**Analysis of the UK Government’s 10-Year Drugs Strategy – a resource for practitioners and policymakers**

Dr Adam Holland, Honorary Research Fellow, Bristol Medical School, University of Bristol, BS8 2BN, UK

Prof Alex Stevens, Professor, School of Social policy, Sociology and Social Research, University of Kent, CT2 7NZ

Dr Magdalena Harris, Associate Professor, Department of Public Health, Environments and Society, London School of Hygiene & Tropical Medicine, WC1E 7HT, UK

Dr Dan Lewer, Public Health Specialty Registrar, Department of Epidemiology and Public Health, University College London, WC1E 6BT, UK

Prof Harry Sumnall, Professor, Public Health Institute, Liverpool John Moores University, L3 5UX, UK

Mr Daniel Stewart, Public Health Specialty Registrar, Bristol Medical School, University of Bristol, BS8 2BN, UK

Prof Eilish Gilvarry, Honorary Professor, Population Health Sciences Institute, Faculty of Medical Sciences, Newcastle University, NE1 7RU, UK

Ms Alice Wiseman, Alcohol and Drugs Lead, Association of Directors of Public Health, EC4Y 0HA, UK

Dr Joshua Howkins, Public Health Specialty Registrar, NHS Grampian, Aberdeen, AB15 6RE, UK

Prof Jim McManus, President, Association of Directors of Public Health, EC4Y 0HA, UK

Dr Gillian W Shorter, Lecturer, School of Psychology, Queen’s University Belfast, BT7 1NN

Dr James Nicholls, Senior Lecturer, Faculty of Health Sciences and Sport, University of Stirling, FK9 4LA, UK

Dr Jenny Scott, Senior Lecturer, Department of Pharmacy & Pharmacology, University of Bath, BA2 7AY

Dr Kyla Thomas, Consultant Senior Lecturer, Bristol Medical School, University of Bristol, BS8 2BN, UK

Ms Leila Reid, Director of Corporate Services, Hepatitis C Trust, SE1 3YD, UK

Dr Edward Day, Institute of Mental Health, University of Birmingham, B15 2TT

Dr Jason Horsley, Public Health Consultant, National Institute for Health Research Evaluation Trials and Studies Coordinating Centre, University of Southampton, SO17 1BJ, UK

Prof Fiona Measham*,* Professor, Department of Sociology, Social Policy and Criminology, University of Liverpool, L69 3BX

Prof Maggie Rae, President, Faculty of Public Health, NW1 4LB, UK

Prof Matt Hickman, Professor, Bristol Medical School, University of Bristol, BS8 2BN, UK

**Corresponding author:**

Dr Adam Holland – adam.holland@bristol.ac.uk

**Abstract**

In 2021, in the midst of a drug-related death crisis in the UK, the Government published its ten-year drugs strategy. This article, written in collaboration with the Faculty of Public Health and the Association of Directors of Public Health, assesses whether this Strategy is evidence-based and consistent with international calls to promote public health approaches to drugs, which put ‘people, health and human rights at the centre’. Elements of the Strategy are welcome, including the promise of significant funding for drug treatment services, the effects of which will depend on how it is utilised by services and local commissioners and whether it is sustained. However, unevidenced and harmful measures to deter drug use by means of punishment continue to be promoted, which will have deleterious impacts on people who use drugs. A public health approach to drugs should tackle population level risk factors which predispose to harmful patterns of drug use, including adverse childhood experiences and socioeconomic deprivation, and institute evidence-based measures to mitigate drug-related harm. This would likely be more effective, and just, than the continuation of policies rooted in enforcement. A more dramatic re-orientation of UK drug policy than that offered by the Strategy is overdue.

**Keywords**

Drugs; Policy; Strategy; United Kingdom; Drug-related deaths

**Introduction**

In December 2021, the UK Government published its 10-year drugs strategy, *From Harm to Hope* (1) (hereafter referred to as ‘the Strategy’) following Dame Black’s Independent Review of Drugs (2). The Strategy has been published during a period of escalating drug-related deaths in the UK (3-5) surpassing the rates of many countries (6). The following analysis, undertaken with the Faculty of Public Health and Association of Directors of Public Health, assesses whether the Strategy is evidence-based and consistent with calls from the highest coordination forum of the United Nations to ensure drug strategies promote public health and human rights (7). The Strategy is structured under three strategic priorities: to ‘Break drug supply chains’, ‘Deliver a world-class treatment and recovery system’, and ‘Achieve a generational shift in demand for drugs’. This article discusses drug-related harm in the UK, the Strategy’s three pillars, and highlights missing elements of policy.

**Drug-related harm in the UK**

The Black review was undertaken to explore what could be done to reduce drug-related harm in the UK (2), informing elements of the subsequent drugs strategy. Drug-related harms encompass the negative health and social impacts associated with illicit drug use, and drug market involvement. As acknowledged by the Black review (2) and the Strategy, current policy and practice has not effectively reduced many of these harms. Many health and social issues including socioeconomic deprivation, mental and physical health problems, stigma, trauma, and homelessness are associated with more harmful patterns of drug use. These issues may both predispose to and be exacerbated by drug dependence.

Amongst the health harms directly related to drug use, drug-related deaths provide the most obvious metric. Between 2010 and 2019, age standardised drug-related mortality rates increased in Scotland by 171% (from 90 to 244 per million) (4); Northern Ireland by 149% (from 35 to 87 per million) (5); and England and Wales by 61% (from 31 to 49 per million) (3). It is not clear from the Strategy or previous analyses what has caused these increases (2,8). A common argument is that deaths have increased because people with drug dependencies are older, with comorbidities increasing the risk of overdose. Two recent studies, however, demonstrated ageing alone does not explain the increase (9-10). Other potential contributory factors include: (i) increasing polydrug use, with the risk of opioid overdose increasing with concomitant use of benzodiazepines, gabapentinoids, and alcohol (11-14); (ii) increasing homelessness and incarceration, which are associated with greater risk of mortality, and human immunodeficiency virus (HIV) and hepatitis C (HCV) transmission (15-17); (iii) changing patterns of socioeconomic deprivation, which is strongly associated with drug-related harm (18-20); and (iv) cuts to services that would otherwise protect against all-cause and drug-related mortality (2,20-21).

The Strategy makes some unsupported assumptions about the relationship between drugs and social problems. It suggests that drugs ‘blight’ neighbourhoods, stopping them from reaching their potential. This implies drugs cause socioeconomic deprivation, as opposed to the contrary. Socio-economic deprivation and adverse childhood experiences are inter-related (22), and both are associated with more harmful patterns of drug use (18-19,23). Furthermore, disinvestment in health and social services in socioeconomically deprived areas may have contributed to increasing levels of harm since 2010 (21).

Harms to third parties related to drug use and markets include acquisitive crime and drug-related violence. However, in some instances the Strategy exaggerates the causative relationship between drugs and crime. For example, it states drugs ‘contribute’ to almost half of all homicides. In 2020, 48% of homicides were related to drugs in some way – in most cases, either the victim or perpetrator was known to be a person who uses or deals drugs, and sometimes were under the influence of drugs at the time (24). In a small proportion of cases the suspects’ motives were related to obtaining drugs or stealing drug proceeds (24), but for the most part it is not clear that drugs caused the homicides, and in no cases is it clear that stricter drug controls would have prevented them.

**Breaking drug supply chains**

The first pillar of the Strategy aims to reduce drug availability by targeting supply chains, including international, wholesale, and retail providers; with a particular focus on ‘county lines dealing’ (when illicit drugs are transported from major cities to other areas, and sold using a mobile phone ‘line’). There is some evidence that limiting the supply of a drug increases its purity adjusted price (25), which can reduce demand for that drug (26), thereby reducing hospital attendances and overdoses related to its use (27). There are, however, three issues with enforcement-led approaches to reduce drug supply.

First, there is limited evidence of their effectiveness. The Government’s evaluation of the 2010 Drug Strategy highlighted there is a lack of evaluative research in this area (28) and available evidence does not suggest that arresting dealers or seizing drugs has a long-term impact on supply (29). Internationally, there have been some isolated reductions in drug supply, for example, after global market disruption interrupted heroin supply in Australia in 2000 (30) and Western Europe in 2010 (31); and controls on precursor chemicals in the USA in 1989 and 2006 impacted cocaine availability (32). These reductions were, however, temporary, and it is not clear what caused them when other international efforts have not had the same effect. Despite recent drug seizures, such as those reported in the Strategy, global production and purity of drugs continues to increase (33) and the UK has amongst the cheapest and most affordable heroin and cocaine in Europe (34).

Second, there is limited understanding of how restricting the supply of certain drugs affects the supply of, demand for, and harm related to other drugs. For example, during ‘droughts’ of specific drugs, people may use adulterated drugs, alternative drugs, or resort to polydrug use (35-38).

Third, law enforcement measures to restrict drug supply may have unintended consequences on the drug market and people who use drugs, leading to increased levels of harm. Focussing on the most violent and exploitative forms of drug supply, such as those associated with county lines dealing (39) may shape the market to adopt less harmful practices (40-41). However, as the Black Review highlighted (2), arresting suppliers can create conditions that favour competition, promoting innovation and violence (40-50).

**Delivering a world-class treatment and recovery system**

The second pillar of the Strategy aims to rebuild treatment services following significant public sector cuts; promote integration of drug treatment, health, and criminal justice services; and improve employment and accommodation opportunities.

Additional drug treatment funding promised by the Strategy is welcome, however this follows years of sustained disinvestment (2), which has been associated with reductions in numbers of people in treatment (51), and an increase in the proportion of people who use opioids and crack cocaine not engaged with services (52). Furthermore, drugs workers have experienced increasing caseloads and greater administrative responsibilities, sometimes limiting the capacity of services to provide psychosocial interventions (53).

The Strategy suggests ‘recovery from drug addiction’ is a key aspect of its approach. As the UK Government Recovery Champion highlights, recovery and harm reduction should not be considered as opposing approaches, and it is necessary to provide a full range of evidence-based interventions (54). Opioid agonist therapy (OAT - treatment of opioid dependence with methadone or buprenorphine) reduces the risks of all-cause mortality, overdose, suicide, self-harm, HIV and HCV; and improves quality of life (15,55-60) and duration of OAT improves survival (61-64). Whilst model projections demonstrate that comprehensive OAT and harm reduction programmes reduce drug-related mortality (65-66) this is dependent on retention in treatment, which should be a key performance indicator. Focusing on treatment completion may incentivise premature OAT cessation, limiting the benefits of treatment and the impact of the new funding promised by the Strategy.

Increased funding and targeted commissioning could allow the introduction of innovative interventions, including drug checking services and diamorphine-assisted treatment - neither of which are mentioned in the Strategy. No intervention alone can avert the drug-related death crisis, but in combination with wider treatment systems, these evidence-based interventions could have beneficial impacts on patterns of drug use and harms (67-70). Local areas may need additional funding and technical support to commission diamorphine-assisted treatment, which is more expensive than oral OAT (71). These costs, however, are more than compensated by savings to wider services, including those related to reductions in acquisitive crime (71). Drug checking, on the other hand, is beginning to expand, as the first regular Home Office licensed, local authority funded drug checking service in the UK has recently launched in Bristol (72).

Despite their relevance for drug-related harm, HCV and HIV prevention are not mentioned in the Strategy. 89% of people infected with HCV in the UK have injected drugs (73) and a recent outbreak of HIV occurred amongst people who inject drugs in Glasgow (74). The UK is a leader in providing HCV treatment for people who inject drugs, which has led to clear reductions in chronic infections and liver-related deaths (9,75-78). However, achieving the World Health Organisation (WHO) target of “eliminating HCV as a public health problem” (73) will depend on preventing reinfection among people who inject drugs, with HCV infection a critical indicator for assessing the success of drug treatment and harm reduction systems (79).

People with drug dependence often have co-occurring health problems. People who use drug treatment services are getting older and more deaths are now caused by long-term conditions than by overdoses (9,80). 63% of people starting drug treatment have a mental health need (52) and people with substance dependence are at greater risk of suicide (81). As the Strategy highlights, it is necessary to improve integration and continuity of care between healthcare and drug treatment services. This is highlighted by a recent study demonstrating one in fourteen opioid-related deaths in England occur amongst people recently discharged from hospital (82). Additionally, drug services will need to recruit more clinically trained staff to identify and manage these issues, which will be challenging as the specialised workforce has been impacted by years of disinvestment. Furthermore, hospital care for people with drug dependence requires improvement. Stigmatising attitudes towards people who use drugs and fear of opioid withdrawal are key barriers to healthcare access (83-85), underpinned by hospital policies that create numerous procedural barriers to providing OAT with significant geographical variability (86).

Drug-related harm remains a key issue in prison, with overdose risk substantially elevated in the month following release (87-89) and incarceration a risk factor for HIV and HCV (17). Prison OAT reduces mortality and drug use in prison and critically also mortality following release (90-91). Alternatives to prison OAT proposed in the Strategy, including detoxification, are experimental and it is necessary to demonstrate they do not increase drug-related deaths (in and out of prison) compared to OAT.

The Strategy’s proposed zero-tolerance approach to drugs is inconsistent with the Inspectorate of Prisons acknowledgement of the important role of harm reduction strategies in prison settings (92). Evaluations of previous Drug Recovery Wings, which utilised abstinence and harm reduction-based approaches, highlighted their potential benefits but identified challenges, particularly related to a lack of support on release (93). The Strategy recognises the need for improved inter-agency coordination during and following incarceration, however recommendations from the Advisory Council on the Misuse of Drugs to improve custody-community transitions have not been realised (94).

**Achieving a generational shift in the demand for drugs**

The third pillar of the Strategy aims to reduce the demand for drugs by applying ‘tougher and more meaningful consequences’ to deter use, including ‘tough consequences out of court disposal schemes’; delivering education programmes in schools; and supporting at risk families.

The Strategy suggests that the threat of punishment will reduce demand. This is, however, not supported by evidence, and there is no clear relationship between the stringency of drug laws and drug use prevalence (95-99). The Home Office previously concluded “levels of drug use are influenced by factors more complex and nuanced than legislation and enforcement alone” (100). These include socioeconomic deprivation (18) and adverse childhood experiences (23); predisposing factors that may be exacerbated by the health and social harms associated with contact with the criminal justice system (101). Additionally, the stigma associated with punitive policies may deter people with drug dependence from seeking support (102).

The proposed ‘tough consequences out of court disposal schemes’ provide an opportunity to divert people who use drugs from the criminal justice system. Available evidence tentatively suggests that diversion schemes reduce re-offending more effectively and cost-effectively than criminal sanctions (103-106). However, there is limited research evaluating their impacts on drug-related harms (107). Existing diversion schemes use different approaches, and it is not clear what form the proposed schemes will take. With further detail expected in a forthcoming White Paper, the Strategy proposes sanctions including referrals to drugs awareness courses, curfews, the temporary removal of passports or driving licenses, fines; and in some cases, requirements to attend drug treatment. Whilst these approaches may mitigate some of the harms associated with criminal sanctions, most are designed to have significant negative impacts on people who use drugs, which may exacerbate the issues that predispose to harmful drug use. Furthermore, coerced treatment, and mandatory drug testing, which is also supported by the Strategy, contravene accepted norms in medical ethics (108), and there is limited evidence that coerced treatment reduces future drug use (108-109).

The Strategy proposes to ensure ‘more people face the consequences of their use’. By ‘widening the net’, more people will receive punishments of some kind, which may escalate to criminal sanctions. It remains to be seen how the schemes will contribute to the stigma faced by people who use drugs, and whether they will reproduce the ethnic and socioeconomic disparities apparent in current drug enforcement. People who are black are nearly nine times more likely to be stopped and searched for drugs than people who are white and are more likely to be arrested, prosecuted, and sentenced to immediate custody (110). Whilst the Strategy recognises the problem of disproportionate policing, the conclusion that sanctions should be applied more universally may be difficult to achieve, given the entrenched nature of the problem, thought to be related to officer biases, as well as more frequent patrols in areas with larger populations of people who are black (111).

**What’s missing?**

The Strategy states it is taking a new approach to reducing drug-related harm. Although it includes some new developments, most elements are a continuation of former approaches proposed in the context of existing legislation, rather than allowing for legislative reform that would decriminalise the possession of drugs and facilitate innovative harm reduction interventions.

The Strategy suggests that decriminalisation risks increasing drug use, however this is not supported by evidence (95-99). Whilst criminalisation has no clear benefits, it causes significant harm to people who use drugs (112). Since the Misuse of Drugs Act 1971 was introduced, more than three million criminal records have been generated for drugs offences (113). In 2017, 60% of prosecutions for drug offences in England and Wales were for possession rather than supply, including 36% for the possession of cannabis (110). In the UK, decriminalisation has been recommended by bodies including the 2019 Health and Social Care Committee on Drug Policy (114); the Royal College of Physicians (115); the Royal Society of Public Health, and the Faculty of Public Health (116). Internationally, more than 30 countries have some degree of decriminalisation (99), and it has been recommended by the highest coordination forum of the UN, comprising the Executive Heads of organisations including the WHO and the UN Office for Drugs and Crime (7).

There is also no indication that legislative barriers, which restrict innovation in harm reduction and treatment will be removed. The Government has resisted the introduction of overdose prevention centres (117), despite promising evidence they could reduce drug-related deaths and engage the most marginalised with services (70,118). The introduction of pilot sites has been recommended by numerous health, academic, and third sector organisations (119), the Advisory Council on the Misuse of Drugs (20), the 2019 Health and Social Care Committee on Drugs Policy (114) and the Scottish Drug Deaths Taskforce (120). Although overdose prevention centres may be provided in the UK with agreement with local law enforcement agencies (121), legislative change and governmental endorsement would facilitate pilot sites, allowing UK based research to evaluate their effectiveness and cost-effectiveness (117). Currently, legislation also creates barriers to providing smoking paraphernalia to engage people who use crack cocaine with services (122), as is the case in other countries (123).

There was no opportunity for public consultation in the Strategy’s development. For other health and social policies, in health research and service commissioning, the views of the public are included as a matter of priority (124-125). Generally, the views of people who use drugs, who entreat that there should be “nothing about us without us” (126), have not been adequately considered when planning responses to drugs (127). Communities who use drugs and UN agencies highlight that consideration of human rights, including the right to non-discrimination should be of primary importance when determining drug strategies (7,128-129). The UK Strategy does not mention human rights, and punitive policies and restrictions on access to harm reduction programmes are often at odds with human rights norms (112,130).

Stigma related to drug use and dependence, including stigma propagated by the language used to describe people who use drugs (131) creates barriers to seeking support and treatment (102). The Strategy identifies the need to reduce stigma. However, this is inconsistent with the language it uses, for example referring to acquisitive crime in terms of “[t]he innocent families whose homes are broken into by addicts seeking to feed their habits” and the Government previously suggested that stigma is a valued means to deter drug use initiation (132). Independent campaigns have been launched to tackle stigma (133,134), but in general, the evidence for the effectiveness of stigma-reduction approaches is limited (135), as the sources of stigma are complex (136), and efforts would need to translate into policy and practice to have meaningful impact.

**Conclusion – prioritising people, health, and human rights**

There are significant inconsistencies between the UK Drugs Strategy and the call from the highest coordination forum of the UN to promote public health approaches to drugs, putting “people, health and human rights at the centre” (7). A public health approach would tackle upstream population factors that predispose to harmful patterns of drug use alongside many other health and social disadvantages. Whilst promised investment in drug treatment is welcome and likely to be beneficial, this alone will not solve the drug-related death crisis. Realising the potential benefits of additional funding and achieving the Government’s ambition to develop a ‘world class treatment and recovery system’ will depend on utilising appropriate metrics, with details awaited of the proposed national outcomes framework; and addressing fundamental flaws in the Strategy’s approach. Furthermore, a public health approach would be based on evidence. Whilst the Strategy states evidence is ‘at the heart’ of its approach, this is not always the case as it continues to promote un-evidenced and harmful measures attempting to deter drug use with punishment.

We believe a public health approach to drugs would be more effective than policies rooted in criminalisation and enforcement. Framing drug use as something deserving of punishment promotes stigmatising attitudes which pose a barrier to accessing support; and approaches that do not adequately consider the views and human rights of people who use drugs. For more than fifty years, this has failed to effect improvements and a more dramatic re-orientation of the UK response to drugs is overdue.

 **Acronyms**

HCV – Hepatitis C (virus)

HIV – Human immunodeficiency virus

OAT – Opioid agonist therapy

UK – United Kingdom

UN – United Nations

USA – United States of America

**Declarations**

**Acknowledgements**

This work was completed in collaboration with the Faculty of Public Health and the Association of Directors of Public Health.

**Funding**

No funding supported this research.

**Conflicts of Interests**

AH is a volunteer harm reduction adviser for the Loop – a not-for-profit drug checking service provider. AS is a trustee for Harm Reduction International. DS is a volunteer for the Loop. JN is a Trustee at Cranstoun, a third sector drug and alcohol treatment provider. JS works as a pharmacist prescriber with a third sector drug and alcohol treatment provider. LR is Director of Corporate Services for the Hepatitis C Trust. ED is the UK Government Recovery Champion. FM is the Director of the Loop.

**References**

1. HM Government. From harm to hope - A 10-year drugs plan to cut crime and save lives. 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/1043484/From\_harm\_to\_hope\_PDF.pdf (accessed 26 May 2021).

2. Home Office and Department of Health and Social Care. Independent review of drugs by Professor Dame Carol Black. 2021. https://www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black (accessed 26 May 2022).

3. Office for National Statistics. Deaths related to drug poisoning in England and Wales: 2020 registrations. 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2020 (accessed 15 Apr 2022).

4. National Records of Scotland. Drug-related Deaths in Scotland in 2020. 2021. https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland/2020 (accessed 15 Apr 2022).

5. Northern Ireland Statistics and Research Agency. Drug-Related Deaths. 2022. https://www.nisra.gov.uk/statistics/cause-death/drug-related-deaths (accessed 15 Apr 2022).

6. European Monitoring Centre for Drugs and Drug Addiction. Drug-related deaths and mortality in Europe - Update from the EMCDDA expert network. 2021. https://www.emcdda.europa.eu/system/files/publications/13762/TD0221591ENN.pdf (accessed 15 Apr 2022).

7. United Nations Chief Executives Board for Coordination. United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration. 2019. https://unsceb.org/sites/default/files/2021-01/2018%20Nov%20-%20UN%20system%20common%20position%20on%20drug%20policy.pdf (accessed 24 May 2022).

8. Public Health England. Understanding and preventing drug-related deaths. 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/669308/Understanding\_and\_preventing\_drug\_related\_deaths\_report.pdf (accessed 16 Mar 2022).

9. Lewer D, Brothers TD, Van Hest N, et al. Causes of death among people who used illicit opioids in England, 2001–18: a matched cohort study. *Lancet Public Health* 2022;7(2).

10. McDonald SA, McAuley A, Hickman M, et al. Increasing drug-related mortality rates over the last decade in Scotland are not just due to an ageing cohort: A retrospective longitudinal cohort study. *International Journal on Drug Policy* 2021;96.

11. Macleod J, Steer C, Tilling K, et al. Prescription of benzodiazepines, z-drugs, and gabapentinoids and mortality risk in people receiving opioid agonist treatment: Observational study based on the UK Clinical Practice Research Datalink and Office for National Statistics death records. *PLoS Medicine* 2019;16(11).

12. McAuley A, Matheson C, Robertson JR. From the clinic to the street: the changing role of benzodiazepines in the Scottish overdose epidemic. *International Journal on Drug Policy* 2022;100.

13. Lyndon A, Matheson C, Robertson JR. Risk to heroin users of polydrug use of pregabalin or gabapentin. *Addiction* 2017;112(9);1580-89.

14. Hill R, Lyndon A, Withey S, et al. Ethanol Reversal of Tolerance to the Respiratory Depressant Effects of Morphine. *Neuropsychopharmacology* 2016;41(3);762-73.

15. Degenhardt L, Grebely J, Stone J, et al. Global patterns of opioid use and dependence: harms to populations, interventions, and future action. *Lancet* 2019;394(10208);1560-79.

16. Stone J, Artenie A, Hickman M, et al. The contribution of unstable housing to HIV and hepatitis C virus transmission among people who inject drugs globally, regionally, and at country level: a modelling study. *The Lancet Public Health* 2022;7(2);136-45.

17. Stone J, Fraser H, Lim AG, et al. Incarceration history and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis. *Lancet Infectious Diseases* 2018;18(12);1397-1409.

18. Marmot M. Fair Society, Healthy Lives - The Marmot Review. *Institute of Health Equity.* 2010. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf (accessed 19 Feb 2022).

19. Kontopantelis E, Buchan I, Webb RT, Ashcroft DM, Mamas MA, Doran T. Disparities in mortality among 25–44-year-olds in England: a longitudinal, population-based study. *Lancet Public Health* 2018;3(12);567-75.

20. Advisory Council on the Misuse of Drugs. Reducing Opioid-Related Deaths in the UK. 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf (accessed 6 Sep 2021).

21. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. Health Equity in England: The Marmot Review 10 Years On. 2020. https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf (accessed 5 May 2022).

22. Lewer D, King E, Bramley G, et al. The ACE Index: mapping childhood adversity in England. *Journal of Public Health* 2020;42(4);487-95.

23. Public Health Wales. Welsh Adverse Childhood Experiences (ACE) Study. 2015. http://researchonline.ljmu.ac.uk/2648/1/ACE%20Report%20FINAL%20%28E%29.pdf (accessed 26 May 2022).

24. Office for National Statistics. Homicide in England and Wales: year ending March 2020. 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2020#drug-and-alcohol-related-homicides (accessed 19 Apr 2022).

25. MacCoun RJ, Reuter P. *Drug War Heresies: Learning from Other Vices, Times & Places.* Cambridge. Cambridge University Press. 2001.

26. Payne J, Manning M, Fleming C, Pham H-T. Trends & issues in crime and criminal justice - The price elasticity of demand for illicit drugs: A systematic review. 2020. https://www.aic.gov.au/sites/default/files/2020-10/ti606\_price\_elasticity\_of\_demand\_for\_illicit\_drugs.pdf (accessed 28 Mar 2022).

27. Hughes C, Hulme S, Ritter A. The relationship between drug price and purity and population level harm. 2020. https://www.aic.gov.au/sites/default/files/2020-07/ti598\_relationship\_between\_drug\_price\_and\_purity.pdf (accessed 13 Apr 2022).

28. HM Government. An evaluation of the Government's Drug Strategy 2010. 2017. https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/628100/Drug\_Strategy\_Evaluation.PDF (accessed 14 Mar 2022).

29. Eggins E, Hine L, Higginson A, Mazerolle L. The impact of arrest and seizure on drug crime and harms: A systematic review. *Trends & issues in crime and criminal justice* 2020;602.

30. Weatherburn D, Jones C, Freeman K, Makkai T. Supply control and harm reduction: lessons from the Australian heroin 'drought'. *Addiction* 2003;98(1);83-91.

31. Griffiths P, Mounteney J, Laniel L. Understanding changes in heroin availability in Europe over time: emerging evidence for a slide, a squeeze and a shock. *Addiction* 2012;107(9);1539-40.

32. Cunninham JK, Callaghan RC, Liu L-M. US federal cocaine essential ('precursor') chemical regulation impacts on US cocaine availability: an intervention time-series analysis with temporal replication. *Addiction* 2015;110(5);805-20.

33. United Nations Office on Drugs and Crime. Global Overview: Drug Demand Drug Supply. 2021. https://www.unodc.org/res/wdr2021/field/WDR21\_Booklet\_2.pdf (accessed 13 Apr 2022).

34. Groshkova T, Cunningham A, Royuela L, Singleton N, Saggers T, Sedefov R. Drug affordability–potential tool for comparing illicit drug markets. *International Journal of Drug Policy* 2018;56;187-96.

35. Harris M, Forseth K, Rhodes T. "It's Russian roulette": adulteration, adverse effects and drug use transitions during the 2010/2011 United Kingdom heroin shortage. *International Journal on Drug Policy* 2015;26(1);51-8.

36. Kesten JM, Holland A, Linton M-J, et al. Living Under Coronavirus and Injecting Drugs in Bristol (LUCID-B): A qualitative study of experiences of COVID-19 among people who inject drugs. *International Journal of Drug Policy* 2021;98.

37. Matheson C, Parkes T, Schofield J, et al. Understanding the health impacts of the COVID-19 response on people who use drugs in Scotland (PWUD). 2020. https://www.cso.scot.nhs.uk/wp-content/uploads/COVSTG2010-1.pdf (accessed 28 Mar 2022).

38. Pascoe M, Radley S, Simmons HTD, Measham F. The Cathinone Hydra: Increased Cathinone and caffeine adulteration in the English MDMA market after Brexit and COVID-19 lockdowns. *Drug Science, policy and Law* 2022;8.

39. Spicer J, Moyle L, Coomber R. The variable and evolving nature of ‘cuckooing’ as a form of criminal exploitation in street level drug markets. *Trends in Organized Crime* 2020;23;301-23.

40. Stevens A. Applying harm reduction principles to the policing of retail drug markets. 2013. https://www.drugsandalcohol.ie/19567/1/MDLE-report-3\_Applying-harm-reduction-to-policing-of-retail-markets.pdf (accessed 14 Mar 2022).

41. Waal H, Clausen T, Gjersing L, Gossop M. Open drug scenes: responses of five European cities. *BMC Public Health* 2014;14(853).

42. Bowlin, Ben. *Criminal Iatrogenesis.* Leicester. British Society of Criminology. 2010.

43. Curtis R, Wendel T. “You're Always Training the Dog”: Strategic Interventions to Reconfigure Drug Markets. *Journal of Drug Issues* 2007;37(4);867-91.

44. Dickenson M. The Impact of Leadership Removal on Mexican Drug Trafficking Organizations. *Journal of Quantitative Criminology* 2014;30;651-76.

45. Bowling B. Transnational criminology and the globalization of harm production. [ed.] Mary Bosworth and Carolyn Hoyle. *What is Criminology.* Oxford. Oxford University Press. 2011.

46. Calderón G, Robles G, Diaz-Cayeros A, Magaloni B. The Beheading of Criminal Organizations and the Dynamics of Violence in Mexico. *Journal of Conflict Resolution* 2015;59(8);1455-85.

47. Moeller K, Hesse M. Drug market disruption and systemic violence: Cannabis markets in Copenhagen. *European Journal of Criminology* 2013;10(2);206-21.

48. Vargas R. Criminal Group Embeddedness and the Adverse Effects of Arresting a Gang’s Leader: A Comparative Case Study. *Criminology* 2014;52(2);143-68.

49. Werb D, Rowell G, Guyatt G, Kerr T, Montaner J, Wood E. Effect of drug law enforcement on drug market violence: a systematic review. *International Journal of Drug Policy* 2011;22(2);87-94.

50. Bretteville-Jensen AL, Mikulic S, Bem P, et al. Costs and Unintended Consequences of Drug Control Policies. 2017. https://rm.coe.int/costs-and-unitended-consequences-of-drug-control-policies/16807701a9 (accessed 13 Apr 2022).

51. Roscoe S, Pryce R, Buykx P, Gavens L, Meier PS. Is disinvestment from alcohol and drug treatment services associated with treatment access, completions and related harm? An analysis of English expenditure and outcomes data. *Drug and Alcohol Review* 2022;41(1);54-61.

52. Office for Health Improvement & Disparities. Adult substance misuse treatment statistics 2020 to 2021: report. 2022. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report (accessed 25 Mar 2022).

53. Day E, Mitcheson L. Psychosocial interventions in opiate substitution treatment services: does the evidence provide a case for optimism or nihilism? *Addiction* 2017;112;1329-36.

54. Home Office and Department of Health & Social Care. UK Government Recovery Champion Annual Report. 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/956729/Recovery\_Champion\_First\_Annual\_Report.pdf (accessed 30 Apr 2022).

55. Santo Jr T, Clark B, Hickman M, et al. Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People With Opioid Dependence: A Systematic Review and Meta-analysis. *JAMA Psychiatry* 2021;78(9);979-93.

56. Padmanathan P, Forbes H, Redaniel MT, et al. Self-harm and suicide during and after opioid agonist treatment among primary care patients in England: a cohort study. *Lancet Psychiatry* 2022;9(2);151-59.

57. Hickman M, Steer C, Tilling K, et al. The impact of buprenorphine and methadone on mortality: a primary care cohort study in the United Kingdom. *Addiction* 2018;113(8);1461-76.

58. Pierce M, Bird SM, Hickman M, et al. Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. *Addiction* 2016;111(2);298-308.

59. Platt L, Minozzi S, Reed J, et al. Needle and syringe programmes and opioid substitution therapy for preventing HCV transmission among people who inject drugs: findings from a Cochrane Review and meta-analysis. *Addiction* 2018;113(3);545-63.

60. Cornish R, Macleod J, Strang J, Vickerman P, Hickman M. Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. *BMJ* 2010;341.

61. Kimber J, Copeland L, Hickman M, et al. Survival and cessation in injecting drug users: Prospective observational study of outcomes and effect of opiate substitution treatment. *BMJ* 2010;341.

62. Nosyk B, Anglin MD, Brecht, M-L, Dias V, Hser Y-I. Characterizing durations of heroin abstinence in the California Civil Addict Program: results from a 33-year observational cohort study. *American Journal of Epidemiology* 2013;117(7);675-82.

63. Hser Y-I, Hoffman V, Grella CE, Anglin MD. A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry* 2001; 58;503-8.

64. Termorshuizen F, Krol A, Prins M, Geskus R, van den Brink W, van Ameijden EJC. Prediction of relapse to frequent heroin use and the role of methadone prescription: an analysis of the Amsterdam Cohort Study among drug users. *Drug and Alcohol Dependence* 2005;79(2);231-40.

65. Stone J, Degenhardt L, Grebely J, et al. Modelling the intervention effect of opioid agonist treatment on multiple mortality outcomes in people who inject drugs: a three-setting analysis. *Lancet Psychiatry* 2021;8(4);301-9.

66. Irvine MA, Kuo M, Buxton JA, et al. Modelling the combined impact of interventions in averting deaths during a synthetic-opioid overdose epidemic. *Addiction* 2019;114(9);1602-13.

67. Strang J, Groshkova T, Uchtenhagen A, et al. Heroin on trial: Systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction. *The British Journal of Psychiatry* 2018;207(1);5-14.

68. Kilmer B, Taylor J, Caulkins JP, et al. Considering Heroin-Assisted Treatment and Supervised Drug Consumption Sites in the United States. 2018. https://www.rand.org/pubs/research\_reports/RR2693.html (accessed 19 Apr 2022).

69. Maghsoudi N, Tanguay J, Scarfone K, et al. Drug checking services for people who use drugs: a systematic review. *Addiction.* 2021;117(3);532-44.

70. Measham F, Turnbull G. Intentions, actions and outcomes: A follow up survey on harm reduction practices after using an English festival drug checking service. *International Journal of Drug policy* 2021(95)

71. European Monitoring Centre for Drugs and Drug Addiction. EMCDDA Insights - New heroin-assisted treatment. 2012. https://www.emcdda.europa.eu/system/files/publications/690/Heroin\_Insight\_335259.pdf (accessed 22 Feb 2022).

72. Bushby M, Ellson A. First licence for service to test purity of illegal drugs. *The Times* 2022. https://www.thetimes.co.uk/article/first-licence-for-service-to-test-purity-of-illegal-drugs-9fsdzs7p2 (accessed 24 May 2022).

73. UK Health Security Agency. Hepatitis C in England 2022 - Working to eliminate hepatitis C as a public health problem. 2022. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/1057271/HCV-in-England-2022-full-report.pdf (accessed 22 Apr 2022).

74. Ragonnet-Cronin M, Jackson C, Bradley-Stewart A, et al. Recent and Rapid Transmission of HIV Among People Who Inject Drugs in Scotland Revealed Through Phylogenetic Analysis. *The Journal of Infectious Diseases* 2018;217(12);1875-82.

75. Harris RJ, Harris HE, Mandal S, et al. Monitoring the hepatitis C epidemic in England and evaluating intervention scale-up using routinely collected data. *Journal of Viral Hepatitis* 2019;26(5);541-51.

76. Bardsley M, Heinsbroek E, Harris R, et al. The impact of direct-acting antivirals on hepatitis C viraemia among people who inject drugs in England; real-world data 2011-2018. *Journal of Viral Hepatitis* 2021;28(10);1452-63.

77. Byrne CJ, Beer L, Inglis SK, et al. Real-world outcomes of rapid regional hepatitis C virus treatment scale-up among people who inject drugs in Tayside, Scotland. *Alimentary Pharmacology and Therapeutics* 2021;55(5);568-79.

78. Palmateer NE, McAuley A, Dillon JF, et al. Reduction in the population prevalence of hepatitis C virus viraemia among people who inject drugs associated with scale-up of direct-acting anti-viral therapy in community drug services: real-world data. *Addiction* 2021;116(10);2893-907.

79. Yeung A, Palmateer NE, Dillon JF, et al. Population-level estimates of hepatitis C reinfection post scale-up of direct-acting antivirals among people who inject drugs. *Journal of Hepatology* 2022;76(3);549-57.

80. Larney S, Thi Tran L, Leung J. All-Cause and Cause-Specific Mortality Among People Using Extramedical Opioids. *JAMA Psychiatry* 2020;77(5);493-502.

81. Ferrari AJ, Norman RE, Freedman G, et al. The burden attributable to mental and substance use disorders as risk factors for suicide: findings from the Global Burden of Disease Study 2010. *PLoS One* 2014;9(4).

82. Lewer D, Eastwood B, White M, et al. Fatal opioid overdoses during and shortly after hospital admissions in England: A case-crossover study. *PLoS Medicine* 2021;18(10).

83. Muncan B, Walters SM, Ezell J, Ompad DC. “They look at us like junkies”: influences of drug use stigma on the healthcare engagement of people who inject drugs in New York City. *Harm Reduction Journal* 2020;17(53).

84. van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug and Alcohol Dependence* 2013;131(1-2);23-35.

85. Harris M. Normalised pain and severe health care delay among people who inject drugs in London: Adapting cultural safety principles to promote care. *Social Science & Medicine* 2020;260.

86. Harris M, Holland A, Lewer D, et al. Barriers to management of opioid withdrawal in hospitals in England: a document analysis of hospital policies on the management of substance dependence. *BMC Medicine* 2022;20.

87. Binswanger IA, Stern MF, Deyo RA, et al. Release from Prison — A High Risk of Death for Former Inmates. *The New England Journal of Medicine* 2007;356;157-65.

88. Seaman SR, Brettle RP, Gore SM. Mortality from overdose among injecting drug users recently released from prison: database linkage study. *BMJ* 1998;316(7129);426-8.

89. Zlodre J, Fazel S. All-cause and external mortality in released prisoners: systematic review and meta-analysis. *American Journal of Public Health* 2012;102(12);67-75.

90. Durjava L. Effectiveness of prison-based opioid substitution treatment: a systematic review. *MOJ Addiction Medicine & Therapy* 2018;5(4);176-85.

91. Marsden J, Stillwel G, Jones H, et al. Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. *Addiction* 2017;112(8);1408-18.

92. HM Inspectorate of Prisons. Changing patterns of substance misuse in adult prisons and service responses. 2015. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/12/Substance-misuse-web-2015.pdf (accessed 17 Mar 2022).

93. Lloyd C, McKeganey N, Liebling A. The Evaluation of the Drug Recovery Wing Pilots. 2017. https://www.york.ac.uk/media/healthsciences/documents/research/mentalhealthresearch/DRWsFinalPublishedReport.pdf (accesed 22 Apr 2022).

94. Advisory Council on the Misuse of Drugs. Custody-Community Transitions. 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/902762/CMD\_Custody\_community\_transitions\_report\_June\_2019.pdf (accessed 22 Apr 2022).

95. Gabri AC, Galanti MR, Orsini N, Magnusson C. Changes in cannabis policy and prevalence of recreational cannabis use among adolescents and young adults in Europe—An interrupted time-series analysis. *PLOS ONE* 2022;17(1).

96. Stevens A. Is policy 'liberalization' associated with higher odds of adolescent cannabis use? A re-analysis of data from 38 countries. *International Journal of Drug Policy* 2020;66;94-9.

97. Hughes B, Matias J, Griffiths P. Inconsistencies in the assumptions linking punitive sanctions and use of cannabis and new psychoactive substances in Europe. *Addiction* 2018;113(12);2155-57.

98. Scheim AI, Maghsoudi N, Marshall Z, Churchill S, Ziegler C, Werb D. Impact evaluations of drug decriminalisation and legal regulation on drug use, health and social harms: a systematic review. *BMJ Open* 2020;10(9).

99. Eastwood N, Fox E, Rosmarin A. A Quiet Revolution: Drug Decriminalisation Across the Globe. 2016. https://www.release.org.uk/sites/default/files/pdf/publications/A%20Quiet%20Revolution%20-%20Decriminalisation%20Across%20the%20Globe.pdf (accessed 27 May 2022).

100. Home Office. Drugs: International Comparators. 2014. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/368489/DrugsInternationalComparators.pdf (accessed 27 May 2022).

101. Revolving Doors Agency. Balancing Act - Addressing health inequalities among people in contact with the criminal justice system*.* 2013. https://revolving-doors.org.uk/publications/balancing-act/ (accessed 28 May 2022).

102. UK Drug Policy Commission. Getting Serious about Stigma:: the problem with stigmatising drug users. 2010. https://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Getting%20serious%20about%20stigma\_%20the%20problem%20with%20stigmatising%20drug%20users.pdf (accessed 19 Apr 2022).

103. Lösel FA, Koehler JA, Hamilton L, Humphreys DK, Akoensi TD. Strengthening Transnational Approaches to Reducing Reoffending - Final Report. 2018. https://www.cep-probation.org/wp-content/uploads/2018/10/STARR-final-report.pdf (accessed 22 Mar 2022).

104. Holloway K, Bennett T, Farrington D. The effectiveness of criminal justice and treatment programmes in reducing drug-related crime: a systematic review. 2005. https://www.crim.cam.ac.uk/sites/www.crim.cam.ac.uk/files/olr2605.pdf (accessed 22 Mar 2022).

105. Harvey E, Shakeshaft A, Hetherington K, Sannibale C, Mattick RP. The efficacy of diversion and aftercare strategies for adult drug-involved offenders: a summary and methodological review of the outcome literature. *Drug and alcohol review* 2007;26(4);379-87.

106. Stevens A, Hughes CE, Hulme S, Cassidy R. Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession. *European Journal of Criminology.* 2019;19(1);29-54.

107. European Monitoring Centre for Drugs and Drug Addiction. Alternatives to punishment for drug-using offenders. 2015. https://www.emcdda.europa.eu/system/files/publications/1020/TDAU14007ENN.pdf (accessed 14 Apr 2022).

108. Stevens A. The Ethics and Effectiveness of Coerced Treatment of People Who Use Drugs. *Human Rights and Drugs* 2012;2(1), Vol. 2, 1.

109. Werb D, Kamarulzaman A, Meacham MC, et al. The effectiveness of compulsory drug treatment: A systematic review. *The International Journal of Drug Policy* 2016;28;1-9.

110. Shiner M, Carre Z, Delsol R, Eastwood N. The Colour of Injustice: 'Race', drugs and law enforcement in England and Wales. 2018. https://www.release.org.uk/sites/default/files/pdf/publications/The%20Colour%20of%20Injustice.pdf (accessed 15 Mar 2022).

111. Vomfell L, Stewart N. Officer bias, over-patrolling, and ethnic disparities in stop and search. *Nature Human Behaviour.* 2021;5;566-75.

112. Csete J, Kamarulzaman A, Kazatchkine M, et al. Public health and international drug policy. *The Lancet* 2016;387(10026);1427-80.

113. Kincová E, Rolles S. The Misuse of Drugs Act 1971: Counting the Costs. 2022. https://transformdrugs.org/assets/files/PDFs/Misuse-of-Drugs-Act-Briefing.pdf (accessed 15 Mar 2022).

114. House of Commons Health and Social Care Committee on Drugs Policy. 2019. https://publications.parliament.uk/pa/cm201919/cmselect/cmhealth/143/143.pdf (accessed 29 Dec 2021).

115. Royal College of Physicians. RCP supports Royal Society for Public Health report on drug policy. 2018. https://www.rcplondon.ac.uk/news/rcp-supports-royal-society-public-health-report-drug-policy (accessed 22 Mar 2022).

116. Royal Society for Public Health and the Faculty of Public Health. Taking a new line on drugs. 2016. https://www.rsph.org.uk/uploads/assets/uploaded/68d93cdc-292c-4a7b-babfc0a8ee252bc0.pdf (accessed 22 Feb 2022).

117. Holland A, Harris M, Hickman M et al. Overdose prevention centres in the UK. *Lancet Public Health* 2022;7(3).

118. Shorter GW, Harris M, McAuley A, Trayner KM, Stevens A. The United Kingdom's first unsanctioned overdose prevention site; A proof-of-concept evaluation. *International Journal of Drug Policy* 2022;104.

119. Faculty of Public Health. FPH lead cross-sector call to pilot Overdose Prevention Centres in the UK. 2021. https://www.fph.org.uk/news-events/fph-news/fph-lead-cross-sector-call-to-pilot-overdose-prevention-centres-in-the-uk/ (accessed 29 Dec 2021).

120. Scottish Drug Deaths Taskforce. Report on Drug Law Reform. 2021. https://drugdeathstaskforce.scot/media/1248/drug-law-reform-report-sept-6th-21.pdf (accessed 21 Oct 2021).

121. Fortson R, McCulloch L. *Evidence and Issues concerning Drug Consumption Rooms.* 2018. Queen Mary University of London, School of Law.

122. Harris M. An urgent impetus for action: safe inhalation interventions to reduce COVID19 transmission and fatality risk among people who smoke crack cocaine in the United Kingdom. *International Journal of Drug Policy* 2020;83.

123. Prangnell A, Dong H, Daly P, Milloy MJ, Kerr T, Hayashi K. Declining rates of health problems associated with crack smoking during the expansion of crack pipe distribution in Vancouver, Canada. *BMC Public Health* 2017;17.

124. NHS Health Research Authority. Public Involvement. 2022. https://www.hra.nhs.uk/planning-and-improving-research/best-practice/public-involvement/ (accessed 17 Feb 2022).

125. NHS England. Patient and Public Participation Policy. 2017. https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-policy.pdf (accessed 17 Feb 2022)

126. Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute. "Nothing About Us Without Us" - Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical and Human Rights Imperative - International Edition. 2008. https://www.opensocietyfoundations.org/publications/nothing-about-us-without-us (accessed 17 Feb 2022).

127. Ti L, Tzemis D, Buxton JA. Engaging people who use drugs in policy and program development: A review of the literature. *Substance Abuse Treatment, Prevention and policy* 2012;7(47).

128. International Network of People Who Use Drugs. Drug War Peace. 2014. https://www.unodc.org/documents/ungass2016/Contributions/Civil/INPUD/DUPI-Violations\_of\_the\_Human\_Rights\_of\_People\_Who\_Use\_Drugs-Web.pdf (accessed 17 Mar 2022).

129. United Nations Development Programme. International Guidelines on Human Rights and Drug Policy. 2019. https://www.undp.org/publications/international-guidelines-human-rights-and-drug-policy (accessed 17 Mar 2022).

130. Jürgens R, Csete J, Amon JJ, Baral S, Beyrer C. People who use drugs, HIV, and human rights. *Lancet* 2010;376(9739);475-85.

131. The Asian Network of People who use Drugs and the International Network of People who use Drugs. WORDS MATTER! Language Statement & Reference Guide. 2020. https://www.inpud.net/sites/default/files/000596\_INP\_Terminology%20booklet\_v11.pdf (accessed 12 Feb 2022).

132. UK Government. Problem drug use in Scotland: Government response to the Committee’s First Report of Session 2019. 2020. https://publications.parliament.uk/pa/cm5801/cmselect/cmscotaf/698/69802.htm (accessed 19 Apr 2022).

133. Scottish Drug Deaths Taskforce. A Strategy to Address the Stigmatisation of People and Communities Affected by Drug Use. 2020. https://drugdeathstaskforce.scot/media/1111/stigma-strategy-for-ddtf-final-290720.pdf (accessed 22 Feb 2022).

134. NHS Addictions Provider Alliance. Stigma Kills. 2022. https://www.nhsapa.org/\_files/ugd/d8f2eb\_f884f11c3bfe4821abbbc758cc83d7de.pdf (accessed 22 Feb 2022).

135. Lancaster K, Seear K, Ritter A. Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use. 2017. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Reducing%20stigma%20and%20discrimination%20for%20people%20experiencing%20problematic%20alcohol%20and%20other%20drug%20use.pdf (accessed 19 Apr 2022).

136. Strangl AL, Earnshaw VA, Logie CH, et al. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine* 2019;17.