Introduction: Crew is an award-winning public health charity based in Edinburgh. Our aim is to reduce the harm and stigma associated with psychostimulant drug use by providing a range of services for young people and adults, their families, friends and communities, using a ‘stepped care’ approach which includes primary, secondary and tertiary harm reduction and prevention.

Crew’s primary prevention work includes drug education training for teachers, social, prison, NHS and youth workers and developing peer-produced, non-judgemental risk and harm reduction information and dialogue (step 1). Secondary harm reduction and prevention includes outreach, welfare peer support and specialist crisis intervention at music festivals and night clubs, delivered in partnership with paramedics (step 2). Tertiary harm reduction and prevention includes person-centred counselling for adults wishing to reduce, stabilise or stop stimulant drug use, developing on-going tier 3 support for young with problematic drug use in our Drop-in shop (step 3) as well as National Acupuncture Detox Association ear acupuncture to support people to manage cravings, sleep and anxiety, contributing to sustaining recovery; and mindfulness-based relapse prevention (step 4).

1. To what extent do you believe the Scottish Government’s national drugs strategy, The Road to Recovery (R2R), and the approach by Integration Authorities and NHS Boards are preventative?

The commitment to prevention in the strategy is clear (1) and the strong recognition of the links between social, economic, educational and health inequalities and problem drug use (2, 3) embedded in this chapter is still pertinent.

Key point 32 identifies the need for an integrated, cross-sector approach to address these links. Part of the Program of Action is to prioritise: “cross-cutting work, involving all arms of SG and public services, to prevent drug use by tackling factors associated with drug use, as well as improving education and information”. This encompasses economic strategy, early years/early intervention, health inequalities and organised crime in communities.

NHS Health Scotland’s 2017 paper ‘Tackling the Attainment Gap by Preventing and Responding to Adverse Childhood Experiences’ (ACEs) (4) highlights the association between trauma or stressful events with young people’s health and wellbeing outcomes. One key finding from the ACEs study showed that if children and young people experienced four or more adverse events in early life they were more likely to smoke, be a high-risk drinker and use heroin or crack cocaine.

Recommendation 1: Ensure economic, health, education, welfare and justice policy development, construction and review is indeed “cross-cutting”, including impact assessment on problematic drug use and related harms in its development as well as evaluation stages, and that policy is developed with and for the people and communities it seeks to serve.

Funding cuts in real terms, whether reductions in funding, stand-still budgets for Alcohol and Drug Partnerships (ADPs) (5) or inconsistencies in funding across Integrated Joint Boards (IJBs) (6) create the risk of geographical inequality in access to services and, it could be argued, of preventive spend losing out to the demands of the ‘front-line’ or tertiary services. Fighting to keep a service open is not conducive to rigorous quality improvement or embedded prevention. Full cost recovery for voluntary sector drug services is of crucial importance within commissioning.
Protective factors supporting young people’s resilience (including strong family bonds; strong parental engagement and boundaries, successful school experiences, strong bonds with local community activities; a caring relationship with at least one adult) interact in complex ways and do not guarantee to prevent early or problematic drug use in themselves, however sustaining the conditions where these factors can thrive is key to a preventive approach (7).

**Recommendation 2: Funding for drug, education and community services needs to be consistent and sustained.**

2. Is the approach adequate or is more action needed?
To be effective, or even 'adequate' the approach needs to consider recent developments and changes to the drug market. For example:

**Technology:** Access to illegal drugs is no longer restricted to “highly concentrated pockets of intense deprivation with multiple social problems” (1) in Scottish communities. The development of online technology has resulted in significantly increased access to a greater number and variety of legal and illegal drugs since 2008 (8) many of which test higher for purity and UK purchase of drugs from the dark web has more than doubled from 12.4% in 2014 to 25.3% in 2017 (9).

In 2017, Afghanistan’s total area under opium poppy cultivation increased by 63% from the previous year as farming methods and technology have improved, in addition to many other factors such as increased political instability and lessening engagement with the international aid community. This is despite opium poppy destruction having increased by 111% (10).

Advances in technology have not only expanded the online market and improved mass manufacturing methods but have also allowed for the development and synthesis of hundreds of new drugs. Improved transport infrastructure and connectivity means we are working within an international drugs market, not a Scottish one.

**Trends and legislation:** When invited by the Home Office in 2015 to give evidence of potential risks and harm foreseen as a result of the introduction of the Psychoactive Substances Act 2016 (PSA) and the removal of Novel Psychoactive Substances (NPS) from open sale, Crew identified serious potential impacts for people who had previously been taking NPS returning to traditional controlled drugs including heroin and other opioids (likely to have reduced tolerance thus at increased risk of overdose) and an increase in non-prescription use of medicines such as benzodiazepines, gabapentin and pregabalin. We also noted the risk that people having developed a taste for stimulant drug effects while using NPS might lead to an increase in people using stimulants like cocaine (11). Our counselling clients between 2016 and 2017, after the lead up and implementation of the PSA, reported higher use of cannabis, cocaine, MDMA and heroin than in previous years.
Cannabis, MDMA and cocaine were the drugs most reported as being used in the last 12 months in Scotland by participants in the Global Drugs Survey 2017 (12) and Scottish participants also reported being more likely to access emergency treatment with cocaine, MDMA and alcohol use compared to the rest of the UK.

**Recommendation 3:** There is little reference to stimulant drugs or emerging, harmful drugs within the R2R. To ensure our future drug strategy is effective, the needs of people who take these drugs and a response to changing technologies must be included.

The emergence of chemsex (sex intentionally involving primarily stimulant drugs) in recent years demonstrates a need for quality harm reduction information and dialogue, and bespoke services for a cohort whose use may indeed be problematic but who may be unlikely to access mainstream treatment and are perhaps more likely to utilise emergency services once in crisis.

**Recommendation 4:** Drug services should continue to develop a more consistently joined up approach with sexual health services.

**Education and prevention:** The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) provides national level data on secondary school-aged students’ self-reported use of alcohol, tobacco and illegal drugs as well as ‘lifestyle trends’ and forms part of the evidence base for drug and health policy. Limitations of this approach include the fact that the survey is self-selecting: schools are not obliged to take part and students must complete the survey in 45 minutes under exam conditions in order to contribute.

We need to hear from the young people who aren’t likely to sit down and write about highly sensitive, potentially criminalised topics for 45 minutes under exam conditions because they are truanting, excluded, experiencing conflict at home or struggling with Attention Deficit Hyperactivity Disorder or ACEs – all risk factors for higher than average likelihood of early onset drug use and greater harm as a result (2; 3; 4; 7).

**Recommendation 5:** Conduct additional research to enhance SALSUS and Scottish Drug Policy. This should be conducted by, with and for young people most at risk of using drugs harmfully and should build on existing relationships between targeted young people and their trusted peer and youth workers.

Evidence-based approaches to education and assets exist in Scotland, but aren’t as ‘joined up’ as they could be (13). Approaches with stronger evidence of effectiveness include:

- interventions based on social influence approaches and/or on learning social and life skills
- interactive and/or peer-led interventions
- targeted interventions for young people at highest risk of developing problematic use
- school-based programmes that help to reduce bullying and victimisation, both behaviours that can be associated with substance use
- interventions which take cognisance of the local context

and approaches with weaker/no evidence of effectiveness or evidence of adverse outcomes include:

- knowledge-focussed/information provision alone
- fear arousal approaches or shock tactics
- using testimonials from people who used to take drugs in the classroom
- one-off sessions (14)

There is a legislative duty on Ministers and local authorities to ensure schools are health-promoting Schools and the new Curriculum for Excellence Health and Wellbeing Outcomes rightly place drugs education in the context of mental, emotional, social and physical wellbeing.

**Recommendation 6:** Develop a national strategy for consistent drug education which is evidence-based, up to date, starts with the person and builds on the good intentions of R2R. Key factors for effective, evidence-based drugs education include:
• promoting inclusion of young people and local services in its development and delivery
• promoting support, recognising the impacts on students affected by parental/carer drug use, or their own, including tobacco
• drawing on further research into effective targeted interventions for young people at risk
• interactive, multi-modal approaches including media, parental and community as well as classroom components
• promoting collaboration between ADPs, NHS, local authorities, schools and wider community mental health/wellbeing and youth organisations
• steering group to develop more effective drug education in schools, consistently across Scotland, providing advice, guidance and proposals aimed at helping schools/authorities achieve the outcomes sought through Curriculum for Excellence. This was a key action in prevention strand of R2R.
• producing short-form guidance on ‘what works’
• training and guidance equipping teachers to develop and evaluate evidence-based, student-centred, student-involving, on-going programmes integrated within health and wellbeing and centred on local context
• support and sufficient resourcing over time to evaluate longer term impacts and effectiveness of interventions and methodologies: “a nation’s social context, drug policies and the need for high quality supporting structures are all important in determining the success of a programme” (7)

Recovery and harm reduction: The ministerial foreword of R2R defines recovery as “the desire of people who use drugs to become drug-free” and the strategy describes supporting individuals to move toward a “drug free” life to become an active and contributing member of society. If we are to truly “treat each person using drugs on their own terms, and centre care around the person, not the addiction” (1) then a wider definition of the principle of recovery in our ‘refreshed’ strategy, recognising that people may wish to reduce or stabilise their use, rather than only seeking strict abstinence may be more inclusive and fruitful as part of the Scottish Government’s ‘seek, keep and treat’ treatment concept. It’s encouraging that the Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services 2014 (15) do not include the words “drug-free” but emphasise approaches being responsive to peoples individual needs and beliefs and keeping them “safe and free from harm”. Ian Paylor (16) argues that England’s new drug strategy’s emphasis on abstinent recovery or becoming “drug free”, and a lack of focus on harm reduction can, in practice, hinder engagement by more vulnerable people seeking to reduce their use or use more safely; and unintentionally reinforce stigmatising approaches which suggest that only those willing or ready to “get clean” deserve support.

Harm reduction dialogue and practical support: This offers a ‘way in’ for people who would otherwise not access a ‘mainstream’ or opiate-focussed, abstinence-focussed drug service, because abstinence might not feel achievable at that point in their lives. This is especially important for those who are taking non-opiates as there are few recognised current substitution therapies available. Reducing the barriers on the ‘way in’ offers our best chance of reaching those people most at risk: those who are not engaged and retained in specialist addiction treatment.

### Scottish Drug Related Deaths 2016

<table>
<thead>
<tr>
<th>Drug</th>
<th>2015</th>
<th>2016</th>
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</thead>
<tbody>
<tr>
<td>Etizolam</td>
<td>43</td>
<td>225</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>42</td>
<td>71</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>102</td>
<td>145</td>
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</tbody>
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<tbody>
<tr>
<td></td>
<td>5 for entire period</td>
<td>24</td>
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In 2016, 176 people died as a direct result of psychostimulant drugs, 20% of the highest annual total of drug-related deaths (DRDs) since records began (16).
Deaths by Drug

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<tbody>
<tr>
<td>Total DRDS</td>
<td>292</td>
<td>356</td>
<td>574</td>
<td>581</td>
<td>867</td>
<td>197%</td>
</tr>
<tr>
<td>Heroin</td>
<td>196</td>
<td>225</td>
<td>324</td>
<td>221</td>
<td>473</td>
<td>141%</td>
</tr>
<tr>
<td>Methadone</td>
<td>55</td>
<td>80</td>
<td>169</td>
<td>237</td>
<td>362</td>
<td>558%</td>
</tr>
<tr>
<td>Heroin, Methadone or Buprenorphine</td>
<td>232</td>
<td>275</td>
<td>445</td>
<td>399</td>
<td>650</td>
<td>180%</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>164</td>
<td>140</td>
<td>149</td>
<td>196</td>
<td>426</td>
<td>160%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>4</td>
<td>38</td>
<td>36</td>
<td>31</td>
<td>123</td>
<td>2,975%</td>
</tr>
<tr>
<td>Ecstasy-type</td>
<td>3</td>
<td>10</td>
<td>11</td>
<td>18</td>
<td>28</td>
<td>83%</td>
</tr>
</tbody>
</table>

Deaths from psychostimulant drugs may result from occasional recreational use, but also from routine and prolonged use. Psychostimulant drug use, however, is not included in the current official definition of problematic drug use used by the Information Services Division/NHS National Services Scotland.

People who use non-opiate/opioid drugs may not find ‘mainstream’ or opiate-focussed drug services relevant to their needs. The Global Drug Survey 2017 found that 30% of people using cannabis and 36% of people using cocaine reported wishing to reduce their use with a smaller proportion indicating they would like treatment to support this. The 2008 strategy noted the need for a more fundamental change in response should cocaine use continue to increase, and the rapid increase in deaths over time shows that this need has increased.

Recommendation 7: We propose that some of the £20m additional funding announced to address drug-related harm in Scotland should be used to develop needs-based and evidence-based harm reduction and treatment interventions for people using psychostimulant and other drugs across ADP areas.

3. What evaluation has been done of interventions?

The Novel Psychoactive Substances Treatment UK Network’s guidance includes a summary of the substantial evidence for the effectiveness of psychosocial interventions including harm reduction for problematic psychostimulant drug use, including National Centre for Clinical Excellence (NICE) guidelines. These are the primary form of treatment for problematic stimulant drug use or dependence as few new or psychostimulant drugs have recognised pharmacological interventions (17).


John Davies’ 2017 review into drug education work in schools (13) drew the following conclusions:

- local authorities/ADPs had a rounded understanding of components and effectiveness of drug education and prevention interventions: knowledge as a precursor to skills development, social norms and peer-led approaches
- there is an opportunity for collaborative development of resources between local authority, ADPs, NHS and community partners in order to develop quality assurance
- embedded, multi-modal programmes focusing on social norms and social competences are more effective than one-off interventions – teachers may need to build confidence in developing these
- resources may have diminished for targeted interventions in recent years (ADP funding)
- time, guidance and financial support are needed for developing rigorous evaluation methodologies.

School’s work is currently subject to school’s internal self-evaluation and Her Majesty’s Inspectorate of Education inspections.
4. Are the services and national drugs strategy being measured and evaluated in terms of cost and benefit?

Offering effective, acceptable harm reduction and support before people’s use becomes problematic, among people using cocaine and MDMA in particular, could prevent and save the significant financial, health and community costs of people using psychostimulants accessing emergency treatment at the point of crisis (12).

Robust evaluation and measurement of costs and benefits will require significant additional investment and more co-operation across the voluntary, health, education and social justice sectors.

**Recommendation 2: Funding for drug, education and community services needs to be consistent and sustained.**

**Notes:**

8. Power, M 2013: ‘Drugs 2.0: The web revolution that’s changing how the world gets high’