ACMD

Advisory Council on the Misuse of Drugs

Standard Operating Procedure for using evidence in ACMD reports

Intended purpose of this Standard Operating Procedure

This Standard Operating Procedure (SOP) is a central document developed by the Advisory Council on the Misuse of Drugs (ACMD) to allow the Council to follow a consistent mechanism to prepare evidence-based advice.

This document describes the process by which the ACMD collects, analyses, summarises and presents different types of evidence in a consistent and transparent manner to lead to the formulation of recommendations.

Chapter 1- Identifying and approving a report theme

Proposals for new ACMD projects should follow a consistent mechanism of being considered and approved centrally by the ACMD Full Council before being taken forward by an ACMD Standing Committee or working group. This will ensure that the projects are governed by the ACMD Full Council and will allow ACMD members to contribute to the scope of the proposed areas of work.

1. Identifying the scope of a new report

- The origin of the report needs to be stated, i.e. whether this was commissioned by Government, or self-commissioned by the ACMD's membership.
- The scope of the report needs to be described with clear and defined questions, and an explanation of what is and is not covered within the report.

2. Process for approving the initiation of a new report

ACMD members have the opportunity to present and discuss potential proposals at away days - however, a proposal for a new project can be submitted to the ACMD Full Council for consideration via the ACMD's Secretariat at any time.

A Project Initiation Document (PID) outlining the aims of the project along with a brief description of the strength of evidence available on the topic will be presented to the ACMD's Full Council for consideration. The ACMD Full Council will then collectively decide on whether to approve the project.

Structure of an ACMD project initiation document (PID)

Proposals should include:

1. Project title

2. Topic background & key issues

3. Overview of the strength of available evidence in the area. Projects are unlikely to be approved if there is insufficient evidence upon which to draw recommendations.

4. Project aim

5. A consideration of membership, Chair and possible co-option

6. Proposed timescale for completion

7. Whether the proposal would be likely to require the commissioning of further work (if this is possible to foresee). This will help with the allocation of resources.

Chair of proposed committee/working group

Traditionally, the Chair of the chosen inquiry is the ACMD member who proposed the subject area. However, this is not always the case and members who have proposals but who are unable to Chair the group should not be discouraged from submitting a proposal.

Chapter 2: Collecting, analysing and presenting evidence

The ACMD uses evidence from a wide range of sources to develop its recommendations - examples include peer-reviewed research, published reports and expert opinion. Assessing the quality and relevance of different types of evidence is a critical part of the ACMD's work.

Collecting evidence to answer the identified questions

For each question, the working group should identify:

(i)   specific keywords to help answer the question, then search appropriate databases using these keywords.

(ii)   organisations/individual experts who should be approached.

Table 1: Sources of data

Sources of data	Examples of types of data
a) Published research literature	Peer reviewed journals
b) Conference papers/abstracts, 'grey' literature	(e.g. unpublished/not peer reviewed)
c) Evidence from Government departments and devolved administrations	(e.g. reports from Home Office, National Crime Agency, Public Health England, Department for Health and Social Care, Office for National Statistics and other datasets)
d) Evidence from other UK organisations	(e.g. NPSAD, NPIS, WEDINOS)
e) Evidence from non-UK organisations	(e.g. European Monitoring Centre for Drug and Drug Addiction including focal point)
f) Expert opinions and stakeholder opinions	
g) Other sources	(e.g. media, user fora)

Analysing evidence

Once evidence has been collected a bespoke analysis will be agreed by the Working Group. The chosen method of analysis will depend on the purpose of the report and the identified questions. The Working Group may choose to finalise the specific methodology once it is clearer what evidence is available.

The Chair of the Working Group will be responsible for deciding the methodologies used.

Presenting the quality of evidence in reports

Each ACMD report should include an appendix describing the methods used in data collection and analysis, for example:

      a. Range of evidence sources;
      b. Quality of evidence (design, limitations, bias);
      c. Applicability to report questions;
      d. Determination of causality (using for example the Bradford Hill criteria).

Where possible, the annex should discuss the strength of the evidence supporting individual recommendations.

Presenting recommendations

Each ACMD report should include specific and targeted recommendations, including:

a) Who the recommendation is intended for;
b) A measure of implementation (i.e. likely indicators to show that the recommendation has been carried out);
c) Metrics for assessing the intended effect (i.e. how one could measure the intended (or unintended) effect of the recommendation).

- Identified gaps in evidence (or where there is weak or contradictory evidence) should be highlighted and where appropriate, a recommendation for further research made.

Quality assurance for ACMD reports

The ACMD's secretariat will be responsible for undertaking a quality assurance step prior to final draft advice being presented to ACMD Full Council for approval. At this stage of the approval process, the Secretariat will detail the quality assurance process followed for the report to the ACMD Chair and the respective committee/working group chair(s).

Checklist for ACMD projects

a) Has the scope of the workstream been identified?
b) Has the Working Group agreed the terms of reference with clearly defined questions that need to be answered?
c) Has the collected evidence answered the identified questions?
d) Does the report include in the annex:
   - a description of the methods used in data collection, search criteria and analysis?
   - the organisations and experts approached?
e) Has the methodology for analysing the evidence changed as a result of the evidence?
f) Does the report clearly state the sources of the data and types of data?
g) Do each of the recommendations indicate the strength of evidence?

Chapter 3: Consideration of health and social harms

Introduction

This summary outlines the process the ACMD follows for assessing the health harms and social harms associated with a drug when developing recommendations.

All ACMD reports which assess the overall harms of a drug should use the health harms matrix (Table 2) and social harms matrix (Table 3) to consider and identify potential harms across a range of domains to inform that assessment. The matrices are not intended to be prescriptive but instead provide a relatively simple mechanism to ensure that drug-related health and social harms are described comprehensively and consistently, to support literature searching, evidence review and decision making.

Health harms are classified by health professionals using a range of different approaches. These metrics include type of harm (physical versus psychiatric), time of occurrence (acute versus chronic), body system involved (e.g. cardiovascular, respiratory) and disease process (e.g. infection, trauma).

Social harms may emerge as a direct consequence of drug use or indirectly from drug use or through policy and enforcement responses to drug use. Many of these harms are predictable, but others may be unexpected and/or unintended.

Part of the complexity of describing drug-related harm is that it can occur across multiple systems and with poorly understood underlying mechanisms. The distinction between a health harm and a social harm is not always very clear. Many drugs will cause harms across several harm domains.

Drug-related harm may also be experienced by those who are not using drugs themselves. Relatives, friends, the wider community and the environment are examples. These have been described in the matrices under the section 'harm to others'.

Definitions

For the purposes of ACMD's work:

Health harms can be defined as "a negative effect on health resulting from drug use, whether direct or indirect".

Social harms can be defined as "damages to human welfare, security and autonomy that occur in the relations between individuals, communities and institutions of society".

There are multiple bearers of drug-related harm. These should be identified in reports and are broadly categorised as:

- - The individual who uses drugs;
- - Others affected by drug use, such as family and peers;
- - Communities and social structures.

Methodology and development of the matrices

Two working groups of the ACMD developed the matrices for health harms and social harms, having considered the methodologies utilised for assessing both.

The methodology for assessing health harms reviewed existing work already carried out in this area, existing models and frameworks, including classifications used by the National Institute for Health and Care Excellence (NICE), the Medicines and Healthcare products Regulatory Agency (MHRA), Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5 (APA, 2013)) and International Statistical Classification of Diseases and Related Health Problems (ICD 10/11 (WHO,1992; WHO, 2018)). None were suitable for the needs of the ACMD and were not able to encompass the range of harms a drug could cause to an individual or others.

We also considered other ways which drug harms have been considered such as the "multi criteria decision analysis model" (Nutt, 2010) but again this set out to compare drug harms and rank harm which is not the goal of the ACMD's work.

The methodology for assessing social harms has been adapted from the work of Greenfield and Paoli (2013) on the assessment of the harms of crime, and the EMCDDA (2009) operating guidelines on the risk assessment of new psychoactive substances.

The properties of a drug and characteristics of the user

It is useful to consider factors related to (1) the drug's properties and (2) characteristics of the drug users.

Drug properties

- Routes of administration
- Dose
- Potency
- Purity and risks of adulteration
- Frequency of use
- Pattern of use
- Length of use
- Potential for dependence
- Potential interactions with other drugs/alcohol

Characteristics of the drug user

- Age
- Sex
- Physical health (e.g. liver and renal function, underlying heart or lung disease)
- Psychiatric/psychological health (e.g. depressive episode)
- Social health (e.g. disrupted social networks)
- Genetic factors (e.g. vulnerability to drug dependence)

Presenting conclusions

Through structured discussion, a subjective conclusion on overall harm should be drawn by an ACMD sub-committee or working group, taking into account the domains and the bearers of the main harms identified.

Associated recommendations should be justified by indicating, where appropriate, how the recommended action is considered to reduce the identified harms. Similarly, where the report has shown that there is a risk of indirectly increasing harm through recommendations, ameliorating actions should also be identified.

The ACMD did not find any evidence that the use of formal quantification or scoring in a harms assessment was likely to be more meaningful than structured descriptions, therefore the use of harm metrics in this process is not recommended.

Health harms matrix (Table 2)

Harm domain	Harm Example	Data source example
Harms to user		
1. Physical health harms		
1.1. Mortality	acute overdose, misadventure, drug-impaired fatal road crashes	Mortality statistics (ONS NRS, NISRA, NPSAD) Coroners' reports Confidential enquiries Fatal accident inquiries
1.2. Neurological	drug-induced coma, seizures	Case reports Case series studies Service user feedback Treatment trials Clinician feedback HES data MHRA Yellow Card scheme (for licensed medicine) NPIS data Congenital anomaly registries UK Teratology Information Service
1.3. Cardiovascular	acute cardiac arrhythmias or MI, venous thrombosis from injections, health harms associated with injecting crushed tablets	
1.4. Respiratory	respiratory depression, lung disease associated with smoking drugs	
1.5. Hepatic/ gastroenterological	drug-induced hepatitis, drug-induced vomiting, constipation	
1.6. Genitourinary/ renal	ulcerative cystitis, nephropathy, drug-induced glomerulosclerosis	
1.7. Blood/ nutrition/ endocrine	clotting abnormalities, drug-induced disseminated intravascular coagulation, drug-induced SIADH, indirect nutritional deficiencies	
1.8. Reproductive	early labour, adverse foetal effects of drug use, testicular atrophy	
1.9. Musculoskeletal	drug-induced rhabdomyolysis	
1.10. Immunological	immunosuppression	
1.11. Ear, Nose & Throat (ENT)	septal damage from drug snorting	
1.12. Dermatological / dental	skin abscess and necrosis secondary to injecting, oral cancer, dental decay from long-term drug use	

Harm domain		Notes and examples	Notes on data sources
1.13.	Multiple	issues related to repeated non-lethal overdoses, health harms related due to routes of administration covering direct and indirect effects (e.g. blood-borne virus)	
2. Mental health harms			
2.1.	Intoxication		Case reports Case series studies Service user feedback Treatment trials Clinician feedback HES data MHRA Yellow Card scheme (for licensed medicine) NPIS data
2.2.	Delirium	acute confusional states	
2.3.	Psychosis	drug induced psychosis, persecutory thinking	
2.4.	Mood disorders	including suicide risk	
2.5.	Memory disorder	dementia and other memory deficits, short term memory loss, cognitive impairment	
2.6.	Anxiety		
2.7.	Psychological dependence and addiction	Including tolerance, withdrawal symptoms and craving	
Harms to others			
3. Physical health harms			
3.1.	Infective process	blood borne virus (BBV) transmission	Surveys of BBV Public Health England and Devolved Administrations
3.2.	Other physical harms to others	road traffic accidents whilst intoxicated, violence whilst intoxicated	Department for Transport

Social harms matrix (Table 3)

Harm domain		Notes and examples	Notes on data sources
Harms to User			
4. Loss of tangibles			
4.1.	Education	including exclusion from education, educational disengagement, and under achievement (qualifications)	Drug and alcohol related permanent and fixed period pupil exclusions (DfE; Devolved Administrations)
4.2.	Employment	including loss of employment; lack of and under-employment; loss of income and low wages; and tangible losses through workplace discrimination (identification as a person who uses drugs)	UK labour market data does not include reason for loss of employment. Organisations such as the Health and Safety Executive, Unions, employers' associations and sector bodies occasionally publish the findings

			of surveys and enquiries into substance use in the workplace
4.3.	*Housing*	Loss of accommodation as a direct or indirect consequence of drug use, including loss of employment, imprisonment or break down in relationships	Ministry of Housing, Communities and Local Government homelessness statistics; PHE drug treatment (and equivalent bodies in devolved administrations) includes data on housing status; homelessness and housing charities/third sector organisations, and housing associations periodically commission research into this topic.
4.4.	*Crime*	direct harms may include loss of autonomy and liberty as a result of sanctions (e.g. imprisonment, supervision orders, licence conditions), whilst indirect harms may include loss of other tangibles (e.g. employment, housing, travel) as a result of disclosure of penalties (e.g. imprisonment, police/court caution). There may also be secondary escalation of criminality (and drug use) through involvement in criminal justice system. This category also includes harms related to being a victim of drug-related crime.	Ministry of Justice (and equivalent bodies in devolved administration) datasets on arrests for recorded crime, prison population; local analyses of orders including DTTO, DRR; bespoke analyses of NDTMS; nature of crime Module from the CSEW ('the victim believed the perpetrator(s) to be under the influence of drugs')
5.	**Loss of relationships**		
5.1.	*Personal relationships*	Loss of relationships with children and other family members, friends and social support networks and the wider community. As positive social relationships are considered important forms of social capital and a component of recovery capital, loss of these may compound drug-related harm. Similarly, a narrowing of social relationships and social identity around drug-use may promote harm.	Public Health England Profiles (indicator Parents in drug treatment (rate per 100,000 children aged 0-15))
6.	**Other harms to the user**		
6.1.	*Sexual exploitation and violence*	Including exploitative sex work to pay for drugs, sexual violence, and human trafficking. Children and young people may	HO Annual report on modern slavery; PHE young people treatment data on service users reporting experiencing sexual

		be provided with drugs as part of sexual exploitation practices by adults, involvement in 'county lines'	exploitation; Sexual violence and grooming data (MoJ recorded crime data) does not include breakdown by offences related to substance use; NSPCC annual reports on child safety may include exploitation themes; Barnardo's reports.
6.2.	*Stigmatisation*	Stigmatisation may lead to prejudice and discriminatory practice and behaviour towards both people who use drugs and associated groups (e.g. siblings, children of people who use drugs). This can lead to negative (self) labelling, prejudice, exclusion, and discrimination, which may undermine the provision, access, and the quality of support, and which serves to reproduce and reinforce broader health and social inequity.	Scottish Government Public attitudes towards people with drug dependence and people in recovery research 2016. Stigma frameworks (Stangl et al, 2019) can assist in identifying relevant domains for analysis; Social Media review/ survey.
Harms to others			
7. Injury			
7.1.	*Violence (general)*	Including psychopharmacological, economic-compulsive, and systemic violence	Nature of crime Module from the CSEW ('the victim believed the perpetrator(s) to be under the influence of drugs'); Offending, Crime and Justice Survey
7.2.	*Intimate partner violence*	Including harm resulting from aggression, sexual coercion, psychological abuse and controlling behaviours	Intimate violence Module from the CSEW - victims of partner abuse in the last year are asked whether they thought the offender (or offenders) was under the influence of alcohol or illicit drugs at the time of the incident. In addition, they are asked whether they (the victim) were under the influence of alcohol or illicit drugs at the time of the incident.
8. Accidents			
8.1.	*Traffic*	Including harms related to fatal and non-fatal accidents, property damage, loss of earnings, social costs of injury direct costs (e.g. emergency and health services, courts, traffic delay expenses)	Ministry of Justice (and equivalent bodies in devolved administration) datasets on arrests for recorded crime; Department for Transport Reported Road Casualties Great Britain self-reported drug driving tables; British Social Attitudes
8.2.	*Industrial*		
8.3.	*Personal*		

			Survey; NatCen Omnibus Survey Driver behaviour Module; DVLA data on number of individuals who have been disqualified from driving after a drug-driving offence; Health and Safety Executive (HSE)
8.4.	*Foetal harm*	Long term social harms to children resulting from pre-natal effects of drugs, poor maternal health and wellbeing during pregnancy, or harmful environments during pregnancy. These are distinct from developmental harms	
8.5.	*Developmental*	Including family adversity, economic and emotional wellbeing, and harms resulting from adverse childhood experiences (ACEs) directly and indirectly related to parental/family drug use. Indirect adverse childhood experiences include physical abuse; sexual abuse; emotional abuse; physical neglect; emotional neglect; witnessing intimate partner violence; household mental illness; parental separation or divorce; imprisoned household member. ACEs may cluster and they have been associated with substance use, and behavioural and social problems later in life (including economic costs)	Local routine ACE enquiry data; National ACE Survey Public Health Wales
8.6.	*Crime against others*	Social harms to victim of crime; loss of economic support for family members; increase in acquisitive crime, growth in serious and organised crime, fear of crime leading to a loss in confidence in formal criminal justice structures; fraud and money laundering; corruptions of public official and public office	Ministry of Justice (and equivalent bodies in devolved administration) datasets on arrests for recorded crime; Nature of crime Module from the CSEW ('the victim believed the perpetrator(s) to be under the influence of drugs'); Offending, Crime and Justice Survey
8.7.	*Environmental damage*	Harms resulting from the production of drugs including environmental contamination, deforestation, land (re)appropriation, and	

		unsustainable agricultural and production practices	
8.8.	*Economic costs to society*	Including costs from reduced productivity, loss of productive life years; healthcare; police; prisons; probation; courts; crown prosecution service; implementation of legislation; social services; customs; insurance; societal and personal costs of victims of crime	Academic papers; Government reports
8.9.	*Community costs*	Harms resulting from the impact of drug use, drug markets, and legislative responses on social cohesion, community reputation, perceptions of community safety, and stigmatisation	Local authority Land and Environmental Services routinely collect data on call out responses for needle pickups. These trends give a useful proxy measure of public nuisance associated with drug related litter. National and local trading Standards.
8.10.	*Global harms*	Harms that are borne by producer and transit countries because of drug use in consumer countries and global legislative responses. These include all of the harms described in other categories, destabilisation of government, economies and infrastructure; violent conflict; exploitation and people trafficking. These are harms that may disrupt achievement of the goals of the UN's 2030 Agenda for Sustainable Development	Sustainable Development Goal Indicators (ONS; 2030 Agenda for Sustainable Development)

Information from the World Health Organisation and UNODC. |

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