloxone-Canada-2016-en.pdf>

³⁵ Irvine, M. A., Buxton, J. A., and Otterstatter, M., Balshaw, R., Gustafson, R., and Tyndall, M. et al. 2018. Distribution of take-home opioid antagonist kits during a synthetic opioid epidemic in British Columbia, Canada: a modelling study. *Lancet Public Health*, 3(5): 218-225.

³⁶ Schweitzer, C., Gill, S. J., Kennedy, A., and Eppler, K. 2018. Youth and the opioid crisis: Strategies for intervention and the British Columbian experience. *UBC Medical Journal*, 9(2): 34-35.

administer naloxone. Moreover, in New Brunswick, paramedics, the RCMP, police, and firefighters carry and administer naloxone.³⁷

Overdose Factsheet

Another method to reduce the number of drug-related deaths is the factsheet to prevent overdoses. This factsheet is updated monthly with current information on the overdose crisis in B.C., including provincial actions, statistics and announcements.³⁸

BC Facility Overdose Response Box Programme

British Columbia's Facility Overdose Response Box Programme (FORB) was launched in 2016. The response boxes include 3, 5, 10 or 20 doses of naloxone and other overdose response supplies which are supplied at no charge by the BC Centre for Disease Control to sites registered in the programme.³⁹ Boxes have been distributed to community organisations in which overdoses are likely to occur, including supportive housing (46%), subsidised housing (20%), drop-in centres (21%), and shelters (16%).⁴⁰

Mobile Medical Units

The Mobile Medical Unit, in Vancouver is a critical care unit and health care team that can be moved to locations requiring emergency support. From December 13, 2016 to March 12, 2017, more than 2,158 visits presented at the province's Mobile Medical Unit station in the Downtown Eastside, including 523 overdoses, relieving pressure on local emergency departments and paramedics.⁴¹

In 2017, B.C. Emergency Health Services ran a pilot project testing cycling teams on the streets of Victoria and Vancouver's lower east side. In 123 days on the street that year, B.C. Emergency Health Services said the agility and access of the cycling squads resulted in nearly 200 traditional ambulances being cancelled from entering Victoria's core. Teams of two ride specially equipped mountain bikes which are loaded with medical supplies. The bikes are tracked by GPS, and from a mobile phone, the two-person teams can see any call coming across the city. A driving force in putting two-wheeled ambulances on the frontlines is B.C.'s overdose epidemic.⁴²

³⁷ CADTH. 2018. *Funding and Management of Naloxone Programs in Canada*. Available at:

https://www.cadth.ca/sites/default/files/pdf/ES0319_funding_and_management_of_naloxone_programs_in_canada.pdf

³⁸ BC Government News. 2017. *FACTSHEET: Actions to prevent overdoses in B.C.* Available at: <https://news.gov.bc.ca/factsheets/actions-to-prevent-overdoses-in-bc-1>

³⁹ Toward the Heart. 2018. *Facility Overdose Response Box*. Available at: <https://towardtheheart.com/forb>

⁴⁰ BC Centre for Disease Control (BCCDC). 2017. *The BC Public Health Opioid Overdose Emergency March 2017 Update*. Available at: http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/Public%20Surveillance%20Report_2017_03_17.pdf

⁴¹ Ibid.

⁴² Cunningham, S. 2017. *Bike ambulance service returns to Victoria as overdose crisis rages on*. Available at: <https://vancouverisland.ctvnews.ca/bike-ambulance-service-returns-to-victoria-as-overdose-crisis-rages-on-1.3934850>

Early Warning Systems

Responding to emerging risks in the drug supply requires inter-sectoral collaboration between public health officials, toxicology laboratories, law enforcement officials, health-care workers, and people who use drugs, who are often the first to identify an issue and provide insights on how and with whom to communicate. Thus, the Drug Overdose and Alert Partnership (DOAP) was formed in 2011. The goal of DOAP was to coordinate stakeholder communication and actions to enable timely alerting and responses to illicit drug use issues.⁴³

DOAP is a multi-sectoral committee that was established to prevent and reduce the harms associated with substance use. The group identifies and disseminates timely information about harms related to substance use including overdose, adverse reactions to contaminated products, and other emerging issues.⁴⁴

All agencies and partners involved in the emergency response to fentanyl-associated overdoses were active DOAP members and were aware of the increasing contamination of drugs with fentanyl through information sharing facilitated by DOAP meetings and resources. Participation in DOAP also enabled comfort and familiarity between members, ensuring commitment to information sharing during such events.

This example illustrates how a public health surveillance system that combines quality population-level data and strong community collaborations enables a flexible, timely response to reduce harm and improve health outcomes.⁴⁵

The Canadian Community Epidemiology Network on Drug Use (CCENDU) is a nation-wide network of community partners that informs Canadians about emerging drug use trends and produces alerts and bulletins on drug use trends or topics of immediate concern. CCENDU alerts and bulletins use rapidly assembled information ranging from scientific literature to observations by people directly assisting high-risk populations.⁴⁶

It is co-ordinated by the Canadian Centre on Substance Abuse (CCSA) that is made up of representatives from areas across Canada. Each representative collects quantitative information on drug harms from local data sources (e.g., poison control centres, coroners) and anecdotal reports from those directly working with drug-using populations (e.g., law enforcement, harm reduction programmes), and people who use drugs. This information is then collated, and the risk assessed at the national level. If warranted, CCENDU issues alerts to advise first responders, healthcare

⁴³ Buxton, J. A., Spearn, B., Amlani, A., Kuo, M., Lysyshyn, M., Young, S., and Purssell, R., et al. 2019. The British Columbia Drug Overdose and Alert Partnership: Interpreting and sharing timely illicit drug information to reduce harms. *Journal of Community Safety and Wellbeing*, 4(1): <https://journalcswb.ca/index.php/cswb/article/view/92/187>

⁴⁴ BC Centre for Disease Control (BCCDC). 2016. *BC DOAP Opioid Overdose Response Strategy (DOORS)*. Available at: <http://www.bccdc.ca/resource-gallery/Documents/Opioid%20Overdose%20Response%20Strategy.pdf>

⁴⁵ Buxton, J. A., Spearn, B., Amlani, A., Kuo, M., Lysyshyn, M., Young, S., and Purssell, R., et al. 2019. The British Columbia Drug Overdose and Alert Partnership: Interpreting and sharing timely illicit drug information to reduce harms. *Journal of Community Safety and Wellbeing*, 4(1): <https://journalcswb.ca/index.php/cswb/article/view/92/187>

⁴⁶ Canadian Centre on Substance Use and Addiction. 2018. *CCENDU Drug Alerts and Bulletins*. Available at: <http://www.ccdus.ca/Eng/collaboration/CCENDU/CCENDU-Drug-Alerts-and-Bulletins/Pages/default.aspx>

practitioners, treatment providers, people who use drugs, law enforcement, and others about drug-related health threats and what can be done to prevent and reduce harms.⁴⁷

In August 2015 the CCENDU network released a bulletin on deaths involving fentanyl indicating that between 2009 and 2014 there were more than 650 deaths in Canada where fentanyl was either a cause or contributing cause. The release of the bulletin in conjunction with media outreach by partners in BC, Québec, and elsewhere brought a great deal of attention to the issue. The attention also included a joint statement from Health Canada and the Public Health Agency of Canada warning the public about the dangers of illicit fentanyl indicating that they were reviewing the prescription-only status of the opioid overdose treatment Naloxone on an urgent basis.⁴⁸

Supervised Consumption Services (SCSs)

Supervised consumption services refers to supervision of injecting and/or smoking of illegally obtained substances.⁴⁹ The primary aim of a SCS is to diminish the social and public health impacts of drug use, and they are a harm reduction measure aimed mainly at reaching the most chaotic, marginalised, and hard to reach people who take drugs. SCSs in Canada consist of facilities where people who take drugs can bring illicitly purchased drugs – typically heroin or cocaine – for consumption under supervision. SCSs emerged as a response to the public health risks associated with open drug scenes: public areas where people who take drugs congregate in large numbers to purchase and inject or smoke drugs.⁵⁰

In September 2003, Canada's first legally sanctioned SCS opened. This came about after a Vancouver-based non-government organisation, the Portland Hotel Society (PHS), quietly built a SCS within a boarded up and seemingly vacant building, and then one day announced publicly that the SCS had been built. Eventually, the regional health authority agreed to work with the PHS to open the SCS, although it is unclear how long this may have taken if the PHS had not taken the rather extraordinary measure of building the physical site in secret.⁵¹

Health Canada had released its SCS guideline document shortly before this development, which set out how individual municipalities could obtain an exemption from the federal Health Minister to legally establish a SCS. The document detailed several conditions and required site visits by Health Canada officials, but eventually Insite opened with federal approval of an exemption under Section 56 of the Controlled Drugs and Substances Act granted by the federal Health Minister. Insite includes 13 spaces for injecting and is usually open 18 hours a day from 10 am to 4 am, although some experimenting with 24-hour of operation has been undertaken.

⁴⁷ Young, M. M. Pirie, T., Buxton, J. A., and Hosein, S. F. 2015. Op. Cit.

⁴⁸ Ibid.

⁴⁹ Wallace, B., Pagan, F., and Pauly, B. B. 2019.

⁵⁰ UK Home Office. 2014. *Drugs: international comparators*. Available at: <https://www.gov.uk/government/publications/drugs-international-comparators>

⁵¹ Kerr, T., Mitra, S., Kennedy, M. C., and McNeil, R. 2017. Supervised Injection Facilities in Canada: Past, Present, and Future. *Harm Reduction Journal*, 14(1): doi:10.1186/s12954-017-0154-1.

Insite was opened under the condition that it operate as a scientific pilot and be rigorously evaluated. This was deemed essential, especially given the limited peer-reviewed data specific to SCSs in Europe. The evaluation quickly showed that Insite was meeting its objectives of reducing public disorder, infectious disease transmission, and overdose and was successfully referring individuals to a range of external programmes, including detoxification and addiction treatment programmes. Further, the evidence indicated that Insite was not resulting in increases in crime or promoting initiation into injecting, and Insite was found to be cost-effective. To date, over 40 peer-reviewed studies have been published which highlight the many benefits and lack of negative impacts of this site.⁵²

In January 2019, there were 9,638 visits to the Insite supervised injection room. Among those, 95 overdoses were reversed. In January 2019, there were 3,005 visits to the Powell Street Getaway SCS. Among those, 6 overdoses were reversed.⁵³

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Harm Reduction Report (2010)⁵⁴ highlights that Drug Consumption Rooms (DCRs) (Supervised Consumption Services) are effective in terms of providing a safer injecting environment, providing a lower-risk and more hygienic environment for the consumption of drugs, compared to public spaces, targeting a difficult, and at times, hard-to-reach population. Moreover, SCSs are associated with increasing access to social, health and drug treatment services, whilst helping to reduce the stigma around drug addiction.

In a systematic review of the evidence mostly from Australia and Canada, Potier and colleagues (2014)⁵⁵ found that SCSs are effective in both attracting and maintaining contact with marginalised people who inject drugs, enhancing access to primary health care and promoting safer injection conditions. Furthermore, the authors also report that drug injecting, drug-related crime in the vicinity of the SCS did not increase. It was found that SCSs are associated with reduced levels of public drug injections and drug litter. Crucially, it is reported that that zero deaths from overdose have been recorded since the opening of the facility.

It should be noted that in the countries where they have been established, SCSs have often been legally problematic. Facilities in Canada and Australia have been the subject of legal challenges, and at least one facility in Canada has been forced to close on the instruction of the local health authority, which was concerned that the user-run facility did not meet safety standards. For a facility to operate effectively, staff and police officers are required to allow the possession and consumption of illicit drugs.⁵⁶

⁵² Ibid.

⁵³ Vancouver Coastal Health. 2019. Op. Cit.

⁵⁴ European Monitoring Centre for Drugs and Drug Addiction. 2013. *Monographs. Harm reduction: evidence, impacts and challenges*. Available at: <http://www.dldocs.stir.ac.uk/documents/EMCDDA-monograph10-harm%20reduction.pdf>

⁵⁵ Potier C., Laprevote, V., Dubois-Arber, F., Cottencin, O., and Rolland, B. 2014. Supervised injection services: What has been demonstrated? A systematic literature review. *Drug & Alcohol Dependence*, 145: 48-68.

⁵⁶ UK Home Office. 2014. Op. Cit.

Overdose Prevention Sites (OPSs)

Overdose prevention sites (OPSs) provide a space for people to inject their previously obtained substances with sterile equipment in an environment where staff (often peers) can observe and mediate to avert overdoses. OPSs are there to provide access to supervised injection services and overdose responses, harm reduction provisions, and referrals to wider health and social services.⁵⁷

Unsatisfied by the apparent lack of emergency responses and specifically the lack of sanctioned SCSs, community activists (including drug-user groups) established “pop up” unauthorised injection sites in cities in BC in 2016. Building on these actions, the Overdose Prevention Society in Vancouver was established to provide an ongoing service under a tent in an alley in Vancouver’s Downtown Eastside. Responding to the rising overdose deaths and emergence of ‘unsanctioned’ OPSs, the province’s Minister of Health moved to enact a Ministerial Order as part of the declared public health emergency to hastily sanction overdose prevention sites as an extraordinary measure to respond to the overdose crisis in December 2016.⁵⁸

By issuing the order, all BC regional health authorities were directed to set up and fund OPSs as ancillary health services for the purpose of monitoring persons who are at risk of overdose and providing rapid intervention as necessary. OPSs were not implemented as an alternative to federally sanctioned SCSs. Rather, the province described the response as a temporary measure that would save lives without breaching the Controlled Drugs and Substances Act (federal laws criminalising substances across the country) while waiting for federal approval of SCSs.

Rapid implementation of OPSs meant that within a few days to a few months approximately 20 sites were implemented across the province. Thus, OPSs moved from unsanctioned and unsupported ‘pop ups’ to become a significant part of the overdose response across BC by the beginning of 2017. Within a year, there were approximately 550,000 visits, 2500 non-fatal overdoses, and no overdose deaths recorded at OPSs in BC. The legislative process to implement OPSs in BC was unprecedented as it sanctioned injection services to be implemented widely as an extraordinary measure under the provincial Health Minister’s declared public health emergency. The sanctioning of OPSs provincially was a significant external policy shift in the outer setting that emerged within the context of a public health emergency influencing the rapid implementation of services for people who inject drugs.⁵⁹

Language Change

Collins and colleagues⁶⁰ suggest that, in Canada, language change was apparent within the context of the implementation of a public health emergency strategy which proved critical to opening the way for responses to the increasing drug-related deaths. Openly, BC supported the fast

⁵⁷ Wallace, B., Pagan, F., and Pauly, B. B. 2019. The implementation of overdose prevention sites as a novel and nimble response during an illegal drug overdose public health emergency. *International Journal of Drug Policy*, 66: 64–72.

⁵⁸ Wallace, B., Pagan, F., and Pauly, B. B. 2019. Op. Cit.

⁵⁹ Ibid.

⁶⁰ Collins, A. B., Bluthenthal, R. N., Boyd, J., and McNeil, R. 2018. Harnessing the language of overdose prevention to advance evidence-based responses to the opioid crisis. *International Journal of Drug Policy*, 55: 77–79.

implementation of OPSs, following the public health emergency declaration, and the increase in overdose deaths. Reframing the overdose response strategies as *Overdose Prevention Sites*, and implementing them without approval by the federal government, was made possible by the imperative to address overdoses within the context of a local crisis. Shifting away from “supervised injection facilities,” terminology that risks arousing moralistic understandings of harm reduction, the term ‘Overdose Prevention Sites’ refocuses attention away from perceived individual cause and control of drug use to the need for rapid interventions to address a public health issue.

Collins and colleagues further suggest that evolving discourses around substance use in Canada have been critical to emphasising collective action amid a public health emergency. Moreover, the public health emergency crossed age, racial, and socio-economic boundaries and has incited a continued change in how drug use is discussed. Such language change has altered dialogue in Canada to now include updated drug education curriculums and outreach in schools, wide-reaching efforts by parent groups to highlight the damaging effects of stigmatising language and changing support for overdose prevention interventions.⁶¹

Drug Checking

Drug checking is a harm reduction intervention which has been implemented in a variety of settings. Drug-checking offers testing of street drugs to assess their composition (including potential contaminants) and allows for more informed decision-making by people who use drugs. In an evaluation of a fentanyl drug checking service for clients of a SCS in Vancouver, Canada, Karamouzian and colleagues (2018) report that, although only 1% of visits resulted in a drug check, a high proportion (79.8%) of the drugs checked were contaminated with fentanyl. Out of 1411 drug checks conducted by clients, 1121 were positive for fentanyl. The results suggest that drug checking at harm reduction facilities such as SCSs could offer a practicable intervention that could contribute to preventing overdoses.⁶²

Good Samaritan Act

The Good Samaritan Drug Overdose Act is part of the Canadian Government’s comprehensive approach to addressing the opioid crisis. It is hoped that it will help encourage Canadians to save a life during an overdose situation. The Act provides some legal protection for individuals who seek emergency help during an overdose. The Act became law on May 4, 2017. It complements the Canadian Drugs and Substances Strategy, the comprehensive public health approach to substance use. The Good Samaritan Drug Overdose Act applies to anyone seeking emergency support during an overdose, including the person experiencing an overdose. The Act protects the

⁶¹ Ibid.

⁶² Karamouzian, M., Dohoo, C., Forsting, S., McNeil, R., Kerr, T., and Lysyshyn, M. 2018. Evaluation of a fentanyl drug checking service for clients of a supervised injection facility, Vancouver, Canada. *Harm Reduction Journal*, 15(1): 46. doi: 10.1186/s12954-018-0252-8.

person who seeks help, whether they stay or leave from the overdose scene before help arrives. The Act also protects anyone else who is at the scene when help arrives.⁶³

Peer Engagement

Peer engagement is a community-based approach which Ti and colleagues define as the process of consulting and collaborating with decision makers using a bottom-up approach in order to better address the needs of the community.⁶⁴ Engaging people with lived experience and past or current substance use, or 'peers,' in decision-making helps to ensure harm reduction services reflect current need.⁶⁵

Peers have been involved with several newly implemented interventions throughout Canada including in Vancouver, BC.⁶⁶ Peer intervention has been shown to facilitate treatment access for marginalised populations,⁶⁷ whereas engaging with peers has the potential to foster communication, build trust, increase knowledge, and reduce stigma and discrimination to remove barriers and increase utilisation of harm reduction services. This could, in turn, have a direct impact on mental and physical health.⁶⁸ Peer work is also suggested to be effective in reducing risky behaviour and improving overall health and has also been shown to be effective with people who inject drugs, sex workers, and marginalised youth populations.⁶⁹

The Vancouver Area Network of Drug Users is one of the first and longest running people who take drugs organisations in North America that has advocated for the health and wellbeing of people who use drugs and marginalised members in one of the poorest urban postal codes in Canada.⁷⁰

In a recent study on peer worker involvement in overdose prevention sites (OPS), Kennedy and colleagues⁷¹ found that OPS implementation and operations depended on peer worker involvement and thus allowed for recognition of capacities developed through roles that peers were already undertaking through local programming for people who use drugs. Peer involvement at OPS also enhanced feelings of comfort and facilitated engagement with an OPS among people who use drugs. The authors further add that, within an ongoing overdose crisis, expanding formalised peer worker

⁶³ Government of Canada. 2018. *About the Good Samaritan Drug Overdose Act*. Available at: <https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/about-good-samaritan-drug-overdose-act.html>

⁶⁴ Ti, L., Tzemis, D., and Buxton, J. 2012. Engaging people who use drugs in policy and program development: A review of the literature. *Substance Abuse Treatment, Prevention, and Policy*, 7(1): 47.

⁶⁵ Greer, A.M., Luchenski, S.A., Amlani, A.A., Lacroix, K., Burmeister, C., and Buxton, J.A., 2016. Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada. *BMC Public Health*, 16, (452). <https://doi.org/10.1016/j.drugalcdep.2018.05.023>

⁶⁶ Ibid.

⁶⁷ Deering, K., Kerr, T., Tyndall, M., Montaner, J., Gibson, K., Irons, L. and Shannon, K. 2011. A peer-led mobile outreach program and increased utilization of detoxification and residential drug treatment among female sex workers who use drugs in a Canadian setting. *Drug and Alcohol Dependence*, 113(1): 46-54

⁶⁸ Greer, A.M., Luchenski, S.A., Amlani, A.A., Lacroix, K., Burmeister, C., and Buxton, J.A., 2016. Op. Cit.

⁶⁹ Jozaghi, E., Lampkin, H., & Andresen, M. A. 2016. Peer-engagement and its role in reducing the risky behavior among crack and methamphetamine smokers of the Downtown Eastside community of Vancouver, Canada. *Harm reduction journal*, 13(1): 19.

⁷⁰ Greer, A.M., Luchenski, S.A., Amlani, A.A., Lacroix, K., Burmeister, C., and Buxton, J.A., 2016. Op. Cit.

⁷¹ Kennedy, C., Boyd, J., Mayar, S., Collins, A., Kerr, T and McNeil, R. 2019. Peer worker involvement in low-threshold supervised consumption facilities in the context of an overdose epidemic in Vancouver, Canada. *Social Science & Medicine*, 225: 60-68.

involvement in supervised consumption programming may help to alleviate overdose-related harms, particularly in settings where peers are actively involved in existing programming.

The Atlantic: How Iceland Got Teens to Say No to Drugs

Before the Project

Twenty years ago, Icelandic teens were among the heaviest-drinking youths in Europe. “You couldn’t walk the streets in downtown Reykjavik on a Friday night because it felt unsafe,” “There were hordes of teenagers getting in-your-face drunk.” (Harvey Milkman, an American psychology professor).

After the Project

Young people aren’t hanging out in the park they’re in after-school classes in these facilities, or in clubs for music, dance, or art. Or they might be on outings with their parents.

Today, Iceland tops the European table for the cleanest-living teens. The percentage of 15- and 16-year-olds who had been drunk in the previous month plummeted from 42 percent in 1998 to 5 percent in 2016. The percentage who have ever used cannabis is down from 17 percent to 7 percent. Those smoking cigarettes every day fell from 23 percent to just 3 percent.

Harvey Milkman

Milkman’s doctoral dissertation concluded that people would choose either heroin or amphetamines depending on how they liked to deal with stress. People who use Heroin wanted to numb themselves; People who use amphetamine wanted to actively confront it. After this work was published, he was among a group of researchers drafted by the U.S. National Institute on Drug Abuse to answer questions such as: why do people start using drugs? Why do they continue? When do they reach a threshold to abuse? When do they stop? And when do they relapse? He concluded that people could be on the threshold for abuse before they even took the drug, because it was their style of coping that they were abusing.”

At Metropolitan State College of Denver, Milkman was instrumental in developing the idea that people were getting addicted to changes in brain chemistry. Kids who were “active confronters” were after a rush—they’d get it by stealing hubcaps and radios and later cars, or through stimulant drugs. Alcohol also alters brain chemistry, of course. It’s a sedative but it sedates the brain’s control first, which can remove inhibitions and, in limited doses, reduce anxiety.

From there he developed the idea “Why not orchestrate a social movement around natural highs: around people getting high on their own brain chemistry—because it seems obvious to me that people want to change their consciousness—without the deleterious effects of drugs?”

What Iceland Did

In 1991, Milkman was invited to Iceland to talk about this work, his findings and ideas. In 1992, 14-, 15- and 16-year-olds in every school in Iceland filled in a questionnaire with these kinds of questions. This process was then repeated in 1995 and 1997.

Nationally, almost 25 percent were smoking every day, over 40 percent had got drunk in the past month. But when the team drilled right down into the data, they could identify precisely which schools had the worst problems—and which had the least. Their analysis revealed clear differences between the lives of kids who took up drinking, smoking and other drugs, and those who didn't. A few factors emerged as strongly protective: participation in organized activities—especially sport—three or four times a week, total time spent with parents during the week, feeling cared about at school, and not being outdoors in the late evenings.

Laws were changed. It became illegal to buy tobacco under the age of 18 and alcohol under the age of 20, and tobacco and alcohol advertising was banned. Links between parents and school were strengthened through parental organizations which by law had to be established in every school, along with school councils with parent representatives. Parents were encouraged to attend talks on the importance of spending a quantity of time with their children rather than occasional “quality time”, on talking to their kids about their lives, on knowing who their kids were friends with, and on keeping their children home in the evenings.

A law was also passed prohibiting children aged between 13 and 16 from being outside after 10 p.m. in winter and midnight in summer. It's still in effect today. Parental agreements were introduced and varies depending on the age group. For kids aged 13 and up, parents can pledge to follow all the recommendations, and also, for example, not to allow their kids to have unsupervised parties. These agreements educate parents but also help to strengthen their authority in the home, then it becomes harder to use the oldest excuse in the book: ‘But everybody else can!’”

State funding was increased for organized sport, music, art, dance and other clubs, to give kids alternative ways to feel part of a group, and to feel good, rather than through using alcohol and drugs. Crucially, the surveys have continued. Each year, almost every child in Iceland completes one. This means up-to-date, reliable data is always available.

Between 1997 and 2012, the percentage of kids aged 15 and 16 who reported often or almost always spending time with their parents on weekdays doubled—from 23 percent to 46 percent—and the percentage who participated in organized sports at least four times a week increased from 24 percent to 42 percent. Meanwhile, cigarette smoking, drinking and cannabis use in this age group plummeted.

“Although this cannot be shown in the form of a causal relationship—which is a good example of why primary prevention methods are sometimes hard to sell to scientists—the trend is very clear, notes Álfgeir Kristjánsson, who worked on the data and is now at the West Virginia University School of Public Health in the US. “Protective factors have gone up, risk factors down, and substance use has gone down—and more consistently in Iceland than in any other European country.”

Across Europe, rates of teen alcohol and drug use have generally improved over the past 20 years, though nowhere as dramatically as in Iceland, and the reasons for improvements are not necessarily linked to strategies that foster teen wellbeing. In the U.K., for example, the fact that teens are now spending more time at home interacting online rather than in person could be one of the major reasons for the drop-in alcohol consumption.

Inga Dóra says: "We learned through the studies that we need to create circumstances in which kids can lead healthy lives, and they do not need to use substances, because life is fun, and they have plenty to do—and they are supported by parents who will spend time with them."

Not all the strategies would be acceptable in the U.K.—the child curfews being one, parental walks around neighbourhoods to identify children breaking the rules perhaps another. And a trial run by Mentor in Brighton that involved inviting parents into schools for workshops found that it was difficult to get them engaged.

Public wariness and an unwillingness to engage will be challenges wherever the Icelandic methods are proposed, thinks Milkman, and go to the heart of the balance of responsibility between states and citizens. "How much control do you want the government to have over what happens with your kids? Is this too much of the government meddling in how people live their lives?"

In Iceland, the relationship between people and the state has allowed an effective national program to cut the rates of teenagers smoking and drinking to excess—and, in the process, brought families closer and helped kids to become healthier in all kinds of ways. Will no other country decide that these benefits are worth the costs?

Drug decriminalisation in Portugal: A Different Approach

Summary

- By 1999, Portugal had the highest rate of drug-related AIDS in the EU and the second highest prevalence of HIV amongst people who injecting drugs, whereas drug-related deaths had increased in Portugal to a peak of 369 in 1999.
- In July 2001 Portugal decriminalised the use, purchase and possession of all illicit drugs, including both Cocaine and Heroin, if for personal use.
- A crucial aspect of Portugal's decriminalisation policy is the way sanctions imposed for personal possession and consumption of drugs changed from a criminal to administrative process. A person caught using or possessing a small quantity of drugs for personal use, where there is no suspicion of involvement in drug trafficking, will be evaluated by the local Commission for Dissuasion of Drug Addiction (CDT), rather than be imprisoned.
- CDT's can provide a variety of sanctions, or supports, but their main goal is to dissuade the individual's drug use and to encourage those reliant on drug into treatment.
- Portugal is an example of a country in which substance abuse and dependence are mostly treated with public funds.
- Small treatment teams, belonging to integrated response centres, provide services associated with prevention, harm reduction, social reintegration and treatment. Some of these services are outsourced, but those costs are allocated to the relevant treatment team.
- All doctors, psychologists and nurses in Portugal receive education about drugs and addiction as part of their formal medical training.
- The number of people entering treatment has increased significantly since decriminalisation.
- A key aspect of the Portuguese approach is the focus on the individual person using drugs and their wellbeing.

Decriminalisation Policy

In July 2001 Portugal decriminalised the use, purchase and possession of all illicit drugs, including both Cocaine and Heroin, if for personal use.⁷² Decriminalisation did not legalise drugs or change the criminal penalties prohibiting the sales, production, and distribution of drugs, nor did it permit use. Rather, Portugal decriminalised drug use, which, as defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), '*entailed the removal of all criminal penalties from acts relating to drug demand: acts of acquisition, possession, and consumption*'.^{73,74} There is a clear

⁷² Cabral, T. 2017. The 15th Anniversary of the Portuguese Drug Policy: Its history, its success and its future. *Drug Science, Policy and Law*, 3(1): doi: 10.1177/2050324516683640

⁷³ Hughes, C. A., and Stevens, A. 2012. A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs. *Drug and Alcohol Review*, 31(1): 101-113.

⁷⁴ Laqueur, H. S. 2015. Uses and Abuses of Drug Decriminalization in Portugal. *Law and Social Inquiry*, 40(3): 746-781.

distinction to be made between decriminalisation of drug possession and legalisation. Decriminalisation retains the recognition that drug possession is illegal but removes criminal penalties in most cases.⁷⁵ The reform was the result of more than two decades of drug policy debates in which there had been ongoing tension between the criminalisation of drug use and the desire to help the people who use drugs.⁷⁶ Portuguese drug policy is detailed in three strategic documents:

- The National Strategy for the Fight Against Drugs 1999;
- The National Plan for the Reduction of Addictive Behaviours and Dependencies 2013-20 and its Action Plan 2013-16, which remains in force pending the finalisation of the 2017-20 Action Plan).

The changes discussed below cannot be attributed to the decriminalisation policy alone. Portugal made several changes to its approach to drugs around the same time as implementing decriminalisation, including extensive implementation of harm-reduction programmes and an increase in investment in drug treatment. Therefore, separating the effects of decriminalisation from the effects of wider changes which occurred is a problematic task.⁷⁷ Moreover, as Stevens and Hughes (2010) suggest, decriminalisation of illicit drug use and possession does not appear to lead automatically to an increase in drug-related harms. Nor does it eliminate all drug-related problems. But, the authors note, it may offer a model for other nations that wish to provide less punitive, more integrated and effective responses to drug use.⁷⁸

Drug Possession Treated as a Health Issue

A crucial aspect of Portugal's decriminalisation policy is the way sanctions imposed for personal possession and consumption of drugs changed from a criminal to administrative process. Before the policy reform in 2001, possession, purchasing and the cultivation of drugs for personal use were criminal offences punishable with imprisonment. However, the introduction of Law 30/2000 resulted in drug possession and acquisition becoming a public order or administrative offence. Law 30/2000, in place since 2001, decriminalised consumption, acquisition and possession for personal consumption of drugs. However, a person caught using or possessing a small quantity of drugs for personal use, where there is no suspicion of involvement in drug trafficking, are evaluated by the local Commission for Dissuasion of Drug Addiction (CDT), which are regional lay panels comprising of three people, which includes solicitors, social workers and medical professionals.⁷⁹,⁸⁰ Accused individuals can be referred to the CDT's by police, and then the panel discuss with the accused the motivations for, and circumstances, of their offence. The panel are then able to provide a variety of

⁷⁵ UK Home Office. 2014. *Drugs: international comparators*. Available at: <https://www.gov.uk/government/publications/drugs-international-comparators>

⁷⁶ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2011. *Drug Policy Profiles: Portugal*. Available at: http://www.emcdda.europa.eu/system/files/publications/642/PolicyProfile_Portugal_WEB_Final_289201.pdf

⁷⁷ UK Home Office, 2014. Op. Cit.

⁷⁸ Stevens, A., and Hughes, C. E. 2010. What can we learn from the Portuguese decriminalization of illicit drugs? *The British Journal of Criminology*, 50(6): 999–1022.

⁷⁹ Laqueur, H. S. 2015. Op. Cit.

⁸⁰ Stevens, A., and Hughes C. E. 2010. Op. Cit.

sanctions, or supports, but their main goal is to *dissuade* the individual's drug use and to encourage those reliant on drug into treatment.^{81, 82}

There is limited research exclusively on the impacts of dissuasion commissions. It is unclear therefore whether the changes in drug use and related harms in Portugal since decriminalisation and dissuasion commissions were established in 2001 can be attributed to the availability of dissuasion commissions, to decriminalisation, or to the considerable improvements in access to treatment. Research does suggest that dissuasion commissions have increased steadily since they were introduced. In the years after their introduction, the proportion of referrals to dissuasion commissions that resulted in a decision was relatively low (less than half in 2006). The proportion is now considerably higher (7,394 decisions against 8,573 processes commenced). This reflects improvements to the administration and resourcing of commissions.

In 2012, 78% of cases referred to dissuasion commissions involved cannabis only, 8% of cases involved heroin only and 8% involved cocaine only. 6% of cases involved more than one drug, of these, the most common combination was heroin and cocaine. Individuals were predominantly male (93%) with a mean age of 27. While dissuasion commissions aim to explore the need for treatment, a recommendation to attend treatment is only made in a minority of cases. In most cases, people referred to the panels are not drug dependent. The most common outcome of the dissuasion commission process is a provisional suspension, where the individual is deemed not to be drug-dependent: 67% of rulings in 2012. In these cases, education may be a more appropriate intervention. Suspension of proceedings, with a recommendation to undergo drug treatment, accounted for 14% of decisions in 2012 and punitive sanctions accounted for 15% of decisions.⁸³

Treatment and Harm Reduction

Portugal is an example of a country in which substance use and dependence are mostly treated with public funds. The National Strategy for the Fight Against Drugs, approved by the Portuguese government in 1999, is based on a health-oriented rationale and encompasses various policy measures, including, from 2000 onwards, the decriminalisation of illicit drug possession and consumption. It also includes an extension of the healthcare services network, a syringe exchange programme, an increase in scientific research funding and specialist training, and a significant financial budget increase for drug-related problems. It led to the setting up of the Portuguese Institute for Drugs and Drug Addictions (IPDT), a public organisation with several responsibilities. From 2005 onwards, the Portuguese Institute for Drugs and Drug Addictions became responsible for the drug-related healthcare treatment network and for the elaboration and implementation of the National Action Plan Against Drugs and Drug Addiction.⁸⁴

⁸¹ Ibid.

⁸² UK Home Office. 2014. Op. Cit.

⁸³ Ibid.

⁸⁴ Goncalves, R., Duran, D., Nogueira, S., da Silva, S., and Trigueiros, F. 2017. *Empirical estimation of drug treatment costs in Portugal*. Available at: http://www.emcdda.europa.eu/system/files/publications/6238/TI_PUBPDF_TDXD17001ENN_PDFWEB_20171005172306.pdf

To pursue these objectives, an innovative organisational model was introduced. Small treatment teams, belonging to integrated response centres, provide services associated with prevention, harm reduction, social reintegration and treatment. Some of these services are outsourced, but those costs are allocated to the relevant treatment team. In addition, some of these services are provided at the individual level, but others may be provided to larger groups and, naturally, the associated costs may be very different. A major advantage of this organisational model, from a research perspective, is that it keeps track of costs at the treatment team level, thus generating a rich and useful database of treatment team costs and outputs or activities carried out.⁸⁵

What architects of the Portuguese model emphasise is that ending criminalisation alone is not the reason for improvements in the lives of people who use drugs. A key aspect of the Portuguese approach is the focus on the individual person using drugs and their wellbeing. Drug treatment in Portugal is founded on a holistic understanding and assessment of a person's socioeconomic situation. Portugal has made major efforts to increase the availability, accessibility and quality of treatment, and the training of medical staff. All doctors, psychologists and nurses in Portugal receive education about drugs and addiction as part of their formal medical training. Treatment options available to people who use drugs include detoxification, psychotherapy and methadone. Methadone is given free of charge, available seven days a week, and is often distributed via mobile van units. The number of people entering treatment has increased significantly since decriminalisation. Treatment centres also coordinate with social reintegration teams, which offer advice and support on finding a job or returning to higher education, though Portugal has significantly scaled back this work since the economic recession of 2009. There is also limited housing available to people undergoing or leaving treatment, usually offered on a short-term basis, from six months to a year.⁸⁶

A nationwide network of harm reduction programmes and structures, including needle and syringe exchange programmes, low-threshold substitution programmes, drop-in centres/shelters, refuges, contact units and outreach teams, has been consolidated in areas of intensive drug use with the aim of preventing drug-related risks such as infectious diseases, social exclusion and crime. The National Commission for the Fight Against AIDS implements the national needle and syringe programme, *Say No to a Used Syringe*. The programme involves pharmacies, primary care health centres and NGOs, and includes several mobile units. Approximately 55 million syringes have been distributed under this needle and syringe programme between its launch in October 1993 and December 2016. An increasing trend in the number of syringes dispensed has been observed in the recent years, with more than 1.35 million syringes distributed in 2016. Treatment for human immunodeficiency virus (HIV) infection/acquired immunodeficiency syndrome (AIDS), and hepatitis B and C virus infections

⁸⁵ Ibid.

⁸⁶ Drug Policy Alliance. 2019. *Drug Decriminalization in Portugal Learning from a Health and Human-Centred Approach*. Available at: http://www.drugpolicy.org/sites/default/files/dpa-drug-decriminalization-portugal-health-human-centered-approach_0.pdf

is included in the range of services provided by the National Health Service of Portugal and is available free of charge.⁸⁷

The Portugal drug report 2018⁸⁸ using data from specialised treatment centres shows that the first-time treatment demands attributable to heroin use have declined since 2009. In contrast, new treatment entries resulting from the primary use of cannabis have almost doubled in recent years. Following a period of some stability in cocaine related new treatment demands, an increase was noted in the most recent years.

In 2016, a total of 27 834 clients received treatment, and the majority were treated in outpatient services. Of the 3,294 clients entering treatment in 2016, three out of every five were first-time clients. The number of previously treated treatment entrants has been decreasing since 2012, while the number of first-time entrants has been stable over this period. Since 2012, there has been an increase in the proportion of entrants reporting primary cannabis use and a decrease in the proportion reporting primary opioid use. The number of opiate substitutions treatment (OST) clients in Portugal decreased between 2010 and 2013; however, the number has remained relatively stable since then. In 2016, more than 16,000 clients received OST.

Prevention Interventions

Universal drug prevention is part of the Portuguese school curriculum and is mainly implemented in, biology and other science. Throughout 2016, several prevention actions and projects were developed nationally in the school setting, either from an overall perspective of health promotion or by focusing on specific aspects of addictive behaviours and dependencies. Activities were developed by teachers, with the involvement of students and often other stakeholders in this area: public healthcare centres, municipalities, SICAD and civil society organisations.

In 2016, school-based prevention continued to be implemented by the Ministry of Education, responsible for the inclusion of health promotion and substance use prevention, and the Ministry of Health, responsible for the prevention component of PORI. Other standardised school-based prevention programmes are available at regional and local levels. Drug prevention activities in workplaces, for the military, in communities and for families have also taken place. The Safe School programme continued in the 2016/2017 school year, promoting awareness of alcohol and drugs. Different types of selective prevention interventions including community-based interventions for vulnerable groups, family-based interventions for vulnerable families and interventions for vulnerable neighbourhoods have been carried out.⁸⁹

⁸⁷ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2019. *Portugal Drug Report 2018*. Available at: <http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>

⁸⁸ Ibid.

⁸⁹ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2019. Op. Cit.

Wider Reforms

Portugal complemented its policy of decriminalisation by allocating greater resources across the drugs field, expanding and improving prevention, treatment, harm reduction and social reintegration programmes. The introduction of these measures coincided with an expansion of the Portuguese welfare state, which included a guaranteed minimum income. Though decriminalisation was important, it is likely that the positive outcomes described below would not have been achieved without these wider health and social reforms.⁹⁰

Drug Use

The policy of decriminalisation is known across the world as one of the most successful policies of its kind. As highlighted by Cabral (2017), since it was adopted the consumption of drugs and psychotropic substances decreased, whereas the early concerns that the policy change may turn Portugal into a 'drug-tourist' destination did not come into fruition.⁹¹ Trend data from Portugal shows how levels of drug use changed in the years following decriminalisation in 2001. Although levels of drug use rose between 2001 and 2007, use of most drugs has since fallen to below-2001 levels.⁹²

Despite whatever increases there were in reported drug use and cannabis use, drug use in Portugal was, and remains, substantially lower than the European average. On the other hand, Portugal's rate of problem drug use, defined by the EMCDDA guidelines as injecting use or prolonged use of heroin, cocaine, and/or amphetamines, has been closer to or above the European average since the 1990s.⁹³

It is estimated that there were around 33,290 high-risk opioid users in Portugal in 2015, which is about 5.2 per 1 000 of the adult population.⁹⁴ Portuguese Decriminalisation did not lead to major increases in drug use.⁹⁵

⁹⁰ Transform. 2018. *Drug decriminalisation in Portugal: setting the record straight*. Available at: <https://transformdrugs.org/drug-decriminalisation-in-portugal-setting-the-record-straight/>

⁹¹ Cabral, T. 2017. Op. Cit.

⁹² UK Home Office, 2014. Op. Cit.

⁹³ Laqueur, H. 2015. Op. Cit.

⁹⁴ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2019. Op. Cit.

⁹⁵ Hughes, C.E and Stevens, A. 2010.

Drug-related Deaths

The number of deaths by drug overdose in Portugal is one of the lowest in all of the European Union, at just 4 per million of inhabitants against the average in the EU of 22.4.⁹⁶ According to data from the special registry of the National Institute of Forensic Medicine, since 2011 the number of drug-induced deaths in Portugal has remained below those reported for the period 2008-10.⁹⁷ In 2016, the majority of deaths occurred among males. The mean age of victims was 43 years. Opioids were detected in most drug-related deaths, with opiates mentioned in 21 cases; however, in most cases more than one substance was detected, and many cases recorded the presence of alcohol and benzodiazepines. The drug-induced mortality rate among adults (aged 15-64 years) was 3.86 deaths per million in 2016, which is lower than the most recent European average of 21.8 deaths per million.⁹⁸ The proportion of deaths in which opiates were the main substance in Portugal has continued on an almost steady decline from 95% in 1999 59% in 2008. The Portugal Drug Report 2018 shows that in 2008 there were 94 deaths attributed to overdose, whereas in 2016 there were 27.⁹⁹

Health Outcomes

By 1999, Portugal had the highest rate of drug-related AIDS in the EU and the second highest prevalence of HIV amongst people who inject drugs, whereas drug-related deaths had increased in Portugal to a peak of 369 in 1999 (an increase of 57 per cent since 1997).¹⁰⁰ HIV diagnoses, attributed to injecting drug use, have decreased dramatically; from 500 cases in 2006 to 30 in 2016.¹⁰¹ That said, the number of newly diagnosed HIV cases among people experiencing drug problems (13.4 per million population in 2009) is well above the European average (2.85 cases per million in 26 countries) and one of the highest in the EU. There is, nonetheless, a clear declining trend over recent years¹⁰², however outcomes cannot be attributed to decriminalisation alone, and are likely to have been influenced by increases in the use of treatment and harm reduction.

In 2016, 14.3% of people experiencing drug problems who had ever injected drugs and who were tested at outpatient treatment services were HIV positive, indicating an overall downward trend since 2013. Among people who inject drugs admitted to treatment, the reports show that the rate of chronic hepatitis B virus (HBV) infection ranged between 0% and 5% in 2016. In the case of hepatitis C virus (HCV) infection, the prevalence of antibodies among patients in drug treatment was 82.2%.

⁹⁶ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2018. European drug report. Available at: http://www.emcdda.europa.eu/system/files/publications/8585/20181816_TDAT18001ENN_PDF.pdf

⁹⁷ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2019. Op. Cit.

⁹⁸ The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2019. Op. Cit.

⁹⁹ Ibid.

Country Drug Report 2018. http://www.emcdda.europa.eu/countries/drug-reports/2018/portugal_en

¹⁰⁰ Hughes, C.E and Stevens, A. 2010.

¹⁰¹ The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Portugal*

Country Drug Report 2018. Available at: http://www.emcdda.europa.eu/countries/drug-reports/2018/portugal_en

¹⁰² European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2011. *Drug Policy Profiles: Portugal*. Available at: http://www.emcdda.europa.eu/system/files/publications/642/PolicyProfile_Portugal_WEB_Final_289201.pdf

The Portugal Drug Report 2018¹⁰³ shows that, in general, a decreasing trend in the total number of notifications of human immunodeficiency virus (HIV) infection and AIDS cases has continued to be registered since the early 2000s. Moreover, in 2016, a total of 1,030 new HIV-positive individuals and 261 new AIDS cases were reported for all risk groups together, and less than 1 in 10 new cases of HIV infection or AIDS were associated with injecting drug use. Similarly, there has been a large decline in the incidence of HIV and AIDS associated with injecting drug use in this risk group since 1999-2000.

Social Costs

Gonçalves and colleagues¹⁰⁴ analysed the social costs of illicit drug use after the approval of the Portuguese National Strategy for the Fight Against Drugs (NSFAD) in 1999, which paved the way for the decriminalisation of illicit drug use in 2000. Taking into consideration health and non-health related costs, the authors found that the social cost of drugs decreased by 12% in the five years following the NSFAD's approval and by 18% in the eleven-year period following its approval. Whilst the reduction of legal system costs (possibly associated with the decriminalisation of drug consumption) is clearly one of the main explanatory factors, it is not the only one. In particular, the rather significant reduction of health-related costs has also played an important role.

Criminal Justice System

Decriminalisation appears to have reduced the Portuguese prison population and eased the problem on the criminal justice system. After decriminalisation in Portugal, incarceration for drug-related offences decreased. Moreover, the number of people imprisoned for drug offenses fell by 43% since decriminalisation, from 3,863 in 1999 to 2,208 in 2016.¹⁰⁵ Data from Portugal also provides some indication of the impact of decriminalisation on police resources. Although since 2001 police have referred possession offenders to an administrative, rather than criminal process the number of people coming into formal contact with the police for possession offences has remained broadly stable at around 6,000, notwithstanding a brief spike immediately before the implementation of decriminalisation. The number of people encountering contact with police for supply offences has also remained stable.¹⁰⁶

Goncalves and colleagues, also provide evidence that legal costs in terms of drug related offences reduce and they also cite a decrease in offenses for drug consumption between 1999 and 2010. They report a significant reduction was observed in legal system (direct) costs associated with criminal

¹⁰³ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). 2019. *Portugal Drug Report 2018*. Available at: <http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>

¹⁰⁴ Gonçalves, r., Lourenço, A., and da Silva, S. N. 2015. A social cost perspective in the wake of the Portuguese strategy for the fight against drugs. *International Journal of Drug Policy*, 26(6): 199–209.

¹⁰⁵ Drug Policy Alliance. 2019. *Drug Decriminalization in Portugal Learning from a Health and Human-centred Approach*. Available at: http://www.drugpolicy.org/sites/default/files/dpa-drug-decriminalization-portugal-health-human-centered-approach_0.pdf

¹⁰⁶ UK Home Office, 2014. Op. Cit.

proceedings for drug-law offences and, particularly, (indirect) costs associated with lost income and lost production of individuals imprisoned for drug law offences.¹⁰⁷

¹⁰⁷ Gonçalves, R., Lourenço, A., and da Silva, S. N. 2015. Op. Cit.

APPENDIX VI: RELATED CONFERENCES - MATERIALS

Across the lifespan of the Drugs Commission, members of the Commission and the Figure 8 support team have attended a number of conferences in Scotland that have had significant relevance to the issues that have been under consideration.

A summary of the conferences attended is provided below. The conference materials obtained have been included in our full review of evidence.

Overdose Prevention in Scotland: what can we learn from British Columbia?

Drugs Research Network Scotland (May 2019, Dundee).

For more details and available research / conference slides visit:

<https://drns.ac.uk/files/2019/07/Overdose-Prevention-in-Scotland-Dundee-seminar-report.pdf>

Programme and presentations

- 'Lessons from British Columbia: Preventing overdose deaths'- presentation by Bernie Pauly and Bruce Wallace, Canadian Institute for Substance Use Research (CISUR)
 - Bernie and Bruce provided an outline of drug-related deaths (DRD) in Canada and BC to provide the context in terms of DRD distribution across geography and over time, substances implicated in deaths, the location of deaths and the initial political response. They described development of the multi-agency Drug Overdose and Alert Partnership, informed by a Community Action Team model, and components of the programmatic response. The response included scale-up of naloxone provision, access to addiction treatment, and overdose prevention sites (also known as safe/r or supervised injecting facilities).
 - Bernie and Bruce also highlighted the involvement of people with lived and living experience of drug use in the response, and the role of community activism in the form of unsanctioned 'pop-up' injection sites and peer involvement in the design of services.
- Delegate discussion
 - Following the presentation delegates engaged in small group discussions prompted by the following questions: • What relevance does the work Bruce and Bernie have presented have for us here in Scotland? • Might an equity-oriented model gain traction here? If so, why? If not, why not? • What good practice is currently happening in Scotland? • What barriers and facilitators do you think are relevant? • What further questions do you have for the speakers that might be helpful in exploring the potential of this model for Scotland?
- 'Peer-to Peer support and interventions in overdose prevention' presentation by Bernie Pauly and Bruce Wallace, Canadian Institute for Substance Use Research (CISUR)

- Bernie and Bruce's second presentation outlined their approach to the meaningful and respectful involvement of people with lived and living experience of drugs in the BC response. They described helpful models of peer involvement, basic considerations of language and other factors that make involvement acceptable and accessible for peers. They noted that advocacy and other peer-based organisations paved the way long before public involvement was adopted by statutory services and policy makers. Key barriers to involvement were outlined including labour market discrimination and organisational factors that can make peer involvement impractical.
- Small group discussions on application of the learning of the Scottish context
 - Delegates participated in small group discussion prompted by the following questions: • What relevance does the work Bruce and Bernie have presented have for us here in Scotland? • What good practice is happening here in Scotland and the UK related to peer to peer work? • What barriers and facilitators do you think are relevant? • What further questions do you have for the speakers that might be helpful in exploring the potential of peer led work in Scotland?

Working together to prevent drug-related deaths

Scottish Drugs Forum (August 2018, Glasgow).

For more details and available research / conference slides visit:

<http://www.sdf.org.uk/resources/conference-presentations/>

Programme and presentations

- Building on the GP Role to Prevent Drug-Related Deaths - Dr Joe Tay, Sighthill Green Practice, Edinburgh;
- Developments in Alcohol and Drug Partnerships to Prevent Drug-Related Deaths - Laura Kerr, Lead Officer, Tayside Alcohol and Drugs Partnership;
- Harm Reduction in Canada: Lessons Learned and Reflections - Marilou Gagnon, University of Victoria;
- Understanding the Nurse's Role in Harm Reduction - Marilou Gagnon, University of Victoria & Kirsten Horsburgh, Scottish Drugs Forum;
- Staying Alive: How to Prevent Drug-Related Deaths - Alan McRobbie, Scottish Drugs Forum;
- Preventing Drug-Related Deaths in a Custodial Setting - Bob Bartlett, Scottish Prison Service;
- A Daily Dose of Pharmacy Intervention - Dr Carole Hunter, Alcohol and Drug Recovery Services, NHS GGC & Jean Logan, Pharmacy Community Services, NHS Forth Valley;
- A Daily Dose of Pharmacy Intervention (Workshop Activity) - Dr Carole Hunter, Alcohol and Drug Recovery Services, NHS GGC & Jean Logan, Pharmacy Community Services, NHS Forth Valley;

- Working Together to Prevent Drug-Related Deaths in Scotland - Craig Bookless, Substance Harm Prevention Team – Safer Communities, Police Scotland;
- How the Third Sector Works to Reduce Harm - Danny Kelly, Gowrie Care;
- Older People Who Use Drugs - Graham MacKintosh, Scottish Drugs Forum;
- Understanding the Vital Role of Peers in Harm Reduction - Jason Wallace, Scottish Drugs Forum & Danny Hutcheson, Naloxone Peer Supplier-Educator.

Reducing drug-related deaths in Scotland: learning from the Canadian experience

Glasgow Caledonian University and Drugs Research Network Scotland (18 June 2018, Glasgow).

For more details and available research / conference slides visit:

<https://drns.ac.uk/reducing-drd-seminar/>

Programme and presentations

- Scotland's National Naloxone Programme: What have we learned? - Dr Andrew McAuley, GCU & HPS
 - Dr McAuley's presentation focussed on five Key questions 1. Did the National Naloxone Programme (NNP) reach those most at risk of opioid overdose? 2. Who engages most with the NNP? 3. Are PWID in Scotland following the NNP training protocol? 4. Did the NNP have an impact on opioid-related overdose? 5. What are the priorities for the NNP moving forward?
- Take Home Naloxone in Scotland - Kirsten Horsburgh, Scottish Drugs Forum
 - Kirsten provided evidence to show that over 40,000 take-home Naloxone (THN) kits have been distributed in Scotland to date. Kirsten then described the development of the peer supply model in Glasgow. From September 2017-May 2018 peers have trained 903 people; supplied 635 individuals and supplied 892 THN kits. Kirsten went on to detail that over 300 Scottish Prison Service officers have been. A key message from the presentation was that anyone likely to witness an overdose should have access to Naloxone.
- Intranasal Naloxone: Latest developments and evidence - Dr Rebecca McDonald, Kings College (London)
 - Dr McDonald provided an overview of Naloxone, since its 1971 introduction, and then discussed the various routes of administration. She then explored why non-injectable naloxone is needed and provided examples such as the risk of needle-stick-injury. An overview of nasal kits was offered, and a key message was that Intranasal Naloxone kits are a promising overdose prevention mechanism which can be used by a lay person. Nonetheless, Dr McDonald discussed remaining issues such as the impact of nasal membrane damage or blockage, dose titration, and device preference among "consumers"?

- Naloxone perspectives from British Columbia, Canada - Prof. Jane Buxton, University of British Columbia & British Columbia Centre for Disease Control
 - Dr Buxton provided an overview of the overdose crisis in Canada and the role of fentanyl contributing to drug-related deaths. An overview and also the impact of THN take-home naloxone → THN sites, kits distributed & used → Training – videos and apps → Facility Overdose Response Box (FORB) program → Research: → Evaluations: program, youth, corrections, ED (A&E) → Data from administration forms of Withdraw symptoms; # amps used; o Giving breaths; Calling 911 → Lives saved (modelling) → Summary policy changes.
- Drug Overdose & Alert Partnership: Collaboration and data sharing in an opioid overdose crisis; - Prof. Jane Buxton, University of British Columbia & British Columbia Centre for Disease Control
 - Utilisation of overdose data in Scotland.
- Utilisation of overdose data in Scotland - Lee Barnsdale, NHS National Services Scotland, Information Services Division
 - World leading initiatives & data: • 1st national THN programme in world • Rapid death registration (8 days) • Extensive DRD data collection • Reports unique in UK • NRS report: Drug Poisoning Deaths (E&W) – registration delay • NDRDD report: no comparable publication? Major Public Health issue - areas for improvement: • Fill gap in drug trend info • THN administration data • Enhance data on OD-related treatments • DRD data: translating evidence into action • Purpose of data collection? (retrospective/prospective) • Improve timeliness of reporting • 'Imperfect' data may enhance public engagement • But don't ignore the bigger picture.

APPENDIX VII: RAPID INEQUALITIES REVIEW (DUNDEE)

Introduction

Problem drug use has strong links to poverty and deprivation, with individuals from deprived areas more likely to have experienced psychological trauma and mental health issues, which can result in the use of high-risk drugs to escape psychological stress and trauma. That is not to say, however, that deprivation causes addiction, given the links between poverty and drug misuse are multifaceted.¹⁰⁸

Recent local data suggests that 73% of individuals who died as a direct consequence of drug use in Tayside in 2017 lived in areas that were classified in the two most deprived SIMD quintiles. This suggests an inequality incline associated with drug-related deaths, with more than half of drug-related deaths occurring in areas of greatest socioeconomic deprivation.¹⁰⁹

Life expectancy

Dundee City has a male life expectancy at birth of 74.5 years, which is the second lowest behind Glasgow City when compared to other cities. The life expectancy at birth for males in Dundee City is 2.6 years lower than the Scottish average.

Dundee City had a female life expectancy at birth of 79.6 years, which again, is the second lowest behind Glasgow City when compared to other cities. The life expectancy at birth for a female in Dundee City is 1.5 years lower than the Scottish average.¹¹⁰

Mental Wellbeing

The Warwick-Edinburgh Mental Well-Being Score (WEMWBS) was developed by researchers at the Universities of Warwick and Edinburgh to enable the measurement of mental wellbeing of adults in the UK. WEMWBS is a 14-item scale of mental well-being covering subjective well-being and psychological functioning, in which all items are worded positively and address aspects of positive mental health.

The Dundee Partnership Annual Citizens survey 2017 contained some questions relating to mental wellbeing. The survey found that for Dundee City as a whole, the mean score for the Warwick-

¹⁰⁸ Scottish Parliament Information Centre. 2017. *SPICe Briefing Drug Misuse*. Available at: http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_17-22_Drug_Misuse.pdf

¹⁰⁹ Tayside Drug Death Review Group. 2018. *Drug Deaths in Tayside, Scotland, 2017*. Available at: https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1&dDocName=prod_310127

¹¹⁰ Dundee Partnership, Dundee City Council. 2019. *About Dundee 2018*. Available at: https://www.dundee.gov.uk/sites/default/files/publications/about_dundee_2018.pdf

Edinburgh Mental Well-Being Scale (WEMWBS) was 56.5. This has increased when compared to the results of the 2016 Annual Citizens Survey where the mean score was 54.3.

At a Scottish Level, the Scottish Governments Scottish Health Survey found that average levels of wellbeing for adults, as measured by the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) has remained stable since 2008, with scores ranging from 49.7 to 50.0. The 2016 Scottish Health Survey reported that the average mean WEMWBS score for both men and women (aged 16 and over) was 49.8.¹¹¹

The Scottish Index of Multiple Deprivation (SIMD)

The Scottish Index of Multiple Deprivation (SIMD) is the Scottish Government's official tool for identifying places in Scotland suffering from deprivation. Deprivation in this context refers to the range of problems that arise due to the lack of resources or opportunities covering health, safety, education, employment, housing and access to services as well as financial aspects.

The most recent Scottish Index of Multiple Deprivation (2016) divides Scotland into 6,976 small areas called data zones with roughly an equal population in each data zone. The Scottish Government then look at the indicators to measure the different sides of deprivation in each data zone including pupil performance, travel times to GP's, crime, unemployment etc. These 38 indicators of deprivation are then grouped into 7 types called domains. These domains are:

- Income (considers the percentage of people who are income deprived and receive certain benefits or tax credits);
- Employment (considers the percentage of working-age people who are employment deprived and receive certain benefits);
- Education (contains indicators including school pupil attendance, attainment of school leavers, working age people with no qualifications, proportion of people aged 16-19 not in full time education);
- Health (contains indicators including comparative Illness Factor, hospital stays related to alcohol misuse, hospital stays related to drug misuse, mortality);
- Access to Services (contains indicators including average drive time to GP surgery, post office, and retail centre; public transport travel time to GP surgery, post office, and retail centre);
- Crime (considers recorded crimes of violence, sexual offences, domestic housebreaking, vandalism, drugs offences, and common assault per 10,000 people);
- Housing (considers the percentage of people in households that are overcrowded or have no central heating).¹¹²

¹¹¹ Ibid.

¹¹² Scottish Government. 2016. *SIMD analysis 2016 Dundee city*. Available at: <https://www2.gov.scot/Topics/Statistics/SIMD/analysis/councils>

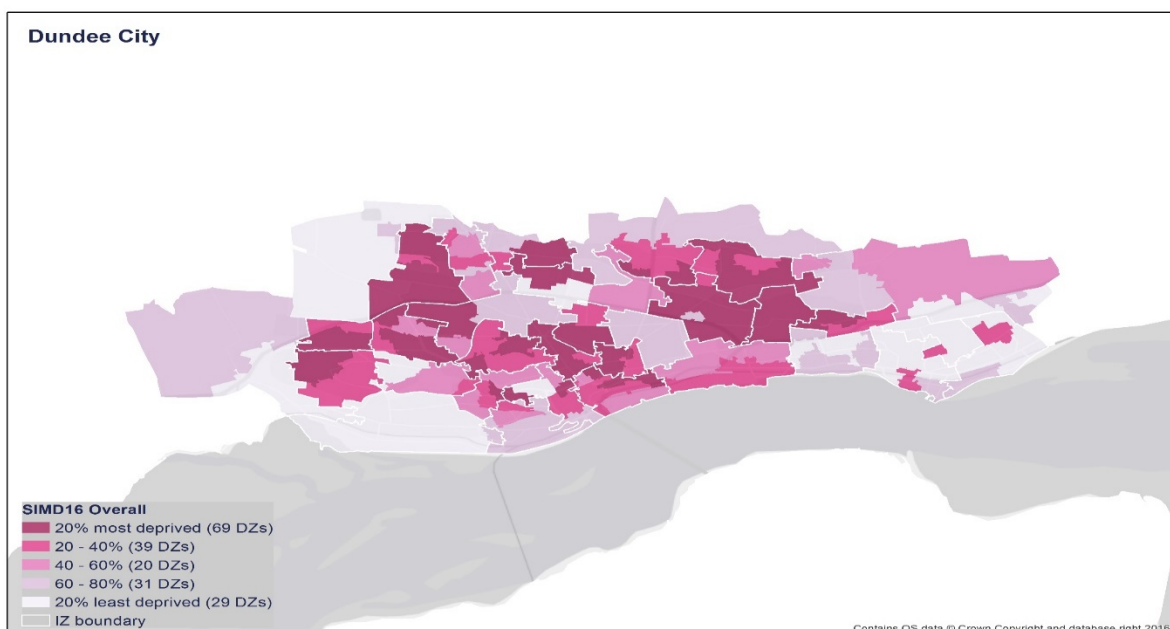
The 7 domains are combined into one SIMD, ranking each data zone in Scotland from 1 (Most Deprived) to 6,976 (Least Deprived). The SIMD allows organisations to target policies and place resources in the areas with greatest need.

The following information below shows SIMD 2016 data for Dundee City. The 188 DZs are grouped into 31 larger administrative areas, called intermediate zones (IZs).

SIMD profile

The following maps give an overview of deprived and less deprived areas in the council area and show the most deprived areas in more detail. The image below is datazones by the 20% band (quintile). Quintiles split up the dataset into 5 groups, each containing 20% of the data.

Figure 1: SIMD16 Most Deprived Quintiles ¹¹³

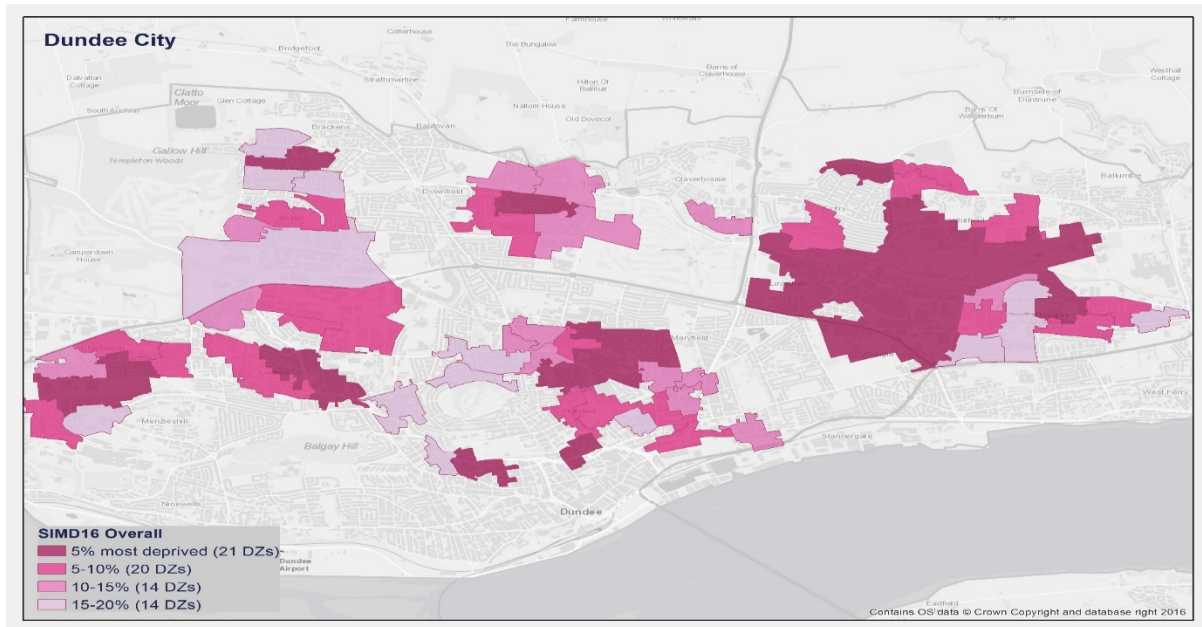


Source: Scottish Government, Scottish Index of Multiple Deprivation 2016

The image below is datazones by the 5% band (vigintile). Vigintiles split up the dataset into 20 groups, each containing 5% of the data (Note that the most deprived 15% therefore consists of the most deprived three vigintiles).

¹¹³ Scottish Government. 2016. Op. Cit.

Figure 2: SIMD16 Most Deprived Vigintiles ¹¹⁴



Source: Scottish Government, Scottish Index of Multiple Deprivation 2016

Dundee City has 21 data zones which are in the 5% most deprived in Scotland:

- 11% of the Dundee City population live within these areas;
- 65% of the Dundee City population who live within the 5% most deprived areas are of working age. ¹¹⁵

Dundee City has 55 data zones which are in the 15% most deprived in Scotland:

- 29% of the Dundee City population live within these areas
- 65% of the Dundee City population within the 15% most deprived areas are of working age
- Whilst Dundee City has a slightly smaller percentage of its population living in the 15% most deprived data zones the number of people has remained almost the same since 2012. The drop-in percentage is due to a larger overall population. ¹¹⁶

The table below lists the ten most deprived datazones in Dundee City and where they rank compared to the rest of Scotland. As seen below, City Centre-01 is the most deprived area in Dundee city.

¹¹⁴ Scottish Government. 2016. Op. Cit.

¹¹⁵ Dundee Partnership, Dundee City Council. 2019. Op. Cit.

¹¹⁶ Ibid.

Table 1: SIMD16 Ten Most Deprived Datazones in Dundee City ¹¹⁷

Datazone name	Rank (out of 6,976)	Vigintile
City Centre -01	36	≤ 5%
Linlathen and Midcraigie -02	76	≤ 5%
Lochee -04	79	≤ 5%
Whitfield -02	110	≤ 5%
Linlathen and Midcraigie - 01	121	≤ 5%
City Centre - 04	126	≤ 5%
Kirkton - 02	129	≤ 5%
Hilltown - 04	133	≤ 5%
The Glens - 03	197	≤ 5%
Linlathen and Midcraigie -04	201	≤ 5%

Further analysis of the ten most deprived datazones is presented in the table below which is broken down into the different domains which are combined into the SIMD. SIMD combines data from seven different domains of deprivation: Income, Employment, Health, Education, Access, Crime and Housing. The table presents a list each area if it was in the top ten most deprived datazone for each domain. For example, City Centre-01, the most deprived datazone overall, is in the top ten most deprived datazones for the income, employment, health and education domains, but not in the top ten for the access, crime and housing domains.

Table 2: SIMD16 Ten Most Deprived Datazones for Each Domain in Dundee City ¹¹⁸

Datazone Name	Income	Employment	Health	Education	Access	Crime	Housing
City Centre – 01	✓	✓	✓	✓			
City Centre – 04	✓	✓	✓	✓			
Linlathen and Midcraigie - 01	✓	✓	✓	✓			
Linlathen and Midcraigie - 02	✓	✓	✓	✓			
Hilltown - 04	✓	✓	✓				

¹¹⁷ Scottish Government. 2016. Op. Cit.

¹¹⁸ Ibid.

Whitfield - 02		✓	✓	✓			
Lochee-04	✓	✓	✓				
Kirkton - 02	✓	✓	✓				
The Glens - 03		✓	✓				
Linlathen and Midcraigie - 04	✓						

Distribution of Services in the top 5% of Deprived Areas in Dundee

In a three-year reflexive mapping exercise involving the identification of 135 frontline services available to those who find themselves homeless in Dundee, the authors report an inequitable distribution of services for those living in the top 5% of deprived areas in Dundee. Furthermore, there is a lack of services to support homeless people in the most deprived areas of Dundee. The people who live in these areas are the most likely to experience conditions which limit their opportunities in life and their capacity to access available health and social care services.

The report also highlighted that services are concentrated in the central area of the city, away from areas of high social deprivation. According to the Primary Health Care Approach, this inequitable distribution will reduce access and users' ability to attend health and social care appointments, since these services are outside a 5 km radius of their residences.¹¹⁹

¹¹⁹ NHS Health Scotland. 2019. Smile4life Reflexive mapping exercise Better health and social care for homeless people. NHS Health Scotland: Edinburgh.

APPENDIX VIII: SCOTTISH AFFAIRS COMMITTEE INQUIRY INTO PROBLEM DRUG USE IN SCOTLAND – SUMMARY OF RELEVANT WRITTEN SUBMISSIONS

Introduction

The Scottish Affairs Select Committee has been receiving evidence as part of its inquiry into the use and misuse of drugs in Scotland.¹²⁰ The Committee is exploring, amongst other things, the specific drivers of drug use in Scotland, the relationship between poverty, deprivation and drug use. Furthermore, what lessons can be learned from other countries is being explored. Oral and written evidence is being provided by stakeholders, academics, individuals with lived experience and service providers. The committee will also consider whether the Scottish Government has enough powers to implement the drug treatment or prevention strategies which could most effectively deal with emerging trends in problem drug use in Scotland.

All responses to the Scottish Affairs Select Committee have timely relevance to the Dundee Drugs Commission. A rapid review of submissions responding to the questions 'What are the unique drivers of drugs abuse in Scotland?', 'How is drugs misuse in Scotland different from the rest of the UK?' and 'recommendations' has highlighted themes of significant relevance which are presented below. The summary below is taking from written evidence provided by Crew 2000; Angus Alcohol and Drug Partnership; Dundee Alcohol and Drug Partnership; Glasgow City Alcohol and Drug Partnership; Turning Point Scotland; NHS Shetland; Addaction Scotland; and NHS Health Scotland. The full submission from Dundee Alcohol and Drug Partnership is also presented.

This rapid review adds timely and relevant evidence as an additional layer over the other quantitative and qualitative evidence the gathered by the Dundee Drugs Commission.

What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?

- Drivers are not unique to Scotland, but they appear to manifest and impact in a way that is different to the rest of the UK;
- Issues relating to poverty and deprivation, high levels of vulnerability in terms of childhood and prolonged trauma and mental health, and high levels of domestic abuse;
- A vulnerable (ageing) cohort;

¹²⁰ Scottish Affairs Committee. 2019. *Problem drug use in Scotland inquiry*. Available at: <https://www.parliament.uk/business/committees/committees-a-z/commons-select/scottish-affairs-committee/inquiries/parliament-2017/problem-drug-use-scotland-17-19/>

- A longstanding issue with poly-substance use, primarily the use of opioids and benzodiazepines. This is reflected in the proportion of drug-related deaths in which individuals were found to have opiate/opioids and benzodiazepines present;
- Socio-economic disadvantage. People who experience socio-economic disadvantage disproportionately also experience problematic drug use. Council areas with some of the most deprived communities in Scotland, such as Glasgow City and Dundee City have higher rates of problematic drug use than the national estimates;
- Personal experiences, for example ACES (adverse childhood experiences) or trauma experienced by adults, and social factors, for example deprivation. Personal and social experiences often occur together and lead to poorer outcomes overall for people's health and wellbeing;
- A wide range of biological and social factors that influence whether or not drug use becomes problematic;
- Severe mental health issues and using drugs as a coping mechanism;
- The lack of services such as rehab clinics and longer waiting lists for opiate treatment;
- The lack of mental health provision for people with substance use issues, particularly during times of crisis;
- Social dislocation;
- Austerity, universal credit and other welfare cuts leading to poverty and;
- Lack of education/opportunity.

What could Scotland learn from the approach taken to tackle drug misuse in other countries?

- Decriminalisation (such as the example from Portugal);
- Legalisation, liaison and diversion from criminal justice (taking a public health approach) and comprehensive treatment information;
- The Portuguese approach of involving the criminal justice system of supporting, but most importantly not forcing, people into treatment rather than prison could reduce significant harm and save lives;
- Improved harmonised monitoring of, and timely reaction to, emerging drug trends and associated health harm;
- Supervised drug consumption facilities;
- Increased support for people with non-opioid problematic drug use;
- Improved access to residential rehabilitation;
- Health and social responses to drug problems;
- Heroin-assisted treatment is already provided in several European countries and in a small number of specialist services in the UK;

- Although Scotland can introduce programmes such as Heroin-assisted treatment and drug testing facilities it can only do so through exceptions and licences granted through UK wide legislation.

Recommendations

- Welcome the opening of a Heroin Assisted Treatment service in Glasgow city;
- Amend or devolve the relevant legislation to enable the implementation of a pilot Safer Drug Consumption Facility in Glasgow city;
- Recognise the impact of wider social policy on deprivation, poverty and drug misuse
- Make the necessary changes to the Misuse of Drugs Act 1971 to enable the Scottish Government to pursue their public health approach to drugs policy (including the piloting of a safer consumption facility in Glasgow City Centre) or devolve the powers in this area;
- Address socio-economic disadvantage by providing adequate protection against destitution and hardship (in and out of work) along with employment support to help people secure good work;
- Recognise the unique aspects of Scotland's experience of the negative impact of poverty, deprivation and inequality and work closely with the Scottish Government, and Public Health Scotland when it comes into being later this year, in order that an effective whole-system response can be made to problematic drug use in Scotland, and lives saved;
- Scotland should adopt an evidence-based approach to drug legislation and policy with robust evaluation of intended and unintended impacts, recognising that criminalisation of drugs and punitive approaches to people who use them are often the biggest barriers to getting help and that even the most expensive treatments as alternatives to imprisonment are more cost effective;
- Improve access to services and reduce drug related deaths;
- Problematic psychostimulant drug use is included in the Information Services Division/NHS National Services Scotland definition of problematic substance use as soon as possible in order to reflect the changing patterns of drug harm in Scotland and ensure that research, budgets and services can be developed according to changing national needs;
- Include the views and lived experiences of people affected by drug harms in developing legislation which is fit for purpose and which empowers the public to keep themselves safe;
- A Scottish working group should be established to draw on existing evidence of best practice in music festival and event welfare and set a minimum, multi-agency standard with specific reference to preventing and addressing drug-related harms from a health perspective.

Dundee Alcohol and Drug Partnership Response

1. What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?

It is likely that there are no 'unique drivers' as such – as increased drug-related harm is currently a national and international concern. However, Scotland historically has a worse record with regards to all social circumstances, health and well-being outcomes compared to the rest of the United Kingdom, and this will be reflected in drug-related harm also. More specifically, issues relating to poverty and deprivation, high levels of vulnerability in terms of childhood and prolonged trauma and mental health, and high levels of domestic abuse are some drivers that could have an impact.

2. To what extent does UK-wide drugs legislation affect the Scottish Government's ability to address the specific drivers of drugs abuse in Scotland?

The constraints of UK-wide drugs legislation results in Scotland being less able to react dynamically to emerging threats and potential solutions that may be a particular priority to the population in Scotland compared to elsewhere in the United Kingdom. For example, the ability to test the impact of injecting rooms on a wider scale could be a positive measure in Scotland.

3. What is the relationship between poverty and deprivation and problem drug use?

Poverty and deprivation are intrinsically linked to poor mental health and problematic drug use. They are also a factor in abusive and violent relationships which affect many women experiencing drug problems. 73% of people who died as a direct consequence of drugs in Tayside in 2017 lived in areas that were in the two most deprived SIMD quintiles. People who develop problematic drug use and die because of drugs frequently experience multiple adverse events in childhood and adulthood and often have concurrent mental health issues. 74% of drug death casualties in Tayside in 2017 were known to have a co-existing mental health condition at the time of their death, most commonly depression (58%) and or anxiety (48%).

We also know that poverty and deprivation affect people's aspiration and the personal drive requires to recover from drug misuse. The issue of the cyclical nature of adverse childhood experiences (ACE) should also be considered in this context. We know that many individuals affected by drug misuse have been subject to adverse early childhood experiences which continue to impact of their ability to recover.

4. What role could reserved social security policy play in addressing problem drug use?

The best approach to this policy would be to devolve it to the Scottish Government and enable it to introduce specific measures that will be more supportive to the process of recovery from drug misuse. Universal credit often pose a real barrier to individuals who live chaotic and challenging lives.

5. How is the drugs market in Scotland changing? How well do current regulations meet the challenges of new trends in drug disruption, such as the "dark web" Are any changes needed to the current regulatory landscape?

Drugs market internationally are changing and this is, in part, driving the increased drug-related harm in Scotland. For example, the 2018 European Drug Report describes the increased production of cocaine in central and South America resulting in increased cocaine-related harm across Europe – Scotland, in this context is no different. The number of drug deaths where cocaine is involved has increased in recent years. Furthermore, a greater variety of substances are available (due to increases in the number of new psychoactive substances in recent years), and there is greater availability of diverted prescription medications such as gabapentinoids due to increases in gabapentinoid prescribing. Substances are therefore more available and affordable. In addition, substances are more easily accessible due to home production, for example in the case of etizolam, and through the internet (both the 'normal' web and the darkweb). The person with problematic drug use must be supported and drug-taking seen as a public health concern and not a criminal concern. However, as in the Psychoactive Substances Act, there must still be a drive to restrict supply of substances and curtailing supply through the internet has to be a key priority in this area to address.

6. Are there other areas of reserved policy which is influencing the Scottish Government's ability to address drugs misuse in Scotland?

Increasing drug related harm is a significant public health concern for the population of Scotland. The Scottish Government must be able to react quickly, specifically and appropriately to implement all evidence-based measures to address this public health priority.

7. How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland? Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?

It is imperative that best practice, information and policy outcomes is shared across all partner agencies, localities, regions and nations both within the United Kingdom and abroad. This is done sub-optimally at all levels currently. We believe there is much room for improvement, including the sharing of areas where approaches haven't worked and proposals for improvement.

8. Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland's needs?

Inevitably yes, for the aforementioned reasons. However, should further powers be devolved, the Scottish Government has to ensure that, in addition to setting up its own policies and approach, appropriate resources are allocated to address drug misuse from a wider, holistic perspective (including addressing the underlying cases of substance misuse) in order to maximise any health and social gains from legislative change.

9. What could Scotland learn from the approach taken to tackle drug misuse in other countries?

Options to consider that are implemented elsewhere:

- Improved harmonised monitoring of and timely reaction to emerging drug trends and associated health harm;
- Supervised drug consumption facilities;

- Increased support for people with non-opioid problematic drug use;
- Increase focus on recovery by addressing the underlying causes (including greater focus on housing and employability);
- Improved access to residential rehabilitation;
- There are also a number of Whole family Approaches progressed by organisations including Children 1st, Aberlour and Local Authorities' Children& Families Services (including Dundee) that offer a joint response to the needs of children and parents and aims to keep families together.

APPENDIX IX: AVAILABILITY AND ENFORCEMENT

In relation to availability and enforcement issues this has proved to be beyond the ability of the Commission to give due attention to at this stage. However, one of our Commissioners (Suzie Mertes, Superintendent, Police Scotland) has helpfully provided a precis of current approaches to availability and enforcement in Dundee (see **Appendix XXI** in the Supporting Evidence Report). It must be noted though that the Commission has not had the time to review this area.

'As an active member of the DADP, Police Scotland's D (Tayside) Division plays a leading role in developing thinking and practice in tackling drug misuse and a range of prevention activities have been shaped by police practice. Early in 2017, practice around Prevention was refreshed within the Division to better focus activities on interventions that might make a difference, working alongside partners. An example of this was joint work between Police, Scottish Ambulance Service and NHS to identify prescription medication found at the scene of drug-related death and near misses and to ensure that those who were associated with such deaths and near misses were assessed rapidly for their continued suitability for larger doses of medication. Police Scotland was a lead organiser and participated in the multi-agency Drug Summit held in March 2018 with partners from NHS, Scottish Government, Local Authorities, Academia and the third sector in attendance. The focus of the day was for collaborative efforts to reduce the incidence and impact of drug-related deaths, and the launch of the Dundee Drugs Commission. Complementing this, but separate from the Dundee Drugs Commission, is the D Division Local Approaches to Policing action. This involves a collaborative approach to understanding the nature and impact of drug abuse in Dundee by utilising a partnership with the two Dundee Universities (Dundee and Abertay), and local statutory and third sector partners, to develop an evidence base to drive prevention and intervention activities aimed at reducing drug-related death and drug misuse. In early 2018, the Division was restructured to place prevention and intervention under a single "virtual" Tayside Preventions Hub, to ensure equity of service and focus, and to deliver on the Christie Principles, with that Hub sitting under the direction of the Superintendent Partnerships and Performance, who is a Dundee Drugs Commission member. An example of prevention being delivered upon by the Tayside Preventions Hub is the delivery of Naloxone Awareness Training for officers in Dundee, in collaboration with the Scottish Drug Forum.

Police Scotland is committed to reducing the tragic impact of drugs on individuals and communities by tackling those who would seek to cause harm and benefit from their supply. Enforcement, whilst not the answer to all drug misuse problems, is still a key facet of the police response and so with the support of partner agencies and specialist national resources, D Division continues to look at all enforcement and disruption opportunities. Under the banner of Operation Slate, officers in D Division, last year recovered the following drug types and values: Heroin in excess of £1,203,000, Cocaine in excess of £1,063,000, Cannabis in its various forms in excess of £324,000 and over 24,000 tablets being sold on the street as Valium or derivatives. In addition to the drugs, large amounts of cash have been seized from those involved

in the supply and distribution of drugs. Operation Fundamental is a multi-agency, intelligence led operation to impact on the critical level of drug-related deaths in Dundee. This Operation is unique in the fact that information has been shared with partner agencies from the outset of the planning stage to enable them to offer support to vulnerable individuals who may become known during the course of the operation. Police Scotland officers are also being supported by officers from the National Crime Agency. For the first time, representatives of the city's integrated substance misuse service, children and families social work and neighbourhood services were located within the hub from where the Operation was co-ordinated. This allowed them, in real time, to look at what additional support anybody involved in the Operation might require. Working in partnership with Dundee Alcohol and Drugs Partnership and Dundee City Council the Operation is part of a wider, longer term approach to tackling the issue of drugs and drugs deaths in Tayside. With police enforcement coupled with access to support services, Operation Fundamental hopes to significantly impact on criminal activity and to address the wider social and health problems which drug use can create in communities.'

[Suzie Mertes QPM, Superintendent (Partnerships and Performance), D Division, Police Scotland]