

ACMD

Advisory Council on the Misuse of Drugs

Chair: Professor Les Iversen
Secretary: Linsey Urquhart
1st Floor (NE), Peel Building
2 Marsham Street
London
SW1P 4DF
Tel: 020 7035 1121

Email: ACMD@homeoffice.gsi.gov.uk

Karen Bradley MP
Minister for Preventing Abuse, Exploitation and Crime
Home Office
2 Marsham Street
London
SW1P 4DF

01 February 2016

Dear Minister,

Re: ACMD Response to Drug Strategy

The Advisory Council on the Misuse of Drugs (ACMD) has considered the 2016 skeleton drug strategy received and is pleased to provide comment.

Given the limited timeframe available ACMD have provided a summary of key points for consideration in relation to three key strands identified in the strategy, rather than a comprehensive commentary.

Included at Annex A are recommendations that ACMD have provided over the past two years that we feel should be reflected within the strategy.

Yours sincerely,



Professor Les Iversen
ACMD Chair

2016 DRUG STRATEGY: ACMD COMMENTS

1.0 OVERVIEW

1.1 The ACMD response comprises the collective view of the committee on 'the strategy'. The ACMD have provided commentary in relation to the three main strands of the strategy:

- Reducing Demand
- Restricting Supply
- Building Recovery

1.2 **Additional comments are appended in paragraph 5.0.**

2.0 REDUCING DEMAND

2.1 On the estimation of drug-related crime

2.1.1 The strategy includes the claim that 45 per cent of acquisitive crime is committed by heroin or crack-cocaine users. It would be useful to explore the evidential basis for this claim, especially if it is taken from surveys of arrestees. Estimates based on arrestee samples should take into account both that arrestees are not a random sample of offenders and are likely to include an over-representation of drug users (Stevens, 2008) and that offending tends to peak in the weeks before arrest (NTA, 2012).

2.2 Emphasis on research including gaps and opportunities

2.2.1 Evidenced based decisions are sometimes problematic for the ACMD because of the lack of any quantitative information on the matter under discussion. It would be helpful for the Drug Strategy going forward to accept that, in some cases, research to provide a definitive evidence base on which to base a decision is needed. Areas of recent interest include whether or not poppers are truly psychoactive, whether current controls on anabolic steroids actively control their misuse and whether changing the legal status of a drug under the Misuse of Drugs Act (MDA) has the effect of reducing its misuse.

2.2.2 Many analysts of drug policy outcomes have noted that the evidence base for policy decisions is not sufficiently developed (Strang *et al.*, 2012). This is especially true of interventions aimed at reducing the supply of illicit drugs, which

are rarely piloted or subject to thorough evaluation. Even for those initiatives that are evaluated, it is rare for them to be designed and implemented in ways that enable the production of valid information on their effects. It is rare, for example that the opportunity is taken to randomise the implementation of a new initiative in order to be able to attribute any changes in outcomes to the intervention.

- 2.2.3 The ACMD therefore suggests that the government consider investing more money in rigorous and independent evaluations, including of supply reduction interventions, and to implement new policies in ways that enable such evaluation. This would have the long-term effect of saving money by increasing the cost-effectiveness of drug policy interventions.

2.3 Addressing the risk to young people from online markets

- 2.3.1 The use of social media and the ease of access to unregulated internet present particular challenges when it comes to addressing drug use and misuse, particularly among young people and young adults. In some ways there is a new cohort of young people vulnerable to pro-drug messages, peer support for illicit drug use and drug suppliers.
- 2.3.2 The proposal to develop better educational programmes for use in schools to support controls is important given that children are exceptionally adept at surfing the net and seeing what is being sold. Whilst targeting prevention etc. to this group through the same communication channels, such as social media, may be fraught with difficulty in respect of delivering coherent and credible messages we feel that such measures should be considered and evaluated in concert with more conventional methods. Whilst the Psychoactive Substances Bill (PSB) may end high street sales, there is a likelihood that online marketing networks may increase.

2.4 Preventing risky behaviours and building resilience

- 2.4.1 The emergence of effective, evidence-based programmes for the prevention of risky behaviour in young people (as noted in the ACMD's recent report on prevention) provides an opportunity to engage more young people in effective preventive interventions. Developing the evidence base for behavioural based interventions for young people in schools could augment information/education based approaches by building resilience and reducing risky behaviours.

- 2.4.2 ACMD thinks that it is critical that the drug strategy outlines what resources will be made available for both behavioural based interventions and education/information interventions to prevent substance misuse.

3.0 RESTRICTING SUPPLY

3.1 Responding to changing markets and supply routes

- 3.1.1 Shared intelligence and shared analysis is vital to react to the emergence and potential rapid spread of drug use as happened with heroin use in the 1980's.
- 3.1.2 Continued instability in Afghanistan and the Middle East will challenge efforts to stem the flow of heroin into the UK. Efforts should continue to be focused at the national/regional level (borders etc.).

3.2 Challenging Internet markets

- 3.2.1 It is clear that the suppliers of psychoactive substances are utilising the internet for a number of reasons including to be more responsive to changing and moving trends and to reach wider international markets. Expansion of the online market for psychoactive substances (including through encrypted, dark net sites) will enable a wide range of drugs to enter the UK.
- 3.2.2 Effective early warning and intelligence gathering systems are essential as is a flexible and dynamic approach to enforcement.

4.0 BUILDING RECOVERY

4.1 Loss of financial resources and loss of prioritisation

- 4.1.1 Much of the aspirations and content in the draft drug strategy section on 'Building recovery' are supported by the ACMD including: enhancing treatment capacity; improving outcomes for different groups of drug users; and ensuring that all key stakeholders including local health commissioners are involved in strategic commissioning of drug treatment and recovery interventions. However, as stated in our previous reports and letter to the Home Secretary, ACMD think that biggest threat to achieving recovery outcomes, and maintaining the quality and capacity in current drug treatment systems in England is the loss of financial resources and loss of prioritisation of the highly marginalised group of drug users who require treatment and recovery interventions.

- 4.1.2 It is difficult to see how treatment capacity and quality will be maintained, let alone expanded, in the context of localism and the potential significant loss of local public health funding. The ACMD are of the view that localism and the devolution of local budgets to local areas without either 'ring fencing' or levers to protect resources will result in a loss of funding for adult and young peoples drug treatment and recovery interventions.
- 4.1.3 ACMD suggests that the drug strategy provides clear expectations around maintaining current capacity and funding levels and finds a way to implement levers, incentives and/or sanctions if local drug treatment capacity or resources reduce. In this light it may be helpful to reset quality standards for drug treatment services.

4.2 Impact of frequent re-procurement of drug services

- 4.2.1 The ACMD are also concerned about the impact of frequent re-procurement of drug services which incurs significant costs, disrupts continuity of local service provision and often result in a negative impact on recovery outcomes. We urge the drug strategy to discourage this unnecessary 'churn', cost and disruption in local drug treatment systems and promote longer term, investment approach to commissioning. ACMD current work indicates that frequent re-procurement also severely undermines workforce development and staff security, which in turn, impacts on the quality and safety of drug treatment services.
- 4.2.2 Furthermore, it appears that re-procurement and reductions in resources is resulting in a significant loss of staff with qualifications in substance misuse including nurses, doctors, psychologists and practitioners with graduate qualifications in substance misuse. Whilst ACMD welcomes the growth in 'experts by experience' in drug treatment, this should be balanced by employment of qualified and experienced staff. The current draft of the drug strategy does not recognise these real human resources challenges facing drug treatment. ACMD recommend that this part of the drug strategy is redrafted to address the above issues.

4.3 Development of strategies to meet different needs

- 4.3.1 The ACMD fully supports the aspiration of all drug users being supported to achieve recovery outcomes. However, as stated in the draft drug strategy, drug

users are a very diverse group. ACMD welcomes approaches which involve 'segmentation' of the population – with the recommendation of strategies to meet different needs of those groups including current treatment populations and emerging populations such as users of novel psychoactive substances.

4.4 More nuanced approach to recovery

4.4.1 ACMD would also welcome a more nuanced approach to 'recovery'. As outlined in recent ACMD reports, recovery is a wide concept that involves improving outcomes in a range of domains including substance misuse, health and wellbeing and being a participating member of a community. Recovery should not be equated purely with abstinence from drugs. Evidence indicates that although many drug users will overcome freedom from drug dependence, many will not do so by being totally abstinent from drugs: however, many may achieve a wider range of recovery outcomes.

4.4.2 For long term heroin users with significant or complex problems and/or few assets, extended medication assisted recovery may be required to prevent relapse and reduce the likelihood of drug-related deaths and time limited treatment is not appropriate. There is a relatively small group of opiate users for whom mainstream opiate substitution treatment is not effective. Heroin-assisted treatment has proven to be effective (and cost-effective) for this group (Byford *et al.*, 2013; Strang *et al.*, 2015) and it should be made available to those patients who need it.

4.5 More nuanced approach to key performance indicators

4.5.1 Similarly, ACMD would welcome a more nuanced approach to key performance indicators (KPI's) for drug treatment – which can recognise what successful achievement of a range of recovery outcome looks like for a diverse range of groups of drug users. It is critical that the drug strategy key performance indicators do not unwittingly stigmatise those who cannot overcome their drug dependence, or 'complete treatment'.

4.5.2 The ACMD would welcome a wider set of KPI's which included better recognition of a wider range of recovery outcomes. Similarly ACMD would welcome drug strategy reference to strategies and KPI's to reduce drug related harm including reducing drug-related acute health incidents and deaths and the spread of drug related blood borne virus' and infections.

- 4.5.3 ACMD previous reports also stress the vital contributions required by ‘mainstream’ services to enable drug misusers to achieve a range of recovery outcomes. We have drawn attention to the difficulties in access that some drug users face in getting critical support to help them achieve wider recovery outcomes including access to treatment for mental health problems, access to volunteering, training and job opportunities and housing that can promote recovery.
- 4.5.4 The ACMD therefore recommends that the drug strategy creates levers and advocates the use of mainstream health, social care, housing and social welfare resources and responsibilities to support drug users. Specifically, drug users with dual diagnosis should be given access to mental health and drug treatment from mainstream mental health budgets in line with mental health services having a lead role for the treatment of this group. Similarly bespoke programmes to enable drug users on recovery pathways (including medication assisted recovery) should be available to enable access to recovery-friendly housing, volunteering, employment, education and training.

4.6 Implementation of evidence based interventions

- 4.6.1 ACMD reports have also highlighted an apparent lack of implementation of some evidence-based interventions recommended by NICE and UK clinical guidelines including Family Therapy, Behaviour Couples Therapy and contingency management. ACMD urge the drug strategy to find levers to ensure evidence-based interventions are available in all areas. Some barriers appear to be financial – even though these interventions have been proven to be cost-effective they cost more to deliver eg requiring qualified staff, more frequent drug testing etc.

4.7 How to deal with ‘localism’ of drug services?

- 4.7.1 Several ACMD members questioned the cohesiveness of the drug strategy given that the delivery services are devolved locally and whether decisions made centrally would or could be impacted locally and universally given differences in local priorities, capability and capacity. This, however, would present an extra workload to local services, already feeling the effects of reduced budgets.
- 4.7.2 There is an opportunity to improve maternity and early childhood services for parents who have problems with drugs. These are currently poor in many areas, with staff often displaying stigmatising attitudes that deter parents from engaging

with services that could otherwise help to improve their parenting and the resilience of their children. The keys here are to create better integration between efforts carried out under the drug strategy and maternity and early years, education, mental health (including child and adolescent) and criminal justice services (including police, CPS, courts, prisons, probation and CRCs).

4.8 Development of improved metrics to monitor use and recovery

- 4.8.1 As noted during the ongoing work of the ACMD Psychoactive Substances Impact Working Group there is a clear role for the centre in reviewing the veracity of current metrics, including the refinement of existing metrics where necessary, to improve the evidence base underpinning and providing measures of the impact of the strategy. For example, there is scope to extend measurement and/or reporting of treatment outcomes that are indicative and to reconsider the baselines against which changes in target populations occur alongside more complex factors.
- 4.8.2 Where possible, metrics should take account of differing and changing levels of complexity within the drug treatment population. For example, the expected outcomes for younger, less established, heroin users might be better than those for older users who have more complex and entrenched problems. Similarly, outcomes for Opiate or Crack Users (OCU's) are likely to be more pessimistic than those for non-OCUs.
- 4.8.3 Further, in developing metrics it is necessary to consider that the baseline population is changing: for example, that the number of opiate users is likely to be declining and that this population is ageing. This is particularly pertinent for metrics, such as drug related deaths, that are reported on the basis of their occurrence in the general population, where the size of the target population is not considered. A focus on, for example, reducing the number of drug related deaths might fail to take note of important changes in the rate of such deaths and is likely to be confounded by the increased background risk of fatal overdose that is known to occur as opiate users age (Pierce *et al.* 2015).
- 4.8.4 As far as possible, metrics should consider the rate of occurrence of outcomes in the target population. This is made more complex due to imprecision in the available estimates of prevalence, which may confound comparison by epoch or sub-group. However, Public Health England (PHE) and others have made

significant progress in case linkage of datasets for large drug user cohorts, providing a partial solution to calculating outcome rates.

- 4.8.5 There may be scope to review and refine some current metrics, for example, as we understand it, the current measure of clients who complete treatment successfully and who do not return to treatment includes, as a positive outcome, those clients who do not return to treatment as a consequence of having suffered a fatal overdose (Pierce *et al.* 2015).

4.9 Review of the Crime Survey for England and Wales

- 4.9.1 The Crime Survey for England and Wales (CSEW) provides an enormously valuable resource in terms of assisting our understanding of patterns and the prevalence of drug use. We suggest that, in addition to prevalence of past year use, we maximise its utility by prioritising those questions asked and including the prevalence of frequent use, which may be more indicative of use that may cause problems.
- 4.9.2 We also recommend that maintaining and expanding the drug misuse element of the CSEW should be afforded as much priority as possible, given its value as an indicator in this key policy area. CSEW should be reviewed in line with impact analysis of the PSB, and as part of the Drug Strategy document.

4.10 Integrated recovery pathways

- 4.10.1 We feel the strategy focusses very much on youth. Whilst this cohort are extremely significant because this is about prevention of young people getting involved in drug use, current service users also need targeting in order to motivate them and offer interventions to assist them to recover from their current use.
- 4.10.2 Whilst the strategy refers to wider recovery for individuals, and includes issues around housing, employment and family support, we don't think it goes far enough to fully integrate a 'recovery' pathway.
- 4.10.3 The strategy should move away from isolated interventions for substance misuse and encourage all organisations involved with drug users (and not just specific treatment providers) to have a holistic approach to an individual's recovery, of which substance misuse is a part.

5.0 Additional

5.1 Clarification of the roles of MDA and PS Bill

- 5.1.1 A major concern that most ACMD members share is that the revised drug strategy makes no mention of the relative roles played by the MDA and the PSB. While the MDA makes possession of illicit drugs a criminal offence, the PSB does not. This seems inequitable. A minority view of two ACMD members was that the current staged response to drug offences, and the deterrent effect of penalties for possession, were adequate. The intention to divert drug users away from a criminal path to a psychosocial/treatment path is positive and ACMD are keen to see this implemented.
- 5.1.2 There is currently no consensus view on whether punitive measures do or do not have an effect on the prevalence of illicit drug use. A common argument used against reducing the harms and costs imposed through the criminalisation of drug possession is that removal of criminalisation would lead to an increase the prevalence of illicit drug use. The role of punitive measures in reducing prevalence is not borne out by Home Office research (Home Office, 2014) that suggested that national rates of drug use were not generally lower in countries which take a more punitive approach to drug possession. Similarly, peer-reviewed studies have not found that removing criminal penalties for possession is associated with higher rates of drug use (Degenhardt & Hall, 2012; Vuolo, 2013). A recent article (Shi *et al.*, 2015), which suggested 'liberalisation' of laws on cannabis possession was associated with higher use among adolescents, was found to suffer from misinterpretation of its own results. Correct interpretation of the results of the statistical models produced by these authors' shows that 'liberalisation' had very little, if any, association with rates of use (Rogeberg *et al.* 2016).
- 5.1.3 ACMD need to be consulted and agree their role in relation to the operation of the MDA and PSB. ACMD's future role of "Temporary Class Drug Orders" and ACMDs role in monitoring psychoactive substances entering the UK, at a rate of approximately two per week, and the interpretation of complex genetic descriptions remains unclear. ACMD strongly believe a clear statement of the roles of MDA and PSB should be included as part of the Drug Strategy.

5.2 Consultation with ACMD throughout the life of the Drug Strategy

5.2.1 ACMD are keen that they are consulted with regard to further developments of the Drugs Strategy and related documents. ACMD recommend that clear review points are set within the life of the Drug Strategy at which point ACMD are consulted, the evidence base supporting current proposals re-examined and bolstered the strategy adjusted to reflect the best available evidence.

PERTINENT ACMD RECOMMENDATIONS SINCE 2013

1. How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users? (2015)

<https://www.gov.uk/government/publications/how-can-opioid-substitution-therapy-be-optimised-to-maximise-recovery-outcomes-for-service-users>

- Government and local areas should protect the investment in recovery-orientated drug treatment and recovery systems, and prevent disinvestment.
- Local areas should strive for a culture of stability and quality improvement in drug treatment. The 'churn' in services and staff through frequent re-procurement is impacting on the quality of OST, particularly if local budgets are reduced. We urge local authorities not to engage in costly and disruptive re-procurement if systems are recovery-orientated and achieving adequate outcomes.
- Government should implement a national quality improvement programme for recovery-orientated OST and ensure implementation of evidence-based practice.
- Local areas should ensure all local drug treatment and recovery systems have enough community and residential abstinence pathways and ongoing recovery support.
- Discrimination and stigmatising of those in medication assisted recovery should be tackled at all levels: nationally; among local health services; among employers; and in local communities.
- Further research should be undertaken to build the UK research evidence on recovery-orientated treatment and interventions for heroin users.

2. Cocaine Powder: review of its prevalence, patterns of use and harm (2015)

<https://www.gov.uk/government/publications/cocaine-powder-review-of-its-prevalence-patterns-of-use-and-harm>

- Public Health England, the Home Office and Devolved Administrations to continue monitoring the outputs of the population surveys and treatment presentations for

any emerging indications of an increase in the prevalence of cocaine powder dependence.

- Local Authority based public health commissioners (and the equivalent in Devolved Administrations) of drug treatment services to ensure that local services for the treatment of cocaine powder are sufficient to meet local needs and should ensure that these services are properly accessible to the cocaine powder user group.
- Drug Treatment service providers to ensure that their workforce is competent to deliver cocaine powder treatment/interventions.
- Public Health England and the Devolved Administrations to seek further expert advice from suitable health professionals and academics regarding the development of assessment and brief intervention models for cocaine powder and other substances, for use in generic settings.
- The Department of Health, NHS England, the Ministry of Justice and Devolved Administrations to ensure that key staff working in primary and acute health services, and criminal justice services, be better equipped to identify problems that may be related to illicit drug use; including cocaine powder (and cutting agents), to ensure early identification and appropriate intervention including referral for treatment, where indicated.
- In line with the ACMD's Prevention briefing, the ACMD recommends that Public Health England, Local Authorities and schools ensure the issues surrounding cocaine powder are embedded within education initiatives about generic substance use prevention.
- The ACMD does not consider that it would be appropriate, or helpful, for mass education initiatives that specifically highlight cocaine powder.

3. Prevention of drug and alcohol dependence (Feb 2015)

<https://www.gov.uk/government/publications/prevention-of-drug-and-alcohol-dependence>

- The IoM Prevention taxonomy should be accepted as a first step towards a common prevention language
- Commissioners of prevention activities should be mindful that drug and substance use prevention is likely to have only limited effects as a standalone activity.

Prevention activities should be embedded in general strategies that support development across multiple life domains.

- Prevention projects should incorporate evaluation, and be developed from the findings of evaluation (ideally with economic evaluation)
- Policy stakeholders should be mindful that prevention of adverse long-term health and social outcomes may be achieved even without drug abstinence, although for some target groups' drug abstinence may be preferable.

4. Ketamine: a review of use and harm (Dec 2013)

<https://www.gov.uk/government/publications/ketamine-report>

- Policy stakeholders should be mindful that prevention of adverse long-term health and social outcomes may be achieved even without drug abstinence, although for some target groups' drug abstinence may be preferable.
- Ketamine should be considered as dependence forming for some users and treatment services need to be able to respond to this need with NICE-recommended psychosocial interventions.
- The scale of ketamine supply to the UK is unknown due to challenges with identifying border seizures of the drug. Testing at the border should be made more effective by providing the technology to accurately field test.
- The new Chief Coroner should promote awareness of the importance of accurately documenting ketamine and other substance-related deaths.

5. What recovery outcomes does the evidence tell us we can expect? (Nov 2013)

<https://www.gov.uk/government/publications/acmd-second-report-of-the-recovery-committee-november-2013>

- Policy makers, commissioners and treatment and recovery providers look at the different populations of those dependent on drugs or alcohol or in recovery separately (or segment the population) to gain a better understanding of the recovery potential of different groups and target interventions more appropriately.
- Policy makers and commissioners of local systems take an extensive or longer-term approach to recovery from drug and alcohol dependence, with caution around policy initiatives and local systems that expect recovery to occur in the

short term for the majority who require treatment without longer-term interventions to support sustained recovery.

- Local commissioners and providers of recovery-oriented systems should support initiatives to build recovery capital in a *range* of recovery outcome domains to enable sustained recovery. A narrow focus on drug and alcohol dependence outcomes without helping individuals build broad-based recovery capital will not maximise recovery outcomes – especially for those with severe and complex dependence on heroin, crack or alcohol and other co-existing problems acquired prior to dependence or during dependence.
- Commissioners, providers, mutual aid groups and local communities should support the development of recovery-orientated drug and alcohol treatment systems.
- The focus on recovery from heroin dependence is welcome but we urge an evidence-based approach which tempers optimism with a recognition that achieving recovery outcomes from heroin dependence is very challenging, especially for those living in a state of ‘capital deprivation’. The push for recovery-orientated opioid-medication-assisted treatment (without blanket time limits) with interventions to maximise outcomes in all recovery domains is commended and should be supported by commissioners and providers.
- Local commissioners and providers should invigorate a focus on achieving health and wellbeing outcomes, especially for those with alcohol and heroin dependence.
- Development of UK mutual aid and Recovery Community Organisations is positive and should be encouraged in local communities by local commissioners, providers and other stakeholders.
- Initiatives are implemented to tackle stigma around recovery from drug and alcohol dependence, especially among employers, media and local communities. A culture should be created where recovery is acceptable and, where possible, celebrated.
- Government should commission additional work to examine in depth international recovery outcome studies to understand the variation in outcome results in similar groups and to glean good practice from studies yielding higher rates of recovery on how to maximise recovery outcomes among different groups (e.g. different substances, genders and ages).

- Government should commission UK long-term studies of recovery from drug and alcohol dependence (not just among those who receive formal treatment), to inform policy and practice.

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