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# Overdose Prevention in Scotland: what can we learn from British Columbia?

Tuesday 14<sup>th</sup> May, The Steeple, Dundee.

## EVENT REPORT

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### 1 Background

This interactive workshop was organised by the Drugs Research Network for Scotland (DRNS) in partnership with Scottish Drugs Forum (SDF) and Dundee City Council. Keynote speakers were Professor Bernie Pauly and Dr Bruce Wallace from the [Canadian Institute for Substance Use Research](#).

There are parallels between British Columbia (BC) and Scotland in terms of general population and a significant challenge associated with drug-related deaths (DRD). In BC the rise in mortality prompted the provincial government to declare a Public Health Emergency which facilitated the introduction of a range of interventions in partnership with academics, provider organisations, and people who use drugs. Community activists had previously set up unsanctioned ‘pop-up’ supervised injecting facilities; safe spaces where people could prepare and inject drugs and where there was support in case of overdose. The Public Health Emergency facilitated rapid change in practice, resulting in 25+ official supervised injection facilities opening across the province. These responses were “[novel and nimble](#)” and have been shown to have saved lives and engaged people who use drugs in harm reduction and treatment services.

The Dundee event brought together key stakeholders, including academic and peer researchers, Scottish Government, Local Authorities, Health and Social Care planners, NHS Health Scotland, technical experts, addiction service providers, Police Scotland, voluntary sector services, family members, concerned community members, students, and people with lived experience of drug use. Professionals paid £10 to attend and 30 free places were made available to unwaged delegates. 107 people booked a place at the event and 95 attended.

Delegates learned about current multi-level approaches to overdose prevention in BC; engaged in small group discussion to explore how learning could be applied in Scotland; shared insights and ideas; and engaged in networking and informal dialogue with speakers.

This report provides an overview of the topics covered during the presentations and discussion groups. Copies of the speakers’ slides and video of their presentations will be available on the DRNS website in due course.

### 2 Organisers



[drns.ac.uk](http://drns.ac.uk)



[dundee.gov.uk](http://dundee.gov.uk)



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

### 3 About the speakers

#### [Prof Bernie Pauly](#)



Bernie is a registered nurse, educator and researcher whose focus is on substance use and promoting health equity in health systems. She is a Professor in the School of Nursing at the University of Victoria and a Scientist at the Canadian Institute for Substance Use Research. Bernie is also a University of Victoria Provost's Community Engaged Scholar and an Honorary Professor at the University of Stirling.

Bernie leads the Canadian Managed Alcohol Program Study which is the first national study to focus on the implementation and impacts of Managed Alcohol Programs in Canada. Bernie is co-investigator on the NIHR-funded 'Supporting Harm Reduction through Peer Support' (SHARPS) feasibility study based at the Salvation Army Centre for Addictions Services and Research at the University of Stirling.

#### [Dr Bruce Wallace](#)



Bruce is an Associate Professor with University of Victoria's School of Social Work, a scientist with the Canadian Institute for Substance Use Research, and the co-chair of the Pacific Housing Research Network (PHRN). His research focuses on substance use and harm reduction, poverty and homelessness and access to health care, including dental care. He is an engaged scholar with many years of community-based research in Victoria employing health equity and social justice approaches to his projects.

Bruce co-leads several research initiatives including analysis of the implementation and impacts of the novel overdose prevention sites established in Victoria BC and a drug checking pilot project and evaluation. Bruce teaches in both the graduate and undergraduate social work program, currently teaching policy and research courses. He was recently awarded the Victoria Community Leadership Award and the University of Victoria Provost's Advocacy and Activism Award.

### 4 Introduction by Dr Tessa Parkes

Delegates were welcomed to the event by [Dr Tessa Parkes](#), Deputy Convenor of DRNS and a member of the Dundee Drugs Commission. Tessa outlined the programme for the day and introduced the speakers.

### 5 Equity Orientated and Informed Overdose Responses

Bernie and Bruce provided an outline of DRD in Canada and BC to give the context in terms of DRD distribution across geography and over time, substances implicated in deaths, the location of deaths and the initial political response.

They described development of the multi-agency Drug Overdose and Alert Partnership, informed by a Community Action Team model, and components of the programmatic response. The response included scale-up of naloxone provision, access to addiction treatment, and overdose prevention sites (also known as safe/r or supervised injecting facilities). They highlighted the involvement of people with lived and living experience of drug use in the response, and the role of community activism in the form of unsanctioned 'pop-up' injection sites and peer involvement in the design of services. Research was also described as a key component in assessing the effectiveness of the response programme overall, as well as the individual harm reduction and treatment components in various settings. They also shared experiential learning regarding challenges, limitations and lessons learned.

## 6 Delegate discussion and discussion

Following the presentation delegates engaged in small group discussions prompted by the following questions:

- What relevance does the work Bruce and Bernie have presented have for us here in Scotland?
- Might an equity-oriented model gain traction here? If so, why? If not, why not?
- What good practice is currently happening in Scotland?
- What barriers and facilitators do you think are relevant?
- What further questions do you have for the speakers that might be helpful in exploring the potential of this model for Scotland?

Each table was joined by a facilitator and a note-taker to capture main discussion points which are presented here using headings from the [Systems Health Equity Lens](#) model described by Bernie in her presentation.

### **Value shift**

- Language is crucial. Focus on overdose prevention sites rather than drugs consumption facilities; problematise deaths not drugs and the people who use them. Help the public and politicians understand what constitutes a Scottish public health emergency.

### **Interpersonal**

- There is lots of talk of 'trauma informed' and 'public health informed' strategies and services, but (how) is this being implemented on the ground? How are we creating healthy, supportive relationships between people?
- There are still examples of punitive culture in addiction services that diminish trust and openness in relationships.

### **Social networks**

- There is an appetite and desire among people to deliver interventions that, although not officially sanctioned, could save lives now, e.g. overdose prevention sites.
- People currently using drugs have existing social networks that can be traumatised by the loss of their peers. How can we engage with people and their networks to support change?

### **Organisations**

- How do we scale up existing harm reduction services across Scotland, taking account of different socio-geographical contexts?
- BC experience demonstrates the need for a widespread, coherent-and-evolving programmatic response. Are we currently focussing on isolated, individual interventions?
- We need services that are flexible, accessible and adapt to people's needs – including low threshold, outreach, and not limited to office-hours.
- We have access to good DRD data, but this is not being used to its full potential, there is a lack of national coordination and annual, retrospective publications don't help inform responses now.
- Existing treatment services and staff are stretched to capacity. We need to review budgets and allocations from national to local levels.

### **Communities**

- The voice of lived experience must be much louder. Not everyone wants to engage in recovery – where are their voices?
- We need to address community and media perceptions of people who use drugs, those in recovery, and those who experience overdose.

- BC aren't just addressing overdoses in isolation but adopting a more holistic approach with people who use(d) drugs.

### **Public policy**

- The shift from Justice to Health is welcome, but there is an urgent need for action – what challenges are associated with NHS and policy-level bureaucracies?
- Decriminalisation and legal protection to open overdose prevention sites is needed now.
- There is growing evidence of need and of what works. Bold changes are needed, yet here we are again talking and not acting – are Scottish policy makers and planners too risk-averse?

## 7 Peer-to Peer support and interventions in overdose prevention

Bernie and Bruce's second presentation outlined their approach to the meaningful and respectful involvement of people with lived and living experience of drugs in the BC response. They described helpful models of peer involvement, basic considerations of language and other factors that make involvement acceptable and accessible for peers. They noted that advocacy and other peer-based organisations paved the way long before public involvement was adopted by statutory services and policy makers. Key barriers to involvement were outlined including labour market discrimination and organisational factors that can make peer involvement impractical. They discussed BC approaches, policies and guidance that were developed to address these barriers in line with the equity-oriented approach. The 'Peer 2 Peer Support Project' was described including their wellness model, methods, findings to date, and plans for development. Other initiatives include a community network of observatories to monitor structural conditions that produce drug-related harms, and cooperative approaches focussed on safe supply.

They concluded by highlighting the need for shifts in organisational cultures and the importance of developing public policies that maximise health for all in need, including harm reduction for people who currently use drugs and the decriminalisation of people, not just substances.

## 8 Small group table discussions on application of the learning of the Scottish context

Delegates participated in small group discussion prompted by the following questions:

- What relevance does the work Bruce and Bernie have presented have for us here in Scotland?
- What good practice is happening here in Scotland and the UK related to peer to peer work?
- What barriers and facilitators do you think are relevant?
- What further questions do you have for the speakers that might be helpful in exploring the potential of peer led work in Scotland?

### **Value shift**

- Scotland should widen its concept of harm reduction (beyond injecting equipment and naloxone provision) and this this was an important aspect of the BC response. Scotland could be bolder. Harm Reduction is a philosophy, not a service.
- How do you define a peer? Actively using or not? Actively using what – methadone and/or illegal substances? In Scotland the majority of peers are abstinent/in recovery, whereas in BC seems to be more peers are current users. What are the implications for development of Scottish harm reduction?
- Recognise that lived experience is unique and not necessarily comparable (drugs and locations change over time)

- In many ways our practices still revolve around punitive measures. It's easier to refer people into detox/rehab if they go into prison, than doing so via the health service at present.
- Challenging values within many services regarding peers. They are seen as recipients not providers of care, are not always trusted by staff, can be stigmatised by being given vouchers not cash, sometimes seen as 'cheap' workers.

### **Interpersonal**

- There are issues for people affected by drug-related deaths, e.g. parents and families, who may be at risk of (relapse into) problematic drug use.
- Peers can be at risk of being retraumatised through their work and need support.

### **Social networks**

- SDF and Scottish Recovery Consortium were highlighted as current examples of genuine peer and community involvement / development.
- The safe supplies club proposed for BC offers a really interesting model – people having knowledge of drugs is really important.
- Advocacy is defined as working within the system to promote change; activism is working outside the system. Both have a role. Protesting has a role to play – this is not about protesting against policymakers and civil servants who are often allies in the cause, rather it is protesting to progress shared political goals that will lead to improvements.

### **Organisations**

- A peer-led take-home naloxone service, with support from a dedicated coordinator has been shown to work in some parts of Scotland, but this model isn't more widely implemented.
- Many statutory sector organisations don't have a good understanding or experience of supporting meaningful peer engagement.
- Stigma is sustained by not providing cash to peers, vouchers are usually the norm for peer involvement. However, pay does affect benefits and it is a huge risk for PWUD to come off benefits
- Although we have a unified Police Scotland – attitudes and responses differ by region.
- In Scotland there is too much emphasis on trying to 'professionalise' peers instead of learning from them.
- Lack of employment opportunities for people who use drugs is a barrier, especially where criminal records associated with drug use (acquisitive crime, possession) are an issue.

### **Communities**

- Activism can help encourage people in power to listen to advocates for change – it is people telling politicians "we need this to happen". Bruce related examples from BC where there were vibrant demonstrations outside political buildings whilst people inside were discussing the same issue and need for supportive action.
- There is a current public interest in DRD. Such interest is helping ensure political support and public awareness of the need for change.

### **Public policy**

- Sometimes the evidence base is limited but this should not hinder important actions. As well as research evidence, look at what people affected by the crisis are telling us – e.g. affected communities advocate for cannabis as an alternative to illicit drugs.

- There are difficulties for people with lived experience to access volunteering and/or employment opportunities in the NHS and government, which are the sectors which would most benefit from people's experience of addiction, the justice and health systems.
- In BC, law enforcement took a position of non-interference with respect to Overdose Prevention Services. Under the Ministerial Order that enabled these services, police input and involvement were not required. There was no need for police authorities to publicly support these services, provide letters of comfort etc. - they just acknowledged this is a health and not a criminal justice issue. This facilitated development of Overdose Prevention Services and avoided the need for protracted interagency discussions and permissions.

## 9 Impact

Media coverage was supportive and enhanced by engagement with journalists in advance and on the day. Coverage included Dundee's [Evening Telegraph](#), [STV News](#) and That's TV local news station. Channel 4 News picked up on Tweets during the event and while they could not send a camera crew to the event, they have noted their intention to visit Bernie and Bruce in BC to report on their work and the applicability to the UK context which will be brokered by DRNS.

## 10 Next steps

Members of the Scottish Government Substance Misuse Unit and Health and Social Care Research Analysis Division attended and confirmed that they would discuss how learning from the event can help inform the Scottish response. The Minister for Public Health, Sport and Wellbeing has announced plans to establish a Drug-Related Deaths Taskforce: an expert group to examine the key drivers of drug deaths and to advise on what further changes, either in practice or in the law, could help to save lives and reduce harm.

The Dundee Drugs Commission and Scottish Affairs Committee Inquiry into Problem Drug Use in Scotland are due to report their findings soon.

DRNS is currently mapping Scottish drug-related death research to inform a gap analysis and develop projects to address evidence gaps.

We will circulate this event report to delegates and make it publicly available to inform ongoing discussion about the Scottish response to drug-related deaths.