

**SCOTTISH
DRUG DEATHS
TASKFORCE**

**Scottish Drug Deaths Taskforce Evidence
Paper**

August 2022

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Navigating this paper

The evidence presented and summarised in this paper is split into sections on topics relevant to the research and evidence gathered in preparation for our final report *Changing Lives*. As some topics cover more than one section in our final report the format of this paper does not follow the four section layout of the report. You can navigate the paper by using the contents section to go to a particular topic of interest, alternatively Annex A lists the recommended actions from *Changing Lives* with a link to the sections of this paper that are relevant to each action.

Acronyms

ADPs	alcohol and drug partnerships
BBVs	blood-borne viruses
COPFS	Crown Office and Procurator Fiscal Service
COSLA	Convention of Scottish Local Authorities
DAISy	Drug and Alcohol Information System
DDARS	Dundee Drug and Alcohol Recovery Service
DRNS	Drug Research Network Scotland
DTTO	Drug Testing and Treatment Order
DWP	Department of Work and Pensions
GPs	general practitioners
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HAT	heroin-assisted treatment
HSCP	Health and Social Care Partnership
IEP	injecting equipment provision
MAPPA	multi-agency public protection arrangements
MAT	medication-assisted treatment
MAV	Medics Against Violence Pathfinder
MCN	multiple complex needs
NCS	National Care Service
NES	NHS Education for Scotland
NRS	National Records of Scotland
NFO	near-fatal overdose
NUJ	National Union of Journalists
ODART	Overdose Detection and Responder Alert Technologies (programme)
OST	opioid substitution treatment
POM	prescription-only medicine
RCP	Royal College of Physicians
RRDWG	Residential Rehabilitation Development Working Group
SAS	Scottish Ambulance Service
SDCFs	supervised drug consumption facilities
SDF	Scottish Drugs Forum
SFAD	Scottish Families Affected by Alcohol and Drugs
SIMD	Scottish Index of Multiple Deprivation
SHARPS	Supporting Harm Reduction through Peer Support
SRC	Scottish Recovery Consortium
THN	take-home naloxone
WAND	W ound management, A ssessment of injecting risk, N aloxone supply and D ry blood-spot test for BBV (initiative)

Introduction

Since the Taskforce was established in 2019 we have reviewed and discussed a huge amount of evidence in developing our recommendations and reports prior to our final report *Changing Lives*. Much of this has been covered in our previously published reports and except where necessary we have not gone over the same ground in preparing this paper which covers the evidence used to specifically support the recommendations and action points made in *Changing Lives*. Prior Taskforce publications and the minutes of our meetings can be found on our [website](#).

A variety of sources have been used to inform our recommendations including scientific and academic research, national statistics, government reports, project evaluations, government compiled evidence reviews, academia compiled evidence reviews, independent reviews of drug service provision, information provided from organisations at our request, reports compiled by third sector organisations and updates provided by projects we have funded. Evidence was further discussed at our meetings and the conference we held in April 2022 with wider stakeholders, as well as input from a number of sub-groups, short life working groups and reference groups which have supported our work. We considered evidence from international sources to understand what has worked elsewhere and what could be translated effectively into the Scottish context.

However, it quickly became apparent that a reliance on standard evidence sources would result in standard conclusions that were heavily weighted towards traditional responses to problem drug use. Our members with lived experience of their own and family drug use highlighted that their voices have long been ignored in the design and development of drug services, and one of our key recommendations in *Changing Lives* is that the voice of lived *and living* experience should be listened to, and people with experience of the harms of drug use (their own and loved ones) should be included in all stages of the response to this public health crisis. As such, a great deal of our learning has come from anecdotal evidence that was part of our meetings and broader engagement, rather than from peer reviewed qualitative research. Where this has been supported by other evidence we have included that evidence in the following, however there are instances where such research does not yet exist.

We hope that with a significant shift towards the inclusion of people with lived and living experience that further research will be conducted which places significant value on the voices of these individuals and the organisations which support them. However, we also believe that sufficient evidence already exists to support our recommendations to change the ways in which we are responding to problem drug use and supporting those who experience the harms related to it. Whilst further research is welcome, we cannot wait for it before seeing the changes we have recommended being implemented.

1. What is the cause of Scotland's higher rates?

1.1. High-risk drug use

In the most recent data published for Scotland (2020), in 93% of drug-related deaths more than one drug was present. The average number of drugs implicated has increased from 4 in 2008, to 6 in 2020¹.

This is a rising trend, with benzodiazepines at the forefront. These drugs are part of the relatively new arrivals in the Scottish context – 'street benzo's', unregulated and illegally sourced. Benzodiazepines were present in 73% of all drug related deaths – 'street benzos' were implicated in 66% of all drug related deaths, increasing from 8.2% in 2015

A recent benzodiazepine trend and evidence review² highlights that the harms of street benzodiazepines largely stem from their illicit manufacture and to their often being disguised and sold as genuine medications, with exceptionally high availability and affordability leading to consumption of large quantities.

The use of higher doses – often suprathereapeutic or 'megadoses' – greatly increase the risk of overdose, dangerous drug interactions and adverse effects. Additionally, both their generally shorter half-lives and common side-effect of memory loss may lead to more frequent dosing.

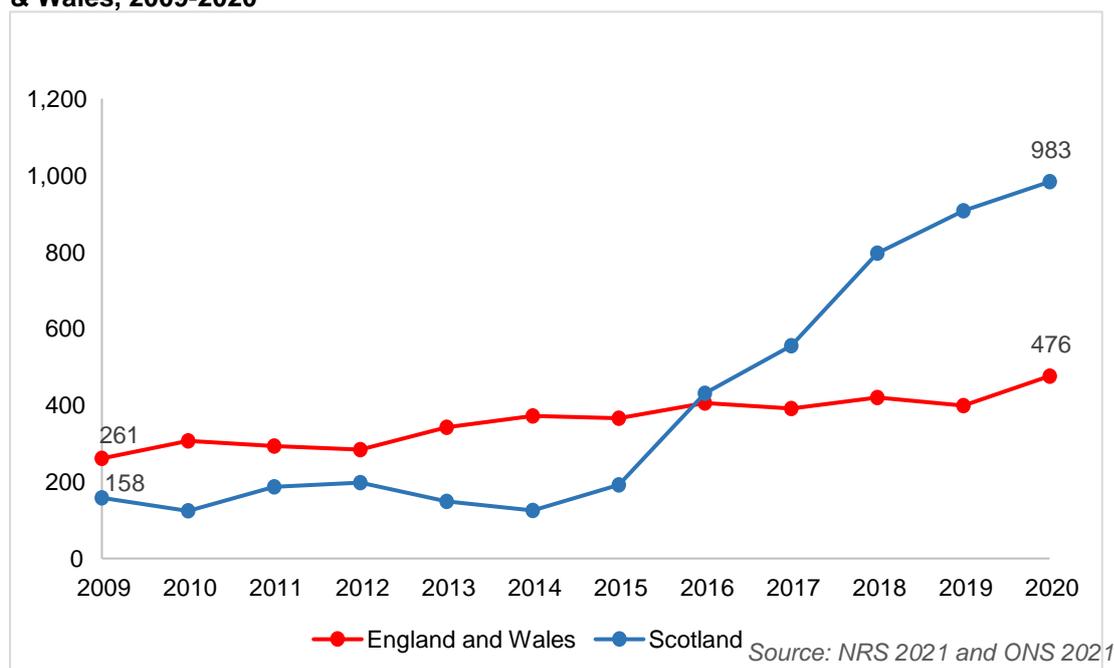
Deaths related to benzodiazepine use are significantly higher in Scotland than in England and Wales, although rates have been increasing in both areas. Figure 1 displays the absolute numbers of benzodiazepine poisoning deaths in Scotland and England and Wales between 2009 and 2020.³ Given Scotland's smaller population, the rates of benzodiazepine poisoning deaths are markedly higher.

¹ National Records of Scotland. (2021). *Drug-related deaths in Scotland 2020* [Online] Available at: <https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/20/drug-related-deaths-20-pub.pdf>

² [Benzodiazepine use - current trends: evidence review - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/benzodiazepine-use-current-trends-evidence-review/pages/1-1-introduction.aspx)

³ Some difference may be accounted for by different toxicology practices among Scotland and England & Wales.

Figure 1: Comparison of the trend in benzodiazepine poisoning deaths in Scotland and England & Wales, 2009-2020



The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) notes that benzodiazepines are related to an increasing proportion of drug-related deaths in several countries, and highlights Scotland as a primary country of concern⁴. The EMCDDA also note growing concerns across Europe around increasing availability of benzodiazepines through prescription diversion or the proliferation of unlicensed benzodiazepines on the illicit market.⁵

It has been noted that a shift has occurred in recent years towards the domestic production of benzodiazepines, particularly etizolam, in Scotland, with “domestic industrial laboratories capable of producing millions of pills per day,” at extremely low cost to consumers⁶.

1.2. A high-risk group

Problematic drug use is different in Scotland than in the rest of the UK, primarily due to its impact; Scotland generally has poorer health outcomes than other areas of the UK⁷ and Glasgow, in particular, is significantly worse when compared to English cities of similar social and economic history, such as Manchester and Liverpool⁸. A study found that the overall burden of drug use disorders is 17 times higher in Scotland's

⁴ EMCDDA (2021). Available at: [Drug-related deaths and mortality in Europe: update from the EMCDDA expert network \(europa.eu\)](https://www.emcdda.europa.eu/en/press-releases/2021/04/2021-04-20-01)

Many countries do not register deaths involving only benzodiazepines as an overdose death, which may affect data reporting.

⁵ EMCDDA (2021). Available at: [European drug report 2021: trends and developments \(europa.eu\)](https://www.emcdda.europa.eu/en/press-releases/2021/04/2021-04-20-01)

⁶ EMCDDA (2021). Available at: [European drug report 2021: trends and developments \(europa.eu\)](https://www.emcdda.europa.eu/en/press-releases/2021/04/2021-04-20-01)

⁷ McCartney et al. (2011). Available at:

https://www.gcph.co.uk/assets/0000/1080/GLA147851_Hypothesis_Report_2_.pdf

⁸ Walsh et al. (2016). Available at: [History, politics and vulnerability: explaining excess mortality in Scotland and Glasgow - ScienceDirect](https://www.sciencedirect.com/science/article/pii/S0965229616300000)

most deprived than its least deprived areas⁹. The most recent figures on drug related deaths published by National Records Scotland (NRS) which covers drug related deaths in 2021 showed that people in the most deprived areas of Scotland are just over 15 times more likely to die as a result of drugs than those in the least deprived areas¹⁰.

In Scotland, there is a high-risk cohort of people who use drugs, whose first exposure began in the 1980s in a post-industrial era when unemployment was high and the heroin market expanded and took hold in deprived communities¹¹.

Cohort effects¹² are considered to be somewhat responsible for trends in drug-related deaths. Research has shown higher drug-related deaths for people born between 1960 and 1980, with those in the most deprived areas, and men, most affected. Additionally, it was noted that people born between 1970 and 1975 were at the greatest risk¹³.

The average age of drug related deaths has increased to 43 years old. In addition, 75% of all drug-related deaths are observed in people aged 34 years and above¹⁴.

Trends in non-fatal drug overdose patient rates provided clear evidence of an ageing patient profile - from 1997/98 to 2019/20, there was an upward trend in patient rates among those aged 35-44 years (14 to 89 patients per 100,000 population)¹⁵. Whilst there was a decrease, the 35-44 age group remained the most common age group with an overdose-related hospital stay in 2020/21.

Among 45-54 year olds, there was also a clear upward trend in overdose patient rates from 1997/98 to 2020/21 (4 to 47 patients per 100,000 population). This was the only age group where overdose patient rates increased considerably from 2019/20 (39) to 2020/21 (47). From 2002/03, an increase in overdose patient rates was observed among those aged 55-64 years (1 to 16 patients per 100,000 population in 2020/21)¹⁶.

1.3. Concentrated social deprivation

'Deprived' does not just mean 'poor' or 'low income'. It can also mean people have fewer resources and opportunities, for example in health and education. Whilst the

⁹ Scot PHO. (2016). Available at: <https://www.scotpho.org.uk/media/1656/sbod2016-deprivation-report-aug18.pdf>.

¹⁰ [Drug-related deaths in Scotland in 2021, Report \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk)

¹¹ Parkinson et al.(2018).Available at: [Drug-related deaths in Scotland 1979–2013: evidence of a vulnerable cohort of young men living in deprived areas | BMC Public Health | Full Text \(biomedcentral.com\)](https://doi.org/10.1186/s12889-018-5267-2)

Pearson (1987). Available at: [Social deprivation, unemployment and patterns of heroin use | SpringerLink](https://doi.org/10.1186/s12889-018-5267-2)

¹² Cohort effects are variations over time, in one or more characteristics, among groups of individuals defined by some shared experience such as year or decade of birth, or years of a specific exposure

¹³ Parkinson et al. (2018). Available at: <https://doi.org/10.1186/s12889-018-5267-2>

¹⁴ National Records of Scotland. (2021). Available at: <https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/20/drug-related-deaths-20-pub.pdf>

¹⁵ Public Health Scotland. (2021). Available at: <https://www.publichealthscotland.scot/publications/drug-related-hospital-statistics/drug-related-hospital-statistics-scotland-2020-to-2021/summary/>

¹⁶ Public Health Scotland. (2021). Available at: <https://www.publichealthscotland.scot/publications/drug-related-hospital-statistics/drug-related-hospital-statistics-scotland-2020-to-2021/summary/>

Scottish Index of Multiple Deprivation (SIMD) is useful to identify areas where people need support, it should be noted that not everyone experiencing disadvantage lives in a deprived area.

In England and Wales from 2009 to 2019, rates of drug poisoning deaths were higher in the most deprived compared with the least; particularly among those aged in their forties where rates reach peaks that are at least 5.5 times higher in the most deprived areas¹⁷.

Figures for 2020 showed that drug misuse death rates in England and Wales have a marked North-South divide¹⁸. The highest rate of drug misuse deaths was in the North East (104.6 deaths per million; 258 registered deaths), while the lowest rate was in London (33.1 deaths per million; 296 deaths).

Scotland has a number of communities which have suffered long-term acute deprivation, in 2020 six council areas had a larger share of the 20% most deprived data zones in Scotland compared with 2016¹⁹.

Deprivation is associated with more people who use drugs in a problematic way, as well as high levels of trauma and adverse childhood experiences, which are recognised risk factors for drug use.

People in these communities suffer multiple, complex disadvantage in terms of poor physical and mental health, unemployment, unstable housing, involvement with criminal justice and family breakdown. Issues around the funding and consistency of access to treatment and support services in the past may have led to insufficient emphasis placed on addressing these underlying issues with psychosocial support.

NRS reported that in 2020, after adjusting for age, people in the most deprived areas in Scotland were 18 times as likely to have a drug-related death as those in the least deprived areas (68.2 per 100,000 population compared with 3.7)²⁰. This has shown a slight reduction to 15 times more likely for people in the most deprived areas to have a drug related death in 2021²¹.

In the early 2000s, those in the most deprived areas were around 10 times as likely to have a drug-related death as those in the least deprived areas²².

¹⁷ ONS. (2020). Available at: [Deaths related to drug poisoning in England and Wales - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/health-and-social-care/deaths-and-mortality/deaths-related-to-drug-poisoning-in-england-and-wales)

¹⁸ ONS. (2021). Available at: [Deaths related to drug poisoning in England and Wales - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/health-and-social-care/deaths-and-mortality/deaths-related-to-drug-poisoning-in-england-and-wales)

¹⁹ ONS. (2021). Available at: [Deaths related to drug poisoning in England and Wales - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/health-and-social-care/deaths-and-mortality/deaths-related-to-drug-poisoning-in-england-and-wales)

²⁰ National Record Scotland. (2021). Available at: <https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/20/drug-related-deaths-20-pub.pdf>

²¹ [Drug-related deaths in Scotland in 2021, Report \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk/publications/drug-related-deaths-in-scotland-in-2021-report)

²² [Drug-related deaths in Scotland in 2021, Report \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk/publications/drug-related-deaths-in-scotland-in-2021-report)

Annual reporting for 2020/21 drug-related hospital stays highlights that patients from the most deprived areas were most likely to experience a drug-related hospital stay with 50% of patients for this period lived in the most deprived quintile²³.

Among people living in the most deprived areas, drug-related patient rates increased steadily per 100,000 population between 1997/98 (171), and 2012/13 (275). A sharp rise in 2019/20 (533) before decreasing (485) in 2020/21. The largest percentage increase over the time series was observed in the second most deprived quintile²⁴.

In 2020/21, 46% of overdose patients lived in the most deprived quintile - overdose patient rates decreased consistently from most deprived to least deprived areas - the overdose patient rate in the most deprived quintile was 83 per 100,000 population compared to 50 per 100,000 population in the second most deprived quintile²⁵.

Additionally, patients from more deprived areas were more likely to experience an overdose-related hospital stay. In each year, just under half of patients with an overdose related hospital stay lived in the 20% most deprived areas in Scotland.

2. Taskforce Funding & Projects

This section provides an overview of funding allocation, projects and governance process.

2.1. Alcohol and Drug Partnership (ADP) direct funding interventions

ADPs received additional funding in 2020/2021 and 2021/2022.

- £3 million per year was identified by the Taskforce for spend by ADPs in 2020/2021 and 2021/2022; allocations were based on the prevalence of drug problems within the area covered by the ADP.
- To receive this funding ADPs were required to submit a proposal, clearly setting out how they would use this funding to address gaps in delivering the Taskforce's six evidence-based strategies to help reduce drug-related deaths.

Using this funding, in excess of 85 interventions were developed by ADPs, based on their local needs to address drug related deaths (see Annex A).

2.2. Research Programme Fund

The [Research Programme Fund](#) was developed in April 2020 (with applications to be submitted by June 2020) to contribute to the evidence base to inform future actions. The purpose of this call for proposals was to ensure that evidence on how we might further understand and act to reduce drug related harms and deaths was the best available and accessible.

²³ Public Health Scotland. (2021). Available at: [Summary - Drug-related hospital statistics - Scotland 2020 to 2021 - Drug-related hospital statistics - Publications - Public Health Scotland](#)

²⁴ Public Health Scotland. (2021). Available at: [Summary - Drug-related hospital statistics - Scotland 2020 to 2021 - Drug-related hospital statistics - Publications - Public Health Scotland](#)

²⁵ Public Health Scotland. (2021). Available at: [Summary - Drug-related hospital statistics - Scotland 2020 to 2021 - Drug-related hospital statistics - Publications - Public Health Scotland](#)

We sought proposals that would contribute to the evidence base on interventions to reduce drug-related deaths and overdose, the experience of people who are most at risk and the services which support them.

The Corra Foundation facilitated review panels with members from a wide range of backgrounds, including those with lived experience, to review and consider applications made to the Research Programme Fund. The final recommendations were presented to the Minister for Drug Policy for endorsement. This resulted in 11 Research Programme Projects (see Annex B).

2.3. Innovation and National Development Fund

The Multiple Complex Needs sub-group created an [Innovation and National Development Fund](#).

Local areas then sent in applications which had to be endorsed by a sub-group of the Taskforce before being reviewed by a panel of Taskforce members, including lived experience representation.

Thirty-two Innovation Fund Projects were provided with funding (see [Annex C](#)). Due to a range of factors including the COVID-19 pandemic and difficulties and delays with recruitment (particularly in statutory services), a number of the projects have been delayed in starting their work, and one project was cancelled. Several remain ongoing and their findings will feed into the Scottish Government's National Mission. Monitoring of the projects has been undertaken by The Corra Foundation, which will continue until the projects conclude. Regular reporting has been provided throughout the development and delivery of the projects, the evidence from which is included in this paper.

2.4. Response to the COVID-19 pandemic

At our April 2020 meeting, considerations of what actions could be taken to respond to the COVID-19 pandemic, with particular regard to addressing harms or deaths which may arise were discussed. A series of actions and recommendations were made to support individuals and services during the pandemic.

Several services shared how they responded to the COVID-19 pandemic on our website:

[Harm Reduction Team Spittal Street- The COVID Response- Rapid access to OST - July 31, 2020](#)

[COVID-19 Pandemic - The Edinburgh Response by Homelessness & Drug & Alcohol Services - July 31, 2020](#)

[COVID-19 – a Catalyst for Edinburgh's Harm Reduction Renaissance? - August 31, 2020](#)

Drug Deaths Taskforce Research Programme Fund 1

Assessing the impacts of novel coronavirus outbreaks on people who use drugs, drug-related deaths and the effectiveness of service responses to them: A systematic review to inform practice and drug policy responses to COVID 19 in Scotland (University of Dundee)

This systematic literature review identified and critically appraised the extant literature relating to the impact of the novel coronavirus outbreaks of the 21st century on people with problematic drug use, with a particular focus on COVID-19, on drug related deaths and other drug-related harms, as well as on service responses to people who use drugs including any evidence of the effectiveness of such responses.

The review found good quality evidence that the pandemic has had serious impacts on thoughts, feelings and behaviours such as stress, anger and feelings of isolation and varied evidence that it reduced quality of life for people who use drugs. However, it stressed that there was a lack of high quality research in this area and limited research relating to the UK or Scotland. It concluded that further robust and high quality research is required to provide empirical evidence to inform responses to future pandemics.

Drug Harms Prevention Research Group, 2021

3. Legal Context

3.1. Misuse of Drugs Act 1971

In Scotland, the subject matter of the [Misuse of Drugs Act 1971](#) (the 1971 Act) is reserved to the UK Government. The main purpose of the 1971 Act and its associated regulations is to regulate the management and use of controlled drugs.

The 1971 Act divides drugs into three classes, and creates a range of offences relating to those substances, including personal possession, production, cultivation, supply, distribution, and allowing a premises to be used for these purposes. The vast majority of recorded drug crimes under the 1971 Act in Scotland are for possession or possession with intent to supply. The legislation does not specify the amounts that would be considered personal possession or supply; the relevant charge is decided in Scotland by the Procurator Fiscal, depending on the circumstances of each case²⁶.

3.2. International Approaches to Drug Law

In March 2021 the Scottish Government published a review of approaches to drug law reform *International Approaches to Drug Law Reform*²⁷. Headline findings were:

- Excessively punitive measures may exacerbate harms; major policing crackdowns had only modest impact on supply and overall tend to exacerbate harms by pushing drug use into more dangerous places with riskier transport and consumption methods.
- There was no clear evidence that decriminalising drugs increases their use but it could lead to net widening where easier processing procedures for lower level drug offences makes the police more likely to formally process people who would otherwise have benefitted from discretion. In general, cannabis decriminalisation provides an opportunity to divert people away from the harms of the justice system.
- A harm reduction approach seems to be effective at reducing deaths: supervised consumption contributed to reducing the number of overdose deaths, as well as improving relationships between police and service users.

3.3. Drug Law Reform

There was a commitment in 2019-20 Programme for Government²⁸ to consult on drug law reform alongside another commitment in Scotland's alcohol and drug strategy to set up a group to advise on the contribution and limitations of the Misuse of Drugs Act (1971) in support of health outcomes in Scotland.

²⁶ Scottish Government. (2021). Available at:

<https://www.gov.scot/publications/recorded-crime-scotland-2020-2021/>

²⁷ Scottish Government. (2021). Available at: <https://www.gov.scot/publications/international-approaches-drug-law-reform/>

²⁸ Scottish Government. (2019). Available at: <https://www.gov.scot/publications/protecting-scotlands-future-governments-programme-scotland-2019-20/>

Our Criminal Justice and Law Sub-group explored how existing drug legislation affects the access of people who use drugs to health and social care services, promotes evidence based public health interventions and how changes could contribute towards a truly public health approach. The intention of this working group was to improve the understanding of the critical barriers in relation to accessing health and social care services under the current legislation and to inform on how the current law affects our ability to implement strategies to reduce drug deaths and drug related harms.

We engaged with more than 100 stakeholders, individuals or organisations, that operate in the intersection between health and justice in relation to drug use, or those that may be impacted by the legislative framework. These included experts in the field, comprising of members of the Taskforce, those who work in Alcohol and Drug Partnerships, Academics, Community Justice Partnerships, third sector organisations, lived experience representatives and family members.

Our Drug Law Reform report, includes thirty proposals for the UK and Scottish Governments and partners²⁹. These range from what can be done in the shorter term and what require wholesale changes, including a root and branch review of the reserved Misuse of Drugs Act 1971, to support a public health approach. Three key themes are identified that could enable a more effective national response:

- Changes within the law – changes to the process and implementation of the existing legal framework, which in Scotland is the Misuse of Drugs Act 1971, itself reserved to the UK Government;
- Changes to the culture surrounding the law – how the re-calibration of the outcomes we want from the implementation of drug laws and moving toward a public health approach (reducing risk and vulnerability), away from crime and punishment could transform their effect;
- Changes to the Law and Regulation – specific areas where current legislation should be amended to better fit the realities and evolving nature of Scotland’s drug and drug deaths challenge. This includes examples such as regulations regarding the prescription and supply of controlled drugs, the control of the supply of pill presses, and the introduction of safer consumption facilities. These examples, amongst others, highlight where current law acts as a barrier to the implementation of a public health approach which the Taskforce believes is a necessity.

There was general support for a move towards decriminalisation or a regulated market but it was highlighted that any moves by government towards regulating, legalising or the decriminalisation of the drug market is a complex issue and requires careful consideration, engagement and consultation on a wider scale.

3.4. Drug Crime in Scotland

The vast majority of recorded drug crimes under the 1971 Act in Scotland are

²⁹ Drug Deaths Taskforce. (2021). Available at: <https://drugdeathstaskforce.scot/media/1248/drug-law-reform-report-sept-6th-21.pdf>

for possession (86%), or possession with intent to supply. Drug crimes account for 50% of “Other crimes”. Over the ten-year period from 2011-12 to 2020-21 this crime has increased by 1%, including a small increase from 35,303 crimes in 2019-20 to 35,410 in 2020-21³⁰.

4. Review of Publications on Scotland’s Drug Problem

We have reviewed a number of Scottish publications which set out strategic approaches and recommendations on drugs, in addition to wider UK reports. This evidence has supplemented the evidence provided by our members and sub-groups.

4.1. Audit Scotland

Audit Scotland conducted a review of Scotland’s drug strategy the *Road to Recovery: a new approach to tackling Scotland’s drug problem* in 2009³¹. This was updated in 2019³² after the updated strategy *Rights, Respect, Recovery* was published and again in 2022³³.

The 2019 update highlighted that:

- stigma presents a significant barrier to treatment and support;
- there is a strong link between problem drug and alcohol use and deprivation;
- the Scottish Government recognised of problem drug and alcohol use as a public health issue, which needs a holistic, human rights-based approach;
- there have been successes with recovery communities and drug harm reduction strategies, singling out Opioid Substitution Treatment, Take Home Naloxone, and the provision of injecting equipment;
- ADPs need to improve partnership working with wider services;
- the cost effectiveness and value for money of the investment made over the last ten years has not been set out;
- the Scottish Government has not identified what level of investment in prevention is required to achieve maximum benefit.

The report provided an assessment of areas where progress will help successful implementation:

- effective performance monitoring;
- clear actions and timescales;
- clear costings;
- linking spending and outcomes;
- public performance reporting;
- evaluation of harm-reduction programmes;

³⁰ Scottish Government. (2021). Available at: <https://www.gov.scot/publications/recorded-crime-scotland-2020-2021/>

³¹ Audit Scotland. (2009). Available at: <https://www.audit-scotland.gov.uk/publications/drug-and-alcohol-services-in-scotland>

³² Audit Scotland. (2019). Available at: <https://www.audit-scotland.gov.uk/publications/drug-and-alcohol-services-an-update>

³³ Audit Scotland. (2022). Available at: https://www.audit-scotland.gov.uk/uploads/docs/report/2022/briefing_220308_drugs_alcohol.pdf

This updated review was ten years on from the 2008 strategy and noted the publication of *Rights, Respect, Recovery* in 2018. It was noted that the development of Drug and Alcohol Information System (DAISy) started in 2013 with a scheduled launch in 2019. This launch date subsequently changed and DAISy was launched in April 2021.

The latest publication in May 2022 provides a further update on the key challenges and areas for improvement:

- progress addressing challenges has been slow since they first reported on drug and alcohol services in 2009, with a lack of drive and leadership by the Scottish Government;
- funding for tackling problem drug and alcohol use reduced over several years but has recently increased significantly;
- spending on drug and alcohol services is difficult to track and needs to be more transparent;
- more focus is needed on prevention and tackling inequalities;
- new initiatives have been introduced over the last few years, but it is too early to assess their effectiveness;
- work is under way to evaluate new initiatives and improve data;
- delivery of drug and alcohol services is complex and clearer accountability is needed;
- a clear integrated plan is needed to show how investment is improving outcomes.

Taking into account the recommendations from Audit Scotland we considered if there was a need for a short term change to the governance of ADPs in advance of the National Care Service (NCS) (see section 34) and determined that whilst the framework it was inconsistently applied across ADPs, therefore a benchmarking is needed to ensure that ADPs are operating as outlined

4.2. House of Commons Health and Social Care Committee

The 2019 House of Commons Health and Social Care Committee report on Drugs Policy³⁴ concluded that UK drugs policy is failing and that a radical change from a criminal justice to a health approach was required. It reported that a health focused and harm reduction approach would not only benefit those people who use drugs but reduce harm to and the costs for their wider communities. It also recommended that the Government should consult on the decriminalisation of drug possession for personal use moving it from a criminal offence to a civil matter. The report recommended examining the Portuguese system, where decriminalisation was implemented as one part of a comprehensive approach to drugs, including improving treatment services, introducing harm reduction interventions, and better education, prevention and social support.

The report specifically supported Heroin Assisted Treatment (HAT), naloxone, needle and syringe exchange, drug checking at festivals and within the night time economy and pilots of safer drug consumption rooms. It recommended a comprehensive package of education, prevention and support measures focused on prevention of

³⁴ House of Commons. (2019). Available at: [Drugs policy \(parliament.uk\)](https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care/committees-reports-and-publications/2019-drugs-policy/)

drug use amongst young people, as well as the establishment of a central drugs policy agency, which could coordinate drugs policy responses between departments.

4.3. Scottish Affairs Committee Inquiry

The Scottish Affairs Committee 2019 report *Problem Drug Use in Scotland*³⁵ is one of the most extensive drugs inquiries in Scotland and was built upon the findings of many experts.

The Inquiry heard that the Misuse of Drugs Act 1971 is:

- outdated,
- its classification system is arbitrary, and
- that it is fundamentally incompatible with a public health approach.

It concluded that if the UK Government is to implement a public health approach, as the Committee called for, then the 1971 Act must be substantially reformed.

The inquiry advised that the UK Government should declare a public health emergency and that both governments should be open to implementing innovative evidence based solutions. It called for radical whole-system change and criticized welfare sanctions from the Department of Work and Pensions (DWP) stemming from problem drug use. The report supported the call from the Health and Social Care Committee to transfer responsibility for drugs policy from the Home Office to the Department for Health and Social Care, a shift which has already occurred in Scotland.

The report outlined that there was more the Scottish Government could and should be doing within its powers including in mental health, housing, education, community regeneration, policing and justice. It also commented on the need for properly funded services.

4.4. Dundee Drugs Commission

The Dundee Drugs Commission was established in 2018. The remit of the group was to better understand the problem of drug related harms and deaths in Dundee and to identify solutions. It was also hoped that new strategies, developed to tackle problem drug use in Dundee, could be shared across Scotland.

The initial report was published in 2019 concluding that there needs to be³⁶:

- challenge and elimination of stigma towards people who experience problems with drugs, and their families;
- a levelling of the 'playing field' to ensure that all partners, statutory and third sector are held equally accountable. This is necessary to enhance patient safety and quality of provision;

³⁵ Scottish Affairs Committee. (2019). Available at: <https://publications.parliament.uk/pa/cm201919/cmselect/cmsscota/44/4402.htm>

³⁶ Dundee Drug Commission. (2019). Available at: <https://www.dundee.gov.uk/sites/default/files/publications/part1reportfinal.pdf>

- meaningful involvement of people who have experienced problems with drugs, their families and advocates;
- recognition that choice is important and people should have access to the full menu of services to support recovery;
- services that prioritise access, retention, quality of care and safety, including having an unambiguous 'no unplanned discharges' policy alongside optimised OST; psychological treatments; assertive outreach; and broad integrated care;
- changes to primary care and community pharmacy;
- integration of substance use and mental health services;
- progress to address the root causes of drug problems and appropriate and specific support for women, children and young people;
- consideration by Scottish Government on equal regulation of the whole substance use services/treatment sector;
- clarity on how the declaration of a public health emergency will unlock any new powers or resources;
- devolution of powers from the UK government should allow for a full Scottish review of drug laws.

The most recent report³⁷ and evidence paper published in 2022³⁸ provides an update two years on from their initial report.

Positive changes outlined in the 2022 report were:

- senior leader engagement had increased and a joint commitment has been made to achieve the desired level of change;
- there is greater clarity of governance and accountability, particularly the role of Dundee Health and Social Care Partnership (HSCP);
- the restructuring of Dundee Alcohol and Drug Partnership (DADP) membership, including an independent Chair leading has resulted in participation and work stream levels improving;
- there has been increased Public Health involvement – a significant achievement, particularly given the pressures faced due to COVID-19 over the past two years;
- there remains a genuine desire from statutory and third sectors to make things better in Dundee.

However, the report highlights that there are areas where further progress is still required:

- the pace of change is too slow and the root causes of drug related harms and deaths are not being tackled;
- a clear line of sight is needed between the Dundee Partnership and clinical leaders of the Dundee Drug and Alcohol Recovery Service (DDARS);
- decision making as to who should lead/manage substance use services is needed;

³⁷ Dundee Drug Commission. (2022). Available at: https://www.dundee.gov.uk/sites/default/files/publications/ddc_review_-_part_1_-_the_report_-_final.pdf

³⁸ Dundee Drug Commission. (2022). Available at: https://www.dundee.gov.uk/sites/default/files/publications/ddc_review_-_part_2_-_supporting_evidence_-_final.pdf

- access to quicker treatment is needed and there have been missed opportunities to break down barriers – the report stated that “*things are worse now [in terms of treatment] than before the pandemic*”;
- the programme of cultural change received the greatest criticism; the report stated “*there has been limited visibility of such change and people have certainly not experienced a shift in the culture*”;
- the type of distributed leadership envisioned has not been seen or experienced;
- stakeholders are not aware that Dundee has focused on immediately implementing learning from elsewhere.

4.5. The Royal College of Physicians of Edinburgh

The Royal College of Physicians (RCP) of Edinburgh 2021 report *Drug Deaths in Scotland: an increasingly medical problem*³⁹ is based on the views of leading experts. It asked that serious, evidence-based consideration is given to the issue of the decriminalisation of drug use in Scotland. The report recognises that Scotland’s drug deaths crisis is complex, but says much more can be done to tackle the problem, including action on harm reduction and on the social determinants of drug use. It believes that bold policies, such as decriminalisation of the possession of drugs, safe drug consumption facilities, and rolling out a heroin assisted treatment programme in all major centres in Scotland should be considered to help reduce drug- related harms.

5. Lived and living experience

5.1. Lived experience reference group

We set up a lived experience reference group to contribute to discussions and provide feedback on research, evidence and the proposals from the perspective of those with experience of problem drug use and the support and treatment services and pathways that are and have been available. The reference group provided valuable insight in the discussions, which has fed into all our work and the recommendations and actions laid out in *Changing Lives*. However the most fundamental learning that we have taken from working with this reference group and the families reference group (see section 6.2) and from the family and lived experience representatives on the Taskforce is the necessity to include voice of experience, both lived and living, in every aspect of the response to drug related deaths and harms. It will not be possible to implement effective changes without understanding the needs and experience of those who have and have and are experiencing those harms.

5.2. Peer Support

Research conducted by Drug Research Network Scotland (DRNS) for the Multiple Complex Needs sub-group⁴⁰ (see section 10) highlighted the importance of peer-led approaches and advocacy in support services. Peer workers can be preferred by clients for support, greater safety and can be better able to connect and communicate

³⁹ Royal College of Physicians of Edinburgh. (2021). Available at: https://www.rcpe.ac.uk/sites/default/files/drugs_deaths_in_scotland_report_final_0.pdf

⁴⁰ A list of evidence reviewed for this rapid evidence synthesis is available in [Annex E](#)

due to shared life experiences. It was identified that it would be important to develop and embed a range of peer-led, mutual aid support services.

The importance of support for peer volunteers as well as providing pathways into paid support roles was also present in the evidence reviewed, with a need for peer support to be clearly defined, and for peer and lived experience roles to be recognised for their value and importance in supporting individuals through an often long and challenging process. The knowledge and experience that is contributed cannot be learned and is invaluable when reaching a vulnerable person and as such peer support workers should be funded and receive remunerations akin to any other skilled individual.

As any other skilled worker would expect to progress in their career, peer support workers should also be able to develop and progress in their careers with defined pathways for progression.

Need for Peer Support in both Statutory Services and Third Sector

Our assertive outreach short-term working group (see section 20.6) considered the value of peer support in assertive outreach, however the points put forward by them are applicable to all peer support and lived experience workers.

Key points raised were:

- peer support should not be seen as a service people can be referred to when services do not know where else to send them;
- it should be possible for gain experience in peer support without it being considered unpaid work and therefore affecting benefits;
- peer support cannot just be seen as a cheaper option;
- there has to be funding for career progression;
- peer support workers are continually managing their own recovery. They should be supported to avoid relapse. Vicarious trauma needs to be addressed and there needs to be support built in for this, which should be clearly built into funding considerations;
- there needs to be a statement that the third sector are equal partners in this;
- a full assessment of learning ability is needed. Education is critical to supporting people to develop and allowing their past to become the past ensuring this ceases to define them.

6. Families

6.1. Family Inclusive Practice

The Scottish Government strategy for drug and alcohol treatment *Rights, Respect and Recovery* acknowledges that families are assets and are key partners⁴¹. The strategy promotes families having the access to support in their own right as well as the right to be involved in their loved one's treatment and support, as appropriate. Families come in many shapes and sizes, they can play a vital role in recovery and reduce the risk of drug and alcohol related deaths, even where relationships are fragile or damaged.

⁴¹ Scottish Government (2018). Available at: <https://www.gov.scot/publications/rights-respect-recovery/>

Consistency and stability in everyday family life often means families affected by substance use are in contact with universal services to meet their fundamental needs such as:

- housing;
- opportunities for employment and training/education;
- benefits and debts;
- accessing affordable childcare;
- families spending time together;
- ability to visit a family member in prison.

Family inclusive practice holds families at the heart of service design, implementation, evaluation and workforce development, as well as family inclusive systems change and improvement⁴². This should take into account the perspectives of different family members, capturing diversity including race, gender and sexuality and lead to the development of a variety of pathways to access positive/consistent support for all families in a safe and responsive way.

Change in family dynamics and circumstances will invariably create times where families require additional support and stability. The whole family approach workforce needs to have the right levels of awareness and be able to adapt and respond to these circumstances. Building trusting, respectful, bounded relationships along with motivation to sustain change is essential. Recent Scottish based research⁴³ recognises the importance of this relationship-based practice, with consistent, reliable, flexible, accessible, and long-term support.

Family Inclusive Practice is more likely to exist and develop where services have a culture and ethos of openness and transparency, demonstrably respecting individuals and understanding and respect their lived experience. Similarly, an understanding of the issues faced by families – individually and collectively and that families are key to so many aspects of progress – with a commitment to helping family members grow through awareness and accumulation of knowledge, skills and resilience.

6.2. Family Reference Group

The Family Reference Group was initially independently set up to support the Families' Representative on the Taskforce and was formally adopted by us as a sub-group in 2021. The group have published a report on their experience of supporting our work⁴⁴. The work of the group, and the need to support families with experience of drug related harms and deaths goes beyond stigma and the need for fundamental cultural change and the work of the reference group has fed into the work across all sections of *Changing Lives* and our previous publications. However, the stigma that is experienced by the families of people who use drugs, and the barriers that they face

⁴² Scottish Government (2021). Available at: <https://www.gov.scot/publications/improving-holistic-family-support-towards-whole-family-approach-family-inclusive-practice-drug-alcohol-services/pages/8/>

⁴³ Scott. (2019). 'What works for children and young people in family support'
SFAD et al (2021) Available at: [Supporting documents - What do we already know? our whole family evidence bank: report - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/supporting-documents-what-do-we-already-know-our-whole-family-evidence-bank-report-gov.scot/pages/8/)

⁴⁴ [What-About-Families-Family-Reference-Group-Report-July-2022-FINAL-PUBLISHED.pdf \(sfad.org.uk\)](https://www.gov.scot/publications/what-about-families-family-reference-group-report-july-2022-final-published/pdf/pages/8/)

when supporting loved ones, as well as the harms they experience themselves were identified as key areas for change that are specific to the experience of family members.

Engagement with the family reference group highlighted additional examples of stigma and the effect this has:

- disenfranchised grief where following a substance related death families do not feel like they deserve support or sympathy which complicates the grief point;
- support for families is seen as conditional on the basis that a loved one needs to be accessing or engaged in some form of treatment for families to receive help or support;
- levels of trust in services are affected and vice versa; as families detach from services there are delays in seeking support that come with increasing risk of harm within the family;
- families are afraid to come forward for fear of threats from speaking up about illicit behaviour, supply of substances and stay silent to avoid exposure, negative consequences or threats from violence over debts;
- families can become complicit in hiding or minimising the extent of substance use in the family or seek to prevent those using substances from making changes; often leading to tensions/conflict within the family;
- the broader prevention agenda can be hampered if there is a lack of visibility of families. The result of this being limited access opportunities for early intervention to reduce cycles of substance use, this in turn may impact on mental health, wellbeing and relationships and future coping strategies for Children and Young People.

Project: *Holding On (Scottish Families Affected by Alcohol and Drugs (SFAD))*

The Holding On project aimed to work with family members who are deeply concerned about their loved one's substance use with a particular focus on drugs. Family members can self-refer to the service or this can be done on their behalf. The project has specific criteria utilising an initial risk assessment to confirm those with a medium to high level of risk, the risk assessment will look at factors such as had the loved one had a recent Near-Fatal overdose, concerns around self-harm, homelessness, recent discharge from prison or residential rehab etc. However, for those who are concerned about their loved one but the level of risk is deemed lower than the criteria for the Holding On project there will still be support offered through Scottish Families.

The purpose of the project is to create a bespoke package of intensive support for the family, depending on their specific situation. For example, Naloxone training, Community Reinforcement and Family Training (CRAFT), specific tailored training that suits the needs of the family, working with family members on their own self-care, connecting family members with other family members virtually through the use of online platforms i.e. video calls, empowering families and looking at self-advocacy/family rights.

The project has received 39 referrals since its inception. This is fewer referrals than originally planned (annual target for 2021/22 was 65 referrals), however the intensity of the support required has been much greater than originally anticipated. Between 1 April 2021 and 28 February 2022, 495 one to one support sessions for Holding On family members were provided.

Scottish Families has been named as one of the 10 winners of the UK-wide 2022 GSK Impact Awards which recognise excellence in health and social care. In making the award, the judges noted in particular their ongoing delivery and development during the pandemic; the range of flexible support services for families, as well as their ability to influence and shape substance use policy. The judging panel were also impressed by Scottish Families' work to reach those most in need, and cited the *Holding On* service as part of this.

SFAD, update to CORRA Foundation, March 2022

7. Stigma

7.1. Stigma Strategy 2020

In 2020 we worked with Scottish Drugs Forum (SDF), Scottish Families Affected by Alcohol and Drugs (SFAD) and Scottish Recovery Consortium (SRC) to develop our Stigma Strategy *A strategy to address the stigmatisation of people and communities affected by drug use – we all have a part to play*⁴⁵. We drew upon evidence from Scottish communities, Taskforce engagement activity and international academic literature and reports. The Stigma Strategy sets out the evidence base for addressing stigma.

7.2. Services and Treatment

The *Alcohol and drugs workforce: mixed methods research compendium*⁴⁶ published by Scottish Government in March 2022 highlighted issues around stigma that were present in services. Services that work with people with substance use problems are stigmatised. This may explain under investment and the often poor physical location and condition of these services. Such services can seem isolated within wider treatment and support systems. Some people who may benefit from using these services refuse to engage with them because of the associated stigma. People delay engagement with services because the services themselves are stigmatised. In Scotland, the medical treatment received by people with an opiate-based drug problem is stigmatised and people in receipt of this treatment can be doubly stigmatised.

Medication assisted treatments (MAT) are often stigmatised by assumptions, frequently propagated through the media; that compulsive drug use is a choice, that methadone is a crutch, that methadone simply replaces one ‘addiction’ with another, and that methadone prolongs addiction. Further, those on methadone maintenance are encouraged to lower their dose and end treatment as soon as possible regardless of personal circumstances. Evidence suggests this can lead to relapse⁴⁷. The stigma associated with taking long term medication seems to be significantly greater with medication for problem drug use than that for other conditions.⁴⁸

We also gathered anecdotal evidence of the often stigmatising nature of the physical locations of support services, with people being required to travel through multiple security doors and sit in isolation before being seen, a lack of privacy in pharmacy settings when receiving MAT prescriptions, facilities in poor condition and in unwelcoming hidden away locations.

⁴⁵ [Stigma Policy and Strategy | Drug Deaths Taskforce](#)

⁴⁶ Scottish Government. (2022). Available at: <https://www.gov.scot/publications/scotlands-alcohol-drugs-workforce-compendium-mixed-methods-research/documents/>

⁴⁷ White. (2009). *Long-term strategies to reduce the stigma attached to addiction, treatment, and recovery* Available at: www.williamwhitepapers.com

⁴⁸ Scottish Government. (2022). Available at: <https://www.gov.scot/publications/scotlands-alcohol-drugs-workforce-compendium-mixed-methods-research/documents/>

Many in recovery report brief and superficial interactions with counsellors and other support workers when on methadone maintenance treatment; these include arbitrary dose restrictions, restrictions on duration of treatment, disciplinary discharge from programmes for other drug use, and shaming rituals such as public queueing and observed urine drops for testing. This exacerbates stigma for those in treatment. Furthermore, internalised stigma can lead to an elaborate pecking order within the illicit heroin culture which often carries over into the culture of methadone treatment⁴⁹. People engaged in treatment and support as well as those with lived and living experience should bear in mind the nature, extent and impact of this internalised stigma. Many personal narratives, including recovery narratives, are often imbued with notions based in stigma and so transmit rather than challenge stigma.

A rapid evidence synthesis conducted by DRNS for the Multiple Complex Needs subgroup⁵⁰ (see section 10) made the following suggestions for actively addressing service and societal stigma based on the evidence analysed:

- training around stigma and engagement should be provided for those working with people who use drugs with multiple, complex needs;
- service providers must review their services for evidence of systematic stigmatisation and proactively counter it;
- involve people with lived experience and affected family members in official forums and service provision to help break the stigma attached to homelessness, mental health and substance use problems, by valuing lived and living experience;
- ensure a well-planned approach to public relations via community education that appeals to community values, presents the evidence, and addresses concerns of major stakeholders;
- disrupt stereotypes regarding personal choice and fatalism connected to homelessness, substance use and criminal justice system contact;
- highlight policy decisions and structural causes of inequalities and collective solutions.

The Women's working group (see section 12.2) highlighted that the impact of stigma may be particularly important for women. Due to societal norms and expectations those who are mothers are likely to face added stigma. Stigmatising attitudes can be held by service providers as well as peers, family members and wider society. This can make it significantly harder for women to be honest and open, seek help and access treatment. Women involved in transactional sex are doubly stigmatised. They may fear criminalisation due to their involvement in transactional sex as well as their drug use.

⁴⁹ Scottish Government. (2022). Available at: <https://www.gov.scot/publications/scotlands-alcohol-drugs-workforce-compendium-mixed-methods-research/documents/>

⁵⁰ A list of evidence reviewed for this rapid evidence synthesis is available in [Annex E](#)

7.3. Alcohol and Drug Workforce

A mixed methods research compendium conducted by Scottish Government⁵¹ identified that services need to have sufficient staff with the appropriate skills and training; this is a complex, multi-level workforce and there are several tiers of services in Scotland which work with people who use drugs and alcohol⁵². All tiers provide an important aspect of support and treatment for people who use drugs and alcohol.

Tier 1 services provide drug and alcohol related information and advice, and signposting, and are typically agencies whose primary focus is on providing another service, for example the Scottish Ambulance Service, A & E Departments, Housing Officers etc.

Tier 2 services have more structured input for people who use drugs and alcohol, and provide drug and alcohol related advice and information, harm reduction interventions, triage assessments and referral on to specialist services. Tier 2 services are provided by GPs, outreach services, pharmacies and criminal justice settings where people who use drugs are detained or on programmes such as a Drug Treatment and Testing Orders (DTTOs).

Tier 3 services are specialist drug and alcohol assessment and intervention services.

Tier 4 services are residential services.

The issue of stigma among the workforce was a factor present in the literature. This was more commonly noted in relation to staff in tier 1 and tier 2 services but was also noted in relation to staff in tier 3 specialised services. Stigma was conceptualised variously as the perception that people who use drugs and alcohol were viewed negatively⁵³, or were to blame for their substance use and its consequences. Stigma, as discussed in the literature, was not necessarily expressed verbally, although this could be the case, but was present in the way services were designed and operated and in the way in which staff viewed and treated people who use drugs and alcohol.

An international review demonstrated that staff regard among health care professionals towards people who use drugs was found to be more negative than towards other patient groups such as people with depression or diabetes. Staff not only reported feeling negative attitudes towards service users but health professionals often report that caring for people who use drugs can be unrewarding and unpleasant⁵⁴. Staff who worked in more specialist settings with people who use drugs were found to have a more positive regard, with the researchers attributing this to more specialised training among this group, and to a younger workforce which had undergone this training more recently. This research was undertaken across a number of countries in Europe, including Scotland, so it is fair to conclude this is an issue which is not unique to Scotland.

⁵¹ Scottish Government. (2022). Available at: <https://www.gov.scot/publications/scotlands-alcohol-drugs-workforce-compendium-mixed-methods-research/documents/>

⁵² Scottish Government. (2022). Available at: <https://www.gov.scot/publications/scotlands-alcohol-drugs-workforce-compendium-mixed-methods-research/documents/>

⁵³ Clark et al. (2014) Available at: 24408- AssessingTheAvailabilityOfAndNeedForSpecialistAlcoholTreatment.pdf (healthscotland.com)

⁵⁴ Gilchrist et al. (2011). Available at: [Staff regard towards working with substance users: a European multi-centre study](#)

As well as being present among professionals the review highlighted that, in Scotland, people who use drugs recognised that they were being negatively perceived and treated. Researchers found that people who use drugs and alcohol experienced stigma from staff in primary health care settings including acute hospital settings, pharmacies, GPs and Consultants and also in other services such as housing. One report noted that older people who use drugs experienced additional stigma because there was not only a negative view among staff regarding their drug use, but also a perception that they should not continue to do so at their age. Some older people who use drugs also believed that specialist services were geared towards younger people, and were more willing to work with and help them because they had a longer future ahead of them.

Researchers found that the impact of stigma included people who use drugs being given inadequate treatment for issues such as pain, barriers (perceived or actual) being put up for people who use drugs to access services and that people who use drugs could be reluctant to engage with services because of being stigmatised. Training for the workforce on stigma was recommended in the literature.

7.4. Third Sector Services

The *Dundee Drug Commission two year review*⁵⁵ reiterated their concern around third sector services engaged in work around substance use in Dundee, specifically regarding the relationship with DDARS.

Consultations throughout the review evidenced that the Third Sector still feel that there is a vastly 'unequal playing field' when it comes to available funding. Whilst the recent additional funding has been welcomed, there has been challenges such as:

- the significant time required to complete funding applications having a detrimental impact on the ability to continue with existing responsibilities;
- recruiting to short-term posts;
- uncertainty of new developed services being sustainable long-term;
- the focus being taken away from any long-term redistribution of core funding towards the third sector.

It was noted that communication and relationships between the services had showed signs of improvements following the publication of *Kindness, Compassion, Hope* in 2019⁵⁶ which was associated to co-locating DDARS staff within third sector services to meet and work with individuals, however, this review noted the impact of COVID-19 restrictions on the progress.

The review concludes that many Third Sector voices are still restrained from speaking honestly for fear of the perceived consequences of so doing and the necessary progress in regard to creating the right conditions for this change in culture and partnership working still needs to be made. The review also identified that there are differences in the self-assessment in relation to the role and place of the Third Sector when compared to their findings.

⁵⁵ Dundee Drug Commission. (2022). Available at:

https://www.dundee.gov.uk/sites/default/files/publications/ddc_review_-_part_1_-_the_report_-_final.pdf

⁵⁶ <https://www.dundee.gov.uk/sites/default/files/publications/part1reportfinal.pdf>

The Commission concluded that the ongoing situation will require increased genuine and extensive efforts over the long-term. Developing a clear plan towards establishing an equal and reciprocal partnership between all partners, rather than focusing on the involvement and engagement of the Third Sector as led by statutory partners has to be prioritised.

These concerns have also been seen by the Taskforce in the challenges faced by many of the Third Sector organisations funded through the innovation fund. Many organisations have found working with statutory partners challenging as a result of a reluctance to share data and engage in new ways of working.

7.5. Equalities Issue

Prejudice, stereotype and discrimination are three related concepts. Understanding these reveals the close link between stigma and inequalities⁵⁷.

Prejudice can be understood as a preconceived negative attitude often associated with stigma.

Stereotypes are common, oversimplified or even totally false, conceptualisations of a group of people based, in part at least, on stigma. Stereotypes help perpetuate stigma.

Discrimination occurs when people's action reflects their prejudice in ways that impact on people who are the subject of their prejudice.

This has practical impacts on the lives and wellbeing of the people affected. Discrimination is rooted in a power imbalance between people. Stigma therefore results in inequalities and is an equalities issue. This is perpetuated by the Equality (Disability) Act 2010 (the 2010 Act) which explicitly excludes an individual's "drug or alcohol dependence" from the protected characteristic of disability under the 2010 Act, unless that addiction "*was originally the result of administration of medically prescribed drugs or other medical treatment.*" There are very few explicit exemptions to the Equality Act - others include, tendencies "to set fires", "to steal", and "to physically and sexually abuse people". Categorising people who use drugs with these behaviours promotes the concept of deviant behaviour. It clearly categorises problem drug use as a behaviour that should be punished⁵⁸.

7.6. Addressing Stigma

Several frameworks addressing the social (e.g. cultural and gender norms) and structural (e.g. legal environment and health policy) pathways leading to general health stigma have been proposed⁵⁹. A number of reviews and evidence based toolkits exist for strategies to address stigma. Some target all substance use, some refer to

⁵⁷ Drug Deaths Taskforce. (2020). Available at: <https://drugdeathstaskforce.scot/news-information/publications/policy-and-strategy/stigma-policy-and-strategy/>

⁵⁸ Scottish Affairs Committee. (2019). Available at: [Problem drug use in Scotland - Scottish Affairs Committee - House of Commons \(parliament.uk\)](https://www.parliament.uk/commons/debates/2019-03-14/problem-drug-use-in-scotland)

⁵⁹ Stangl et al. (2019). Available at: <https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-019-1271-3>

'addiction'⁶⁰, and some focus on mental health including drug and alcohol use⁶¹. A review⁶² on the stigma specifically towards people who use drugs covered the nature of stigma, particular stigmatised groups and the role of the media rather than evidence of strategies to address stigma. The review discussed what can be done to tackle stigma, drawing on evidence from the mental health literature which was all that was available and identified three approaches to address the stigmatisation of mental health: i) protest, ii) education and iii) contact.

These strategies are developed further in a more recent review by the US National Academy of Sciences (NAS) report which provides a comprehensive review of the evidence on what works for stigma change⁶³. This review details five areas, which are essentially an expansion of the three areas already noted above. These include; Protest and advocacy, Education, Contact (social contact), Peer programmes, and Media campaigns.

Protest and Advocacy is the formal objection to negative portrayals of people with drug problems or lived experience. Groups such as journalists, politicians, community leaders and professional groups can be targeted. Legal challenge could be considered, for example challenging the 2010 Act exemption for people with drug or alcohol dependence. The evidence base for this approach is less well studied than other strategies but there are parallels with the HIV/AIDS movement in which campaigns were considered successful at addressing misperceptions. One study advocated that using professional voices can help to advocate and counter negative perceptions⁶⁴.

Education based campaigns use factual information to address stigma by confronting negative beliefs and incorrect information. A robust meta-analysis review of public stigma-reducing interventions found educational programmes reduced stigma towards mental illness⁶⁵. Some education campaigns also aim to improve health literacy. This approach aims to inform and educate, not only on the condition, but on how to seek help. The evidence from the mental health field suggests this can be effective and evaluations of targeted groups such as young people, ethnic minorities and families were effective. This is of relevance to the drug and alcohol field in which there is a need to increase engagement with support services.

Contact with people with lived and living experience has proved effective in the mental health field. There is also evidence from professional groups in Scotland that experience of working with people with drug problems is associated with improved attitudes towards that group over time⁶⁶.

⁶⁰ Landry. (2012). Available at <https://attcnetwork.org/sites/default/files/2019-04/Anti-Stigma%20Toolkit.pdf>

⁶¹ NAS. (2016). Available at: <https://nap.nationalacademies.org/catalog/23442/ending-discrimination-against-people-with-mental-and-substance-use-disorders>

⁶² Lloyd, C. (2013). The stigmatization of problem drug users: A narrative literature review. *Drugs: Education, Prevention, and Policy*, 20(2), 85-95

⁶³ NAS. (2016). Available at: <https://nap.nationalacademies.org/catalog/23442/ending-discrimination-against-people-with-mental-and-substance-use-disorders>

⁶⁴ Peek et al. (2015). Blogging and social media for mental health education and advocacy: a review for psychiatrists.

⁶⁵ Griffiths et al. (2014). Effectiveness of programs for reducing the stigma associated with mental disorders.

⁶⁶ Matheson et al. (2014) Public opinion of drug treatment policy: exploring the public's attitudes, knowledge, experience and willingness to pay for drug treatment strategies. Available at: [Public opinion of drug treatment](#)

Peer Programmes are a form of contact that have been found to be effective. Peer services include having people with lived experience in health and support services which “provides a counterbalance to the discrimination, rejection and isolation people may encounter when trying to seek mental health or substance use treatment or services”⁶⁷.

Media Campaigns were discussed at length in the NAS review with several high profile media campaigns around mental health considered such as the *See Me* campaign in Scotland. There is evidence from the mental health field that public information campaigns can have a role in addressing negative perceptions⁶⁸. Evidence suggests that campaigns based on education or contact with people affected by stigma, or education have been considered the most effective at reducing the stigma of mental health⁶⁹.

The NAS review was supportive of media campaigns but strongly endorsed the application of communication science to ensure appropriate messaging to targeted audiences. From assessment of a number of national campaigns this review also found that changing attitudes of the general public is a long term project that requires sustained effort. Important to the success of any media campaign are that it should have well defined goals and be targeted to defined audiences in a manner in which messages are repeated and reinforced⁷⁰.

However, some might feel concerned that media campaigns confer a fixed identity to specific groups whereas people’s identity can change and there needs to be careful messaging to not fix a person to a particular identity. Using a communication science informed approach requires the range of attitudes and beliefs in the target group to be identified. Development of a message strategy and an implementation plan are key components of a successful campaign. The message source must be credible and the message should be specific and focused.

There is evidence to support the use of protest and advocacy, education and, contact based strategies and these can be delivered through targeted protest, contact based education, peer support and targeted media campaigns that use communication science to ensure messaging is appropriate.

7.7. Media Case Study - Research Project

SFAD and the Scottish Recovery Consortium (SRC) undertook a research project in 2020⁷¹ to answer the question: “how addiction and recovery is being portrayed in the Scottish media?”. The research methodology included a thematic analysis of media articles and reports from late 2017 to mid-2019, with a total of 23 news articles and

[policy: exploring the public's attitudes, knowledge, experience and willingness to pay for drug treatment strategies - PubMed \(nih.gov\)](#)

⁶⁷ NAS. (2016). Available at: <https://nap.nationalacademies.org/catalog/23442/ending-discrimination-against-people-with-mental-and-substance-use-disorders>

⁶⁸ Corrigan et al. (2012). Challenging the public stigma of mental illness

⁶⁹ Corrigan & Rao. (2012). On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change.

⁷⁰ Griffiths et al. (2014). Effectiveness of programs for reducing the stigma associated with mental disorders.

⁷¹ Scottish Families Affected by Alcohol & Drugs. (2020). Available at: <https://www.sfad.org.uk/new-report-insert-standard-stigmatising-headline-image-here>

reports reviewed/analysed; consultation with SFAD and SRC's recovery communities through an online survey and face-to-face workshop and a review of National Union of Journalists (NUJ) *Responsible Reporting on Mental Health, Mental Illness and Death by Suicide* guidelines.

This resulted in six recommendations on best practice to journalists and editors for reporting on problem drug use and recovery. A [further toolkit](#) was published by SFAD and Adfam in June 2022. This includes more in depth recommendations for media and we strongly endorse the adoption of these recommendations.

8. No Wrong Door

No wrong door is a model or approach taken in the integration of health and social care services to increase collaborative partnerships, improve access to treatment, quality of care and outcomes for various groups. It has been used to link mental health and substance use services. It is grounded in the idea that no client should be turned away from treatment; rather, it is necessary to establish where the client will receive the most appropriate care. When a person presents at a facility that is not equipped to provide a particular type of service, they should be guided to appropriate facilities⁷².

People who use drugs will often experience a range of other difficulties in their lives. Including issues with family relationships, employment, housing, debt and offending behaviour⁷³. Substance use issues can impact on all of these areas and vice versa. In order to help an individual with substance use problems a wide range of connected resources, responses and support is required.

Service providers may deliver a less than effective service if they are not appropriately linked or integrated with other complementary services. For instance, they may lack access to relevant information about an individual from other support services. They may also miss the opportunity to involve other agencies who could become involved in an individual's care improving their situation and supporting treatment and recovery⁷⁴.

Service users (and indeed providers) can often feel that there is no communication between agencies leading to frustration and disappointment for them⁷⁵. Service users also commonly feel that support is weighted towards the beginning of the recovery process and lacking in ongoing support, jeopardising this process in the long-term⁷⁶.

⁷² Australian Comorbidity Guidelines. (2022). Available at: [Adopt a 'no wrong door' policy \(comorbidityguidelines.org.au\)](#)

⁷³ [Integrated Care for drug users: Principles and practice: Contents Page \(scot.nhs.uk\)](#)

⁷⁴ [Integrated Care for drug users: Principles and practice: Contents Page \(scot.nhs.uk\)](#)

⁷⁵ [Integrated Care for drug users: Principles and practice: Contents Page \(scot.nhs.uk\)](#)

⁷⁶ [Integrated Care for drug users: Principles and practice: Contents Page \(scot.nhs.uk\)](#)

8.1. International Evidence

Where has this been implemented?

A no wrong door policy for dual diagnosis initiatives was implemented in Australia in 2007, directing that people presenting to a mental health service should not be turned away if they are considered to be experiencing substance use problems and, in turn, that substance use services welcome people presenting with comorbid mental health problems⁷⁷.

An evaluation of ten years of a dual diagnosis capacity-building initiative in Victoria, Australia found that clinical mental health organisations were particularly unwilling to implement no wrong door reform in their own organisations⁷⁸.

Barriers to implementation

A number of studies have found that attitudinal barriers among psychiatric professionals present a key barrier to the effective treatment of dual diagnosis. A UK study from 1990⁷⁹ found that psychiatrists were more likely to rate patients with a previous diagnosis of alcohol dependence as difficult, annoying, less in need of admission, uncompliant, having a poor prognosis and less likely to receive psychiatric aftercare. In Victoria, Australia, rural mental health clinicians were described as frustrated, resentful and powerless in their attempts to understand their clients' substance misuse⁸⁰.

Another Australian study focusing on substance use disorders in pregnant women found further barriers to implementation of this model of care included fragmentation or siloing of the service network and workforce sustainability⁸¹.

What were the outcomes?

Treating individuals with a dual diagnosis of mental health and problem substance use disorders is a complex endeavour and requires strong but flexible service models. A range of services were surveyed across Australia, reflecting the diversity of approaches and settings detailed in other literature, and it was found that they shared a range of common characteristics related to service linkages; workforce; policies, procedures and practices; and treatment⁸². Typically involving an intake process

⁷⁷ Roberts & Mayberry. (2014). Dual Diagnosis Discourse in Victoria Australia: The Responsiveness of Mental Health Services

⁷⁸ Australian Healthcare Associates (AHA). (2011). Evaluation of the Victorian Dual Diagnosis Initiative. Melbourne, Victoria: Department of Health, State of Victoria.

⁷⁹ Farrell, M., & Lewis, G. (1990). Discrimination on the grounds of diagnosis. *British Journal of Addiction*, 85(7), 883–890.

⁸⁰ Roberts, B. M., & Mayberry, D. (2014) Dual Diagnosis Discourse in Victoria Australia: The Responsiveness of Mental Health Services *Journal of Dual Diagnosis* 10(3):139-44

⁸¹ Coupland H, Moensted ML, Reid S, White B, Eastwood J, Haber P, et al. Developing a model of care for substance use in pregnancy and parenting services, Sydney, Australia: Service provider perspectives. *J.Subst.Abuse Treat.* 2021;131:108420-108420

⁸² Merkes, M., Lewis, V., and Canaway, R. (2010) Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models *BMC Health Serv Res.* Dec 3;10:325.

designed with considerations of comorbidity and what other services the client might need to make use of; robust links with other organisations and service providers to provide timely and appropriate care via referrals; as well as continued communication with those agencies involved regarding a client's treatment and progress.

Beyond no wrong door there is a growing and significant body of work supporting the greater integration of services for those with problem substance use. With case management meetings and continuing communication between agencies being critical as well as adopting joint care planning⁸³.

9. Housing First Scotland as a model for a holistic approach to care and support

[Housing First](#) provides permanent, mainstream accommodation as the first response for people experiencing homelessness who have multiple and complex needs, for example, experiences of trauma, substance use and mental health problems.

Branching Out⁸⁴ is the National Framework For Housing First in Scotland. It provides a how to and why guide for all sectors planning, commissioning and delivering Housing First. It sets out the context in which Housing First can be successfully delivered, and should act as a guide to planning, commissioning and implementing the approach.

Aberdeenshire Council introduced a Housing First pilot in July 2017. Outcomes of the council's Housing First scheme were assessed up until October 2020 and have shown an overall positive impact on participant outcomes with improvements in health and wellbeing, and decreases in substance use, criminal activities, admission to prison and increased tenancy sustainment⁸⁵.

The biggest impact of its Housing First scheme was a reduction in the number of admissions into prison custody: from the 41 participants included in the sample, 10 participants had never been in prison custody, 28 had a reduction in prison admissions, one had an increase and two had the same number of admissions prior to, and since, starting Housing First⁸⁶.

South Ayrshire Council began its Housing First service in January 2019. Participants of the service have reported significant progress in improving their lives. Feedback from participants has demonstrated the benefit of the support provided, particularly helping them resolve situations that would have been triggers for housing crisis in the past, including experiencing anti-social behaviour, access to healthcare, and household maintenance issues. Two participants specifically noted that they would

⁸³ Savic, M., Best, D., Manning, V., & Lubman, D., (2017) Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review Substance Abuse Treatment, Prevention, and Policy volume 12, Article number: 19

⁸⁴ Housing First Scotland. (2022). Available at: <https://homelessnetwork.scot/wp-content/uploads/2022/06/Branching-Out-Housing-First-National-Framework-v230622.pdf>

⁸⁵ Scottish Government. (2022). Available at: <https://www.gov.scot/publications/rapid-rehousing-transition-plans-annual-report-2020-21/pages/housing-first/>

⁸⁶ Scottish Government. (2022). Available at: <https://www.gov.scot/publications/rapid-rehousing-transition-plans-annual-report-2020-21/pages/housing-first/>

have '*just handed their keys back*' and '*would have been in jail*' had it not been for the support received through Housing First⁸⁷.

South Lanarkshire Council reported that Housing First participants saw positive life improvements as a result of their Housing First support across the spectrum of indicators such as emotional and mental health, physical health, money management skills and self-care and living skills. One example noted is a significant reduction in the number of presentations to Accident and Emergency over the year amongst the client group, with 63.6% reportedly presenting during April 2020 reducing to 15.2% during March 2021⁸⁸.

⁸⁷ Scottish Government. (2022). Available at: <https://www.gov.scot/publications/rapid-rehousing-transition-plans-annual-report-2020-21/pages/housing-first/>

⁸⁸ Scottish Government. (2022). Available at: <https://www.gov.scot/publications/rapid-rehousing-transition-plans-annual-report-2020-21/pages/housing-first/>

Project: *Working Better Together* (Dundee Alcohol and Drug Partnership)

From September 2021, the Dundee Working Better Together (WBT) project board met every 6 weeks to direct, guide and support toward a whole system model of care and tests of change using a 3-stage approach:

- Getting ready for change (discovering and defining) – September 2021 – January 2022
- Enhancing community hubs (developing and testing) – January 2022 onward
- Strengthening existing provision (delivering implementation for sustainability) - 2022 - 2023

Given the closeness in aims and objectives with the Healthcare Improvement Scotland (HIS) Pathfinder project in Tayside, it was decided to increase and formalise the level of joint-working and co-operation between the Pathfinder and WBT projects. Both projects are working to improve greater collaboration for substance use and mental health services in Tayside and Dundee, paying particular attention to the following objectives:

- involving people with lived or living experience by progressing Co-Design Groups;
- considering the project from a gendered perspective by creating close links with women's services, including up-skilling all services to have a gendered perspective, and planning to test a weekly multi-agency triage meeting;
- engaging to ensure the project is supported by local resources by encouraging participation from various organisations in working groups and tests of change panning, designing and implementing;
- focusing on trauma-informed practice by exploring cross organisation resource for planning, training and support for implementation;
- building on interconnection with other projects, driven locally and nationally, for substance use and mental health service improvements;
- strengthening collaborative working between children and adult service by involving children, young people and families service leads.

Based on identified themes and insights from the initial phase, a multi-agency table-top exercise held in January 2022 explored how best to progress a test of change from a gendered perspective as well as drawing more generic conclusions and learning.

The collaboration between the HIS Pathfinder and the WBT projects was found to be very effective. HIS bring a wealth of experience at engaging and co-producing with lived experience, and the broader Tayside perspective. The WBT project connects all the relevant frontline services in Dundee and has capacity to organise and run specific tests of change and progress with the learning. There has been an overall commitment to this work in Dundee and Tayside.

Project: *Recovery Hub* (East Ayrshire Alcohol and Drug Partnership)

The East Ayrshire Recovery Hub is available 7 days a week (Including evenings), offering a welcoming place for all, helping to raise the profile of recovery, and reducing stigma across East Ayrshire. The hub approach encourages attendance not only for those experiencing drug/alcohol issues but also their families, carers, friends, and children. An accessible and non-judgemental peer guided community hub enables partners to provide their services from the premises and beyond, moving from a service centred model to an inclusive person-centred approach.

With cooperation from the existing Recovery Network a development day was held to encourage existing recovery groups and newly involved community groups to work closer together and support ventures collaboratively. This day has been successful in bringing groups together allowing focus on those in need and creating a support network for the Hub.

Recruitment and the sourcing of premises delayed the project start date. A service manager and recovery coordinator have now been recruited and a premises identified.

Creating relationships within the existing community assets have been successful. The manager has agreement from 4 community hubs to proactively add Recovery as part of their existing business. Two of the community groups are on the cusp of starting Recovery groups with the focus on creating a pool of volunteers which will contribute to the creation of rural hubs and positive activity for those that have been hard to reach.

Discussion with existing services and treatment providers resulted in a clear agreement to work collaboratively. These discussions have proven very successful in particular statutory services such as NHS and the Police taking steps to cooperate fully with the Hubs. Other services such as We Are With You and Advocacy have discussed options of using hubs to engage with individuals and to bring their group work to those in hard to reach places.

10. Multiple Complex Needs Sub-Group

The Multiple Complex Needs Sub-group commissioned examination of evidence on how to support those most vulnerable to overdose.

The aim of this was to synthesise and distil lessons from Scotland, the UK and international evidence regarding what works to prevent drugs deaths among those with multiple complex needs (MCN)⁸⁹.

The documents reviewed confirmed that the Subgroup's focus on certain health and social criteria was justified in terms of creating a set of clear recommendations for action. They showed common intersections between experiences of homelessness, problem drug (and alcohol) use, street culture activities, criminal justice contact, physical and mental health problems, domestic abuse and other experiences of violence, and histories of institutional care that has been described in different ways – through different lenses - but helpfully understood as diverse forms of multiple or deep exclusion⁹⁰.

There is strong evidence of high rates of multiple morbidities, i.e. severe mental health problems and long-term physical health conditions, among those who are homeless who use drugs and alcohol. The 2018 Scottish National Drug-related Death Database Report⁹¹ reported figures occurring in 2015 and 2016 (most recent in-depth analysis) showing that 70% of people who had died from drugs had a medical condition recorded in the six months before death. Reported recent medical ill health among those dying has increased since 2009 (46%). Respiratory illness (29%), blood borne viruses (18%) and chronic pain (11%) were the recent conditions most commonly recorded. Respiratory and cardiac conditions were more common among people aged 35 and over at the time of death, with the prevalence of these conditions increasing over time, in line with increases in average age. Medical multiple morbidity was associated with age and high-risk, long-term drug use. Approximately two-thirds of people who died (65%) had a recent psychiatric condition recorded in the six months prior to death. The percentage of drug-related deaths with recent psychiatric ill health had also increased since 2009 (40%).

Depression and anxiety were the most common psychiatric conditions recorded in the six months prior to death. Both conditions were more common among females and older individuals and increased over time. Sixty-two percent of individuals had experienced a significant event in the six months before death (most commonly, ill health or a recent diagnosis (medical or psychiatric)). Eighteen percent of people who had a drug related death had experienced domestic violence prior to death. Sexual abuse at some point prior to death was recorded in 16% of deaths.

Individuals with multiple complex needs were identified as experiencing extensive and widely differing barriers to improving their health and to accessing existing services.

⁸⁹ The Drugs Research Network for Scotland (DRNS) was able to support this work. A list of evidence reviewed is available in [Annex E](#)

⁹⁰ Fitzpatrick et al. (2011). Available at: https://pure.hw.ac.uk/ws/portalfiles/portal/7456920/SP_S_MEHIntersectionsPaper.pdf

⁹¹ National Records of Scotland. (2020). Available at: <https://www.nrscotland.gov.uk/files/statistics/homeless-deaths/17-18/homeless-deaths-17-and-18-publication.pdf>

Individual barriers to accessing healthcare and support include: the demands and severity of problem drug use, the precariousness of an individual's social circumstances, fear, shame, language and communication difficulties, loneliness and isolation. Structural and cultural barriers include: material deprivation, judgmental attitudes and stigma of staff working in services towards people who use drugs, wider negative stereotyping by the media and public misconception towards those who use drugs, blaming and punishing treatment regimes, restrictive requirements to access services including primary care services (e.g. proof of address or proof of benefits), geographical inequity in the availability of services, not meeting service requirements/priority lists, and legal status, immigration, or asylum related issues.

In Glasgow, people who currently and formerly used drugs identified a number of barriers to better health including: the demands of problem drug use, adverse social circumstances, the influence of peers, and a lack of awareness of available services⁹². In a 2017 rapid evidence review⁹³, barriers were noted to be stigma, loneliness and isolation among older people with drug problems which prevented individuals from addressing the harms they experienced, together with personal, social and financial circumstances restricting opportunities for change, as well as intense feelings of shame and negative perceptions of services.

A lack of mental health service provision was highlighted in many documents reviewed with people with problem drug use facing particularly high barriers to accessing mainstream mental health services. Specialist domestic violence and abuse services were reported as commonly being unable to cater for survivors facing severe and multiple disadvantage or problem substance use.

Drawing on qualitative findings from Scotland⁹⁴ it was concluded that drug use, social isolation and loneliness can culminate in individuals feeling that they merely exist rather than engage in a fulfilling life. Participants reported a daily routine and social network centred on drug use, they had no friends, mostly having only acquaintances who use drugs and very limited (if any) contact with family. Participants identified that being isolated and/or lonely had a negative impact on their mental health, as well as an indirect impact upon their physical health via increased problematic drug use. Most exhibited an ambivalent attitude to life or death, connected with high-risk drug taking as well as suicidal ideation. Key support staff and family connections were identified by participants as being able to improve their existence, although these did not often feature in participants' lives.

10.1. Models of support/interventions for supporting improvements in health, wellbeing and social functioning

Conclusions drawn from the literature⁹⁵ were that improved joint working/integrated services were required. This should include more co-ordinated, cross-sectoral and holistic approaches across substance use treatment, mental health, physical health,

⁹² Tweed & Rodgers, (2016). Available at: [Taking away the chaos: the health needs of people who inject drugs in public spaces in Glasgow city centre](#).

⁹³ Dickie et al. (2017). Available at: [Drugs-related deaths rapid evidence review: Keeping people safe](#).

⁹⁴ Hamilton et al. (2020). Existing not Living: A qualitative exploration of social isolation and loneliness among older male drug users in Glasgow

⁹⁵ A list of evidence reviewed is available in [Annex E](#)

and social support including housing, benefits, employment, legal and financial advice. Elements of this approach might range from multidisciplinary meetings and training, and robust referral pathways to a holistic approach to treatment eligibility and thresholds, and greater integration of services.

There should be development of one stop shops, whether physical premises or through full collaborative working and the implementation of a no wrong door approach across substance use, mental health and wider health services alongside promoting the use of link workers/outreach workers/case managers who can operate flexibly based on needs of clients. This would require clear communication channels and referral pathways in place between drug services, mainstream health/mental health and social care services, welfare systems and a restructuring to ensure services that address both health and social care and welfare needs.

Mental health and substance use treatment services should work effectively together at both operational and strategic levels. Therapeutic approaches to tackle co-occurring substance use and mental health problems, whether pharmacological, psychological or both, must address both disorders from the first point of contact to identify the best option for an individual. Homelessness services must support clients to ensure that they are registered with GP, dental and optician services and receive full assessments/health checks and a holistic care plan put in place to address any physical, mental health, substance misuse or wellbeing issues identified. Models of inclusion health were identified as having promise.

The approach to services should have involvement, inclusion, person-centeredness, and relationships at the heart with relational interventions being a key feature of many promising models and should include people with multiple complex needs in all aspects of the development and implementation of policies and programs that impact their lives to ensure respect, choice, dignity and the uniqueness of the person are at the core of the design and delivery of services.

Power must be shared with those using services, support and they should be supported to identify their own goals, develop trusting relationships and punitive practices should be avoided. Clear information must be provided on what is available, on choices, and how to access services. Services should consider particular individual barriers to access (e.g. geographic, financial, childcare) barriers and actively reduce these and ensure minority groups have a voice in service design and that they are encouraged as active partners.

Individuals should be provided with the autonomy to identify their own goals or barriers and how they want to tackle them, work with people's strengths, interests and abilities, help them to take control of their lives. Support should not be conditional on drug use behaviour, or on an ability to demonstrate stability.

10.2. Specific changes in policy and practice which can reduce drug-related harms, including risk of death, for individuals with multiple complex needs

It will be essential to recognise that people with multiple complex needs present with a wide variety of challenges whilst experiencing the effects of marginalisation and discrimination. Services must ensure people with multiple complex needs are informed

of their rights regarding accessing health services, utilising advocacy and levers like the NHS Constitution. There should be an independent complaints system and support to access this.

10.3. Test of Change Framework

A Test of Change Framework was published by the MCN sub-group to further build the evidence base for proposed interventions and pilots.

1. **One-stop shop** – to develop a one stop shop (hub) with outreach capacity, able to meet the health and social care needs of people with multiple complex needs.
2. **Peer Navigators (general)** – to install a number of Peer Navigators across various settings, responsible for engaging and supporting people with multiple complex needs to improve their health and social circumstances.
3. **Peer Navigator (Criminal Justice)** – to install Peer Navigators across various criminal justice settings, responsible for supporting people with multiple complex needs transitioning from custody back into the community.
4. **Drug Liaison Service** – to situate drug liaison nurses (DLNs) across various hospital sites, and outreach settings, with the purpose of engaging people with multiple complex needs and providing them access to relevant treatment and support.
5. **Distress Brief Interventions** – to develop a comprehensive Distress Brief Intervention (DBI) training programme for all frontline staff to ensure individuals with multiple complex needs experiencing acute distress are offered a DBI at first point of contact. Key partners (primary/acute care, Police Scotland, Scottish Ambulance Service, third sector) will work together to ensure there are robust pathways of care for people with multiple complex needs experiencing acute distress.
6. **Peer Engagement Training and Advocacy Programme (PEERTAP)** – to develop a peer-led engagement and advocacy service for people with multiple complex needs. Taking a rights-based approach, the Peer Engagement Training and Advocacy Programme (PEERTAP) supports individuals with multiple complex needs to access a diverse range of health, housing and social care options. PEERTAP's advocacy services are delivered by and for people with experience of multiple complex needs. Volunteering and training/employment opportunities are intrinsic to the model, enabling personal recovery.
7. **Integrated mental health and substance use services** – to implement and develop a model of practice integrating mental health and substance use treatment, for people with multiple complex needs, to ensure they receive timely and appropriate care from the initial point of contact. This integration can be reinforced through a shared physical premises but this is not essential.

8. **Welfare Advocacy** – to develop an independent, expert-led welfare rights and advocacy service for people with multiple complex needs at risk of drug-related death.
9. **24-hour crisis support service/centre** – to provide a 24-hour support service for people with multiple complex needs experiencing mental health and substance use related crises. As well as a 24-hour helpline, the centre also provides a safe space for people in distress to receive support, including overnight accommodation if required. Crucially, individuals are not excluded on account of their drug/alcohol use.
10. **Intermediate Care Centre linking physical healthcare between hospital and community** – to provide intermediate care, between hospital and community, for vulnerable patients with complex needs. This will include homeless vulnerable patients medically stable for discharge from acute hospital settings but with no access to secure safe accommodation in the community. This group will include those with complex infections related to intravenous drug use including endocarditis, skin and soft tissue infection, infected thromboses, trauma related care including wound management and those where there is no safe discharge pathway. It will also provide admission from the community to people with palliative care needs unable to be met in the community, and those with complex and substance use related care needs requiring more intensive support.

Project: *Community Recovery Hub (Change Grow Live (CGL))*

This project aimed to develop a Community Recovery Hub that would maximize the opportunity to engage with high risk service users by offering a one-stop approach to holistically supporting people who use drugs and alcohol across Forth Valley.

The Recovery Hub is running one day per week each in Alloa, Stirling and Falkirk. The Community Recovery Hubs deliver a flexible, person centred approach drawing from the Café Clinic concept, offering open access for service users to key agencies and drop-in medical reviews. This gives service users greater flexibility to engage with a broad range of health and social care support services alongside existing structured specialist substance use provision.

Between September 2021 and 28th February 2022, a total of 260 individuals accessed the Hubs, 118 of whom were new to the service. 45% of all individuals attending the Hub were new and had not sought support in the past. This is a significant number and indicates that the Hub is attracting and engaging their intended population.

The self-assessment clinics incorporated into the Hub see individuals engaging in the triage assessment process with the support of a Recovery Coordinator and a CGL Service User Involvement Rep. Using a self-assessment approach is intended to empower and emancipate service users from the outset of their journey with the service and is gaining positive feedback. Literacy ability is not assumed in this self-assessment, so all support is fully given.

The co-location of a worker from Citizen's Advice Bureau (CAB) in the Hubs has become an integral part of recovery plans developed by CGL Recovery Coordinators for individuals. The input from CAB workers has increased capacity within CGL caseloads to focus on delivering effective, high quality interventions to address an individual's drug and alcohol use, confident that social and economic need are being met by CAB. For example, between October and December 2021, CGL Forth Valley engaged with 53 new drug and alcohol users through the Recovery Hub, and 23 (43%) of those engaged with CAB for support on their first visit.

CGL Recovery Coordinators work with the Advanced Nurse Practitioner (ANP) to identify and engage with high-risk service users and directly support their attendance at the Hub. The ANP reviews conducted at the Community Recovery Hub cover physical health problems such as cardiovascular, respiratory, contraception and sexual health, a mental health review and MAT discussion. This clinical role has supported individuals to effectively engage with their GP for prescribed interventions for alcohol, and is testing rapid assessment and access to MAT.

The Hub approach is building a strong reputation among the service user group and is a simple, but effective model to promote widely as it uses a drop in approach that does not require an appointment. The Hubs have a relaxed and welcoming feel, with the Service User Involvement Reps, staff and key partners offering encouragement and support from first point of contact. Service Users are reporting that they feel hopeful when they are leaving the Hub, that they feel heard and are confident that they will receive support. Having an open door for the Hub is clearly working for service users.

Project: *Addressing the complex needs of people with co-occurring mental health and substance use issues* (Midlothian Health and Social Care Partnership)

No 11 in Dalkeith accommodates Substance Misuse Services (SMS) alongside Mental Health and Justice Services - both statutory and non-statutory organisations/teams. This project aimed to intervene early to provide mental health assessment, signposting and treatment to reduce the likelihood that people using substances harmfully will resort to self-managing by increasing their drug use or using additional drugs to manage symptoms. It sought to test out the model of introducing a specific role into the No 11 Services, hosted in the Mental Health Team, that provides crisis support to see whether undertaking joint work with clients in crisis can influence the culture and ability of SMS practitioners to respond to clients who develop mental health symptoms.

30-35 individuals were supported in the first 5 months of the project through psycho social support, assessment and brief intervention. However, it was identified in the project's cycle 1 review that this does not capture the multiple brief contacts that are opportunistic. Early findings from the project indicate success in positive relationship building, building confidence between teams and joint working including clarity regarding role. The project has also identified positives in access and early intervention with hard to reach individuals identifying needs both across mental health and substance use. Having presence in the local hostels also allows individuals who would most likely not attend appointments to access support giving rise to opportunistic discussions and people responding well to informal meetings.

Midlothian Health and Social Care Partnership, update to CORRA Foundation, March 2022

Drug Deaths Taskforce Innovation and Development Fund 6

Project: *Recovery Hubs* (Community Help and Advice Initiative (CHAI))

Since 1 June 2021 a welfare rights adviser has been providing outreach services within Edinburgh city centre for people accessing Streetwork's Holyrood Hub, Salvation Army's Well-Being centre and the Salvation Army Homeless Hostel. The team have also taken referrals for those that have been unable to continue engaging with recovery hubs, through the four locality recovery hubs, Spittal Street Low-Threshold Methadone Clinic and the NHS blood borne virus teams (BBV team).

Work has involved the following:

- reapplying/restoring benefit claims for prison leavers;
- liaising with Safeguarding Officer in respect of transferring claims for Universal Credit from online to telephone claims involving vulnerable claimants with who struggle with literacy as well as mental health/substance use and lack of means to access/manage an online claim easily, resulting in sanctions;
- furnishing clients with basic mobile phones/SIM Cards/top-ups via the Taskforce Digital Inclusion Scheme to facilitate the above;
- request Mandatory Reconsiderations in respect of sanctions to prevent recovery of hardship payments;
- working with Social Workers and Resource Workers from Drug Testing Treatment Orders (DTTO) to resolve difficulties in claims and where necessary action for rent arrears;
- liaising with prison work coach at city centre jobcentre to manage the operation of claim;
- receiving Referrals from blood born virus (BBV) Team and referring clients to them in respect of Hepatitis C treatment;
- taking referrals from Harm Reduction Team at Low-Threshold Methadone to assist restoration of lost Benefits.

Seeing people in environments in which they are comfortable and familiar on an ad hoc basis has allowed for successful engagement. Being in locations where there are support workers who have a relationship with the service users has proved helpful.

For two months the project had additional digital support via another fund which also included giving out devices and connectivity. The project continues to use Digital inclusion funding to provide basic mobile handsets, with SIM cards and credit. This is invaluable in re-connecting clients with DWP, in making or transferring to telephone claims for Universal Credit and to facilitate engagement with health and support services such as the BBV Team and homeless support. Also, having a means of telephone contact enables the progress and process of new and existing benefit claims and can facilitate telephone assessments. In particular, a work coach can contact the client directly to advise of appointments which can prevent the sanctioning of a claim.

Keeping people engaged with the process of income maximisation, which can take time and repeated appointments, has been a challenge. Often, once the initial crisis is resolved, further engagement is sporadic.

Many clients are involved with the criminal justice system which results in stopping and restarting claims. There are also high instances of people being admitted to hospital, or simply disappearing for some time resulting in the same issue that financial stability is not reached.

73 people have been seen as advice clients in this project since 1 June 2021. All were at risk of drug death and were not as yet engaging with recovery hub.

Drug Deaths Taskforce Research Programme Fund 2

Evaluating the impact of public health interventions in Scotland's Drug-Related Death epidemic (Glasgow Caledonian University)

This study measured the risks of mortality related to problem drug use in Scotland and determined the extent to which specific interventions Medication-Assisted Treatment (MAT) and Take-Home Naloxone (THN) are protective against drug-related deaths. Using linked and unlinked administrative data to measure the risks of mortality related to problem drug use in Scotland, the study aimed to determine to what extent these specific interventions are protective against drug-related deaths.

The study had two objectives:

- to estimate the extent to which MAT is protective against drug related deaths in Scotland, and how this effect varies over time and by key factors such as age, sex, homelessness, injecting, co-morbidity, co-prescription, MAT episode duration, and OAT engagement.
- To estimate the impact of Scotland's National Naloxone Programme (NNP) in preventing (a) drug-related hospital admissions and (b) deaths related to opioid-overdose.

Secondary data analysis, using a pre-linked dataset by Public Health Scotland (PHS) that included prescription data, treatment waiting times, acute hospital inpatient and psychiatric data, deaths and laboratory diagnostics data was used to estimate the extent to which MAT is protective against drug related deaths in Scotland. In total, following exclusions, the study included 46,749 individuals in their cohort with around 350,000 person years of follow-up. Most of the cohort (59.6%) were already receiving prescriptions in or before 2011 (the first year of follow-up) and the majority (60.7%) were still receiving prescriptions into 2020/2021. We recorded 7,804 and 4,287 all-cause and drug-related deaths among the cohort, at rates of 22.89 and 12.58 (per 1000 patient years (pys) respectively. The vast majority, 83%, of deaths (both all-cause and drug-related) occurred within -60 to +365 days from the date of last prescription.

Both all-cause and drug-related mortality rates increased over time. All-cause mortality increased more than two-fold from 14.67 per 1000 pys in 2011 to 31.68 in 2020. In the same period, the rate of drug-related deaths among the cohort trebled from 6.05 per 1000 pys to 18.30. Age-standardised drug-related mortality showed similar patterns increasing from 6.92 per 1000 pys in 2011-12 to 17.00 in 2019-20. Over time, all-cause mortality rates increased in all age-groups apart from those aged 55+ which have been decreasing since 2013-14. Drug-related mortality increased relatively consistently across all age-groups with rates in 2019-20 generally 2.5 times greater than they were in 2011-12.

All-cause mortality rates for those on MAT at time of death increased each year, and more than doubled between 2011 and 2020, from 10.74 per 1000 pys to 25. All-cause mortality rates for those off OAT at time of death treatment increase more gradually over the decade with rates increasing from a low of 29.18 per 1000 pys in 2013 to 39.32 per 1000 pys in 2020. Drug-related death rates for those on OAT at time of death more than tripled across the decade from 4.44 per 1000 pys in 2011 to 15.51 per 1000 pys in 2020. For those off OAT at time of death, drug-related death rates decreased between 2011 and 2015 before a step change in 2016 which peaked in 2018 at 22.07 per 1000 pys. By 2020, the drug-related mortality rate for those off OAT at time of death had stabilised at 21.96 per 1000 pys.

A quantitative time-series analytical approach was used to estimate the impact of Scotland's National Naloxone Programme in preventing (a) drug-related hospital admissions and (b) deaths related to opioid-overdose. Opioid overdose-related hospital admissions reduced shortly after start of the NNP before stabilising at the pre-implementation trend. However, like deaths, from 2015 the number of opioid overdose-related hospital admissions increased rapidly.

McAuley et. al, update to DDTF, October 2021

11. Accessible information

Audit Scotland⁹⁶ highlighted the need for transparency about the services that are available to people and we have had feedback from our Scottish Ambulance, COPFS and Police Scotland members that they find it challenging to know where to find information on potential referrals in their area. This was also a key aspect of the priorities for the Family Reference Group⁹⁷.

We have had significant feedback on the challenges of navigating services when people do not know what is available to them, or how to access it. There can also be significant variation across areas resulting in a postcode lottery that makes the process all the more frustrating.

The consensus reached among our members was that there should be a publically available resource listing all available services, what areas they cover and how they can be accessed by individuals, families and professionals. The example of [NHS 24](#) and was used as an information service which is available at all times and can refer people to the appropriate pathway for support, including for emergency needs. This facility was expanded in response to COVID-19 with the intention that '*this improvement provides patients with a straightforward dedicated route to clinical advice and support*⁹⁸'. It was possible to receive advice on symptoms as well as general information and advice.

12. Women

The gap between drug related deaths for men and women has decreased from the early 2000s. In 2002 men were more than 4 times as likely to have a drug related death. In 2020, men were 2.7 times as likely after adjusting for age⁹⁹.

Drug-related deaths have increased at a faster rate among females, with women accounting for 25% of drug related deaths in 2010, increasing to 31% in 2015 and again in 2019. In 2020 women represented 27% of all drug related deaths between 2010 and 2020 - a 300% increase¹⁰⁰.

In 2020/21, the rate of female patients who had a drug-related hospital stay was 112 patients per 100,000 population (3,048 patients), showing a more than threefold increase from their lowest rate in 2005. There was a slight decrease in drug-related deaths among women in 2020, but it is unclear to what extent this may have been impacted by COVID-19¹⁰¹.

⁹⁶ Audit Scotland. (2022). Available at: https://www.audit-scotland.gov.uk/uploads/docs/report/2022/briefing_220308_drugs_alcohol.pdf

⁹⁷ [Family Reference Group Report | Drug Deaths Taskforce](#)

⁹⁸ [New NHS 24 arrangements for coronavirus - gov.scot \(www.gov.scot\)](#)

⁹⁹ National Records of Scotland. (2021). Available at: <https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/20/drug-related-deaths-20-pub.pdf>

¹⁰⁰ National Records of Scotland. (2021). Available at: <https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/20/drug-related-deaths-20-pub.pdf>

¹⁰¹ Public Health Scotland. (2021). Available at: <https://www.publichealthscotland.scot/publications/drug-related-hospital-statistics/drug-related-hospital-statistics-scotland-2020-to-2021/summary/>

PHS's 2020/21 drug related hospital stays report also highlighted a significant increase in female overdose rates, increasing from 15 stays per 100,000 population in 2010/11 to 27 per 100,000 population in 2020/21¹⁰².

12.1. Factors affecting Women

A project examined potential explanations for the disproportionate rise in drug-related deaths among women in 2018¹⁰³ and was updated in 2020¹⁰⁴.

Key factors were identified as:

- 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.

Research identified that there are both practical barriers for women engaging in treatment (such as caring responsibilities) and psychological or relational barriers such as stigma, coercion or concern about losing custody of their children. None of these barriers sit in isolation and the interaction between them and the factors highlighted as impacting on increasing drug deaths in women must be considered.

While all people who use drugs face stigma, women are likely to face increased stigma¹⁰⁵. Pregnant women, and mothers who use drugs can have additional barriers to accessing treatment, including through stigma, perceived stigma and fear of consequences¹⁰⁶.

Women may be less likely to seek specialised services than men, which may also be linked to stigma¹⁰⁷. Women may also be more likely to enter treatment for drug use through other services such as mental health or children and family services¹⁰⁸ highlighting the importance of a no wrong door approach.

¹⁰² Public Health Scotland. (2021). Available at: <https://www.publichealthscotland.scot/publications/drug-related-hospital-statistics/drug-related-hospital-statistics-scotland-2020-to-2021/summary/>

¹⁰³ Tweed et al. (2018). Available at: <https://www.gov.scot/publications/drug-related-deaths-women-increasing-scotland/documents/>

¹⁰⁴ Tweed et al (2022). Available at: [Why are drug-related deaths among women increasing in Scotland? A mixed-methods analysis of possible explanations \(tandfonline.com\)](https://www.tandfonline.com/doi/full/10.1080/14622502.2022.2088888)

¹⁰⁵ Lee & Boeri. (2017). Available at: [Managing Stigma: Women Drug Users and Recovery Services - PMC \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/31811111/)

¹⁰⁶ Stone (2015). Available at: [Pregnant women and substance use: fear, stigma, and barriers to care | Health & Justice | Full Text \(biomedcentral.com\)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4581111/)

¹⁰⁷ European Monitoring Centre for Drugs and Drug Addiction. (2017). Available at: https://www.emcdda.europa.eu/system/files/attachments/6235/EuropeanResponsesGuide2017_BackgroundPaper-Women-who-use-drugs.pdf

¹⁰⁸ Grella et al. (2008). Available at: [Gender Similarities and Differences in the Treatment, Relapse, and Recovery Cycle - Christine E. Grella, Christy K. Scott, Mark A. Foss, Michael L. Dennis, 2008 \(sagepub.com\)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2541111/)

Child protection procedures can also be a high risk time for women. There was a significant proportion of women with substance use problems who die in the perinatal period whose '*deaths are closely associated with child protection proceedings or the removal of a child into care*'¹⁰⁹. Cross-sectoral collaboration is crucial throughout the care system but is even more important at these high risk times including across drugs, mental health, education and children's services.

The rapid evidence synthesis conducted by DRNS for the Multiple Complex Needs sub-group¹¹⁰ (see section 10) highlighted a cohort of women who use drugs who are at increased risk due to a combination of factors such as older age, changes in patterns of substance use, particularly polysubstance use and potential increases in use of specific prescription medications, increasing prevalence of physical and mental health problems, changes in relationships and parenting roles; problems getting their needs met within existing drug treatment and wider health and social services, changes in the welfare benefits system which may particularly impact on women, psychological/relational issues such as stigma, coercion, and fear of losing custody of children, and previous experiences of trauma and adversity.

These reports show the complexity of harms and risks for women and how attention needs to be placed across many areas of potential opportunities for intervention. In addition, known barriers for women engaging with services can be practical (caring responsibilities) or psychological/relational (stigma, coercion, and fear of losing custody of children).

Many women with problem drug use have experienced domestic violence and there is a need for greater awareness of the implications of domestic violence, trauma and mental health for treatment and health and social care provision for women with drug problems. The absence of childcare can be a barrier for women attending health and wider treatment and after-care services.

Evidence showed that women who are homeless experience multiple oppressions and discriminations and many of them report domestic violence prior to being homeless. A substantial proportion of women who are sleeping rough have reported sexual, physical and verbal assaults whilst on the streets¹¹¹. These are dimensions where risks will be gendered and careful thought will be needed when implementing the Taskforce's recommendations.

12.2. Taskforce Women's Working Group

12.2.1. Women's Report

In February 2021, the particular issues facing women who use drugs and their families were discussed and a short term working group was set up to further explore the key

¹⁰⁹ Perinatal Mental Health Network Scotland. (2021). Available at: [SUPPORTING-WOMEN-REDUCING-HARM-Report-V1.pdf \(scot.nhs.uk\)](#)

¹¹⁰ A list of evidence reviewed for this rapid evidence synthesis is available in [Annex E](#)

¹¹¹ Advisory Council on the Misuse of Drugs. (2019). Available at: [Drug-related harms in homeless populations and how they can be reduced.](#)

themes and recommendations from the literature, and to consider their practical application. All members of the working group had a strong interest in this work, some with professional experience and others with lived experience. The group's report was published on 1 December 2021¹¹². The report highlighted several areas where further work is needed to support women who use drugs, including recommendations in four key areas: developing services, collaboration, information services and workforce training.

The recommendations are relevant to a wide range of services and government policy areas. When considering and implementing the recommendations of the working group, local need and what is already available (in terms of local service provision) must be taken into account. Furthermore, this work cannot be undertaken in isolation but must be coordinated with other work streams, including the implementation of Medication Assisted Treatment (MAT) Standards.

Commonalities and Gender mainstreaming

For generations women have lived with systemic disadvantage in a healthcare service predominately designed by men, for men. Drugs services are the extreme of this. In many cases the women requiring these services have also experienced trauma and multiple disadvantage which can present further barriers to accessing services; especially those designed with men in mind.

The group were therefore supportive of further development and provision of women only services and spaces whilst also continuing to ensure that mainstream services are safe and accessible to women and that a gender informed approach is taken in all policy development.

Tomorrows Women Glasgow was identified as an example of an excellent women's only service. There are however no examples of these services being up-scaled more widely. A key barrier to this was felt to be funding; with recognition that these services often save money in the long run but that these savings may be indirect and are seen across multiple different sectors and therefore hard to quantify.

Trauma informed

The group were strongly supportive of a trauma informed approach. However, the consensus was that it could be further improved by specifically addressing the unique needs of women who use drugs in a dedicated module.

The group recognised that previous trauma can be a significant barrier to attending services. As part of being trauma informed services should not exclude people from accessing their care due to previous failure to attend.

Holistic

A holistic approach is likely to benefit all service users but women in particular may benefit due to parenting responsibilities, housing and safety needs and medical requirements.

¹¹² Drug Deaths Taskforce. (2021). Available at: <https://drugdeathstaskforce.scot/news-information/publications/reports/womens-report/>

The group feel that women in particular gain a lot of benefit and holistic support from being in peer groups. The Peer Recovery Network was discussed as an example.

Engagement with services

It was noted that women are particularly likely to be in position of power imbalance and may not be in control of the purchase or administration of the drugs they use. For these women there will be further barriers to harm reduction or treatment services and safety concerns when attempting to seek help. Uncertainty about treatment pathways and accessibility and availability of services can add further anxiety and barrier. There was also a concern that limited provision shifts the dynamic between the service user and provider into one where the woman may feel they need to 'beg' for services, furthering a power imbalance. A significant disparity between this and the cohesive systems with clear treatment pathways and timeframes seen in other long-term conditions and cancer care was highlighted.

It was recognised that maternity care and interactions with social services are times where women may engage with services when they otherwise wouldn't and they therefore present an opportunity to create supportive relationships. Access to sexual health and reproductive services was discussed including how drug and alcohol services could help enhance or support access. The majority of the group strongly advocated for the provision of reproductive education and delivery of long-acting reversible contraception in all possible settings including drug and alcohol services but also considering other services vulnerable women may access such as housing and mental health services. The group advocated for this being offered within a framework of reproductive choice, autonomy, and respect.

The group were strongly opposed to contraception being a prerequisite to treatment or care. There was a suggestion that some women may be affronted by reproductive planning being discussed in drugs services. However, it was felt when done sensitively, with a focus on individual choice and respect, discomfort could be avoided.

Family sensitive

It was recognised that individualised care and a whole family approach is vital in supporting women and their families. Fear of children being taken into care was recognised to be a significant barrier to accessing services. The group strongly felt that women should be supported to feel safe to access services without unnecessary fracturing of families. They should be actively supported to keep their children and thrive as parents wherever possible. The group very much advocate for keeping families together and recognised that women who use drugs can be good mothers.

The group highlighted that a lot of literature and leaflets about substance use were written with men in mind and didn't consider implications on women and families. It was discussed that literature to help children and families understand drug use better, akin to that available in other conditions such as alcohol dependency and cancer, would be beneficial. It was felt that more should be done to make medication collection family friendly and free of stigma.

Enhanced support

Women can experience loss of hope and a feeling of worthlessness when they are bereaved, this includes losing a child/children to care or the loss of a loved one and

drug related deaths of friends and acquaintances. Particular pathways dedicated to supporting women during these periods of extreme vulnerability was seen as a priority. There was recognition that drug related deaths following bereavement/loss of children to care may be intentional. Children and Families policy in Scottish Government are currently proposing funding (Pathfinders Fund) to better support families who are at risk of losing their children to care. This is particularly focused on helping young women and those from areas of deprivation. It aims to continue to support women even after loss of children, something the group strongly supported. The group also advocated for family decision making where possible during social work proceedings such that women can be involved in decision making and feel empowered.

Mental Health

The group discussed that training on neurodiversity including recognising different conditions and how that might impact on an individual's drug use and interactions with services would be beneficial. Holistic support is vital with an approach that asks *what happened to you?* not *what is wrong with you.* Women should feel supported, valued, seen, connected, included and be treated with compassion.

Group members described cases where women were labelled as having a personality disorder or mental health condition, when really what they were experiencing was trauma and grief; and what they needed was compassion and support.

Lived Experience

The group highlighted the need to ensure a gender mix in lived experience inclusion in development and evaluation of policy and practice. It should also be noted that mothers of young children may have time, family and financial pressures that reduce their capacity to take on such roles and thus their voice may not be heard.

13. Young People

13.1. Taskforce Young People report

Issues affecting young people were explored at a meeting in June 2021. Further evidence and information was requested that resulted in the *Young People Drug Related Deaths*¹¹³ findings summary paper that was published in January 2022.

Drug related deaths among young people (under 25 years) have risen sharply in recent years with 78 deaths recorded in 2020: more than double the number in 2017¹¹⁴.

In 2020/21 there were 1,755 drug-related hospital stays among people aged under 25 years. Of these, 90% included a mental and behavioural diagnosis and 16% included a drug poisoning/overdose diagnosis. Ninety-seven percent (1,701) of drug-related hospital stays among under 25 year olds were emergency admissions¹¹⁵.

¹¹³ [Young People | Drug Deaths Taskforce](#)

¹¹⁴ National Records of Scotland. (2021). Available at: [Drug-related deaths in Scotland in 2020, Report \(nrscotland.gov.uk\)](#)

¹¹⁵ Public Health Scotland. (2021). Available at: <https://www.publichealthscotland.scot/publications/drug-related-hospital-statistics/drug-related-hospital-statistics-scotland-2020-to-2021/summary/>

The pattern of drugs recorded within hospital stays among under 25 year olds was markedly different from that observed in older age groups. In 2020/21 the drugs most commonly observed were cannabinoids; this rate has steadily increased since 2012/13. The second most commonly observed drug in hospital stays among under 25 year olds was cocaine, increasing steadily from 2011/12¹¹⁶.

Since 2016/17, there has been a sharp rise in sedative/hypnotic related hospital stays among young people, increasing from 6 stays to 16 per 100,000 of population in 2019/20 and 2020/21¹¹⁷. The 2020/21 sedative/hypnotic stay rate was the highest recorded in the time series for this age group.

12% of drug related deaths occurred for this age group (under 25) within 12 weeks of prison release and 22% of drug related deaths occurred for this age group (under 25) within 12 weeks of hospital discharge¹¹⁸.

Substance use among young people is an important public health concern. The *Scottish Crime and Justice Survey* (SCJS) 2018/2020¹¹⁹ provides the most recent prevalence data for drug use among those aged 15-24 years across Scotland. Given the criminal justice orientation of the survey, it is likely to be even more limited by underreporting.

Some key points were identified:

- drug use is far more common among younger people – nearly one in ten (23.5%) of those aged 16-24 had taken drugs in the 12 months prior to survey. This was the highest proportion of any age group, and over ten times higher than among those aged 60 and over (1.6%);
- cannabis is by far the most commonly used drug – cannabis was the most frequently used in the previous 12 months (21.4%), followed by cocaine (7.9%), ecstasy (5.6%), ketamine and LSD (both 3.6%). Drug use was higher among males (30.4%) than females (25.1%). 4.9% of those aged 16-24 years reported having ever used ‘legal highs’;
- the survey from 2017-2019 (Scottish Government, 2019) demonstrates that most young people first try drugs in their teens – most of those aged 16-24 years first used drugs aged 16-19 years (54.3%), followed by 10-15 years (12.7%) and 20-24 years (8.7%). 0.9% used drugs when less than 10 years old;
- 15% of concerns raised at child protection case conferences related to parental substance misuse (1,135 of 7,315).

¹¹⁶ Public Health Scotland. (2021). Available at: <https://www.publichealthscotland.scot/publications/drug-related-hospital-statistics/drug-related-hospital-statistics-scotland-2020-to-2021/summary/>

¹¹⁷ Public Health Scotland. (2021). Available at: <https://www.publichealthscotland.scot/publications/drug-related-hospital-statistics/drug-related-hospital-statistics-scotland-2020-to-2021/summary/>

¹¹⁸ Public Health Scotland. (2022). Available at: <https://publichealthscotland.scot/publications/national-naloxone-programme-scotland-annual/national-naloxone-programme-scotland-monitoring-report-201920-202021/>

¹¹⁹ Scottish Government. (2021). Available at: <https://www.gov.scot/publications/scottish-crime-justice-survey-2019-20-main-findings/>

13.2. Risk Factors and Accessibility of Treatment

A 2021 review of the experiences of drug related harms among young people found a range of risk factors which increase the likelihood of substance use issues, including “*structural (e.g. Socioeconomic and political determinants), environmental/contextual (e.g. Interpersonal relations) and individual level determinants (e.g. Psychological, biological)*”¹²⁰

The review also found wide geographical variation in treatment and recovery service provision for young people with access to treatment not being consistent across Scotland. In 2019/20, 84% (26) of ADPs reported some availability of alcohol or drug treatment or support services targeted to under 25s in their area. However, what is available in each area was markedly varied with no ADPs reporting structured community or residential services which were tailored towards the specific needs of children and younger people. A 2020 report found that there were no residential services tailored towards the specific needs of children and younger people in Scotland and that facilities across Scotland typically operated with minimum age requirements of 16 or 18 years¹²¹.

Currently, data is not routinely gathered about those under the age of 18 seeking treatment for substance use issues. The usual referral route for this age group is through Child and Adolescent Mental Health Services (CAMHS) which indicates a joined up approach to mental health and substance use issues however it makes it difficult to establish data solely for substance abuse services¹²². While it is not possible to determine how many of these children and young people had co-occurring substance use issues the data demonstrates that there are considerable pressures on the system¹²³.

A 2016 study suggests that given that young people are at a different stage of life to the adult population, the focus of responses to substance use is typically heavily dependent on prevention, early intervention, and the reduction of harms, among those who have initiated substance use¹²⁴. The responses to substance use in young people will differ in their nature and in their effectiveness based on their age, stage of life, level of substance use, and the socio-environmental and economic context. There is a need to take into consideration the specific needs of young people throughout this period of rapid growth and development.

13.3. Vulnerable Groups

The literature highlights a number of groups more likely to develop problematic alcohol and drug use and experience harms.

¹²⁰ Scottish Government. (2021). Available at: <https://www.gov.scot/publications/review-existing-literature-evidence-young-people-experiencing-harms-alcohol-drugs-scotland/pages/1/>

¹²¹ Scottish Government. (2020). Available at: <https://www.gov.scot/publications/residential-rehabilitation-scotland-service-mapping-report-2019-20/>

¹²² Scottish Government. (2021).] Available at: <https://www.gov.scot/publications/review-existing-literature-evidence-young-people-experiencing-harms-alcohol-drugs-scotland/pages/1/>

¹²³ Scottish Government. (2021).] Available at: <https://www.gov.scot/publications/review-existing-literature-evidence-young-people-experiencing-harms-alcohol-drugs-scotland/pages/1/>

¹²⁴ Stockings et al. (2016). Available at: [Prevention, early intervention, harm reduction, and treatment of substance use in young people - ScienceDirect](#)

Care Experienced Children and Younger People: While relatively dated, a 2001 study of young people leaving care (14-24 years) in Glasgow found that 84% and 60% had respectively used cannabis and ecstasy at least once and 14% were drunk almost every day¹²⁵. Two-thirds had started taking drugs (31%) and drinking alcohol (29%) while in care. Use was attributed to being '*stressed out in care*' and as an attempt to forget negative experiences. Another showed that 45.8% of individuals resident in children's units had used drugs in the last month¹²⁶. Those in foster care consume less alcohol and have been found to be less likely to use drugs than children in residential care¹²⁷ due to those in residential care being exposed to factors including frequent movement of care placements, and rejection by adoptive or foster parents.

US research found that care-experienced younger people were five times more likely to have received a drug dependence diagnosis in the past year¹²⁸. In the UK in 2011/12, approximately 7% of young people accessing specialist alcohol and drug services reported that they were in care¹²⁹.

Younger People who are homeless: Homelessness forms both a risk factor for and a consequence of harmful alcohol and problem drug use. Substance use in this population has been reported as two- to three-times higher than that of non-homeless young adults. Four out of five people start using at least one new drug after becoming homeless¹³⁰. Estimates across European countries range from 30-70% prevalence rates for problematic drug use among homeless populations¹³¹. While data is not available by age, in Scotland 12% of people accessing specialist drug treatment in 2018/19 were recorded as being homeless¹³²; likely an under-estimate, as it may not include less severe forms of housing insecurity and levels of missing data were high.

Young Offenders: Criminal offending may predate and lead to problematic alcohol and drug use, or may be caused by it. Scottish prison surveys have shown that a large proportion of individuals serving sentences engaged in problem drug or alcohol use on the outside¹³³.

Younger People with adverse childhood experiences: Younger people who have experienced traumatic experiences in childhood are at substantially greater risk from developing problematic alcohol and drug use.

¹²⁵ Ridley & McCluskey (2003). Available at: [Exploring the Perceptions of Young People in Care and Care Leavers of the Health needs - CLOK - Central Lancashire Online Knowledge \(uclan.ac.uk\)](https://www.uclan.ac.uk/clok/central-lancashire-online-knowledge/young-people-in-care-and-care-leavers-of-the-health-needs)

¹²⁶ McKeganey, N. & Beaton, K. (2001). Drug and alcohol use amongst a sample of looked after children in Scotland Centre for Drug Misuse Research (unpublished)

¹²⁷ McCann et al. (1996). Available at: [Prevalence of psychiatric disorders in young people in the care system | The BMJ](https://www.bmj.com/content/313/7037/1000)

¹²⁸ Pilowsky & Wu. (2006). Available at: [Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care - ScienceDirect](https://www.sciencedirect.com/science/article/pii/S0893320006000000)

¹²⁹ National Treatment Agency for Substance Misuse. (2012). Available at: https://findings.org.uk/PHP/dl.php?f=NTA_26.cab&s=eb&sf=rel

¹³⁰ Fountain & Howes. (2002). Available at: [homeanddrycrisis.pdf \(drugsandhousing.co.uk\)](https://www.homeanddrycrisis.pdf).

¹³¹ EMCDDA (2008). Available at: https://www.emcdda.europa.eu/attachements.cfm/att_64250_EN EMCDDA_Sl08_vulnerable-young.pdf

¹³² Public Health Scotland. (2020). Available at: <https://beta.isdscotland.org/media/3878/2020-03-03-sdmd-report.pdf>

¹³³ Scottish Government. (2021).] Available at: <https://www.gov.scot/publications/review-existing-literature-evidence-young-people-experiencing-harms-alcohol-drugs-scotland/pages/1/>

Early School Leaving: As noted above, research among 15-18 year olds in Ireland found that those leaving school early were considerably more likely to engage in the use of other drugs than those still attending school¹³⁹.

Transition to Independent Living from Care: The period of leaving the care system represents a critical point in the development of problematic substance use. A review found that, while drug use may have begun while in care, the transition towards independent living forms a critical period within which such use may develop towards problematic use¹⁴⁰.

14. Prevention and Early Intervention

Prevention is a critical element in reducing the number of individuals turning to drugs. This includes changing the structural drivers of problem drug use outlined earlier. There are also other preventative measures such as education in schools, however, there is conflicting evidence on what is effective in this space.

Prioritising prevention is not a new concept. In 2011 the Christie Commission¹⁴¹ highlighted that *“a cycle of deprivation and low aspiration has been allowed to persist because preventative measures have not been prioritised. It is estimated that as much as 40 per cent of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach.”* The commission emphasised that, at that time, the pressure on budgets was intense and the economic downturn would intensify and prolong demand. Eleven years on there is clear ongoing pressure on budgets and the economy. However, we are yet to see a meaningful shift to a preventative approach, including in drugs policy and interventions.

Dame Carol Black argued in part two of her review of drugs that government policy in the area of prevention and early intervention should include *“drug-focused prevention programmes in schools, non-drug focused support for young people to reduce their risk for many problems including but not limited to drugs, and population-wide approaches to reduce recreational drug use.”*¹⁴²

The Advisory Council on the Misuse of Drugs (ACMD) review on prevention of drug misuse in vulnerable groups¹⁴³ highlighted that solely focusing on vulnerable groups will limit the reach of prevention activities. Instead they suggest that prevention should also be targeted at the risk factors, contexts, and behaviours that make individuals vulnerable, including targeting the structural and social determinants of health, well-being and drug use. It highlights that the most efficient interventions target multiple

¹³⁹ National Advisory Committee on Drugs. (2010). Available at: https://www.drugsandalcohol.ie/14100/1/NACD_RiskYoungPeopleSchool.pdf

¹⁴⁰ Ward et al. (2003). Available at: [One problem among many: drug use among care leavers in transition to independent living. - Drugs and Alcohol](https://www.drugsandalcohol.ie/14100/1/NACD_RiskYoungPeopleSchool.pdf)

¹⁴¹ Scottish Government. (2011). Available at: <https://www.gov.scot/publications/commission-future-delivery-public-services/documents/>

¹⁴² Dame Carol Black. (2021). Available at: <https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery>

¹⁴³ Advisory Council on the Misuse of Drugs. (2022). Available at: <https://www.gov.uk/government/publications/drug-misuse-prevention-review/acmd-drug-misuse-prevention-review-accessible>

risk behaviours. Rather than focusing on only drug use, successful interventions seek to enhance wider well-being and healthy development.

The ACMD review also emphasises that some drug prevention activities have been demonstrated to be ineffective, such as fear arousal approaches (including ‘*scared straight*’ approaches) or stand-alone mass media campaigns. The ACMD strongly advises that these should not be pursued.

A wide range of evidence is considered in the United Nations Office on Drugs and Crime (UNODC) and World Health Organisation (WHO) International Standards on Drug Use Prevention¹⁴⁴. The paper “*describes the interventions and policies shown by scientific evidence to be efficacious or effective in preventing substance use and which could serve as the foundation of an effective health-centred national substance use prevention system*”. As recommended by the ACMD, the selective prevention activities recommended in these standards should be the starting point for delivering prevention activities.

14.1. Education

Schools and other educational settings are frequently used for prevention interventions in the form of education, because of ease of delivery and access to young people. A 2016 systematic review highlights substantial issues with the quality of evidence on school-based prevention work¹⁴⁵. While intended to reduce drug use and problems associated with drug use, much of the evidence reports only on changes in attitudes and knowledge.

Overall, generic prevention programmes appear to have greater effectiveness than substance-specific offerings¹⁴⁶. The majority of research highlights that interventions targeting only knowledge and awareness of drug use do not alter drug use in young people¹⁴⁷. There is little evidence to suggest that prevention programmes are effective in preventing the use of drugs such as heroin, cocaine and amphetamines. School-based prevention programmes are also limited in that they are less likely to affect those who are frequently absent or have left school - a group who are at greater risk of substance use¹⁴⁸.

¹⁴⁴ World Health Organization. (2018). Available at: https://www.unodc.org/documents/prevention/UNODC-WHO_2018_prevention_standards_E.pdf

¹⁴⁵ Stockings et al. (2016). Available at: [Prevention, early intervention, harm reduction, and treatment of substance use in young people - ScienceDirect](#)

¹⁴⁶ Foxcroft & Tsertsvadze. (2011). Available at: [Universal multi-component prevention programs for alcohol misuse in young people - Foxcroft, DR - 2011 | Cochrane Library](#)

¹⁴⁷ Ennett & Bauman (1994). Available at: [The contribution of influence and selection to adolescent peer group homogeneity: The case of adolescent cigarette smoking. - PsycNET \(apa.org\)](#)

Faggiano et al. (2010). Available at: [The effectiveness of a school-based substance abuse prevention program: 18-Month follow-up of the EU-Dap cluster randomized controlled trial - ScienceDirect](#)

Faggiano et al. (2014). Available at: [Universal school-based prevention for illicit drug use - Faggiano, F - 2014 | Cochrane Library](#)

Strang et al. (2012). Available at: [Drug policy and the public good: evidence for effective interventions - ScienceDirect](#)

¹⁴⁸ Degenhardt et al. (2004). Available at: [Patterns of ecstasy use in Australia: findings from a national household survey - Degenhardt - 2004 - Addiction - Wiley Online Library](#)

A 2016 report highlights that there is more robust evidence about what is ineffective in drug education, than what is effective¹⁴⁹. However, the report highlights that wider programmes that are delivered in schools, which target multiple risk behaviours, and help build self-esteem and life skills are more likely to be effective in preventing drug use. No reviews suggest using a one off single session and there was emphasis that programmes should be of sufficient intensity and duration to influence change. Having those with lived experience to provide testimonials in the classroom is also associated with no or negative prevention outcomes.

Whilst the evidence presented in the report suggests that “*drug prevention is better embedded in more holistic strategies that promote healthy development and wellbeing, drug-specific prevention interventions for those young people most at risk of harm, or already misusing drugs should be maintained.*” It does note, however, that young people at greater risk will also benefit from universal approaches.

There are prevention models that have demonstrated some success in specific environments. For example, the Icelandic model of Adolescent Substance Use Prevention, which is a community-based approach, focused on reducing risk factors and increasing preventative factors. Dundee are currently exploring taking forward the Icelandic model, and learning should be taken from this pilot.

Over a ten year period of using the Icelandic model of Adolescent Substance Use Prevention, Iceland saw a decline in substance use amongst its adolescents¹⁵⁰. The Icelandic Model focuses on reducing known risk factors for substance use, while strengthening a broad range of parental, school and community protective factors. The annual data from two cohorts of over 7000 adolescents (>81% response rate) show that the proportions of those who reported being drunk during the last 30 days, smoking one cigarette or more per day and having tried hashish once all declined steadily from 1997 to 2007¹⁵¹. The study notes that “*although these data suggest that this adolescent substance use prevention approach successfully strengthened a broad range of parental, school and community protective factors, the evidence of its impact on reducing substance use needs to be considered in light of the correlational data on which these observations are based.*”

While other factors were also likely to have impacted on this decline, and causation cannot be evidenced, it does demonstrate a possible approach that is worth further consideration. Scotland’s context is different to the unique Icelandic culture and context therefore it would be important to consider if any elements might be transferrable. Whilst some barriers to implementation have been identified, there is a desire from stakeholders for primary prevention activities in Scotland¹⁵².

¹⁴⁹ Scottish Government. (2016). Available at: <https://www.gov.scot/publications/works-drug-education-prevention/>

¹⁵⁰ Sigfúsdóttir et al. (2009). Available at: [Substance use prevention for adolescents: the Icelandic Model | Health Promotion International | Oxford Academic \(oup.com\)](#)

¹⁵¹ Sigfúsdóttir et al. (2009). Available at: [Substance use prevention for adolescents: the Icelandic Model | Health Promotion International | Oxford Academic \(oup.com\)](#)

¹⁵² Carver et al. (2021). Available at: [How might the 'Icelandic model' for preventing substance use among young people be developed and adapted for use in Scotland? Utilising the consolidated framework for implementation research in a qualitative exploratory study | BMC Public Health | Full Text \(biomedcentral.com\)](#)

Those developing and commissioning preventative interventions also need to be educated about their effectiveness and how to establish them. We have been made aware of the European Prevention Curriculum¹⁵³ which may be worthy of further exploration to establish if it may prove beneficial to those who procure and fund interventions.

15. Risk factors for substance use

There are areas for exploration to both reduce the number of people using drugs, and to intervene as early as possible to prevent drug use becoming problematic. There are several risk factors that may increase the likelihood of someone using drugs or dying from a drug related death.

15.1. Socioeconomic deprivation and poverty

When including recreational, occasional or experimental use, findings from the international and UK literature suggest a weak or non-existent relationship between background socioeconomic position and alcohol and drug use in children and adolescents¹⁵⁴, and in younger adults¹⁵⁵. Two Scottish school-based studies of adolescents, for example, found no association between family socioeconomic status and either lifetime¹⁵⁶ or regular¹⁵⁷ drug use.

However, as the individual ages, a far stronger relationship emerges between deprivation and harms from alcohol and drugs, with this relationship stronger for *current* rather than *background* socioeconomic position¹⁵⁸. Studies conducted internationally show a clear and persistent socioeconomic gradient in acute and chronic alcohol- and drug-related morbidity and mortality. Analysis of Scottish Health Survey data between 1995 and 2012¹⁵⁹ found that deprivation was associated consistently with strikingly raised alcohol-attributable harms.

Importantly, harms experienced by those of lower socioeconomic position were greater than those of higher socioeconomic position even after accounting for factors such as weekly consumption, drinking patterns, obesity and smoking status. Further, this study showed that reverse causation – that is, high-risk consumption leading to social disadvantage – did not explain these findings.

While the majority of people with problematic drug use have experienced deprivation and poverty, individuals who are experiencing deprivation will not necessarily develop

¹⁵³ EMCDDA. (2019). Available at: [The European Prevention Curriculum \(EUPC\) | www.emcdda.europa.eu](http://www.emcdda.europa.eu)

¹⁵⁴ Hanson. & Chen (2007). Available at: [Socioeconomic Status and Health Behaviors in Adolescence: A Review of the Literature | SpringerLink](#)

¹⁵⁵ Wiles et al. (2007) Available at: [Socio-economic status in childhood and later alcohol use: a systematic review* - Wiles - 2007 - Addiction - Wiley Online Library](#)

¹⁵⁶ West et al. (2004). Available at: [School effects on pupils' health behaviours: evidence in support of the health promoting school: Research Papers in Education: Vol 19, No 3 \(tandfonline.com\)](#)

¹⁵⁷ Karatzias et al. (2001). Available at: [Quality of School Life. A Cross-Cultural Study of Greek and Scottish Secondary School Pupils on JSTOR](#)

¹⁵⁸ Daniel et al. (2009). Available at: [Is socioeconomic status in early life associated with drug use? A systematic review of the evidence - DANIEL - 2009 - Drug and Alcohol Review - Wiley Online Library](#)

¹⁵⁹ Katikireddi et al. (2017). Available at: [Socioeconomic status as an effect modifier of alcohol consumption and harm: analysis of linked cohort data - ScienceDirect](#)

problematic drug use. Poverty itself is not the primary driver of harmful alcohol or problematic drug use, but it increases the risk of exposure to a range of associated risk factors¹⁶⁰. Further, it reduces access to a range of factors that support recovery, including education, secure housing and secure employment.

Findings from the qualitative literature in the UK suggest that the individual's motives for alcohol and drug use play a role in linking deprivation to problematic but not recreational use, with harmful drinking and problem drug use forming a mechanism of escape or coping mechanism for those most excluded from society¹⁶¹.

15.2. Environmental and contextual risk-factors

Environmental and contextual risk factors play an important role in shaping the likelihood of developing problematic alcohol and drug use. It is important to note that these risk factors are shaped by the wider structural determinants outlined above. While focus is placed here on psychosocial risk factors, it is important to note that other environmental risk-factors, such as aspects of the neighbourhood environment, have been found to exert an effect.

15.3. Adverse childhood experiences

Adverse childhood experiences can be defined as stressful or traumatic experiences that occur during childhood (between 0 and 18 years of age)¹⁶². The ten most widely recognised adverse childhood experiences include: domestic violence; physical or sexual abuse; emotional neglect; parental separation; household alcohol and drugs misuse; mental illness, suicide or imprisonment affecting a household member¹⁶³. Analysis of data collected in the *Growing Up in Scotland* (GUS) cohort study suggests that by age 8, two-thirds of Scottish children will have experienced one or more adverse childhood experience-related factors and one in ten will have experienced three or more related factors. In the Scottish Health Survey 2019¹⁶⁴, over three-quarters (77%) of those aged 18-24 years reported one or more adverse childhood experience, while 15% reported having experienced four or more. Previous analysis of routine data¹⁶⁵ suggests that a high proportion of individuals growing up in Scotland will have one or more adverse childhood experience.

Strong, graded associations between these experiences and future problematic alcohol and drug use have consistently been found across the literature. An English

¹⁶⁰ Beckett et al. (2004). Available at: <http://www.dldocs.stir.ac.uk/documents/rdsolr1504.pdf>

¹⁶¹ MacDonald & Marsh. (2002). Available at: [Crossing the Rubicon: youth transitions, poverty, drugs and social exclusion - ScienceDirect](#)

¹⁶² Dong. et al. (2004). Available at: [The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction - ScienceDirect](#)

¹⁶³ Existing measures of ACEs are relatively crude and limited in a number of aspects; they fail to capture the severity or duration of these events; they provide equal weighting to all included experiences (for example, parental separation and sexual abuse); they do not take into consideration the subjective perceptions of these experiences by children and younger people, and; they do not take into account resilience.

¹⁶⁴ Scottish Government. (2019). Available at: <https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/>

¹⁶⁵ Smith et al. (2016). Available at: [Is there a link between childhood adversity, attachment style and Scotland's excess mortality? Evidence, challenges and potential research | BMC Public Health | Full Text \(biomedcentral.com\)](#)

survey¹⁶⁶ found that, in comparison with those with no adverse childhood experiences, those with four or more were twice as likely to currently binge drink and eleven times more likely to have used heroin or crack cocaine. A 2015 Welsh study¹⁶⁷ found even higher margins; those with four or more adverse childhood experiences were four times more likely to be a high risk drinker, eleven times more likely to have smoked cannabis, and sixteen times more likely to have used crack cocaine or heroin. While such data is limited in Scotland, *The Scottish Health Survey 2019*¹⁶⁸ found that the prevalence of adults with an AUDIT (Alcohol Use Disorders Identification Test) score of eight or more (indicating hazardous, harmful or possibly dependent drinking behaviour) was higher among those reporting one or more adverse childhood experiences (17-19%) than those reporting none (11%).

A systematic review of the relationship between childhood socioeconomic position and adverse childhood experiences concluded that there is a clear relationship between higher risk of adverse experiences and lower socioeconomic status¹⁶⁹.

16. Residential Services

In May 2022, the Scottish Government published a residential rehabilitation literature review¹⁷⁰. It highlighted that there is a relatively robust body of evidence which suggests that residential rehabilitation is associated with improvements across a variety of outcomes relating to substance use, health and quality of life. The literature review also identifies areas where there is a need for future research to inform our understanding of, and the ongoing development of, residential rehabilitation in Scotland. The need for a more strategic, systematic approach to developing the residential rehabilitation evidence base in Scotland has been noted previously¹⁷¹.

Various models for residential treatments exist for individuals with problem substance use but most provide safe housing and medical care in a 24 hour recovery environment¹⁷². There is growing recognition that residential treatment to help stabilise an individual's drug use, prior to further engagement with outpatient or other care, can help in the individual's recovery process.

Internationally there is moderate evidence that residential substance misuse services are effective for some types of patients. Most of the literature suggests that residential services are at least equally as effective as alternative models with a few that suggest

¹⁶⁶ Bellis et al. (2014). Available at: [National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England | BMC Medicine | Full Text \(biomedcentral.com\)](#)

¹⁶⁷ Bellis et al. (2016). Welsh Adverse Childhood Experiences (ACE) Study - Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population.

¹⁶⁸ Scottish Government. (2019). Available at: <https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/>

¹⁶⁹ Walsh et al. (2019). Available at: [Relationship between childhood socioeconomic position and adverse childhood experiences \(ACEs\): a systematic review | Journal of Epidemiology & Community Health \(bmj.com\)](#)

¹⁷⁰ Scottish Government. (2022). Available at: [Residential rehabilitation: literature review - gov.scot \(www.gov.scot\)](#)

¹⁷¹ Best et al. (2010). Available at: [\(PDF\) Crime and Justice Research For Recovery: A Review of the Drugs Evidence Base \(researchgate.net\)](#)

¹⁷² Reif et al. (2014). Available at: [Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence | Psychiatric Services \(psychiatryonline.org\)](#)

it is more effective. Though it is noted that these conclusions are based on evidence with noted methodological concerns and that further robust research is warranted¹⁷³.

The EMCDDA¹⁷⁴ report identified three main therapeutic approaches to residential treatment in Europe, including:

- therapeutic community principles, emphasising self-help, mutual self-help, peer mentorship and often co-residence of staff and residents;
- emphasising 12-Step programmes, group sessions and understandings of problem substance use as a chronic illness or disease;
- psychotherapy, drawing on cognitive-behavioural therapy (CBT) or other psychotherapeutic models, and emphasising group sessions/learning coping skills.

As demonstrated in the Scottish context by the Scottish Government's pathways survey¹⁷⁵, the report notes that facilities often use a combination of the above, and may tailor interventions to the needs of the individual. Most approaches continue to be abstinence-based, though there is a growing recognition that there may be benefits of continuing MAT in residential settings¹⁷⁶. However, studies of continued methadone maintenance and other MAT in residential settings are few and this remains a significant gap in the literature¹⁷⁷.

Moreover, the debate on the effectiveness of rehabilitation was flawed as studies show that the key problem is with aftercare, highlighting that there are six things that were needed for rehabilitation to be effective: service delivery, in-reach, out-reach, community building, assertive linkage and the mobilisation of community resources¹⁷⁸.

17. Stabilisation services

Stabilisation services can provide a bridge between or preparation for long term management or maintenance strategies or detoxification and abstinence based approaches.

Little empirical information exists on the trends in inpatient services for stabilisation or detoxification of patients who with problem substance use¹⁷⁹. The NHS National Treatment Agency for Substance Abuse explored opiate detoxification in an inpatient setting in 2005 and found that there is evidence that inpatient treatment leads to good

¹⁷³ Reif et al. (2014). Available at: [Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence | Psychiatric Services \(psychiatryonline.org\)](#)

¹⁷⁴ EMCDDA. (2014). Available at: https://www.emcdda.europa.eu/system/files/publications/813/TDAU14005ENN_475698.pdf

¹⁷⁵ Scottish Government. (2021). Available at: [Supporting documents - Pathways into, through and out of Residential Rehabilitation in Scotland - gov.scot \(www.gov.scot\)](#)

¹⁷⁶ Galanter et al. (2016). Available at: [Full article: Medication-assisted treatment for opioid dependence in Twelve Step-oriented residential rehabilitation settings \(tandfonline.com\)](#)

¹⁷⁷ Schuman-Olivier et al. (2014). Available at: [Is residential treatment effective for opioid use disorders? A longitudinal comparison of treatment outcomes among opioid dependent, opioid misusing, and non-opioid using emerging adults with substance use disorder - ScienceDirect](#)

¹⁷⁸ [Effectiveness of Residential Rehabilitation - Residential rehabilitation: literature review - gov.scot \(www.gov.scot\)](#)

¹⁷⁹ Mark et al. (2002). Available at: [Trends in inpatient detoxification services, 1992–1997 - ScienceDirect](#)

outcomes overall and could possibly be slightly more cost-effective if the high costs are compared against evidence of effectiveness for different populations¹⁸⁰.

Residential stabilisation services are low threshold interventions, designed to keep the barriers to participation as low as possible and they typically operate on a 24/7 basis. Clients can self-refer and the type or level of substance use should not be a barrier to accessing the service. Those who poly-drug use and those with comorbid mental health issues should not be excluded except where the individual's mental or physical health is a barrier to their receiving the stabilisation service. In the case of poly-drug use it is considered that this kind of low threshold service can be more flexible and appropriate in meeting the needs of the individual client than other types of residential care models, at least initially¹⁸¹. A key component in the success of such interventions is appropriate aftercare planning and provision to ensure further engagement with services.

Our benzodiazepine working group (see section 25) considered the need for stabilisation and highlighted the need for a place of safety for individuals with access to appropriate treatment (including psychological), governance and clinical and support staffing 24/7. This service should be available to anyone at immediate risk of harm with clear pathways to allow partners to refer into the service and to ensure ongoing support that includes medical and non-medical support needs. The working group emphasised that the service should go beyond a medical model and must be developed in partnership with people with lived and living experience to ensure a fully accessible and non-stigmatising service is developed.

17.1. Glasgow Stabilisation Service

The Stabilisation service in Glasgow is a residential project with 10 beds at present, which offers a six week stay supported by nursing and project staff, with a primary focus of supporting individuals to stabilise their drug and alcohol use. This may include optimising medication assisted treatment (MAT), managing benzodiazepine use through detox or stabilised dosing (with a view to possible future community detox), and medication-assisted detox from alcohol, including the commencement of protective medication¹⁸².

During its first six months the service had 33 direct admissions, 22 were male and the average age of all admissions was 42.3 (the youngest admission being 19 and the oldest 59). Benzodiazepines were the most commonly used substance reportedly used by all clients prior to admission and by 14 post discharge. Alcohol, opiates (both intravenous and non-intravenous) and cocaine (both intravenous and non-intravenous) were also reported as being used by clients both prior to and following discharge. Around three quarters of all discharges from the service were planned with 75.6% completing the six week stay at the facility, 100% maintained their opiate substitution treatment (OST) dose during their stay, and 42.4% were established on prescribed diazepam. In total at the end of the first six months 65.6% clients reported

¹⁸⁰ Day. (2005). Available online: [Research Practice No.3 \(researchgate.net\)](https://www.researchgate.net/publication/266111111)

¹⁸¹ Curtin, M., (2015) Low-threshold residential stabilisation service (LTRSS) in Ireland. Drugnet Ireland, Issue 55, Autumn 2015, pp. 21-22. Available at: [Low-threshold residential stabilisation service \(LTRSS\) in Ireland. - Drugs and Alcohol](https://www.drugnetireland.com/low-threshold-residential-stabilisation-service-ltrss-in-ireland-drugs-and-alcohol)

¹⁸² Middleton et al. (2022). Available at: [Review of the first six months of a residential drug stabilisation service - SSA \(addiction-ssa.org\)](https://www.addiction-ssa.org/review-of-the-first-six-months-of-a-residential-drug-stabilisation-service-ssa)

a reduction in drug use and 53.3% reported a reduction in their injecting drug use. There was one fatal overdose following discharge.

The six-month study also noted the destinations of clients following discharge and 14 went onto engage with structured daily activities such as employment, occupation therapy, recovery communities or education and training. A breakdown for each destination is not given.

The study concluded that stability service admission was notably effective in reducing both intravenous and non-intravenous drug use, optimising OST and increasing engagement with structured activities. Though further analysis and research on the impact on non-fatal overdose and a further six month follow up on outcomes was also recommended¹⁸³.

18. Recovery

At the Recovery Rising event on 23 April 2022, the Taskforce heard from Professor David Best that 50 to 70% of clients relapse in the first year with this number decreasing to 14% after 5 years, the goal therefore, should be supporting people to reach this milestone as it can take around 28 years for a recovery journey to become established. The biggest factors in determining the success of recovery were jobs, housing and friends, and meaningful activity and social networks were seen as the most important aspects of recovery¹⁸⁴.

Volunteering activities in the general population is 39%, however, for people in recovery it is significantly higher, at 79%. There is an important role in reducing stigma through giving back to the community and there should be high visibility recovery communities to show that recovery is possible and that highly visible recovery can provide early intervention and prevention¹⁸⁵.

¹⁸³ Middleton et al. (2022). Available at: [Review of the first six months of a residential drug stabilisation service - SSA \(addiction-ssa.org\)](#)

¹⁸⁴ Best. (2019). Available at: <https://doi.org/10.2307/j.ctvpwhfpp.6>

¹⁸⁵ Best. (2019). Available at: <http://www.jstor.org/stable/j.ctvpwhfpp.13>

Project: *Milestone House* (Edinburgh Health and Social Care Partnership)

Milestone House is a long established 10 bed unit offering care to those with HIV and complex needs and run by Waverley Care. In April 2020 it was temporarily re-provisioned as an intermediate care unit for homeless patients. Initially this was anticipated to be principally COVID patients, but in fact it has enabled those with multiple and complex needs to access medical and social care which, due to their circumstances, would historically have gone unmet; it has served as a means of continuing high-quality, integrated care for patients admitted with complex infections, trauma and substance use complications by extending care, supporting people into suitable accommodation and improving their access to OST and other drug and alcohol interventions. It has also supported individuals at risk of being acutely admitted to hospital as a place of last resort, providing them with more appropriate care and support to tackle issues related to substance misuse, chronic health conditions and homelessness.

Patient outcomes have included:

- stabilisation of or detox from alcohol and drug use for people who are challenging to engage either in effective, controlled community prescribing or to coordinate an admission for standard, abstinence focused inpatient treatment;
- reduced hospital admissions;
- more effective care for wounds and infections;
- hepatitis C treatment undertaken;
- comprehensive assessment, diagnosis and treatment of the comorbidities associated with risk of drug related death;
- improved diet and self-care;
- improved mental health due to being in a safe, secure environment with support;
- enabled cognitive/capacity assessments to be carried out and packages of treatment and social care to be developed in a setting of safety and support.

From 1st April 2021-31st March 2022 there were a total of 69 admissions (7 were already resident at 1st April). The service reports that it is now established within the system of local care, support and housing and has a track record of achieving outcomes for those who use it. It has contributed to reduced in-patient stays in acute hospital wards, decreased re-admissions, improved clinical outcomes and provided the necessary and supportive environment to enable continued clinical care and completion of treatment that would not be possible in homeless accommodation. Service users with no fixed abode on referral into the unit have been supported through a planned discharge into sustained accommodation.

19. Safer Drug Consumption Facilities

A review of Safer Drug Consumption Facilities (SDCFs) highlighted that there are more than 100 SDCFs operating in at least 66 cities around the world, within 10 countries - Switzerland, Germany, the Netherlands, Norway, France, Luxembourg, Spain, Denmark, Australia and Canada, with support from bodies in both the UK and Europe¹⁸⁶.

The aims of SDCFs are to:

- reduce drug-related overdose deaths;
- reduce the transmission of blood-borne diseases e.g. HIV and hepatitis B and C;
- reduce infection-related wounds and infections;
- reach people who inject drugs and who might otherwise not engage with any type of service;
- benefit the surrounding community by reducing drug-related litter and the visibility of public drug use;
- gain valuable insight into trends and patterns in drug use;
- engage with people who use drugs and connect them with support treatment services.

An SDCF will be able to provide medical attention in the case of an overdose. They are able to provide naloxone which reverses an opioid overdose. There will also be a defibrillator to use in the case of a cardiac arrest and the availability of oxygen to be used in the case of respiratory depression.

Studies from multiple countries show that SDCFs are able to engage with people who use drugs and offer support to connect with treatment services. They are also able to provide or refer those most at risk of injecting-related harms to many additional services. This can include wound dressing, medication provision, take home naloxone, as well as specialist services such as diagnosis and treatment of infectious diseases, oral health services and OST. An SDCF can also provide links with services to housing and mental health interventions.

In 2019, both the UK Parliament's Scottish Affairs Committee¹⁸⁷ and the Health and Social Care Committee¹⁸⁸ recommended the use of these facilities as an approach to support those with multiple complex needs.

There is strong evidence of a particularly vulnerable cohort of street injectors within the city centre of Glasgow who would benefit from access to an SDCF. Factors contributing to their vulnerability include:

- from the beginning of 2015, Glasgow saw an increase in HIV transmissions amongst people who inject drugs in the city. An initial investigation indicated a

¹⁸⁶ Scottish Government. (2021). Available at: [Safer drug consumption facilities: evidence paper](#)

¹⁸⁷ Scottish Affairs Committee. (2019). Available at: [Problem drug use in Scotland - Scottish Affairs Committee - House of Commons \(parliament.uk\)](#)

¹⁸⁸ Health and Social Care Committee. (2019). Available at: [Drugs policy - Health and Social Care Committee - House of Commons \(parliament.uk\)](#)

link between the outbreak and injecting drug use in public places within the city centre;

- there were also outbreaks of serious infectious disease among people who inject drugs including botulism (2014-2015) and anthrax (2009-2010);¹⁸⁹
- high levels of public injecting within Glasgow City Centre;
- there have been concerns raised for some years from local residents and businesses about the large amounts of discarded injecting equipment in public places across the city and neighbouring areas that are negatively impacting on the community's safety and amenities.

Glasgow continues to see high levels of drug related deaths. Since 2015 they have risen by 185% from 157 to 291 in the year 2020.

19.1. Evaluation

Research and evaluation from existing SDCFs has found consistent evidence of effectiveness of these facilities in reducing harms associated with drug use.

Evaluations show that these facilities:

- contribute to lower rates of fatal overdoses;
- reduce rates of infection transmission;
- reduce levels of public drug consumption and publically discarded drug-related litter.

In addition, these evaluations demonstrate that:

- those who are homeless or who are without a fixed address are more likely to use an SDCF;
- SDCFs have been used to provide people who use drugs with education on safer drug use;
- SDCFs provide access to medical services or other referrals to health and social care services;
- ambulance call-outs for overdoses are generally reduced in the vicinity of a SDCF;
- crime rates do not increase in areas where SDCFs operate.

A 10 year evaluation¹⁹⁰ of an Australian SDCF took place between May 2001 and April 2010 in Sydney. It showed success in decreasing drug overdose deaths. There were no deaths on the site despite 3426 overdoses occurring in the SDCF. Also, analysis of external data sets suggested that the SDCF reduced public opioid overdoses in the local area.

A more recent 18-month trial of a SDCF in Melbourne, Australia, starting in June 2018 took place and recorded no deaths onsite although 2657 overdoses occurred within the SDCF. Of these responses, 271 required the use of naloxone and 2615 required

¹⁸⁹ Tweed & Rodgers. (2016). Available at: [Taking away the chaos: the health needs of people who inject drugs in public spaces in Glasgow city centre \(scot.nhs.uk\)](https://www.scot.nhs.uk/taking-away-the-chaos/)

¹⁹⁰ MSIC Evaluation Committee. (2010). Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011). Sydney.

oxygen and other measures to respond to breathing difficulties as a result of an overdose. There was also a 36% reduction in ambulance attendances involving naloxone in the 1km vicinity of the SDCF during opening hours¹⁹¹.

There have been no deaths from overdose recorded in SDCFs since they began, despite the millions of injecting episodes¹⁹².

19.2. Injecting-related harms

Reviews have found that SDCFs were associated with significant reductions in risky injecting practices¹⁹³.

By significantly reducing the sharing of injecting equipment, and consequently reduces the behaviours that increase the risk of HIV and hepatitis C transmission and providing sterile injection equipment and harm reduction advice.

During the 10 year evaluation in Sydney there was a notable decline observed in HIV and hepatitis C infections in the local area of the SDCF and the New South Wales Health Final Report¹⁹⁴, found that 97% of clients surveyed reported that since attending the SDCF in Sydney they now inject more safely. Almost 80% of clients interviewed reported that they had changed their behaviour to reduce the risk of overdoses and were able to identify early signs of an overdose in themselves and others.

Cross-sectional community surveys among people who inject drugs in Sydney have suggested modest reductions in the prevalence of injecting in the street (47% in 2000 to 40% in 2002, $p=0.06$) or in public toilets (39% to 29%, $p=0.01$) following introduction of an SDCF¹⁹⁵. The Melbourne Safer Drug Consumption Facility also found a reduction in reports of public injecting by residents and local business respondents with a decrease in the proportion of residents from 24% to 20% and business respondents from 27% to 22% who saw public injecting¹⁹⁶.

A 2007 study from Vancouver, Canada, surveyed a randomly selected cohort of 1082 people from the SDCF. The survey found that 75% reported that their injecting behaviour had changed as a result of the SDCF. 71% indicated that the SDCF had led to less outdoor injecting and 56% reported less unsafe syringe disposal¹⁹⁷.

¹⁹¹ Review of the Medically Supervised Injecting Room Medically Supervised Injecting Room Review Panel, June 2020

¹⁹² Hedrich et al. (2010). Available at: [Chapter 11. Harm reduction: evidence, impacts and challenges \(europa.eu\)](#)

¹⁹³ Potier et al. (2014). Available at: [Supervised injection services: What has been demonstrated? A systematic literature review - ScienceDirect](#)

Hedrich, D. (2004). Available at: [Report on drug consumption rooms | www.emcdda.europa.eu](#)

¹⁹⁴ Dertadian and Tomsen. (2021). Available at: [The Experience of Safety, Harassment and Social Exclusion Among Male Clients of Sydney's Medically Supervised Injecting Centre | International Journal for Crime, Justice and Social Democracy \(crimejusticejournal.com\)](#)

¹⁹⁵ MSIC Evaluation Committee. (2003). Available at: [FINALMSICREPORTWORD070703.doc \(drugsandalcohol.ie\)](#)

¹⁹⁶ Medically Supervised Injecting Room Review Panel. (2020). Available at: [Medically supervised injecting room trial - Review panel full report \(health.vic.gov.au\)](#)

¹⁹⁷ Pertrar et al. (2007). Available at: [Injection drug users' perceptions regarding use of a medically supervised safer injecting facility - ScienceDirect](#)

19.3. Treatment

Reviews also found that attendance at an SDCF is associated with increased uptake of support. At the Sydney SDCF it was able to reach a socially marginalised and vulnerable population group of long-term injecting drug users, of whom 40% had no previous interaction with any form of drug treatment. Staff were able to make 8508 referrals, nearly half of which were related to drug treatment (3871). They also found that the more frequently a client visited the SDCF, the more likely they were to have accepted a referral to a drug treatment service¹⁹⁸. During the 18-month review of an SDCF in Melbourne it provided or referred 10,540 additional services beyond supervision of injecting as well as providing specialist clinics.

The same was also found in Vancouver, Canada, among a cohort of people who inject drugs recruited from the Vancouver SDCF, regular attendance was associated with a 33% greater likelihood of initiating treatment (hazard ratio 1.33, 95% CI 1.04 – 1.72) and a 72% greater likelihood of entering a detoxification programme (hazard ratio 1.72, 95% CI 1.25 – 2.38)¹⁹⁹.

There have been concerns that SDCFs could promote drug injecting use, but these have been unfounded. Evaluations from both Australian sites and Vancouver, as well as several other cities across the world have found no increase in the local prevalence of injecting drug use after the introduction of a SDCF to the area.

From this information, SDCFs are unlikely to encourage individuals to begin or recommence drug use. They may however, play an important role in facilitating access to treatment and recovery services.

19.3.1. Public Injecting

When North America's first SDCF was opened in Vancouver in September 2003, they used a standardised prospective data collection protocol. They measured injection-related public order problems during 6 weeks before and the 12 weeks after the opening of the SDCF.

The results found the 12 weeks after the facility was opened were independently associated with reductions in the numbers of publically discarded syringes and injection-related litter. By comparing the data collected from before the SDCF opened to afterwards, statistically it was found to show significant reductions in publically discarded syringes (average daily publically discarded syringes reduced from 11.5 to 5.4) and injection related litter²⁰⁰.

The SDCF in Sydney also saw similar reductions throughout its 10-year study. It found there was a steady decline in the proportion of residents who reported seeing publicly discarded syringes. There was a reduction from two thirds of residents reporting prior

¹⁹⁸ Dertadian and Tomsen. (2021). Available at: [The Experience of Safety, Harassment and Social Exclusion Among Male Clients of Sydney's Medically Supervised Injecting Centre | International Journal for Crime, Justice and Social Democracy \(crimejusticejournal.com\)](#)

¹⁹⁹ Wood et al. (2006). Available at: [Attendance at Supervised Injecting Facilities and Use of Detoxification Services \(nejm.org\)](#)

²⁰⁰ Wood et al. (2004). Available at: [Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users | CMAJ](#)

to the opening of the SDCF (66% in 2000) to 46% of respondents in 2010. There has been a similar decline amongst business respondents, from 80% of respondents in 2000 to 46% in 2010. Data on needle and syringe collections suggests that since the commencement of the SDCF services there has been a considerable reduction of the total number of needles and syringes collected in its vicinity during the period 2004 to 2009. Moreover, the greatest reduction has been in the areas immediately adjacent to the SDCF. Nearly all (92%) current clients of the SDCF interviewed reported that the facility had helped them reduce injecting in public places. Based on information analysed, since the commencement of the supply trial in 2001, there has been reduced problems with public injecting and discarded needles and/or syringes.

Overall, the data indicated a decline in the total number of publically discarded needles and syringes collected during the period reported from 2003-04 to 2008-09. Specifically, the number of needles and syringes collected across all relevant sectors more than halved from 28,231 in 2003-04 to 12,646 in 2008-09. In addition, it is highlighted that the majority (81%) of surveyed clients agreed with the statement: *“since coming here, the SDCF has helped me to not leave injecting equipment in public”*²⁰¹.

²⁰¹ NSW Health. (2010). Available at [NSW Health - Final report \(nsw.gov.au\)](http://nsw.gov.au)

Drug Deaths Taskforce Research Programme Fund 3

Perceptions and attitudes of strategic decision-makers and affected families across Scotland towards Drug Consumption Rooms to prevent drug-related deaths (University of Stirling)

Drug Consumption Rooms (DCRs) are low threshold settings which allow: supervised consumption of pre-obtained drugs; provision of clean injecting equipment; and immediate intervention by trained staff in the event of an overdose. Some service models also aim to engage those not in formal drug treatment and who may be particularly marginalised and not engage with services.

The study set out to better understand the perceptions, barriers and facilitators as well as the decision-making and workforce needs around DCRs with decision-makers and family members.

Both family members and decision-makers were supportive of DCR implementation. There were high levels of awareness of DCRs (in terms of existence, role and function) among both groups, with decision-makers on the whole more aware of DCR delivery models, but this also varied within those interviewed.

Both groups perceived DCRs to be an important intervention to prevent drug-related harm among people who use drugs. DCRs were viewed as a harm reduction intervention and as a key part of a public health approach that recognises problem drug use is primarily a health and social issue, as opposed to a purely criminal justice issue.

Nicholls et al (2022) [IJERPH | Free Full-Text | Drug Consumption Rooms and Public Health Policy: Perspectives of Scottish Strategic Decision-Makers \(mdpi.com\)](#)

20. Assertive Outreach

20.1. Assertive outreach models

Assertive outreach is generally used in the literature to describe services which proactively seek out people who would benefit from their input. Assertive Community Treatment (ACT) is a term commonly used in North American literature on this topic and refers to a model which was developed initially to work with people with severe mental health issues. The model was later adapted to work with people who use drugs and alcohol²⁰².

Assertive outreach services operate by identifying potential service users who have come into contact with one service, for example a hospital, and it is at this point that they are identified as being in need of assertive outreach follow up. Services will then engage with the individual to offer further interventions, for example OST, welfare benefits advice or housing services²⁰³, following up where necessary.

There are different models of how assertive outreach services operate. Some services take referrals solely from one type of location, for example the Navigator service which operates in hospital emergency departments in Scotland. Navigators will engage with patients affected by violence to offer people support to make positive changes in their lives, which can include addressing substance use issues. Navigators will support people to engage with other services outside the emergency department in order to achieve this²⁰⁴. Other assertive outreach services operate across more than one service type, making contact with people in hospitals, criminal justice settings and homeless accommodation, but are restricted to geographical areas, for example Local Authority or NHS Board areas. Finally, some assertive outreach services will actively go out into the community to identify people who may be in need of their services, for example Streetwork, which operates in Edinburgh²⁰⁵.

A literature review which focused on those working in assertive outreach who have lived experience of drug and/or alcohol use was conducted. In the literature they are referred to variously as peer support workers, peer navigators, peer workers, peer mentors, peer educators, peer recovery coaches or people with lived experience.

For clarity we refer to this role as peer navigators, defined as people with lived experience who are either working or volunteering in an assertive outreach service to support people with drug and alcohol use issues.

There is a strong theme in the literature that assertive outreach services for people who use drugs are a positive intervention. This is particularly the case for people who

²⁰² The Lewin Group. (2000). Available at: [Assertive Community Treatment Literature Review \(www.bhpc.org\)](http://www.bhpc.org)

²⁰³ Parkes. et al. (2022). Available at: [Assessing the feasibility, acceptability and accessibility of a peer-delivered intervention to reduce harm and improve the well-being of people who experience homelessness with problem substance use: the SHARPS study | Harm Reduction Journal | Full Text \(biomedcentral.com\)](https://doi.org/10.1186/s12916-022-02111-1)

²⁰⁴ Scottish Violence Reduction Unit. Available at: [Navigator | Scottish Violence Reduction Unit \(svru.co.uk\)](https://www.svru.co.uk)

²⁰⁵ Simon Community Scotland. Available at: [Our Services in Edinburgh: Streetwork | Simon Community Scotland \(simonscotland.org\)](https://www.simonscotland.org)

are homeless and use drugs²⁰⁶. Similarly there is another strong theme that people with lived experience have a valuable role to play in volunteering and working with people who use drugs²⁰⁷.

The rapid evidence synthesis²⁰⁸ conducted for the MCN sub-group also identified some key requirements for an effective assertive outreach model. A holistic approach is favoured, which is designed and tailored to the health and social needs of the individual, helping to provide stability. There should be adequate provision of, and access to, low-threshold (no barrier) services and crisis provision, and targeted outreach to support those at especially high risk of a drug-related death, with a requirement for trained community staff, including peer navigators, can be well suited for effective outreach and engagement.

It was established that Navigator models have promise – both peer and non-peer delivered to help connect vulnerable people to the services that can meet their needs enhancing access and reach and also quality through a needed advocacy role. ‘Sticky’ support, such as case management and keyworker or link worker models show most promise, including when community -based, delivered by peers (see below) and advocates, and wraparound and consistent / longer-term.

Enhanced support should be provided at specific times of vulnerability, such as bereavement and loss of child custody. Services, engagement, and pathways should be psychologically- and trauma-informed. Services also need to be responsive to the ongoing risk of adversity, abuse and violence, through initiatives for prevention, recognition, support, and onward referral. Attention to risks of self-harm and suicide as well as drug related death and the importance of suicide prevention training for staff and volunteers, family members, and interventions such as Distress Brief Interventions.

20.2. Peer support in health care settings

Two studies were identified²⁰⁹ which report findings from the same assertive outreach service developed in Houston, America (which has a high level of drug-related deaths). The service utilises paramedic staff and peer navigators and works with people who have experienced a near fatal overdose. The rationale for working with this group is

²⁰⁶ Miler et al. (2020). Available at: [Provision of peer support at the intersection of homelessness and problem substance use services: a systematic 'state of the art' review | BMC Public Health | Full Text \(biomedcentral.com\)](#)

Rozylo et al. (2020). Available at: [Case report: Successful induction of buprenorphine/naloxone using a microdosing schedule and assertive outreach | Addiction Science & Clinical Practice | Full Text \(biomedcentral.com\)](#)

Fisk et al. (2006). Available at: [Assertive Outreach: An Effective Strategy for Engaging Homeless Persons with Substance Use Disorders into Treatment: The American Journal of Drug and Alcohol Abuse: Vol 32, No 3 \(tandfonline.com\)](#)

Tommasello et al. (1999). Available at: [Effectiveness of outreach to homeless substance abusers - ScienceDirect](#)

²⁰⁷ Cos et al. (2020). Available at: [Do Peer Recovery Specialists Improve Outcomes for Individuals with Substance Use Disorder in an Integrative Primary Care Setting? A Program Evaluation | SpringerLink](#)

²⁰⁸ A list of evidence reviewed for this is available in [Annex E](#)

²⁰⁹ Langabeer et al. (2020). Available at: [Outreach to people who survive opioid overdose: Linkage and retention in treatment - ScienceDirect](#); Langabeer et al. (2020). Available at: [A Framework for EMS Outreach for Drug Overdose Survivors: A Case Report of the Houston Emergency Opioid Engagement System: Prehospital Emergency Care: Vol 25, No 3 \(tandfonline.com\)](#)

that those who have suffered a near fatal overdose are more likely to go on to have a fatal overdose.

The service operates by following up people who have experienced a near fatal overdose through visiting them in their own homes and providing motivational interviewing by a peer navigator²¹⁰. They are then asked if they want to be referred on to treatment services, with the researchers noting that 33% of people went on to engage in treatment services. After 30 days 88% were still engaging with services and after 90 days the figure was 56%²¹¹. The articles note that this was deemed to be a cost-effective service and that for those who did not engage in treatment services harm reduction strategies had been discussed and distributed (through pamphlets) and so some health benefits may have occurred for these people.

Researchers who undertook an evaluation project²¹² in a Federally Qualified Health Centre (FQHC) in a large city in the northeast of the United States, utilised peer navigators in an assertive outreach service to patients who used or had used drugs. Participants were identified while using the FQHC services but also through street outreach in areas of high drug use. Peer navigators provided 9 months of support focusing on harm reduction, recovery planning and assistance with connecting to the community. Support was offered on a 1-1 and group basis, in person and via telephone. Researchers found that participants reported significant reductions in their drug use in the last 30 days, and there was a significant reduction in the number of people reporting using any drug in last 30 days (however no figures are given for what qualifies as a significant reduction).

There was also an identified reduction in the number of unplanned hospital visits, and an increase in attendance at planned appointments. Employment rates and school enrolment rates increased (it is unclear if this is high school or college). However, there was an increase in days spent in prison. The researchers concluded that this project had positive outcomes²¹³.

Another study from New Jersey²¹⁴, examined the efficacy of a pilot project whereby people who were admitted to hospital for a substance use issue were referred to an assertive outreach service, which operated within the hospitals. The researchers argued that the location of the service enabled faster response times, and therefore higher levels of engagement. There were two distinct roles within the service – Recovery Specialists and Patient Navigators.

Recovery Specialists had lived experience of substance use and, in their role, could assist patients to develop coping skills, help them to access the social security system, talk about harm reduction interventions including naloxone use and offer support

²¹⁰ Langabeer et al. (2020). Available at: [A Framework for EMS Outreach for Drug Overdose Survivors: A Case Report of the Houston Emergency Opioid Engagement System: Prehospital Emergency Care: Vol 25, No 3 \(tandfonline.com\)](#)

²¹¹ Langabeer et al. (2020). Available at: [Outreach to people who survive opioid overdose: Linkage and retention in treatment - ScienceDirect](#)

²¹² Cos et al. (2020). Available at: [Do Peer Recovery Specialists Improve Outcomes for Individuals with Substance Use Disorder in an Integrative Primary Care Setting? A Program Evaluation | SpringerLink](#)

²¹³ Cos et al. (2020). Available at: [Do Peer Recovery Specialists Improve Outcomes for Individuals with Substance Use Disorder in an Integrative Primary Care Setting? A Program Evaluation | SpringerLink](#)

²¹⁴ Liebling et al. (2021). Available at: [Implementing hospital-based peer recovery support services for substance use disorder: The American Journal of Drug and Alcohol Abuse: Vol 47, No 2 \(tandfonline.com\)](#)

regarding treatment services. However, they were not able to refer patients to treatment services. This enabled their role to remain non-clinical. It is unclear from the article why maintaining a non-clinical status was important for this role.

Patient Navigators within the service were able to refer on to treatment services but they did not have to have lived experience of substance use for their role. The researchers note that Recovery Specialists being based on site at hospitals enabled the median time from referral to the Recovery Specialist being at a patient's bedside to be 8 minutes. However, the findings for the effectiveness of the Recovery Specialists' interventions are unclear.

Figures are given for the number of referrals made, bedside consultations accepted and follow-up contacts made but what these consisted of, and their impact, is not recorded. The study concludes that "*evidence of improved patient outcomes is needed prior to widespread adoption.*"

20.3. Community settings

One study²¹⁵ reported findings from a pilot scheme in Chicago which used peer navigators to identify and engage with people in the community who were using heroin and not in treatment services. Individuals were approached in communities which had been identified as being places where there were high levels of drug use. If individuals self-identified as using drugs, motivational interviewing techniques were used by peer navigators to discuss treatment options.

Researchers found that out of 72 people who were eligible for the service 70 agreed to engage in treatment and attended an initial session. After 30 days 69% continued to engage and after 60 days this figure was 70% (this increase was due to a small number of people who had left treatment but then re-engaged). Researchers concluded that this was an effective intervention for a difficult to reach population.

20.4. Criminal Justice settings

A study²¹⁶ discussed peer navigators working in assertive outreach in criminal justice settings. This article related to a programme that the authors had developed for prisons in New Jersey, USA. The article noted that many prisoners in the USA are not offered substance use treatments in prison, which may be a different context to the UK, and should be borne in mind.

The article discussed the programme which had been developed using peer navigators to work with people identified as having problem substance use issues 6 months prior to their release, and continue to work with them for 12 months post release. The peer navigators built a relationship with the person and worked to identify goals during the initial 6-month period in prison. Once the person is released they worked with them to access treatment and recovery services as well as education,

²¹⁵ Scott et al. (2018). Available at: [Opioid recovery initiation: Pilot test of a peer outreach and modified Recovery Management Checkup intervention for out-of-treatment opioid addicts - ScienceDirect](#)

²¹⁶ Swarbrick, M. et al. (2019) Peer Health Navigators Support Individuals with an Opioid Use Disorder Transitioning from Prison, *Drug and Alcohol Dependence*, Available at: [Peer Health Navigators Support Individuals with an Opioid Use Disorder Transitioning from Prison - ScienceDirect](#)

vocational and community supports with a view to integrating back into the community and avoiding relapse into substance use and recidivism.

The article noted some key learning which the researchers had identified - primarily the need to work closely with other professionals and agencies both in the prisons and community and also the importance of the first 48-hour period post-release for assertively intervening with individuals.

The researchers spoke about the fact they had learned that it was important to come and collect individuals from prison on discharge and to take them to their first appointments to maximise their levels of their engagement. However, it must be noted that the article does not record any outcomes from the programme and so it is unclear if it has been evaluated, and if so how successful it has been.

20.5. Homeless services settings

A mixed methods research study from Scotland and England - SHARPS (Supporting Harm Reduction through Peer Support)²¹⁷ - was a pilot study which examined the role of peer navigators with people who were homeless and used drugs in assertive outreach settings.

The researchers acknowledged the current lack of evidence for the effectiveness of peer delivered services and part of the rationale for their study was to begin to address this. The researchers found that the peer navigators were able to build positive relationships with service users, their interventions were valued by service users, and their engagement with service users meant they were more likely to attend appointments and engage with services including OST, housing and health care.

The study found that some drug use among service users did decline (crack cocaine and gabapentinoids) as did injecting behaviour. There was also an increase in the number of service users on OST. However, opioid use increased, and no service user stopped using opioids. The researchers also found that there had been challenges around lack of clarity from support workers regarding the differences in their roles from the peer navigators.

The researchers recommended that if the SHARP service was rolled out more education should be done with existing workers in services.

20.6. Short Term Working Group - Assertive Outreach

A short life working group was set up to further explore Assertive Outreach. The group consisted of Scottish Drugs Forum, Police Scotland, the Scottish Violence Reduction Unit, Medics Against Violence Pathfinder (MAV), Inverclyde Health and Social Care Partnership and Scottish Ambulance Service. The group met on 30th March and 25th April 2022 and a summary of discussions is provided below.

²¹⁷ Parkes. et al. (2022). Available at: [Assessing the feasibility, acceptability and accessibility of a peer-delivered intervention to reduce harm and improve the well-being of people who experience homelessness with problem substance use: the SHARPS study | Harm Reduction Journal | Full Text \(biomedcentral.com\)](#)

Initial considerations were surrounding existing Assertive Outreach programmes in Scotland; Glasgow was perceived as fortunate to have coverage, however, it was noted that the challenges could be seen as excessive availability and a lack of awareness of roles offered. Navigators in custody suites were viewed positively in terms of input and being beneficial. The group recognised the ability to access people at a '*catchable, reachable, teachable moment*'.

Overdose response teams appear to be working well and are funded for one year via the Taskforce. However, a representative from Police Scotland highlighted a concern regarding next steps for funded groups, as was raised at a recent ADP meeting.

The group agreed that a fundamental challenge with the expansion of navigator models across Scotland is lack of consistency and quality assurance of services using this term. Many services call themselves navigators but do not provide the level of service that would be expected. It was agreed that a Navigator service should incorporate a:

- need to leave no stone unturned, ensuring there is appropriate partnership working, which breaks down barriers to support;
- service which is simple and easy to use for the individual;
- holistic approach which involves seeing the person as a whole, providing support for all issues not focusing in on one particular need.

A need for similar programmes across different streams (mental health, alcohol, violence, drugs) was identified. It seems that, in many cases, people are directed into silos, as funding can't be used holistically, e.g., supporting an individual with their mental health issues but not their substance use issues because the funding is provided for mental health.

The group felt that each individual should be able to expect, the following at a minimum:

Standards, training, support

Navigators should develop a close professional relationship with the individual. Everyone needs to work to same standard and there should be minimum requirements for training, regardless of service (e.g. third sector or statutory). There should be no overcharging and services should be run as non-profit where possible. There needs to be a commitment to funding e.g. 5 years of funding would allow services to work confidently and develop the organisation and staff. All organisations should be Quality Assured and national agreement and guidance is needed.

Members reflected on where people were directed and the group noted that drug dependence does not present on its own, so to be kept within single streams, or silos, is unhelpful to those who need to access the service. Providing a service in this way does not represent value for money. It was felt that there is a need for a consistent service which can be provided in a range of settings including prison and police custody with referrals being made on the basis of vulnerability not just criminality.

Peer Navigator

The group noted that peer navigators were successful in building relationships, providing a softer side, as well as linking in with recovery communities. They noted that Navigators normally have lived experience of interacting with services.

They noted that often the label of peer remains even when an individual has 5 or 10 years' experience in their role or similar positions. They highlighted that the culture of professionals vs. peers needs to change, with a peer's experience being properly valued. They reflected that there was a need for development and progression.

The group also felt the following should be considered when developing the recommendations:

- there is a need for significant investment;
- there should be reference to recovery oriented care;
- any service needs to be trauma informed, person centred and co-produced;
- early intervention should be prioritised where possible;
- youth navigators should be considered;
- there must be a support package, including education and qualifications;

A draft vision was shared with the group, encompassing what had been discussed at the first group meeting:

“Every person with dependency issues should be given holistic support that is trauma informed, person centred, and co-designed with the individual. Peers should be valued to their full extent, acknowledging their wealth of experience, ability to understand and empathise with the challenges people face and facilitating both career and recovery progression.”

20.6.1. Achieving and effective assertive outreach model

The group identified a number of steps to implementing an assertive outreach model.

Setting up and consolidating a national Navigator framework

The implementation of a national Navigator framework in Scotland, delivering successfully and consistently in all areas, would help to remove the current postcode lottery. A set of standards, guidance, training and support should be available to ensure a consistency of service that individuals can expect. A centralised system would provide Police Scotland and other partners with ways to assist when people are at a reachable teachable moment, and looking to access support or treatment.

Security and stability of services – level playing field, no postcode lottery, no constant searching for funding

Services should be provided with funding for five years or more, to allow for stability of service, and development of the service. It is harder to retain good staff if there is no assurance that the service can be maintained. This will also in turn help with Police and partners, as they can build relationships with the services, and in turn, direct individuals to the right service for them. Furthermore, local knowledge is required in order to understand the local community. The Navigator needs to be relatable, local, and to have an understanding of local areas and services.

Training and control - standards and guidance (quality assurance and consistency)

There should be a set of standards and guidance provided at Scottish Government level in collaboration with existing Navigator services, to which all services must adhere, in order to continue to provide a Navigator service. Training can be provided, alongside a programme of continuous development. This will help to ensure that individuals can expect and obtain a standard level of service.

Information sharing

All services and agencies should be able to share data to protect someone's life. If someone refuses consent then this may be overruled as a result of their vulnerability, however all attempts should be made to ensure that decisions are shared and not taken for the individual without their involvement. Third sector and statutory services should be able to easily share information without fear of fines through GDPR.

Remove silos

People rarely present with just one issue. Individuals should not be turned away because they present with two or more issues, such as drug use, mental health and alcohol issues. This would be helped be joined up working on all levels, up to and including Government level.

Drug Deaths Taskforce Innovation and Development Fund 8

Project: *Recovery Support Navigators* (Renfrewshire Alcohol and Drug Partnership)

Two Navigator posts have been recruited and embedded into the Recovery Team to enhance the already growing recovery programme within Renfrewshire. This includes one to one contact with clients in various settings including Alcohol and Drug Recovery Services (ADRS), Recovery Communities and Acute Hospital settings. The Navigators have been applying their lived experience skills to engage with individuals and to sign-post to relevant services.

The Navigators have supported 63 individuals. Navigators have engaged with individuals not in contact with services; signposted to other relevant services; engaged with socially isolated individuals who have been house bound and have supported individuals to engage with relevant services and CIRCLE (new Recovery Hub). They have offered Navigator pop ups in 15 services (workers would attend services) offer peer support interventions and signpost to relevant organisations.

Renfrewshire ADP, update to CORRA Foundation, March 2022

Drug Deaths Taskforce Innovation and Development Fund 9

Project: *Navigating ExPEERience* (South Lanarkshire Alcohol & Drug Partnership)

This project has faced significant delays due to recruitment challenges. The first Peer Support Worker commenced in post in December 2021 a second has been recently recruited.

The first 4 months of the Peer Support Worker role have facilitated:

- positive profile raising of recovery role modelling that has been beneficial for service users and staff alike;
- opportunity to build relationships based on trust and respect;
- identification of interventions that Peer Support worker can provide that complements treatment plan;
- best use of resource to enable linkages to recovery community.

There is early evidence that stigma is being addressed through the presence of colleagues who are:

- open to sharing their own lived experience;
- capable of positively challenging long held views within treatment services;
- competently facilitating increased linkage to Recovery Community.

South Lanarkshire ADP, update to CORRA Foundation, May 2022

Project: *Navigating Support for people involved with Justice* (South Lanarkshire Alcohol and Drug Partnership)

The new Justice Peer Support Worker Service (JPSW) was introduced on 1st August 2021 across South Lanarkshire Council. This service was developed to introduce and enhance the provision of peer support to people transitioning from Justice Services at the end of their statutory orders. The (JPSW) service offers ongoing support to people at the end of their orders to help maintain attendance and participation in community-based treatment, harm reduction and therapeutic intervention services to sustain their recovery during and beyond the life span of any statutory order.

The service takes a mentoring approach and is delivered by two dedicated fulltime Justice Support Workers with lived experience to individuals who are seeking to address issues relating to drug or alcohol misuse.

The Justice Peer Support Service works with individuals as part of their Community Payback Order exit strategies and promote relationship building and empower their motivation to utilise suitable recovery focused services in the community.

COVID-19 has placed unprecedented restrictions on face-to-face engagement however the JPSWs have utilised digital technology and managed to provide support in person whilst adhering to Scottish Government and South Lanarkshire Council guidance.

The JPSWs told us that it was easier to trust someone who is not a professional and who has shared experiences. They also advised that people with substance use issues can experience shame and talking to someone who has had the same experience can be helpful. Workers provided specific examples of how they had contributed to service provision which included: taking someone to have first covid vaccination; supporting attendance at AA meetings, the Beacons, and medical appointments.

Two dedicated full time Justice Peer Support Workers commenced their roles in August/ September 2021. The Justice Services have developed relevant inhouse referral pathways, processes, and paperwork for cases to be allocated to the Justice Peer Support workers when assessed as suitable. The first referral was progressed around third week of August 2021, since then 30 cases have been allocated to the Justice Peer Support workers across South Lanarkshire Council.

21. Drug Checking Services

Drug checking²¹⁸ is a service which allows people to confidentially hand in a sample of drugs to be tested by professionals. Service users receive feedback such as the substances detected, their potency and purity, and the presence of any adulterants. This provides an opportunity for service users to either dispose of their drugs or use them in a more informed manner - reducing the risk of serious harm, including overdose.

These services can also provide an opportunity to engage in harm reduction counselling and can support access into other services. The primary aim of drug checking is to reduce the risk of harms, including drug-related deaths, to people who use drugs, with an associated reduction of harm to families, communities, and wider society.

Drug checking services allow individuals to have the potency and content of their drugs tested before use, and to receive information regarding what these drugs contain. Drug checking also contributes to public health surveillance of drug markets in local areas, when particularly dangerous samples are identified the service can issue tailored public health alerts. There are currently no drug checking services in Scotland.

Drug checking services are growing in number globally, and are increasingly recognised as an important component of wider drug harm reduction strategies. Drug checking services in Europe have traditionally been aimed at more 'recreational' use associated with the night-life and party scenes. Recent developments in Canada have utilised drug checking as a means of reducing deaths and other harms in the context of an ongoing opioid overdose epidemic. A global review in 2017²¹⁹ found 31 drug checking services across 20 countries. The review identified 23 services in Europe, with others in South and North America, and Australasia. Drug checking services in Europe have been in operation since the 1990s, with the longest-standing of these, Drug Information and Monitoring System (DIMS), established in 1992. More recently, drug checking services have been implemented in Canada and the USA. Research on these services highlights generally high levels of engagement and a range of positive outcomes.

Poly-drug use is a key contributor to the high death rate in Scotland, with many people using a number of drugs concurrently. The potency of these drugs is often unknown and can vary significantly, increasing the risk of fatal consequences.

21.1. Criminal Justice and the Law Subgroup: Engagement event Drug Checking Facilities

During the course of the Drug Law Reform working group (see section 3.3) drug checking facilities were also discussed and respondents were unanimous that this is a critical tool that should be available in Scotland. They felt that where people are accessing sterile injecting equipment, or other support for drug related issues,

²¹⁸ [Researching and developing key components of a new Scottish drug checking programme | Drug Deaths Taskforce](#)

²¹⁹ [Global review of drug checking services operating in 2017.pdf \(idpc.net\)](#)

specialist staff should be able to test substances and provide information to reduce harm. They highlighted that in this way current drug trend data could be used for real time drug alerts. Drug checking should be available in ways that do not stigmatise and are easy to access. It was felt that this could have a huge impact on drug death and Near-Fatal overdose rates. Limits on the availability of drug checking facilities restricts intelligence sharing and the provision of harm reduction advice being provided, which could help people use drugs more safely. Authorities should be doing more to make these facilities widely available to those working with people who use drugs and highlighted anecdotal challenges with accessing licensing for these services.

21.2. UK Drug Checking Case studies

Welsh Emerging Drugs and Identification of Novel Psychoactive Substances Project (WEDINOS)

In the UK, the *Welsh Emerging Drugs and Identification of Novel Psychoactive Substances Project* (WEDINOS) was established in 2009²²⁰. WEDINOS operates a postal drug checking service, where results of drug checking are provided on their website.

Results from the pilots were promising and showed a range of positive outcomes. These included: people disposing of their drugs in the event of an unexpected result; people communicating results to their wider social networks; people reporting intent to use less of a substance; and people being referred onto substance use support services.

The Loop Service

In 2010, [The Loop Service](#) started an annual programme of research on festival drug use and associated topics at summer music festivals. The first onsite event-based drug testing service was in Manchester in 2013. The move from non-public onsite testing to public onsite testing in the UK allowed The Loop to build up direct partnerships with the events industry, policing and public health stakeholders.

It also has the additional benefit of monitoring changing trends in illicit drug markets through direct engagement with people who have bought drugs, to assess the disparity between purchase intent and actual contents.

In 2016 The Loop introduced the UK's first event-based drug checking services (at Secret Garden Party and Kendal Calling festivals) and in 2018, The Loop introduced the UK's first community-based drug checking services (in Bristol and Durham) with the full support of local police.

This model involves testing concerning substances submitted by members of the public. On their return, a tailored healthcare consultation with a health professional is facilitated that also considers the test result. A confidential, non-judgemental dialogue between staff and service users is enabled to communicate relative risk regarding high

²²⁰ [WEDINOS - Welsh Emerging Drugs & Identification of Novel Substances Project](#)

strength substances, adulterants, poly-drug use, dehydration and other topics, with the aim of reducing drug-related harm.

Intelligence gained from this drug checking services feeds in to local stakeholder networks, early warning systems and wider drug using communities. No substances are returned to service users after testing.

No substances are ever deemed safe to use - the service communicates relative risk and all service users are told that the safest choice is not to take drugs at all. All remnants of testing are handed to the police for onward safe destruction upon completion of analyses.

Project: *Drug Checking Service* (University of Stirling)

The two-year project aims to build an evidence base for, and facilitate the development of, drug checking services in Scotland across three cities: Glasgow, Aberdeen and Dundee. It involves interviews with people with experience of drug use, affected family members, and a range of professionals, to gain an understanding of the key opportunities and barriers to providing city-based drug checking services in Scotland. The project will also analyse the international evidence on drug checking, and assess how such findings fit with a Scottish context.

The project works closely with city leads in Dundee, Aberdeen and Glasgow to help inform the implementation of drug checking services. Other Scottish cities are also involved in the project as part of their fact-finding process about drug checking and what it can offer. The study also involves the development of standard operating procedures and Home Office licence applications for sites; and a community of practice, to share good practice in Scotland and internationally.

University of Stirling, update to CORRA Foundation, March 2022

22. Targeted Distribution of Naloxone

Accidental overdose is a common cause of drug related deaths, and opioids are often implicated. In 2020, 93% (1,242) of all drug related deaths in Scotland were due to accidental poisoning and opioids/opiates were implicated in 89% (1,192) of all drug related deaths²²¹.

Naloxone (naloxone hydrochloride) is a drug that rapidly reverses an opioid overdose by binding to opioid receptors and temporarily blocking or reversing their effects²²². It has been used reliably in hospital settings for this purpose for over 50 years²²³ and can be injected or administered intranasally, with multiple studies supporting the efficacy of these routes²²⁴.

In response to rising global drug-related death rates, the first community-based naloxone interventions were introduced in Europe and the United States in the 1990s²²⁵. These were initially limited to trained health care professionals, however as naloxone's success in reversing an overdose relies on timely administration, some countries around the world have since expanded access through community-based initiatives to people who use drugs and "bystanders" (lay individuals who are likely to be present during an overdose)²²⁶.

This model of peer administered "take-home naloxone" (THN) usually includes an element of training in overdose recognition and management, and has been widely adopted in more recent years²²⁷.

22.1. Accessibility

Naloxone access is subject to different levels of regulation across the world and in many countries it is only available to health professionals or with a prescription. Only Australia, France, Canada, Italy, Norway, the United Kingdom and Ukraine currently allow certain forms of naloxone to be dispensed by a pharmacy or drug treatment centre without a prescription²²⁸.

However, there is some evidence from the existing literature on naloxone access laws in the United States that only the widest access laws are associated with a significant

²²¹ National Record of Scotland. (2021). Available at: [Drug-related deaths in Scotland in 2020, Report \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk)

²²² European Monitoring Centre for Drugs and Drug Addiction. (2015). Available at: [Preventing fatal overdoses: a systematic review of the effectiveness of take-home naloxone | www.emcdda.europa.eu](https://www.emcdda.europa.eu/systematic-review-of-the-effectiveness-of-take-home-naloxone)

²²³ Doyon et al. (2014). Available at: [Expanding Access to Naloxone in the United States | SpringerLink](https://www.springerlink.com)

²²⁴ Ryan & Dunne. (2018). Available at: [Pharmacokinetic properties of intranasal and injectable formulations of naloxone for community use: a systematic review | Pain Management \(futuremedicine.com\)](https://www.futuremedicine.com)

Yousefifard et al. (2020). Available at: [Intranasal versus Intramuscular/Intravenous Naloxone for Pre-hospital Opioid Overdose: A Systematic Review and Meta-analysis - PMC \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov)

²²⁵ McDonald & Strang. (2016). Available at: [Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria - McDonald - 2016 - Addiction - Wiley Online Library](https://onlinelibrary.wiley.com)

²²⁶ Giglio et al. (2015). Available at: [Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis | Injury Epidemiology | Full Text \(biomedcentral.com\)](https://pubmed.ncbi.nlm.nih.gov)

²²⁷ Moustaqim-Barrette et al. (2021). Available at: [Take-home naloxone programs for suspected opioid overdose in community settings: a scoping umbrella review | BMC Public Health | Full Text \(biomedcentral.com\)](https://pubmed.ncbi.nlm.nih.gov)

²²⁸ European Monitoring Centre for Drugs and Drug Addiction. (2021). Available at: https://www.emcdda.europa.eu/publications/topic-overviews/take-home-naloxone_en

reduction in the rate fatal opioid overdoses²²⁹. A 2019 study evaluating the impact of access laws across 50 American states found a significant effect only for those granting direct authority to pharmacists to provide naloxone²³⁰.

22.2. Prevalence of Take-home Naloxone Ownership and Carriage

Even where naloxone is accessible, the literature suggests there are additional barriers to the distribution of take-home kits. A 2019 cross-sectional survey of people who inject drugs in the UK (excluding Scotland) found that 40% of respondents did not own naloxone despite believing that it was available to them²³¹. A number of factors affecting ownership and carriage are suggested, including gender, regional variations in take-home naloxone provision, stigma, cost, legality, drug usage behaviour and use of support services²³².

Furthermore, assessing global levels of THN ownership and carriage is hampered by limited evidence and methodological variation across studies. Evaluations of THN interventions generally rely on the number of kits distributed, of refills requested and carriage of kits as proxy indicators for whether naloxone is likely to be available or readily accessible during an emergency overdose situation²³³.

A further methodological weakness relates to the lack of a standardised definition and operationalisation of “carriage” within the literature, with reviews highlighting that many studies of prevalence fail to interrogate whether individuals are simply in possession of naloxone or whether it is regularly carried and therefore available at the time of need²³⁴.

A recent review of the available data from the international literature found low levels of carriage among people who use drugs despite moderate levels of ownership²³⁵. This was reflected in evidence from a 2016 cross-sectional survey of support service users in Lanarkshire that found low carriage rates among people who use drugs²³⁶.

²²⁹ Smart et al. (2021). Available at: [Systematic review of the emerging literature on the effectiveness of naloxone access laws in the United States - Smart - 2021 - Addiction - Wiley Online Library](#)

²³⁰ Abouk et al. (2019). Available at: [Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose | Clinical Pharmacy and Pharmacology | JAMA Internal Medicine | JAMA Network](#)

²³¹ Spring et al. (2022). Available at: [Perceived availability and carriage of take-home naloxone and factors associated with carriage among people who inject drugs in England, Wales and Northern Ireland - ScienceDirect](#).

²³² Spring et al. (2022). Available at: [Perceived availability and carriage of take-home naloxone and factors associated with carriage among people who inject drugs in England, Wales and Northern Ireland - ScienceDirect](#).

Bessen et al. (2022). Available at: [Barriers to naloxone use and acceptance among opioid users, first responders, and emergency department providers in New Hampshire, USA - ScienceDirect](#)

²³³ Burton et al. (2021). Available at: [A systematic review and meta-analysis of the prevalence of take-home naloxone \(THN\) ownership and carriage - ScienceDirect](#)

²³⁴ McDonald et al. (2021). Available at: [Rethinking 'carriage' of take-home naloxone - ScienceDirect](#)

²³⁵ Burton et al. (2021). Available at: [A systematic review and meta-analysis of the prevalence of take-home naloxone \(THN\) ownership and carriage - ScienceDirect](#)

²³⁶ Hill et al. (2021). Available at: [Take-home naloxone carriage among opioid users in Lanarkshire — University of Strathclyde](#)

22.3. Effectiveness

Several independent systematic reviews support the effectiveness of community-based naloxone programmes in reducing opioid-related overdose deaths²³⁷. There is consistent evidence across the literature that THN is associated with increased odds of recovery and lower mortality rates for opioid-related overdoses²³⁸.

A significant limitation of the available data is the lack of randomised controlled studies, although it is worth noting that this may not be possible due to the ethical unacceptability of withholding life-saving medication for this purpose. However an interrupted time-series analysis of 19 communities in Massachusetts followed up for seven years found that overdose mortality rates reduced significantly following implementation of THN programmes compared to communities without such programmes²³⁹. A systematic review of the international evidence estimated that around 9% of naloxone kits will be used within the first three months for every 100 people trained through THN initiatives²⁴⁰, which suggests that the scale of THN initiatives is an important factor in reducing mortality rates.

In addition, there is weaker but growing evidence that THN programmes lead to improved knowledge of overdoses and their management using naloxone, and improved attitudes towards the use of naloxone and opioid overdoses²⁴¹. A meta-analysis of the available data found that trained participants scored significantly higher than their untrained peers on tests of knowledge related to naloxone administration, overdose recognition and response²⁴².

22.4. Cost-effectiveness

While there is limited data evaluating the economic impact of THN programmes internationally, a recent systematic review found six high quality studies supporting their cost-effectiveness with incremental cost-utility ratio ranges of between USD111-58,738 for every quality life-adjusted life-year gained²⁴³.

²³⁷ Moustaqim-Barrette et al. (2021). Available at: [Take-home naloxone programs for suspected opioid overdose in community settings: a scoping umbrella review | BMC Public Health | Full Text \(biomedcentral.com\)](#)

²³⁸ Chimbar & Moleta. (2018). Available at: [Naloxone Effectiveness: A Systematic Review : Journal of Addictions Nursing \(lww.com\)](#)

²³⁹ Walley et al. (2013). Available at: [Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis | The BMJ](#)

²⁴⁰ McAuley et al. (2015). Available at: [Exploring the life-saving potential of naloxone: A systematic review and descriptive meta-analysis of take home naloxone \(THN\) programmes for opioid users - ScienceDirect](#)

²⁴¹ European Monitoring Centre for Drugs and Drug Addiction. (2015). Available at: [Preventing fatal overdoses: a systematic review of the effectiveness of take-home naloxone | www.emcdda.europa.eu](#)

Williams et al. (2014). Available at: [Training family members to manage heroin overdose and administer naloxone: randomized trial of effects on knowledge and attitudes - Williams - 2014 - Addiction - Wiley Online Library](#)

²⁴² Giglio et al. (2015). Available at: [Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis | Injury Epidemiology | Full Text \(biomedcentral.com\)](#)

²⁴³ Cherrier et al. (2022). Available at: [Community Distribution of Naloxone: A Systematic Review of Economic Evaluations | SpringerLink](#)

22.5. Scotland's National Naloxone Programme (NNP)

The NNP in Scotland is the first national programme of its kind in the world, and has been in place since April 2011. This was following successful outcomes of local THN pilots in Scotland, and agreed in November 2010²⁴⁴.

The first supplies via non-drug treatment services in Scotland were made in the first quarter of financial year 2020/21. The number of THN kits supplied from October to December 2021 was the largest since the beginning of the NNP.

The Lord Advocate announcement on 27 April 2020 expanded the supply of THN to non-drug treatment services²⁴⁵, prior to this, from April 2011 to March 2016 the co-ordinated distribution of THN kits was in two settings - community outlets (usually specialist drug treatment services) and prisons. However, injectable naloxone supplied by lawful drug treatment services came into effect in October 2015 due to Human Medicines Regulations (2012).

It was observed that supply via dispensing in a community pharmacy by prescription increased in some NHS Boards in late 2015, by 1 April 2016 reimbursement (by Scottish Government) of THN kits costs had ceased, and NHS Boards assumed responsibility for funding.

Nyxoid, an intranasal naloxone product was licensed in February 2019. Previously, the only naloxone product licensed for lay use and distributed as part of the NNP was administered by intramuscular injection (Prenoxad).

22.6. Taskforce Strategy and Evidence

The targeted distribution of naloxone was one of our six core strategies. The aim was to ensure naloxone availability to all those who might need it. We supported relevant training around naloxone and supported the provision of kits to a range of people, including first responders and care providers including UK-leading provision through Police Scotland and the Scottish Ambulance Service. We funded the Police Test of Change for carriage on Naloxone, it's success has led to a full national roll-out being approved by the Chief Constable of Police Scotland. We also worked with partners to develop distribution networks further.

We regularly discussed this strategy during meetings. It was discussed at 15 meetings.

At our meeting on 13th May 2020, we heard evidence from SFAD who provide a Naloxone Click & Deliver Service. Following the Lord Advocate announcement on 27 April 2020 to expand the number of services able to distribute take-home naloxone kits (THN) during the COVID-19 pandemic, this service was suggested during a discussion between Scottish Drugs Forum (SDF) and SFAD.

²⁴⁴ Public Health Scotland. 2022. Available at: [National Naloxone programme Scotland - Monitoring report 2019/20 2020/21 - National naloxone programme Scotland: annual - Publications - Public Health Scotland](#)

²⁴⁵ COPFS. (2020). Available at: [Lord Advocate's guidelines: Supply of naloxone during COVID-19 pandemic | COPFS](#)

SFAD developed their website, took receipt of the naloxone supplies and had the service operational within 3 weeks. It went live on 22 May 2020. They are now able to provide a Click & Deliver THN service to anyone living in Scotland who is over the age of 16 who may witness an overdose.

There is an online application form explaining Naloxone which provides overdose information and links to SDF online “Overdose Prevention, Intervention and Naloxone Training”.²⁴⁶

Each individual who requests a kit has to confirm they have undertaken the training in the administration of Naloxone. If they have not indicated they are trained they are contacted to receive a brief Naloxone training session over the phone prior to dispatching their kit. Each kit is dispatched the day after request in a plain padded envelope including an instruction leaflet as a training refresher.

22.7. Ethypharm

In 2020 we set up an agreement with the pharmaceutical company Ethypharm, as part of increasing the accessibility and distribution of naloxone. It was negotiated for the provision of 10,000 naloxone kits to be issued across the country at no cost. This was split into three quarterly allocations to distribute the kits to individual health board areas.

Feedback was requested from ADPs. No area who replied reported any issues with these additional kits and every area detailed the positive impacts of these kits in their area. Areas reported that they had a plan in place to maintain naloxone provision going forward and the majority said this would be done through their ADP.

We also funded a range of projects exploring the use of naloxone through both our Research Fund and our Innovation and Development Fund.

²⁴⁶ [E-learning on Overdose Prevention, Intervention and Naloxone updated for International Overdose Awareness Day – SDF – Scottish Drugs Forum](#)

A mixed methods evaluation of peer-to-peer naloxone training and supply in Scotland

This study sought to understand the impact of the Naloxone Peer Training and Supply Programme (NPTSP) at the individual and community level, and to use findings to develop good practice to inform scale up of peer to peer naloxone supply across Scotland.

It used a mixed methods approach, with statistical analysis of NHS surveillance data, and semi-structured interviews with programme facilitators (n=5), peer workers (n=8), and programme recipients (n=6) to explore potential barriers and facilitators of aspects of the programme and of the peer based approach.

The implementation of the NPTSP in Greater Glasgow & Clyde (GG&C) was associated with an increase in supply of around 25 naloxone kits per week. By comparison in the Lothian control group in the same period the increase was around 3 kits per week. The increase in naloxone supplies driven by the NPSTP was particularly pronounced in older adults (45+) and females when compared to naloxone supplies overall in GG&C over the same period.

The programme had a range of facilitators to successful engagement including: shared lived experience resulting in quick bonds of trust and meaningful engagement with peers; peers acting beyond naloxone distribution to be examples of successful recovery; authenticity of help and advice provided based on lived realities of drug use; and a stigma free approach.

Some of the challenges associated with the programme included: stigmatising cultures within partner services that were critical barriers; potential negotiations around risk and resilience of peers in high risk environments; self-inflicted pressure within peer roles; and attrition within peer roles.

Key improvements for the future were identified as: flexible payment schemes for peers; expanding targets to broader harm reduction (e.g. dry blood spot testing); capacity for direct referrals through the programme; and scale up across the UK.

The NPTSP demonstrated an innovative and successful approach to naloxone distribution, particularly to those who might not have access due to lack of service engagement, and that peers should form a core of engagement efforts due to their wealth of knowledge and experience. Peer to peer naloxone distribution should be adapted across the UK.

Smith et al (2022) [unpublished manuscript] *A mixed methods evaluation of peer-to-peer naloxone training and supply in Scotland.*

Police Naloxone Pilot Evaluation (Edinburgh Napier University)

The research was a mixed-methods process evaluation of a test of change pilot project for the carriage, and use, of intra-nasal spray Naloxone by Police Scotland officers. It was focused on the implementation and processes of the test of change to allow elements of learning and best practice to be identified and to inform any future national implementation of Naloxone carriage/administration within Police Scotland.

By the end of the pilot, 808 officers had been trained in the use of naloxone, representing 87% of the workforce in the pilot areas. Uptake of naloxone packs by police officers at the end of training sessions was 81% (656 packs). Between March and October 2021 there were 51 naloxone administration incidents where a suspected opioid overdose was treated. No adverse responses were reported. The outcomes suggest that the intervention was feasible for and acceptable to police.

Overall, the training was acceptable to and effective for police officers in developing their knowledge of and attitude towards drug overdose and naloxone administration. Officers who administered naloxone were positive about the experience. Findings from qualitative data highlighted that naloxone provided an effective first-aid tool which allows police to carry out their duty to preserve life. Police are often first responders to overdoses and may be in a position to reverse an overdose until ambulance services arrive. Barriers to the intervention included concerns about liability, taking on a more medicalised role and lack of consistent follow-up support. The report recommended that naloxone be rolled out across Police Scotland.

Hillen et al (2022) *Naloxone in Scotland: pilot evaluation*. Available at: https://www.sipr.ac.uk/wp-content/uploads/2022/04/Naloxone-in-Police-Scotland_Final_9.2.22.pdf

Project: *Peer to Peer Naloxone Programme* (Scottish Drugs Forum)

SDF received funding to develop and support peer to peer naloxone supply by people who have experience of drug use.

The project has two key short-term objectives:

- Establish, embed and support high quality peer supply of naloxone as a core service across Scotland
- Ensure those involved in peer supply have an active voice in delivery of naloxone and other harm reduction interventions, including the sharing and promotion of good practice

The project provides people who have experience of drug use with paid role in their communities, or an incentivised role within prisons. In its first year, peers have been recruited in services across six areas including in three Glasgow prisons.

Prior to training, 50% of peer workers had no previous naloxone training despite 28 of them having previously experienced or witnessed an overdose. The training itself was effective with feedback showing that the question of confidence in recognising and managing an overdose situation increased.

Of the 478 kits that had been supplied in the first year, 269 were first supplies showing the efficacy of a peer supply model in reaching people who are not in contact with services elsewhere.

Barriers were identified in peer to peer work including:

- benefit concerns;
- full PVG disclosures – both the difficulty of those with previous drug use undertaking this and long waiting times.
- ID requirements for employment;
- attrition;
- digital access and literacy.

SDF, update to CORRA Foundation, March 2022

22.8. Scottish Ambulance Service (SAS)

We provided support for a pilot to support SAS to provide THN. This would enable naloxone to be distributed to those most at risk, who have experienced a Near-Fatal overdose. Following the success of a pilot programme in the SAS, we funded three regional naloxone leads to take this forward across Scotland.

The three Clinical Effectiveness Leads for Drug Harm Reduction, who cover the North, East and West of Scotland, have been in the post since January 2021. They have taken a leading role in the roll out of training to ambulance clinicians.

By January 2022, a total of 75% of crews had been trained to give THN kits to people at risk of a Near-Fatal overdose or potential future overdose, with over 1,000 kits being distributed across Scotland. THN kits have been provided to any family, friends or service workers who may have to administer naloxone in the future.

22.9. Naloxone Distribution

Quarterly management information is published to provide up to date information about THN supply in Scotland. The latest Quarterly Monitoring Bulletin available covers Quarter 3 - 2021/22²⁴⁷. A total of 9,006 THN kits were supplied from October to December 2021 - a 23% increase compared to the previous quarter - and a 66% increase compared to the same quarter in the previous year.

The number of kits supplied from October to December 2021 was 12% higher than the number supplied in 2020/21 Quarter 1, when a marked increase was seen following the introduction of measures to ensure naloxone provision during the COVID-19 pandemic²⁴⁸.

At the end of 2021/22 Quarter 3, the reach of the NNP was estimated to be 63.3% – a 2% increase compared to the previous quarter.

Distribution of THN kits

Of 9,006 kits distributed in 2021/22 Quarter 3:

- 7,237 (80%) were intramuscular (Prenoxad©) kits and;
- 1,769 (20%) were intranasal (Nyxoid©) kits.

The main distributors of intranasal (Nyxoid©) naloxone were SFAD. 1,230 kits were supplied across all Scottish NHS Board areas during 2021/22 Quarter 3.

Of the 1,900 kits issued which were a 'repeat supply' (for community, prison and Scottish Ambulance service only), 541 (28%) were because the previous kit was used on a person at risk.

²⁴⁷ Public Health Scotland. 2022. Available at: [National Naloxone programme Scotland - Quarterly Monitoring Bulletin October to December \(Q3\) 2021 to 2022 - National naloxone programme Scotland - Quarterly monitoring bulletin - Publications - Public Health Scotland](#)

²⁴⁸ Public Health Scotland. 2022. Available at: [National Naloxone programme Scotland - Quarterly Monitoring Bulletin October to December \(Q3\) 2021 to 2022 - National naloxone programme Scotland - Quarterly monitoring bulletin - Publications - Public Health Scotland](#)

This comprised of; 402 cases *used on another*, 102 cases *used on self* and 37 cases *used on other/self*.

Services based in the community

Services based in the community include; drug treatment services, non-drug treatment services, pharmacies (non-prescribed), police custody and A&E/Hospital.

Of the 6,656 THN kits issued by services based in the community:

- 3,078 (46%) of kits issued by Drug Treatment Services
- 2,989 (45%) of kits issued by Non-Drug Treatment Services
 - 2,743 of these kits issued were by SFAD
- 289 (4%) of kits supplied by pharmacies as non-prescribed kits
- 23 (<1%) issued from police custody
- 3 (<1%) issued from A&E/Hospital
- 236 (4%) were recorded as unknown

This was a 16% increase in total distribution of THN compared to the previous quarter (5,756) and a 129% increase compared to the same quarter the previous year (2,904).

Of the 246 kits supplied by non-drug treatment services (excluding SFAD):

- 211 (86%) kits were intramuscular naloxone (Prenoxad©) and 35 (14%) kits were intranasal naloxone (Nyxoid©) supplies. Intranasal naloxone was supplied from three different ADPs.
- 145 (59%) kits were provided to people at risk, 50 (20%) to service workers and 51 (21%) to family/friends.
 - 125 (51%) were first supplies, 104 (42%) were repeat supplies, and 15 (6%) were spare supplies.
- Of the 104 kits which were a *repeat supply*, in 42 (40%) cases this was because the previous kit was used on a person at risk (comprising 33 cases *used on another* and nine cases *used on self*).
- 242 (98%) of kits supplied were distributed face to face.

Of the 2,743 kits supplied by SFAD:

- 1,513 (55%) kits were intramuscular naloxone (Prenoxad©) and 1,230 (45%) kits were intranasal naloxone (Nyxoid©) supplies. Intranasal naloxone was supplied to all ADPs.
- 1,514 (55%) kits were provided to members of the public, 725 (26%) kits were provided to professionals, 430 (16%) kits were provided to family/friends, and 74 (3%) to people at risk.
- 1,768 (64%) were first supplies, 110 (4%) were repeat supplies, and 865 (32%) were spare supplies.
- All kits supplied by SFAD were distributed by post.

Scottish Families Affected by Alcohol & Drugs (SFAD) distribution has increased markedly from 161 kits in 2021/22 Quarter 1 to 2,743 in 2021/22 Quarter 3.

521 THN kits were issued by prisons in Scotland.

This was a 31% increase compared to the previous quarter when 399 kits were issued, and a 104% increase compared to the same quarter last year (255).

Of the 521 kits distributed on prison release:

- 368 (71%) were intramuscular (Prenoxad©) kits and
- 153 (29%) were intranasal (Nyxoid©) kits.

The number of intranasal kits supplied in 2021/22 Quarter 3 increased by 155% compared to the previous quarter (60).

- 469 (90%) kits issued in prisons were supplied to people at risk of opioid overdose and;
- 52 (10%) kits were supplied to family/friends.
 - 212 (41%) were reported to be a first supply
 - 263 (50%) a repeat supply and
 - 8 (2%) a spare supply.
 - A further 38 kits (7%) were of unknown supply type.

HMP Barlinnie commenced peer supply in November 2020. There were 76 kits provided by peer supply in HMP Barlinnie. This comprised 36 kits to persons at risk and 40 kits to family/friends. This comprised 33% of all THN kits distributed by HMP Barlinnie.

1,465 THN kits were dispensed via community pharmacies.

This was a 70% increase compared with the previous quarter (862) and a 35% decrease compared to the same quarter in the previous year (2020/21 Quarter 3: 2,251).

The high number of community prescribing supplies made in 2020/21 Quarter 3 may have been associated with the COVID-19 pandemic.

Of the 1,465 kits dispensed:

- 785 (54%) were issued by medical prescribers (e.g. GPs)
- 609 (42%) were issued by hospital-based prescribers dealing with substance use
- 68 (5%) were issued by nurse prescribers
- 2 (<1%) were issued by hospital-based prescribers, and
- 1 (<1%) was issued on the basis of a pharmacy prescription.

All kits dispensed were intramuscular (Prenoxad©) kits. No intranasal (Nyxoid©) kits were dispensed in 2021/22 Quarter 3.

NHS Boards

- NHS Greater Glasgow & Clyde pharmacies dispensed 795 THN kits (54% of community pharmacy THN supplies) via prescription in 2021/22 Quarter 3. **This was a 394% increase compared with 2021/22 Quarter 2 (161).**
- NHS Forth Valley dispensed 500 THN kits (34% of community pharmacy THN supplies)
- NHS Tayside dispensed 108 THN kits (7% of community pharmacy supplies)
- NHS Lothian dispensed 50 THN kits (3% of community pharmacy supplies)

22.10. Expanding Access to Naloxone

The evidence clearly shows that efforts of the Taskforce and partners, and the decision of the Lord Advocate to issue a statement of prosecution policy in relation to the supply of naloxone during the COVID-19 restrictions, has had an impact on supply of naloxone across the country.

A four nations consultation, led by the UK government, was launched in August 2021 on amending current legislation and permanently widening access to naloxone. We contributed to the consultation²⁴⁹ which ran for 8 weeks and was open to all interested individuals and organisations.

While the UK government has yet to formally respond to the consultation, it has published a summary²⁵⁰ of the consultation responses. There was strong support for the proposals in the consultation. Most of the 704 respondents agreed that the individuals and services consulted on who should be able to supply naloxone without a prescription. More than 80 of respondents agreed that allowing the individuals and services consulted on to supply take-home naloxone without a prescription would help reduce overdoses and drug-related deaths.

Evidence supporting the expanded access to naloxone is also provided by the recent report from SDF²⁵¹. The paper highlights both the need for more people to be trained in using naloxone and the need for increased availability of it.

The ACMD published a review of UK naloxone implementation²⁵² in June 2022. The ACMD reviewed the evidence of both provision and availability of naloxone and made recommendations to optimise its use in order to reduce drug-related harms. It emphasises the importance of naloxone, highlighting an association between administration of naloxone and a reduction of opioid overdose-related deaths.

However, the ACMD are clear that more work is needed: *“a national joined-up approach to promote the delivery of take-home naloxone across different sectors is necessary, supported by rigorous data recording to measure progress. Interventions are needed across a range of different sectors, ranging from delivery of take-home*

²⁴⁹ [Naloxone Consultation | Drug Deaths Taskforce](#)

²⁵⁰ [Expanding access to naloxone: summary of feedback - GOV.UK \(www.gov.uk\)](#)

²⁵¹ Scottish Drugs Forum. (2022). Available at: [SDF.Providing-Emergency-Help-to-someone-having-an-overdose-Your-Experiences.pdf](#)

²⁵² [ACMD review of the UK naloxone implementation \(accessible\) - GOV.UK \(www.gov.uk\)](#)

naloxone within community pharmacies, promotion of peer-to-peer take-home naloxone programmes, police training, and increasing take-home naloxone supply amongst prison leavers."²⁵³

23. Near-Fatal Overdose

Near-fatal overdose is a significant risk factor for repeat non-fatal and subsequent fatal overdose.²⁵⁴

In the literature the terms near-fatal and non-fatal are used, for clarity we refer to near-fatal overdose in our report *Changing Lives* although both are used in this evidence summary reflecting usage in the referred to literature. The literature highlights that, from a public health perspective, the period soon after a near-fatal overdose provides an opportunity for the identification of individuals at high-risk, and an opportunity to engage them in treatment and harm reduction in order to reduce their future overdose risk²⁵⁵.

The data for 2016 shows that over half of people who died from a drug-related death had previously experienced a non-fatal overdose (440, 54%); a similar percentage to previous years²⁵⁶. Among those who had previously overdosed, 70 (16%) were known to have overdosed at least five times prior to their death. In 2016, where known, the mean number of previous overdoses among drug related deaths was 2.8 (yearly averages over the time series ranged from 2.7 to 3.6).

In 2016, of those who had experienced a previous overdose, 24% (105) had overdosed within six months of death and 15% (67) had overdosed in the three months prior to death.

Hospital Stays

There were 2,247 overdose-related hospital stays among 1,938 patients from 1 April 2020 to 31 March 2021²⁵⁷. Patients were classed as new patients if they had not had a similar drug-related stay in hospital within the previous ten years.

The new patient rate for overdoses was 27 new patients per 100,000 population. However, between 2006/07 and 2014/15 this rate was consistently in the range of between 16 and 18 new patients per 100,000 population²⁵⁸.

²⁵³ [ACMD review of the UK naloxone implementation \(accessible\) - GOV.UK \(www.gov.uk\)](#).

²⁵⁴ Caudarella et al. (2016). Available at: [Non-fatal overdose as a risk factor for subsequent fatal overdose among people who inject drugs - ScienceDirect](#)

Bagley et al. (2019). Available at: [A scoping review of post opioid-overdose interventions - ScienceDirect](#)

Olofson et al. (2018). Available at: [Causes of Death After Nonfatal Opioid Overdose | Addiction Medicine | JAMA Psychiatry | JAMA Network](#)

²⁵⁵ Bagley et al. (2019). Available at: [A scoping review of post opioid-overdose interventions - ScienceDirect](#)

²⁵⁶ Information Services Division. (2018). Available at: [The National Drug-Related Deaths Database \(Scotland\) Report \(isdscotland.org\)](#)

²⁵⁷ Public Health Scotland. 2021. Available at: [Summary - Drug-related hospital statistics - Scotland 2020 to 2021 - Drug-related hospital statistics - Publications - Public Health Scotland](#)

²⁵⁸ Public Health Scotland. 2021. Available at: [Summary - Drug-related hospital statistics - Scotland 2020 to 2021 - Drug-related hospital statistics - Publications - Public Health Scotland](#)

Barriers to Treatment

Previous research highlights that survivors of near-fatal overdoses do not typically seek treatment or overdose risk reduction services immediately after an overdose. This occurs for a variety of reasons. A randomized controlled trial among emergency department patients with opioid use disorder found patients who required buprenorphine/naloxone within the emergency department, relative to those who received an appointment for a non-emergency department had better engagement in treatment and reduced opioid use. However, only 8.8% of the study participants were overdose survivors²⁵⁹.

Some individuals find that shame and stigma form significant barriers to entering treatment²⁶⁰. Others may not be interested in medical care and refer instead to substance use treatment²⁶¹. It is challenging for overdose programmes to engage high-risk individuals at a time when they are particularly vulnerable and strongly driven to relapse and to continue opioid use and a 2019 review found that there are no established standards of care for individuals (or their families or loved ones) following overdose²⁶².

23.1. Models of Aftercare following a Near-fatal overdose

Europe

Recommendations regarding aftercare for NFO survivors in Norway were set out and these are split into the hours and days after the overdose²⁶³. Recommendations for the hours after include withdrawal treatment, take home naloxone and overdose prevention education. The days after should include peer counselling, treatment referral, specialist assessment, buprenorphine maintenance and case management.

UK

Blackpool has had the highest rate of drug related deaths by Local Authority in England and Wales since 2009. Since 2019, Blackpool has developed a Drug-Related Death and Non-Fatal Overdose (DDRDNFO) Review Panel which is a multi-agency panel which seeks to provide targeted support and interventions to people at high risk of a drug related death. The panel first met in 2019 and meets monthly and undertakes a comprehensive review of all aspects of every suspected drug related death or near-

²⁵⁹ D'Onofrio et al. (2015). Available at: [Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial | Emergency Medicine | JAMA | JAMA Network](#)

²⁶⁰ Luoma et al. (2007). Available at: [Augmenting continuing education with psychologically focused group consultation: Effects on adoption of group drug counseling. - PsycNET \(apa.org\)](#)

Paquette et al. (2018). Available at: [Stigma at every turn: Health services experiences among people who inject drugs - ScienceDirect](#)

²⁶¹ Vilke et al. (2003). Available at: [Assessment for Deaths in Out-of-hospital Heroin Overdose Patients Treated with Naloxone Who Refuse Transport - Vilke - 2003 - Academic Emergency Medicine - Wiley Online Library](#)

DiClemente et al. (2004). Available at: [Citations: Readiness and Stages of Change in Addiction Treatment \(tandfonline.com\)](#)

Pollini et al. (2006). Available at: [Non-fatal overdose and subsequent drug treatment among injection drug users - ScienceDirect](#)

Wampler et al. (2011). Available at: [No Deaths Associated with Patient Refusal of Transport After Naloxone-Reversed Opioid Overdose: Prehospital Emergency Care: Vol 15, No 3 \(tandfonline.com\)](#)

²⁶² Bagley et al. (2019). Available at: [A scoping review of post opioid-overdose interventions - ScienceDirect](#)

²⁶³ [aftercare-for-overdose-survivors-during-the-first-hours-and-days-following-an-intoxication.pdf \(ui.o.no\)](#)

fatal overdose to identify lessons learned, address gaps in service provision and prevent future deaths. The process includes recommendations of immediate actions for partnership including safeguarding opportunities for those who have experienced an NFO.

The panel also identifies a list of the clients most at risk of a drug related death utilising the knowledge of key workers. The aim is to ensure these individuals receive enhanced and tailored support.

A 2020 review of the panel highlights some key successes of the approach despite it still being in its infancy. These include achieving risk reduction in service users and enabling true collaboration. Challenges to the approach were highlighted as funding, commissioning and data and information sharing. The review did not consider any challenges of the panel only meeting once a month thus potentially missing opportunities to intervene immediately after an NFO.

The Taskforce's recommendations set out in the report are similarly aimed at setting out an overarching expectation of what can be expected across the country.

23.2. Effectiveness of NFO Interventions

A US-focused scoping review found 27 non-fatal overdose interventions which had been tested or implemented across the US. Naloxone training and distribution, and linkage to treatment formed core features of most of the programmes. Only three of the programmes mentioned immediate initiation of medication for opioid use disorders²⁶⁴.

Many programmes were peer based. Previous qualitative research with participants who have experienced overdose has highlighted that individuals reported greater levels of comfort talking with a peer, and that peers are seen to have more credibility due to their shared experiences²⁶⁵.

There is increasing evidence that the incorporation of peers has positive effects on engagement²⁶⁶ and retention²⁶⁷ in care. Powell's US-based Opioid Overdose Recovery Programme findings suggested that lived experience among peers helped build up trust with survivors, but also highlighted other barriers, including challenges in terms of lack of ways to communicate for follow-up, no-IDs among survivors, and lack of treatment beds for individuals with chronic medical conditions²⁶⁸.

Evidence showed that mandating or coercing overdose survivors into treatment risks reducing the likelihood that people seek emergency treatment for overdose for fear of being forced into treatment. This fear may be particularly acute among those who have

²⁶⁴ [aftercare-for-overdose-survivors-during-the-first-hours-and-days-following-an-intoxication.pdf \(uio.no\)](#)

²⁶⁵ Bardwell et al. (2018). Available at: [Negotiating space & drug use in emergency shelters with peer witness injection programs within the context of an overdose crisis: A qualitative study - ScienceDirect](#)

²⁶⁶ Bassuk et al. (2016). Available at: [Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review - ScienceDirect](#)

²⁶⁷ Tracy et al. (2012). Available at: [Mentorship for Alcohol Problems \(MAP\): A Peer to Peer Modular Intervention for Outpatients | Alcohol and Alcoholism | Oxford Academic \(oup.com\)](#)

²⁶⁸ Powell et al. (2019). Available at: [Promoting opioid overdose prevention and recovery: An exploratory study of an innovative intervention model to address opioid abuse - ScienceDirect](#)

been involved with the criminal justice system or exposed to traumatic experiences with law enforcement or healthcare. Similarly, risks exist around targeting high-risk individuals given concerns around information-sharing and loss of privacy which may erode trust in outreach providers. Alongside individual-focused interventions, other approaches include targeting high-risk communities, regions, recruitment methodologies, or use of public health surveillance.

A study of people who use drugs in rural Kentucky found that network and spatial analyses may be a promising way to target overdose education and naloxone distribution²⁶⁹. Peer specialists set up injecting rooms in seasonal shelters in British Columbia, Canada, after a significant increase in fatal overdoses in a particular location. A community intervention in San Francisco alerts practitioners to increases in overdose deaths and any changes to the drug supply, as well as intensifying street outreach where overdoses were occurring.

Across some areas, overdose is a reportable medical condition, and it has been suggested using public health surveillance (similar to other reportable diseases) to identify overdose survivors; then deploy public health teams composed of nurses, social workers, or peers to offer risk reduction, routes to treatment, and respond to survivors, families, and friends. This approach, however, also raises concerns about privacy and how such information could potentially be used for law enforcement. An alternative would be to use syndromic surveillance to monitor trends including overdose clusters and then target interventions to those geographic locations²⁷⁰.

It is acknowledged within the literature that there is a need for further research and the development of programmes. A 2019 review highlights the need to understand when are optimal times to intervene and follow up – at overdose, at emergency department, after discharge, or all?²⁷¹

There are also questions around the optimal composition of the intervention team – should it incorporate those with peer experience (and at what levels of training and background experience)? Should it be restricted to people with whom the individual has had previous contact, if applicable? Another consideration relates to incentives to engage in treatment for individuals; how can services best leverage and protect individual overdose and other private health information in these interventions?

Understanding how these interventions should be tailored towards specific population groups (children and young people, women, those with criminal justice involvement, those with mental health comorbidities and those with recurrent overdoses, for example) should also be considered. The role of the family should also be explored.

A retrospective cohort study using eight linked data sets from Massachusetts government agencies was conducted²⁷². From this data the authors were able to identify eight candidate touchpoints which were associated with increased risk of fatal

²⁶⁹ Powell et al. (2019). Available at: [Promoting opioid overdose prevention and recovery: An exploratory study of an innovative intervention model to address opioid abuse - ScienceDirect](#)

²⁷⁰ Powell et al. (2019). Available at: [Promoting opioid overdose prevention and recovery: An exploratory study of an innovative intervention model to address opioid abuse - ScienceDirect](#)

²⁷¹ Bagley et al. (2019). Available at: [A scoping review of post opioid-overdose interventions - ScienceDirect](#)

²⁷² Larochelle et al. (2019). Available at: [Touchpoints – Opportunities to predict and prevent opioid overdose: A cohort study - ScienceDirect](#)

opioid overdose. The 8 “touchpoints” - 4 opioid prescription touchpoints (high dosage, benzodiazepine co-prescribing, multiple prescribers, or multiple pharmacies) and 4 critical encounter touchpoints (opioid detoxification, nonfatal opioid overdose, injection-related infection, and release from incarceration) were identified as potential targets for the development of overdose prevention interventions. Similar analysis with Scottish Government data could potentially identify opportunities for interventions that could enhance the effectiveness of NFO overdose pathways.

The nature of the intervention may prove to be an important factor. Medication Assisted Treatment has been shown to have an impact. In one study²⁷³ it was found that, for each increase in number of buprenorphine dispensations, the likelihood of a fatal overdose decreased by 94%. Other impacting factors, such as an increase in criminal arrests, increased likelihood of fatal overdose and increases in number of arrest encounters diminished the protective effects of the number of buprenorphine dispensations.

23.3. Taskforce Strategy and Evidence

Developing immediate response pathways for NFOs was one of our six core strategies. Intervention and providing support as quickly as possible after an NFO is a clear way of avoiding or reducing the risk of a fatal overdose. We identified bringing a greater consistency and focus on how this at-risk group can be best treated as an opportunity to reduce drug-related deaths in Scotland.

We promoted collaboration and information-sharing protocols between multiple agencies when reviewing NFO cases. We regularly discussed this strategy during its meetings.

At the meeting on 1 December 2021, we heard evidence from Dundee’s NFO Rapid Response Team. Although this work was not funded by the Taskforce, the model has been demonstrated to be effective (including the team being recognised for their work at the COSLA Excellence Awards in 2022²⁷⁴). Their work began as part of a test of change following the Dundee Drug Commission Report and has now been in operation for more than two years. We consider this a model that could and should be replicated in other areas.

²⁷³ Victor et al (2021) Available at: [Buprenorphine Treatment Intake and Critical Encounters following a Nonfatal Opioid Overdose: Substance Use & Misuse: Vol 56, No 7 \(tandfonline.com\)](#)

²⁷⁴ [COSLA Award for Dundee Non-Fatal Overdose Response Team | Dundee City Council](#)

Drug Deaths Taskforce Research Programme Fund 6

Designing a Behaviour Change Intervention to Reduce the Risk of Overdose (University of Dundee)

This study aimed to understand the psychosocial factors associated with near-fatal overdose among people who use drugs and to identify intervention strategies that would have an effect on rates of NFO, thereby reducing the incidence of drug related deaths. This was a pilot study for the development and small scale trial of a novel behavioural change intervention. Its development was informed by a literature review and qualitative work with individuals with lived experience.

The study found a complex interplay of both internal and external factors affecting risk taking and drug use and the intervention focused on addressing behaviours influencing this. The researchers recommend consultations with stakeholders to further develop the intervention and inform a larger scale evaluation of its effectiveness.

Malaguti et al (2022) *Designing a Behaviour Change Intervention to Reduce the Risk of Overdose*,
Final report to DDTF

Drug Deaths Taskforce Research Programme Fund 7

Ambulance Call-Outs to Drug Overdoses in Scotland: Patterns & Practice (University of Stirling and Scottish Ambulance Service)

This study sought to describe the nature, circumstances, paramedic experiences, and management of drug overdoses presenting to Scottish Ambulance Service, to inform future practice, and local and national interventions to reduce drug-related deaths in Scotland.

The research adopted a mixed methods approach by carrying out a descriptive analysis using secondary data to summarise the characteristics and outcomes of overdose-related ambulance call-outs, including geographical variations, patterns in terms of time of day/day of the week, and changes over time.

Semi-structured interviews with Scottish Ambulance Service staff were used to contextualise this data; capturing views on barriers and facilitators to optimal clinical care and patient outcomes, and on local approaches to service provision and information sharing. This study is currently being written up.

Draft findings demonstrate that ambulance call-outs to overdose (where naloxone was administered by an ambulance clinician) occur more when daylight hours are longer – peaking in June and July. Calls are more frequent at weekends and in the afternoons up to 8pm, though 13% occur between 1 and 8am. The average age of patients was between 39 and 43 and almost 70% were male.

Paramedics had diverse experiences of overdose calls, some reporting them as straightforward and rewarding, others finding the circumstances and handling of the calls challenging. Particular challenges were around ensuring patient safety when they were at risk should the initial dose of naloxone wear off; patients were often reluctant to be taken to A&E and ambulance clinicians felt it was not always suited to their needs.

3,555 individuals identified over 8 years (2013-2021) had been attended by paramedics for more than one overdose call in which naloxone was administered twice or more. 7,542 calls to these patients were not the first call to the patient – each of these are opportunities for intervention. In 1,190 calls, the patient had been attended for overdose at least five prior times. 428 individuals had 10+ calls in this time period.

University of Stirling, update provided to CORRA Foundation, March 2022

Project: *Continuum of Recovery* (Scottish Recovery Consortium)

The Continuum of Recovery for Near-Fatal Overdose (CoRNFO) project is targeted directly towards those people most at risk from drug related death who have experienced a near-fatal overdose. It supports people into an immediate response pathway for NFO which combines the community based response with a residential rehabilitation service. This is the first time this has been done in Scotland.

It provides rapid, flexible and person-centred care, led by frontline staff and the person at risk, and includes a planning and commissioning approach designed to respond to individual cases in a timely, coordinated and empathic manner.

The pathway takes a three phase approach which intensively supports the individual through an initial assessment process and into residential rehabilitation where appropriate, throughout the period of residential rehabilitation and then on discharge during resettlement back in the community.

Following challenges in recruitment and appointment processes, the pathways for referrals went live for referrals the 1 September 2021 and the first CoRNFO client entered into residential rehabilitation early January 2022. The service had received 30 clients by March 22 with the following positive patient outcomes:

- *Two clients supported within a residential rehabilitation placement.*
- *One client within their residential rehabilitation placement had been accepted to onto a health and social care college placement.*
- *Three clients were ready and awaiting admission to chosen residential rehabilitation.*
- *One client had entered into full time employment.*
- *One client had been supported through children and families social work.*
- *All referrals had been supported into the recovery community, with 11 clients actively participating in group work within the Beacon's recovery community.*

The project has identified some elements of learning from their experiences to date:

The importance of having partnership buy in to improve outcomes and the impact of individualised person centred care. Although some clients made an informed choice not to participate in the CoRNFO model and residential rehabilitation, initial therapeutic relationships were made with both CoRNFO staff and community recovery services for when the person is ready to begin their recovery journey. The CoRNFO project has been successful at identifying a group of high risk individuals who have complex needs. While most of the individuals referred have not been admitted to residential rehabilitation, they have been referred to CARES for appropriate community based services.

Scottish Recovery Consortium, update to CORRA Foundation, March 2022

Project: *Rapid Response to near Overdose (Turning Point Scotland)*

Turning Point Scotland was funded for a test of change to improve rapid, short term response to an NFO. The Glasgow Overdose Response Team (GORT) started in November 2020 and has since expanded into the Greater Glasgow and Clyde Area and [Lanarkshire \(LORT\)](#). The project aims to provide a rapid response after an NFO, giving a short focused period of support through assertive outreach and helping individuals to connect or reconnect with services.

An [interim report](#) in May 2022 provided some initial results on the impact and effectiveness of the service. It found that the service has been able to find people, engage with them, save lives and help individuals engage with other services.

It emphasises that time is a critical factor with the shortest engagement times having more favourable outcomes. Referrals directly from hospitals appear to provide one of the quickest referral pathways. Testimonies provided in interviews with 23 individuals who have used the ORT services highlight the impact on their experiences including saving lives, supporting people into treatment, improving physical and mental health and helping them to regain hope. The service reaching out to people where they are seen as a crucial element as was its out of hours availability.

The service has however faced some challenges including data/information sharing and professional competition in a crowded organisational landscape in Glasgow in particular. The original Glasgow service has been reported as a catalyst for strategic change, with the resultant HSCP Crisis Outreach Service now being the main overdose response service in Glasgow.

Turning Point Scotland, update to CORRA Foundation, March 2022

PHOENix after drug overdose for people experiencing homelessness: pilot randomised controlled trial (Simon Community Scotland)

This study was a pilot randomised controlled trial (RCT) of the Pharmacy Homelessness Outreach Engagement Non-medical Independent Prescribing (Rx) (PHOENix) intervention, designed to generate sufficient information on recruitment, intervention fidelity, retention, sample size, resource use, outcomes and perspectives of patients, to demonstrate an impact on Near-Fatal/fatal overdose, and inform a subsequent definitive RCT.

The intervention was focused around ensuring wrap around and out of hours care after hospital/Emergency Department discharge is provided, through assertive outreach bridging the gap back to mainstream care. Specifically, a pharmacist or nurse prescribes, treats and refers, and the team take the patient to Alcohol and Drug Recovery Services for same day re/initiation or dose increase, and follow-up. A Simon Community Partnership (SCS) worker then is involved to address potential issues around housing, benefits, advocacy, and social prescribing.

The RCT embedded qualitative and economic evaluation within its design and built on previous feasibility work. Mixed methods were used to assess the assertive outreach intervention that was centred around the relationship between pharmacist independent prescribers working in partnership with SCS workers and patients who are homeless and have overdosed on drugs. This study is currently still in the field.

Simon Community Scotland, update to CORRA Foundation, December 2021

24. Medication Assisted Treatment (MAT)

24.1. Development of MAT Standards

Medication-Assisted Treatment (MAT) is used to refer to the use of medication, such as opioids, together with any psychological and social support, in the treatment and care of individuals who experience problems with their drug use. A set of MAT standards were developed by a subgroup of the Taskforce, and are informed by the evidence²⁷⁵ that engagement with treatment is a protective factor against drug-related harms, including death, for people who use opioids.

To support the development and implementation of Standards 6-10, Innovation Fund projects were funded that have a focus on psychological interventions, advocacy support and trauma informed care.

The consultation process on the proposed MAT standards commenced in November 2020, closing in February 2021. Approximately 400 responses were received through the workshops and online survey including 100 from people with lived experience of problematic drug use.

There was widespread support for the ambition of the standards and the need for a system-wide approach to improve outcomes for individuals. Feedback demonstrated a clear commitment to change, with lots of opportunities for learning and improvement identified which indicated that the ambitions of the standards were well founded.

Although the MAT Standards have been agreed and are being implemented albeit with a number of challenges, it remains important to note some of the key takeaways from the consultation to ensure that the aims behind the introduction of the standards and the feedback from stakeholders is not lost or forgotten and that a continuous improvement approach maintains the emphasis on the initial purpose and aims of the standards.

Challenges to implementation should not overshadow that there was significant support for all the MAT standards, with each standard considered likely to make a positive difference to reducing drug deaths in Scotland.

There were a number of key themes taken from the consultation:

- the term 'treatment' was clearly understood to mean holistic care and support;
- acceptability to people in need, and building trust and confidence in the system, was highlighted as critical to successful implementation of the standards;
- equity in implementation of all the standards across the whole country, and accountability for reporting the quality of care defined in the standards, were clear expectations;
- people in services reported mixed experiences of the type of support defined in the standards, and reported feeling that the proposed standard of care would make a positive difference to them.

²⁷⁵ [Drugs-related deaths rapid evidence review - Publications - Public Health Scotland](#)

Feedback also identified areas for consideration and concluded that there was a need for:

- communication on the standards, and in particular rights-based information for people who may use services;
- more explicit recognition of the need for family inclusive practice to be embedded in the standards;
- investment across all sectors of the workforce to enable the change people want to see.

Challenges and barriers to change were also identified through examples of practice and these should continue to be taken into consideration through the process of impeding and implementing the standards:

- attitudes of the workforce, including management, and stigmatisation of the workforce and stigma of treatment itself;
- current and historic lack of funding and other resource implications, including staff capacity and development, service design (e.g. opening hours) and infrastructure;
- lack of prescribing capacity and of general capacity in different settings for example prisons (e.g. lack of through care) and community pharmacies;
- lack of trusting therapeutic relationships, perception and understanding of different medications, as well as structural factors such as availability, licences and costs of different medications. Failure to prioritise need and manage difficult relationships with clients, assuring consent and respecting the privacy of individuals;
- the configuration of different services including lack of effective referral processes or mechanisms for engagement (e.g. reliance on letters, role of police);
- lack of information sharing and local information sharing protocols;
- rural issues around access, transport and availability of staff;
- the scale and complexity of need.

24.2. Implementation of MAT Standards

MAT Standards were to be implemented in all ADPs by April 2022. A National benchmarking report on the progress that ADPs are making in implementing the MAT standards was published by PHS in June 2022²⁷⁶. The report included recommended actions to address the gaps which were identified.

It highlighted that there is unwarranted variation in the implementation of the MAT Standards. Medication Assisted Treatment standards 1 to 5 were assessed across all 29 alcohol and drug partnerships. Of 145 standards of care assessed, 17% (25/145) are fully implemented, 65% (94/145) are partially implemented and 18% (26/145) are not implemented.

The report concluded that systems are not sufficiently intelligence led. The national and local systems for the collection of numerical data are frequently unable to provide the person-centred data that is required for the effective implementation of the MAT standards.

²⁷⁶ Public Health Scotland. (2022). Available at: [National benchmarking report on implementation of the Medication Assisted Treatment \(MAT\) standards - Publications - Public Health Scotland](#)

- process documentation was submitted by ADP areas for 98% of standards. For 27% the documentation was sufficient, 32% partially sufficient and for 39% insufficient to demonstrate full implementation of a given standard. There was no data for 2% of standards;
- numerical data was submitted for 86% of standards. For 21% the data was sufficient, 33% partially sufficient and for 32% insufficient to demonstrate full implementation of a given standard. There was no data for 14% of standards;
- experiential data was submitted for 57% of standards. For 16% the data was sufficient, 22% partially sufficient and for 19% insufficient to demonstrate full implementation of a given standard. There was no data for 43% of standards.

At this point in the MAT programme, systems for the collection of evidence are still under development. As most of the information has not been routinely collected before, there is frequently limited capacity to do this, and ADP areas use different data sources and methods to collect data.

In many ADP areas plans have not yet been implemented because of delays in recruitment, conflicting priorities due to COVID-19, and challenges with leadership and financial planning.

The report outlines 8 recommendations to improve the implementation of the MAT Standards:

- fully implement MAT standards 1–5 in the community by April 2023;
- partially implement MAT standards 6–10 in the community by April 2023;
- map and implement the MAT standards in early adopter sites in justice and custodial settings by April 2023;
- ensure the MAT standards provide improved access, choice and care for specific populations;
- build sustainable numerical data systems to monitor and improve implementation of the standards;
- build sustainable experiential data systems to monitor and improve implementation of the standards;
- conduct targeted national investigations;
- strengthen the improvement and benchmarking programme for the MAT standards.

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Project: *MAT Standards Delivery Support* (Scottish Drugs Forum)

The aim of this project was to support the delivery of the MAT standards. This has involved the running of webinars and events to support the development of, consultation on and eventual implementation of the MAT Standards.

As part of this project SDF ran a series of webinars and events:

- The MAT Standards consultation launch, 20 November 2020 – 416 attendees and over 1000 YouTube views
- 31 online consultation workshops (15 with all stakeholders and 9 dedicated workshops for lived experience representatives and 7 with clinicians.) – 196 attendees (74 for the lived experience only workshops and 39 for the clinicians only workshops)
- cross party group on Drugs and Alcohol on 12 February 2021 – over 300 views.
- MAT Standards launch, 11 June 2021 - 487 attendees and 404 YouTube views
- stakeholder engagement event: Developing Heroin Assisted Treatment – learning from current practice, 22 June 2021 - 255 attendees and 345 YouTube views
- stakeholder engagement event: Responding to Benzodiazepine Dependence within MAT, 25 June 2021 – 254 attendees and 896 YouTube views
- implementing MAT - Living experience perspectives webinar, 08 October 2021 – 166 attendees and 263 YouTube views.

A [resource](#) for each of the first 5 MAT standards was launched on 7 July 2022, and can be distributed by services or service planners locally when they are comfortable that the level of service referred to has been achieved.

A momentum event will be delivered in year two of the project along with five further webinar events relating to MAT / MAT implementation.

SDF, update to CORRA Foundation, July 2022

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Project: *Designing and Implementing Effective Telehealth MAT Projects* (University of St Andrews)

The purpose of this project was to provide information, tools and support to tackle the contextual issues behind the implementation of the MAT standards both conventionally, but primarily through telehealth.

Telehealth has the potential to deliver more efficient care, and through this, increase the capacity of services to reduce barriers to MAT.

The project team carried out a rapid literature review, identifying good practice examples and ran a virtual seminar. Ten presenters from Canada, USA, Scotland and England shared their good practices with 160 Scottish and worldwide stakeholders attending the online seminar.

The team drafted a guidance document and held a consultation on it. A total of 71 people identified good practices and reviewed the document and provided feedback. The document was shared with the stakeholder panel comprising of 12 experts working in the addiction services, healthcare innovation, NearMe, including pharmacy, police and MAT Scotland representatives. The TMAP guidelines are now published. The team have since provided support in accessing and understanding the guidelines and aspects of their implementation.

Following the development of the TMAP guidelines, the project team have now moved to a pilot of the TMAP process in NHS Fife, before exploring a wider roll out.

University St Andrews, update to CORRA Foundation, March 2022

25. Benzodiazepines

A review of benzodiazepine use was conducted by Scottish Government²⁷⁷ which analysed current trends of use across Scotland. Benzodiazepines are a group of anxiolytic or psychoactive drugs originally designed for controlled medical use through prescription in the treatment of a variety of conditions, ranging from anxiety, insomnia, and seizures to musculoskeletal pain and palliative care. Some commonly known brand names for these include Diazepam, Temazepam and Valium.

The use of both prescribed and non-prescribed ('street') benzodiazepines has been well-documented among people who use drugs in Scotland since at least the 1980s, however recent years have witnessed a sharp increase in benzodiazepine-related harms and benzodiazepine-implicated deaths, largely due to street benzodiazepines.

The data suggests that the illicit supply of 'street' benzodiazepines has replaced the brand names that would have been available via prescription up to the mid-2000s. From then, there was a shift in clinical guidance in response to escalating drug-related deaths with decreases in prescribing coinciding with the emergence of novel psychoactive substances (NPS), including new benzodiazepines.

Motivations for benzodiazepine use among people who use drugs are wide-ranging and have been evidenced to include a range of psychological, social, economic, and supply-driven factors. Motivations often include the self-management of psychiatric disorders and adverse experiences; their pleasurable effects, and affordability and ease of access.

The evidence review found that deaths where street benzodiazepines were present have risen significantly since 2015; largely related to etizolam, a substance which only emerged on the market in the mid-2010s and has risen sharply from being found in 43 deaths in 2015 to 806 in 2020.

Etizolam and many other street benzodiazepines were not controlled substances in the UK until the Psychoactive Substances Act of May 2016, before being included under the Misuse of Drugs Act in May 2017. However, a shift has occurred in recent years towards the domestic production of benzodiazepines, in Scotland, with domestic industrial laboratories capable of producing millions of pills per day at extremely low cost to consumers.

The review highlighted evidence of high benzodiazepine use and harms among people who use opioids with high frequency of use and consumption of high doses. Usage of these kind of drugs in conjunction with opiates such as heroin or methadone has become an increasingly prevalent part of Scotland's poly-drug usage.

As unregulated imitations of prescription drugs, street benzodiazepines are often widely variable in potency, often being much more potent than their prescribed counterparts, and may contain a number of unmarked harmful substances. Etizolam

²⁷⁷ Scottish Government. (2022). Available at: [Benzodiazepine use - current trends: evidence review - gov.scot \(www.gov.scot\)](https://www.gov.scot/Benzodiazepine%20use%20-%20current%20trends%3A%20evidence%20review%20-%20gov.scot)

is roughly 6-10 times more potent than diazepam, is a licensed prescription medication in Italy, India and Japan and shows relatively comparable signs of harm to diazepam when used therapeutically²⁷⁸.

The risks associated with street benzodiazepine use are extensive and well documented, relating to both direct and indirect harms that include but are not limited to seizures, risk-taking behaviours, cognitive impairment, homelessness, contact with the criminal justice system, overdose and death²⁷⁹.

While etizolam remained the most prevalent street benzodiazepine in 2020, more detailed toxicology data within the NRS drug-related deaths report also evidence broadly increasing prevalence of different variations. As of 28 February 2021, the EMCDDA was monitoring 30 new benzodiazepines through the EU Early Warning System²⁸⁰. Of these, more than 80% were detected for the first time between 2014 and 2020.

25.1. Benzodiazepine Prescribing

In 83.8% of cases for new patients – with no prescription prior to 2015 – benzodiazepines were prescribed for three months or more. However, there has been a broad decrease in benzodiazepine prescription trends; with 265,000 adults receiving at least one prescription for benzodiazepines in 2010/11, compared with 240,000 in 2014/15 and 225,000 in 2019/20²⁸¹.

Women are currently 1.8 times more likely to receive a prescription for benzodiazepines than men. 6.3% of the adult female population in Scotland in 2019/20 received a benzodiazepine prescription, compared with 3.6% of the adult male population. However, in 2019/20, men were up to 1.2 times more likely to receive long term prescriptions (12 months or more) than women were²⁸².

Deprivation has a consistent effect across all classes of prescription, with higher proportions of those in the most deprived quintiles receiving at least one prescription throughout the year. Those from the most deprived areas are more than twice as likely to receive prescriptions for benzodiazepines than those in the least. Deprivation is also associated with longer treatment duration, with those from the most deprived areas being between 1.3 times as likely to receive benzodiazepine prescriptions for 12 continuous months or more, than those in the least. Trends for benzodiazepine prescribing according to deprivation quintile have been stable for the past ten years²⁸³.

²⁷⁸ EMCDDA (2021). Available at: [New benzodiazepines in Europe – a review \(europa.eu\)](#).

²⁷⁹ Scottish Government. (2022). Available at: [Benzodiazepine use - current trends: evidence review - gov.scot \(www.gov.scot\)](#)

²⁸⁰ EMCDDA (2021). Available at: [New benzodiazepines in Europe – a review \(europa.eu\)](#).

²⁸¹ Scottish Government. (2022). Available at: [Benzodiazepine use - current trends: evidence review - gov.scot \(www.gov.scot\)](#)

²⁸² Scottish Government (2021): [Short Life Working Group On Prescription Medicine Dependence And Withdrawal: consultation - gov.scot \(www.gov.scot\)](#)

²⁸³ Scottish Government (2021): [Short Life Working Group On Prescription Medicine Dependence And Withdrawal: consultation - gov.scot \(www.gov.scot\)](#)

25.2. MAT Standards Informed Response for Benzodiazepine Harm Reduction

When developing the MAT Standards, a benzodiazepine working group was established in 2021 to consider existing practice and approaches to care, including prescribing. This also recognised benzodiazepine prevalence in the drug-related deaths report for 2020.

The working group agreed that the unprecedented harm associated with street benzodiazepines in Scotland is a public health emergency that demands a different approach. The false notion that postponing change in prescribing practice is the safest position and acceptance of the current status quo, is unacceptable. The current rate of high levels of benzodiazepine related harm seen in Scotland qualify in the Orange Guidelines as 'exceptional circumstances'.

There is no straightforward, one size fits all approach to reduce harm from street benzodiazepines. Existing literature has limited applicability in the current Scottish context and national evaluation of current practice and research into future prescribing interventions are both at an early stage.

The group developed guidance²⁸⁴ which places the person at the centre of their care and treatment, taking a holistic and integrated approach in line with realistic medicine. It represents a national consensus of expert opinion to specifically respond to rising harms, incorporating available evidence of effectiveness from practice.

The interim guidance set out a number of key pieces of advice for prescribers:

- **Be prepared to talk about benzodiazepine harm reduction (MAT 1, 3, 4)** – benzodiazepine conversations should happen from first day of presentation to any service as part of harm reduction support to individuals. The ethos of same day treatment for most people will be gaining an understanding of benzodiazepine use and harms to develop a benzodiazepine care plan and to offer immediate harm reduction advice. Individuals should be proactively assessed for appropriate stabilisation prescription and psychological support within specialist services.
- **Empathetic listening – seek to understand (MAT 5, 6, 10)** – Anyone accessing support should be seen regularly and encouraged to discuss their benzodiazepine use. They should have autonomy in relation to their treatment. The guidance offers advice on how to understand and respond to the choice of the individual on whether they wish to change their benzodiazepine usage or not.
- **Needs based assessment (MAT 6, 10)** – A holistic bio-psycho-social assessment will inform a unique and shared understanding of the person's benzodiazepine use. The psychological formulation provided will help to identify the specific factors which will directly inform the care and treatment plan.
- **Zone of accepted risk– collaborative risk assessment (MAT 1, 2, 3)** – The risks associated with street benzodiazepine use are extensive and well documented.

²⁸⁴ [mat-standards-informed-response-for-benzodiazepine-harm-reduction_interim-guidance_august-2021.pdf \(drugdeathstaskforce.scot\)](#)

These risks are acknowledged within The Medicines and Healthcare Regulatory Authority (MHRA) and Competition and Markets Authority (CMA) advice for benzodiazepines and opioids. However, the MHRA guidance does not consider that people using street benzodiazepines are already experiencing many of these harms from their street drug use and that a prescribing intervention is acknowledging these harms and aiming to reduce them. The guidance developed by the working group promotes the ethos of a zone of accepted risk between the prescriber and the person. A summary of risk associated with street benzodiazepine use should be weighed and documented against a summary of the risks of treatment options.

- **Offer benzodiazepine harm reduction (MAT 1, 2, 6, 9, 10)** – The assessment, psychological formulation and risk analysis described above will support the identification of shared goals which may include:
 - an immediate response to support harm reduction
 - offer of appropriate psychosocial/logical interventions
 - supported self-reduction of street benzodiazepines
 - medication assisted detox for abstinence
 - medication assisted stabilisation (maintenance prescribing).
- **Shared goals – review progress (MAT 2, 3, 5, 10)** – Interventions under this guidance should be regularly monitored, reviewed and agreed with the person. Any changes to the treatment plan should be discussed with the person, ideally in advance and a further review date agreed.

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Exploring the utility and safety of benzodiazepine prescribing among people receiving Opiate Replacement Therapy in Scotland (University of Stirling)

This study sought to describe the prevalence, characteristics, and patient outcomes associated with benzodiazepine prescribing among people receiving opiate replacement therapy (ORT) in Scotland.

This study used data gathered from a retrospective cohort of people representative of those who have received ORT from a specialist addiction service in four Health Boards (Lothian, Ayrshire and Arran, Greater Glasgow and Clyde, and Tayside). Health board data on patient characteristics and outcomes was securely linked to national data on prescriptions, hospitalisation, drug related death and all-cause mortality. A survival analysis and modelling exercise then explored differences between exposed and unexposed groups. This study is currently still in the field.

University of Stirling, update to CORRA Foundation, March 2022

26. Heroin Assisted Treatment (HAT)

Heroin Assisted Treatment (HAT) is an evidence based alternative to conventional Medication Assisted Treatment for people seeking support for street heroin use. HAT involves providing prescribed heroin under supervised conditions²⁸⁵ to people with long-standing heroin use who have not been able to stop using drugs despite multiple attempts with other treatments, such as receiving conventional treatment, care services and residential rehabilitation. It is currently used in a number of European countries, including Switzerland, Germany, Austria, the Netherlands, and Denmark, and is legal in the UK under specialist licence.

Patients identified as eligible for HAT are prescribed a set dose of pharmaceutical heroin by a specialist doctor, which they inject two to three times per day under clinical supervision in specialist outpatient facilities. The treatment programme also includes other services, such as counselling and support to resolve issues with housing, benefits, or other health conditions. Patients are not able to take away prescribed heroin from the treatment service; it can only be taken on site under the supervision of clinical staff.

26.1. Criminal Justice and Law Sub Group Engagement

Prescribing heroin is legal and operational in Glasgow but many respondents to research conducted by our Drug Law Reform sub group²⁸⁶ felt this needs to be expanded. Heroin-Assisted Treatment (HAT) refers to the prescribing of injectable, pharmaceutical-grade diamorphine (heroin), which is then self-administered in a specialist outpatient facility under clinical supervision with strict safeguards. There is high-quality evidence to suggest that it can improve individual and social outcomes when provided as a second-line treatment for people with chronic opiate dependency²⁸⁷.

Prescribing heroin usually for use in clinics under medical supervision can be particularly useful for individuals that haven't, for a number of reasons, engaged or responded well to treatment with methadone or other medication.

Respondents felt that the process for submitting a license application for HAT is overly complicated and resource intensive. Currently there is one Enhanced Drug Treatment Service, which includes heroin-assisted treatment, in Scotland that is located in Glasgow City Centre. Respondents suggested that the ability to offer HAT alongside other Medication Assisted Treatment should be more widespread and that any remaining barriers to the provision should be removed.

²⁸⁵ <https://www.glasgow.gov.uk/CHttpHandler.ashx?id=38604&p=0>

²⁸⁶ [drug-law-reform-report-sept-6th-21.pdf \(drugdeathstaskforce.scot\)](#)

²⁸⁷ Tweed et al. (2016). Available at: ["Taking away the chaos" The health needs of people who inject drugs in public places in Glasgow city centre](#)

26.2. Case Study: NHS Greater Glasgow & Clyde Heroin Assisted Treatment Programme

Following an outbreak of HIV in people who inject drugs in Glasgow, a health needs assessment²⁸⁸ confirmed what many clinicians have known for years - that despite having access to methadone and/or buprenorphine (and indeed other evidence based approaches including residential rehabilitation), people may continue to use drugs in a highly risky manner. The assessment recommended that a pilot of HAT for this “hard edges” population be undertaken.

One of the barriers to implementing this treatment has been the high cost. However, the evidence is of favourable cost benefit and Glasgow HSCP were able to evidence the substantial cost to the health and social care system that the target population already incurred, and the likely benefits to police and wider criminal justice systems.

From December 2019 to December 2020, 20 people were referred to the Enhanced Drug Treatment Service (EDTS). After screening and assessment, 16 service users were commenced on injectable opiate therapy. In total, 15 (88%) service users who were commenced on diamorphine completed the baseline evaluation with 9 service users completing the 12-month evaluation tool. The evaluation results largely focus on those who have completed 12 months of treatment as no information was available for those who had left the service.

80% of all referrals into the EDTS came from the homeless addiction team, a smaller number of referrals came through the City Centre (Glasgow) Outreach Team (13%) and the Acute Addiction Liaison Service (7%). Over a quarter (27%) of those referred into EDTS commenced treatment following a stay within the Glasgow Drug Crisis Centre or the Stabilisation Unit.

All of the referred individuals had been homeless in the six months prior to engaging with the EDTS. All service users were tested for blood borne viruses whilst in treatment with 60% overall receiving positive results and all going on to initiate treatment. A third of those who started treatment have completed this with a successful outcome (undetectable HIV/HCV).

Implementation of HAT in Glasgow

Although HAT is a legally permissible treatment, the service site needed a license from the Home Office, as well as prescribers’ licenses issued by the Scottish Government.

Glasgow HSCP developed the treatment criteria and prescribing guidelines, following a review of the international literature. This was influenced by the RIOTT²⁸⁹ study from England, though lowering the threshold from the RCT standards used in the study. Essentially, the HSCP offered the treatment to city centre homeless high risk heroin users who had a record of having tried other treatments. They were not expected to be abstinent from other substances such as street benzodiazepines prior to starting HAT.

²⁸⁸ Tweed et al (2018) [“Taking away the chaos”: a health needs assessment for people who inject drugs in public places in Glasgow, Scotland | BMC Public Health | Full Text \(biomedcentral.com\)](#)

²⁸⁹ [PowerPoint Presentation \(foundationshealthcare.co.uk\)](#)

Recognising the complex needs of the service users, a service specification was developed that addressed their broader health and social care needs, creating a multi-disciplinary approach in the EDTS. This service was co-located with key partners: the homeless addiction team, blood borne virus colleagues, homelessness GPs, Housing First Officers, Welfare Rights workers and others.

Early evaluation²⁹⁰

As at March 2021, 16 individuals had been treated. In terms of outcomes, everyone in the service now has accommodation and access to food, has been out of prison for any new charges and is less like to use emergency services. Only one patient has fallen out of treatment (despite the service's best efforts) and many are benefitting from support from other partner services, particularly the BBV team, GPs and Housing First.

The treatment has been discontinued in some patients who were not only failing to improve, but in whom there was no evidence of reduction in risk despite optimal dosing and intensive support. The absence of meaningful near patient testing for street benzodiazepines and gabapentinoid use has meant an over reliance on presentation and accounts of drug use, and although this is not problematic almost all of the time, the service has on a few occasions had to reverse significant overdoses following injecting diamorphine in patients who, it transpired, had these drugs in their system.

The transformation in most patients is profound. People who had not slept under a roof for an extended time, now have keys to a home. They can afford to buy luxuries such as clothes, haircuts and Christmas presents. There is little culinary ability in the patient cohort, but they can afford to eat. They have wounds dressed, negligible viral (HIV) loads, Hepatitis C clearance and some are engaging with GPs for the first time ever. Most rewarding of all, many seem to have regained some degree of self-respect and dignity. A few have engaged with recovery communities and recovery workers, unimaginable the previous year.

A further evaluation of the service is being conducted by Glasgow Caledonian University and evidence from this should be fully examined and used to assess potential widening of HAT services.

27. Case Study: WAND Initiative

NHS Glasgow Greater and Clyde and third sector partners launched an incentive based harm reduction initiative to further reach out to people who inject drugs at a time where service provision remained limited. The WAND initiative (wound care, assessment of injecting risk, naloxone and dried blood spot testing) encourages clients to participate in 4 key harm reduction interventions and was designed to address key issues faced by people who inject drugs within Glasgow City Centre, including drug related death, injecting related complications and BBVs.

²⁹⁰ [Heroin Assisted Treatment/Enhanced Drug Treatment Service | Drug Deaths Taskforce](#)

The Assessment of Injecting Risk (AIR) tool, a comprehensive assessment tool accessed from any internet enabled device, is aimed specifically at people injecting street drugs. It helps to identify a wide range of injecting-related harms and their causes, and allows in-depth conversations regarding necessary harm reduction. The process is interactive and has demonstrated improved interaction from both specialist workers and clients. The AIR tool uses smart logic to support staff in asking appropriate questions related to current injection activity.

To encourage clients to continue the programme, when all interventions are completed the client is provided with a Pay Point voucher. Although this initiative increased workload, harm reduction staff reported feeling skilled, reinvigorated and focused as the positive interaction of the assessment process improved service users' engagement and gave staff greater role validation. The Glasgow Drug Crisis Centre ensured this activity was given priority even during tight COVID-19 restrictions.

Drug Deaths Taskforce Research Programme Fund 11

Understanding the Role and Potential of Primary Care in the Prevention of Drug Deaths post COVID-19 (University of the West of Scotland and University of Stirling)

This study examined how Primary Care Teams in areas of extreme deprivation respond to drug-related harms, intending to use its findings to inform future policy, practice and research on the prevention of drug deaths¹.

This study combined complex systems mapping and interviews with general practitioners (GPs), patients, family members and other stakeholders to explore models of care and interventions delivered by two Deep End GP practices. In-depth case studies were used to illustrate the role and potential of Primary Care in the prevention of drug-related harms and deaths, as well as the impact COVID-19 has had on how GPs provide care for people who use drugs.

O'Gorman et al. (2022). Understanding the Role and Potential of Primary Care in the Prevention of Drug Deaths post COVID-19.

Project: *Hospital Addiction Care Team (NHS Grampian)*

This aim of this project is to upgrade and expand the existing alcohol liaison service and associated volunteer peer supporters in Aberdeen Royal Infirmary (ARI) into a Hospital Addictions Care Team supporting people who present to hospital with drug or alcohol issues.

The Drugs and Alcohol Care Team (DACT) has now recruited 4 band 6 nurses and consists of Consultant Medical Lead for DACT (2xPA weekly), 1 WTE Band 7 Lead Nurse (RMN), 6 WTE Band 6 Nurses (RMN), Consultant Psychiatrist (1 x PA weekly) and 0.4 WTE Clerical Officer Band 2. The service went live on the 17th of January with wide communication within ARI.

The service runs from 8am until 8pm including weekends and there is a member of staff based in the Emergency Department (ED) more permanently.

The team have developed pathways with the psychiatry team within the Acute Sector and have now recruited a Consultant Psychiatrist who will provide support to the team. The Medical Lead has conducted a staff experience survey with regards to the existing Alcohol Liaison Service (ALN) and the expansion to DACT service and has analysed the results. They are currently in the process of gathering data on clients using the service, re admissions and drugs and alcohol related deaths.

There has been a significant increase in patients being referred to the service, especially from the Emergency Department and the test of change regarding placing a member of staff in the Emergency Department permanently has been perceived very positively. Weekly referrals have been around 40 since the launch compared to 14-15 in previous years. The team has highlighted that stigma towards these patients/client group has been challenging.

28. Community Pharmacies

Community Pharmacy Scotland continually develop and secure a contractual framework for the provision of pharmaceutical services, supported by a sustainable funding model which encourages investment in the network as outlined in the written evidence²⁹¹ for the Joint Scottish Parliament Committee Session on 1 and 2 February 2022. This is achieved by negotiating with the Scottish Government on behalf of their members on all terms of service and remuneration and reimbursement under the NHS.

Community pharmacy owners are independent contractors whose businesses make up a diverse network of 1,258 primary care providers. Their teams are experts in medicines and are highly trained healthcare professionals who can provide advice on preventing and managing ill-health. Increasingly, community pharmacies are the first port of call for people experiencing minor illnesses and managing diagnosed long-term conditions. All Scottish community pharmacies offer core NHS services designed to meet these needs, and these are often complemented by local services that address more specific issues in each HSCP.

28.1. Support for people who use drugs/those in treatment

Currently, almost all community pharmacy teams in Scotland deliver support for people who use drugs and those in treatment on behalf of the NHS. The common denominator across these pharmacies is the supply and (where appropriate) supervision of opioid substitution therapy (OST). National Pharmacy fee negotiations are between Scottish Government and Community Pharmacy Scotland and local negotiations (currently the OST supervision is in this category) are between health boards and local contractors. Not all health boards have moved to a per capita payment but this is supported by the professional body, Royal Pharmaceutical Society²⁹², and the specialist pharmacists group. The main barrier is that different health boards pay different fees and it is difficult to get a nationally agreed figure without additional funding.

There is significant variation in the service that each Health Board has contracted pharmacy owners for. In some areas OST is all that is provided, whilst other areas provide a comprehensive range of services.

28.2. Community Pharmacy Scotland additional observations and recommendations

Through engagement with CPS, they advised that, across the country, there is a lack of consistency when it comes to the support that the NHS contracts community pharmacies to deliver. Additionally, there is an under-realisation of the potential that pharmacies hold given their frequent contact not only with those in treatment but also with people who use drugs within communities, alongside insufficient funding to fully support the needs of the people that they see daily.

²⁹¹ [Evidence for Joint Committee Session of Scottish Parliament | Drug Deaths Taskforce](#)

²⁹² Royal Pharmaceutical Society. (2021). Available at: [The pharmacy team's role in reducing harm and preventing drug deaths \(rpharms.com\)](https://www.rpharms.com)

This has resulted in a significant variance in service provision that is not only inequitable, but challenging to deliver for organisations and individuals whose work extends across multiple areas or Health Boards. The expectations of services are also difficult to manage for those in treatment who then move areas and need to find a different level of support.

To address this growing issue, CPS identified the need for a national service agreement, or a common framework approach to service development and deployment across Scotland – either of which must be designed in line with the MAT standards. This would involve working with key stakeholders to first identify the needs of the population and design impactful interventions. Thereafter, CPS would provide expert input on what is deliverable through the community pharmacy network and the resource required to do so.

More positively, some innovative health boards have moved away from historic transactional models towards a “package of care” concept. This provides a solid base from which to build a service that could make a significant impact to health outcomes and provides improved financial predictability.

CPS have provided an indication of a base service that would be possible in nearly all pharmacies with the appropriate resourcing in place, these have been linked to the MAT Standards:

- advice, information services and signposting for the whole community (MAT Standards 3, 4 and 5);
- dispensing and supervision of OST tailored to the individual’s needs (e.g. frequency) (MAT Standard 2);
- assurance of same-day initiation on receipt of prescription (e.g. through agreed stockholding) (MAT Standard 1);
- Naloxone (MAT Standard 4)
 - complete network coverage of stock in case of emergency;
 - training, provision and re-supply for people who may need it;
- Injecting equipment provision availability wherever physical space permits (MAT Standard 4);
- agreed standards and triggers for care planning, data gathering and information sharing across services (MAT Standards 3, 4 and 5) – would require a shared, easy to use platform;
- mechanism for referring people into treatment (MAT Standard 3);
- targeted public health campaigns (MAT Standard 4).

There is more that would be possible to deliver through all community pharmacies (e.g. Blood Borne Virus (BBV) interventions such as testing, Buvidal administration etc.) but the above list is reflective of a standard that could be developed, agreed and deployed along relatively short timescales. Critical to achieving equity will be agreement between health boards of identified need and proposed service level, as well as the availability of the resource required to make this possible for the people of Scotland.

Feasibility and acceptability of an overdose prevention intervention delivered by Community Pharmacies for patients prescribed opioids for chronic non-cancer pain (CNCP) (University of Stirling)

This research builds on previous work on prescription opioid overdose risk (POOR), known as the POOR 1 study, carried out in 2019 that was based in NHS Fife. The previous study found substantial levels of high-strength opioid prescribing for patients with CNCP, and comorbidities and co-prescribing that increased overdose risk for this group. With CNCP patients often overlooked in harm reduction provision, the team developed a bespoke overdose prevention intervention that patients, non-related family members, and community pharmacists evaluated.

The current study, known as the POOR 2 study, builds on the POOR 1 findings and assesses the feasibility and acceptability of the overdose prevention intervention from the perspectives of the CNCP patients receiving it, and the community pharmacists delivering it. The overdose prevention intervention provided CNCP patients with overdose awareness information, naloxone training, and the provision of take-home naloxone. A mixed methods approach was used to gather data about the feasibility and acceptability of the intervention and to establish how this intervention works in practice, with the potential of later implementing this in a randomised controlled trial.

Both patients and pharmacists were supportive of the intervention. Generally, the level of knowledge amongst patients regarding opioid safety and naloxone were low. Patients perceived that they were at low risk of opioid overdose, even though all were prescribed high-strength opioids. As the intervention delivered essential opioid risk knowledge, patients developed insight into the value of naloxone for themselves as a member of the CNCP community. Community pharmacists noted that there were often breakdowns in the communication of risk to patients, which contributed to low overdose awareness knowledge. Pharmacists also outlined that patient perceptions of risk related to their opioid medications were often very low and proposed the intervention as providing patients with important opioid safety knowledge.

Foster et al (2022), final report to DDTF, February 2022

Drug Deaths Taskforce Innovation and Development Fund 18

Project: *Pharmacist Clinical Input* (NHS Dumfries and Galloway)

The project's aim is to reduce drug related deaths and meet treatment waiting times in rural localities by providing same day prescribing and allowing quicker access to treatment. An additional aim is to improve patient experience, by providing a flexible treatment model which would facilitate an open-door drop-in resource, whilst providing long term maintenance treatment provision in patient's local communities.

Both pharmacists are now in post, holding a case load of 45 patients for a maintenance OST clinic as well as providing medication reviews for these patients. The rapid access clinics are still in the development phase for covering all 4 localities within D&G but there is a rapid access clinic available one day per week in the main Drug and Alcohol Unit in Dumfries currently.

The project has had challenges in the design of the rapid access clinics and through the limited number of prescribers available. However, having a prescriber within the drug and alcohol service five days per week has enabled the service to deal with any urgent prescription queries i.e. patients who have fallen off their OST script and require a re-start. Previously patients would have to wait up to 72 hours for new prescriptions.

NHS Dumfries & Galloway, update to CORRA Foundation, March 2022

29. Criminal Justice System

Scotland's Alcohol and Drug Strategy, *Rights, Respect and Recovery*²⁹³ advocates a public health approach to ensure delivery of the best possible care, treatment and responses for individuals and communities. It has an overarching outcome that vulnerable people are diverted from the justice system wherever possible and those within justice settings are fully supported. The Scottish Government's National Mission²⁹⁴ also aims ensure a humane and responsive justice system.

The Criminal Justice Committee²⁹⁵ identified several issues in relation to the misuse of drugs and the criminal justice system. These included:

- lack of access to treatment – only 35% of the 60,000 people with drug problems in Scotland are in treatment, compared to 60% in England (although data recording and measurement differs);
- problems providing alternatives to prosecution or custody where community-based support and referral to drug services would be more beneficial to people charged with drug offences;
- lack of support for people with problem drug use before, during and after their prison sentences;
- need for more training of police officers and others working in the justice system to become trauma informed, so they understand health issues and the underlying causes of drug use. This would facilitate a more appropriate and compassionate response.

The committee made several recommendations on increasing access to various treatments, increased support for prisoners, and more emphasis on preventative measures and addressing the health and societal disadvantages.

The group mapped the criminal justice journey for someone found by the police in possession of suspected heroin (class A) or benzodiazepines such as etizolam (class C). This approach was taken for simplicity but we recognise that people can enter into the criminal justice system for a range of potential offences, and that often the offence does not relate to the Misuse of Drugs Act 1971.

It was also recognised that the people we are most concerned about are the most vulnerable who often have complex needs. This process map built a shared understanding of the current system. We have also held a number of working groups to conduct deep dives into the key interaction points with the justice system and people who use drugs. These working groups have included representation from the Crown Office and Procurator Fiscal Service (COPFS), Police Scotland, Scottish Courts and Tribunals Service, NHS, SACRO, Community Justice Scotland, Community Justice Partnerships, Scottish Government, Scottish Prison Service, lived experience and family representatives, Academics, ADPs and third sector organisations among

²⁹³ Scottish Government. (2018). Available at: [Rights, respect and recovery: alcohol and drug treatment strategy - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/documents/2018/06/20180613_rights_respect_and_recovery_alcohol_and_drug_treatment_strategy.pdf)

²⁹⁴ Scottish Government. (2021). Available at: [Drugs policy - update: statement by the First Minister - 20 January 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/documents/2021/01/20210120_drugs_policy_update_statement_by_the_first_minister_20_january_2021.pdf)

²⁹⁵ Scottish Parliament, Criminal Justice Committee. (2022). Available at: [Judged on progress: The need for urgent delivery on Scottish justice sector reforms \(parliament.scot\)](https://www.parliament.scot/committees/criminal-justice-committee/2022-03-16-judged-on-progress-the-need-for-urgent-delivery-on-scottish-justice-sector-reforms)

others. There was a consensus that people in custody must have an equivalence of care with people in other communities. There is duty on services to provide this equivalence and any barriers to this must be removed.

The key messages to reduce drug-related deaths have included ensuring support and treatment options are available in the justice system and that release from custody happens at a time when services are immediately available. Services also need to be flexible in ensuring, as part of their anticipatory care planning, that people being released from custody can be provided with support as quickly as possible. Anticipatory care also extends to ensuring appropriate, person-centred care is available to cover the transition from justice settings back into the community. It was agreed that people who use drugs should have access to equivalent support through the most appropriate MAT and that naloxone provision is as available in the criminal justice system as it would elsewhere.

29.1. Police Referral Arrest interventions

The Criminal Justice and the Law sub-group undertook a series of visits²⁹⁶ to allow members to experience first-hand how operational practice could be improved or altered to support better health outcomes for people who use drugs. A number of alternative approaches are now being trialled throughout the UK that endeavour to take a public health approach to drugs and, where appropriate, divert individuals out of the criminal justice system. We were able to visit two examples of such programmes in England.

Durham Constabulary Operation [Checkpoint](#) is a voluntary adult offender diversion scheme operating in the Durham Constabulary's police force area. It is a deferred prosecution scheme that was introduced as a means of reducing reoffending by addressing the root cause of offending behaviour. The scheme is applicable to a range of offences including those of possession, minor production and small-scale supply of all drug types. To be eligible, crimes must be less than three months old and an offender must have made an admission of guilt, or a no reply interview with the provision that there is sufficient evidence to charge. Eligible offenders undergo a needs assessment with the support of a specialist navigator and consent to a bespoke four-month contract to engage. This contract may include: a condition to not reoffend for the length of the contract; restorative approach with victims if asked; undertaking one-to-one work with a navigator to address the issue which contributed to the offence; 18-36 hours of voluntary work and voluntary drug testing.

The Thames Valley [Police Diversion Scheme](#) offers eligible individuals found in possession of drugs a community resolution outcome, such as referral to a drug treatment provider, instead of being prosecuted. The scheme is voluntary. When an individual agrees to participate in the scheme, their details are passed to the drug service provider who arranges for an appropriate intervention. The police then liaise with the drug service provider to confirm that the individual has engaged with them. If the conditions of the referral are broken, then the individual would subsequently be charged with a possession of drug offence and would not be eligible for further diversion if found in possession of drugs again. If an individual declines to take part at

²⁹⁶ [Criminal Justice and the Law Sub Group - Report - Learning from three visits | Drug Deaths Taskforce](#)

all they will continue through the traditional criminal justice route. Individuals are referred in, even if their drug use is not problematic, and the evidence to date suggests that this has enabled the provision of harm reduction advice, and also to make connection in the event that the individual wishes to access services in the future.

Project: *Pathfinder (Medics Against Violence)*

Medics Against Violence (MAV) is a third sector organisation run by healthcare professionals. Their [Navigators](#) have been active since 2015 and are operational in seven Emergency Departments (ED). There is a strong evidence base supporting this model and expansion into the criminal justice space.

The established initiative run by MAV helps to navigate individuals away from chaotic lifestyles. Navigators work in the hospital at the weekend, normally alongside NHS partners on weekend nightshifts. They also work in the surrounding communities during the week through assertive outreach and supporting service users. MAV made a successful funding bid to the Drug Deaths Taskforce Innovation Fund to pilot the police referral navigator model in Scotland called [Pathfinder](#), a service for people with problematic drug use.

The Pathfinder programme has established a referral pathway facilitating support at the earliest point of interaction with the criminal justice system. Police refer individuals to a peer navigator who proactively engages with them to ensure they can access holistic support and connects them with community organisations that can aid their recovery. If subsequent forensic testing indicates that any illegal substances that were recovered from the person are controlled, a report is made to COPFS, sharing the individual's identifiable needs and engagement with services. This will inform decision making, including whether diversion is supported in their case.

MAV have been operating the programme in Inverness in the first year, and are now moving to run the service Dundee. They have engaged with 60 individuals, supporting 58 people, who have come into contact with the police, to access support and treatment services, with only 2 refusing support. They have identified a number of vulnerabilities in the people they have supported as well as a range of drugs being used. They have also noted that many were using a combination of drugs.

Of the 58, 10 met or had contact with Pathfinder on one occasion only, and then either decided that they had enough support elsewhere or were uncontactable. 48 (80%) had a meaningful engagement with the service and had contact with Pathfinder on 2 or more occasions (range 2->20 contacts). Lack of a phone seemed to be an issue for some of these individuals and that prevented contact in some cases.

Pathfinder currently has 19 active service users, all of these individuals have regular contact with the service and most have had over 20 meetings or contacts with the Pathfinders, with some having had over 100. There are 41 archived service users. Two of these were individuals who refused support at the outset. Of the remaining 39, 13 (33%) have successfully completed an action plan put in place at the start of their engagement with Pathfinder and achieved the outcomes they set out for themselves.

Pathfinder continued...

Pathfinder has provided a broad range of support to individuals they have worked with. This includes meeting immediate needs in terms of food, heating, housing, benefits, immediate medical needs including dental treatment. Pathfinders have also assisted with welfare applications, sorting out arrears for fuel bills, assisted with benefit applications and have applied to Connecting Scotland for phones or tablets.

A considerable amount of time has been spent assisting individuals with housing. Individuals have been connected with other supports including Osprey House - Drug and Alcohol Recovery Service (many were already known to them), GP, SMART recovery, HADAS, Mikeysline, the Salvation Army foodbank, Apex, smoking cessation services, Marijuana anonymous, Cocaine anonymous online, Women's Aid, local pharmacies.

Pathfinders have supported people to request access to residential rehabilitation. For one individual they advocated for their change of GP. They have made extensive use of Café 1668 and the NessBank church and food bank for meeting service users and making sure they had food. They have assisted with getting locks changed in accommodation and sourcing household items. Alongside this they have provided consistent in person support to individuals and encouraged them through the ups and downs of their journey. Cases are only ever closed after concerted efforts to contact them or when the service users themselves decide they no longer need the support or move out of area as a few have done. The door is always left open to return.

Forty-nine of the service users were already connected with a service with many already in the care of Osprey House or local psychiatric services and a few with Women's Aid.

Pathfinder has seen positive outcomes for service users in terms of reconnection with family, including children, and improved wellbeing. A few people have managed to gain employment, and some have asked for help in gaining employment.

It should be noted that progress has been significantly impacted by information sharing issues that have prevented the programme from operating as planned in the Inverness area meaning referrals were not being received from the responding police officers. However, the Pathfinders managed to receive referrals through the community police officers. An information sharing agreement was subsequently put in place that can be used to help roll the project out to other areas. With this issue resolved MAV expect to see an increase in the numbers engaged by the service.

MAVs, update to CORRA Foundation, March 2022

29.2. Expanding Pathfinder

Our Drug Law Reform report²⁹⁷ highlighted the Drug Deaths Taskforce Pathfinder project as having the potential to reduce the short-termism of current criminal justice-led service provision. It is hoped that Pathfinder will enable people to stay engaged in recovery-focused supports for longer, while potentially reducing the likelihood of incurring criminal sanctions. It was felt that the scheme has the potential to provide prosecutors with much more in-depth information about an individual's circumstances and the activities they are undertaking to address their underlying issues, which can in turn reduce the likelihood of criminalisation.

Additionally, it was considered that police referral pathways following the peer navigator model should be available and consistent across Scotland, to ensure people with substance use problems have access to services at the earliest stage, and prosecutors have access to information on an individual's identifiable needs.

The working group on police referrals agreed that arrest referrals need to be a quick process and multi-agency working is crucial. Evaluation and monitoring of services and referral pathways is also crucial although the availability of services to be referred to can be an issue in some areas and particularly disproportionately in remote areas. There should therefore be a national approach for consistency that allows for local variation. It could be that solutions such as targeted funding or digital solutions are explored further. It was also agreed that someone doesn't need to be arrested to be supported, the principle of vulnerability should be the trigger. The police are already good at identifying vulnerabilities and there is a vast amount of data in a vulnerable person's report. However, there is a police responsibility to improve community wellbeing and the education of police officers needs to be structured and planned.

29.3. Police Custody

Many people who have died a drug related death have been in recent (within six months) contact with the criminal justice system e.g. in 2016, where known, 12% had been in police custody. The criminal justice system therefore provides an opportunity to detect, intervene or signpost people into treatment and support. Issues accessing police custody records meant that contact data were missing for 22% (140) of the 2015 cohort and 9% (72) of the 2016 cohort. Where known, 33% (164) of people who had a drug related death in 2015 and 28% (206) people who had a drug related death in 2016 had been in police custody in the six months prior to death. In 2016, 40 drug related death (5%) occurred within four weeks of a release from police custody. The equivalent number for 2015 was 38 (6%)²⁹⁸.

Police custody staff identify those who harmfully use drugs through disclosures of drug use during vulnerability assessment questions on their initial attendance at police custody and through presentation and/or any disclosure to arresting officers, custody staff or NHS Healthcare during the individual's time in custody; or if they suffer a non-fatal overdose just prior to or whilst within custody.

²⁹⁷ [drug-law-reform-report-sept-6th-21.pdf \(drugdeathstaskforce.scot\)](#)

²⁹⁸ Information Services Division. (2018). Available at: [The National Drug-Related Deaths Database \(Scotland\) Report \(isdscotland.org\)](#)

Any immediate health concerns are raised with the relevant custody healthcare professional. If there is a risk of withdrawal that requires hospital assessment or treatment, this is arranged. A Vulnerable Persons Database concern report is submitted for any person suffering a non-fatal overdose in custody which ensures statutory partners are made aware of the event and the person's associated vulnerability, particularly to a future overdose. Some Local Authorities hold multi-agency Non-Fatal Overdose Groups which meet several times a week and discuss those individuals in their area who have suffered a non-fatal overdose to ensure urgent support is provided.

The police custody working group heard that there is a presumption of not keeping anyone longer in police custody than needed and they are liberated as soon as possible. This often means there is a quick turnaround and also an opportunity to really focus on high level service users. Whenever a person who is vulnerable is in police custody there should be support. A single portal for referral from police custody would be helpful, one place where all needs could be seen, and digital technology could help with this. Local authorities should be actively coming to police custody and asking who they can help and information sharing agreements should be standardised. The implementation of MAT standards in police custody is crucial although we heard that the national police custody healthcare patient management system needs has to have functionality updates in order to support the clinicians in delivering MAT Standards 1-5 in particular.

We sent a submission²⁹⁹ to the Citizen Participation and Public Petitions Committee as evidence for a petition calling for the Scottish Parliament to urge the Scottish Government to ensure that all detainees in police custody can access their prescribed medication, including methadone, in line with existing relevant operational procedures and guidance. This confirms our position that all relevant individuals, including detainees in police custody, should have access to prescribed medication. We are also aware that the Police Custody Care Network has a focus on the implementation of MAT standards in custody as one of the top priorities for police care.

29.4. Courts and Tribunals

The latest Criminal justice social work statistics (2020-21) highlights that the drug treatment and testing order (DTTO) is available to courts (excluding justice of the peace courts) as an intensive disposal for people with substance-related offending who might otherwise be given a custodial sentence³⁰⁰. In addition, the less intensive DTTO II is available to courts in Edinburgh, East Lothian, Midlothian and Highland, and accounted for around 12 per cent of the DTTOs in these areas in 2020-21. The COVID-19 pandemic and the resulting lack of court cases able to be conducted meant the number of DTTOs commenced fell to a historic low of 230 in 2020-21.

²⁹⁹ [PE1900_C Scottish Drug Death Taskforce submission of 17 January 2022 | Scottish Parliament Website](#)

³⁰⁰ Scottish Government. (2021). Available at: [Criminal justice social work statistics: 2020 - 2021 - gov.scot \(www.gov.scot\)](#)

Over the last five years, people aged 31 to 40 have been the most likely to receive a DTTO and it has consistently been those aged 25 and under and those aged over 40 who have been the least likely³⁰¹. The average length of a DTTO was between 17 and 18 months in the years 2016-17 to 2019-20 but was higher at 18.5 months in 2020-21.

Timescales for Implementation

Scottish Government statistics show that in 2020-21, the proportion of people receiving a DTTO who had first direct contact within one working day of the order being imposed was 62 per cent. The proportion of orders where the first case management meeting took place within five working days was 79 per cent in 2020-21, which was around the levels in years 2016-17 to 2019-20. However, in around 12% of cases in 2020-21, it took longer than ten working days for the first meeting to take place.

Terminations

The data shows that the percentage of orders successfully completed tends to be lower for DTTOs than for other social work orders, due, in part, to the complex needs of those involved and the intensity of the supervision involved. The completion rate for DTTOs terminated in 2020-21 was 66 per cent, substantially higher than at any historical point. This rate may, however, be influenced in some way by the impact of the Coronavirus pandemic and the type of cases where it has been possible for the order to finish. Therefore caution is required in drawing any conclusions on completion rates over time³⁰².

The orders revoked due to review and due to breach in 2020-21 were 71 and 23 respectively. A custodial sentence was imposed in 27% of revoked cases in 2020-21.

Eighty-three per cent of orders were terminated without breach applications. This figure was higher than in 2019-20 and is likely to reflect the higher successful completion rate for orders that finished in 2021. 94% of breach applications were lodged with the court within five working days of the decision being made³⁰³.

29.5. Taskforce Short Term Working Group

The working group on courts heard that more alternatives to incarceration for people with problem drug use should be developed. This should be achieved by reducing the use of remand and recognising alternatives such as bail supervision, ensuring these are consistent across Scotland. Information sharing through the court process should also improve so that decision making can be fully informed. Individuals who are released from remand should also have appropriate transition pathways and plans should be in place to guarantee holistic support. It was highlighted that remand is expensive, traumatising and does not provide sufficient support for recovery. Funding should be provided for bail supervision to ensure it can be provided in all areas in

³⁰¹ Scottish Government. (2021). Available at: [Criminal justice social work statistics: 2020 - 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/consultations-petitions/Publications/2021/03/CriminalJusticeSocialWorkStatistics2020-2021.pdf)

³⁰² Scottish Government. (2021). Available at: [Criminal justice social work statistics: 2020 - 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/consultations-petitions/Publications/2021/03/CriminalJusticeSocialWorkStatistics2020-2021.pdf)

³⁰³ Scottish Government. (2021). Available at: [Criminal justice social work statistics: 2020 - 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/consultations-petitions/Publications/2021/03/CriminalJusticeSocialWorkStatistics2020-2021.pdf)

Scotland, this should be seen as a spend to save, reducing the numbers remanded to custody. This funding should be sustainable and long term to give security to services.

29.6. Prisons

In 2020/21, the average daily prison population was 7,338. Of these 5,550 (76%) were sentenced with the rest remanded to custody. As at 20 May 2022, the population is 7,362 of which 5,188 (70%) have been sentenced. As at April 2022, Scotland's incarceration rate per 100,000 population is 135 which is slightly higher than in England and Wales (132) and substantially higher than most European Union countries.³⁰⁴

The Drug Law Reform group found that many people in Scotland's prisons are repeat offenders and many also have substance use problems. Most participants agreed that incarceration seems ineffective at breaking the cycle of problem substance use and repeat offending. However, there was evidence that effective community-based sentences that address both drug use and offending behaviour in conjunction with one another could be more effective. There was a consensus that the criminal justice system is not resourced to provide support to those in custody with complex needs across mental health, physical health and drug use, and to maintain support for recovery following release. Respondents felt that the Scottish Prison Service understand the need for a public health approach, but there were some key decisions in relation to imprisonment that have not kept up with the change in attitudes.

As part of the consultation conducted by the group (see section 3.3) a gap in support as people are waiting for a sentence was highlighted and most respondents agreed with the principle that whether people are remanded or sentenced in the prison setting, treatment and support must be enabled to continue without interruption, including through-care support for reintegration into the community.

It was clear that a focus on rehabilitation and reintegration would have a positive impact on drug related harms and deaths and that the current drug legislation remains a barrier to providing a proper public health approach through a continued focus on incarceration.

The prisons working group heard that through-care should not just mean aftercare but a pathway that begins before, throughout and after time spent in prison. It should include an assessment on entry, and the development of a plan for release and integration back into the community. This plan should be maintained throughout an individual's time in prison and updated as they continue to engage with treatment and support. All needs should be taken into consideration including health issues such as drug use, mental and physical health, and what else is needed to sustain recovery and community integration such as housing and benefits support and health service provision. It was also noted that the number of individuals in Scotland's prison estate are too high and that better support is needed in the community. That should continue if someone is sent to prison.

³⁰⁴ Scot PHO. (2022). Available at: [Prison population - ScotPHO](#)

Day of Liberation

The Drug Law Reform report outlined the particular challenge of Friday liberations which was raised by the majority of service providers. It was highlighted that this can leave people particularly vulnerable to relapse as there are limited available services at the weekend. In some cases, support will have been in place for the 12 weeks prior to release, however the day of release is often crucial for putting in place the basic building blocks for life outside of prison. As well as needing to attend mandatory appointments with relevant probation staff, prison leavers may need to do a range of things including finding somewhere to live and registering for benefits. Those with health needs also often require access to immediate support and medication. This is critical for people who use drugs as release from prison has been shown to be a time of high risk for drug related death, due to reduced drug tolerance and limited access to support networks.

There is also the opportunity to mitigate against the known elevated risk of drug deaths at transition points including release from custody, such as ensuring naloxone provision and continuity of care on release³⁰⁵. Tolerance levels can be effected by incarceration, increasing the risk of overdose upon their release³⁰⁶. The timing of release from custody should be organised for times when services are available. Across the UK there is a potential increase in deaths associated with Friday release from prison³⁰⁷ yet there are more releases on Friday than any other day.

The Prisoners (Control of Release) (Scotland) Act 2015³⁰⁸, has allowed the Scottish Prison Service to release individuals a day or two prior to their official liberation date (effective from early 2016) if there is sufficient evidence that release on the set date would cause unnecessary risk to the individual by limiting their ability to access services³⁰⁹. This requires service providers to apply to have the liberation date altered. The Drug Law Reform engagement event highlighted that some respondents noted that this mechanism is rarely utilised citing reasons such as data sharing and capacity within services as reasons for this. Data provided by the Scottish Prison Service confirms that this policy is very infrequently used and even less frequently approved. From 2016 to the end of May 2021, only 92 applications were made and only 28 were granted.

Members also highlighted that there is an at risk group, released directly from a court appearance, who have no connections made to services and whose resident local authority will not have been informed of their liberation in advance. These individuals may have spent significant time remanded to custody and will not be captured by a policy which ends Friday liberations, highlighting the importance of through-care plans established from Day 1.

³⁰⁵ Graham et al. (2015). Available at: [Understanding extreme mortality among prisoners: a national cohort study in Scotland using data linkage | European Journal of Public Health | Oxford Academic \(oup.com\)](#)

³⁰⁶ Graham et al. (2015). Available at: [Understanding extreme mortality among prisoners: a national cohort study in Scotland using data linkage | European Journal of Public Health | Oxford Academic \(oup.com\)](#)

³⁰⁷ Advisory Council on the Misuse of Drugs. (2019). Available at: [Custody-community transitions report by Advisory Council on the Misuse of Drugs \(publishing.service.gov.uk\)](#)

³⁰⁸ [Prisoners \(Control of Release\) \(Scotland\) Act 2015 \(legislation.gov.uk\)](#)

³⁰⁹ [Partnership Working \(sps.gov.uk\)](#)

Criminal justice social work departments are expected to provide a through-care service to all those who are subject to statutory supervision on release from prison. This includes people serving sentences of four years or more (or six months or more for sexual offences) as well as those subject to an extended sentence or supervised release order. Through-care begins at the start of the sentence and is implemented through the Scottish Prison Service's Integrated Case Management process. Voluntary through-care services are also available to those who are not subject to supervision on release from prison. These services may be requested while in custody or up to 12 months after release.

29.7. Bail Supervision

Bail supervision is a social work or third sector service that supports people to comply with the conditions of their bail. It is intended to provide a robust and credible alternative to remand in custody, whereby people accused or convicted of an offence (or offences) are assessed as requiring a level of supervision, monitoring, and support to adhere to bail conditions. Those who the court may decide would otherwise be held on remand pending trial or for reports after conviction can instead be released on bail on the condition that they meet with a bail supervisor (or nominated worker from a relevant agency) a specified number of times per week, subject to an assessment of suitability and compliance management. The overarching aim of bail supervision is therefore to reduce the use of remand by giving confidence to the court that people bailed in the community will be supported to comply with the conditions of bail, and that any non-compliance will be robustly managed³¹⁰.

The Scottish Government published its responses to the public consultation on bail and release from custody arrangements in Scotland in March 2022³¹¹. The consultation attracted a strong response from a broad range of stakeholders. It was widely recognised that it would be difficult to legislate for the full range of scenarios that would be presented to the courts, and that it would not be possible to plan for all eventualities, given the complexity of human nature and needs. Key to the success of many of the proposed changes would be collaborative working between statutory and third sector organisations, with honest and open communications that reflect the unique circumstances of individual cases. Overall, subject to refinement and suitable safeguards and appropriate resources being put in place, many of the proposals were seen as potentially contributing to the underlying aim to reduce crime, reduce reoffending and have fewer people experiencing crime.

29.8. Prison to Rehabilitation Pathway

The Scottish Government, in collaboration with the Scottish Prison Service, the Scottish Recovery Consortium (SRC) and others, set out a *Prison Release – Residential Rehabilitation* protocol in June, 2020. This is to be used by Prison Health Care Service and rehabilitation providers to support the referral of people leaving prison who would benefit from accessing an abstinence-based rehab programme to further their recovery. This Prison to Rehab protocol is based on a 7-step process and individuals who enter residential rehab via this referral pathway have their program

³¹⁰ Scottish Government. (2022). Available at: [Bail supervision: national guidance - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/bail-supervision-national-guidance/pages/1-1-introduction.aspx)

³¹¹ Scottish Government. (2022). Available at: [Bail and release from custody arrangements: consultation analysis - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/bail-and-release-from-custody-arrangements-consultation-analysis/pages/1-1-introduction.aspx)

reflect local needs, but common issues include the availability and suitability of services.

29.10. Diversion from prosecution

Police officers in Scotland have a statutory duty to report all offenses to COPFS who determine who will be prosecuted and who will not, based on an assessment of all of the facts and circumstances of each individual case.

Whilst Scottish Police Officers can make a referral to drug treatment, all decisions on prosecution are made by COPFS, and all cases must be reported for prosecutorial decision making. All decisions on prosecution are made based on what is considered to be in the public interest. The prosecution code sets out the factors that Scottish prosecutors should take into account when determining what action, if any, is in the public interest. This includes the nature and gravity of the offense, and the personal circumstances of the individual.

As there is no blanket policy to drugs offenses in Scotland, the prosecutorial action which is appropriate to meet the public interest (including the public interest in addressing the causes of the offending behaviour or to influence the likelihood of re-offending) depends on the particular circumstances. In some cases, therefore, a decision can be made to refer individuals to a treatment alternative, usually conducted via local authority and third sector partnerships, where a suitable service is known to exist and such actions would be considered diversion. This arrangement differs from the rest of the UK, and in particular from England and Wales where Police Officers can divert people away from prosecution using discretionary police diversion schemes³¹⁵.

The Criminal Justice social work statistics provide national-level information on criminal justice social work activity in Scotland³¹⁶. The number of diversion from prosecution cases commenced rose by 12 per cent between 2019-20 and 2020-21 to around 2,200. Numbers had fallen sharply between 2016-17 and 2017-18 but the rise in the most recent year, has brought numbers to their highest in the last seven years³¹⁷.

During 2020-21, there were around 3,900 referrals, 3,600 assessments and 1,600 cases completed.

Numbers of diversion for people aged 16 to 20 fell by 10 per cent over the same period. Despite this fall, people aged 16 to 20 were still substantially over-represented when the population base was taken into account - they accounted for 40 per cent of people diverted from prosecution in 2020-21 but only 7 per cent of the population aged 16 to 70. This continues to reflect a general focus on diversion for younger people.

³¹⁵ Price et al. (2021). Available at: [‘Discursive struggles’ between criminal justice sanctions and health interventions for people who use drugs: a qualitative exploration of diversion policy and practice in Scotland \(tandfonline.com\)](https://www.tandfonline.com)

³¹⁶ Scottish Government. (2022). Available at: [Criminal justice social work statistics: 2020 - 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot)

³¹⁷ Scottish Government. (2022). Available at: [Criminal justice social work statistics: 2020 - 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot)

The number of community payback orders (CPOs) imposed increased in the initial years following their introduction, reaching 19,500 in 2015-16. This rise was expected due to CPOs replacing legacy orders for offences committed on or after 1 February 2011. The total CPOs imposed then fell in the next three years to 16,500 in 2018-19, before a small rise to 16,800 in 2019-20. The COVID-19 pandemic and the resulting decrease in court business meant numbers fell sharply in 2020-21, by 51 per cent to 8,200.

The Drug Law Reform [report](#) sets out how diversion from prosecution avoids a person receiving a criminal sanction, and it could provide a route to targeted person-centred support if sufficient resources are made available to local authorities. Diversions will only be successful where the appropriate services and resources exist to support the individual. This requires adequate service planning and resourcing in all areas of the country, to ensure it can be provided consistently and maintain equality. This is a key focus for Community Justice Scotland and we are aware that progress is being made in this space. However, diversion from prosecution is not a substitute for community treatment and support and remains a criminal justice response. Previous research indicates that it may still involve an element of coercion which is not necessarily compatible with a voluntary model of recovery. Although not intended to be punitive, people can still experience limited choice in decisions made about their support and care. To maximise the effectiveness of diversion in relation to individuals with problem substance use, a whole systems holistic approach should be taken within services which are specifically focused on harm reduction.

Dame Carol Black's independent review³¹⁸ also identified a need for greater use of police diversions and community sentences, with treatment as an alternative to custody. Additionally, it was identified that improvements are needed to treatment in prison to ensure that people have a better experience of and access to treatment and it was recommended that on release from prison, prisoners must have ID and a bank account and the ability to claim benefits on the day of release. Those with problem drug use should be helped to continue with drug treatment in the community as soon as possible.

29.11. Case Study: Glasgow Drug Court

The Glasgow Drug Court was originally set up as a pilot in 2001 and was considered a success therefore ongoing support was provided³¹⁹. Its aim is to reduce problem drug use and the offending caused by problem drug use. This is provided through sentences that are based on practical treatments. The court does not follow the traditional set-up. The DTTO imposes on offenders an obligation to be treated and tested for drug use and to commit to change. The court fast-tracks offenders into the courtroom and has a trained team working together to support the treatments and testing given and provide a good system of review meetings for each person. Graduations happen on a regular basis for those who satisfactorily complete a DTTO.

We visited the Glasgow Drug Court to meet those involved and observe the pre-court review of cases and live cases of the Drug Court. We found that a holistic approach is

³¹⁸ [Review of drugs: phase one report - GOV.UK \(www.gov.uk\)](#)

³¹⁹ [Review of the Glasgow and Fife Drug Courts: Report \(iriss.org.uk\)](#)

taken with three disciplines (health, social work and drug services) working collaboratively, providing first-hand input to the case discussion. A morning pre-meet of the agencies allowed for a detailed and meaningful case discussion between the discipline areas and the presiding Sheriff.

All parties involved clearly had personal knowledge of the individuals being discussed and their ongoing pathway through the court. This allowed for an honest and accurate assessment of the individual's progress and engagement to date, and agreement on what the most suitable course of action was to be taken during that particular court appearance. It was emphasised that the parameters/expectations of the Drug Court need to be realistic and focus on continuous engagement, improvement and longer term outcomes rather than absolute abstinence. The potential for the Glasgow Drug Court to have a significant, meaningful and positive impact was evident as we watched the graduation of one particular individual, following successful completion of the programme.

Members concluded that a formal evaluation/academic research in respect of the Glasgow Drug Court would be beneficial to provide an evidence-base of effectiveness and to identify any associated learning in relation to factors likely to impact on successful engagement and completion i.e. differing demographic groups etc. Such an evidence-base would allow the Glasgow Drug Court to be promoted as good practice which extend across the country. It was apparent that the dedicated Drug Court acted for many individuals as a formal support structure towards recovery, not merely a criminal justice sanction. The transition into community services in such instances is essential. It ensures continued access to an effective support network upon completion of the programme that helps to prevent reoffending and provides ongoing support towards recovery.

Project: *Navigating Early Help* (Inverclyde Health and Social Care Partnership)

Following a Community Justice strategic needs assessment, Inverclyde ADP identified a gap in early help from the point of arrest. Data from the Vulnerability Assessment undertaken in Police custody shows that 23% of people indicated they had a dependency on drugs or other substances with 18% advising they had used drugs or substances in the previous 24-hour period. 35% indicated attempted self-harm or suicide with 7% of people having current thoughts of self-harm and suicide. 49% of people indicated they had a mental health problem or had received treatment for mental health problems. This picture is also reflected in data from Justice Services Level of Service / Case Management Inventory (LS/CMI) where people are asked for details at the point of preparing a Criminal Justice Social Work Report, with the extent of ever having a drug problem is 63% and a current drug problem is 42%. LS/CMI also indicates that 80% of people had 2 or more episodes of offending and 29% of people had accommodation issues. In addition, 80% of people involved in Justice Services live in the 20% most deprived areas of Inverclyde.

This proposal is focusing on early help. The spectrum of opportunities to offer early help to people involved in the justice system stretches from the point of arrest, but includes bail supervision and diversionary activities. A Peer Navigator involved at these key points can have a critical impact.

Intended outcomes include:

- people are offered early help to address multiple complex needs, reducing the risk of drug related deaths;
- a public health approach is evident at the early stages of the justice system in Inverclyde;
- Peer Navigators, as an alternative support, are embedded into the local model of community justice and recovery

Staff have been recruited and the project had been operational for referrals since June 2022.

Service provision includes:

- Early Help in Custody is available 7 days a week 10am -10pm and offers support to those who are or have been in Police custody
- the aim is to deliver short, focused interventions and to link closely with existing pathways and build new ones
- the support offered includes alcohol brief intervention paths to recovery, harm reduction advice, Naloxone kits and Naloxone and overdose awareness training
- aim to engage at an early point in the Criminal Justice journey to provide a short-focused period of support in order to assertively link people into appropriate mainstream services

Inverclyde HSCP, update to CORRA Foundation, July 2022

30. Public Health Surveillance

Good quality data at the national and local level are essential for monitoring and surveillance purposes. Appropriate information sharing protocols, coordination and collaboration between services (Police, A&E departments and other front line services) are critical to reducing harm and preventing premature deaths.

The right data with information and evidence being in the right place at the right time is completely essential to improving outcomes for people. In the digital age and with the need and desire to improve co-operation and co-ordination of effort improved public health surveillance will be crucial to be able to predict and track trends, interventions and outcomes. This will help services be more rapidly responsive to real-world needs.

A monitoring and risk communication system allows better detection, assessment, prioritisation, and response to associated public health and social threats. Assessment is based on an analysis of the nature, number, scale, and timing of serious adverse health events or social problems, as well as risk assessment procedures. Surveillance enables early detection of emerging harms or trends to facilitate a rapid response.

World Health Organisation (WHO) definition:

Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice³²⁰.

Surveillance can:

- serve as an early warning system
- document the impact of an intervention
- track progress towards specified goals
- monitor and clarify the epidemiology of health problems
- allow priorities to be set and to inform public health policy and strategies.

30.1. Public Health Surveillance in Scotland

Audit Scotland highlighted that whilst performance reports in relation to measuring the impact of drug and alcohol services are published, it is not clear how this information has been used to develop and plan services at a national level³²¹. Additionally, it suggested that targets for access to drug and alcohol services be reviewed to determine whether the current target is still appropriate, given the concerns about did not attend rates. This is due to a high proportion of people who died of drug-related causes never having had contact with a drug treatment service.

³²⁰ World Health Organization. Available at: [Surveillance in emergencies \(who.int\)](https://www.who.int)

³²¹ Audit Scotland. (2019). Available at: [Drug and alcohol services: an update | Audit Scotland \(audit-scotland.gov.uk\)](https://www.audit-scotland.gov.uk)

Audit Scotland's 2022 updated report emphasised that there were gaps in drug and alcohol data, as well as a considerable time lag in public reporting³²². Additionally, the report referenced the significant delay in the implementation of the DAISy³²³ national database; initially due to go live in late 2019 but delayed until April 2021. Additional challenges include completeness and quality of data submitted by services, however it was acknowledged that continued improvement works are ongoing to address data gaps. The report also noted the delay in publishing the quarterly national drug and alcohol treatment waiting times for the April to June 2021, noting a five-month publication delay from September 2021 to February 2022.

30.2. DAISy

DAISy is a national database developed to collect drug and alcohol referrals, waiting times and outcome information from staff delivering specialist drug and alcohol interventions. This replaced the Drug and Alcohol Treatment Waiting Times (DATWT) database and the Scottish Drug Misuse Database (SDMD) systems.

The objectives of developing a single system were to enhance the quality and completeness of the data available on treatment for problematic drug and alcohol use while providing a more user friendly means of data entry required by staff working in ADPs and specialist treatment services. DAISy gathers key demographic and outcome data on people who engage with drug and alcohol treatment services. It aims to enable a better understanding of the impact of drug and alcohol treatment services at both a local and national level in order to inform national policy and practice development and provide timely information to support local service delivery, improvement and planning.

30.3. Drug Death Reporting Short Life Working Group

The purpose of this group was to examine the National Drug-Related Death Database³²⁴ NDRDD updated by NRS, NHS Boards and Police Scotland and to recommend how data collection and reporting processes could be modified to ensure its sustainability and fitness for purpose.

The group met four times in early 2021 and included representatives from COPFS, PHS, Police Scotland, Office for National Statistics, Scottish Prison Service, NHS Boards, British transport Police, SFAD, Scottish Government, Academia, DRNS, COSLA, Scottish Recovery Consortium and Scottish Ambulance Service. An overview of the topics discussed and conclusions has been provided below.

Background

Drug death figures are collated and reported on through a number of different publications, by a number of different bodies such as NRS, Public Health Scotland (PHS), local NHS Board reports and Police Scotland. It was noted, however, that the supply of high quality national drug related death data had been reduced due to the increase in the volume of data collection which has subsequently caused delays.

³²² Audit Scotland (2022). Available at: [Drug and alcohol services: An update \(audit-scotland.gov.uk\)](https://www.audit-scotland.gov.uk)

³²³ [Drugs and Alcohol Misuse | Home | Health Topics | ISD Scotland](#)

³²⁴ <https://publichealthscotland.scot/media/12566/drug-death-reporting-short-life-working-group.pdf>

The NDRDD report was first published in 2009 and currently reports biennially. The focus of the report is on describing national trends, although individual NHS Board level data are available on request. The report provides detailed information on the nature and circumstances of individuals who died a drug related death in Scotland, including;

- personal/social circumstances;
- drug use, drug/alcohol treatment;
- contact with health/justice/social care services;
- scene of death;
- toxicology;
- pathology information;

Additionally, the NDRDD dataset is extremely large and detailed with the data being manually input to PHS's web-based NDRDD system by NHS Boards following an audit of the case notes. After data collection is complete, linkage with other datasets routinely held by PHS adds information about hospital admissions and prescribing to the dataset. As this linked information may be added to the database up to two years after the death occurred, it is not timely enough for use in local drug related death reviews and is not routinely shared with NHS Boards. A review of the NDRDD dataset was conducted in 2016 however no changes were made at that time due to the costs of changing the existing NDRDD system and the development of a new national drugs strategy.

The NDRDD dataset relies on information from a number of sources including local drug related death review groups and NRS's annual drug death statistics. In 2019, changes to the way toxicology testing is organised across Scotland resulted in significant delays in the provision of post mortem toxicology findings which impacted all those involved in drug related death data collection. The combined effect of these issues has been that NDRDD reporting has failed to provide users with up-to-date information about drug related deaths at a time when concern about this public health issue has been increasing. On that basis, the potential benefit of learning from these data to help prevent further deaths is not being fully realised.

Group discussions and Conclusions

Purpose and Use

The NDRDD data and report were felt to be useful and of value as it includes data that are widely used and aren't recorded elsewhere. There was a consensus that the purpose of the NDRDD report was to provide detailed contextual information to inform drug related death prevention, rather than identifying changes in the numbers of drug deaths at a local or national level. However, the length of time currently taken to produce the report was too long, resulting in the report being viewed as less relevant and valid. The three system attributes found to be most important for NDRDD were; timeliness, data quality, and flexibility.

Data collection and priorities for development

The group agreed that the timescale for publishing a core dataset should be around three to six months and for expanded data, around six to 12 months. Most survey participants agreed either that NDRDD should '*improve timeliness by reporting lower*

quality data on all deaths or *'wait as long as it takes to get high quality data on all deaths'*. The view that collection of high quality data on fewer drug-related deaths was not widely supported.

Areas identified for expansion of data collections were adverse childhood experiences, homelessness, child removal, adult protection concerns and benefit sanctions. There was support for a development model that prioritised making better use of data linkage and favoured a full dataset review as a means of overcoming some of the current challenges faced. The options of a more limited dataset review and a deep dive exploration of fewer drug-related deaths were preferred by a minority of participants.

There was a broad consensus that more use should be made of data linkage, but it was felt that further work would be required to understand how this can be achieved alongside primary data collection by NHS Boards.

Data Flows

Data flows following a drug related death are complex and involve a range of organisations. In addition, there is substantial variation between NHS Boards in the review and collection of data. There are wide differences in the extent and nature of access to data sources between NHS Boards, and a reliance on informal inter-agency relationships and sharing of other organisations' data. Processes are not resilient enough in circumstances when staff or systems change.

The biggest current challenges in terms of data sharing were identified as changes to police sudden death information, cause of death and toxicology data and access to GP notes. There was felt to be a general lack of understanding that the purpose of information sharing in this process is to save lives. Data collection was seen as already problematic due to the increasing number of drug related deaths but has been stressed further by COVID-19.

Ensuring adequate data collection resource and establishing electronic data sharing arrangements are high priorities. It was felt that it would be feasible to collect new data on issues such as homelessness but that other areas (for example, benefit sanctions) could be problematic. Variations in NHS Board review and data access and collection practices were considered to be unacceptable and undermined the quality and usefulness of the data. There was broad support for a national co-ordinator role with standardisation of practices and co-ordinating data sharing should be key components in developing the role. Data linkage was seen as important in facilitating better access to data but there was uncertainty about how data should be disseminated to NHS Boards and balanced with primary data collection. More work is required to understand obstacles to effective data sharing and to establish innovative solutions.

It was felt that bereaved families were not provided with adequate information or support as part of the existing drug related death process and that this needs to be addressed. Resources for families bereaved following a drug related death are available to Police Scotland, but there were variations in access to these and in families' experiences in these circumstances. The roles of agencies in relation to providing support to families are unclear. While there are examples of good practice around the country, these need to be built upon as part of a co-designed approach.

NDRDD reporting and agreeing recommendations

NDRDD reporting was identified as needing to work to a 12-month reporting timeframe to maintain relevance to the current numbers of drug related deaths. Options such as issuing information at different stages should be considered. The tone of the NDRDD report should reflect the gravity and seriousness of the issue, but reports need to be accessible for different audiences. Alternative outputs, visualisations and a launch event should be considered in order to help achieve this.

The NDRDD report should include recommendations to help prevent drug-related deaths and describe the impact on families and relevant service improvements. The timeframe for the NDRDD report should be the same as the NRS report, focusing on the year of registration of death. This will help to avoid confusion between the two sets of statistics. Death by suicide involving controlled drugs should continue to be included in the report and should be reported alongside accidental deaths. It was recognised that the distinction between these and other drug related deaths can be blurred.

31. Early Warning System

31.1. Rapid Action Drug Alerts and Response (RADAR)

RADAR is Scotland's drugs early warning system³²⁵, coordinated by Public Health Scotland. The use of a partnership approach to support local services, community members and public health teams, ensures the system is relevant and meets the needs of the people and places it serves.

RADAR assesses and validates information to:

- allow for the rapid and targeted deployment of interventions
- prevent and reduce the risk of drug-related harm.

RADAR involves people and services from across the country and it is made up of three multi-agency groups:

- Development Group: formed of communication, data and intervention subgroups that support system design and development, including the creation of a communication and response toolkit;
- Network: a wide and inclusive group that collects and shares drug trends and data, helps to validate information and processes outputs and communications;
- Assessment Group: a specialist technical team that studies data, assesses potential threats and decides on action to reduce harm.

The aim is to identify risks quickly and inform rapid action to reduce harm and save lives. RADAR aims to reduce the short, medium and long-term harms associated with drugs in the Scottish population by:

- identifying trends, risks and clusters of overdose and intoxication;

³²⁵ [What is RADAR? - Rapid Action Drug Alerts and Response \(RADAR\) - Surveillance - Substance use - Our areas of work - Public Health Scotland](#)

- responding to new and emerging substances, changing harms and other relevant scenarios;
- advising on and implementing immediate harm prevention and control measures;
- providing high-quality current public health information;
- informing decision-making about resource allocation, prevention and service design and delivery.

31.2. Police Scotland

Quarterly statistics on suspected drug deaths have been published since September 2021. These estimated figures are based on information from Police Scotland. This operational data is available more rapidly and more frequently than the NRS annual statistics, and provides a more timely indication of the likely trend in drug-related deaths. However, this management information is not subject to the same level of validation and quality assurance as national statistics as classification as a suspected drug death is based on an officer's observations and initial enquiries at the scene of death.

Police Scotland suspected drug deaths³²⁶ correlate very closely with the NRS drug-related death statistics. Since the period ending in December 2018, the rolling 12-month Police Scotland figures have been approximately 6% above the NRS figures.

Drug Deaths Taskforce Research Programme Fund 7 (part 2)

Ambulance Call-Outs to Drug Overdoses in Scotland: Patterns & Practice

This project, also provided in Near-Fatal Overdose section, included a Public Health Surveillance perspective by reviewing geographical variations, patterns in terms of time of day/day of the week, and changes over time. This was in conjunction with semi-structured interviews with Scottish Ambulance Service staff captured views on barriers and facilitators to optimal clinical care and patient outcomes, and on local approaches to service provision and information sharing.

³²⁶ [Suspected drug deaths in Scotland: January to March 2022 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/suspected-drug-deaths-in-scotland-january-to-march-2022/pages/10/)

32. Leadership

Leadership was identified in Dame Carol Black's independent review³²⁷ as needing a clear central government leadership and oversight, with responsibility and activity spanning multiple departments. The review identified that people with drug dependence tend not to be prioritised in policy and funding decisions. Joint arrangements are needed between policy areas; these should have clear ministerial sponsorship. This central sponsoring Minister should take the lead in setting objectives and targets for the rest of Government.

Whilst this review focused on the experience in England and Wales the same requirements were considered as important in Scotland by our members.

Evidence reviewed by DRNS³²⁸ also identified that leadership and accountability are essential to drive improvement in drug and alcohol services and there should be stronger accountability to ensure quality of care improves for people with multiple complex needs who are vulnerable to drug related death across statutory, third sector, public health etc. All agencies should be responsible against clearly measurable indicators and principles. There are problems connected to the commissioning culture (strategic and operational) that need to be addressed.

Consideration should be given to creating commissioning for coordinated and integrated services, longer term planning via a secure funding base, and prioritisation of quality outcomes, longer contracts, joint commissioning and adoption of a wider range of patient-reported outcome measures to evaluate services.

Contracts and deliverables need to recognise the long path to recovery. Services need to be available 24/7 and reflect the diverse needs of communities including women and those without recourse to public funds.

Realistic and meaningful service outcomes need to be set by commissioners with greater involvement of people with lived and living experience and affected family members throughout the commissioning, service delivery and evaluation process and there should be greater emphasis on building positive relationships and open dialogue between service users and service providers.

33. Accountability and Governance

Local partnerships on alcohol and drugs have existed in a number of forms since 1989. In 2009, the Scottish Government published a framework on local partnerships for alcohol and drugs³²⁹. This framework highlighted that for some time there had been concerns that Alcohol and Drug Action Teams (ADATs) had not all performed as well as they might, and established ADPs to replace them.

³²⁷ Dame Carol Black, 2021. *Review of drugs part two: prevention, treatment, and recovery*.

Available at: <https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery>

³²⁸ A list of evidence reviewed for this rapid evidence synthesis is available in [Annex E](#)

³²⁹ Scottish Government. (2009). Available at: [Local partnerships on alcohol and drugs: framework - gov.scot \(www.gov.scot\)](http://www.gov.scot/Local-partnerships-on-alcohol-and-drugs-framework-gov.scot)

A decade later in 2019, after the publication of the *Rights, Respect, Recovery Strategy*, a new delivery framework³³⁰ was produced to replace the 2009 framework.

This 2019 framework sets out the expectations of how an ADP should operate, including:

- a clear and collective understanding of the local system in particular its impact, how it is experienced by local communities, and how effectively it ensures human rights are met;
- informed by the above, a locally agreed strategic plan, which sets out the long term measureable outcomes and priority actions for the local area, focusing on preventing and reducing harms from alcohol and drug use and the associated health inequalities;
- people with experience of problem alcohol/drug use and those affected should be involved in the planning, development and delivery of services. This will require a shared understanding of the roles of duty holders and duty bearers in the context of a human rights based approach;
- a quality improvement approach to service planning and delivery is in place.
- clear governance and oversight arrangements are to be in place which enable timely and effective decision making about service planning and delivery, and enable accountability to local communities;
- a recognition of the role played by the third sector and arrangements which ensure their involvement in the planning, development and delivery of services alongside their public sector partners.

It set out financial arrangements which should enable the ADP to:

- establish a shared understanding of the total investment of resources in prevention of harm and reducing inequalities from alcohol and drugs across the local system;
- make effective decisions to invest in the delivery of these outcomes;
- ensure there is scrutiny over investments in third sector and public sector to deliver outcomes;
- report to local governance structures on investment;
- report to the Scottish Government on specific alcohol and drug funding allocated to Health Boards for onward delegation to Integration Authorities; and in line with financial reporting arrangements agreed with Integration Authorities.

Following the publication of *Rights, Respect, Recovery*, Audit Scotland produced a report, *Alcohol and Drug Services – An update*³³¹, which identifies six areas where progress will help the successful implementation of the strategy:

- effective performance monitoring;
- clear actions and timescales;
- clear costings;
- spending and outcomes linked;

³³⁰ Scottish Government. (2019). Available at: [Alcohol and Drug Partnerships: delivery framework - gov.scot \(www.gov.scot\)](https://www.gov.scot/Alcohol-and-Drug-Partnerships-delivery-framework)

³³¹ Audit Scotland. (2019). Available at: [Drug and alcohol services: An update \(audit-scotland.gov.uk\)](https://www.audit-scotland.gov.uk/Drug-and-alcohol-services-An-update)

- public performance reporting;
- evaluating harm reduction programmes.

34. National Care Service

The Scottish Government undertook a [public consultation](#) on its proposals for a National Care Service (NCS) to achieve changes to the system of community health and social care in Scotland with the consultation running from the 9 August 2021 until the 2 November 2021. We provided a response to the consultation and engaged with the team developing the NCS to share our expert view and experience.

The purpose of these proposals is to reform social care to deliver consistently high quality care and support to every single person who needs them across Scotland, including better support for unpaid carers, and to ensure that care workers are respected and valued.

The definition of social care on which the NCS will be based includes support for people with physical disability, learning disabilities or mental health conditions, older people and those with dementia, **people with or recovering from alcohol or drug addictions**, those who are, have been or are at risk of being homeless, and children and families who may need additional support, or where children are unable to live with their own families.

The National Care Service will define the strategic direction and quality standards for community health and social care in Scotland. It will have local delivery boards which work with the NHS, local authorities, and the third and independent sectors to plan, commission and deliver the support and services that the people of Scotland require.

The proposals will also take forward recommendations of the Independent Review of Adult Social Care³³² around:

- ensuring that care is person-centred and human rights based;
- providing greater recognition and support for unpaid carers;
- improving conditions for the workforce;
- commissioning for public good; and
- more effective approaches to scrutiny and improvement of social care services.

The Bill was introduced to Parliament in June 2022. The legislation is likely to be extensive and complex and is likely to take at least a year to be scrutinised by the Parliament. The Government has committed to having a fully functioning National Care Service by the end of the Parliamentary term.

³³² [Independent Review of Adult Social Care - gov.scot \(www.gov.scot\)](https://www.gov.scot/independent-review-of-adult-social-care/)

35. Multi-Agency Public Protection Arrangements

The Multi-Agency Public Protection Arrangements³³³ (MAPPA) were established in 2007 under the Management of Offenders (Scotland) Act 2005. This legislation imposes a duty on the responsible authorities within a local authority area to jointly establish arrangements for assessing and managing the risks posed by certain categories of offenders.

MAPPA covers:

- Registered Sex Offenders who are subject to notification requirements under the Sexual Offences Act 2003;
- Mentally Disordered Restricted Patients;
- other Risk of Serious Harm Offenders.

MAPPA aims to protect the public by requiring the police, NHS, prison service and local authorities (known as responsible authorities) to work together to assess and manage the risk each individual managed under these arrangements poses.

Detailed [guidance](#) sets out how MAPPA meetings should operate, how reviews should take place and how the meetings should be chaired.

36. Child Death Reviews

The national child death review system was established in 2016 following the Child Death Review Steering Group Report³³⁴.

The function of the framework is to review the circumstances surrounding the death of a child in a nationally uniform manner, and in a collaborative, inquisitorial, multi-agency, and "no blame" approach.

The purpose of a Child Death Review will be to:

- evaluate information about a child's death;
- consider the child's wellbeing concerns; relevant family and environmental aspects; relevant parenting aspects; service provision and delivery;
- engage with relevant family as appropriate;
- categorise the likely cause of death;
- consider any modifiable factors in relation to the death;
- identify lessons to be learnt from a child's death;
- inform local and national learning of child death issues.

The report sets out a clear process for Child Death Review Panels, including proposed membership.

³³³ [Multi-Agency Public Protection Arrangements available at https://www.gov.scot/policies/reducing-reoffending/public-protection-multi-agency-public-protection-arrangements-mappa/](https://www.gov.scot/policies/reducing-reoffending/public-protection-multi-agency-public-protection-arrangements-mappa/)

³³⁴ [Child Death Reviews: Scottish Government Steering Group Report - gov.scot \(www.gov.scot\)](#)

37. Adult Protection

In 2019, a framework³³⁵ was produced for adult protection significant case reviews.

It outlined that the implementation of the Adult Support and Protection (Scotland) Act 2007 placed a duty upon Local Authorities to establish Adult Protection Committees. The Guidance for Adult Protection Committees states that, '*joint consideration of individual cases may help Adult Protection Committee members to develop greater joint understanding of service user concerns and professional practice.*' It then further encourages Adult Protection Committees, '*to evaluate and learn from critical incidents*'.

The purpose of the framework is to support a consistent approach to conducting Adult Protection Significant Case Reviews and improve the dissemination and application of learning both locally and nationally. Supporting and protecting adults at risk of harm should be an inter-agency and inter-disciplinary responsibility supported strategically by an Adult Protection Committee.

The Adult Protection Committee is responsible for deciding whether a Significant Case Review is warranted using the criteria in the framework, and for agreeing the manner in which the review is conducted on behalf of the Chief Officers Group or equivalent. The Convenor of the Adult Protection Committee advises and makes a recommendation to the Chief Officers' Group when a Significant Case Review is required. As such, the Chief Officers' Group is the commissioner of any Significant Case Review with an interest in its findings and the ownership of the process and any reports generated belong to the Adult Protection Committee.

A significant case review should seek to:

- understand the full circumstances of the death/serious harm of the adult (where parallel processes like a criminal investigation are in place, it may not be possible to gather and report full information);
- examine and assess the role of all relevant services, relating both to the adult and also, as appropriate, to relatives, carers or others who may be connected to the incident or events which led to the need for the review;
- explore any key practice issues and why they might have arisen;
- establish whether there are areas for improvement and lessons to be shared about the way in which agencies work individually and collectively to protect adults at risk;
- identify areas for development, how they are to be acted on and what is expected to change as a result;
- consider whether there are issues with the system and whether services should be reviewed or developed to address these; and
- establish findings which will allow the Adult Protection Committee to consider what recommendations need to be made to improve the quality of services.

³³⁵ [Adult protection significant case reviews: interim framework - gov.scot \(www.gov.scot\)](http://www.gov.scot/resources/documents/2019/06/Adult_protection_significant_case_reviews_interim_framework_-_gov.scot.pdf)

38. Standards and Inspection

38.1. Health Improvement Scotland

Health Improvement Scotland³³⁶ (HIS) develops standards and indicators to support health and social care organisations improve the quality of care and support they deliver.

HIS outline that standards are statements of the minimum levels of service performance that people should expect from health services and are based on evidence relating to effective clinical practice, feasibility and service provision that is responsive to patients' needs and views. They cover the key issues relating to the provision of safe, effective and person-centred care and treatment.

The indicators set out by HIS are tools for quality improvement and can be used to support service standards. Services can use the framework to gather statistical information for comparison, benchmarking and monitoring. The process allows for the identification of areas of improvement and improved quality of care for people using the service.

HIS review their catalogue of existing standards and indicators to ensure that they remain fit for purpose, effective, person centred and reflect Scottish Government policy, however, this does not include drug policy (or alcohol).

Her Majesty's Inspectorate of Prisons for Scotland (HMIPS) has had a statutory duty to inspect and monitor the conditions in which prisoners are held and the treatment they receive, whilst NHS Scotland has been responsible for the provision of primary and community healthcare to those in Scottish prisons since 2011.

Healthcare Improvement Scotland works with HMIPS to manage the healthcare element of inspections to prisons. Each prison establishment is inspected every three to four years and prior to each inspection, the NHS board is given the opportunity to update their annual self-evaluation. HIS may decide to carry out a follow up visit if they identify significant concerns during the inspection.

38.2. HIS involvement in implementing actions

HIS has contributed to work that extends across many key areas³³⁷ including supporting the development of the MAT Standards and Benzodiazepine working group. Additionally, HIS has contributed to cross-cutting work regarding Multiple Complex Needs, through ADPs and Homeless Programme³³⁸. HIS is also involved in ongoing work in NHS Tayside to develop and test an integrated approach to mental health and substance use.

38.3. Care Inspectorate

³³⁶ [Standards and indicators \(healthcareimprovementscotland.org\)](https://www.healthcareimprovementscotland.org)

³³⁷ [Evidence for Joint Committee Session of Scottish Parliament | Drug Deaths Taskforce](#)

³³⁸ [Alcohol and Drug Partnerships and Homeless Programme: Reducing Harm, Improving Care | Healthcare Improvement Scotland - ADP and Homeless Programme: Reducing Harm, Improving Care \(ihub.scot\)](#)

The Care Inspectorate is a scrutiny body that supports improvement through reviewing the quality of care in Scotland to ensure it meets high standards. Where improvement is needed, they support services to make positive changes. The Care Inspectorate specialise in health and social care, early learning and childcare, social work, children's services, and community justice. There are approximately 14,000 registered care services in Scotland and inspectors visit every one, with higher-risk services being inspected more often.

Additionally, they work with other scrutiny and improvement bodies to look at how local authorities, community planning partnerships and health and social care partnerships are delivering a range of services in their communities across Scotland. These inspections look at how well services are working together to support positive experiences and outcomes for people. This helps partnerships understand what is working well, and what needs to improve.

This does not include Alcohol and Drug Services.

The Care Inspectorate did undertake an evaluation of ADPs against the quality principles set out in the performance framework in 2017³³⁹.

The findings were that most ADPs had reviewed the way they delivered services to support recovery, and were committed to the principle of a shift in delivering care from traditional clinic-based services to providing services in the community.

The report also identified more could be done to develop ADP services by strengthening links and working in partnership. Examples included working with housing, child protection and mental health services to improve shared assessment, recovery plans and reviews. It was noted that outcomes and performance across ADPs vary widely and, based on the evidence reviewed by the Care Inspectorate, it was unclear how the Scottish Government had used performance information to develop and plan services at a national level.

39. Information Governance

The Information Governance (IG) Review³⁴⁰ was a comprehensive multi-stakeholder consultation process involving over 100 interviews across health and social care in Scotland, and a network of experts from across the UK and Ireland. The Digital Health and Care Institute, Scottish Government legal team and the Public Bodies Unit were also included. The report describes the current information governance (IG) landscape across health and care in Scotland and provides a series of evidenced-based recommendations for the improvement of IG. A summary of the main conclusions is included below.

³³⁹ Care Inspectorate. (2017). Available at: [Alcohol and Drug Partnerships - use and impact of the Quality Principles.pdf \(careinspectorate.com\)](https://www.careinspectorate.com/Alcohol-and-Drug-Partnerships-use-and-impact-of-the-Quality-Principles.pdf)

³⁴⁰ Scottish Government. (2022). Available at: [Information Governance review - gov.scot \(www.gov.scot\)](https://www.gov.scot/Information-Governance-review)

IG landscape in Scotland requires more maturity

The existing IG landscape was identified as being fragmented and lacking the consistency to ensure efficient scrutiny and delivery of health and social care digital solutions, and effective access to and sharing of, data assets. The report concluded that IG Maturity could be improved over time using the Scottish Approach to Service Design.

Policies, procedures and processes are inconsistent

IG guidelines exist in both government and health and care settings, however the IG landscape was assessed as significantly complicated due to inconsistencies across organisations. Challenges included visualising and managing risk at both local and national level.

The high levels of local autonomy in the existing combined IG model resulted in less standardisation and integration and higher costs. The results identified in the review were:

- varying interpretation of regulatory frameworks and risk appetites;
- increased synergies through regional clusters, localities and relationships established during the COVID-19 pandemic;
- complex and dynamic data-control relationships; and
- scattered, inconsistent and erratic decision-making routes.

There are common IG roles across health and care organisations, though the report highlighted a need to standardise the functions and responsibilities of key roles and training and continuing professional development activity. Inconsistencies in policies, procedures and processes were seen to be resulting in frustrations around cross-boundary work.

IG operations in areas such as privacy, transparency and ethics are spread across a range of different data controllers³⁴¹. There are many IG tools, but they can be unfocused, inconsistent, ineffective and inadequate. This was seen to result in:

- a fractured and inconsistent route to data;
- missed opportunities for greater interoperability and resilience of information systems; and
- a lack of transparency.

These difficulties, in turn, raised the level of overall information risks in the system, making it difficult to have visibility and manage potentially negative impacts, leading to missed opportunities for the positive use of data and digital technologies. Assessing the existence of joint participation and convergence in the decision-making process was identified as crucial in complex IG settings, such as health and care settings.

Scotland's response to COVID-19 has accelerated IG transformation

³⁴¹[Guidelines 07/2020 on the concepts of controller and processor in the GDPR | European Data Protection Board \(europa.eu\)](#)

More responsive, user-centred services that cover a spectrum of needs were seen to have been developed in response to COVID-19 and the digital and data solutions delivered during COVID-19 followed the design, development and implementation stages in an extremely condensed and rapid fashion. Culture and behaviour, however, remained significant barriers to change.

The digital transformation of health and care and the IG way of working across NHS Scotland and potentially social care has been accelerated as a result of COVID-19. The review recommended that models used, such as the Data and Intelligence Network, ways of scaling up and rapidly delivering telehealth and telecare solutions, and participatory governance used for programmes such as vaccinations, should be expanded to other areas.

A significant recommendation in the review concluded that the current combined IG model should be adjusted to secure the right balance of centralisation and local autonomy, while improving national leadership.

This would require consideration of:

- clear lines of accountability,
- alignment of IG roles and responsibilities,
- centralisation of some functions and services (e.g. centres of IG expertise, National Information Assurance Officer, National Data Guardian or equivalent) and potentially setting a national IG body in areas of benefit.

40. Digital

40.1. Digital Lifelines

Digital Lifelines is a programme partially funded by us which aims to support people with multiple and complex needs at risk of drug related harms through digital solutions. Isolation from friends, family and support can place people who use drugs at higher risk of a fatal overdose. Equally, initial case studies have suggested that the distribution of digital devices and building the skills and confidence to use them can have a transformative effect.

Digital exclusion (lack of internet access and/or knowledge of how to use devices) is a particular issue amongst people with multiple and complex social needs³⁴² which has become increasingly evident through the national COVID-19 experience and the associated loss of traditional face-to-face care.

Delivery Partners include the Drug Research Network for Scotland (DRNS), the Scottish Council for Voluntary Organisations (SCVO), Turning Point Scotland (TPS), Connecting Scotland and the Digital Health and Care Innovation Centre (DHI).

Guided by the Scottish Approach to Service Design, the programme has gathered a wealth of evidence and insights including engagement with people who use drugs.

³⁴² [Welcome to Digital Lifelines Scotland | Digital Lifelines](#)

Early Adopter programmes

Digital Lifelines Phase 1 (launched September 2021) aimed to understand in greater detail what interventions work most effectively with which people under what circumstances. Small grants were provided to overlay the provision of digital inclusion interventions on to some innovation projects.

Phase 2 (launched January 2022) works with providers with experience of providing digital inclusion support in particular situations (discharge from hospital; at release from custody; experiencing homelessness).

40.2. Overdose Detection and Responder Alert Technologies (ODART)

Overdose Detection and Responder Alert Technologies (ODART) Project³⁴³ is a partnership between the University of Stirling and St Andrews University and is supported by Digital Lifelines Scotland and the DRNS. ODART was launched in February 2021. Their report, due to be published later this year, gives an overview of different technologies developed nationally and internationally to avoid fatal drugs overdose.

The aim of the ODART Project is to transform preventative care for those most at risk of drug-related death by delivering on four main work streams: 1) detect the onset of overdose and alert a responsible person; 2) overdose first responder; 3) community provision of Naloxboxes; and 4) remote consultations.

We have worked closely with DRNS, having received presentations on their work at two Taskforce meetings and have been granted advance sight of their conclusions to inform our recommendations.

40.3. Civtech

[CivTech](#) is a digital accelerator programme intended to resolve challenges in public sector organisations with innovative digital businesses to create a tech revolution in the public sector, harnessing private sector innovation, through open challenges. It is funded by the Digital Directorate in Scottish Government but challenges are primarily run by other public sector organisations.

The whole process takes up to 22 weeks in total and costs £40,000 per challenge, plus the final contract between the sponsor and the company. This can be shortened to 20 weeks with CivTech sprints which do not have as many workshops in the Accelerator Stage.

³⁴³ Daneshvar et al. (2022). Available at: [Mapping of Overdose Detection and Alert Technologies: A Summary | University of Stirling](#)

41. Workforce

A recent survey³⁴⁴ of the drug and alcohol workforce noted that empirical data around staffing in drug and alcohol services is neither specifically-recorded nor well-known.

Overall, the recruitment and retention issues facing the sector are diverse and multifaceted, and differ by organisation type and geography. Respondents highlighted issues with funding and compensation, shortcomings in career development and progression, and a general lack of appreciation and understanding of what working in frontline services entails. The data emphasised the importance of sustained investment in this workforce. The following sections summarise key points from this review.

41.1. Vacancies

The workforce structure may vary depending on service type and location. A sector-wide vacancy rate of 8.8% was observed. Forth Valley had the highest vacancy rate at 17.9%, followed by Tayside at 13.7% and Highland at 13.2%.

Many factors influence geographic patterns in vacancy rates such as health and social care services in remote, rural and island areas face distinct staffing issues. However, the vacancy rates from the survey suggested that recruiting to frontline roles is problematic for both rural and urban areas. For example, qualitative data showed that relatively low pay for recovery workers – especially in third sector settings – as well as the increasing cost of living in the central belt, were deterring potential applicants. The author observed that sustainable workforce planning must therefore account for the specific challenges to recruitment and retention for services in these respective areas

Vacancies by Service Type

At 14%, ADPs reported the highest vacancy rate, followed by the NHS at 10.1%, and HSCPs at 9.1%. The third sector was the second lowest in the sector at 7.8%, just ahead of Local Authority services with 7.7%.

Vacancy rates were identified as having important implications irrespective of organisation type. The ways in which the implications of excessive vacancies manifested themselves were provided via survey responses:

“Demands of service are higher than workforce. Patient’s requiring higher outreach for crisis response and engagement. Caseloads are 30-40% higher what would be workable for amount of enquiries and problems encountered with our vulnerable patient group.” [NHS]

“There is no give in the system when there is sickness staff are having to manage other staff’s caseloads as well as their own.” [NHS]

³⁴⁴ Scottish Government. (2022). Available at: [Alcohol and drugs workforce: mixed-methods research compendium - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/compedium-2022-01/pages/10.aspx)

“We are managing caseloads of staff on maternity leave and long term absence.”
[NHS]

There were significant differences in the vacancy rate experience by clinical staff vs. non-clinical roles. Psychology roles had the highest vacancy rates across the sector (18.3%), followed by medical (16.4%). There was a substantial gap in vacancy rates between these two categories and nursing (9.6%), however nursing positions comprise by far the greatest employment totals amongst clinical roles. Overall, 13 of the 29 individual roles queried in the survey (44.8%) reported vacancy rates exceeding 10%.

No vacancies were reported for family support workers, counselling psychologists, clinical associates in applied psychology, band 8 nurses, or other nurses. Amongst the lowest reported vacancy rates were service managers (2.1%). By contrast, the vacancy rate for team leaders was 10.0%.

The survey authors identified this as suggesting that although there is high demand for roles with a leadership component, there are relatively few opportunities for progression into management positions within frontline services, which may well contribute to the retention issues reported in the qualitative data.

A variety of services listed the core support role that volunteers play in delivering services, especially given that many of them have lived experience. 14% of respondents reported people working for them in a strictly volunteer/unpaid capacity. The qualitative data showed that:

“The health and wellbeing of our staff and volunteers is vital in delivering our services”
[Third sector organisation]

“50% of paid staff identify as in recovery and 100% of volunteer staff also do.”
[Integrated services]

Several organisations reported employing volunteer coordinators to help manage the number of volunteers they have.

41.2. Recruitment and Retention

A key theme emerged from the qualitative responses around the ways in which services are funded, and the impact this has on recruitment. A number of responses noted that short term funding could lead to fixed term contracts. This made these posts less attractive for potential staff due to their precarious nature, and thus more difficult to recruit for. Examples of responses included:

“...lengthy or permanent funding is preferable due to difficulty recruiting to 6 month or 1 year posts and development and embedding of practice.” [HSCP]

“Funding being permanent or for longer fixed terms rather than non-recurring which makes recruitment challenging.” [NHS]

Staff salaries were also extensively commented upon:

“It is still incredibly difficult to recruit skilled and experienced staff as our salary scales cannot match those of statutory organisations such as local authority and NHS. Therefore, there is a need to increase budgets for contracts to allow organisations like ours to increase salary and competitively recruit staff.” [Third sector organisation]

“Higher pay scales all round. We work closely with the housing sector (housing officers) and the pay gap is very disproportionate for the type of work we comparatively do.” [Third sector organisation]

HSCPs, NHS, ADPs and third sector organisations all separately expressed these sentiments, indicating that pay and conditions are considered a challenge across the entire drug and alcohol workforce, rather one particular service type.

Respondents highlighted that the difficulties of recruiting and retaining staff were not simply matters of remuneration and that there is a strong need for the drugs and alcohol workforce to be able to access continuing professional development and training opportunities.

Access to funding to undertake specialist courses in higher education institutions was also highlighted by respondents, especially in terms of career progression for staff in non-clinical roles:

“Increase bursaries to allow more staff to do post graduate study to retain them not just SVQ Health and Social care but specialist courses at University of Stirling and West of Scotland around addiction and harm reduction... As non-clinical staff the staff group are not always valued or seen as less professional than clinical staff. SVQ not valued by other professions in same way as a degree.” [Third sector organisation]

Finally, it was noted that more needed to be done to showcase the valuable jobs that are done by people in this sector. This was directly related to a call for more recognition for those that have opted to work in settings as challenging as frontline drug and alcohol services. For example:

“Strategically, the workforce in our services could be improved if they were given recognition as a specialist professional role. Drug and alcohol services are marginalised and often stigmatised as our service users are, the work that we do, the care and support that we provide is not always understood or appreciated by wider health and social care.” [Third sector organisation]

The survey summarised how the recruitment and retention issues facing the sector are diverse and multifaceted, and differ by organisation type. Funding and remuneration remain major issues, as is the case across the entire health and social care workforce. However, respondents also highlighted shortcomings in career development and progression, as well as a general lack of appreciation/understanding of what working in frontline services entails, underscoring the need for increased investment as well as a cultural shift in perceptions.

41.3. Caseloads

Total caseloads across the sector at 1 November 2021 (the date on which the survey gathered the data) varied substantially, with organisations reporting caseloads ranging from 5 to 1,405 service users. Moreover, caseloads per frontline staff also depended on service size, type and location.

Staff at HCSPs and NHS organisations reported the highest median caseloads per WTE employee, at 46 and 28 respectively.

High levels of caseloads and referrals were directly highlighted as issues in over one in five responses. Moreover, respondents highlighted the increasing levels of complexity in individual cases. These issues were discussed at length, for example:

“Demands of service are higher than workforce. Patient’s[sic] requiring higher outreach for crisis response and engagement. Caseloads are 30-40% higher [than] what would be workable for amount of enquiries and problems encountered with our vulnerable patient group.” [NHS]

“Caseloads are continually rising and the complexity of cases [is] increasing meaning that workers are spending more time on individuals[sic] and the individuals are spending more time in service.” [Third sector organisation]

“Team is extremely busy, new referrals each week (10-20) from which people need to be seen within 21 days of referral.” [Integrated service]

Caseload and employee wellbeing

Respondents outlined specific resource implications in relation to caseload. Service users with multiple complex needs require higher levels of support, and over longer periods of time. As one Integrated Service succinctly remarked, “caseload number does not reflect complexity”. Other respondents explained further:

“We work with increasingly complex individuals who along with significant drug or alcohol issues may also have statutory requirements of engagement from C&F [children and families] and CJ [criminal justice]. Many of our SU [service users] have complex multiple physical and MH [mental health] needs and there may be issues around capacity.” [Local authority]

The survey identified that how these caseload trends impacted individual staff wellbeing was also important. In the UK, mental health conditions (stress, depression, anxiety) alone accounted for as much as 9% of overall work absences in 2020.

Respondents to the survey highlighted how increasing workloads were leading to mental and physical health issues, attrition and burnout amongst frontline workers. Over 10% of respondents flagged how these factors impacted staff sickness, which itself has a cascading effect: overworked employees become progressively more stressed, which leads to them taking more sick days, which then leads to other staff having to manage their caseloads, which leads to stress amongst those employees, which results in more sick days, and so on. As one NHS organisation noted:

“At one point in summer 2021 the team only had one registered nurse and team lead covering caseload for a team of 8. Team lead is not supposed yo[sic] have a casleoas[sic]. Most of their work was not completed ans[sic] they are also supposed to support another team tooo [sic]. This then lead to burnout of one team members[sic]. The team has always been sitting with vacancies or long term sick since may[sic] 2019 with between 2-6 staff short... It is very stressful at times” [NHS]

In addition to the qualitative information, services were asked to report how many days had been lost to sickness amongst paid employees over the period 1 May to 1 November 2021. A variety of values ranging from 0 to 400 were reported, with a median reported rate of 34 sick days per service. A statistically significant relationship was observed between total sick days taken and average caseload per WTE employee - a one-unit increase in the average caseload per WTE employee will increase the number of sick days taken by 5%. This suggests that the employee-service user interface is a more important indicator of staff well-being than is the ratio of employees to vacancies, or the presence of volunteers. Such a finding is especially important for staff given how volatile caseloads and referrals to drug and alcohol services can be.

41.4. Service delivery and design

A further theme which emerged in the qualitative research for the mixed-methods research compendium has highlighted the necessity of service review and redesign of some drugs and alcohol services. Over 13% of the free text responses were related to this and in most cases identified an aspect of their local service which could be overhauled to address localised issues. For example:

“Introduce local alcohol detoxification beds or increase the number of board wide available beds.” [HSCP]

“Better rehabilitation services within the local authority area – the current service is generally at capacity with a lengthy waiting list.” [ADP]

When viewed in the aggregate, these responses suggest that (in some places at least) services are not set up to operate as efficiently as possible. This has implications for service delivery as there are no appropriate destinations for service users to move on to, and they then remain in the existing services. This is not only detrimental to these individuals but it means services have higher caseloads as they cannot discharge' people. In the meantime, however, these services continue to receive new referrals. As the quantitative data around caseloads, sick days and vacancies shows, this has a detrimental impact on the workforce and the services they provide.

41.5. Health and Care (Staffing) (Scotland) Act 2019

The guiding principles for health and care staffing set out in the Health and Care Staffing Scotland Act 2019 are:

- that the main purposes of staffing for health care and care services are:

- to provide safe and high-quality services, and
- to ensure the best health care or (as the case may be) care outcomes for service users,
- that, in so far as consistent with those main purposes, staffing for health care and care services is to be arranged while:
 - improving standards and outcomes for service users,
 - taking account of the particular needs, abilities, characteristics and circumstances of different service users,
 - respecting the dignity and rights of service users,
 - taking account of the views of staff and service users,
 - ensuring the wellbeing of staff,
 - being open with staff and service users about decisions on staffing,
 - allocating staff efficiently and effectively, and
 - promoting multi-disciplinary services as appropriate.

The Act sets out the following duties in relation to the National Health Service:

- ensure appropriate staffing, including:
 - in relation to agency workers;
 - the number of registered healthcare professionals,
 - providing appropriate training,
- have real-time staffing assessments in place;
- have a risk assessment process in place;
- have arrangements to address severe and recurrent risks;
- seek clinical advice on staffing;
- ensure adequate time given to clinical leaders;
- follow common staffing method.

Healthcare Improvement Scotland are tasked with monitoring and reviewing health boards to ensure compliance.

The Act also sets a duty on care service providers to ensure appropriate staffing, as well as provide appropriate training.

42. Education & Training

42.1. Colleges

Analytical colleagues at Scottish Funding Council confirmed that there are currently no courses delivered in colleges which include 'drugs', 'alcohol', 'addiction' or 'substance' in the title. It was therefore not possible to identify offerings specific to substance use treatment services in Scotland. Instead the report looked at the health and social care courses which would be a useful foundation for someone starting a career in the drug and alcohol field³⁴⁵.

³⁴⁵ Scottish Government. (2022). Available at: [Scotland's Alcohol and Drugs Workforce: Skills and qualifications review \(www.gov.scot\)](https://www.gov.scot/review/Scotland's-Alcohol-and-Drugs-Workforce-Skills-and-qualifications-review)

42.2. University

While there have been overall increases in students qualifying in both counselling (+50%) and health & welfare (+29.4%) between 2013-14 and 2018-19, there has been a substantial downturn in pharmacology, toxicology & pharmacy graduates (-71%).

42.3. Continuing Professional Development

Over 350 health and social care professionals have completed courses in substance use offered by NHS Education for Scotland (NES) over the last two years. These have ranged from cognitive behavioural therapy to motivational interviewing to multidisciplinary modules, and have been run across every NHS Health Board in Scotland. These figures do not include enrolments on training courses run in other (yet related) work streams such as anxiety, depression and psychosis. The figures also show that the increase in demand for these courses has coincided with COVID-19 lockdowns, which raises questions about e.g. whether migrating training to online delivery has led to greater uptake or if services are recognising the importance of developing these skills amongst frontline workers.

42.4. Workforce Development Programme

Scottish Government contracts Scottish Drugs Forum (SDF) to deliver a Workforce Development Programme across ADPs. The training and workforce development options available under this scheme cover a range of issues pertinent to frontline workers in drug and alcohol services and beyond.

As with NES, the COVID-19 pandemic forced SDF to discontinue several courses as well as face-to-face delivery. Nevertheless, these changes coincided with an increase in demand. In 2019, SDF recorded 2,140 enrolments on their core training, not including commissioned training or e-modules. This increased to 3,447 (+61%) in 2020, followed by a slight dip to 3,271 in 2021.

SDF delivers training to a range of stakeholders. Leading the way are charity and volunteer organisations with 1,817 enrolments across the time series, followed by social work (1,278), NHS (1,197), housing and homelessness services (1,083) and local authorities (782). Drug and alcohol services were the least-represented sector amongst SDF course participants.

42.5. Scottish Drugs Forum – Addiction Worker Training Project

In addition to the Workforce Development Programme outlined above, SDF also runs an initiative called the Addiction Worker Training Project (AWTP). Launched in 2004, the programme provides supported paid employment, specialist training and vocational learning for unemployed people with a history of drug and alcohol problems. People are recruited to AWTP from areas of high deprivation in Scotland to work with SDF for a total of nine months. After a 12-week induction period, trainees work towards completing a Scottish Vocational Qualification in social services and healthcare (equivalent to completing a modern apprenticeship), following which they are eligible to register as members of the Scottish Social Services Council. Trainees then

undertake two supported placements in organisations where they use their lived experience to provide effective interventions for people accessing services. They also undertake training in relevant topics such as (but not limited to) drug awareness, Naloxone, mental health, motivational interviewing, and others. Following completion of the programme, trainees receive support from SDF and employability partners in seeking employment and preparing for interviews for up to three months. However, there have been instances of trainees moving on to further employment or further education before the course ends.

42.6. Royal College of General Practitioners Scotland

The Royal College of General Practitioners Scotland (RCGP Scotland) offers a Certificate in the Management of Problem Drug Use that has been approved by an expert advisory panel of senior clinicians. Funded in part by Scottish Government, this course is designed to assist primary care professionals care for people affected by drug use, and is open to GPs, pharmacists, allied healthcare professionals, third sector workers, and anyone else working in primary care in Scotland.

Since its relaunch in 2020, this two-part course has proved popular. Data provided by RCGP Scotland shows that a total of 84 people earned this certificate during the first cohort (February - October 2021) – 67 for part 1 and an additional 17 for part 2 of the course. These figures break down as:

- GP or trainee GP: 56
- Pharmacy: 14
- Prison healthcare: 14

Although GPs and GP trainees comprise the majority in both part 1 and part 2, there is also notable participation within the pharmacy and prison sectors as well.

Demand has increased for cohort 2 (which ran from November-December 2021), with 80 people registered for part 1. Part 2 will take place in spring 2022. RCGP Scotland has confirmed that they are able to run this course due to a three-year tranche of Scottish Government funding which is currently in place until 2023. Given the announcement of the National Mission, it is worth discussing how this certificate can be supported beyond the end of the three-year cycle.

42.7. National Trauma Training Programme

The National Trauma Training Programme (NTTP), led by NHS Education for Scotland (NES) to support a trauma informed and trauma responsive workforce and services across Scotland was launched in 2018.

The Programme is intended to provide accessible, evidence-based trauma training resources, including a leadership development component, as well as a team of Implementation Co-ordinators to support all sectors of the workforce to embed and sustain trauma informed practice. In 2021, the Programme further established a network of senior Trauma Champions from across Local Authorities and Health Boards, who will be supported by NES and the Improvement Service to influence change across local areas and ensure sustainability beyond the life of the Programme.

The overarching vision for the NTTP is:

“A trauma informed workforce and services across Scotland, capable of recognising where people are affected by trauma and adversity, that is able to respond in ways that prevent further harm and support recovery, and can address inequalities and improve life chances.”

In 2021 an online survey explored awareness and attitudes to psychological trauma and trauma informed practice, including awareness and uptake of the NTTP in the Scottish workforce³⁴⁶. Staff working in mental health and alcohol and drugs reported significantly higher levels of confidence than those working in other sectors. Scores were generally lower when staff were asked about their workplaces and whether they agreed that the key drivers of trauma-informed practice were embedded within the organisation or service, although again, staff were more likely to provide a higher score if they worked in service areas such as alcohol and drugs or homelessness.

Overall, just under a third of respondents, 31.6%, said that they had been aware of the NTTP prior to completing the survey and only 22% had completed at least one NTTP training or information session. Again, higher scores were recorded for those working in areas such as alcohol and drugs.

The survey also explored the impact of the NTTP. Across all statements for self-assessed confidence, those who had completed an NTTP training session were significantly more likely to report high levels of confidence and were more likely to indicate that their organisation was trauma-informed. As an example, respondents who had undertaken an NTTP session were more likely to agree with the statement “staff are encouraged to undertake training to develop their skills, knowledge and confidence of trauma-informed practice” by a margin of 81.9% compared to 45%. There was also a large difference between the percentages agreeing with the statement “leaders champion trauma-informed practice and policy”, at 55.4% compared to 32%.

Having a trauma informed workforce emphasises the importance of the relationships between individuals. We have been told by those working in services, of the importance of relationships in engaging and retaining people in treatment, and in someone’s ongoing recovery. The importance of relationships has been demonstrated in a range of therapeutical and psychological interventions for a variety of issues and studies highlight that *“the therapeutic relationship is the context within which interventions occur and is itself a critical aspect of treatment”*³⁴⁷.

³⁴⁶ Scottish Government (2021). Available at: <https://www.gov.scot/publications/national-trauma-training-programme-workforce-survey-2021/>

³⁴⁷ Okamoto et al. (2019). Available at: [The therapeutic relationship in cognitive-behavioral therapy: Essential features and common challenges. - PsycNET \(apa.org\)](#)

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Project: *Psychological Informed Environments* (NHS Grampian)

The project's aim was to introduce a Psychological Informed Environment (PIE) across the system. The funded Psychologist took a leadership role, working with staff to upskill and coach them to ensure they are competent and confident to work in a PIE approach.

The first 6-month block of Motivational Interviewing (MI) coaching via MS Teams was completed in February 2022. A Total of 28 out of a possible 30 coaching sessions were delivered across the Aberdeenshire Integrated Drug and Alcohol Service (AIDAS), with 58 staff in attendance.

An initial mapping exercise to establish a baseline of knowledge and skills for both psychological and trauma informed care has been completed and the results shared with Integrated Managers, Team Leaders and the ADP. This will inform workforce development and training discussions with a view to deliver NES transforming psychological trauma training to ensure consistency of approach across the service. A NES trauma skilled (Practice Level 2) half day workshop was delivered to staff working in the newly formed Hospital Drug and Alcohol Care Team and feedback was very positive.

The Aberdeenshire Drug and Alcohol Psychology Service (AIDAPS) is now established providing specialist input across AIDAS. Consultations with staff and clients to support psychological components continue to be offered with a total 12 consultations taking place since the last report in December 2021 (some with clients where they have wanted to be present). Of these 12, 6 have been advanced to referral for direct input within AIDAS.

There have been a number of lessons learned from the project:

- Staff have found attendance at coaching beneficial to consolidate knowledge and skills from training, ensuring fidelity to the model and increasing confidence in application of skills into practice, with having time to reflect on cases highlighted as the most helpful aspects of coaching
- recruitment and access to IT equipment impacted on the start date of the project
- whilst the importance of psychological and trauma informed care is recognised there is a need to build capacity in the service for staff to have additional training, access to supervision and protected time for implementation.

NHS Grampian have already shared learning from the MI coaching with others across the North East who are looking to implement it.

NHS Grampian, update to CORRA Foundation, March 2022

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Project: *Capacity Building Psychological Interventions (NHS Borders)*

This project aims to build capacity within drug services to provide Tier 2 psychological interventions to support individuals whose current complexity or instability means they are not in a position to engage with their recommended psychological therapy. This will support work to meet MAT Standard 6 and will also include a workforce development role to ensure improved competency.

This project has faced significant delays, there have been two main challenges to getting started:

- recruitment: delayed human resource processes and notice periods needing to be accommodated, has pushed back the go live date for the project.
- impact of COVID-19: the impact of COVID-19 pressures on service delivery within NHS Borders and their partner agencies, backlogs and waiting lists had to be prioritised.

The project began April 2022 and will run until 2023.

NHS Borders, update to CORRA Foundation, May 2022

Project: *Developing a Rights Based Approach (REACH Advocacy)*

REACH Advocacy, in partnership with Public Health Scotland, planned to develop a training programme to disseminate awareness of the Medication Assisted Treatment (MAT) Standards within a wider Human Rights Based Approach (HRBA) in order to remove barriers that individuals are experiencing whilst trying to access care and treatment.

REACH have delivered awareness workshops on MAT Standards within a HRBA to 344 individuals over 23 workshops and have facilitated two Award cohorts resulting in 13 certified individuals in human rights based advocacy. These workshops have been delivered to a cross population of participants including lived/ living experience individuals, frontline staff, service managers, clinical leads and volunteers across a range of different sectors within both statutory and third sector services. This cross population approach ensures that those accessing care and treatment and those operating within the parameters of service delivery are upskilled on MAT Standards and underpinning Human Rights legislative frameworks, in turn contributing to lasting cultural and systematic change.

The project has identified a number of key learning points:

- the value of the cross-population approach with the workshops, creating a unique shared space and building informal networks between practitioners and people with lived, living or family experience;
- the accredited Award has an immediate impact in supporting lived/ living experience individuals to become qualified rights based advocates and gain meaningful employment, thus improving wellbeing and quality of life outcomes as a result;
- within the most recent cohort, two graduates (from lived experience & family groups) successfully secured Human Rights Based Advocacy positions as a result of achieving their accredited qualification;
- on average 82% of participants said they rarely or never used the Orange Book in their practice; 69% of participants said they rarely or never used the NICE Guidelines in their practice; and 87% of participants said they rarely or never used the ICD-10/11 in their practice;
- 28% of participant considered that addiction was, or was maybe, a lifestyle choice. After the workshop, 89% of participants considered addiction not to be a lifestyle choice.

The project has identified “lack of awareness from frontline staff regarding clinical guidance and legislative instruments which inform care and treatment standards”. REACH’s “questionnaire responses suggest that staff working in this capacity do not have an informed understanding of substance use disorder as a health condition, and therefore are not providing appropriate well rounded treatment plans for individuals”. They state that ADPs are often unaware of these discrepancies and the need for further training.

43. Monitoring and Evaluation

In their 2022 review³⁴⁸, Audit Scotland highlighted that although Scottish Government has provided additional investment over the last few years for new initiatives, including this Taskforce and new evidence-based treatments and standards. However, it is too early to assess their effectiveness and it is still difficult to track spending and how it is being distributed and monitored.

Work is under way to evaluate new initiatives and improve data, but there are still gaps. More focus is needed on addressing the root causes of problem substance use and breaking the cycle of harm affecting multiple generations across communities. The Scottish Government needs to set out a clear integrated plan on how additional investment can be used most effectively and demonstrate how it is improving outcomes. Good quality, frequent and timely data will be crucial in supporting clear performance measurement and public reporting.

44. Resources

Overall funding to ADPs was reduced over several years but by April 2021 it returned to around the level it was six years ago in cash terms, but with no real terms increase in funding. From 2021/22, ADPs will receive a further £20 million a year over five years³⁴⁹.

Audit Scotland's 2022 review highlighted that spending on drug and alcohol services is difficult to track and needs to be more transparent. The Scottish Government does not publish a full breakdown of all funding in one place and information is incomplete, disparate and presented inconsistently. Various funding announcements are published in different places, including the Scottish Government and Parliament websites, and programme for government and budget documents. Drug and alcohol services funding is not reported in one place and a full breakdown of funding for ADPs is not available. Currently only core funding is published and does not include funding from other streams.

Alongside ADP funding, the government has allocated other additional funding since 2018/19 over three years, including £2 million to a challenge fund for preventing homelessness and £1 million to support national and local projects on advocacy services and testing new approaches to recovery. In September 2021, the Programme for government made a commitment to invest an additional £250 million over the term of this Parliament in the national mission to reduce drug deaths – £50 million each year – with £100 million to be spent on residential rehabilitation over the five years.

Between 2014/15 and 2019/20, overall funding for drug and alcohol services decreased by six per cent in real terms (a slight increase in cash terms from £73.4 to £75.3 million). The recent additional funding announcements by the Scottish Government, mean the real terms increases in funding from 2014/15 were a 16 per

³⁴⁸ Audit Scotland. (2022). Available at: https://www.audit-scotland.gov.uk/uploads/docs/report/2022/briefing_220308_drugs_alcohol.pdf

³⁴⁹ Audit Scotland. (2022). Available at: https://www.audit-scotland.gov.uk/uploads/docs/report/2022/briefing_220308_drugs_alcohol.pdf

cent increase in 2020/21 (total funding was £98.2 million) and a 67 per cent increase in 2021/22 (total funding was £140.7 million).

Evidence compiled highlighted the need for increased funding for drug treatment and wider recovery support, including bringing treatment and recovery services for drug dependence up to parity with other health services will require economic investment as well as improvements in coordination and accountability. It was recognised that a lower standard of care for this vulnerable and stigmatised population was unacceptable. Funding for drug treatment should be allocated to local authorities based on a needs assessment and be protected. Where relevant, other government departments should protect funding at local level for their wider recovery services. Dame Carol Black's independent review states that there is a strong invest to save case for drug treatment; every £1 currently spent on harm reduction and treatment gives a combined health and justice return on investment of £4³⁵⁰.

When comparing the evidence on the commissioning of drug and alcohol services in England as outlined in Dame Carol Black's review to that across Scotland, it was established that many local authorities in Scotland do not commission the full range of services required and there are important gaps in provision, such as suitable treatment services for people who use drugs other than opiates. We agree with the proposals to develop and implements a national Commissioning Quality Standard, based on clinical guidelines. This should specify the range of treatment services that should be available in each local area. There should also be joint local plans across all local organisations involved in treatment and recovery. Commissioners should also work more collaboratively with providers and introduce longer commissioning cycles of at least 5 years, to encourage service stability and improvements to quality.

45. Information Services Division

The latest information on the prevalence of problem drug use in Scotland comes from 2015/16.

The number of individuals with problem drug use in Scotland was estimated to be in the range 55,800 to 58,900 during 2015/16. This represents an estimated prevalence rate of approximately 1.62%. The majority of individuals with problem drug use were male (71%). The prevalence rate amongst males was 2.35%, this compares to 0.92% for females.

The report defined problem drug use as the problematic use of opioids (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines, and implies routine and prolonged use as opposed to recreational and occasional drug use. However, given the often rapid changes in drug use patterns in Scotland, it is important that timely data and analyses is provided on trends and patterns of drug use if effective strategies to reduce drug deaths and harms are to be implemented.

³⁵⁰ [Review of drugs part two: prevention, treatment, and recovery - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/reviews/evaluation-of-drug-treatment-and-recovery)

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Annexes

Annex A: Actions and links to relevant evidence

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
1	Context	The Drug Policy Division of the Scottish Government should work with ongoing Taskforce projects and feed any learning into Scotland's National Mission.	Short	Scottish Government: Drug Policy Division	2
2	Context	The UK Government should amend the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2000 to allow for the legal provision of a wider range of drug paraphernalia through harm-reduction and treatment services. This is essential to enabling safer drug consumption.	Medium	UK Government	3
3	Context	While the Scottish Government is unable to amend the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2000, it should explore all options to support their amendment as suggested by the Taskforce.	Medium	Scottish Government	3
4	Context	The UK Government should review the regulations on dispensing and prescription forms for controlled drugs to take account of clinical and technological advances since implementation in 2001.	Medium	UK Government	Drug Law Reform Report
5	Context	The Scottish Government should work with the UK Government to deliver progress on the regulation of pill presses, including	Short	UK Government Scottish Government	25

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		developing a suitable licensing system to reduce related harm.			
6	Context	The UK Government should urgently remove the exemption set out in S3.1 of the Equality Act 2010, (Disability) Regulations 2010, and make drug dependency part of the protected characteristic of disability.	Medium	UK Government	3
7	Context	The Scottish Government should do everything within its powers to hasten the removal of the exemption set out in S3.1 of the Equality Act 2010, (Disability) Regulations 2010 and make drug dependency part of the protected characteristics of disability.	Medium	Scottish Government	3 7.5
8	Context	The Scottish Government should ensure, as part of the Human Rights Bill and/or National Collaborative work to develop a Charter of Rights, that the right to the highest attainable standard of physical and mental health is accessible and enforceable for people who use drugs, removing any discriminatory separation between drug dependency and other health conditions, as currently exists in the Equality Act 2010.	Medium	Scottish Government	3 7.5
9	Context	The UK Government should undertake a root and branch review of the Misuse of Drugs Act, reforming the law to support	Short/Medium	UK Government	3

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		harm-reduction measures and implement a public health approach.			
10	Context	If the UK Government are not willing to reform the Misuse of Drugs Act, it should commit to exploring all available options openly with the Scottish Government to enable Scotland to take a public health approach.	Short/Medium	UK Government Scottish Government	3
11	Culture	All responses to problem substance use must be co-produced or co-developed with people with lived and living experience.	Short	Everyone	5 6
12	Culture	ADPs should ensure that specific psychological and wellbeing support is provided for people with lived and living experience.	Short/Medium	Alcohol & Drug Partnerships	5
13	Culture	The Scottish Government should work to ensure that barriers to accessing opportunities such as volunteering, training, education or employment are removed for people with lived and living experience wherever possible.	Medium	Scottish Government	5
14	Culture	The Scottish Government should continue to support the whole-family approach and implement the actions set out in the framework at pace.	Medium	Scottish Government	6
15	Culture	The Scottish Government and chief officers should ensure that family-inclusive practice is embedded across the public	Medium	Scottish Government and Chief Officers	6

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		sector, with mandatory training provided for the workforce.			
16	Culture	ADPs should ensure that specific, ring-fenced support, including psychological and wellbeing support, is available for family members. This should not be dependent on the person who uses drugs accessing support.	Medium	Alcohol & Drug Partnerships	6
17	Culture	The Scottish Government should develop and rapidly implement a national stigma action plan, co-produced with people with lived, living and family experience and built on the Taskforce stigma strategy.	Short	Scottish Government	7
18	Culture	The National Collaborative should inform and support the development and implementation of the action plan and hold the Scottish Government and partners to account for delivery.	Short	National Collaborative	7
19	Culture	All services that support people who use drugs should have a defined, collaborative improvement plan for tackling stigma, based on national and local strategies. It should include a full critical review of their service to identify and proactively counter any systemic stigmatising practices.	Medium	Statutory & Third Sector Services	7
20	Culture	Ofcom, media outlets and commissioning editors should use the SFAD and SRC guidelines for journalists and work with organisations representing people who use	Short	Scottish Government, Ofcom, Media Outlets, Editors	7.7

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		drugs and their families to develop guidance on reducing stigma and discrimination in reporting, documentaries and fiction. Scottish Government should support these organisations to deliver this action. .			
21	Culture	The Scottish Government and chief officers should mandate that our Stigma Charter is adopted by all public bodies and services and all other organisations should be encouraged to adopt it. The uptake of this adoption should be recorded and reported publicly, with appropriate and defined sanctions for public bodies and services that do not adopt it.	Short	Scottish Government and Chief Officers	7
22	Culture	People should not be turned away from services because they have additional support needs that are outwith the service's remit. They should be linked with appropriate services and be supported to address their own needs.	Medium	Alcohol & Drug Partnerships, Statutory & Third Sector Services	8
23	Culture	ADPs should ensure that people with multiple and complex needs are not simply passed on to other services. A single lead professional should, with the patient's consent and involvement, take a coordinating role in developing and overseeing a holistic care package.	Medium	Alcohol & Drug Partnerships	8 10

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
24	Culture	Service providers in all sectors and ADPs should ensure that support, including for mental health, is not conditional on people receiving treatment for their dependency, recovery or abstinence.	Medium	Alcohol & Drug Partnerships, Statutory & Third Sector Services	8 9 10
25	Culture	ADPs and services should work effectively across boundaries to ensure that individuals have choice over what services they access and where.	Medium	Alcohol & Drug Partnerships, Statutory Services	8
26	Culture	The Scottish Government should continue to support Housing First and expand coverage to all local areas in Scotland. Learning from the model can be used to support the design of other support services.	Medium	Scottish Government	9
27	Culture	The Scottish Government should gather the evidence from Taskforce projects that continue beyond July 2022 and share these with local areas to inform local strategic plans. Effective changes to support joint working and improve and save lives should be implemented.	Short	Scottish Government	2.2 2.3 10.3
28	Culture	The Scottish Government and ADPs should support the improvement of partnership-working across the sector, including between statutory and third-sector services, and with recovery communities. This should be backed by fair, transparent and sustainable funding to	Medium/Long	Scottish Government, Alcohol & Drug Partnerships	10

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		ensure services are delivered in the most effective way by the right partners.			
29	Care	Local services must consider their provision and pathways through an equalities lens, ensuring that women can access the support they need when they need it.	Short/Medium	Alcohol & Drug Partnerships, Statutory Services	11
30	Care	ADPs and services must ensure specific pathways are developed to ensure young people can access the support they need when they need it.	Short/Medium	Alcohol & Drug Partnerships, Statutory Services	13
31	Care	The Scottish Government must prioritise tackling the root causes of drug dependency, embedding this focus into work across Government to address poverty and structural inequality.	Long	Scottish Government	15
32	Care	Education Scotland should develop a new education programme for drugs based on findings in "What works in Drug Education and Prevention?"	Medium	Education Scotland	14.1
33	Care	Within the next year, the Scottish Government should undertake and publish a mapping exercise of touchpoints outwith the drug and alcohol sector, with the ultimate aim of making every contact count. The Government should then ensure that at these touch points, people are aware of the services available and are	Short	Scottish Government	20

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		able to engage effectively with referral pathways into treatment and support.			
34	Care	The Scottish Government, chief officers and ADPs should ensure that every worker who is public-facing or who works in a publicly funded service completes trauma training appropriate to their role, as set out in the NES Knowledge and Skills Framework for Psychological Trauma and the Scottish Psychological Trauma Training Programme.	Medium	Scottish Government, Chief Officers, Alcohol & Drug Partnerships	42.7
35	Care	ADPs and Healthcare Improvement Scotland (or the Care Inspectorate) should ensure that all drug services are delivered in psychologically- and trauma-informed environments.	Medium	Alcohol & Drug Partnerships, Health Improvement Scotland, Care Inspectorate	42.7
36	Care	Local ADPs should keep a single, up-to-date, publicly available record of services in their area. It should clearly identify referral pathways and feed into a national platform from which information on any local area can be found.	Short	Alcohol & Drug Partnerships	11
37	Care	Within the next year, the Scottish Government, chief officers and ADPs should ensure that every local area has an effective NFO pathway that follows the outlined procedure. Any person flagged as	Short	Scottish Government, Chief Officers, Alcohol & Drug Partnerships	23

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		having an NFO by an emergency responder, service or professional should be referred to the pathway.			
38	Care	The Scottish Government and ADPs should ensure that out-of-hours emergency support for point-of-need care and management of prescriptions is available in every local area. This should provide a place of safety in which individuals can be stabilised and supported to access follow-up support where necessary.	Medium	Scottish Government, Alcohol & Drug Partnerships	17
39	Care	The Scottish Government and NHS 24 should extend the existing phone service to provide a dedicated resource for supporting individuals with their substance use and helping them to access treatment and services in their area. This phone line should be available for individuals and their family members.	Medium	Scottish Government NHS 24	11
40	Care	The UK Government should implement legislative changes to support the introduction of Supervised Drug Consumption Facilities. In the interim, the Scottish Government should continue its efforts with stakeholders to support their implementation within the existing legal framework.	Short/Medium	UK Government Scottish Government	19
41	Care	SDCFs should be available nationally but be locally commissioned to meet the	Medium/Long	Scottish Government	19

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		specific needs of the population, in line with the public health needs assessment. They should be sustainably funded, operated by appropriately trained multi-disciplinary teams and incorporate appropriate aftercare.			
42	Care	Clear engagement with local communities and all relevant stakeholders, including sharing the evidence base for SDCFs, should be taken forward prior to implementation in a local area	Medium/Long	Alcohol & Drug Partnerships	19
43	Care	The Scottish Government should work with NHS naloxone leads and pharmaceutical companies to ensure sufficient supplies are available to meet anticipated demand.	Short/Medium	Scottish Government, NHS Scotland, Pharmaceutical companies	22
44	Care	The UK Government should permanently reclassify naloxone from a POM to a Pharmacy or General Sales List medicine.	Short	UK Government	22
45	Care	In the absence of a full reclassification of naloxone, the Scottish Government should work closely with the UK Government to ensure that the changes planned reflect the breadth of the Lord Advocate's Statement of Prosecution Policy in Scotland.	Short	UK Government, Scottish Government	22
46	Care	The Scottish Government should also engage with the Lord Advocate in relation to extending the time that the current	Short	Scottish Government	22

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		Statement of Prosecution Policy is in place.			
47	Care	The NHS should establish a National Naloxone Coordinator post in NHS National Services Scotland to nationally manage the provision of naloxone. This role should be regularly reviewed to ensure it is effective and still needed. The roles of naloxone leads in health boards should be formalised.	Short	NHS Scotland	22
48	Care	The National Naloxone Coordinator should ensure that all front-facing public services staff are trained and have access to naloxone.	Medium	NHS Scotland	22
49	Care	GPs should be encouraged to supply naloxone on GP10 prescriptions and through direct distribution of naloxone packs, possibly obtained on a stock order to hold in the practice.	Short	Scottish Government, Royal College of GPs	22
50	Care	An awareness campaign should be launched for GPs and practice staff around naloxone to enable them to provide information to patients on its use.	Short	Scottish Government, Royal College of GPs	22
51	Care	All community pharmacies should hold naloxone for administration in an emergency and should be able to supply THN to people who use drugs, families and anyone likely to witness an opioid overdose.	Short	Scottish Government, Community Pharmacy Scotland	22

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
52	Care	The National Naloxone Coordinator should ensure that naloxone training is incorporated into all standard first-aid and resuscitation training, and consideration should be given to supplying “naloxboxes”. Training should be provided for all students in professions where people may reasonably be expected to come into contact with a person experiencing an overdose.	Medium	NHS Scotland	22
53	Care	Clarity must be provided on the legal right to carry and administer naloxone.	Short	Scottish Government	22
54	Care	The NHS Naloxone Coordinator and Public Health Scotland should undertake a rapid review of the monitoring and evaluation of naloxone. The review should lead to changes to more effectively assess the amount of naloxone in circulation, its use and the effectiveness of current initiatives to increase distribution.	Medium	NHS Scotland, Public Health Scotland	22
55	Care	People should continue to be able to access THN through a “click and deliver” service that is accessible to all. ADPs, as well as services that do not offer THN, should direct people who use drugs, peers and family members to this service. The Scottish Government should ensure that the service is adequately funded to meet increasing demand	Short	Scottish Government	22

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
56	Care	The Scottish Government should expand the THN programme, ensuring in particular that it is available where required for all leavers from police and prison custody and on release from hospital.	Short/Medium	Scottish Government	22
57	Care	As part of the roll-out of naloxone provision, the Scottish Government should look to extend its availability wherever possible, including through the support of relevant public-facing services such as taxi and bus companies.	Medium	Scottish Government	22
58	Care	Healthcare Improvement Scotland and the Scottish Government should work with navigator services to develop standards and guidance to which services must adhere. People should be guaranteed a consistent standard of care and support that encompasses all areas, including mental health, violence and drug use.	Medium	Scottish Government, Health Improvement Scotland	20 23
59	Care	The Scottish Government should ensure that a navigator framework is set up and consolidated, allowing local knowledge to link with national funding.	Medium	Scottish Government	20 23
60	Care	The Scottish Government should commission the development of standards and guidance for all services that use peer support, ensuring workers are paid, developed and have career progression opportunities.	Medium	Scottish Government	5 42.3 42.4

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
61	Care	The Scottish Government should support the provision of licensed drug-checking facilities nationally, ensuring they are available within existing services, at key events and through a postal system.	Medium	Scottish Government	21
62	Care	Over the next two years, the Scottish Government, chief officers and ADPs should ensure that all the MAT standards are fully implemented, embedded and mainstreamed, with standards 1–5 implemented in the next year.	Medium	Scottish Government, Chief Officers, Alcohol & Drug Partnerships	24
63	Care	The Scottish Government and Healthcare Improvement Scotland should develop and implement overarching treatment and recovery guidance and standards for alcohol and drug services.	Medium/Long	Scottish Government, Healthcare Improvement Scotland	16 24
64	Care	The Scottish Government should support and promote a national roll-out of HAT.	Medium/Long	Scottish Government	26
65	Care	A whole-systems approach should be adopted nationally and locally to meeting the requirements of the MAT standards for treatment and support for those who wish, and are appropriate for accessing, care in a primary care setting. This should include shared care protocols and contractual arrangements for primary care provision that must be effectively implemented and appropriately resourced. Local and	Medium	Scottish Government NHS Scotland British Medical Association Integration Authorities	24

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		national adjustments to the GP contract may be required.			
66	Care	Drug treatment services should facilitate transfers to and from primary care at all stages of the person's journey, depending on their needs and wishes.	Short	Statutory & Third Sector Services, Primary Care Practitioners	8
67	Care	Referrals to primary care (such as GP, pharmacy, optician and dental services) should be backed by a plan for disengaging from the service. Appropriate aftercare should be in place, with the option for a barrier-free return to specialist care if needed.	Short	Statutory & Third Sector Services, Primary Care Practitioners	8
68	Care	WAND should be expanded throughout Scotland, reflecting the requirement of MAT Standard 4.	Medium	Scottish Government, Alcohol & Drug Partnerships	27
69	Care	The Scottish Government should support a move from pharmacy payments being based on number of supervisions to a per capita system.	Short/Medium	Scottish Government	28
70	Care	A nationally agreed specification should be developed with directors of pharmacy and Community Pharmacy Scotland. This should set out what should be expected of each pharmacy in Scotland.	Medium	Scottish Government, Community Pharmacy Scotland, Directors of Pharmacy	28

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
71	Care	The UK Government should conduct a review of the regulations on prescriptions by the end of this year. The review should take account of the changes made since the initial regulations were implemented in 2001.	Short	UK Government	Drug Law Reform Report
72	Care	The Scottish Government should expand the current commitment on residential rehabilitation to consider crisis and stabilisation, detoxification and residential rehabilitation. Appropriate funding should be provided to ensure that all are available everywhere in Scotland at the point of need.	Medium/Long	Scottish Government	16 18
73	Care	The Scottish Government should work to ensure national coverage of crisis and stabilisation services that include crisis beds to provide a place of safety. This should be available out of hours and have links to SAS to enable SAS personnel to take an individual directly to the service.	Medium/Long	Scottish Government	17
74	Care	The Scottish Government should ensure recovery communities are funded to provide their vital service and are encouraged to develop peer-led services.	Short/Medium	Scottish Government	18 5.2
75	Care	The Scottish Government should look at opportunities for expanded residential and specialised care services to be used as an	Medium	Scottish Government	29.10

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		alternative to remand or custody, where appropriate.			
76	Care	Statutory partners in the justice system should develop standard operating procedures for the sharing of information at all points of the justice system and with services.	Short	Statutory Partners in the Justice System	29
77	Care	The Scottish Government should work with statutory partners in the justice system to develop a single record for people's justice journey to ensure tailored support at all stages of the journey and support decision-making.	Medium	Scottish Government, Statutory Partners in the Justice System	29
78	Care	The Scottish Government and statutory partners in the justice system should ensure that navigators and outreach workers have the resources to follow and support vulnerable individuals throughout their justice journey and beyond.	Medium	Scottish Government, Statutory Partners in the Justice System	29
79	Care	Statutory partners in the justice system should develop standard operating procedures for referral at every point of the justice system. They should work proactively with vulnerable individuals and their families to ensure all policies and procedures are trauma-informed.	Short	Statutory Partners in the Justice System	6.1 29 42.7
80	Care	The current diversion from prosecution guidance should be reviewed to incorporate support for treatment and	Medium	Scottish Government	29.10

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		recovery as part of a diversion pathway. Local authorities should work with specialists and people with lived and living experience to embed the guidance in a consistent and evidence-based way and monitor and evaluate its effects.		Community Justice Scotland Local Authorities	
81	Care	The Scottish Government should support the development of a national diversion from prosecution forum for practitioners and agencies who work with people who use drugs, and a multi-agency tasking and coordination protocol to support people who use drugs and who have multiple complex needs.	Short/Medium	Scottish Government	29.10
82	Care	The Scottish Government and Community Justice Scotland should develop a national diversion toolkit on supporting people who use drugs. It should reflect the tailored support that is needed to promote people's treatment and recovery.	Short	Scottish Government Community Justice Scotland	29.10
83	Care	The Scottish Government and Police Scotland should ensure that police referral pathways are available nationally. This may include developing a national standard operating procedure.	Medium	Scottish Government, Police Scotland	29
84	Care	The Scottish Government and Police Scotland should establish a shared practice and learning network for police	Short	Scottish Government, Police Scotland	29

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		referrals to develop national consistency, with variation based on local needs.			
85	Care	Embedding MAT standards in police and prison custody settings should be a top priority for the Scottish Government, Police Scotland, the Scottish Prison Service and NHS Scotland.	Medium	Scottish Government, Police Scotland, NHS Scotland, Scottish Prison Service	24.2 29.3
86	Care	By the end of 2022, the Scottish Government should publish an action plan with timescales for implementation of the measures supported in the bail and release from custody consultation.	Short	Scottish Government	29
87	Care	The Taskforce would welcome a review of sentencing guidelines by the Scottish Sentencing Council to take greater account of the treatment and recovery needs of people who use drugs. Scottish Government should engage with the Council to request the proposed review.	Medium	Scottish Government Sentencing Council	29
88	Care	The Scottish Government should commission a peer-led evaluation of the Glasgow Drug Court to explore how this approach is more successful than a standard court process and support the expansion of the drug court model.	Medium	Scottish Government	29.11
89	Care	The Scottish Prison Service and NHS Scotland should ensure that all people in	Short/Medium	Scottish Prison Service,	29

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		prison have access to effective treatment and support for recovery. This should be a blanket policy that includes those on remand and is properly resourced through appropriate investment.		NHS Scotland	
90	Care	The Scottish Prison Service and NHS Scotland should ensure that people who use drugs are provided with naloxone on liberation. Peer-to-peer supply should be available across the prison estate.	Short	Scottish Prison Service, NHS Scotland	29
91	Care	The Scottish Government and Scottish Prison Service should, with the support of the third sector and people with lived and living experience, expand the recovery cafes/hubs across the prison estate, developing these into recovery communities that effectively support people who use drugs.	Medium	Scottish Government, Scottish Prison Service	29
92	Care	The Scottish Government and the Scottish Prison Service should establish an integrated case management approach, seamlessly connecting service provision from the community, throughout an individual's time in prison and beyond.	Medium	Scottish Government, Scottish Prison Service	29
93	Care	Individuals should receive treatment and support throughout their time in prison and have a release plan established from day one identifying the services they need to	Short	Scottish Government, Scottish Prison Service	29

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		access on release. This should be continuously updated.			
94	Care	Prisons should be permeable to enable access for services, be they statutory or third sector.	Short	Scottish Government, Scottish Prison Service	29
95	Care	Statutory services should be obliged to continue (or establish) support for all individuals in prison, including those on remand, ensuring that there is no gap in provision on release and that individuals leave prison better supported than when they entered.	Medium	Scottish Government, Statutory Services	29
96	Care	The Scottish Government should change the legislation to implement a blanket policy of no liberations on a Friday or the day before a public holiday.	Medium	Scottish Government	29
97	Care	The Scottish Government should build on the Prison to Rehab programme, utilising the learning from the 2021 evaluation in a wider national roll-out.	Medium	Scottish Government	29.8
98	Care	The Scottish Government should review drug treatment and testing orders, community payback orders and other community sentencing options to assess how they have been used, their outcomes and whether they are the most effective mechanism to support an individual's recovery and reduce recidivism rates.	Medium	Scottish Government	29.4

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
99	Co-ordination	The Scottish Government should undertake a transparent and externally validated benchmarking exercise to ensure that every ADP is implementing the partnership delivery framework.	Short	Scottish Government, Alcohol & Drug Partnerships	4.1
100	Co-ordination	The Scottish Government should publish a statement setting out how governance of alcohol and drug services will be improved by the introduction of the NCS. The statement should clearly articulate how the service will establish the most effective governance structure for managing drug-related deaths and harms.	Short	Scottish Government	34
101	Co-ordination	Chief officers ultimately should be accountable for the response to drug-related deaths in their area, coordinated through the Chief Officers' Group. Chief officers should take responsibility for delivering strategic outcomes against national targets and for improving the system to prevent deaths wherever possible.	Short	Chief Officers	33
102	Co-ordination	The Scottish Government should develop a national framework for the operation of drug-death review groups across Scotland. It should set the expectation that every death is reviewed to learn lessons, with these being reported directly to the Chief	Short	Scottish Government	37

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		Officers' Group to facilitate change and prevent further deaths.			
103	Co-ordination	The Scottish Government should ensure that all services in the alcohol and drugs sector are inspected by either Healthcare Improvement Scotland or the Care Inspectorate. Avenues for individuals to anonymously raise concerns or complaints for investigation should be provided.	Short/Medium	Scottish Government	38
104	Co-ordination	The Scottish Government should ensure that all self-assessments used are externally validated and chief officers are held to account for their quality.	Short	Scottish Government	38
105	Co-ordination	The First Minister should commit to sustaining and accelerating the current focus on drug-related deaths, with a dedicated Minister for Drugs Policy, until there is a meaningful and sustained downward trend in drug-related deaths.	Short	First Minister	32
106	Co-ordination	The First Minister/Minister for Drugs Policy should clearly define what a public health emergency response to drug-related deaths means in practice, what new powers or resources it unlocks and how it influences activity under the National Mission.	Short	First Minister, Minister for Drugs Policy	32
107	Co-ordination	The Scottish Government should work to break down silos in policy-making and ensure that appropriate groups are in place	Medium/Long	Scottish Government	32

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		internally to drive action on drug-related deaths and facilitate the implementation of the Taskforce's recommendations and actions.			
108	Co-ordination	The Scottish Government should publish a national outcomes framework and strategy underpinning the National Mission. This should outline the outcomes, drivers and indicators through which the Mission will be measured. It should also clearly outline what funding is allocated to each overarching objective.	Short	Scottish Government	33
109	Co-ordination	Local leaders at all levels must take ownership of the drug-deaths crisis in their area. They must take responsibility for delivering the whole system of care outlined in this report and embedding the principles of a person-centred, human rights-based and trauma-informed approach in services, with people with lived, living and family experience at its heart.	Short	Chief Officers	33
110	Co-ordination	As outlined by the Drug Death Reporting Short Life Working Group, a National Co-ordinator for Drug-related Deaths role should be created in Public Health Scotland to improve consistency and data-sharing and coordinate a review of the national drug-related death database. This	Short/Medium	Scottish Government, Public Health Scotland	30.3

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		role should be regularly reviewed to ensure it is effective and still needed.			
111	Co-ordination	A full review of public health surveillance should be undertaken, led by the Scottish Government and involving all partners. The aim would be to ensure that the most relevant data is collected and shared in a transparent and accountable way, thereby furthering achievement of the objectives of the National Mission.	Medium	Scottish Government, Public Health Scotland	30
112	Co-ordination	Public Health Scotland should build on the established early warning system to improve data linkage and provide the most up-to-date and accurate information for responding to risks..	Medium	Scottish Government, Public Health Scotland	31
113	Co-ordination	The Scottish Government must publish a detailed evaluation plan for the National Mission as part of the national outcomes framework and strategy.	Short	Scottish Government	33
114	Co-ordination	All services should develop a monitoring and evaluation plan by the end of the year. The plan should embed a quality improvement approach to ensure the best service for people who use drugs.	Short	Statutory & Third Sector Services	43
115	Co-ordination	If not already doing so, ADPs should develop formal mechanisms for capturing lessons learned through service delivery, partnership working, and monitoring and evaluation. They should actively share this	Short	Alcohol & Drug Partnerships	43

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		learning and quality improvement activity with other ADPs and the Scottish Government through the existing engagement structure.			
116	Co-ordination	The Scottish Government and chief officers should ensure that transparent public monitoring information is available for the services delivered in local areas. This should include monitoring the implementation of the Taskforce recommendations and actions and delivery against the outcomes of the national outcomes framework.	Medium	Scottish Government, Chief Officers	43
117	Co-ordination	The Scottish Government should commit to providing sustainable funding to assist individuals in connecting digitally with those who care about them and the services that support them.	Short/Medium	Scottish Government	44
118	Co-ordination	The Scottish Government and wider local leadership should embrace digital innovation, finding ways to improve how people access health, care and support at the point of need.	Medium	Scottish Government, Chief Officers	40
119	Co-ordination	The Scottish Government should explore the conclusions of the Overdose Detection and Responder Alert Technologies (ODART) programme, supporting innovation that has been shown to improve individuals' experiences.	Medium	Scottish Government	40.2

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
120	Co-ordination	The Scottish Government should fund a Civtech round, with partners from across the drug and alcohol sector and wider public service organisations invited to sponsor challenges. Challenges should be targeted to resolve persistent long-term barriers.	Medium	Scottish Government	40.3
121	Co-ordination	The Scottish Government should work with the Information Commissioners Office to provide a guidance note, or an open letter, assuring services that data can be shared between statutory and third-sector partners without consequences under the General Data Protection Regulation.	Short	Scottish Government	39
122	Co-ordination	All partners urgently need to work to formalise inter-agency data-sharing relationships to ensure equality of access to data across services. This must also extend to third-sector partners.	Short	Statutory & Third Sector Services	39
123	Co-ordination	The Scottish Government should run a project to develop a single record that follows an individual throughout their treatment and recovery journey, improving data linkage across the system and enabling a shared understanding of an individual's history, needs and care package. This record can then be shared to inform interactions with the criminal justice system or other support services.	Medium	Scottish Government	39

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
124	Co-ordination	The Scottish Government, in partnership with people with lived and living experience, families and the wider sector, should develop a single platform to ensure that information is available for the people who need it when they need it.	Short/Medium	Scottish Government	11
125	Co-ordination	The Scottish Government should build on the workforce survey by conducting a rapid review to determine the required workforce to deliver the service developments outlined in this report and the key commitments of the National Mission. The review should set out the resources needed to support an expanded workforce across the sector and undertake a training needs assessment.	Short	Scottish Government	41
126	Co-ordination	As part of the wider work to develop standards and guidance set out in previous actions, the Scottish Government should ensure the principles of the Health and Care (Staffing) (Scotland) Act 2019 are applied to this workforce to ensure safe and appropriate workloads for staff and that their wellbeing is supported.	Medium	Scottish Government, Healthcare Improvement Scotland	41.5
127	Co-ordination	The Scottish Government and Healthcare Improvement Scotland should define key competencies and identify mandatory training for workers who support people who use drugs, and provide support for the	Medium	Scottish Government, Healthcare Improvement Scotland	42

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		development of continuous professional development in the service.			
128	Co-ordination	The Scottish Government should improve the availability of specialist dependency modules and courses in higher education, embedding this into undergraduate courses and establishing new post-graduate qualifications.	Medium	Scottish Government	42
129	Co-ordination	The Scottish Government should support professions to develop specific pathways for people with lived and living experience to enter the workforce, ensuring they are appropriately paid and have career progression opportunities.	Medium	Scottish Government	42
130	Co-ordination	The Scottish Government should develop targeted and accelerated pathways into the sector through, for example, apprenticeships and fast-track courses to address the high level of vacancies.	Medium	Scottish Government	42
131	Co-ordination	The Scottish Government should develop and rapidly implement a workforce action plan to: increase the number of qualified professionals in the sector; set standards, competencies and training requirements; and ensure the workforce is supported, well-trained and well-resourced.	Short	Scottish Government	41
132	Co-ordination	The Scottish Government should commission guidance on how employees in recovery can be supported.	Medium	Scottish Government	5.2

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
133	Co-ordination	The Scottish Government must publish a fully funded plan for the National Mission by the end of this year. This should deliver on all elements of the evidence-based strategic plan outlined in this report. It should commit to increasing funding to meet demand and appropriately resource each aspect of the whole system of care to ensure people can access the support they need when they need it.	Short	Scottish Government	33
134	Co-ordination	The Scottish Government and statutory services should commit to providing sustainable medium-/long-term funding across financial years to provide security for services and the workforce.	Medium/Long	Scottish Government, Alcohol & Drug Partnerships, Statutory Services	44
135	Co-ordination	The Scottish Government should commit to providing ring-fenced budgets for alcohol and drug services, even if services are absorbed into the NCS, so there is no reduction in their budgets.	Short/Medium	Scottish Government	44
136	Co-ordination	Portfolios across the Scottish Government should agree ring-fenced funding to support people who use drugs to improve their lives through better access to services and holistic support.	Medium/Long	Scottish Government	44
137	Co-ordination	As part of the National Mission, Scottish Government portfolios should commit to a programme of joint commissioning and	Medium/Long	Scottish Government	44

Reference	Chapter	Action	Timescale	Responsibility	Relevant evidence (paragraph)
		joint working. Projects should work towards supporting holistic care pathways and system integration, with a focus on multiple complex needs.			
138	Co-ordination	Local partners, coordinated by ADPs, should commit to joint commissioning and joint working to deliver key improvements and support local outcomes frameworks.	Medium	Alcohol & Drug Partnerships, Statutory Services	44
139	Co-ordination	The Scottish Government should nationally commission residential services, ensuring adequate funding is available to meet the demand for crisis and stabilisation, detoxification and residential rehabilitation. Placements should be free at the point of need and should be available without lengthy delays.	Medium	Scottish Government	44

Annex B: ADP Funding

ADP & Project	Award (over 2 years)	Details of Project
East Ayrshire	£83,726	<ul style="list-style-type: none"> • Naloxone supply - support development of Injecting Equipment Provision bus. • Contribute to Ayrshire Near-Fatal overdose pathway. • Reduce unplanned discharges by employing a development worker to lead and implement change. • Peer worker to target those not in and dropping out of services.
North Ayrshire	£83,726	<ul style="list-style-type: none"> • Funding for Naloxone kits for distribution from non-treatment services. • Contribute to Ayrshire wide Near-Fatal overdose pathway. • Panel review-Pilot of depot buprenorphine. • Support for people leaving hospital or prison and experiencing homelessness. • Peer supply of naloxone
South Ayrshire	£49,189	<ul style="list-style-type: none"> • Outreach service which provides prescribing, Mental Health assessment etc. • Contribute to Ayrshire wide Near-Fatal overdose pathway.
Borders	£26,668	<ul style="list-style-type: none"> • Improve peer supply of naloxone. • Supervision costs for existing patients on Opioid Substitution Therapy. • Establish further Injecting Equipment Provision outlet.
Dumfries and Galloway	£57,561	<ul style="list-style-type: none"> • Community pharmacist to provide buvidal to those most at need for 18 months.
Fife	£146,520	<ul style="list-style-type: none"> • Peer distribution of Naloxone. • 4x specialist pharmacist services in areas with higher needs. • Increase capacity to support people on release from prison.
Clackmannanshire & Stirling	£85,249	<ul style="list-style-type: none"> • Create a dedicated team to review drug related deaths & suicides.
Falkirk	£62,794	<ul style="list-style-type: none"> • Increase capacity of existing assertive outreach team and provide weekend support.
Aberdeen City	£125,589	<ul style="list-style-type: none"> • Peer supply of naloxone. • Pharmacist to prescribe to those most at risk as well improving the supply of naloxone. • Employ a social worker to link with duty team and provide assertive outreach to those at risk.
Aberdeenshire	£62,794	<ul style="list-style-type: none"> • Increase supply of Naloxone. • Improve the Near-Fatal overdose pathway to treatment, engaging primary care. • Develop clearer pathways for people at risk in a number of settings. • Employ a researcher to carry out an audit risk factors.
Moray	£14,129	<ul style="list-style-type: none"> • Increase capacity in the provision of Opioid Substitution Therapy. • Increased hours for community café & IT equipment.
Glasgow City	£622,711	<ul style="list-style-type: none"> • Embed alcohol/drug workers in out of hours mental health services in hospitals. • Alcohol and Drug Partnership Intelligence Hub to address current gaps in analyst capacity for information gathering. • Increase nyxoid availability at prison release (13k). • PHC harm reduction team (58k).
East Dunbartonshire	£37,153	<ul style="list-style-type: none"> • Increase naloxone supply. • Enhance current assertive outreach programme. • Increase capacity of Opioid Substitution Therapy through a pharmacy prescriber. • Peer support worker, targeting those who are at most risk. • Increase capacity of the Drug Treatment and Testing Order Service.
East Renfrew	£41,863	<ul style="list-style-type: none"> • Distribution of Naloxone by using postal kits. • Recruiting & training peer researchers. • Provide funding to local recovery community.
Inverclyde	£78,493	<ul style="list-style-type: none"> • Improved approaches to naloxone supply. • Residential rehab access for those at most risk.
Renfrew	£141,287	<ul style="list-style-type: none"> • Recruitment of Drug Death Prevention Officer to develop a Drug Deaths Prevention Strategy.

		<ul style="list-style-type: none"> • Scoping study be carried out in relation to Near-Fatal overdoses which will be supported by the Community Engagers. • Training audit of Alcohol and Drug Recovery Service staff to ensure that our workforce is delivering evidence based interventions.
West Dumbarton	£57,561	<ul style="list-style-type: none"> • 1.5 assertive outreach workers as a part of the navigators team to reach those at most risk. • Navigator arrest referral scheme.
Argyll & Bute	£29,304	<ul style="list-style-type: none"> • Increasing Naloxone distribution & training. • Develop the near fatal overdose response. • Review and improve pathways and routes into treatment. • Increasing capacity of Advocacy service
Highland	£73,260	<ul style="list-style-type: none"> • Coordinator to develop peer supply of naloxone. • Develop and improve the Near-Fatal overdose system. • Data linkage programme to better understand drug deaths and harm.
North Lanarkshire	£188,383	<ul style="list-style-type: none"> • Develop Near-Fatal overdose pathway. • Improve supply of naloxone. • Develop a recovery charter to engage business. • Increase capacity within prison through care.
South Lanarkshire	£209,314	<ul style="list-style-type: none"> • Pharmacy provision of Naloxone. • Peer worker to work with ambulance etc. to tie up pathway between ambulance A&E and hospital. • Improve access to depot buprenorphine. • Rapid response assertive outreach service for those at risk. • To provide diversion to treatment from the justice system
City of Edinburgh	£313,972	<ul style="list-style-type: none"> • Maintain Naloxone supply, supply kits to non-drug services. • Increased capacity in secondary care. • Homeless case workers & outreach Injecting Equipment Provision/inter-disciplinary team for remand prisoners & through care
East Lothian MELDAP	£48,124	<ul style="list-style-type: none"> • Improve distribution of naloxone, along with safe storage boxes for medication. • Develop pathway for Near-Fatal overdose to respond within 2 days. • Increased capacity to support accelerated access to MAT. • Engagement and Inclusion Service for those at most risk.
Mid Lothian MELDAP	£39,770	<ul style="list-style-type: none"> • Recruiting a band 6 Substance Misuse Community Psychiatric Nurse to provide assertive outreach and supply naloxone.
West Lothian	£68,027	<ul style="list-style-type: none"> • Employ a Naloxone champion to address the gaps in Naloxone. • Partial funding of advanced nurse practitioner to increase MAT capacity. • Identify issues relating drug death support prevention activities.
Orkney	£1,570	<ul style="list-style-type: none"> • Introduce a postal naloxone service on the islands. • Ensure that everyone who has a Near-Fatal overdose will receive follow up support.
Shetland	£8,896	<ul style="list-style-type: none"> • Increase distribution of naloxone. • Piloting of a new service level agreement with community pharmacy.
Angus	£41,863	<ul style="list-style-type: none"> • Improve the supply of naloxone, through a dedicated coordinator. • Identify a gap in developing constructive activities.
Dundee City	£120,356	<ul style="list-style-type: none"> • Part fund co-ordinator to support Near-Fatal overdose. • Increase GP prescribing to those most at risk. • Increase capacity for assertive outreach. • Support people for 8 weeks post-liberation from prison.
Perth and Kinross	£78,493	<ul style="list-style-type: none"> • The introduction of a mobile unit to provide assertive outreach. • Introduce depot buprenorphine. • Rollout Motivational Interviewing training across Children's Services.
Western Isles	£2,616	<ul style="list-style-type: none"> • Develop a postal service top supply naloxone. • Process data on Near-Fatal overdoses that had naloxone administered received from Scottish Ambulance Service more quickly.

Annex C: Research Programme Fund Projects

Organisation	Project	Award	Details of Project	End Date
University of West of Scotland	Primary Care in the prevention of Drug related deaths	£99,999	Understanding the role and potential of primary care in the prevention of drug related deaths.	Complete May 2022
Glasgow Caledonian University	Evaluating public health interventions	£99,997	Evaluating the impact of public health interventions in Scotland's Drug-Related Death epidemic.	Sept 2022
Glasgow Caledonian University	Evaluation of peer-to-peer naloxone	£70,745	A mixed methods evaluation of peer-to-peer naloxone training and supply in Scotland.	Complete Nov 2021
University of Stirling	Drug Consumption Rooms	£37,284	Perceptions and attitudes of strategic decision-makers and affected families across Scotland towards drug consumption rooms to prevent drug-related deaths.	Complete Nov 2021
Simon Community Scotland	PHONENix	£100,000	PHOENix after overdose for people experiencing homelessness: pilot randomised controlled trial.	Nov 2022
University of Stirling	Patterns and Practice - SAS	£99,996	Ambulance call-outs to drug overdoses in Scotland: patterns & practice.	Complete June 2022
University of Stirling	Benzodiazepine prescribing among ORT	£82,499	Exploring the utility and safety of benzodiazepine prescribing among people receiving opiate replacement therapy in Scotland.	Sept 2022
University of Stirling	Overdose prevention Intervention in Community Pharmacies	£59,690	Feasibility and acceptability of an overdose prevention intervention delivered by community pharmacies for patients prescribed opioids for chronic non-cancer pain.	Complete Feb 2022
University of Dundee	Behaviour change intervention	£94,328	Designing a behaviour change intervention to reduce the risk of overdose.	Complete March 2022
University of Dundee	Coronavirus outbreaks on those who use drugs	£36,436	Assessing the impacts of novel coronavirus outbreaks on people who use drugs, drug-related deaths and the effectiveness of service responses to them: a systematic review to inform practice and drug policy responses to COVID 19 in Scotland.	Complete Feb 2021
Edinburgh Napier University	Police Naloxone Pilot Evaluation		Police Naloxone Pilot Evaluation	Complete Feb 2022

Annex D: Innovation and Development Fund Projects

Organisation	Project	Award	Start Date	End Date
Scottish Families Affected by Alcohol and Drugs	<i>Holding On Project</i> Supporting and empowering families who are concerned about their loved ones who are at risk of death and harm	£174,172	Dec-20	Dec-22
Harm Reduction NHS Lothian	<i>We start by seeing the person</i> Rapid access to treatment and care in Edinburgh Harm Reduction Team/Salvation Army	Project Cancelled		
Scottish Drugs Forum	<i>MAT Standards Delivery Support</i> Workforce development programme highlighting and supporting the implementation of MAT Standards	£104,882	Nov-20	Nov-22
Turning Point Scotland	<i>Rapid Response to near Overdose</i> Team to rapidly respond to overdose by partnership working and proactive engagement.	£1,391,670	Mar-21	Complete
University of St Andrews	<i>Designing and Implementing Effective Telehealth MAT Projects</i> Research into the efficacy of telehealth projects and interventions	£26,000	Mar-21	Sep-23
Scottish Drugs Forum	<i>Peer to Peer Naloxone Programme</i> Peer delivery of Naloxone in prisons and communities	£509,209	Apr-21	Apr-23
Scottish Recovery Consortium	<i>Continuum of Recovery</i> Coordinated support before, during and after a stay in residential rehabilitation	£288,088	Feb-21	Complete
University of Stirling	<i>Researching and developing key components of a new Scottish drug checking programme</i> A research programme that aims to ready the system/legal framework for drug checking in Scotland	£300,082	Jun-21	Jun-23
Medics Against Violence	<i>Pathfinder Programme</i> Peer Navigator project within justice/health settings	£592,860	Jun-21	Jun-23
Angus Health & Social Care Partnership	<i>Angus Multi-Agency Locality Hub</i>	£60,000	Jul-22	Jul-24
Change Grow Live	<i>Community Recovery Hub</i> A community recovery hub operating in Alloa, Stirling and Falkirk	£48,704	May-21	Complete
Midlothian Health and Social Care Partnership	<i>MCN</i> Addressing the complex needs of people with co-occurring mental health and substance use issues	£48,000	Dec-21	Dec-22
Renfrewshire ADP	<i>Recovery Support Navigators</i> Peer navigators working across acute and community sectors to support people into recovery services	£87,600	May-21	Nov-22
South Lanarkshire Alcohol & Drug Partnership	<i>Family First Responders</i> Supporting family members to become more skilled in supporting their loved ones	£35,706	May-21	Nov-22
South Lanarkshire Alcohol & Drug Partnership	<i>Navigating ExPEERience</i> Developing Peer support with treatment and recovery services across South Lanarkshire	£75,000	Dec-21	Dec-23
South Lanarkshire Alcohol & Drug Partnership	<i>MCN Integrated Pathway</i> Systems and workforce project aiming to improve practice and processes for supporting people who use drugs	£78,417	Jul-22	Jul-23
Fife ADP	<i>Peer Advocacy Project</i> Implementing a Peer Advocacy Project in Fife	£90,000	Nov-21	Jun-22
Dundee Health & Social Care Partnership	<i>Dundee Whole Systems Integrated Response</i> Workforce development and system change project aiming to adapt the system and test new ways of working	£450,000	Sep-21	Sep-22

East Ayrshire Alcohol and Drugs	<i>Recovery Hub</i> Work to implement a Recovery Hub in East Ayrshire	£396,000	Oct-21	Oct-22
East Dunbartonshire Justice Social Work Services	<i>Wayfinders</i> A peer navigator project aiming to support people involved with justice services	£76,060	Sep-21	Sep-22
East Renfrewshire Health and Social Care Partnership	<i>Peer Navigators</i> Peer Navigation project aiming to support people to access recovery services	£75,000	Nov-21	Complete
Edinburgh Health and Social Care Partnership	<i>MCN</i> Project aiming to implement trauma informed practice across multiple agencies	£120,000	Jan-22	Jan-23
Inverclyde HSCP	<i>Navigating Early Help</i> Peer Recovery workers to support people access Recovery services after leaving Greenock Custody suite.	£441,882	Apr-22	Apr-24
NHS Grampian	<i>Hospital Addiction Care Team</i> Supporting the development of an enhanced team who will work in acute and community hospitals to improve care and access for people after a drug related stay in hospital.	£308,338	Jan-22	Jan-23
NHS Grampian	<i>Psychological Informed Environments</i> Developing PIE across multiple agencies in Grampian.	£179,622	Aug-21	Aug-23
South Lanarkshire ADP	<i>Navigating Support for people involved with Justice</i> Peer Navigation project supporting people involved with Justice Services	£91,500	Sep-21	Mar-23
Community Help and Advice Initiative (CHAI)	<i>Welfare Benefits Outreach</i> Welfare benefits worker will proactively engage with people in recovery hubs and other locations to maximise welfare benefits for people	£78,418	Jul-21	Jul-23
Edinburgh Health and Social Care Partnership	<i>Milestone House</i> Expansion of services delivered by Milestone House Intermediate Care Unit	£220,000	Aug-21	Aug-22
NHS Borders	<i>Capacity Building Psychological Interventions</i> Enhancing capacity for Tier 2 psychological interventions in NHS and Third Sector organisations	£68,611	Apr-22	Apr-23
NHS Dumfries and Galloway	<i>Pharmacist Clinical Input</i> Enhancing the capacity for Pharmacist Clinical Input to improve access and support for people in rural/remote areas	£75,112	Oct-21	Oct-23
Reach Advocacy	<i>Developing a Rights Based Approach</i> Workforce development and training to ensure a Rights Based Approach to the MAT Standards	£294,720	Apr-21	Apr-23

Annex E :List of sources used in the DRNS Rapid Evidence Synthesis for the Multiple Complex Needs Sub Group

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