

DRUGS AT CREW TREND REPORT 2017-2019

August 2019







Please note that this report contains photos of drugs and drug paraphernalia, and information on drug-related death which some readers may find upsetting.

This document provides an overview of drug trends in Scotland, in the two years from 01 April 2017 to 31 March 2019.

If you would like to volunteer or support the work of Crew, we would love to hear from you!

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or www.crew.scot

Since 1992, Crew has been working in the drugs field to provide credible, non-judgemental and up-to-date information on the drugs that people are taking, so they can make informed decisions about their own health. Over the last few decades, we have documented dramatic shifts in both drug consumption and behaviours.

Crew exists to reduce drug harm and we provide local, Edinburgh-based support services to people who take psychostimulants and we work across Scotland to provide consultancy, training for workers and outreach at festivals and events.

This report was created as a supporting document to the 2018-2019 end of year report for the Emerging Trends and Training Coordinator post, funded by the Scottish Government Substance Misuse Unit.

5 INTRODUCTION

About this report

6 DRUG-RELATED DEATHS

- 12 Introduction
- 13 What is a drug-related death?
- 15 Key figures
- 17 Opioid DRDs
- 20 Depressant DRDs
- 22 Stimulant DRDs
- 24 Ecstasy-type DRDs
- 25 Deaths by age
- 26 Deaths by area
- 27 European drug deaths
- 28 An opioid epidemic

30 DRUG TRENDS

- 31 Introduction
- 32 Timeline
- 33 Stimulants
- 36 Empathogens
- 39 Psychedelics
- 40 Dissociatives
- 42 Cannabinoids
- 47 Depressants
- 52 Opioids
- 53 Naloxone

56 CONCLUSIONS

- 57 Drug-related deaths
- 58 Drug trends
- 59 Overall

60 APPENDIX

Calculations, references and acknowledgements

Drug-related harm in Scotland is rising. The harms caused by drugs and drugs legislation are wide-ranging and, in this report we discuss what they are and how they impact on individuals, families and society. This includes drug-related death, the ultimate drug-related harm, and we delve into the details behind the figures.

Our previous reports focussed on the rise and subsequent fall in use of New Psychoactive Substances (NPS) and the introduction of the Psychoactive Substances Act (2016) (PSA). The PSA was enacted in May 2016, prohibiting the sale of substances capable of producing a psychoactive effect. While the drugs, markets and industries, and society's views are changing, the conservative prohibitionist control of psychoactive substances remains constant.

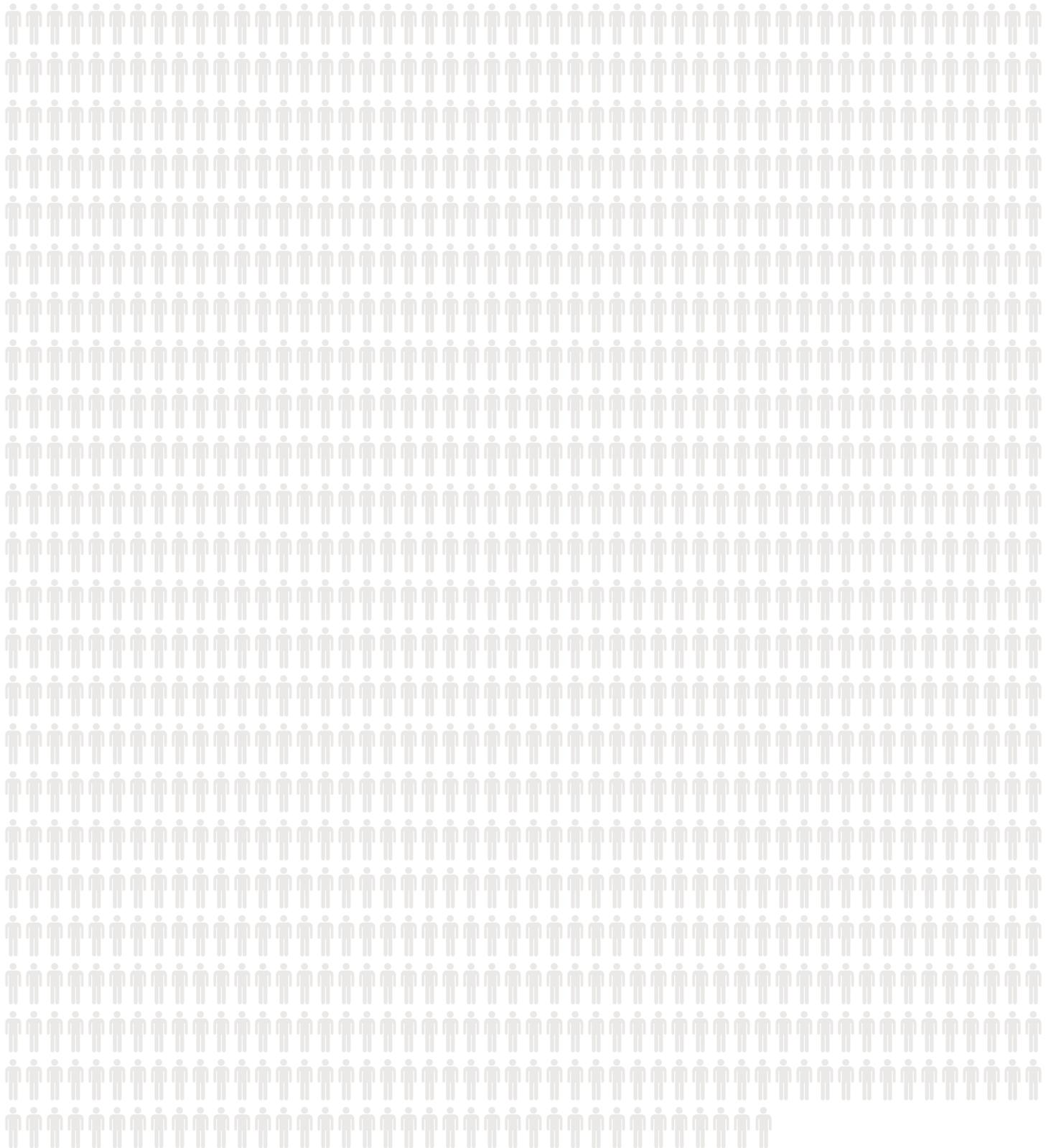
Three years on from the introduction of the PSA, we look at what has changed, what the drugs landscape looks like and what the key trends in the Scottish drug scene are. This report focusses on the most significant drug trends of the last 2 years, if you would like more information, or information on other drugs, please contact Crew or visit our website - www.crew.scot

PREVIOUS REPORTS

This is the fourth drug trend report from Crew. If you want to start at the beginning, click below to view the previous reports:

- [NPS at Crew, Annual Report, 2014-2015 \[1\]](#)
- [NPS at Crew, Annual Report, 2015-2016 \[2\]](#)
- [NPS at Crew, Annual Report, 2016-2017 \[3\]](#)

DRUG-RELATED DEATHS



This chapter discusses drug-related deaths in Scotland. The first 5 pages are statements from friends of Crew who speak openly and bravely about their personal experiences. They tell just a few of the thousands of stories that lie behind the numbers and are a powerful example of the devastating reality of drug-related death in Scotland. We are eternally grateful for their contribution.



"I am in recovery from alcohol and drugs and now work in the addiction field, so have been affected by the very high drug related deaths on a personal and professional level. I am extremely angry, sad and upset at these numbers as I truly believe that many of them could have been avoided.

On a personal level I have lost quite a few friends, the latest one being just last week. I have watched the devastation it has caused to the families. I was very close to being a statistic myself during my addiction, which was also very difficult and that's why I want things to change so that the numbers are drastically reduced. It's a crying shame that Scotland has been named the worst place in Europe for drug related deaths and an even worse shame that so many are losing their lives and becoming just another statistic.

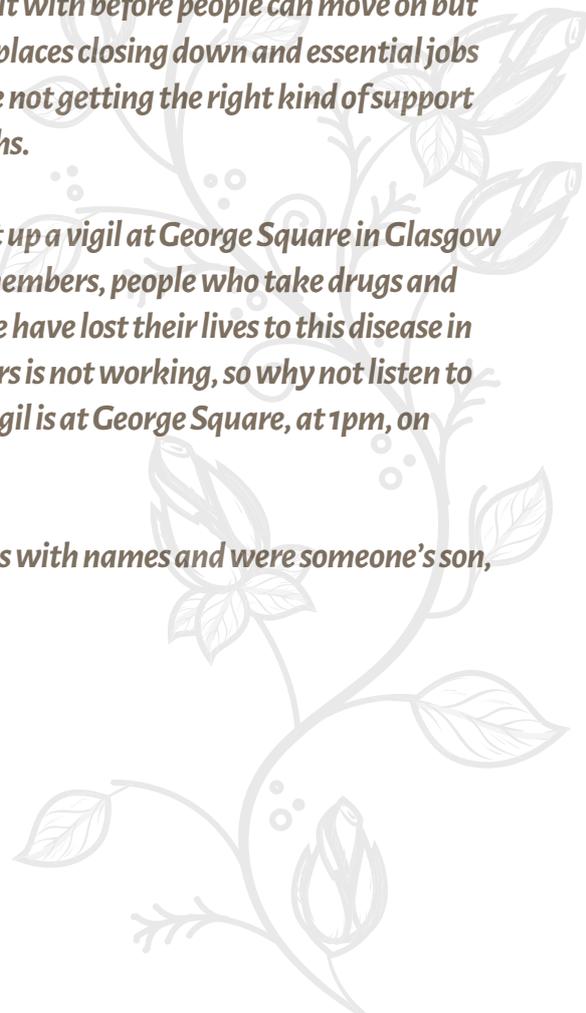
As a professional I find it extremely difficult and demoralising at times because as a person with lived experience I feel that we are not listened to properly. The powers that be don't really have a clue about addiction and what really works. We are kept from telling our stories that could help provide hope to those we are working with. They also put too many rules in place and think of money before the person. We are over worked, under valued, under staffed and paid a pittance for the kind of work we do and the complex people we work with. Is it any wonder that people are dying as they aren't getting the quality of care and support that is needed? I have seen too many people being thrown out onto the streets and far too many who have been put on to ridiculous doses of methadone then left to get on with it and only seen again when they are due their next prescription instead of having support and help to access the recovery options that are available.

It's also well noted that mental health and addiction go hand in hand and yet when someone tries to access mental health help they are told to sort out their addiction first and if they go to see about their addiction they are told to sort out their mental health. Many people have severe underlying traumas and they self-medicate to take away the pain - I truly believe that this is what needs to be dealt with before people can move on but unfortunately due to the huge waiting lists this isn't happening. I see places closing down and essential jobs being lost because of the lack of funding, which then means people are not getting the right kind of support that they need, and this is a reason we are seeing more and more deaths.

Last week I was part of a team of people with lived experience who set up a vigil at George Square in Glasgow to remember all the poor souls that have lost their lives with family members, people who take drugs and people in recovery and since that day (not even a week) 18 more people have lost their lives to this disease in Scotland, so that tells me that whatever they have been doing for years is not working, so why not listen to the voices of the people that have already been through it? The next vigil is at George Square, at 1pm, on Saturday the 31st of August 2019. Please join us.

We seriously need to do something as these people were human beings with names and were someone's son, daughter, brother, sister, dad, mum or friend. Enough is enough."

An advocate for change
#youkeepalkingwekeepdying



"Over the last 12 years I have experienced a lot of different types of drug related deaths, both in my personal and professional life, which gives me a difficult outlook on all drug related deaths. I have learned that people's views on drug related deaths differ from heart break to disdain, but their emotions are always similar.

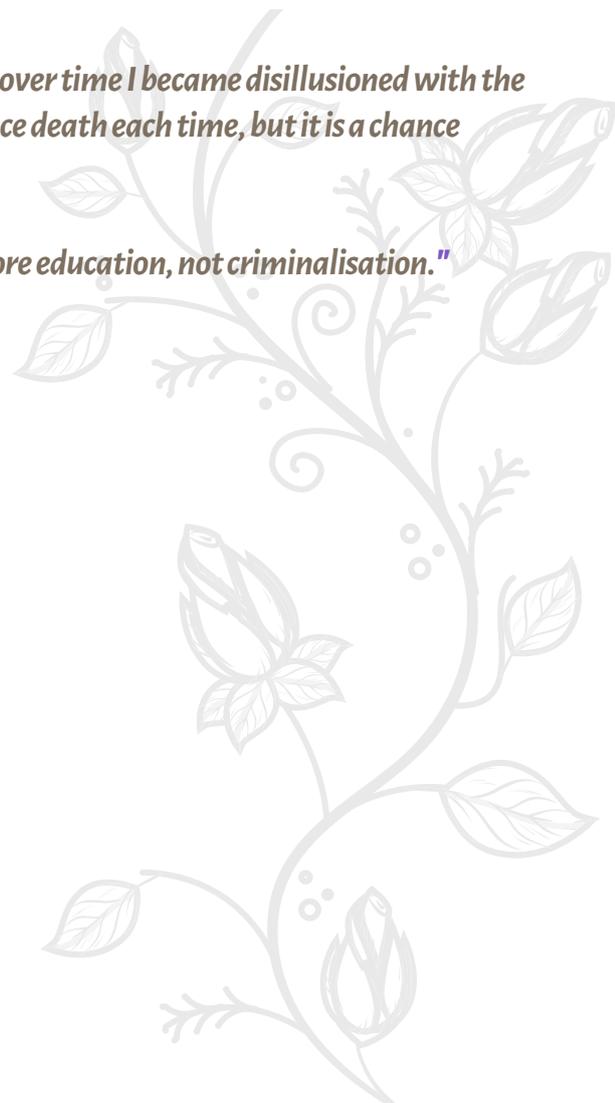
Personally, I lost 3 of my close friends to poly drug use, I felt angry as they were good people who only used drugs every so often. I constantly questioned myself- why did I survive, and they didn't?

8 years ago, I also lost my little brother to a methadone overdose which, by every sense of the word, was hard for me to deal with. Although I have learnt a lot about addiction and the effects of drugs, it still didn't make sense to me on any level and watching my family spiral out of control because of it was a very difficult and emotional time.

I have lost numerous friends and acquaintances to drug deaths and over time I became disillusioned with the idea of death. I had the thought that when you take drugs you chance death each time, but it is a chance people are willing to take, and that is a hard reality to think about.

People need more information on what they're taking. We need more education, not criminalisation."

Crew volunteer



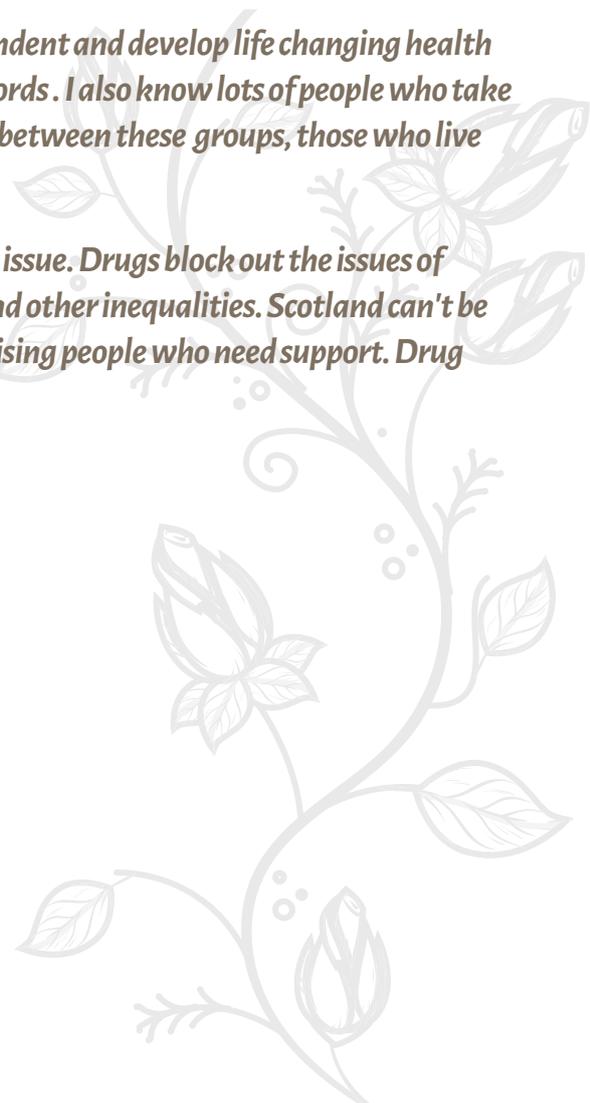
"I was 17 when one of my best friends died after taking drugs. He'd been in my house the day before and I had no idea he was taking them. Neither did his parents. He'd wanted to know what it felt like to inject cocaine. No one even talked about drugs at his funeral.

Two years later I lost another friend. He had anxiety and was struggling after his dad's death so had been taking Valium and drinking. He was also taking heroin with different people, but we didn't know, or notice the changes in behaviour that we see with perfect hindsight. He told us he was going to stop taking Valium. He did! He was looking really healthy. Things were going well. A few weeks later my flatmate called me. I'd never heard him cry before. Our friend was dead - I sat down in the middle of the icy pavement and cried. I couldn't walk up that same street for months. He'd took some heroin and one Valium, not thinking that his tolerance would be down. He never woke up. Again, no one even said the word 'drugs' at his funeral. We can't just not talk about them. We can't be ashamed when someone dies after taking drugs. We should be allowed to mourn their death.

I had two more funerals before I was 21 and saw friends become dependent and develop life changing health conditions. I've seen them lose jobs, get into debt and get criminal records. I also know lots of people who take drugs and don't die, or lose their jobs, or house. What is the difference between these groups, those who live and those who die?

Now, working for a drug service I have realised that drugs are not the issue. Drugs block out the issues of employment, mental health, self-esteem, poverty, social exclusion and other inequalities. Scotland can't be 'against drugs' - we need to be against social inequalities and stigmatising people who need support. Drug related deaths aren't just caused by drugs."

Crew worker



"Wow where do I start - the day my heart died a little - the day my son died. How can I put into words when my world stopped - the pain I felt - the questions I asked, the why, how, why, why, why - when I found out my Billy was dead and I would never see him walk in my front door again.

Terrible does not even begin to describe how I felt - my heart was in so much pain and no one cared. No one could feel my pain. Everything was still turning, the sky was blue and people were doing their thing and I wanted to scream 'feel my pain, my son, my baby boy, my pain, my loss, my heavy sore heart' - but no one did anything.

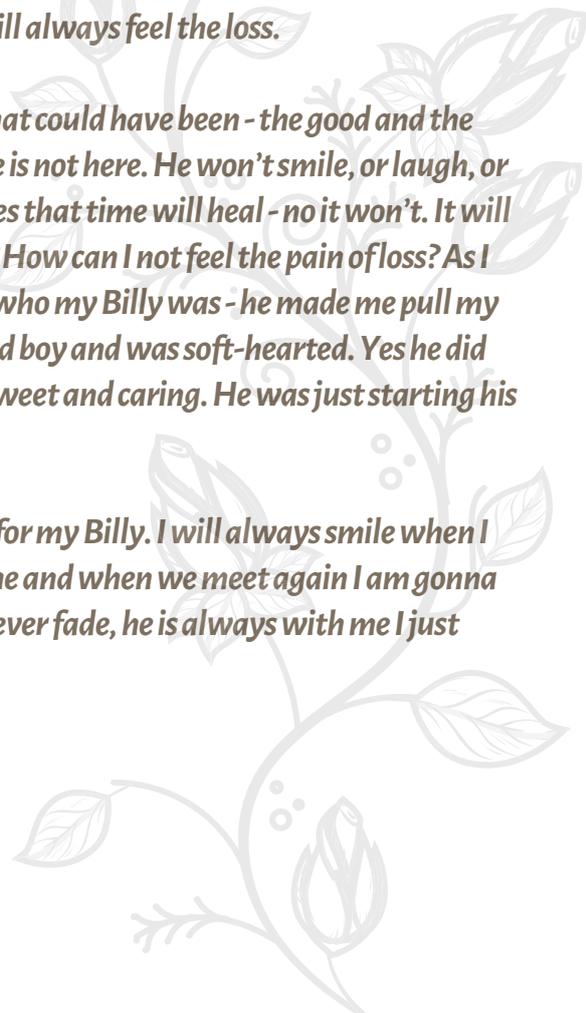
There was my 3 other kids and they lost a brother, my mum who lost a grandson and my brother who lost a nephew but their pain was not MY pain. I had to make sure that everyone was ok. There was so much to do for Billy but everything was taking way too long to arrange. I had to see my Billy in the morgue. My baby boy was there, not moving or giving me his cheeky side smile. My heart broke right there on that very spot - but I had to be strong for the other people - had to keep myself from feeling the pain. We went to a small pub (family) and got a drink in Billy's name. My lad, my boy, my son, my Billy was gone, just gone but he had 2 babies I had to be strong for - only 2 years and 9 weeks old, poor wee mites. After a few weeks it was time for the funeral, which was a good funeral - as funerals go that is.

Then I got the report that my boy Billy died of methadone. I knew he smoked, I also knew he tried a couple of other things but never something hard. He was a silly laddie but not stupid. This shit killed my boy because as he was not a drug user (as in needles). His body was not used to the effects, and that is what killed him. Then the questions started running through my head again - who gave him that? Did Billy know he was taking that? Why would he take something that was going to kill him? I started to blame Billy for dying - for leaving me, for leaving his 2 boys and for giving me this pain and this loss I feel. It has been years now and I know that I will never know the why, who, what - but I do know that my heart will always feel the loss.

My Billy would have been 30 years old this year. I will always miss what could have been - the good and the bad - the laughter and the tears that my son would have given - but he is not here. He won't smile, or laugh, or cry. There are no more happy times with my son. I was told many times that time will heal - no it won't. It will never be better. I lost a piece of my heart, how can that ever be better? How can I not feel the pain of loss? As I sit and write this there have been tears and I have smiled as that was who my Billy was - he made me pull my hair out one min, and the next he was making me smile. He was a good boy and was soft-hearted. Yes he did silly and stupid things, he made mistakes but he was funny, cheeky, sweet and caring. He was just starting his life with his 2 boys and he was trying to get things sorted out.

A part of my life is still with Billy and always will be. I will always cry for my Billy. I will always smile when I remember things with Billy. I will always curse my Billy for leaving me and when we meet again I am gonna kick his arse for the pain he left in my heart! My love for my boy will never fade, he is always with me I just wish he was here with me now and not the one looking down."

A mother's loss



"Perhaps it is hard to admit, even to ourselves, how profoundly vulnerable death can make us feel. Let us take care to remember the lives of those we have loved and lost in the presence of this vulnerability.

Today is not about ending grief or making it better. Today is about acknowledgement: acknowledging the power of being present and staying present to ourselves and those around us at times of aching rawness.

May each of us find strength and support in our grieving, and in the discovery that love can reveal itself even more deeply in times of loss, and in the depth of sadness.

May we be in acceptance and understanding that some things in life cannot be fixed. They can only be carried."

A poem for hope -

The very least you can do in your life is to figure out what you hope for.

And the most you can do is live inside that hope.

Not admire it from a distance but live right in it, under its roof.

What I want is so simple I almost can't say it:

it's kindness.

The possibility that I might live in a world in which I'm neither the destroyer nor the destroyed.

That's about it.

Right now I'm living in that hope, running down its hallway and touching the walls on both sides.'

Words adapted from a poem by Barbara Kingsolver

Minister, Unitarian Church and Former Drug-Related Deaths Review Coordinator



On the 16th of July 2019, the National Records of Scotland (NRS) published their report 'Drug-Related Deaths in Scotland in 2018' [4].

As expected, the death count is higher than ever before, at 1,187 deaths. 1,187 deaths which could have been prevented and lives that could have been saved. 1,187 people who loved and were loved, and who leave behind their friends and families.

These are not just numbers on a page or something that happens to other people; everyone is affected by drug-related deaths (DRDs) in some way. We must stop the deaths but first we need to understand the situation.

In this chapter we look at the figures in detail, identifying key problematic areas and comparing them with previous years. Data, unless otherwise stated, was taken from the National Records of Scotland Reports on Drug-Related Deaths [5] which can be found here:

www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland

1187

WHAT IS A DRD?



A drug-related death is generally a **poisoning caused by the toxic effects of a controlled drug**. Not every death related to the use of drugs is counted as a 'drug-related death' and the definition is not straightforward.

"The **'baseline' definition for the UK Drugs Strategy** covers the following cause of death categories (the relevant codes from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision [ICD10], are given in brackets):

a) deaths where the underlying cause of death has been coded to the following sub-categories of 'mental and behavioural disorders due to psychoactive substance use':

- (i) opioids (F11);
- (ii) cannabinoids (F12);
- (iii) sedatives or hypnotics (F13);
- (iv) cocaine (F14);
- (v) other stimulants, including caffeine (F15);
- (vi) hallucinogens (F16); and
- (vii) multiple drug use and use of other psychoactive substances (F19).

b) deaths coded to the following categories and where a drug listed under the Misuse of Drugs Act (1971) was known to be present in the body at the time of death (even if the pathologist did not consider the drug to have had any direct contribution to the death):

- (i) accidental poisoning (X40 – X44);
- (ii) intentional self-poisoning by drugs, medicaments and biological substances (X60 – X64);
- (iii) assault by drugs, medicaments and biological substances (X85); and
- (iv) event of undetermined intent, poisoning (Y10 – Y14)." [4]

WHAT IS A DRD?



Deaths which are **not counted** by the 'baseline' definition include deaths from:

- ✗ Alcohol, tobacco and volatile substances e.g. butane (lighter gas)
- ✗ Any drug not covered by the Misuse of Drugs Act (1971) e.g. New Psychoactive Substances that are covered by the Psychoactive Substances Act (2016)
- ✗ Bacterial infections, for example, *Clostridium botulinum* (botulism), *Bacillus anthracis* (anthrax), *Staphylococcus aureus*, even if the infection was contracted as a result of drug use
- ✗ Viruses, for example, HIV, hepatitis B and hepatitis C, even if the virus was contracted as a result of drug use
- ✗ Accidents or injuries which occur under the influence of drugs such as road traffic accidents, drowning, falls and exposure
- ✗ Assault by someone who is under the influence of a drug controlled by the Misuse of Drugs Act (1971)
- ✗ Legally prescribed, non-controlled drugs
- ✗ Acute behavioural disturbances
- ✗ Suicide while under the influence (unless it was via an overdose of a controlled drug)
- ✗ Medical conditions related to drug use such as chronic obstructive pulmonary disorder, pneumonia and endocarditis

KEY FIGURES



Number of DRDs based on the 'baseline definition' by year:

2014

2015

2016

2017

2018

614

706

868

934

1,187

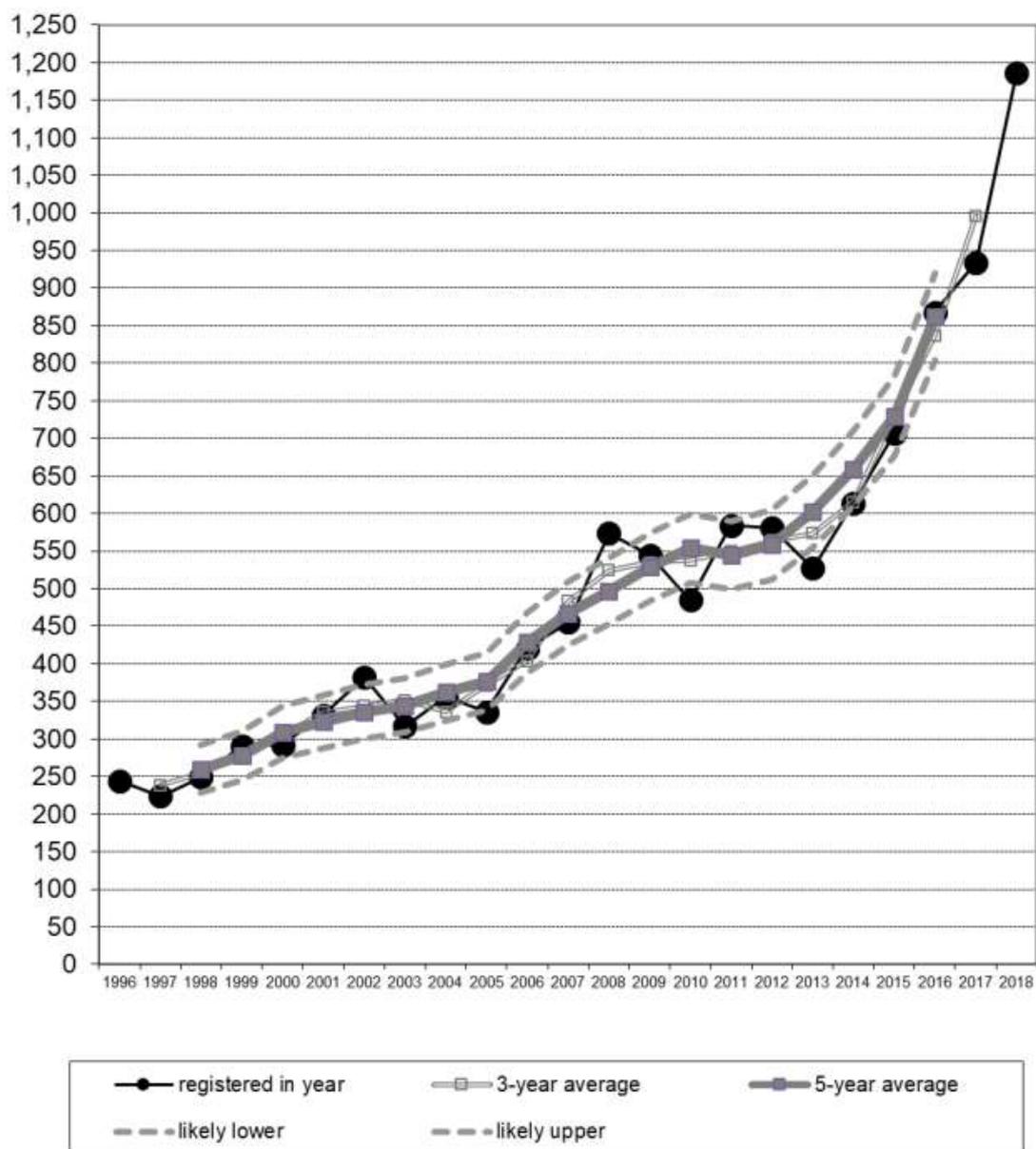


Figure from NRS DRD 2018 report, showing 3- and 5-year moving averages, and likely range of values around 5-year moving average from 1996 to 2018. [4] Note: This graph is copyrighted by NRS.

KEY FIGURES



	2017	2018
Number of DRDs	934	1,187
Male deaths	652 70%	860 72%
Female deaths	282 30%	327 28%
Average age (median)	41	42
More than one drug implicated in death*	765 82%	1,009 85%

*Data from 'Table 7' of NRS DRD report 2018 [4]. Note: The percentages below add up to more than 100 because more than one drug was implicated in, or contributed to, many of the deaths.

	2017	2018
 <p>Any opiate or opioid</p>	815 87%	1,021 86%
 <p>Heroin/morphine</p>	470 50%	537 45%
 <p>Methadone</p>	439 47%	560 47%

- 'Opiate' is generally used to describe drugs that have been derived from the opium plant e.g. morphine. 'Opioid' is used to describe synthetic (man-made) drugs which have similar effects to opiates e.g. methadone. For simplicity, in this report we use the term opioids to refer to all opiate and opioid drugs.
- Opioids are not the most commonly used drugs in Scotland but they are implicated in the highest number of deaths because, in comparison to drugs like ketamine, the difference between a dose that will give the desired effect and a dose that kills is small. "The most toxic recreational drugs, such as ... heroin, have a lethal dose less than 10 times their typical effective dose" [6].

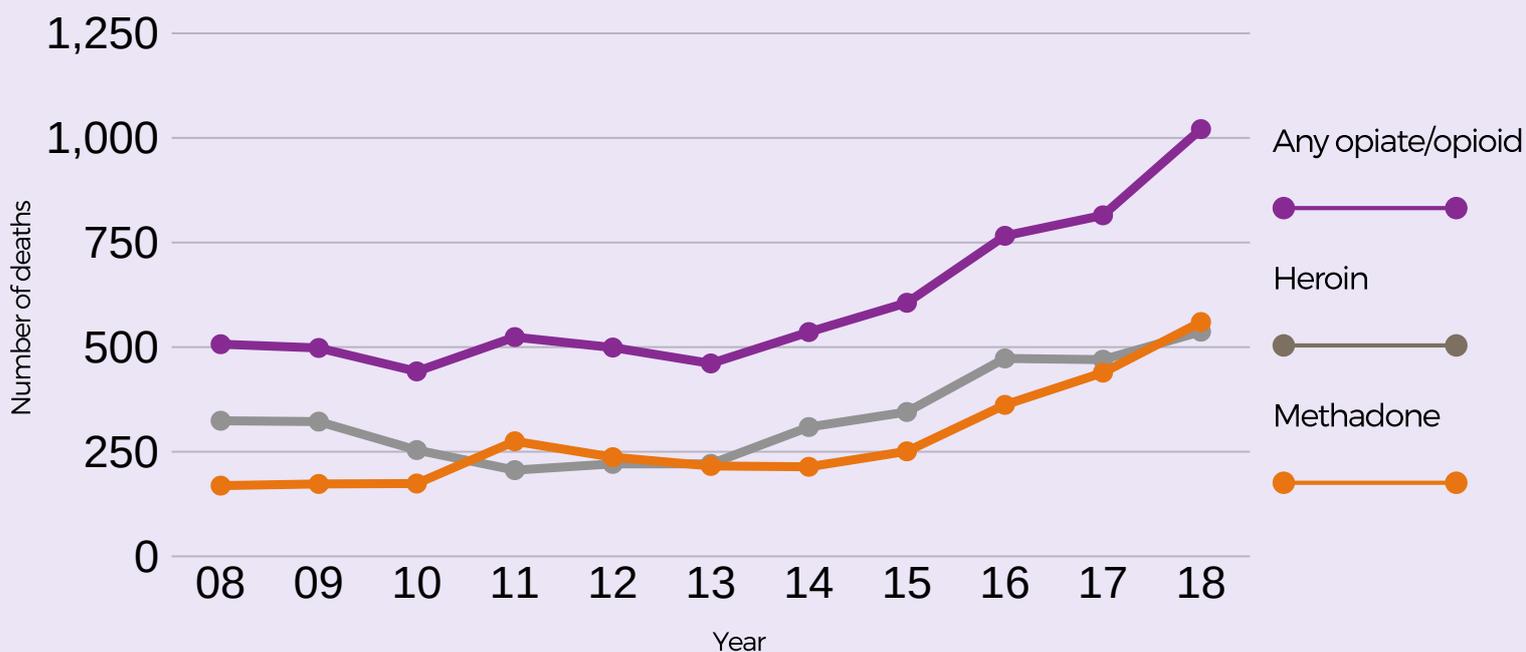
- Deaths related to 'any opioid' have increased by 101% since 2008.
- Morphine is a metabolite of heroin (diamorphine). Toxicology cannot always determine whether heroin or morphine was taken, which is why they are reported together.
- Heroin/morphine-related deaths have increased by 66% since 2008.
- In 2017, there were 48 deaths where heroin/morphine was the only drug implicated (10% of 470 heroin/morphine-related deaths).
- In 2018, there were 32 deaths where heroin/morphine was the only drug implicated (6% of 537 heroin/morphine-related deaths).
- Methadone-related deaths have increased by 231% since 2008.
- In 2018, methadone was implicated in 560 deaths, which is more than any other drug. The data does not differentiate between people who were taking prescribed methadone or illicitly sourced methadone.
- In 2017, there were 19 deaths where methadone was the only drug implicated (4% of 439 methadone-related deaths).

OPIOID DRDS



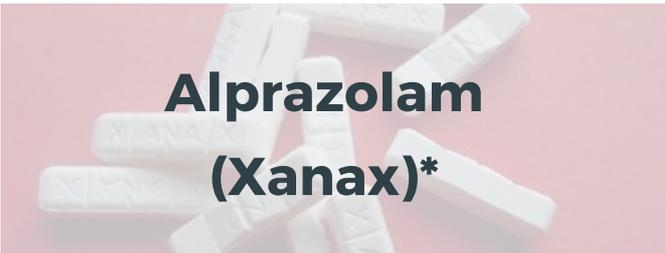
- In 2018, there were 15 deaths where methadone was the only drug implicated (3% of 560 methadone-related deaths).
- In 2017, there were 5 deaths where fentanyl was the only drug implicated (33% of 15 fentanyl-related deaths [7]).
- In 2018, there were 2 deaths where fentanyl was the only drug implicated (17% of 12 fentanyl-related deaths [7]).
- Other opioids implicated in deaths include buprenorphine (Subutex), dihydrocodeine, codeine, tramadol and oxycodone.
- In 2018, 37% of codeine-related deaths and 40% of dihydrocodeine-related deaths were female, compared with 28% of all drug-related deaths.

Opiate/opioid-related deaths since 2008



DEPRESSANT DRDS



	2017	2018
 <p>Any benzodiazepine</p>	552 59%	792 67%
 <p>Etizolam</p>	299 32%	548 46%
 <p>Diazepam (Valium)</p>	205 22%	211 18%
 <p>Alprazolam (Xanax)*</p>	99 11%	137 12%
 <p>Gabapentinoids (gabapentin and/or pregabalin)</p>	242 28%	367 31%

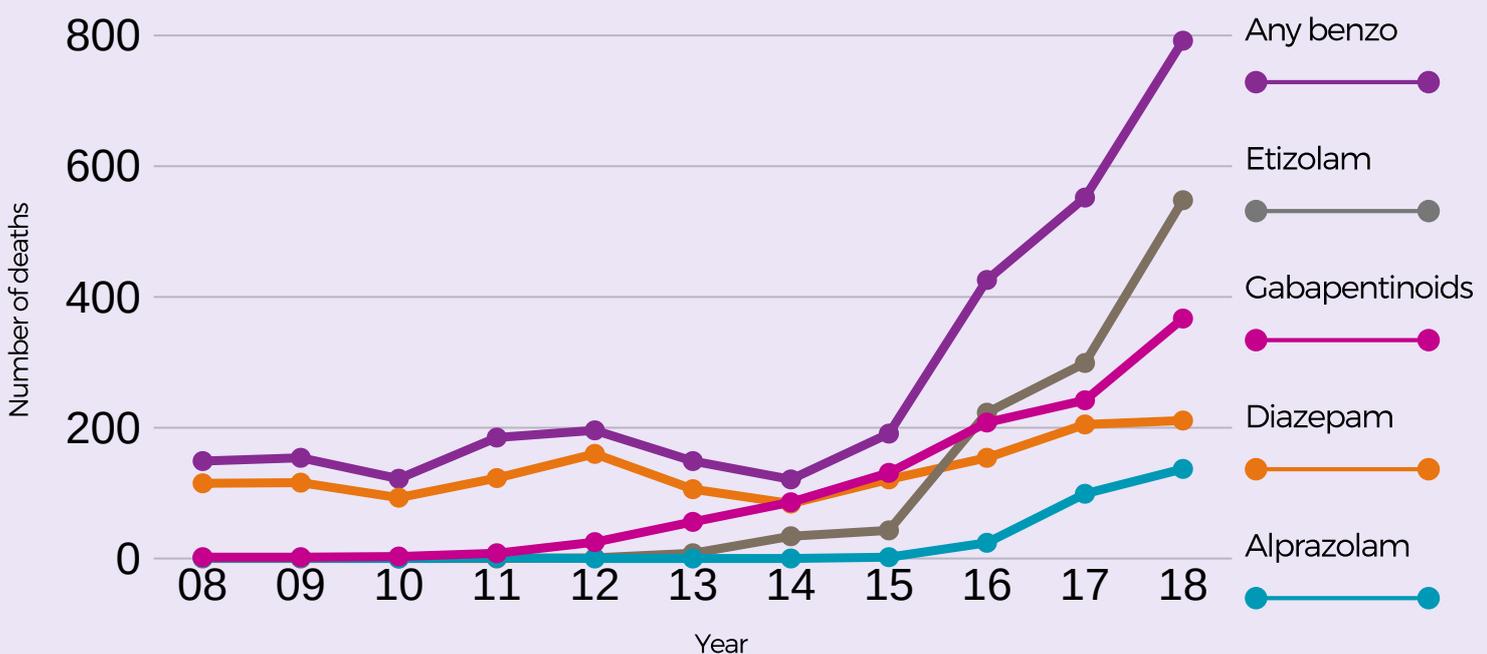
*Data from 'Table Y' of NRS DRD report 2018. The 'wide' definition of a DRD varies in a few ways and it reports higher figures. All other data was taken from 'Table 3' of NRS DRD report 2018 [4].

DEPRESSANT DRDS



- Other depressants implicated in deaths include benzodiazepines such as diclazepam and phenazepam.
- Benzodiazepine-related deaths have increased 432% since 2008.
- In 2017, there were 5 deaths where a benzodiazepine was the only drug implicated (1% of 552 benzodiazepine-related deaths).
- In 2018, there were 11 deaths where a benzodiazepine was the only drug implicated (1% of 792 benzodiazepine-related deaths).
- The rise in benzodiazepine-related deaths is attributed to 'street benzos'. These are benzodiazepines that are not licensed for use in the UK e.g. etizolam, or have been sourced illicitly e.g. alprazolam.

Depressant-related deaths since 2008



STIMULANT DRDS



	2017	2018
 Cocaine	176 19%	273 23%
 Amphetamine	32 3%	46 4%

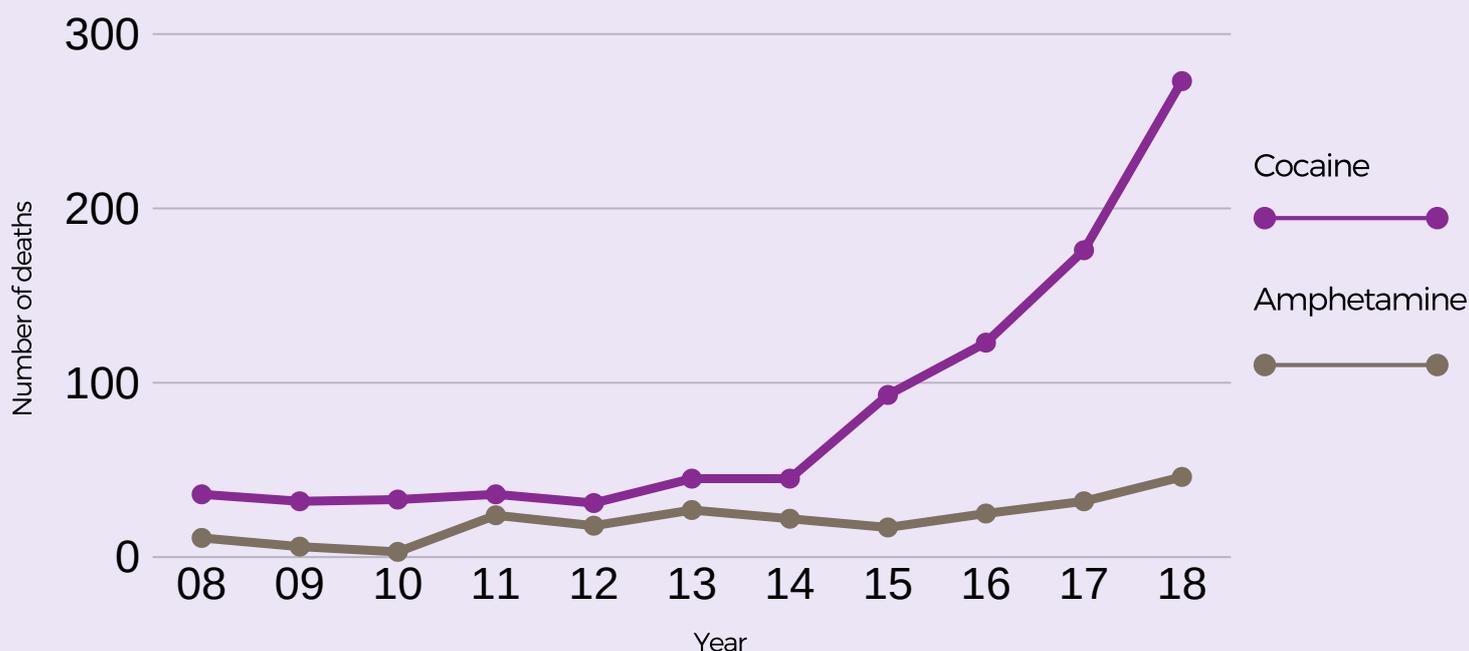
- Powder and crack cocaine are different forms of the same drug therefore toxicology cannot distinguish the type of cocaine taken. The numbers above are for deaths involving any type of cocaine.
- Cocaine-related deaths have increased by 658% since 2008.
- In 2017, there were 20 deaths where cocaine was the only drug implicated (11% of 176 cocaine-related deaths).
- In 2018, there were 32 deaths where cocaine was the only drug implicated (12% of 273 cocaine-related deaths).
- 2018 saw a 55% increase in cocaine-related deaths from the previous year: from 176 to 273.

STIMULANT DRDS



- In 2017, 38% of the 176 cocaine-related deaths were of people aged under 35, compared with 24% of all drug-related deaths.
- In 2018, 35% of the 273 cocaine-related deaths were of people aged under 35, compared with 24% of all drug-related deaths.
- In 2017, there were 9 deaths where amphetamine was the only drug implicated (28% of 32 amphetamine-related deaths).
- In 2018, there were 13 deaths where amphetamine was the only drug implicated (28% of 46 amphetamine-related deaths).
- In 2018, 77% (211 out of 273) of cocaine-related deaths were male, compared with 72% of all drug-related deaths.

Stimulant-related deaths since 2008



ECSTASY-TYPE DRDS



2017

2018



27
3%

35
3%

- In 2018, there were 7 deaths where ecstasy was the only drug implicated (20% of 35 ecstasy-type drug-related deaths).
- In 2018, males accounted for 86% (30 out of 35) of ecstasy deaths.
- In 2018, 69% of the 35 ecstasy-related deaths were of people aged under 35, compared with 24% of all drug-related deaths.

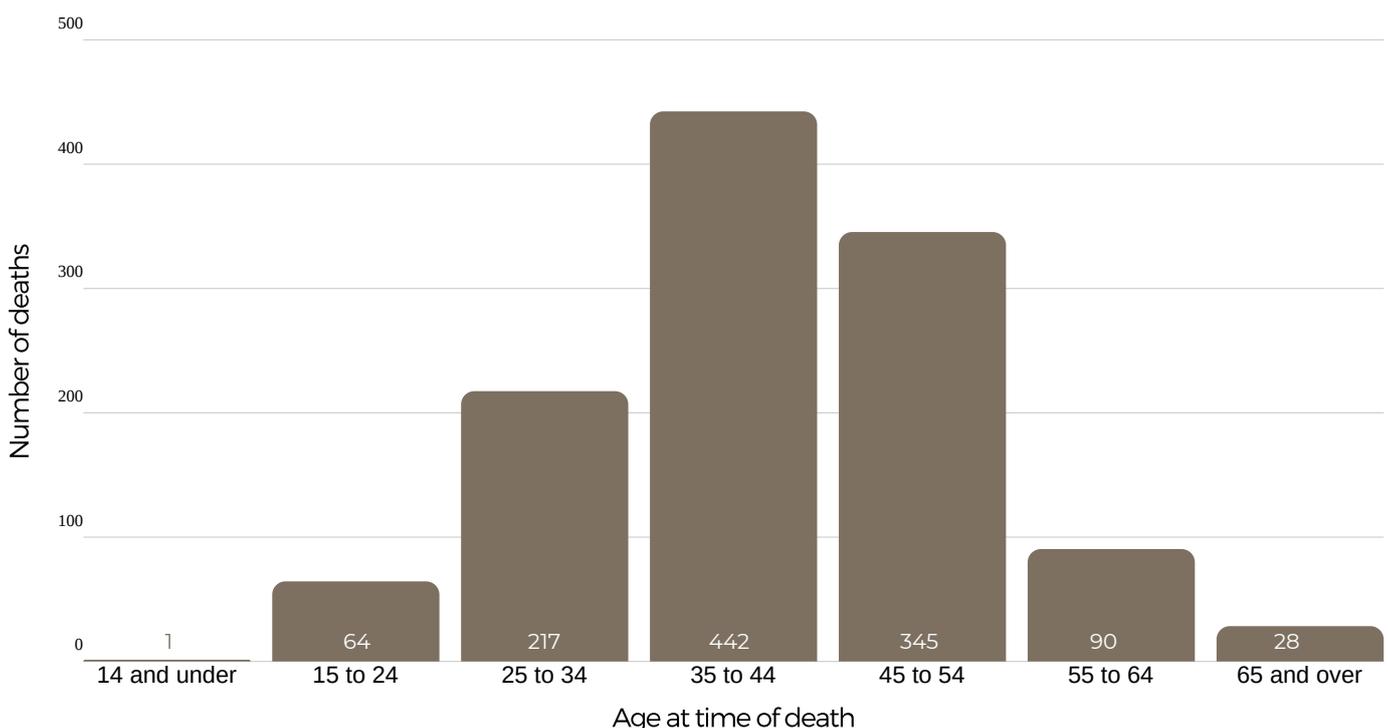
Ecstasy-type drug-related deaths since 2008



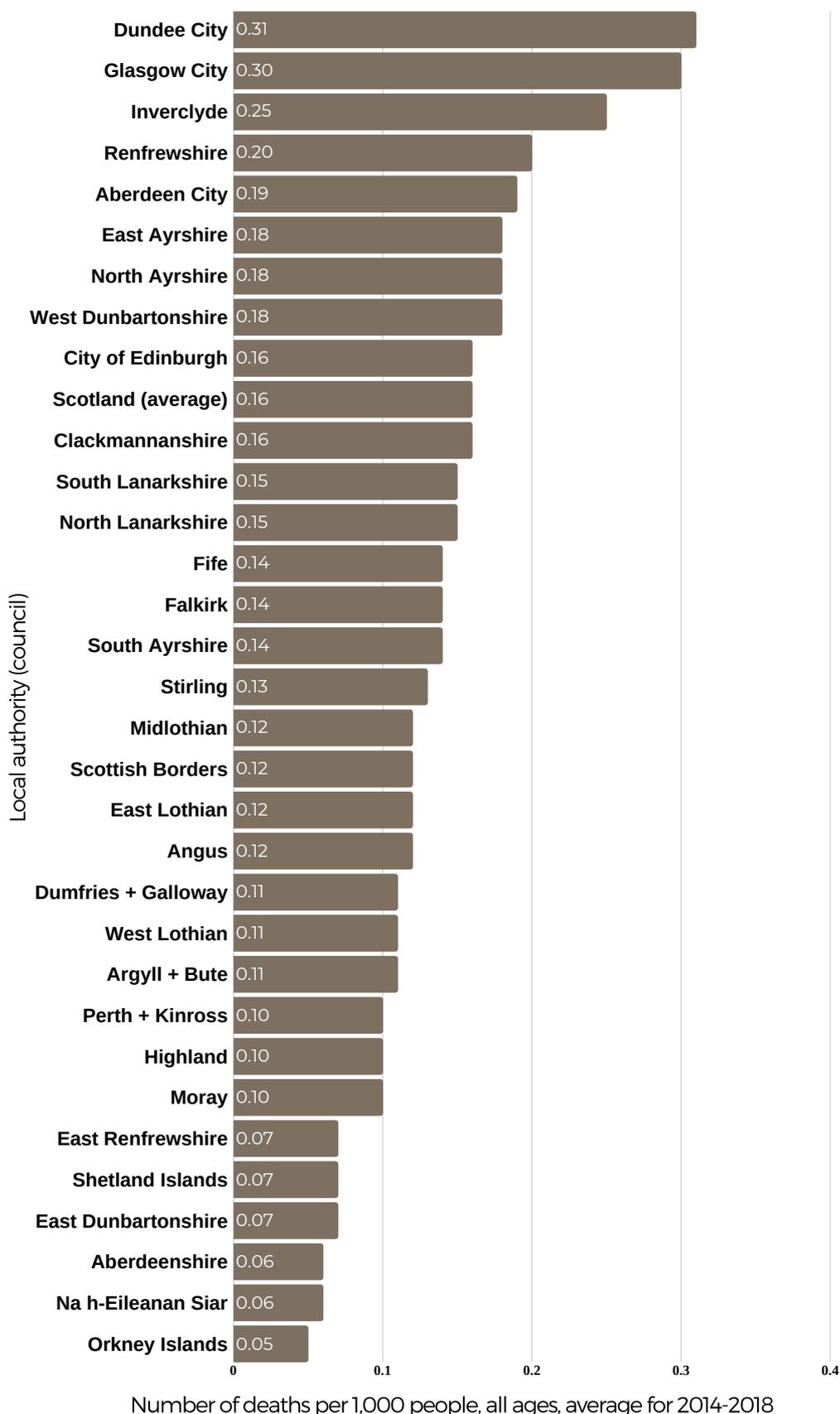
DEATHS BY AGE



- The 35 to 44 age group reported the highest number of deaths (442), followed by 45 to 54 (345), followed by 25 to 34 (217).
- Deaths in the 35 to 44 and 45 to 54 age groups have risen the most significantly since 2009. Death rates for the 15 to 24 age group spiked at 0.10 deaths per thousand in 2018 after a period of gradual decline.
- Some figures (e.g. the data on page 27) may only report on an age range of 15 to 64. Age adjusted rates are used to make countries with different age distributions more comparable.
- Since 2000, 9 children aged 14 and under have died a drug-related death in Scotland. 3 children died in 2017, and 1 in 2018.
- Since 2000, 200 adults aged 65 and over have died a drug-related death in Scotland. 18 people aged 65 and over died in 2017, and 28 in 2018.



DEATHS BY AREA

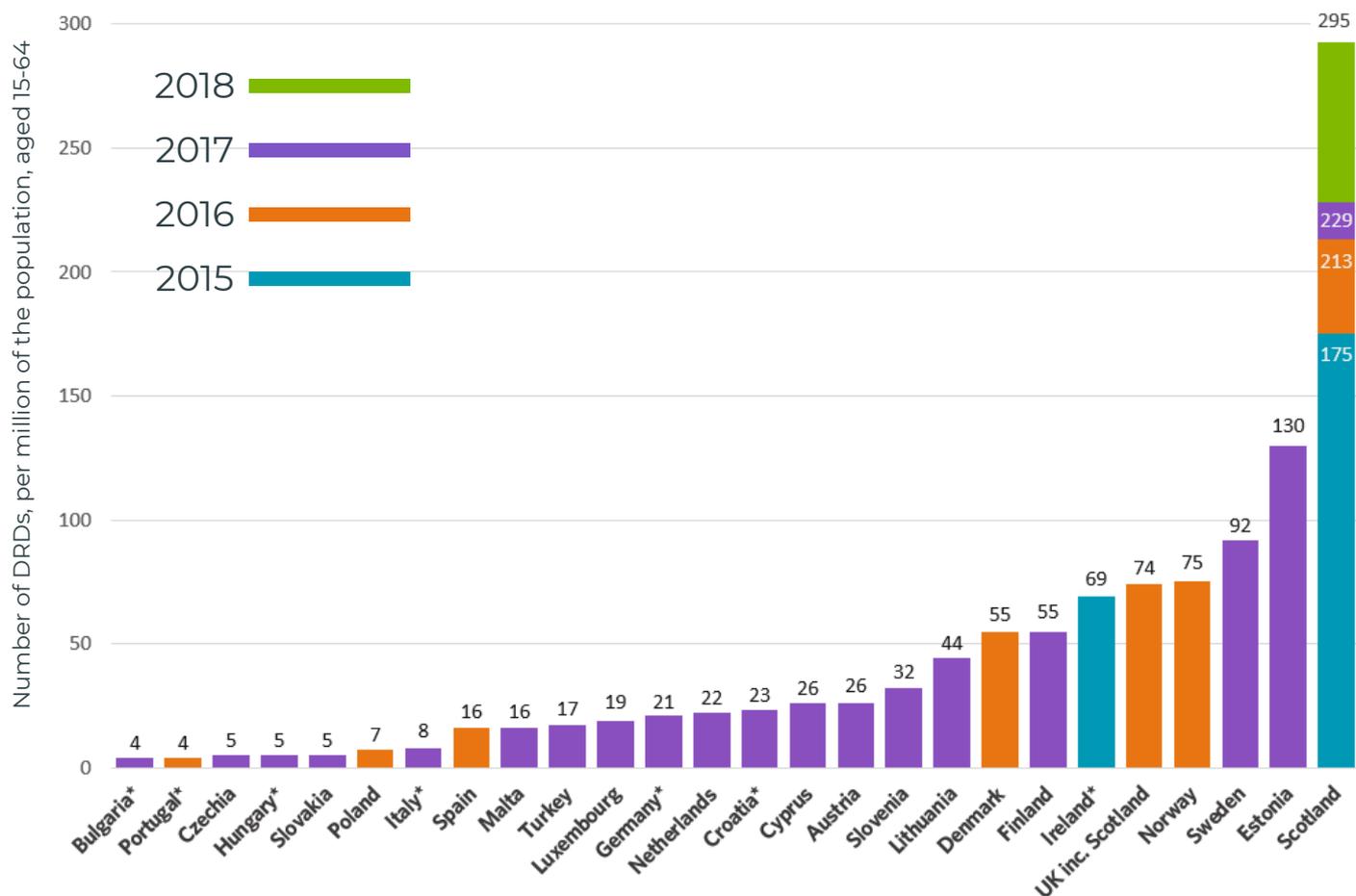


- This data was taken from 'Table C4' of the NRS DRD 2018 report. Rates are based on 5 year averages to remove year to year fluctuations [4].
- Dundee City is the local authority area in Scotland with the highest number of drug-related deaths per 1,000 of the population for both people aged 15 to 64 (0.45) and for people of all ages (0.31).
- Glasgow City has the second highest number of drug-related deaths per 1,000 of the population for both people aged 15 to 64 (0.41) and for people of all ages (0.30).
- The Orkney Islands have the lowest drug-related death rate per 1,000 of the population for both people aged 15 to 64 (0.07) and for people of all ages (0.05).

EUROPEAN DRUG DEATHS



'Drug-induced' deaths aged 15-64: per million population



1. Please use caution when looking at these statistics. There are variations between the way countries analyse, report and record drug-related deaths.
2. This graph shows the latest figures available for each country. The reporting years vary e.g. 2016 for Denmark and 2017 for Italy.
3. For all countries (apart from Scotland) the data was taken from 'Table A6' on page 92 of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) European Drug Report 2019 [8].
4. These figures represent the EMCDDA general mortality register definition of a drug-induced death for people aged 15 to 64 only. The EMCDDA note that the 'age band is not specified' for Germany, Denmark, Poland and Turkey. Data for Greece was not available.
5. The 2015 and 2016 figures from Scotland were taken from the National Records of Scotland Drug-related Deaths in Scotland Reports for 2017 and 2018 [5].
6. The 2017 and 2018 figures for Scotland are not yet published. The figures shown were calculated by Crew. A breakdown of the calculations are shown in Appendix 1.
7. Romania, Latvia, France and Belgium are not included in this graph as they were noted by the EMCDDA as having 'significant levels of under reporting' or under reporting levels of more than 30% [9].
8. (*) denotes countries noted by the EMCDDA as having no estimation/information on under reporting available.

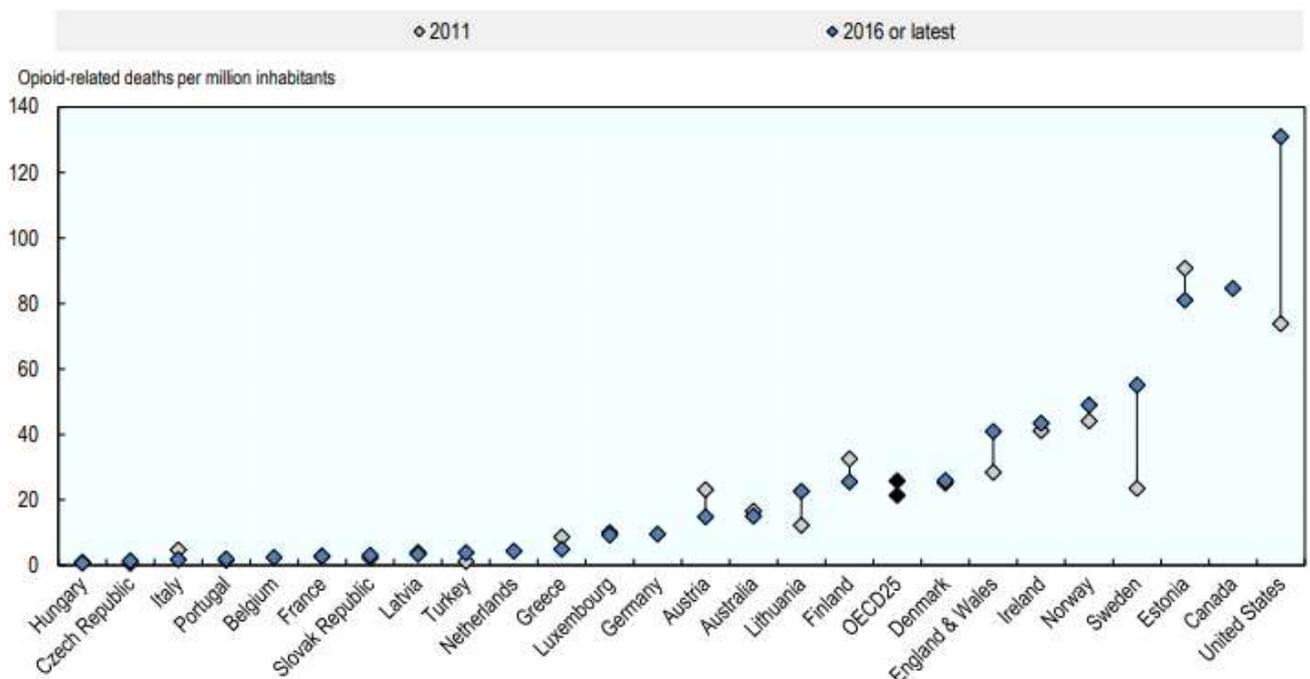
AN OPIOID EPIDEMIC



Drug-related death is an international issue. The UNODC World Drugs Report 2019 states that "The Global Burden of Disease Study 2017 estimated that, globally, in 2017, there were 585,000 deaths and 42 million years of 'healthy' life lost as a result of the use of drugs" [10] and that, globally, the number of deaths attributed to the use of drugs has increased by 134% over the last 30 years.

The graph below is from page 17 of the Organisation for Economic Co-operation and Development's (OECD) report - 'Addressing Problematic Opioid Use in OECD Countries'. The report notes that "**opioid-related deaths (ORD) is a key indicator that reflects the impact of problematic use on population health and, at the same time, how health systems and other related government services are performing in this area**" and that "in 25 OECD countries for which data is available, the average of ORD has increased by 20% in recent years" [11].

Figure 3.4. Opioid-related deaths per million inhabitants, 25 OECD countries, 2011-16



Note: Countries ranked by latest year with available information.

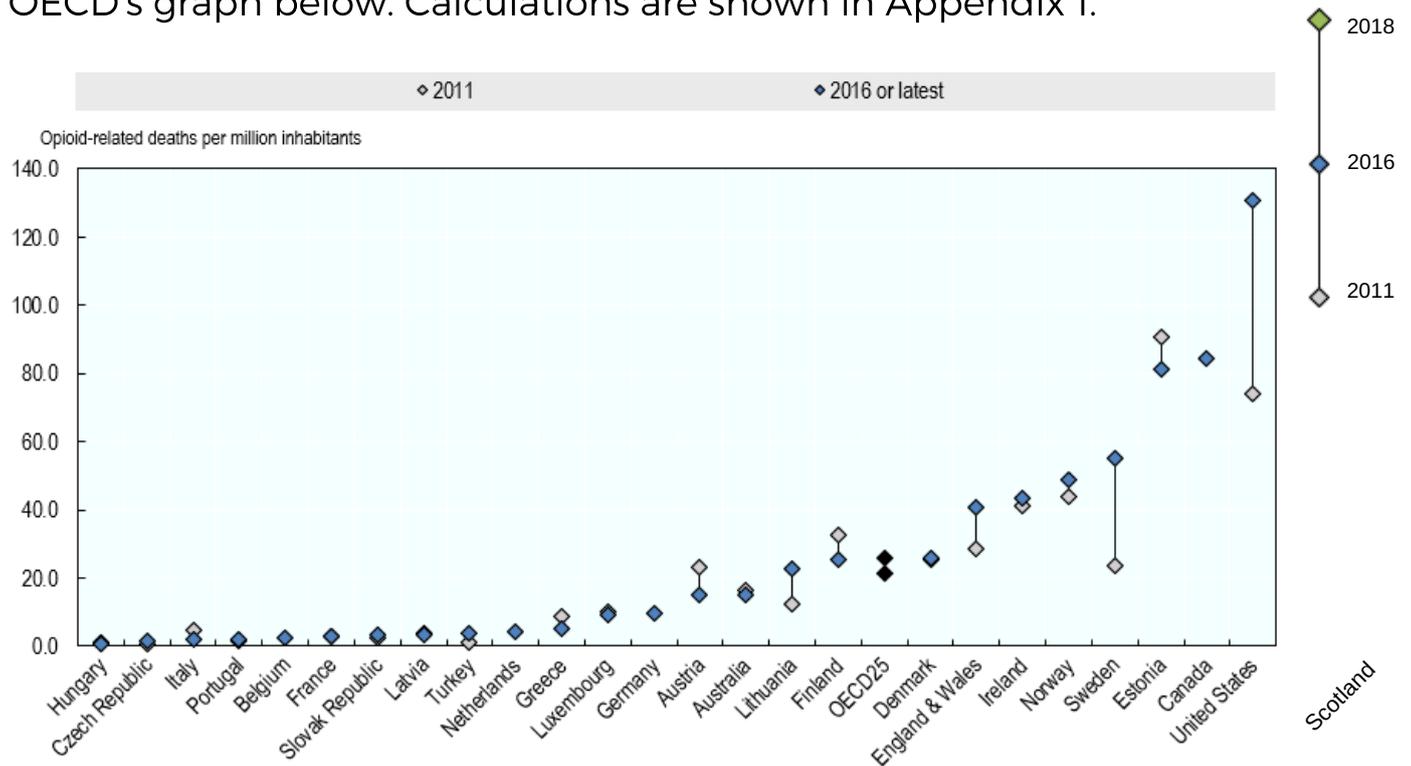
Source: EMCDDA for European countries and country responses to ORD data questionnaire.

Please use caution when looking at these statistics. There are variations between the way countries analyse, report and record drug-related deaths.

AN OPIOID EPIDEMIC



North America is experiencing a well-documented opioid epidemic and a drug-related death rate on par with Scotland. To estimate how Scotland measures against other countries in relation to **opioid-related deaths**, we calculated the full population average of opioid deaths per million people in 2011 (99), 2016 (142) and 2018 (188). This data is shown to the right of the OECD's graph below. Calculations are shown in Appendix 1.

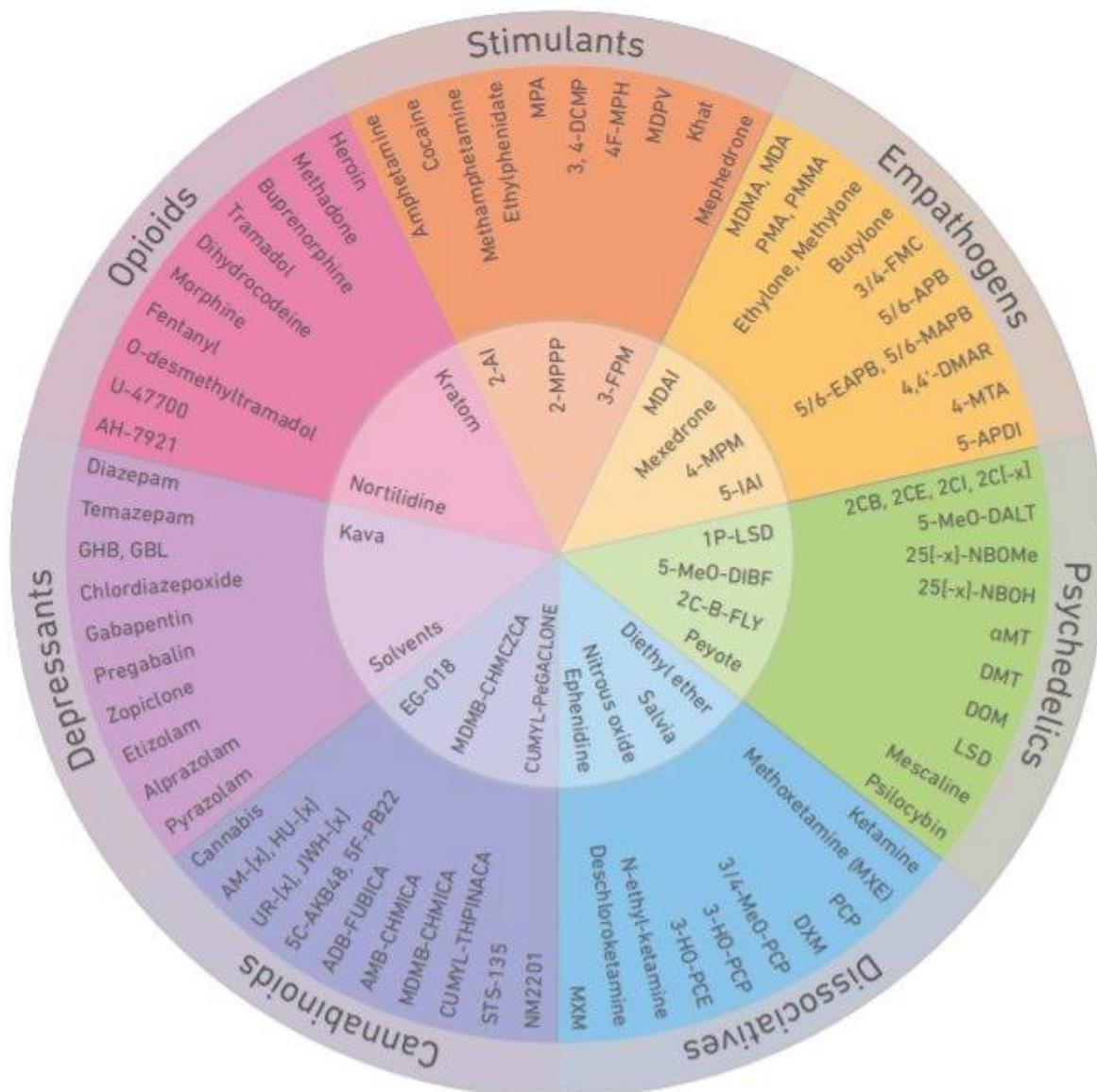


If the USA are experiencing an epidemic with a 2017 opioid-related death rate of 149 per million people [12], why isn't it being recognised as an epidemic in Scotland, with a 2017 opioid-related death rate of 150 per million people?

A 2019 UK Government report stated: "The US and Canada are in the grip of an opioid epidemic" and "the risk of a similar epidemic happening here is a real one and the experience of the US demonstrates the importance of being prepared" [13]. **The UK Government's statement demonstrates a tragic lack of understanding. This is already the reality in Scotland, not merely a "risk". We are amidst an opioid epidemic that we were not and are still not prepared for.**

Scotland's drug-related death rate is far higher than the rest of the UK and the rest of Europe and for **opioid-related deaths** we even outstrip the United States and Canada.

DRUG TRENDS



Outer ring: Controlled under the Misuse of Drugs Act 1971 or The Human Medicines Regulations 2012

Inner ring: Controlled under the Psychoactive Substances Act 2016



[UK version 2.0.7 • 08/09/2018]



The Drugs Wheel is a guide to some of the most commonly taken psychoactive substances in the UK. The wheel categorises drugs based on effect and it is regularly updated to reflect changes in the law.

In this chapter we travel around the Drugs Wheel, from stimulants to opioids, highlighting the key trends in each category between April 2017 and March 2019. Data is taken from Crew's service reports and Police Scotland's trend data, unless otherwise referenced in Appendix 2. This chapter contains photos of drugs and drug paraphernalia throughout.

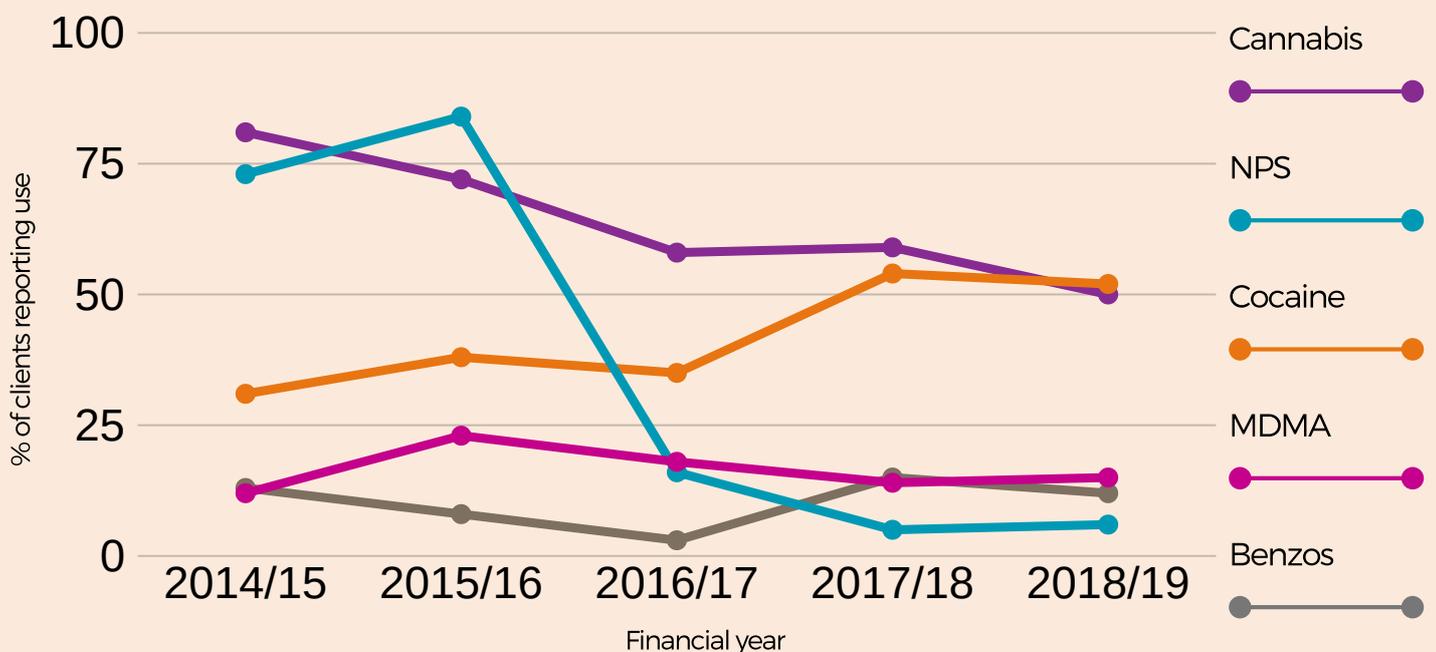


DRUG TRENDS



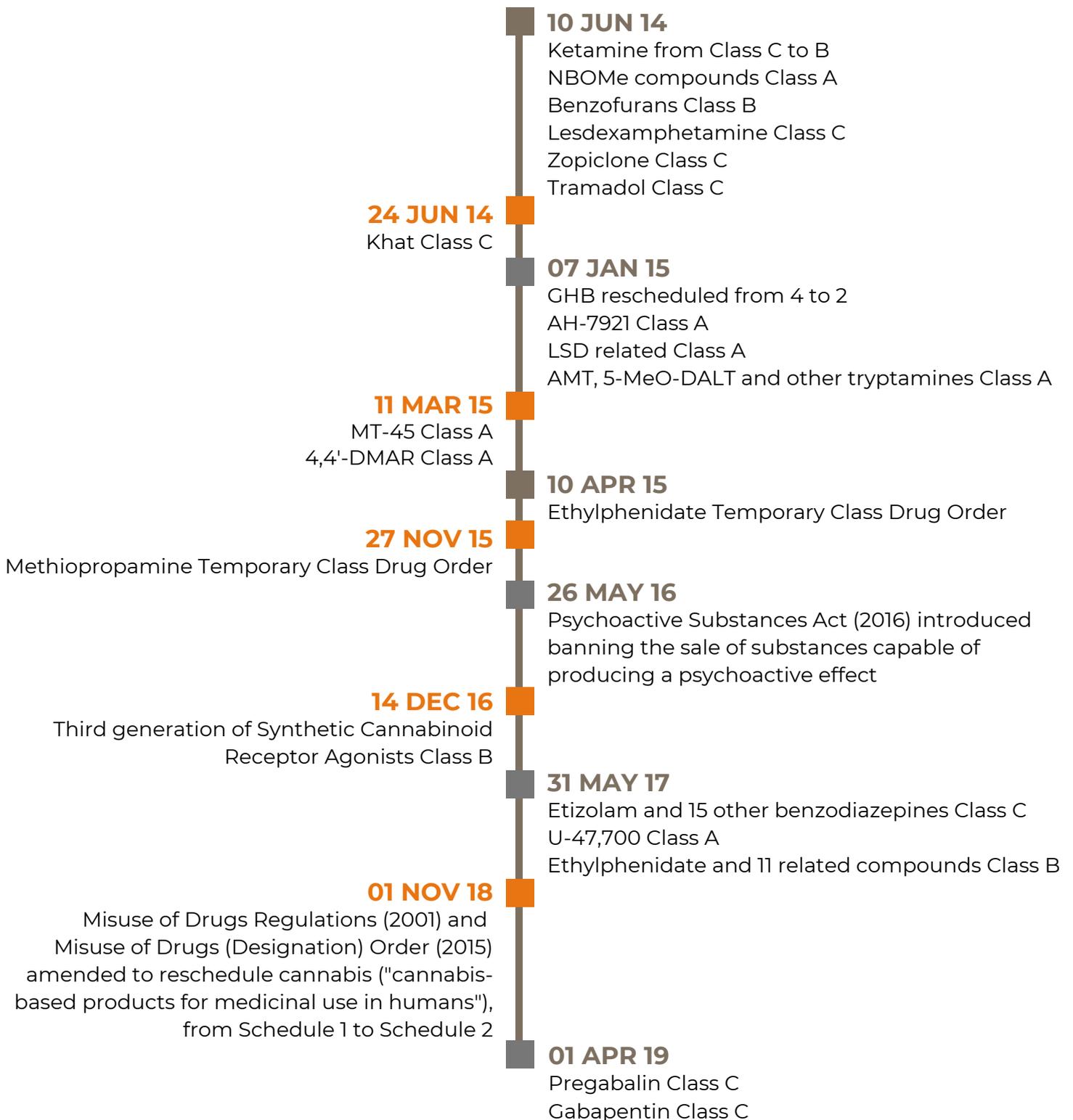
- New psychoactive substances have dominated drug trends in the last decade, from a high of 84% of Crew's counselling clients reporting their use in 2015/16, to a low of 5% in 2017/18.
- The EMCDDA reports that by the end of 2018, they were "monitoring more than 730 new psychoactive substances, 55 of which were detected for the first time in Europe in 2018" [8].
- The latest report from the Scottish Crime and Justice Survey states that "In 2017/18, 7.4% of respondents (aged 16 years and over) had used illicit drugs ... during the previous year, compared with 6.0% in 2014/15". The survey also reports that "individuals aged 16-24 were most likely to report using drugs in the last year (19.2%)" [14], therefore highlighting the need for early intervention and education.

Most common drugs taken by counselling clients at Crew, 2014/19



Note: These percentages add up to more than 100 because the use of more than one drug was reported by many clients. This data is not comparable to Crew's NPS 2016/17 report [3] which shown figures representing only the 'primary drug taken' by clients at Crew.

LEGISLATION TIMELINE



STIMULANTS



Stimulants are also known as uppers. They can increase heart rate and breathing as well as energy and euphoria. They can also cause anxiety and paranoia. Stimulant drugs include cocaine, amphetamine, nicotine, methylphenidate and methamphetamine.

Cocaine powder

Cocaine is the most common drug reported to our counselling service. People taking cocaine can experience a high with increased alertness, focus and sex drive, as well as a decreased appetite.

Other effects include restlessness, aggression, paranoia and over-confidence. Its desirable, instantaneous and short-lived effects create a strong urge to re-dose. Frequency of use and tolerance to cocaine can escalate quickly.

In the last few years, cocaine use has increased across Scotland. This has coincided with a rise in availability and purity of cocaine. Cocaine is now 'better value for money' and its use is not limited to any specific 'group' of people. Its use is even escalating in populations that we previously didn't report as taking cocaine, such as those with no fixed address and prisoners.

On average, low quality cocaine is £20-30 for 0.5 grams or £40-50 for 1 gram. Good quality ('proper') cocaine has an average street purity of 80% and is £40-50 for 0.5 grams, £80-100 for 1 gram and £200-220 for 3.5 grams (1/8 of an ounce).

Only a few years ago the average purity of cocaine was around 15-20%. This means people may now be getting four times as much of the drug for the same price and will need to take four times less to achieve the same effect.



1G OF COCAINE POWDER

Cocaine powder

Cocaine is commonly snorted but we continue to receive reports of people injecting cocaine. Some of these people are new to injecting but most were injecting heroin and have added cocaine to the mix.

The effects of cocaine are short-lived and people may inject frequently. Sterile injecting equipment is required for each injection and if this demand is not met people may resort to re-using or sharing needles, which can result in the transmission of blood borne viruses and infections. Problems are also exacerbated by risk taking behaviour, injecting in groups (as cocaine increases sociability), incorrect injecting technique and the cocaine causing the veins to constrict making injecting more difficult. Cocaine injecting is linked to an ongoing outbreak of HIV in Greater Glasgow and Clyde [15].

Crack cocaine

Crack is a smokable form of cocaine. When smoked, the effects of crack are almost instant but wear off quickly. The effects are similar to those of cocaine powder but it can be more intense.

Crack is a hard substance that is difficult to break up. The weight of crack sold in an average deal can vary considerably as it depends on the size of 'rock'. It is most commonly found in £10 deals containing approximately 100-200 milligrams.



There was an increase in the number of reports of crack cocaine use to Crew between 2017 and 2019. The use of crack is reported in many different groups of people and workers have reported difficulty in engaging with some clients who have started to take crack cocaine.

In Scotland, problem drug use is defined as "the problematic use of opioids (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines" [16]. This means services may not be set up to deal with the impact of routine and prolonged use of cocaine or other stimulants. When working with people who take cocaine powder and crack cocaine check out crew.scot/drugs-information and consider the following:

DENTAL HEALTH

Cocaine is a local anaesthetic. This effect is compounded by cutting agents such as benzocaine.

The effect of cocaine combined with the numbing sensation can cause people to grind teeth or chew their cheek or tongue. Lack of saliva can exacerbate dental decay.

Encourage teeth brushing and regular dental check-ups.

PHYSICAL HEALTH

Provide information on care of administration sites including injecting sites, nose, lips, mouth. The anaesthetic properties of cocaine mean that people can cause damage to the skin without realising it.

Reduced appetite can lead to weight loss – encourage a healthy diet and the use of supplements where necessary.

Encourage regular health check-ups including blood borne virus testing.

MENTAL HEALTH

Stimulants can cause extreme highs and lows, leaving people feeling depressed, anxious and paranoid. Some people may be suicidal or have suicidal thoughts.

Prolonged or excessive stimulant use can cause behavioural disorders and psychosis. Be alert for loss of touch with reality or hallucinations.

SEXUAL HEALTH

Cocaine is linked to risky sexual behaviours, so provision of sex education, condoms, lube and dams is essential.

Sexual impotence can be a side effect of cocaine but erection drugs like Viagra should be avoided.

Medical advice should be sought for any erection lasting more than 4 hours.

SLEEP

Stimulants disrupt sleep. A lack of sleep can have a huge impact on mental wellbeing.

Discuss good sleep hygiene including taking regular breaks and having nights off.

Taking other drugs to aid with sleep is risky and should be avoided.

EMPLOYMENT

Is there lost time at work, or missed work, as a result of cocaine use? Is there a threat of losing employment?

Address bingeing and 'living for the weekend' mentality.

Some people work in industries where cocaine use is normalised.

CRAVINGS

Cocaine leaves you wanting more and frequent redosing is common.

There are no replacement therapies for cocaine currently available in the UK. Try mindfulness exercises to encourage calmness.

Ear acupuncture is an effective tool to help reduce drug cravings and anxiety.

MONEY

Frequent cocaine use is expensive and can cost hundreds (sometimes thousands) of pounds per week.

Watch out for debt which can put individuals, their tenancies and their families at risk.

Debt can be exacerbated by risk taking behaviours – is there problem gambling? Help to set limits on cocaine spending and gambling.

POLYDRUG USE

Mixing cocaine and alcohol produces cocaethylene; a chemical which is harmful and can increase side effects.

The best way to deal with a cocaine-induced comedown is lots of rest and a healthy diet. Taking more cocaine or taking another drug to deal with the side effects can be harmful.

Empathogens can make you feel connected, loved up, warm and understanding. They can also cause mood swings and make you feel low and depressed, especially for a day or two after a session. Empathogen drugs include MDMA (ecstasy), MDA and MDAI. Some anti-depressants work in a similar way to empathogens.



MDMA crystal and powder

40% of ecstasy use reported to Crew at festivals refers to MDMA crystal or powder. MDMA is most commonly swallowed in a “bomb” (powder wrapped in a cigarette paper) or dabbed on the tongue.



MDMA can make you feel chatty and euphoric. People may feel more connected to music and others and are able to have conversations more freely.

It also increases your heart rate and body temperature. Other effects can include visual trails, enhanced colour and sound, jaw tension/clenching, dilated pupils and difficulty urinating.

Long-term or heavy use of MDMA can lead to increased feelings of unease, a chronic low mood and more difficulty in managing feelings of anxiety.

It is most commonly seen as an off-white crystal but it can also be yellow, grey, purple or light brown in colour. On average, 0.5 grams is £10-20 and 1 gram is £30-40.

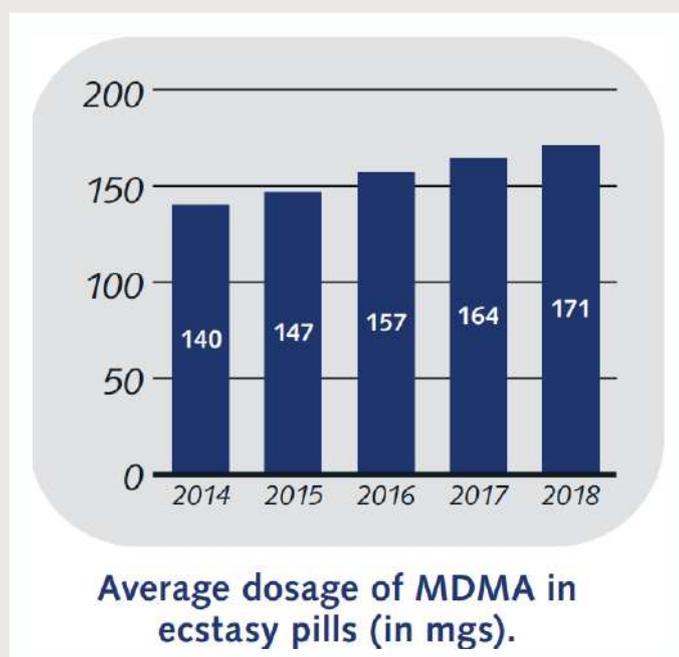
Ecstasy pills

60% of ecstasy use reported to Crew at festivals refers to ecstasy pills. Pills are usually hard-pressed (i.e. not crumbly) and brightly coloured. They are pressed into shapes of logos, characters and brand names. They are most commonly sold for £10 each but prices can range from £5 to £12 per pill, with deals for buying more.

The MDMA content of ecstasy pills has continued to increase over the reporting period. Whilst we do not have any Scotland-specific data, most of the pills in Scotland are imported from Europe, primarily The Netherlands.

Data from the Trimbos Institute's Drugs Information and Monitoring System (DIMS) in The Netherlands, has shown that in 2018, ecstasy pills contained an average of 171 milligrams of MDMA [17].

These figures are similar to data from Safer Party's 'Review of the year 2018 - What has been tested', which reported that ecstasy pills in Switzerland contained an average of 165.6 milligrams of MDMA [18].



DIMS Annual Report 2018 [17]

Ecstasy pills

Research helps us to stay informed. The paper "Variability in content and dissolution profiles of MDMA tablets collected in the UK between 2001 and 2018 - A potential risk to users?" [19] shared new information on the breakdown profiles of ecstasy pills, highlighting the need for renewed harm reduction information.

Research results

"In 2018, the median MDMA content exceeded 100 mg free-base for the first time."

"Dramatic within-batch content variability (up to 136 mg difference) was also demonstrated."

"dissolution profiles at 15-minutes allowed tablets to be categorized as fast-, intermediate-, or slow-releasing, but no tablet characteristics correlated with dissolution classification."

"Clinical manifestations of MDMA toxicity, especially for high-content, slow-releasing tablets, may be delayed or prolonged, and there is a significant risk of users re-dosing if absorption is delayed."

What does this mean for people who take ecstasy pills?

One dose of MDMA for an average person is considered to be around 80 milligrams (this dose should not be taken as a recommendation). This means that, on average, one pill contains more than one dose. Start with a half, or a quarter.

Even if the pill looks the same and was part of the same batch, the amount of MDMA in it can vary. One pill might contain 100 milligrams of MDMA, whereas another that looks the same can contain 236 milligrams. Always dose low.

Some pills release MDMA into the body quickly (about 30 minutes), some pills release MDMA slowly (up to 1.5 hours). A 100 milligram 'fast releasing' pill might give a higher peak MDMA plasma level than a 200 milligram 'slow releasing' pill. There is no way to tell by looking at the pill, so wait at least two hours before taking more. If the effects come on too intense, stay calm, move somewhere quiet and cool and sip on water.

If you don't feel the effects of a pill after an hour, try to not take anymore. It might be that the pill is 'slow releasing' and just hasn't kicked in yet. If you take another one too quickly, you'll increase the chances of MDMA toxicity and unpleasant and dangerous side effects, including overdose. Signs of MDMA toxicity may include, but are not limited to agitation, confusion, uncontrolled body movements or tremors and overheating (high body temperature). Always look out for friends and call 999 in an emergency.

Psychedelics are also known as trips or hallucinogens. They can give a sense of spiritual connection and heighten the senses. They can also cause anxiety, panic and visual or auditory hallucinations. Psychedelic drugs include synthetic substances such as LSD, NBOMe and the 2C family, and natural substances such as psilocybin mushrooms and ayahuasca.

DMT (N,N-dimethyltryptamine)

Between April 2017 and March 2019, the use of psychedelics reported to Crew remained somewhat constant, except for DMT use, which increased.

In the last few years we have seen the use of DMT become more mainstream, with it being reported more frequently at festivals and events.

DMT can cause hallucinations and time distortion; you have altered perceptions and experience heightened mood. Other effects include nausea, disorientation and loss of control. The effects are short-lived but may be very intense, depending on how much you take. It costs an average of £50 per gram.

DMT can be smoked in a pipe or vapourized. Vapourizing is the process of heating a substance to produce a vapour. DMT can be added to e-cigarette liquid and vaped electronically, or it can be vaped from a specific type of vape pen. The trend of vaping is not limited to DMT and we see people vaping other substances, primarily cannabis.



Dissociative drugs can make you feel calm, relaxed, happy and numb. Some dissociatives are used as anaesthetics in veterinary and human medicine. Dissociative drugs include nitrous oxide (laughing gas), methoxetamine and ketamine.

Ketamine

Ketamine can slow down the messages from your brain to your body, make you feel detached from your surroundings and change your perception of time. Low doses can be stimulating.

Higher doses can cause an 'out of body' experience. It can also affect your balance and coordination. Tolerance to ketamine can build quickly and people report taking ever-increasing doses to achieve the desired effect.

In the last few years we have seen the use of ketamine increase. The percentage of counselling clients reporting its use has increased from 2.3% in 2014/15 to 11.9% in 2018/19. It is also commonly reported at festivals and events, where it is being mixed with alcohol and other drugs. This increases the chance of side effects including nausea, vomiting and physical injury caused by a lack of coordination.

In Scotland, ketamine was implicated in 19 drug-related deaths since 2000, 5 of which were in 2018 [7]. Whilst ketamine-related deaths are rare, it can cause mental and physical health including "damage to the urinary system, which can be in the form of severe and in some cases irreversible bladder damage" [20].

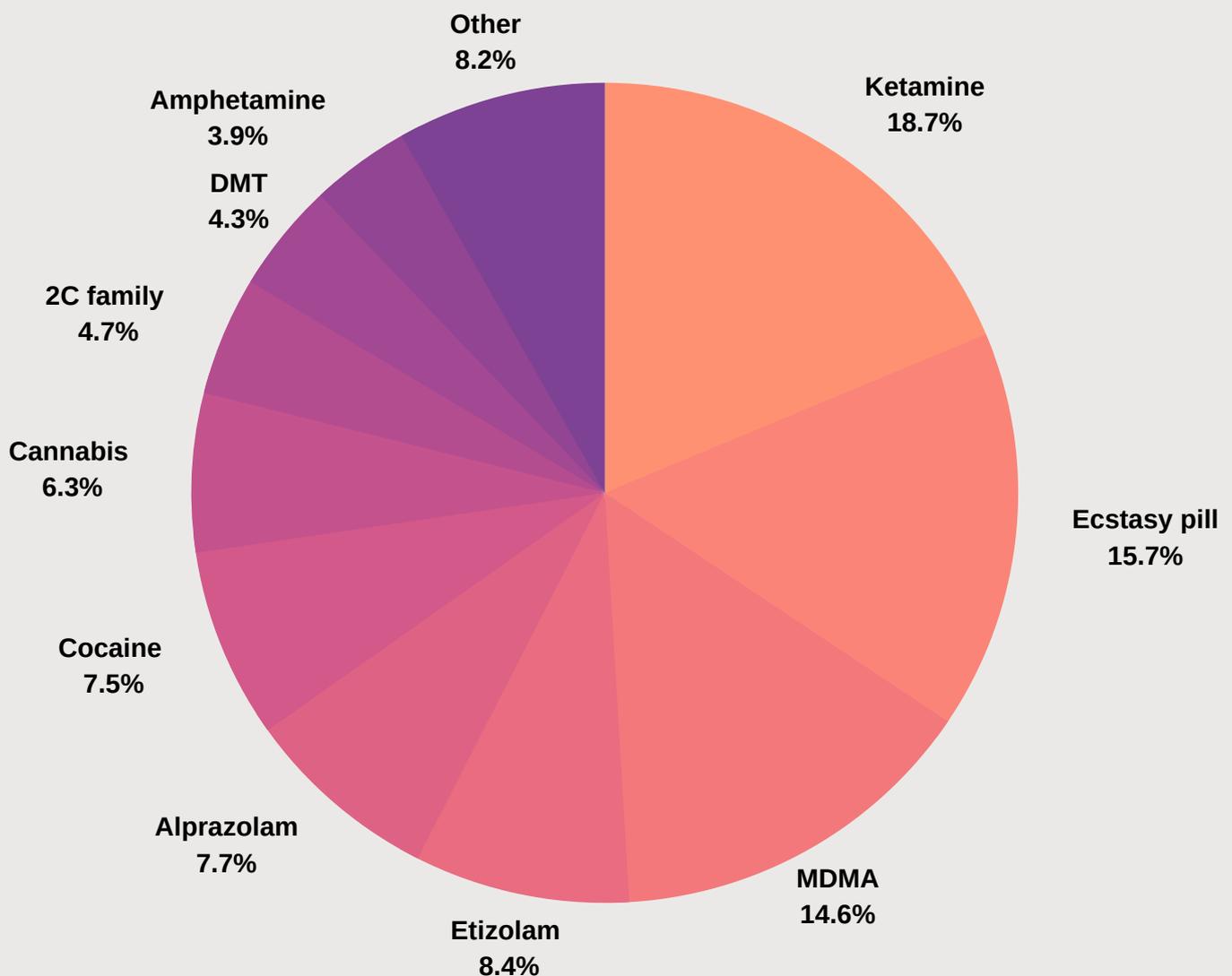
Ketamine is most commonly sold as a white crystalline powder, in 1 gram deals costing an average of £30-40.



Ketamine

Crew launched its new website www.crew.scot in September 2018.

Since the launch in September 2018, to the end of the reporting period in March 2019, our most visited 'drug information' page was ketamine, followed by ecstasy in pill form, and then MDMA.



Note: Trending website hits vary depending on the time of year.

CANNABINOIDS



Cannabinoids are drugs that act on the cannabinoid receptors in the brain. They have a wide range of effects. The effect depends on the type and route of administration. Cannabinoids include all forms of cannabis as well as synthetic cannabinoids such as 5F-ADB and isolated cannabinoids such as cannabidiol.



Cannabis flower and resin

Cannabis comes from the cannabis plant and is the most commonly used illegal drug in the UK.

It is the second most commonly reported drug in Crew's counselling service, after cocaine.

The main psychoactive component is THC (tetrahydrocannabinol). Other cannabinoids in the cannabis plant include CBD, CBG and CBN. Plants may be grown to contain different cannabinoid concentrations and therefore give different effects. Cannabis can make you feel happy, relaxed, calm and introspective. Other effects can include feeling hungry, withdrawn and paranoid.

Herbal cannabis is comprised of the flowers and buds of the cannabis plant and is the most common type of cannabis reported to Crew. On average, 1 gram is £10 and 3.5 grams (1/8 of an ounce) is £30.

Resin is a type of cannabis that is compressed into blocks. It comes in various shades of brown. The price and quality of cannabis resin is wide ranging. On average, 1 gram is £5 and 3.5 grams (1/8 of an ounce) is £15, but it can sell for up to £15 per gram, depending on the type.

Cannabis concentrates

We are also seeing an increasing amount of cannabis concentrates. These are cannabis-derived products that contain high levels of THC, generally over 40%. Concentrates come in forms including oil, shatter, wax and edibles including sweets and syrups.

Prices reflect the high THC content although price (and concentration) can vary widely, from £40 to £100 per gram.



1G 'DAB', CANNABIS CONCENTRATE

CBD (cannabidiol)

THC and CBD are the 2 most notable cannabinoids found in the cannabis plant. THC is known for its mind-altering effects such as euphoria. The effects of CBD are more subtle. CBD counters negative effects from THC by promoting relaxation and reducing anxiety.

CBD products are made from CBD that has been isolated and therefore people taking it won't experience a 'cannabis high'. In its pure form, CBD is not controlled by the Misuse of Drugs Act (1971).



CBD OIL AND VAPE LIQUID

CBD is now sold as a food supplement in many countries. 'Food supplements' are a wide range of products that include vitamins and minerals. In the UK, supplements are not regulated as stringently as other products for 'human consumption', such as food and medicine.

CBD (cannabidiol)

CBD is not a 'medicinal product', so sellers cannot make claims about medicinal properties (such as 'treats depression') and instead they include vague statements about its purpose, using words like 'promising' and 'versatile'. It is also not sold as having any psychoactive effects (such as 'relaxing' or 'anxiety alleviating') as this would contravene the Psychoactive Substances Act (2016), which prohibits the sale of any substance capable of producing a psychoactive effect.

It is difficult to extract CBD from a plant without including other cannabinoids such as THC. Many CBD products tested by Police Scotland have tested positive for THC and are therefore a Class B drug. The UK Home Office guidance states that **"If a CBD 'product' contained any controlled cannabinoids, unintentionally or otherwise ... it is highly likely that the product would be controlled ... presumption has to be one of caution - that is, that a CBD containing product would be controlled under the MDA 1971/MDR 2001 as a result of its other cannabinoid content"** [21].

Cannabis sold as 'CBD flower' or 'bud' is still cannabis, even if it does not contain THC, and it is therefore illegal. However it is still widely available in shops and online where it sells for £10 to £13 per gram.

Despite its vague claims and confusing legal status, the CBD industry has boomed in recent years. There are hundreds of retailers selling CBD oils, pastes and capsules across Scotland. On average, a good quality 600 milligram oil will cost £35 per 10 millilitres. There has also been a rise in the variety of overpriced, novelty items such as CBD lip balms, bath bombs and energy drinks.

For those looking to take CBD oil, we would recommend that they research CBD (including information on its legal status and interactions it may have with medicines), that they only buy from a reputable and trusted supplier, and that they speak to a doctor before making any changes to medical treatment. Those already taking it should be aware that the regulations surrounding CBD products may be tightened, or more heavily enforced in the future.

Synthetic cannabinoids

Synthetic cannabinoids and synthetic cannabinoid receptor agonists (SCRAs) are terms used to describe over 200 different psychoactive drugs. They are sometimes referred to by street names such as spice and mamba.

In Scotland, the use of synthetic cannabinoids has reduced in recent years but between 2017 and 2019 Crew received several concerns regarding their use. These were primarily reports from prison staff and homeless sector workers across Scotland and England.



Despite their overwhelming negative effects (including nausea, paranoia, anxiety, inability to move/talk), they continue to be used within prison settings as they are difficult to detect using traditional drug surveillance tools and mandatory drug testing.

Synthetic cannabinoids are most commonly found sprayed onto paper including children's drawings, letters and greetings cards. This paper is then cut into 1 x 1 or 1.5 x 1.5 cm squares which are sold for approximately £10 each (prison prices).

Until November 2018, synthetic cannabinoids were most commonly smoked in a (homemade) pipe or bong, or rolled into a joint using rolling papers and tobacco. In November 2018, smoking was banned in Scottish prisons and prisoners were provided with e-cigarettes. After the ban, levels of smoking decreased and vaping increased. Synthetic cannabinoids are vaped by placing the paper into the liquid, or onto the heating element of the e-cigarette.

Synthetic cannabinoids

First, second and third generation cannabinoids are controlled by the Misuse of Drugs Act (1971) (MoDA) as Class B substances.

Some newer ones are not controlled by the MoDA but are covered by the Psychoactive Substances Act (2016).

Due to concern about the negative impact of these substances, there were calls for them to be rescheduled from Class B to Class A drugs under the MoDA. This was discussed in UK Parliament in November 2018.

SYNTHETIC CANNABINOIDS SPRAYED ONTO PAPER



The synthetic cannabinoids in use at any time point depend on availability, which is influenced by legislation. For example, 5F-ADB was identified across Scotland but use has declined since it was brought under international control under Schedule II of the Convention on Psychotropic Substances of 1971 in March 2018. Since then manufacturers have switched to other similar compounds.

Synthetic cannabinoids identified in Scotland between 2015 and 2017 include:

- AKB-48
- 5F-AKB-48
- PB-22
- 5F-PB-22
- 5F-MDMB-PINACA (5F-ADB)

Synthetic cannabinoids identified in Scotland between 2017 and 2019 include:

- 5F-MDMB-PINACA (5F-ADB)
- 5F-MDMB-PICA
- 4F-MDMB-BINACA
- AMB-FUBINACA
- AMB-CHMICA

Depressants are also known as downers. They can decrease heart rate and breathing and can increase euphoria and confidence. They can lead to risk-taking behaviour and unconsciousness. Depressant drugs include alcohol, gabapentinoids, benzodiazepines, GHB (gamma-hydroxybutyrate) and GBL (gamma-butyrolactone).



Alcohol

In Scotland in 2017, "24% of adults drank at harmful or hazardous levels, down from 34% in 2003" [22].

The National Records of Scotland reports that "In 2018, there were 1,136 alcohol-specific deaths, on the basis of the new National Statistics (NS) definition. This was an increase of 16 (1%) compared with the previous year, and more than in six of the previous seven years (only 2016, with 1,139, was higher)" [23].

The Alcohol etc. (Scotland) Act 2010 regulates the sale of alcohol in Scotland. Restrictions imposed by this Act include a ban on drinks promotions (e.g. buy one, get one free or buy six, get 20% off), and it prohibits the purchase of alcohol from a shop between the hours of 10pm and 10am.

In a further attempt to curb problem drinking, the Scottish Government introduced the Alcohol (Minimum Pricing) (Scotland) Act 2012 on 01 May 2018. There was a delay in its implementation due to legal challenges, primarily from the drinks industry. This Act means alcohol cannot be sold below a minimum price. The minimum price is currently set at 50 pence per unit.

Alcohol

Controlled pricing has had a dramatic impact on some alcohol sales. This change is most notable for high strength alcohol that was previously sold more cheaply. Before, a 3 litre bottle of white cider, containing 22 units, may have cost £4: now the same bottle would cost a minimum of £11.

Modelling by The University of Sheffield estimated that "there would be the following effects after one year:

- 60 fewer deaths due to alcohol
- 1,300 fewer hospital admissions due to alcohol
- 3,500 fewer crimes due to alcohol

The health gains will continue to increase over 20 years and researchers estimate that the full effect of the policy would be:

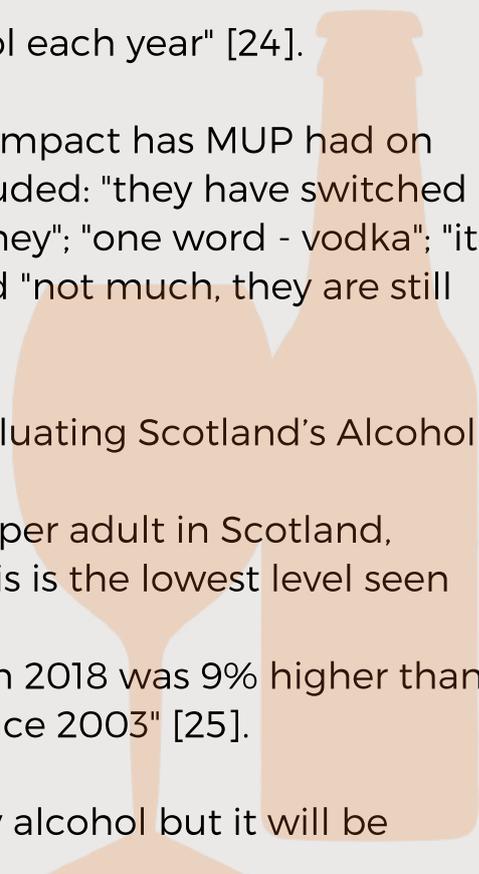
- 120 fewer deaths due to alcohol each year
- 2,000 fewer hospital admissions due to alcohol each year" [24].

At Crew training sessions, we ask workers, "what impact has MUP had on the people you work with?". Responses have included: "they have switched to drinks they perceive to be better value for money"; "one word - vodka"; "it makes no difference, much of it is shoplifted" and "not much, they are still drinking and taking street benzos".

NHS Health Scotland's, 2019 "Monitoring and Evaluating Scotland's Alcohol Strategy" reports:

- "In 2018, 9.9 litres (L) of pure alcohol were sold per adult in Scotland, equivalent to 19.0 units per adult per week. This is the lowest level seen in Scotland over the available time series."
- "The volume of pure alcohol sold in Scotland in 2018 was 9% higher than in England & Wales, the smallest difference since 2003" [25].

We welcome a reduction in the harms caused by alcohol but it will be years before the impact is fully understood.



Benzodiazepines

Benzodiazepines are a group of tranquilliser drugs, with sedative effects. They can cause drowsiness and long periods of sleep.

People taking them can experience a 'floating' sensation as well as a warm, calm and relaxed feeling. Other effects can include lack of coordination, slowed speech, aggression, blackouts, short-term memory loss and reduced mental alertness. Benzodiazepines can also reduce anxiety and therefore impair your judgement of danger. This makes people care less and can result in risky behaviour.



Valium, 'vallies', 'blues' and 'street benzos' are generic, interchangeable terms to describe benzodiazepines which are not prescribed.

Street prices quoted in this section are for 1 or 2 pills. Significant discounts are sometimes given when buying benzodiazepines in bulk e.g. 20 for £10, 50 for £20.

Diazepam (Valium)

Diazepam is widely prescribed in the UK but is a Class C drug when possessed without a prescription.

While the use of benzodiazepines has increased in Scotland in recent years, the use of diazepam has remained relatively stable. This may be because other benzodiazepines that are stronger and cheaper have increased in popularity over diazepam. On average, diazepam is sold for £1 per pill.

Etizolam

Etizolam is not licensed for use in the UK. It was previously sold as a 'legal high' in shops and online but was made a Class C drug under the Misuse of Drugs Act (1971) in May 2017, alongside 15 other benzodiazepines including diclazepam, flubromazepam and pyrazolam. It is 10 times more potent than diazepam [26].

Since the law change, we have seen an increase in the use of etizolam. When it moved from the 'legal high' market to the illegal drugs market, reports of varying content and concentration levels increased. This causes an increase in harm as people know less about what they are taking.

2 X ETIZOLAM TABLETS (MARKED AS DIAZEPAM)



WEDINOS reported that from April 2018 to March 2019, 29% of samples sold as diazepam and 34% of samples sold as alprazolam contained etizolam [27]. On average, etizolam is sold for £1 per pill.

Alprazolam (Xanax)

Alprazolam is generally not prescribed on the NHS. It is a Class C drug under the Misuse of Drugs Act (1971). It is most commonly found in tablet form in various shapes and sizes; it is often found as a blue or white circular tablet or a white oblong bar. Circular 'xans' are sold on average for £1 each, whereas the 'bars' sell for £1-2 each.

Even though some pills are stamped with manufacturing information, or sold in blister packs, almost (if not) all the alprazolam seized in Scotland over the reporting period was counterfeit (fake) and the amount of alprazolam in pills varied widely.

Gabapentinoids

Gabapentinoids (primarily gabapentin and pregabalin) are drugs prescribed for epilepsy and neuropathic pain.

As of 01 April 2019, if possessed without a prescription, gabapentin and pregabalin are Class C drugs under the Misuse of Drugs Act (1971).

People taking them can experience feelings of relaxation, calmness and euphoria. Other effects include confusion, drowsiness and loss of memory. In high doses there is a risk of physical injury, caused by a lack of coordination when taking gabapentin and/or pregabalin.

Part of their continued appeal is their ability to enhance and increase the effect of opioids, therefore people need to take less opioids to achieve the desired effect. When gabapentinoids are taken with opioids, for example heroin, it "increases the risk of acute overdose death, through either reversal of tolerance or an additive effect of the drugs abilities to depress respiration." [28]

Most of the 'street' gabapentinoids in circulation have been rediverted from legitimate medicinal supplies. Gabapentin is most commonly found in 300 milligram gel capsules for £2-3 each. Pregabalin is most commonly found in 150 milligram gel capsules for £1-2 each.



Opioids act on the opioid receptors in the brain. They can make you feel confident and safe. Many are effective painkillers and they are widely used in human medicine. Opioid drugs include heroin, morphine, methadone, codeine, dihydrocodeine, buprenorphine and tramadol.

Heroin

Heroin (diamorphine) is an opioid that is usually found as a brown powder. Heroin is most commonly injected but this is a very risky route of administration. It can also be smoked; clean foil is available from injecting equipment providers.

It is most commonly sold in £10 deals. In recent years, the purity of street heroin has remained relatively constant at an average of 20% but the cost per gram has decreased. The average weight of a 'tenner' bag has increased from 100 milligrams to over 150 milligrams, with some 'tenner' bag seizures in Glasgow weighing up to 230 milligrams.

Opioid New Psychoactive Substances (NPS)

Opioid NPS are a group of new or novel drugs that have opioid effects. "60 different NPS with opioid effects have been reported to the UNODC Early Warning Advisory on NPS, including 50 fentanyl-related substances, as well as other synthetic opioids, such as U-48800 and U-50488" [29].

Despite having the highest opioid-related death rate in the world, use of opioid NPS in Scotland remains low, however several opioid NPS have been detected in seizures and post-mortem toxicology.



NALOXONE



Naloxone is a medicine used to block the effects of opioids such as heroin, methadone and buprenorphine.

It can reverse an opioid overdose, if administered quickly. It does this by binding to the brain's opioid receptors more strongly than the drugs do. The effects are temporary, but it buys time to get medical help.

Crew staff and volunteers are trained to administer naloxone, and we store it on our premises and carry it on outreach.

We encourage all services, who work with people who take drugs, to arrange the provision of naloxone, as well as staff training. Friends or family members of people who take opioids are also encouraged to carry naloxone and they can pick it up from their local NHS drug service.

We advocate its use and would like to share one of our incidents (below) in which naloxone proved lifesaving. The incident, although sad, is reflective of that which happens many times a day across Scotland.



"It was another afternoon in the Drop-in when a man came in. He was a bit out of it but was able to give his name and tell our Drop-in Worker that he had taken some brown [heroin] and some blues [benzodiazepines] on top of his methadone prescription. His speech was slurred and he was clumsy.

His condition began to get worse, so we sat him down and reassured him. The Drop-in Worker called upstairs for a first aider and some support. The staff first aider quickly joined them with naloxone and a first aid kit. In the few minutes it took the staff first aider to get down the stairs, the man's condition had worsened. He was sinking down towards the floor, first leaning forward, then back into the sofa with a drawn-out look on his face. He was pale and his lips were blue and purple. Then his breathing started to become rasping and noisy, like he was starting to struggle to breathe, and he stopped responding to our questions.

The Drop-in Worker called 999 and closed the Drop-in shop while one of our amazing volunteers continued to support the man using a gentle, calm voice. Whilst the volunteer did this, the first aider removed the naloxone from the pack, attached the needle to the syringe and, through his jeans into his thigh, administered one dose of naloxone. After a couple of minutes his condition didn't improve, so he was given another dose.

We then moved him to the floor in case we needed to resuscitate him. He was tall but weighed very little. After moving him to the floor he came around slowly. Whilst still reassuring him, we sat him up and explained what had happened. He was quite restless and was very confused.

It was around this time the ambulance arrived. They quickly checked him over and asked him to attend the hospital. He refused and the ambulance staff left. He remained with us and we sat and drank tea. The effects of naloxone are short lasting, and we explained there was a chance he could go under again but after a while he decided he was well enough to leave, so got up and walked out.

We didn't know who he was, and he didn't want to share his details, so it was upsetting to think he most likely walked back into the same situation that brought him to us in the first place."

Crew worker

The benefits of naloxone are:

- It saves lives and 'does exactly what it says on the tin'.
- It is easy to use and quick acting.

The considerations of naloxone are:

- Each kit comes with 2 separate needles which could be re-purposed to inject drugs, rendering the kit unusable. Ensure people injecting drugs have good access to injecting equipment provision.
- There is a small risk of needle stick injury. This risk can be minimised by being confident and trained in its use. Organisations should carry out a needle stick injury risk assessment. These risks would be eliminated by using nasal naloxone.
- It only works for opioids and not for other drugs such as cocaine or benzodiazepines. However, if you are in doubt over what they have taken, give naloxone.
- Like all medicines, it expires. Keep an eye on the expiry date and get it replaced when you need to.



CONCLUSIONS



Drug-related deaths

- The figure of 1,187 is the highest in Scotland's history, and represents thousands of people, and an even greater number of families and friends who have been failed by the system.
- Opioids were implicated in 86% of the deaths. The average age was 42 but people ranged from under 14 to over 65. In most deaths, more than one drug was implicated and the importance of avoiding polydrug use cannot be emphasised enough.
- The current situation is not news for those who have experienced it, and those working with it every day. Scotland has had the highest drug-related death rate in Europe for many years but nothing has changed for the better.
- As the media frenzy relating to the 2018 drug-related deaths calms, our calls to reduce drug harm and drug deaths must be louder and more focussed than ever. The 2019 figures won't be published until summer 2020 but initial, locality-based reports suggest they are not reducing.
- Crew have spoken extensively about some of the reasons for this increase and ways in which we can improve the situation, however this is not the place to repeat ourselves. One example can be found on page 28 to 33 of our 2016/2017 report [3]. We also submitted evidence to the Scottish Affairs Committee's inquiry on problem drug use in Scotland [30].

#stopthedeaths

#behindthenumbers

Drug trends

- There are now more drugs in circulation than ever before and the use of New Psychoactive Substances has continued, despite efforts to curb availability via legislation including the Psychoactive Substances Act (2016) and updates to the Misuse of Drugs Act (1971). The use of NPS, especially NPS stimulants, is less widespread than it was a few years ago however some drugs, such as etizolam, have become mainstream. Other NPS, primarily synthetic cannabinoids, remain popular in prisons due to their potency and the difficulty in detecting them.
- Since the PSA, the number of Crew counselling clients seeking support for their use of NPS has reduced but this reduction has been met with a rise in people presenting with problematic cocaine use.
- The use of cocaine is of particular concern due to its destabilising effects and mainstream use, combined with an underestimation of its potential harms. Cocaine is also linked to violent and antisocial behaviour and it causes substantial societal harms from its links to organised crime.
- There is an overall trend of drugs getting purer, while prices remain the same. This increased affordability brings with it an increase in drug-related harms.
- Use of stimulants is increasing and people may encounter harms and require services which we simply do not have enough of. Services must adapt to a change in drug use and cater for all people, not just those taking opioids or benzodiazepines. We strongly and urgently recommend that problematic psychostimulant drug use is included in the Information Services Division's definition of problem drug use, in order to reflect the changing patterns of drug harm and ensure that research, budgets and services can be developed according to changing national needs.

Overall

- There has been no overall decrease in drug taking or drug-related harm as a result of legislative approaches taken to control their availability. UK drug laws are based on an outdated ideology and must be revised.
- Drug-related harm, such as drug-related hospital admissions and drug-related deaths have significantly increased over the past few years.
- Drug-related deaths are at their highest level since records began and reflect the poor quality of life and inadequacy of social care experienced by many people in Scotland. Poverty, health inequalities, inadequate and underfunded services and a lack of education are all issues that need to be addressed alongside Scotland's culture of taking to excess.
- Crew backs evidenced-based projects which reduce drug-related harms, such as community testing, heroin-assisted treatment and safer consumption facilities, but even if approval was given for these projects now there would still be a wait of months, if not years, before they were implemented into practice. That won't stop our family and friends dying today, tomorrow, and every day after that.
- As well as showcasing new initiatives we should look at the hundreds of existing drug services and organisations already working tirelessly across the nation. Most services are constrained by money and resources. If governments are serious about treating this as the public health emergency that it is, emergency funding must be given to allow the organisations already delivering effective, evidence-based services to improve and expand operations, reach and outcomes, and to have an immediate impact on reducing drug harms in Scotland. Every day that this is delayed, the head count gets higher.
- With an average of 3 people dying of a drug-related death every single day in Scotland this is a national shame and tragedy. We need action, now.

Table - EMCDDA DRDs - page 27

SCOTLAND DRDS AS PER EMCDDA DEFINITION

Year	Total EMCDDA DRDs (all ages) [A]	Total EMCDDA DRDs (aged 15-64)	Population of Scotland (aged 15-64) [D]	EMCDDA DRDs per million (aged 15-64)
2014	574	563	3,526,673	159.6
2015	637	619	3,534,330	175.1
2016	772	754	3,545,370	212.7
2017	828	813	3,548,079	229.1
2018	1064	1046	3,546,245	295.0

[A] - NRS, Drug-related Deaths in Scotland in 2018 - Table X

[B] - NRS, Drug-related Deaths in Scotland reports 2014-2018 - Table EMCDDA

[C] - NRS, Drug-induced deaths, on the EMCDDA definition, registered in Scotland, unpublished data

[D] - NRS, Drug-related Deaths in Scotland in 2018 - 'All Tables and Figures', sheet '8 calc Scots rates', cell I79

Table - Opioid DRDs - page 29

OPIOIDS ONLY, ALL AGES

Year	Total DRDs [E]	Any opiate or opioid DRD [F]	Population of Scotland (all) [G]	Opioid related deaths per million (all ages)
2013	527	461	5,327,700	86.5
2014	614	536	5,347,600	100.2
2015	706	606	5,373,000	112.8
2016	868	766	5,404,700	141.7
2017	934	815	5,424,800	150.2
2018	1187	1,021	5,438,100	187.7

[E] - NRS, Drug-related Deaths in Scotland in 2018 - Table X, column 2

[F] - NRS, Drug-related Deaths in Scotland in 2018 - Table 3, column 8

[G] - NRS, Drug-related Deaths in Scotland in 2018 - 'All Tables and Figures', sheet '8 calc Scots rates', cell K79

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STREET PRICES AND PURITY

Scotland's average street prices for the drugs in this report were calculated by averaging existing Crew data, with data from the Police Scotland STOP Unit and results from Crew's volunteer street price drug survey 2019. Please note that these are average (mean) prices and can change depending on geographical area, drug quality and market conditions. All reports of purity are from the Police Scotland STOP Unit.

This work is dedicated to all those who have lost their lives, and the loved ones they have left behind.

Our heartfelt thanks go out to everyone who has supported and shared their experience with Crew, including our volunteers, partners and people who accessed our services. We also thank all our multi-agency partners who continue to work through adversity for the greater good.

Thanks to Graeme Paterson from the STOP Unit (East) at Police Scotland for his help and patience in allowing us to source the photographs in this report. All images are copyrighted by SDN, Crew or Police Scotland.

WITH THANKS



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