

**ScottishdrugsForum**



**Towards a new  
Scottish Drugs Strategy...**

**Views from the Scottish Drugs Forum membership**

**[www.sdf.org.uk](http://www.sdf.org.uk)**

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*This document was produced by a short-life working group from SDF's staff and Board of Directors combined with input from our broad membership base. We would like to thank all who contributed to the document.*

## Executive summary of recommendations

### Developing wider responses

1. The vast majority of Scotland's high levels of damaging drug use has its roots in, and is perpetuated by, poverty and inequalities such as income, housing, amenities, jobs and health which can span several generations of a single family. Tackling the deep-rooted social ills associated with these inter-related issues will therefore, require very substantial and widespread will among Scotland's civil society. This must be underpinned by wide-ranging, well-resourced and widely-targeted support across a large spectrum of areas.
2. Addressing these challenges requires sustained support by the Scottish Government on an immediate, and long term, basis through:
  - a) **Provision of more high quality drug treatment services via extra investment** for the next three years, additional to that already announced for 2008-2011. This will assist treatment providers to deliver programmes on the basis of evidence of their effectiveness rather having to provide inadequate services which fail to meet the range and scale of individual need.
  - b) **Robust support and resources for the development and implementation of innovative regeneration programmes** to undermine destructive local drug economies and creating meaningful job opportunities. Part of the Scottish Government housing and regeneration budget (which is just over £1.6 billion in the next three years) could be used to develop new programmes that would significantly address inequalities associated with damaging drug use.
3. **Addressing wider inequalities, such as income, jobs and housing**, will involve redesign to integrate existing drug services with mainstream agencies. This will require the creation of a total of at least **750 posts** covering the key areas of housing, employability, family services and outreach:
  - a) **There is a strong need to ensure that housing needs are met** in light of the cessation of ring-fenced funding for the Supporting People programme, especially since people with drug problems

already receiving limited support in this area of their lives. This will require the creation of at least **200 housing support posts**.

- b) Nearly seven out of 10 drug users seeking help in Scotland are unemployed - many long-term. **There is a need for more education, training and employment opportunities.** At least **200 employability posts** must be created to drive forward the development and implementation of this crucial element of the agenda.
  - c) **There is a need to move beyond the narrow focus on mass media campaigns and drugs “education”** if expectation, opportunity and attainment are to be improved among those most at risk of developing problems – the vulnerable young people living in our most deprived communities, including those who are not living in households with parents or family substance use problems. **At least 250 family support posts** must be created to offer a range of support services covering family planning, pregnancy, children and family projects, parenting support and a range of other early and sustained interventions.
  - d) Whilst progress has been made in taking forward the Hidden Harm agenda, **more sophisticated approaches are required to reduce the risks to, and meet the needs of, children affected by parental substance problems.** This must include sustained support for substance-using parents focusing on improving parenting capacity as well as management of substance use. Research is also required to improve clarity and understanding of what constitutes serious risks to children, and consensus on how best to respond.
4. **Existing needle and syringe programmes must be expanded and improved to reduce the spread of blood borne viruses which are harmful to the health and wellbeing of drug users.** Additional funding is required to increase the distribution of injecting equipment and paraphernalia. We also recommend that at least **100 outreach posts** are created to engage and intervene early with ‘hard to reach’ drug using populations. Innovative distribution schemes should be implemented to target key injecting groups, using proven methods of distribution including mobile, outreach, back packing, peer, delivery and secondary distribution schemes. There is also a need for a national Hepatitis B immunisation

programme for injecting drug users and in the long term all babies should be immunised against Hepatitis B.

5. **Creating single pooled budgets for local Alcohol and Drug Action Teams (ADAT)** will encourage greater accountability and a cultural move towards commissioning holistic services that meet a range of needs - initially funded through health and criminal justice but slowly expanding to other funding streams to create more holistic service provision. Commissioning processes need to be reviewed to ensure that systems are equitable, transparent and that there is separation between purchasers and providers.
6. **SDF supports ADAT Stock Take Team recommendations to sharpen the leadership and focus of ADATs including extending ADAT membership** to a range of mainstream service providers and service users, carers and local communities. This will encourage long-term sustainable solutions that strengthen traditional 'treatment' responses. **Local ADAT membership must include service users, carers and key agencies** addressing inequalities such as income, housing, amenities and jobs.

### Developing specific responses

7. Approximately 22,000 people in Scotland receive a methadone prescription yet programmes in many areas are not working to full effectiveness because they fail the needs and hopes of users. **There is a need to reduce short-term prescribing, unplanned discharges, inadequate dosage and punitive treatment responses.** Promoting evidence-based methadone prescribing will help prevent the efficacy of substitute drug programmes being undermined and maximise their impact. Prescribing choices also need to be expanded to include drugs such as Subutex, Dihydrocodeine and Heroin.
8. **User Involvement (UI) must be better and genuinely supported** if the range of services which meet user (and not service) needs are to be met.

**Funding is also required urgently to expand the sphere of the UI approach from service development to individual advocacy.** This would give an important alternative perspective on how services are working by those using them throughout Scotland. **The Scottish**

**Government should also encourage advocacy agencies to develop specific services for people with drug problems.**

9. **Bold and innovative measures are required to tackle the unacceptably high drug related deaths, especially among older users.** Initiatives such as Take-Home-Naloxone (THN) should be rolled out beyond Glasgow and Lanarkshire. THN pilots should be linked to providing users and carers with appropriate training and rigorous evaluation. Safer consumption rooms in areas with high numbers of deaths among homeless populations should also be considered in depth, with a view to overcoming extant structural obstacles to enable the introduction of pilot schemes which would be rigorously evaluated.
10. Inconsistent access to residential care (crisis respite, detoxification and long-term rehabilitation) throughout Scotland needs urgent attention. The Scottish Government should review funding arrangements to ensure regional residential equity. **The number of short-stay drug crisis centres should be increased from two to at least five** to ensure adequate cover in the north and south of the country.
11. There is a need to move from having only two specialist stimulant services (e.g. cocaine) in Scotland which are both funded in a piecemeal, short-term manner towards **centrally-funded stimulant services within hot spots such as Edinburgh, Glasgow and Aberdeen.**
12. Linked to early intervention, it is vital that we prevent embryonic drug problems becoming entrenched. Therefore, **an increase in the number of specialist young people's drug services (i.e. for under 18s but in some instances also for under 16s)** is required to cover the main geographical areas in Scotland.
13. Increasing reports of **low morale and job dissatisfaction among frontline staff** may be linked to the organisation of structures in the drugs field and inadequate resourcing as referred to previously. Workloads are heavy and increasing (due to structural issues at national and local level, mostly out of the control of the individual case worker); cases are frequently a cauldron of complex, sensitive and difficult issues, which require multi-sectoral responses which may be difficult to manage; and there is an ever-increasing need to meet imposed corporate targets on a wide variety of fronts.

**Service providers, especially larger organisations, should consider anonymous staff surveys to identify and address these service delivery challenges, and also for onward transmission to strategic policy developers at the highest levels.**

14. Despite the existence of the Voluntary Sector Compact, short-term funding (fewer than three years) for voluntary sector agencies persists. **Funding voluntary services MUST be built into government budgets over the long-term**, with agencies given contracts of at least three years to ensure stability, reduce unnecessary competition occurring between agencies and thus strengthen their role in addressing Scotland's drug problem.

## Introduction

Scotland has one of the highest levels of problem drug use in Europe. Just over 50,000 people have a problem with opiate and/or benzodiazepines; there is also an emerging cocaine problem and an alarming crossover between drug and alcohol problems. Most drug-related harms, such as dependency, infections, crime and deaths occur in our most socially deprived areas. The latest drug-related deaths are the highest ever recorded - 421 people in 2006. Over 50,000 people are infected with the Hepatitis C virus (80% through injecting) and it has been estimated that 1000-2000 new infections may occur among injectors each year.

Many drug users also face a range of criminal justice, social and economic problems. With over 35,000 people entering prison each year, the average daily population has reached a record level of 7183, and nearly half of all new prisoners having a drug problem. Moreover, about seven out of 10 people attending drug services in Scotland are unemployed - many long-term - with a similar figure claiming to use their welfare benefit payments to fund their drug use.

**There are no easy, simple solutions to these challenges and it is unrealistic to think that tinkering at the edges of the current response will lead to substantially different results. As we strive towards a more successful Scotland with opportunities for all, the question which faces our society is not whether we could or should afford to make the necessary investment - but can we afford not to?**

Drugs dependency is a complex issue requiring responses which take into account the individual needs and background of everyone seeking help.

Approaches formed on the basis of party politics, personal morality or lifestyle choice should not get in the way of introducing effective responses to drugs harms. What is crucially important is that we have an open debate on the way forward, including looking at more innovative/radical ideas and proposals based on thoughtful and pragmatic approaches which reflect the most effective ways to prevent and/or minimise drugs harm.

The aim of this paper is to inform and influence the Scottish Government in the development of a new Scottish drug strategy against this challenging backdrop.

The main body of this paper is divided into two distinct but inter-related areas with listed recommendations on:

- How we develop wider responses – within the constraints of devolution - to important areas of poverty and deprivation;
- How we develop specific responses relating to treatment and care, for instance promoting evidence-based practice, reducing harmful levels of infections and drug-related deaths.

**These recommendations were developed through a process of open consultation, debate and discussion among the SDF membership. There was consensus that we need to address these wider and specific areas, over the short and long-term, in order to substantially reduce Scotland's drug problem.**

## Developing wider responses

### Drugs as part of a social problem

If we want to make a substantial impact on Scotland's drug problem it is crucial that we recognise that the problem is closely linked with poverty and a range of inequalities such as poor health, lack of employment and low income. It is also important to recognise the links between drugs and alcohol - although alcohol problems are more spread across society there is, as with drug problems, a concentration in our most deprived communities.

These factors help to explain why we have such a large drug problem and why sustaining meaningful progress can be so difficult. It is therefore vital that responding to problem drug use is dealt with in the wider context of the social and economic problems which exist within Scotland.

**Effective drugs treatment must involve more than a prescription or counselling.** Many drug problems arise from people's inability to cope with structural pressures affecting their lives which can be outside their control, such as low income, lack of housing, lack of wider family support and lack of local employment opportunities. Addressing these wider factors will require long term solutions rather than quick fixes.

SDF also recognises that each person's attempt to deal with their drug problem is a unique and deeply personal process. Therefore, also enabling them to live a meaningful and satisfying life, as defined by themselves individually, requires recognition that there are many different paths to wellbeing and recovery which will require different responses.

**Unless there is a policy move from viewing drug problems as primarily a health or criminal justice issue to a social issue, we will continue to tackle the symptoms only and not the causes.**

We must move drug policy beyond a health and/or criminal justice framework to include wider socio-economic policies - such as regeneration and anti-poverty - that acknowledges and addresses the damaging social, economical and cultural effects of local drug markets on particularly vulnerable communities.

## Recommendation 1

**Reducing Scotland's high levels of damaging drug use is linked to addressing poverty and inequalities such as income, housing, amenities, jobs and health - meeting these challenges will require the Scottish Government to invest new resources beyond the additional investment for drug treatment over the next three years.**

A significant amount of the Scottish Government's housing and regeneration budget - topping £1.6 billion over the next three years - will be spent in areas of Scotland that contain drug markets that are socially, economically and culturally damaging.

Most regeneration and local planning partnerships may not have the fullest appreciation of the pervasiveness of local drug markets, how they can seriously hamper any health, community safety, regeneration progress and how best they can assist in overcoming these issues.

A study by the Joseph Rowntree Foundation in 2005, carried out in England, paints a vivid picture of these complex drug markets.

Despite the corrosive impact on a variety of community structures and environments, the study describes an ambivalent relationship that sections of the community (notably those with low incomes) have with some local drug markets. They also see them as bringing a range of 'benefits' such as trading in stolen goods (which may otherwise be unaffordable), topping up low income or even offering 'job' opportunities.

The traditional enforcement response remains a highly important element of the response to illegal drugs but we need to move beyond that if we are serious about undermining these destructive drug markets.

Despite the number of drug seizures in Scotland steadily increasing over the last five years to record levels (just under 25,000 seizures in 05-06), overall street prices still remain steady with very high levels of those involved being imprisoned.

Moreover, there is scant evidence to suggest that investment in enforcement has the same positive return as investment in treatment (e.g. £1 spent on treatment saves £10 in other costs) or that it significantly disrupts trans-national drug markets or has a sustainable impact on drug supply, price or purity.

Moving beyond a singular, traditional, enforcement response would allow us to increase our understanding of the complex socio-economic drivers behind local drug markets and how they can be addressed.

Regeneration initiatives and other local planning partnerships could link up with the Department of Work and Pensions to play an important role - ensuring that existing and also potential drug users are encouraged not to automatically look at (or look up to) drug markets as a consumer or 'job' pathway.

This will become increasingly important as the Westminster Parliament's Department of Work and Pensions welfare-to-work target determines to move one million people within the UK off sickness/incapacity benefits and into the labour market by 2016. Recent research by Warwick University shows that unemployed people who took a low-wage job were twice as likely to become jobless again compared to someone who secures a high-paid job after being unemployed.

Moreover, sensitive and imaginative housing policies could also help seriously undermine these pernicious drug markets by avoiding the creation of a concentration of multiple social problems within deprived areas.

## **Recommendation 2**

**The Scottish Government should undertake a specific review of regeneration and anti poverty measures with particular reference to problem drug use and other entrenched social problems to ensure a more 'joined up' use of resources to deliver sustained results.**

**There may be opportunities within the housing and regeneration budget of just over £1.6 billion in the next three years to develop new programmes to significantly address inequalities associated with damaging drug use. Innovative regeneration programmes that create meaningful work opportunities could undermine destructive drug economies.**

## Developing and strengthening a wider integrated response

Acknowledging the role structural inequalities play in creating and maintaining Scotland's drug problem serves to highlight the pressing need to ensure that drug policies are integrated into mainstream policies such as social inclusion, housing, homelessness and regeneration.

Accepting that drug problems are fundamentally a social problem means that there is a **pressing need to move from narrow medicalised approaches to creating new, local holistic services** that meet other important needs such as prevention (family planning, and needle exchange), social support (housing, child and family welfare, employability and family support) and specific needs such as co-location of blood borne virus services.

With too few people with Hepatitis C diagnosed and in treatment, it is crucial that services are made more accessible. SDF supports the national Action plan to co-locate HCV treatment services within specialist drug services.

Co-locating HCV treatment services within specialist drug services, can serve as a platform to adopting a new holistic approach that involves addressing wider social problems. Developing this holistic approach would also involve a **reconfiguration in key areas such as preventing future drug problems, accessing services, 'wraparound' care including housing support, outreach services and family support.** This would enable service commissioners to reconfigure services so that they are better able to meet the range of needs presented by drug users.

These newly created local services could play a pivotal role to ensure continuity of care – for example, a housing specialist within these new teams would act as link between mainstream housing providers, residential services and also prisons to prevent future drug-related harms from occurring.

It is difficult to estimate the level of funding for specialist treatment and care services. However, it is clear that even with better use of existing funds there is a need for additional resources to be devoted to the wider 'wrap around' care of those with drug problems.

Additional investment should not be made available immediately but should involve a stepped approach allowing sufficient 'lead in' time to ensure that a strategic approach is adapted to the new investment. This should ensure that the commissioning procedures are in order and appropriate planning for an increased workforce is undertaken.

### Recommendation 3

**Addressing wider inequalities, such as income, jobs and housing, will involve a redesign of existing drug services and mainstream agencies, such as housing and employability. Therefore, this will require the creation of a total of at least 750 posts covering all these key areas such as prevention, housing and family support.**

Outlined below are the key areas which the 750 posts could cover.

#### *Housing and housing support*

Housing and housing support is continually identified as a major problem both in terms of preventing problem drug use and in helping an individual stabilise their drug problem and move away from drug dependency.

**All too often, people receive little or no support or have difficulty securing or maintaining their tenancy.** For instance, with a regular and large population of drug users entering prison - thus increasing the risk of losing a tenancy - the number of drug users receiving housing support in Scotland are low.

The latest annual 'Supporting People' figures (covering major vulnerable client groups in Scotland) show that a total of 163,758 received housing support in 2005-06 - only 2,493 people with drug problems received this support. This major gap in support is occurring during a period when ring fencing for Supporting People monies has ended.

To avoid vulnerable drug users being further excluded from mainstream housing provision, there is an urgent need for dedicated housing and housing support (e.g. help with benefits, paying bills, securing and maintaining a tenancy) for those with drug problems.

### Recommendation 4

**With ring-fenced funding for Supporting People ending and people with drug problems receiving limited support, there is a strong need to ensure that their housing needs are met. This will require at least 200 housing support posts created to meet these needs.**

## ***'Employability'***

Long-term unemployment and welfare benefits being used to fund drug use are a daily reality for the majority of drug users seeking help in Scotland. Yet despite facing such a range of employability barriers (which includes health problems and criminal records), Scotland has had a positive track record in addressing these challenges through the New Futures Fund (NFF).

Hailed as a successful employability initiative that guided the development of the UK-wide Progress-2-Work initiative, the aim of NFF was to engage and work with those furthest from the labour market, such as drug users. Positive NFF outcome results showed that this approach was working - 21% were employed/self-employed, 12% went into education, 14% went into government programmes and 10% were involved in voluntary work. However, despite this positive track record, NFF has not been actively developed in Scotland and has been subsumed within larger Community Planning structures.

**There is a risk that those furthest from the labour market, such as drug users, will miss out on the chance to move beyond 'treatment only', if NFF style initiatives are not actively developed in Scotland. There is also a concern that the only option available will be through UK-wide welfare-to-work reforms that involve restructuring existing sickness and incapacity benefit systems.**

A key Department of Work Pensions welfare-to-work target will involve moving one million people within the UK off sickness/incapacity benefits and into the labour market by 2016. However, the pressures placed on frontline employability services to meet these targets could create a culture whereby those nearest the labour market are 'cherry-picked' to ensure positive outcomes.

With many drug users furthest from the labour market (and possibly perceived as offering 'poor target outcomes' for frontline employability staff), it is likely that they will be overlooked in favour of populations groups nearer the labour market.

If we wish to see this level of NFF positive outcomes, then there is a need to re-visit funding this employability approach. New NFF approaches could involve integrating or co-locating projects across treatment services in Scotland that work with key vulnerable populations including those with drug and alcohol problems. These employability services could offer a range of moving on options such as volunteering, education/training, Intermediate Labour Market and Social Firms.

Moreover, a recent study by the University of Warwick has found that unemployed people who took a low-wage job were twice as likely to become unemployed again compared to someone who secures a high-paid job after being unemployed.

The research by Professor Mark Stewart has potential significance for policies aimed at encouraging or driving jobless drug users and others excluded groups indiscriminately into the labour market. Professor Stewart recently stated: "Low-wage jobs act as the main conduit for repeat unemployment. Not all jobs are 'good' jobs in the sense of improving future prospects and that low-wage jobs typically do not lead on to better things.

"If unemployed individuals' future employment prospects are to be permanently improved, they need to find jobs where they can augment their skills (for example through training) and move up the pay distribution. Low paid jobs typically do not provide this."

#### **Recommendation 5**

**Nearly seven out of ten drug users seeking help in Scotland are unemployed - many long-term. Therefore, there is a need for more education, training and employment opportunities which set in motion the ability for individuals to progress to higher quality jobs. This will require at least 200 employability posts created to meet these needs.**

#### ***Family services – harm prevention, education and support***

**There are two interlinked imperatives. Children at serious risk from parental substance problems must be protected and families having difficulty coping must be supported.** Also, more effective measures need to be put in place to reduce the likelihood of the next generation developing problems.

There is a need to move beyond the narrow focus on mass media campaigns and drugs "education" for improving expectation, opportunity and attainment among those most at risk of developing problems – vulnerable young people living in our most deprived communities, including those who are not living in households with parents or family substance use problems.

A significant proportion of the most at-risk young people live with parent(s) with a drug problem, though many do not. We need to ensure a consistent and

holistic approach towards early intervention and family support to all – and at all levels within - vulnerable families, not just those where parents are experiencing problem drug use. **There is a broad body of evidence that early intervention with vulnerable families can deliver significant savings in costs – emotional, social and economic - over the long term**

There are serious questions about the effectiveness of both education and media campaigns. In terms of drug education for children, there is little evidence to suggest a significant impact on drug use for future use. It appears only the most comprehensive programmes with multi components can be 'modestly successful', while other approaches such as providing information have little or no effect. Some studies suggest that media campaigns that use 'shock tactics' may be counter productive or actually increase harm.

Serious prevention of future problems must substantially focus on our most vulnerable young people by improving educational attainment, expectations and opportunities for young people in our most deprived communities. The health and wellbeing of those closest to the young people is also absolutely critical for the creation of the type of nurturing environment which can achieve these goals.

We must adopt more meaningful, more intensive, more targeted and better supported health and welfare advice throughout the family if we are serious about preventing future generations from developing drug problems.

A number of experts at a recent conference in Edinburgh on social marketing highlighted the need for highly relevant messages, stepped/intermediate approaches and intensive support for target groups if programmes promoting health and social behaviour change are to be successful among "hard-to-reach" groups

Significantly, there also remains a gap in understanding and perspective between the adult-focused specialist drug services and children's services - despite it being clear that their interests often cannot be separated. Children and young people living with parental substance use must be kept safe and protected from harm but **protecting the interests of young people and their parents is not necessarily mutually exclusive.**

If vulnerable young people are to have the opportunity to reach their full potential from birth through to adulthood, the focus must be on taking the holistic approach which takes account of, and seeks to reconcile, the often varying perspectives and needs of all closely associated people central to the

young people's lives – their parents, themselves and frequently extended family or friends.

**This must include sustained support for substance-using parents focusing on improving parenting capacity as well as management of substance use.**

In Scotland, considerable progress has been made in taking forward the Hidden Harm agenda on an inter-agency basis but this is work in progress and a better across-the-board understanding of what constitutes serious risks to children is needed and how best to respond to this is required.

The number of specialist projects for children and their families facing serious difficulties is limited and further research is needed into best practice in this area. In addition further provision is required for families where there is no immediate risk but where children's needs are not being fully met.

There has been significant UK government investment in supporting families with very young children through initiatives such as Sure Start. Launched in 1998, Sure Start received £3 billion of government funds up until 2008 to create 3,500 Children's Centres by 2010. However

- a National Audit Office report noted that families with high levels of need were not being targeted and were missing out on Sure Start support
- there is an overdue need for significant investment to extend this work supporting vulnerable families with very young children to include others at risk, such as older children and also to acknowledge the important role played by all kinship carers.

**At least 250 family support posts** must be created to offer a range of support services covering family planning, pregnancy, children and family projects parenting support and a range of other early and sustained interventions.

This would have twin aims of i) reducing the adverse impacts of the parent or carer's substance use on the young person while ii) increasing the young person's capacity for resilience.

In addition to establishing the family support posts and extending the range of services as detailed above, research is required to provide:

- Greater across-the-board clarity and understanding of what constitutes serious risks to children
- Consensus on best practice on how best to respond to situations of serious risks, which takes into account and reflects the views of substance-using parents on the range and type of support they require.

### **Recommendation 6**

**There is a need to move beyond mass media campaigns and drugs “education” to improve expectation, opportunity and attainment among those at risk of developing a problem: vulnerable young people living in our most deprived communities. This will require at least 250 family support posts and funding for the creation/extending of a range of support services covering family planning, pregnancy, children and families projects, parenting support and a range of other early and sustained interventions.**

**Consideration must be given to more sophisticated ways of identifying children at serious risk from parental substance problems. Research is required to provide greater clarity and understanding of what constitutes serious risks to children. Consensus must be reached on what constitutes best practice response to serious risk. That process must take into account and reflect the views of substance-using parents on the support required.**

### ***Outreach services***

Over the last 10 years, there has been a greater policy focus towards criminal justice priorities in the provision of drug treatment care and rehabilitation. This policy shift has created major access problems with the existing provision which must be specifically addressed.

For instance, the range of accessible services offering early intervention in a person’s drug problem are very patchy in Scotland. ‘Bottleneck’ waiting lists are a major challenge within specialist drug services (some drug users face a two year waiting list), and there is a need to develop more mixed and flexible responses from low threshold services (basic GP substitute drug prescribing or brief interventions with local drug services) right up to high threshold provision e.g. specialist teams working with drug users with mental health problems.

This flexible approach could cover existing engagement with clients. For instance, a move away from a rigid system which offers appointments three months away (resulting in high levels of 'Did Not Attends') could be reduced by systems which remind clients of forthcoming appointment (e.g. text messaging).

Other flexible options could involve choosing not to offer extended opening hours for all clients but tailored services that offer crisis support, particular at weekends and public holidays. Stakeholder days with planners, practitioners and services users could help highlight some of these bottlenecks and service provision problems and offer other potential local solutions.

Against this service delivery backdrop, in particular, we are concerned about the **continued spread of blood borne viruses** among injecting drug users in Scotland – estimated at between 1,000 and 2,000 new infections each year.

Therefore, there is a need to develop assertive outreach services to help those most at risk of infection and overdose, especially among hard-to-reach populations such as chaotic and homeless injectors.

There is also an urgent need to **increase provision of injecting equipment** including paraphernalia and to instigate awareness programmes about the risk of sharing all drug equipment including spoons and water.

Furthermore, with pockets of new HIV infections among injectors in England, we cannot afford to be complacent that we have sufficient needle and syringe coverage to prevent possible future outbreaks of HIV in Scotland.

**The goal must be to provide sufficient injecting equipment for each episode of drug injecting which will require a significant scaling up of existing provision** – one major way of achieving this level of injecting equipment coverage is through outreach into wider injecting drug using community. This would involve extending outreach support for injectors, which is patchy throughout Scotland.

Beyond additional funding for injecting paraphernalia and outreach support, there is also a need for a national Hepatitis B immunization programme for injecting drug users and in the long term we would like to see all babies immunised against Hepatitis B.

In developing these outreach services for drug injectors, opportunities exist to extend the remit and role beyond exclusive health concerns - such as Hepatitis C - to include other "wraparound" areas. For example, outreach staff could

establish links with mainstream drug services and other essential providers, such as those covering housing, welfare and money advice.

### Recommendation 7

**Additional support is required within existing needle and syringe programmes which will include additional funding for injecting paraphernalia and developing outreach services across Scotland to intervene earlier and reduce a range of drug-related harms. We recommend that at least 100 outreach posts are created to engage with 'hard to reach' drug using populations. There is also a need for a national Hepatitis B immunisation programme for injecting drug users and in the long term we would like to see all babies immunised against Hepatitis B.**

### Sharpening and improving leadership and governance

There is a need to improve and sharpen the leadership and governance arrangements in Scotland in order to deliver a more strategic and adaptable response to Scotland's drug problem.

There has been much debate regarding a more centralised command style (akin to the National Treatment Agency in England) aimed at changing frontline service provision. **SDF's view is that existing planning structures must be able to lead a proactive response to drug problems in local areas which will require them to have control over funding.**

This can be achieved through a pooled or 'ring fenced' budget which brings together the existing streams and new funding in one pooled budget. Adopting this pooled budget approach (used in England to cover a spending budget of £800 million) would provide local Alcohol and Drug Action Teams (ADATs) with the resources and leverage to address the range of needs faced by those with drug problems. It would also create greater accountability.

Although the ADATs should remain responsible for the strategic direction of services and for ensuring the creation of more holistic services that meet the full range of needs, a review of commissioning arrangements in Scotland is overdue. Separation of purchasers and providers in the commissioning process is needed to ensure equity and to maintain quality.

**Independent monitoring would be required to ensure that service providers are held accountable in providing quality services.**

There will also be a need for leadership from those running the specialist services to ensure that they are open to new ways of delivering services.

**This new form of governance would improve local ADAT effectiveness, transparency, accountability and allow their performance to be measured against agreed criteria.**

With independent monitoring links created, key measurable performance criteria could include time span between initial referral to receiving 'treatment'; reduction in drug related deaths; retention in treatment and care services including planned and unplanned discharges; and, independent feedback through user satisfaction surveys.

Other measurable performance criteria could include increasing the proportion of injecting equipment disbursed compared to local frequency of injecting; increasing the proportion of clients moving into Further Education, training or work (paid/unpaid).

Moving beyond traditional 'treatment' responses will involve a range of mainstream providers, such as housing, and local communities and service users becoming more actively involved in developing sustainable approaches that ensure drug users have equitable access to new and existing services.

#### **Recommendation 9**

**Creating single-pooled local ADAT budgets will encourage greater accountability and a cultural move towards commissioning holistic services that meet a range of needs - initially funded through health and criminal justice but slowly expanding to funding streams to create more holistic service provision. Guidance regarding best practice in commissioning is needed.**

#### **Recommendation 10**

**There is also a need to extend ADAT membership to a range of mainstream providers thus encouraging long-term sustainable solutions that strengthen traditional 'treatment' response. Local ADAT membership must include service users, carers and key agencies addressing inequalities such as income, housing, amenities, and jobs.**

## Developing specific responses

### Improving prescribing issues and service delivery

The evidence is clear that investment in treatment, care and rehabilitation in its broadest sense makes the biggest impact on individual harm and harms to the wider society.

For example, the National Treatment Outcomes Study in England showed that for every £1 spent, savings in other wider societal costs were at least £10. There is also an overwhelming international evidence base for the positive impact of methadone prescribing in reducing mortality, illicit drug activity, crime and blood borne virus transmission.

However what is clear is that there is variability in programme effectiveness. For instance, factors associated with better outcomes are reduced barriers to entry, optimal daily dose, high quality medical and social services, treatment retention and orientation towards social rehabilitation.

The factors associated with poor outcomes include restriction of methadone daily dose, a controlling and administrative rather than supportive and empathetic culture, shorter duration of treatment and stopping treatment before a person wishes to do so.

In Scotland, about 22,000 individuals receiving methadone each year with just over 12,200 receiving daily supervised methadone consumption – this latter figure includes 5,675 people receiving “up to 7 days supervision”. This overall supervision figure is probably a conservative underestimate due to under-reporting in parts of Scotland.

**With supervised dispensing alone costs estimated at £12.4 million a year, there is a need to re-visit the rationale for this widespread, daily supervision in Scotland.** We need to look at the cost effectiveness of this approach and explore whether the required level of supervision can be delivered through other means.

Although many press reports suggest that many individuals are ‘parked’ on long-term on methadone, the daily reality is that within this population, there is a significant turnover. This high turnover rate may be linked to a range of factors such as low-dose prescribing or a punitive ‘*one strike and you’re out*’ approach towards drug testing e.g. a positive drug test for substances other than those

prescribed may involve serious sanctioning rather than a re-assessment of the treatment plan.

Despite the overwhelming international evidence base for the positive impact of methadone prescribing, there appears to be a centralising trend in some of Scotland's specialist drug services towards factors that are associated with poor instead of positive outcomes.

These variations in prescribing and operational policies can only serve to undermine the credibility and effectiveness of substitute prescribing schemes in Scotland. **There needs to be a far more person-centred as opposed to service-centred approach** which takes a more holistic view and is flexibly delivered. The prescribing menu and choice on offer also needs to extend beyond Methadone to consider alternatives such as Subutex, Dihydrocodeine and heroin prescribing.

#### **Recommendation 11**

**With approximately 22,000 people receiving a methadone prescription, there is a need to reduce short-term prescribing, unplanned discharges, inadequate dosage and punitive treatment responses. Promoting evidence-based methadone prescribing will help prevent substitute drug programmes being undermined and also maximise their impact. Prescribing choices also need to be expanded to include drugs such as Subutex, Dihydrocodeine and Heroin.**

#### **Strengthening user involvement and developing advocacy**

SDF concurs with the Scottish Government's guidance on user involvement which supports active participation of people who, because they have used services, can bring their knowledge and experience to contribute to the design, planning, delivery and evaluation of services at a local, regional and national level.

SDF also endorses the recent ADAT stock take which supports the need for ADATs to take a more active role in ensuring effective involvement of service users.

However with an existing piecemeal approach to funding UI work throughout Scotland, there is a risk that it ends up becoming an empty "tick-box" exercise, rather than a genuine consultation leading to service improvement.

In addition, the complexities, lack of integration and lack of resources affecting service delivery structures in many areas are resulting in growing tensions between the needs of individual service users and the services charged with providing those services. Linked to UI activity, therefore, is the issue of advocacy services for drug users needs to be considered – especially with the introduction of Quality Standards for substance misuse services.

#### **Recommendation 12**

**Independent UI funding is needed to ensure that we have an accurate and up-to-date picture of how services are perceived by those using them throughout Scotland.**

**It has increasingly become apparent through complaints received about services to SDF and English-based advocacy agencies that there is a need to introduce and develop advocacy services. The Scottish Government should encourage advocacy agencies to develop specific services for people with drug problems.**

#### **Tackling drug-related deaths**

Drug-related deaths continue to be a major concern, particularly as there is no sign of any decrease in the overall numbers – the latest figures are the highest ever recorded at 421 people in 2006. However, new solutions to address this major problem have been put forward in the inaugural annual report of the National Forum on Drug-related Deaths in Scotland.

SDF welcomes the report's recommendations especially the need for dedicated funds to encourage new responses such as extending take-home naloxone provision beyond Glasgow and Lanarkshire into other areas (linked to rigorous evaluation) and more emphasis placed on the importance of suicide prevention work.

SDF also supports the importance of implementing the revised "Orange Guidelines" (Drug misuse and dependence - UK guidelines on clinical management) which reminds clinicians that rapid detoxification, long waiting lists and under-medicating patients is not only ineffective but can be dangerous.

There is no doubt that increasing the range quality and accessibility of drug services will make an impact in the long term. However, given the significant number of deaths among older problem drug users (in their 30s and 40s) and homeless populations, there is a need for targeted, intensive support for those who are at greater risk of mortality.

Therefore, it is important that in areas with a high death rate among older users, local ADATs should look at developing services specifically for this high risk population, such as exploring the need for consumption rooms in locations with high numbers of deaths among homeless populations.

### **Recommendation 13**

**Bold and innovative measures are required to tackle the unacceptable high drug related deaths, especially among older users. Initiatives such as Take-Home-Naloxone (THN) should be rolled out beyond Glasgow and Lanarkshire. THN pilots should be linked to providing users and carers with appropriate training and rigorous evaluation. Safer consumption rooms in areas with high numbers of deaths among homeless populations should also be considered in detail, with a view to overcoming structural obstacles to establishing a pilot scheme, which would be rigorously evaluated.**

### **Widening access to residential care**

There has been much debate around residential care for people with drug problems in Scotland. We support the need for residential care. However, it is not a panacea and its success, like that of other treatment options, will be based on being the right option for the right person at the right point in their life. There is certainly a need to ensure that this treatment is accessed by those who would benefit from it the most.

Access to the provision is also too often driven by whether or not there is funding rather than need. There is also a need to link rehabilitation services more effectively to community-based services and vice versa to ensure continuity of care.

In addition to long term residential care, there is a need for short-stay crisis/respice centres which can provide an alternative but at times vital, quick route into mainstream services, particularly at times of pressing need.

Despite a 1994 Scottish Office Ministerial Drugs Task Force report urging that proposals for crisis-intervention centres in Aberdeen and Dundee should be developed as quickly as possible, there are only two short-stay drug crisis centres in the central belt (Edinburgh and Glasgow) and still NONE in the north and south of the country.

#### **Recommendation 14**

**Inconsistent access to residential care (crisis respite, detoxification and long-term rehabilitation) throughout Scotland needs attention. The Scottish Government should review funding arrangements to ensure regional residential equity. The number of short-stay drug crisis centres should be increased from two to at least five to ensure adequate cover in the north and south of the country.**

#### **Addressing the stimulant problem**

While Scotland's major drug problem continues to be with depressant drugs (opiates and benzodiazepines), it is important not to lose sight of the emerging problem of psychostimulant drugs such as cocaine.

Tackling increasing cocaine use has, until now, been a major plank of the Know the Score (KtS) national information campaign – it focused on the negative health effects of cocaine with a key message that it can make users up to 24 times more likely to have a heart attack. However, despite this emerging stimulant problem and KtS campaign, the majority of specialist drug services in Scotland (which focus on opiate and benzodiazepine problems) are not fully equipped to respond to this situation. Specialist alcohol services may also be overlooking a hidden cocaine problem within their service users.

There is therefore a need for all specialist services to develop effective responses to psychostimulant use among their clients. Furthermore, we need to develop beyond existing specialist service for stimulant users. There are still only two specialist services in Scotland (Aberdeen and Edinburgh) which are both funded in a piecemeal, short-term manner and there is no specialist help available in other 'hot spot' stimulant areas, such as Glasgow and other emerging areas.

#### **Recommendation 15**

**There is a need to move from having only two specialist stimulant services (e.g. cocaine), in Scotland which are both funded in a piecemeal, short-term manner towards centrally-funded stimulant services within hot spots such as Edinburgh, Glasgow and Aberdeen.**

## Providing services for young people with a drug problem

There is little evidence to suggest that drug education has a significant impact on halting the development or reversing embryonic drug problems. However, obtaining specialist service for those young people with a drug problem (i.e. under 18 but in some instances also under 16) remains extremely patchy in Scotland and many areas of Scotland have no services for young people.

Provision of adequate services is vital if we are to intervene early to prevent drug problem from becoming entrenched and also avert related harms (such as Hepatitis C infection among new injectors).

Despite the particularly sensitivities surrounding the issue of under 16s with a drug problem, there are some examples of good specialist services being developed to work with young people. In respect of the voluntary sector, the Lloyds TSB Partnership Drugs Initiative has been an effective lever in enabling an increase in provision.

While specialist treatment may only be required by a relatively small proportion of young people developing a drug problem, it is vital that specialist help is available to all who need it.

### **Recommendation 16**

**Linked to early intervention, it is vital that we prevent embryonic drug problems becoming entrenched. Therefore, an increase in the number of specialist young people's drug services (i.e. under 18 but in some instances also under 16) is required to cover the main geographical areas in Scotland.**

## Increasing morale and job satisfaction among frontline staff

In Scotland, drug treatment and care services have expanded considerably in recent years with just under 240 specialist drug services operating throughout the country. We have also witnessed the rise of large, centralised services which, although providing widespread support and prescribing services, have also developed a working culture that appears to be rigid and inflexible

Many workers are struggling to reconcile their personal instincts to make a difference to individuals against the background of this new working culture

include heavy workloads, imposed targets and a “conveyor belt” system that tries to manage “the entire problem” by offering narrow models of treatment and choice.

The emphasis towards performance management, monitoring and measuring systems often than not appear to be detached from drug users’ day-to-day lives and realistic outcomes. Moreover, despite attempts to move towards ‘single shared assessments’ service users still report having to undergo repeated (and sometimes lengthy) assessments.

This situation echoes a recent Drugscope report which noted a similar trend in England whereby drug users claimed that they were being ‘assessed to death’. And, in a recent SDF report looking at the role of methadone, service users also frequently described the impersonal nature of many drug services. The report also noted that many workers complained of working in large bureaucratic structures that limited their ability to respond flexibly to individual need.

Staff pay and conditions may also be an important factor.

This workforce dissatisfaction is occurring against a backdrop of recent industrial action over pay conditions among social care staff - many working within a major urban addiction service provider – and general poor staff pay and conditions for frontline staff. For instance, in January 2008, a major service provider in Scotland was seeking a sessional worker - with experience in providing assessment, care planning, key working, counselling, group work or other activities to people with substance misuse and related problems such as offending - at a rate of £7.92 per hour. Meanwhile, a vacancy for a temporary Checkout Team Leader in a very large supermarket in Glasgow, also in January 2008, offered £7.32 per hour.

It is important that existing commission and monitoring processes acknowledge and do not gloss over poor morale and job dissatisfaction among frontline staff engaged in such difficult work. Big may not necessarily be beautiful - service commissioning processes should consider covering smaller geographical areas and encouraging more flexible cultures (for both client and worker) that have the potential to improve both client and worker satisfaction and as a result deliver more effective services offering meaningful and realistic outcomes.

## Recommendation 17

**Increasing reports of low morale and job dissatisfaction among frontline staff may be linked to heavy workloads, meeting imposed targets and a developing culture of “conveyor belt” drug services that try to manage “the entire problem” by offering narrow models of treatment and choice. Staff pay and conditions may also be an important factor. Service providers, especially larger organisations, should consider anonymous staff surveys to identify and address these service delivery challenges, and also for onward transmission to strategic policy developers at the highest levels**

### Securing voluntary sector funding

The role of the voluntary sector has expanded considerably over the last decade. There are just under 240 specialist drug services operating throughout Scotland and more than half of these are provided by the voluntary sector. **This expanding voluntary sector role is occurring within a changing landscape in which the sector has to compete for funding contracts that are linked to Service Level Agreements which do not apply to public-sector funded drug services.**

Often, this contract culture can lead to unhealthy competitive behaviour and prevent smaller voluntary sector agencies from securing funding more frequently secured by large UK providers. Competitive tendering can also lead to a ‘race to bottom’ which may result in a successful bid that leaves the “winner” having to offer unattractive salary scales and overlook an important organisational issue, full cost recovery.

Full cost recovery has been defined as the means of recovering or funding the full costs of a project or service, such as essential overheads like adequate staff training, human resources and IT systems. Unmet full cost recovery can lead to organisational strains such as salaries being frozen and redundancy fears in other parts of the organisation.

As we move towards the end of the financial year (07 - 08), the voluntary sector faces another spell of funding anxiety and uncertainty as to whether certain projects/services will be renewed or discontinued, especially in key areas such as employability. This includes recent concerns from the director of the Big Lottery Fund in Scotland that lottery cash of up to £51m intended to have a direct impact on groups in Scotland could be at risk because of the rising cost of the London 2012 Olympics.

Within this funding climate, which also negatively impacts on workforce retention, there is need a need for government budgets, as part of a longer-term approach, to develop rolling contracts that ensure service stability, reduce unnecessary and inefficient competition occurring between agencies thus strengthening the role that the sector can play in addressing Scotland's drug problem.

#### **Recommendation 18**

**Despite the existence of the Voluntary Sector Compact, short-term funding (less than three years) for voluntary sector agencies persists. Funding voluntary services needs to be built into government budgets over the long-term with agencies given contracts of at least three years duration to ensure stability, reduce unnecessary competition occurring between agencies, thus strengthening their role in addressing Scotland's drug problem.**

## Conclusion

Scotland's current drugs problem is a manifestation of wider social ills which have their roots in long-standing economic, social and cultural developments over the past 30 years and beyond. Scottish Drugs Forum has proposed here a strong, co-ordinated set of responses at national and local level necessary to:

- undermine and counteract the environments in which problem drug use will flourish, especially among the younger generation
- provide easily accessible, high quality and effective treatment, care and rehabilitation programmes to assist those who are experiencing problems already.

The challenges are immense, given the impact of global economic and political trends, along with Westminster and devolved Scottish Government policy, as they filter down and set the tone for the way in which many people affected by problem drug use live – or exist within – their day to day lives.

At regional and local level too, a huge concerted effort is required from health, social work, housing, and employability services to design (and to be able to fund) more effective protocols, programmes and projects which keeps the needs of the service user – not the services – paramount.

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