Combined research and studies

First author surname	Year	Study type	Country	NZ	Setting	Participants/ studies	Drug type	Population	Lived experience involvement	Intervention	How intervention was funded	Legal context of intervention	Outcome measures	GRADE assessment	Comments on GRADE rationale	Comment on outcomes
WHO	2025	Briefing	Global	No	N/A	n/a	Alcohol	n/a	n/a	n/a	n/a	n/a	n/a	Low	briefing so automatically starts at low. No down or upgrade	Suggests policy makers should identify opportunities to restrict alcohol availabilty, reducing downstream costs. Invest in enforcement of regulations Partner with, and fund, community based orgs and researchers. Consider equity and how interventions will affect subpopulations. Consider how to prevent those with vested interest from serving on boards.
WHO	2024	Report	Global	Yes	N/A	n/a	Alcohol and other drugs	n/a	n/a	Screening, brief interventions and referrals to treatment Pharmacological treatment services and interventions Psychosocial	n/a	n/a	n/a	Low	report so automatically starts at low. No down or upgrade	Calls for strengthening of prevention and treatment capacity in health and social care systems. Calls for active engagement and empowerment of civil society organizations, professional associations and people with lived experience of substance use disorders
WHO	2010	Report	Global	n/a	N/A	n/a	Alcohol	n/a	n/a	Several	n/a	n/a	n/a	Low	report so automatically starts at low. No down or upgrade	Area 5: reducing availability of alcohol. Calls for policy and interventions to reduce alcohol availbility, while avoiding too strict restrictions which promote illict markets.
Kennedy	2017	Systematic Review	Global	no	N/A	n/a	Illicit drugs	People who use or inject drugs and the broader communities in which supervised drug consumption facilities (SCFs) are located	n/a	Supervised drug consumption facilities	n/a	n/a	All individual- or population-level health or social outcomes	Low	downgrade for bias, indirectness	6 of 8 studies found protective effect of SCFs for overdose related morbidity and mortality. 3 of 4 found an inverse relationship between SCF use and syringe sharing. 2 studies found decreased unsafe injecting behaviours associated with SCF use. Positive association between SCF use and uptake of addiction treatment.

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Amato	2011	Cochrane Review	USA (x10) UK (x1)	n/a	N/A	11 studies (1592 participants)	Opioids	patients with opioid detoxification	Not stated	Any Psychosocial plus any Pharmacological versus any Pharmachological alone	n/a	n/a	Primary: 1) Dropout as number of participants dropped out from detoxification program; 2) Use of opioid drugs measured as number of participants with positive urinalysis during the treatment; 3) Results at follow-up as number of participants using opioids at follow up Secondary: 1) Compliance as clinical absences during the study period; 2) Use of other drugs; 3) Mortality; 4) Engagement in further treatment	Moderate	Downgrade for bias	The results of this review show that psychosocial treatments offered in addition to pharmacological detoxification treatments are effective in terms of completion of treatment, use of opiate and participants abstinent at follow-up. Their effectiveness seems to be stronger than those observed if these treatments were associated with maintenance treatment. Given that methadone detoxification is such a widely used procedure, it appears reasonable to attempt to develop more efficacious detoxification techniques and to add psychosocial interventions to detoxification techniques seems to improve this procedure.
Rahimi-Movaghar	2013	Cochrane Review	Iran	no	Outpatient treatment centre	3 studies (843 participants)	Opium	Opium dependent patients who underwent maintenance treatment. Trials including patients with additional physical or psychological illness were also eligible	Not stated	Pharmacological therapies, including low, medium, high and flexible doses of methadone, buprenorphine, naltrexone, and opium maintenance.	n/a	Not stated	Primary: 1) Retention in treatment; 2) Opium use during treatment (reduction in use and abstinence) measured by self-report or positive urinalysis during the treatment. Secondary: 1) Opium withdrawal symptoms; 2) Secondary drug use during treatment; 3) Criminal activity; 4) Physical health; 5 Psychological health; 6) Social functioning; 7) Mortality rate (for all causes, for overdose and for acute diseases); 8) Side effects and nonfatal overdose; 9) Client satisfaction.	Very low	Downgrade for bias, inconsistency	Two RCTs with 843 patients compared different doses of buprenorphine from 1 mg/day to 8 mg/day and the results showed that the higher doses of buprenorphine were more effective than lower doses in retention of the patients in treatment. However, other important outcomes, such as drug use and drug side effects were not assessed; the quality of the studies was unknown and the risk of biases was unclear. One other study assessed the effectiveness of baclofen on maintenance treatment of opioid dependence after detoxification, but only 27 of the participants were opium dependent. The study had been done with a good quality and low risk of bias. It showed that baclofen increased the retention in treatment, but the difference from placebo was not significant. Overall, the results from three RCTs are not sufficient to form a view on the effectiveness of any pharmacological intervention for opium dependence.

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Pani	2011	Cochrane Review	USA (x6 studies) Australia (x1)	no	In and outpatient	7 studies (482 participants)	Opioids	patients with depression during opioid agonist treatment for opioid dependence	n/a	Antidepressants	Not stated	N/A	Primary: 1) Dropouts from the treatment as number of participants who did not complete the treatment, looking separately at dropouts from antidepressant treatment and from opioid agonist treatment; 2) Severity of depression measured with validated scales, e.g. Hamilton Depression Rating Scale, (HDRS), Beck Depression Inventory (BDI), Profile of Mood States Scale (POMSS), etc; 3) Acceptability of the treatment as number and type of adverse events experienced during the treatment. Secondary: 1) Use of primary substance of abuse as number of participants that reported the use of opioids, cocaine, alcohol during the treatment, and/or number of participants with urine samples positive for opioids or cocaine; 2) Psychiatric	Low	downgrade for bias, inconsistency	No clear difference was found in the number of dropouts from an opioid agonist maintenance program between people receiving antidepressants and those in the placebo groups. Neither was drug use different (two studies). Severity of depression was reduced with the use of antidepressants (two studies), including tricyclic antidepressants. Adverse events were important as more of the participants who received antidepressants withdrew from the studies for medical reasons compared with those participants on placebo (four studies). The differences between studies in clinical (participant characteristics, the medications used, services and treatments delivered) and methodological characteristics (study design and quality) made it difficult to draw confident conclusions about the efficacy and safety of antidepressants for the treatment of depression in people who are dependent on opioids.
Gates	2016	Cochrane Review	USA (x15 studies) Australia (x2) Germany (x2) Switzerland (x1) Canada (x1) Brazil (x1) Ireland (x1)	no	Outpatient treatment centre	23 studies (4045 participants)	Cannabis	adults with cannabis use disorder or frequent cannabis use	Not stated	psychosocial intervention	Not stated	N/A	Primary: 1) Self reported use of cannabis (number of days, rate of abstinence, times per day) with or without confirmation by objective means (urinalysis or hair/saliva analyses, as well as collateral reports); 2) Severity of cannabis use disorder observed as an index measured by a standardised questionnaire (such as the Addiction Severity Index (ASI) (McLellan 1980) or the Severity of Dependence Scale (SDS) (Swift 1998)) or as a count of symptoms of dependence following clinical assessment; 3) Level of cannabis-related problems such as medical problems, legal problems, social and family relations, employment and support (typically assessed by questionnaires such as the Marijuana Problem Scale (Stephens 2000) or the Cannabis Problems	Low	Downgrade for bias, inconsistency	the weight of evidence focusing on motivational enhancement therapy (MET) and cognitive-behavioural therapy (CBT) interventions. Although moderate evidence indicates that significant reductions in cannabis use frequency are likely in the short term (within six months), complete abstinence was not often attained. Moreover, treatment was not consistently effective in reducing cannabis-related problems or in addressing secondary outcomes such as other substance use and mental health concerns.

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Amato	2013	Cochrane Review	USA (x6 studies) UK (x5) Spain (x4) China (x2) Iran (x2) Germany (x2) Austria (x1) Italy (x1)	no	In and outpatient	23 studies (2467 participants)	Opioids	patients with the management of opioid withdrawal	Not stated	Tapered methadone versus any other treatment	Not stated	N/A	Primary: 1) Completion of treatment as number of participants completing the detoxification program; 2) Acceptability of the treatment as a) duration and severity of signs and symptoms of withdrawal, including patient self-rating, b) side effects; 3) Results at follow-up as (a) number of participants abstinent at follow-up, (b) naloxone challenge. Secondary: 1) Use of primary substance of abuse as a) number of participants who referred to the use of opioid during the treatment, b) number of participants with urine samples positive for opiate.	Moderate	downgrade for inconsistency	The studies included in this review confirm that slow tapering with temporary substitution of long- acting opioids, can reduce withdrawal severity. The results indicate that the medications used in the included studies are similar in terms of overall effectiveness, although symptoms experienced by participants differed according to the medication used and the program adopted.
Leone	2010	Cochrane Review	Italy (x11 studies) Germany (x1) Austria (x1)	no	In and outpatient	13 studies (648 participants)	Alcohol	patients with alcohol withdrawal	Not stated	GHB 50mg	Not stated	N/A	Short term primary: 1) Global severity of overall alcohol withdrawal syndrome as measured using a prespecified scale, including Clinical Institute Withdrawal Assessment for Alcohol [CIWA-Ar], and others. Short term secondary: 1) Severity of single symptoms and signs, measured with either qualitative or quantitative scales; 2) Side effects Mid term primary: 1) Drop-out rate; 2) Abstinence rate; 3) Relapse to heavy drinking; 4) Craving (as measured in prespecified scales). Mid term secondary: 1) Length of stay in treatment; 2) Controlled drinking; 3) Number of daily drinks; 4) Number of heavy drinking days; 5) Side effects.	Low	downgrade for bias	There is insufficient randomised evidence to be confident of a difference between GHB and placebo, or to determine reliably if GHB is more or less effective than other drugs for the treatment of alcohol withdrawl or the prevention of relapses. The small amount of randomised evidence available suggests that GHB 50mg may be more effective than placebo in the treatment of AWS, and in preventing relapses and craving in previously detoxified alcoholics during the first 3 months of follow-up

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Minozzi	2014	Cochrane Review	USA (x2)	No	Outpatient treatment centre	2 studies (187 participants)	Heroin	heroin-addicted adolescents (14 to 21 years old)	Not stated	buprenorphine-naloxone maintenance	Not stated	N/A	Primary: 1) Drop-outs, measured as the number of participants that did not complete the maintenance treatment; 2) Use of primary substance, measured as number of participants with opiate-positive urinalysis during and at the end of treatment or using self reported data, or both; 3) Results at follow-up, measured as the number of participants relapsed at the end of follow-up. Secondary: 1) Use of other substances of abuse; 2) Side effects; 3) Mortality, any cause; 4) Non-fatal overdose; 5) Criminal activity; 6) Social functioning	Very low	downgrade for bias, imprecision	Maintenance treatment appeared to be more efficacious in retaining patients in treatment but not in reducing patients with a positive urine test at the end of the study. Self reported opioid use at one-year follow-up was significantly lower in the maintenance group, even though both groups reported a high level of opioid use and more patients in the maintenance group were enrolled in other addiction treatment programmes at 12-month follow-up. It is difficult to draw conclusions on the basis of only two trials with few participants. One of the possible reasons for the lack of evidence could be the difficulty of conducting trials with young people for practical and ethical reasons.
Minozzi	2011	Cochrane Review	USA (x4 studies) Israel (x2) Russia (x2) Italy (x1) Spain (x1) China (x1) Malaysia (x1) Germany (x1)	No	Outpatient treatment centre	13 studies (1158 participants)	Opioids	People with opioid addiction after detoxification	Not stated	naltrexone versus placebo or no pharmacological treatments	Not stated	N/A	Primary: 1) Abstibence in using heroin measured by (a) number of participants retained at the end of the study or (b) number of participants retained and abstinent at the end of the study or (c) number of participants without positive urinalysis at the end of the study and self report data; 2) Relapse at follow up measured as number of participants relapsed at the end of follow up; 3) Mortality. Secondary: 1) Side effects measured as number of participants with at least one side effect; 2) Criminal activity measured as number of participants re-incarcerated during the treatment	Very low	downgrade for bias, inconsistency, imprecision	The findings of this review suggest that oral naltrexone did not performed better than treatment with placebo or no pharmacological treatments a part from the number of participants re-incarcerated during the study period. If oral naltrexone is compared with other pharmacological treatments such as benzodiazepine and buprenorphine, no statistically significant difference was found. The percentage of people retained in treatment in the include studies was low (28%). The conclusion of this review is that the studies conducted to date have not allowed an adequate evaluation of oral naltrexone treatment in the field of opioid dependence.

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Minozzi	2014	Cochrane Review	USA	No	Outpatients	2 studies (190)	Opiates	opiate dependent adolescents (13 to 21 years old)	Not stated	buprenorphine versus clonidine buprenorphine detox	Not stated	N/A	Primary: 1) Drop outs measured as number of participants who did not complete the detoxification treatment; 2) Use of primary substance measured as number of participants with opiate positive urine analysis during and at the end of treatment or self-reported data; 3) Acceptability of the treatment as (a) duration and severity of signs and symptoms of withdrawal, including patient self-rating (b) side effects; 3) Results at follow-up measured as number of participants who relapsed at the end of follow-up. Secondary: 1) Engagement in further treatment measured as number of participants who enrolled in any psychosocial or pharmacological treatment; 2) Use of other substances of abuse; 3) Overdose, fatal or nonfatal; 4) Criminal activity; 5)	Moderate	downgrade for imprecision	The trial comparing buprenorphine with clonidine reported a trend in favour of buprenorphine in reducing the drop-out rate but no difference between treatments in the duration and severity of withdrawal symptoms. More participants in the buprenorphine group went on to long-term naltrexone treatment. Side effects were not reported. In the second trial comparing buprenorphine maintenance versus buprenorphine for detoxification, for drop out the results were in favour of maintenance treatment, At one-year follow- up, self-reported opioid use was clearly less in the maintenance group and more adolescents were enrolled in other addiction programs.
Minozzi	2020	Cochrane Review	Global (Austria, Canada, USA)	No	Outpatients	4 studies (271 participants)	Opioids	opioid-dependent pregnant women	Not stated	Methadone	Not stated	N/A	For the woman: 1) Dropout from treatment, as measured by the number of women who had dropped out at the end of the intervention; 2) Use of primary substance of abuse; 2.1) Use of primary substance as measured by the number of women using heroin during or at the end of treatment (self-report or urine analysis results); 2.2) Use of primary substance at follow-up as measured by the number of women using heroin at the end of follow-up (after childbirth) Obstetric outcomes: 1) Third trimester bleeding; 2) Fetal distress and meconium aspiration; 3) Caesarean section; 4) Abnormal presentation; 5) Medical complications at delivery; 6)Breastfeeding following delivery; 7) Puerperal morbidity. For the child: 1) Health status	Low	downgrade for bias, imprecision	Methadone and buprenorphine may be similar in efficacy and safety for the treatment of opioid-dependent pregnant women and their babies. There is not enough evidence to make conclusions for the comparison between methadone and slow-release morphine. Overall, the body of evidence is too small to make firm conclusions about the equivalence of the treatments compared. There is still a need for randomised controlled trials of adequate sample size comparing different maintenance treatments.

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Darker	2015	Cochrane Review	Canada (x6 studies) USA (x3) Netherlands (x1) Finland (x1)	No	Outpatient	25 studies (1666 participants)	benzodiazepines	patients with BZD harmful use, abuse or dependence	Not stated	CBT (plus taper) versus taper MI versus TAU	Not stated	N/A	Primary: 1) Use of BZDs at the end of treatment measured by (a) Any biological marker of BZD metabolites provided in original studies (e.g. urine drug screen or hair analysis), (b) Self-reported use of BZDs, (c) Degree of effective dose reduction (e.g. frequency of BZD intake), (d) Abstinence rates, (e) Time to relapse, (f) Drop-outs/loss to follow-up. Secondary: n/a	Low	downgrade for bias, inconsistency	We found that CBT studies showed a short term benefit when added to taper but this benefit was not sustained beyond three months. MI studies did not support the use of MI to reduce BZD use. Currently there is insufficient evidence to support the use of MI to reduce BZD use. There is some evidence to suggest that a tailored GP letter versus a general GP letter, standardised interview versus TAU and relaxation versus TAU could be effective for BZD reduction. There is currently insufficient evidence for other psychosocial approaches to reduce BZD use.
Amato	2011	Cochrane Review	Asia (4) Australia/NZ (5) Europe (73) North America (50) South Africa (7) New Zealand (5)	Yes	In and outpatient	5 reviews, 114 studies (7333 participants)	Alcohol	patients with alcohol withdrawal	Not stated	Pharmacotherapy	Not stated	N/A	alcohol withdrawal seizures adverse events dropouts	Low	downgrade for bias, imprecision	benzodiazepines showed a protective benefit against seizures, when compared to placebo and a potentially protective benefit for many outcomes when compared with antipsychotics. Nevertheless, no definite conclusions about the effectiveness and safety of benzodiazepines were possible, because of the heterogeneity of the trials both in interventions and in the assessment of outcomes.
Traccis	2024	Cochrane Review	USA (11) Brazil (1) Italy (1)	No	Outpatient	13 studies (1191 participants)	Cocaine	people with cocaine dependence	Not stated	disulfiram	Not stated	N/A	Primary: 1) Efficacy; 2) Acceptability; 3) Safety Secondary: 1) Individual adverse events, measured subjectively or objectively; 2) Craving, as measured by validated scales such as the Brief Substance Craving Scale (BSCS) or a visual analogue scale (VAS); 3) Severity of dependence, as measured by validated scales such as the Addiction Severity Index (ASI), the Clinical Global Impression (CGI) scale (self-report and observer versions), or the Severity of Dependence Scale (SDS); 4) sychiatric symptoms/psychological distress, diagnosed using standard instruments such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), or measured by validated scales such as the Hamilton Depression Rating Scale (HDRS), the Profile of	Very low	downgrade for bias, inconsistency, imprecision	Disulfiram compared to placebo may increase the number of people who are abstinent at the end of treatment. However, compared to placebo or no pharmacological treatment, disulfiram may have little or no effect on frequency of cocaine use, continuous abstinence, and dropout for any reason. Disulfiram compared with naltrexone may reduce the frequency of cocaine use and may have little or no effect on amount of cocaine use. Disulfiram compared to placebo may increase point abstinence. However, disulfiram compared to placebo or no pharmacological treatment may have little or no effect on frequency of cocaine use, amount of cocaine use, continued abstinence, and dropout for any reason. We are unsure if disulfiram has any adverse effects in this population.

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Temmingh	2018	Cochrane Review	USA (x6 studies) Netherlands (x2)	No	In and outpatient	8 trials (1073 participants)	Various	people with serious mental illness and co-occurring substance misuse	Not stated	Risperidone	Not stated	N/A	Primary: 1) Mental state; 2) Substance use; 3) Adverse effects. Secondary: 1) Subjective well-being as measured by validated rating scales; 2) Craving for substances; 3) Adherence to antipsychotic medication; 4) Adverse effects; 5) Leaving the study early; 6) Mortality; 7) Quality of life.	Very low	downgrade on bias, inconsistency, imprecision	No great effect favouring risperidone over any of the other comparison medications. Very limited data were available for side-effects; and again, we found no real differences between risperidone and other antipsychotics. Currently there is not sufficient evidence to indicate risperidone is superior or inferior to other antipsychotics in the treatment of people with severe mental illness and co-occurring substance misuse.
Schwenker	2023	Cochrane Review	USA (x72 studies) Australia (x5) UK (x4) Netherlands (x4) Canada (x2) Germany (x1) Mexico (x1) New Zealand (x1) South Africa (x1) Sweden (x1) Switzerland (x1)	Yes	inpatient and outpatient clinics, universities, army recruitment centres, veterans' health centres, and prisons.	93 studies (22,776 participants)	Various	people with substance use (adults, young adults, adolescents)	Not stated	Motivational interviewing	Not stated	N/A	Primary: 1) extent of substance use, measured by self-report, report by companions, urine or blood samples, or other methods. Secondary: 1) Readiness to change; measured, for example, by the Readiness to Change Questionnaire (RCQ; Heather 1993); 2) Retention in treatment	Low	downgrade for bias, inconsistency	Comparing MI to no intervention revealed a small to moderate effect of MI in substance use post-intervention. Comparing MI to treatment as usual revealed a very small negative effect in substance use post-intervention. Comparing MI to assessment and feedback revealed no difference in substance use at short-term follow-up. Comparing MI to another active intervention revealed no difference in substance use at any follow-up time point

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Roberts	2016	Cochrane Review	USA (x12 studies) Australia (x2)	No	Community addiction and mental health services, prison services	14 studies (1506 participants)	Various	Individuals with post-traumatic stress disorder and comorbid substance use disorder	Not stated	psychological therapy	Not stated	N/A	Primary: 1) Severity of traumatic stress symptoms using a standardised measure such as the Clinician Administered PTSD Symptom Scale (CAPS); 2) Reduction in drug use, alcohol use, or both as measured by a standardised measure such as the Addiction Severity Index (ASI) or biological markers of drug and alcohol use, such as urine, saliva, and hair analysis, or self reported days of substance use/abstinence within a specified period such as the Timeline Followback Interview; 3) Treatment completion as measured by number of participants who were identified as treatment completers by study authors. Secondary: 1) PTSD diagnosis after treatment; 2) SUD diagnosis after treatment; 3)Adverse events reported by number and type; 4)	Low	downgrade for bias, inconsistency	Individual-based psychological therapies with a trauma-focused component plus adjunctive SUD intervention was more effective than treatment as usual (TAU)/minimal intervention for PTSD severity post-treatment. Individual-based psychological therapy with a trauma-focused component did not perform better than psychological therapy for SUD only for PTSD severity. vidence showed that individual trauma-focused psychological therapy delivered alongside SUD therapy did better than TAU/minimal intervention in reducing PTSD severity post-treatment and at long-term follow-up, but only reduced SUD at long-term follow-up. All effects were small, and follow-up periods were generally quite short.
Rahimi-Movaghar	2013	Cochrane Review	Not stated	No	In and outpatient	3 studies (870 participants)	Opium	Opium dependent patients who underwent maintenance treatment.	Not stated	Pharmacological therapies, including low, medium, high and flexible doses of methadone, buprenorphine, naltrexone, and opium maintenance.	Not stated	N/A	Primary: 1) Retention in treatment; 2) Opium use during treatment (reduction in use and abstinence) measured by self-report or positive urinalysis during the treatment. Secondary: 1) Opium withdrawal symptoms; 2) Secondary drug use during treatment; 3) Criminal activity; 4) Physical health; 5) Psychological health; 6) Social functioning; 7) Mortality rate (for all causes, for overdose and for acute diseases); 8) Side effects and nonfatal overdose; 9) Client satisfaction	Very low	downgraded for bias, inconsistency, imprecision	Two RCTs with 843 patients compared different doses of buprenorphine from 1 mg/day to 8 mg/day and the results showed that the higher doses of buprenorphine were more effective than lower doses in retention of the patients in treatment. However, other important outcomes, such as drug use and drug side effects were not assessed; the quality of the studies was unknown and the risk of biases was unclear. One other study assessed the effectiveness of baclofen on maintenance treatment of opioid dependence after detoxification, but only 27 of the participants were opium dependent. The study had been done with a good quality and low risk of bias. It showed that baclofen increased the retention in treatment, but the difference from placebo was not significant. Overall, the results from three RCTs are not sufficient to form a view on the effectiveness of any pharmacological intervention for opium dependence.

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Perry	2025	Cochrane Review	USA (x5 studies) France (x1) Ukraine (x1)	No	Primary and specialty care	7 studies (1992 participants)	Opioids	people with opioid use disorder (OUD) currently receiving or seeking opioid agonist therapy (OAT)	Not stated	initiation or maintenance of OAT in a primary care setting (compared to a specialty care setting)	Not stated	N/A	Primary: 1) Treatment retention; 2) Abstinence from non-prescribed opioids; 3) Major adverse events Secondary: 1) Quality of life; 2) Patient satisfaction; 3) All-cause mortality; 4) Opioid-related mortality; 5) All-cause hospitalization or emergency room visit; 6) All-cause incarceration; 7) Minor adverse events	Low	downgrade for indirectness, inconsistency	The evidence is very uncertain whether there was a difference in treatment retention in a primary care setting. Abstinence from non-prescribed opioids at the end of follow-up may have been higher in participants managed in primary care.
Perry	2019	Cochrane Review	USA (x13 studies) Spain (x1) UK (x1) Sweden (x1)	No	Secure setting (x8) Community (x2) Court (x2) Medium forensic secure hospital (x1)	13 trials (2606 participants)	Various	drug-using offenders with co-occurring mental health problems	Not stated	therapeutic community	Not stated	N/A	Primary: 1) drug use (self-reported drug use or biological drug use); 2) criminal activity	Low	downgrade for bias, inconsistency	Therapeutic community interventions and mental health treatment courts may help people to reduce subsequent drug use and/or criminal activity. For other interventions such as interpersonal psychotherapy, multi-systemic therapy, legal defence wrap-around services, and motivational interviewing, the evidence is more uncertain. Studies showed a high degree of variation, warranting a degree of caution in interpreting the magnitude of effect and the direction of benefit for treatment outcomes.
Perry	2019	Cochrane Review	USA (x12 studies) Spain (x1)	No	Community based (x6) Secure based (x7)	13 trials (2560 participants)	Various	Drug-using female offenders	Not stated	collaborative case management, community-based buprenorphine, interpersonal psychotherapy Acceptance and commitment therapy (ACT), cognitive behavioural therapy and other therapies, cognitive behavioural therapy and standard therapy, single computerised session, dialectic behaviour therapy with case management, therapeutic community, intensive	Not stated	N/A	Primary: 1) Drug use (self reported or biological measurements); 2) Criminal activity (self or official report)	Low	downgrade for bias, imprecision	studies showed a high degree of heterogeneity for types of comparisons, outcome measures and small samples. Descriptions of treatment modalities are required. On one outcome of arrest (no parole violations), we identified a significant reduction when cognitive behavioural therapy (CBT) was compared to a therapeutic community programme. But for all other outcomes, none of the interventions were effective. Larger trials are required to increase the precision of confidence about the certainty of evidence.

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Pani	2011	Cochrane Review	USA (x36 studies) Brazil (x1)	No	Outpatient (community or mental health centre	37 studies (3551 participants)	Cocaine	Patients with cocaine abuse and dependence	Not stated	Antidepressants	Not stated	N/A	Primary: 1) Dropouts from the treatment; 2) Number and type of side effects experienced during the treatment; 3) Use of primary substance of abuse; 4)Results at follow-up. Secondary: 1) Compliance; 2) Craving; 3) Severity of dependence; 4) Amount of cocaine use; 5) Psychiatric symptoms/psychological distress; 6) Quality of life measures; 7) Death.	Low	downgrade for bias, inconsistency	data do not support the efficacy of antidepressants in the treatment of cocaine abuse/dependence. Partially positive results obtained on secondary outcome measures, such as depression severity, do not seem to be associated with an effect on direct indicators of cocaine abuse/dependence. Antidepressants cannot be considered a mainstay of treatment for unselected cocaine abusers/dependents.
Nielson	2022	Cochrane Review	USA (x7 studies) Iran (x1)	No	Outpatient	8 studies (709 participants)	pharmaceutical opioids	people dependent on pharmaceutical opioids	Not stated	methadone opioid agonist	Not stated	N/A	Primary: 1) Illicit opioid use; 2) Illicit opioid use at end of treatment completion; 3) Retention; 4) Adverse effects. Secondary: 1) Pain; 2) Risk behaviours; 3) Aberrant opioid-related behaviours; 4) employment; 5) quality of life; 6) physical health; 7) psychological health	Moderate	downgrade for bias	There is very low- to moderate-certainty evidence supporting the use of maintenance agonist pharmacotherapy for pharmaceutical opioid dependence. Methadone or buprenorphine did not differ on some outcomes, although on the outcomes of retention and self-reported substance use some results favoured methadone. Maintenance treatment with buprenorphine appears more effective than non-opioid treatments
Minozzi	2025	Cochrane Review	USA (x15 studies) Netherlands (x1) Sweden (x1) Finland (x1) Germany (x1) Canada (x1) Denmark (x1)	No	Outpatient	21 studies (4746 participants)	Alcohol use	People with alcohol use disorder	Not stated	Combination pharmacological and psychosocial	Not stated	N/A	Primary: 1) Continuous abstinent participants; 2)Heavy-drinking participants; 3)Frequency of use; 4) Frequency of use; 5) Amount of use; 6) Adverse events; 7) Serious adverse events; 8) Dropouts from treatment; 9) Dropouts from treatment due to adverse events at the end of the active treatment phase. Secondary: 1) Cravings; 2) Anxiety; 3) Depression; 4) Alcohol related consequences; 5) Psychosocial functioning and psychosocial consequences.	Low	downgrade for bias, indirectness	The most studied pharmacological and psychosocial interventions were naltrexone (81.0%) and cognitive behavioural therapy (66.7%), respectively. Compared to psychosocial intervention alone, combined pharmacological and psychosocial interventions probably reduce the number of heavy drinkers. Findings indicate that adding pharmacological to psychosocial interventions is safe and helps people with AUD recover. These conclusions are based on low- to moderate-certainty evidence.

Combined research and studies

First author surname	Year	Study type	Country	NZ	Setting	Participants/ studies	Drug type	Population	Lived experience involvement	Intervention	How intervention was funded	Legal context of intervention	Outcome measures	GRADE assessment	Comments on GRADE rationale	Comment on outcomes
Minozzi	2015	Cochrane Review	USA (x14 studies) Netherlands (x1) Mexico (x1)	No	Outpatient	15 studies (1066 participants)	Cocaine	Patients with cocaine dependence	Not stated	any anticonvulsant versus placebo	Not stated	N/A	Primary: 1) Dropouts from treatment; 2) Use of primary substance of abuse; 3) Acceptability of treatment. Secondary: 1) Compliance; 2) Craving; 3) Severity of dependence; 4) Psychiatric symptoms	Very low	downgrade for bias, indirectness	Upon comparison of anticonvulsant versus placebo, we found no significant differences for any of the efficacy and safety measures. Although the findings of new trials will improve the quality of study results, especially in relation to specific medications, anticonvulsants as a category cannot be considered first-, second- or third-line treatment for cocaine dependence.
Minozzi	2015	Cochrane Review	USA (x22 studies) Brazil (x1) Spain (x1)	No	Outpatient	24 studies (2147 participants)	Cocaine	patients with the treatment of cocaine dependence	Not stated	any dopamine agonist versus placebo. amantadine versus placebo. amantidine versus antidepressants.	Not stated	N/A	Primary: 1) Drop outs; 2) Acceptability; 3) Drop outs due to adverse effects; 4) Abstinence; 5) Results at follow-up. Secondary: 1) Craving; 2) Severity of dependence; 3) Clinical Global valuation; 4) Psychiatric symptoms/psychological distress diagnosed using standard instruments.	Very low	downgrade for bias, inconsistency	Comparing any dopamine agonist versus placebo, we found no differences for any of the outcomes considered. This was also observed when single dopamine agonists were compared against placebo. Comparing amantadine versus antidepressants, we found low quality of evidence that antidepressants performed better for abstinence. Current evidence from RCTs does not support the use of dopamine agonists for treating cocaine misuse
Kornor	2025	Cochrane Review	USA or Canada (x12 studies) Russia (x5) Norway (x3) UK (x1) Australia (x1)	No	Outpatient	22 studies (3416 participants)	Opioids	people with opioid dependence	Not stated	sustained-release naltrexone	Not stated	N/A	Primary: 1) Illicit opioid use during treatment; 2) Retention; 3) Acceptability; 4) Adverse effects during treatment. Secondary: 1) Opiod craving at end of treatment; 2) Use of alcohol, amphetamines or cocaine, benzodiazepines and/or cannabis during treatment; 3) Mental health at the end of treatment; 4) Quality of life at the end of treatment.	Low	downgrade for bias, inconsistency	Sustained-release naltrexone may slightly increase illicit opioid use and serious adverse events compared to opioid agonists, with uncertain effects on retention and acceptability. It may reduce illicit opioid use compared to oral naltrexone but has uncertain effects on other outcomes. Compared to placebo, it may have little to no impact on key outcomes. Compared to treatment as usual, it reduces illicit opioid use and may reduce serious adverse events but has little effect on retention and slightly reduces acceptability.

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Klimas	2018	Cochrane Review	USA (x4 studies) Ireland (x2) Switzerland (x1)	No	outpatient/community	7 studies (825 participants)	Alcohol	concurrent problem alcohol and illicit drug users	Not stated	cognitive-behavioural coping skills training (CBCST). brief intervention (BI). motivational interviewing (MI). brief motivational interviewing (BMI). motivational interviewing intensive (MII)	Not stated	N/A	Primary: 1) Alcohol use (reduction or stabilisation); 2) Retention in treatment. Secondary: 1) Illicit drug use; 2) Alcohol-related problems or harms	Very low	downgrade for bias, inconsistency, indirectness	We found low to very low-quality evidence to suggest that there is no difference in effectiveness between different types of psychosocial interventions to reduce alcohol consumption among people who use illicit drugs, and that brief interventions are not superior to assessment-only or to treatment as usual. No firm conclusions can be made because of the paucity of the data and the low quality of the retrieved studies.
Hides	2019	Cochrane Review	USA (x7 studies)	No	Outpatient	7 studies (608 participants)	Various	Individuals experiencing co-occurring depression and substance use disorders	Not stated	Integrated CBT Interpersonal Psychotherapy for Depression (IPT-D)	Not stated	N/A	Primary: 1) Depression: changes in symptom severity on a standardised questionnaire; 2) Substance use: changes in the frequency (including abstinence), quantity, severity of use; 3) Treatment retention. Secondary: 1) Functioning: changes in social, occupational/educational functioning; 2) Anxiety: changes in symptom severity; 3) Global clinical severity of mental health disorders; 4) Adverse effects linked to treatments delivered.	Low	downgrade for bias, inconsistency	No conclusions can be made about the efficacy of psychological interventions (delivered alone or in combination with pharmacotherapy) for the treatment of comorbid depression and substance use disorders, as they are yet to be compared with no treatment or treatment as usual in this population. In terms of differences between psychotherapies, although some significant effects were found, the effects were too inconsistent and small, and the evidence of too poor quality, to be of relevance to practice.
Goldberg	2021	Cochrane Review	USA (x23 studies) Iran (x11) Thailand (x2) China (x1) Taiwan (x1) Brazil (x1) Spain & USA (x1)	No	Residential treatment	40 studies (2825 participants)	Various	People with substance use disorder	Not stated	mindfulness-based interventions (MBIs)	Not stated	N/A	Primary: 1) Continuous abstinence rate; 2) Percentage of days with substance use; 3)Consumed amount; 4) Adverse event rate. Secondary: 1) Craving intensity; 2) Treatment acceptability; 3) Serious adverse events	Low	downgrade for bias	In comparison with no treatment, the evidence is uncertain regarding the impact of MBIs on SUD-related outcomes. MBIs result in little to no higher attrition than no treatment. In comparison with other treatments, MBIs may slightly reduce days with substance use at post-treatment and follow-up (4 to 10 months). The evidence is uncertain regarding the impact of MBIs relative to other treatments on abstinence, consumed substance amount, or craving. MBIs result in little to no higher attrition than other treatments. Few studies reported adverse events.

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Ghetti	2022	cochrane Review	USA (x18 studies) Venezuela (x1) Iran (x1) China (x1)	No	detox and inpatient/out patient rehabilitation settings	21 studies (1984 participants)	Various	people with substance use disorders	Not stated	music therapy plus standard care	Not stated	N/A	Primary: 1) Psychological symptoms; 2) Substance craving; 3) Motivation for treatment/change; 4) Motivation to stay sober/clean. Secondary: 1) Alcohol or substance use, or both, in terms of amount, frequency, or peak use; 2) Retention in treatment; 3) Severity of substance dependence/use; 4) Serious adverse events.	Low	downgrade for bias, imprecision	Good evidence for reduced OD M&M, decent evidence for accessing addiction treatment programs, poor evidence for reduced injection risk behaviours, varying low evidence for reducing crime / public nuisance
Castells	2016	Cochrane Review	USA (x24 studies) Australia (x1) Switzerland (x1)	No	Outpatient	26 studies (2366 participants)	Cocaine	people with cocaine dependence	Not stated	psychostimulants	Not stated	N/A	Primary: 1) Reduction of cocaine use; 2) Sustained cocaine abstinence; 3) Retention in treatment. Secondary: 1) Self-reported cocaine use; 2) Cocaine craving; 3) Survival; 4) Clinical severity; 5) Depression symptoms	Low	downgrade for bias, inconsistency	This review found mixed results. Psychostimulants improved cocaine abstinence compared to placebo in some analyses but did not improve treatment retention. Since treatment dropout was high, we cannot rule out the possibility that these results were influenced by attrition bias. Existing evidence does not clearly demonstrate the efficacy of any pharmacological treatment for cocaine dependence, but substitution treatment with psychostimulants appears promising and deserves further investigation.
Amato	2011	Cochrane Review	USA (x31 studies) Germany (x1) Malaysia (x1) China (x1) Scotland (x1)	No	Not stated	35 studies (4319 participants)	Opioids	patients with treatment of opioid dependence	Not stated	Any Psychosocial intervention plus pharm versus pharm standard	Not stated	N/A	Primary: 1) Retention in treatment; 2) Abstinence by primary substance; 3) Results at follow-up. Secondary: 1) Compliance as number of psychosocial sessions attended; 2) Craving; 3) Psychiatric symptoms/psychological distress; 4) Quality of life; 5) Severity of dependence; 6) Death.	High	no downgrade	Comparing any psychosocial plus any maintenance pharmacological treatment to standard maintenance treatment, results do not show benefit for retention in treatment. Comparing the different psychosocial approaches, results are never statistically significant for all the comparisons and outcomes.

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Kilian	2023	Systematic review and meta-analysis	Australia (x6) China (x1) Estonia, Latvia, Lithuania, Poland (x2) Lithuania (x1) Russia (x2) Switzerland (x2) Thailand (x1) USA (x11) Canada (x3) UK (x7) Spain (x1) Sweden (x2)	No	N/A	36 studies	Alcohol	n/a	Not stated	Alcohol taxation. Minimum unit pricing. Temporal availability.	n/a	mixed	Primary: relative change in the level of alcohol consumption (percentage change) following each policy intervention. Secondary: changes in consumption patterns (e.g., changes in the alcohol use or heavy episodic drinking prevalence) narratively	Low	downgrade for bias, inconsistency	found pricing policies to be the most promising at lowering consumption levels. Restrictions on the availability of alcohol, including restricted sales hours and days, were also effective in lowering alcohol consumption, particularly spontaneous drinking events.
Eassey	2024	Systematic Review	Switzerland (Perneger 1998; n=51), Netherlands (van der Brink 2003; n=174 injected + 375 inhaled), Spain (March 2006; n=62), Germany (Haasen 2007; n=1,015), Canada (Ovideo-Joekes 2009; NAOMI n=226; 10%/n=25 injectable hydromorphone blinded), UK (Strang 20	Yes	n/a	100 studies	Alcohol and other drugs	n/a	Not stated	Laws and regulations. Alcohol availability. Risk-based licensing (RBL) schemes. Change in trading hours. Legal purchase age. Smoking ban. Regulatory compliance and enforcement. Drug checking/pill testing. Transport interventions. Policing strategies. Chill/safe spaces and roaming support services. Staff and venue interventions. Patron surveys and assessment	Not stated	N/A	n/a	Low	downgrade for inconsistency, imprecision	Findings provide consistent support for onsite medical services for reducing ambulance transfer rates, multicomponent interventions targeting alcohol accessibility and availability for reducing assaults, and promising behavioral outcomes for patrons who use drug checking services. Furthermore, findings of this review suggest that policing strategies rarely reduce criminal justice outcomes and, in some instances, lead to an exacerbation of negative health outcomes.

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Sanchez-Ramirez	2018	Systematic Review	Australia (x5 studies) UK (x5) USA (x5) Canada (x4), Sweden (x2) Brazil (x1) Colombia (x1) Germany (x1) Netherlands (x1) Norway (x1)	No	n/a	26 studies	Alcohol	n/a	Not stated	policies regulating alcohol trading hours and days	Not stated	N/A	assault/violence, motor vehicle crashes/fatalities, injury, visits to the emergency department/hospital, murder/homicides and crime.	High	no downgrade	Evidence suggests a potential direct effect of policies that regulate alcohol trading times in the prevention of injuries, alcohol-related hospitalisations, homicides and crime. The impact of these alcohol trading policies in assault/violence and motor vehicle crashes/fatalities is less compelling.
Wilkinson	2016	Systematic Review	Australia (x7 studies) UK (x6) Canada (x3) Germany (x1) Netherlands (x1) Norway (x1) Switzerland (x1) US (x1)	No	n/a	21 studies	Alcohol	n/a	Not stated	Trading hours for licensed premises	Not stated	N/A	Alcohol related harm	Moderate	downgrade for inconsistency	Increasing trading hours tends to result in higher rates of harm, while restricting trading hours tends to reduce harm. The evidence of effectiveness is strong enough to consider restrictions on late-trading hours for bars and pubs as a key approach to reducing late-night violence in Australia.
Gruenewald	2015	Mixed methods	New Zealand	Yes	n/a	16 420	Alcohol	New Zealand National Alcohol Surveys respondents	n/a	Reduction to minimum purchase age from 20 to 18	n/a	Legislative change	(a) drinking in each context, (b) greater amounts consumed in each context (dose–response), (c) association of the lowered MPA with problems related to each context and (d) relationship of the lowered MPA to dose–response.	Very low	downgrade for bias	The reduced MPA in New Zealand was related to increases in the proportion of 18–19-year-old drinkers, frequencies with which this age group drank in different contexts, especially commercial contexts such as pubs/nightclubs (rising an average of 15 occasions per year), and problem risks associated with drinking in these contexts.
Clifford	2024	interrupted time series	Australia	No	Northern Territories, Australia	n/a	Alcohol	People living in remote and very remote areas of the NT. Aboriginal and Torres Strait Islander people account for 30% of population	n/a	1) Banned Drinker Register. 2) Minimum Unit Price. 3) Police Auxiliary Liquor Inspectors. 4) restrictions on daily purchases/opening hours.	funded by an ARC Linkage grant (LP180100701), FARE, Central Australian Aboriginal Congress, Northern Territory Govtt, and the NT Primary Health Network.	Australian legislation	1) domestic and family violence assaults . 2) breaches of violence orders. (police recorded)	Very low	downgrade for indirectness	PALIs and DPOH were associated with some reductions in DFV; the BDR was associated with some increases. The upward trend commences prior to the BDR, so it is also plausible that the BDR had no effect on DFV outcomes. Although MUP was associated with reductions in the NT-wide model, there were no changes in sites without cooccurring PALIs.

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Randerson	2018	Mixed methods	New Zealand	Yes	n/a	n/a	Alcohol	n/a	n/a	Sale and Supply of Alcohol Act 2012 (SSAA)	n/a	Legislation	1) Changes in perceived enforcement and compliance with alcohol regulations 2) Changes in alcohol availability and promotion	Low	no downgrade	Little change was reported in the overall extent of enforcement of pre-existing alcohol regulations between 2013 and 2015, and resources for enforcement did not increase. A slight reduction in on-licensed premises' operating hours in main cities was the main impact of the SSAA on alcohol availability identifi ed in this study.
Ford	2018	Cross-sectional survey	New Zealand	Yes	Emergency Department	302	Alcohol	ED presentations	n/a	Sale and Supply of Alcohol Act 2012	n/a	Legislation	alcohol-related emergency department (ED) attendances	Low	no downgrade	From 2013 to 2017 there was a non-significant (p=.41) reduction in the proportion of ED attendees. In both waves, most participants had purchased alcohol from o -licence venues and consumed their last drink at a private location.
Mateu-Mollá	2025	Systematic Review	USA (x32 studies) Germany (x4) England (x3) Italy (x2) Canada (x2) Iran (x2) Netherlands (x2) Japan (x2) Austria (x2) Finland (x1) Scotland (x1) France (x1) Denmark (x1)Sweden (x1) Brazil (x1)	No	n/a	49 studies (25,365 participants)	Various	People with a diagnosis of substance use disorder	n/a	pharmacological treatments	n/a	n/a	n/a	Low	downgrade for bias, consistency	For alcohol, established medications such as acamprosate, naltrexone, and topiramate were identified, with solid evidence supporting their effectiveness in reducing consumption and maintaining abstinence. However, some emerging treatments, such as ibudilast and baclofen, showed promising results despite specific limitations. For cannabis, CBD (in specific doses) and nabiximol showed encouraging results in reducing consumption and improving abstinence. Other options, such as varenicline and topiramate, were also explored, showing significant behavioral benefits. For psychostimulants, ifenprodil and modafinil emerged as promising options for the treatment of methamphetamine dependence. For cocaine, CBD demonstrated potential in the cognitive domain, although results remain inconclusive. Finally, for opiates, the combination of naloxone and morphine proved to be the most effective option, complementing psychotherapy.

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Ghafouri	2024	Systematic Review	Unknown	Unknown	n/a	24 studies	Cannabis	People with cannabis use disorder	n/a	pharmacological psychosocial behavioral	Not stated	N/A	abstinence, reduction in cannabis use frequency or quantity, withdrawal symptoms, cravings, and treatment retention.	Low	downgrade for bias, consistency	addressing cannabis use disorder (CUD) demands tailored interventions that acknowledge the unique developmental stages and challenges individuals face across their lifespan. Although interventions such as contingent rewards for adolescents, technology-based platforms for young adults, and pharmacological adjuncts for older individuals show promise, the optimal treatment combination remains uncertain. Although psychosocial interventions offer personalized strategies, age-specific pharmacological recommendations lack adequate evidence
Preto	2023	Systematic Review	Unknown	Unknown	In and outpatient	22 studies (1619 participants)	Cannabis	People with cannabis cravings	n/a	pharmacological. psychotherapeutic. combination.	n/a	n/a	craving severity, relapse rates, withdrawal symptoms, and other measures of treatment efficacy.	Low	downgrade for bias, consistency	Majority of the studies did not show any significant difference between the interventional drug and placebo. emerging treatments show promise and have the potential to revolutionise current clinical practices, but further investigation is needed to establish their efficacy.
Mellentin	2023	Systematic Review	Unknown	Unknown	In and outpatient	17 studies (747 participants)	Various	People with SUD	n/a	Oxytocin	n/a	n/a	withdrawal symptoms, negative emotional states (stress, anxiety, anger, and depressive symptoms), cravings, and consumption of drugs	Low	downgrade for bias, inconsistency	across the SUD-types, oxytocin reduced withdrawal symptoms (3/5 trials), negative emotional states (4/11 trials), cravings (4/11 trials), cue-induced cravings (4/7 trials), and consumption (4/8 trials).
Sharma	2022	Systematic Review	Unknown	Unknown	Not stated	8 studies (1440 participants)	Cannabis	People with cannabis use disorder	n/a	N-Acetyl Cysteine	n/a	n/a	Unknown	Low	downgrade for bias, imprecision	The studies collectively offer mixed results, although the strength of the evidence available on which to make a recommendation is strong. The results indicate a potential role of NAC in promoting abstinence, reducing craving and cannabis use.
Scott	2022	Systematic Review	Unknown	Unknown	Outpatient	10 studies (861 participants)	Various	Adolescents with SUD	n/a	Pharmacological interventions	n/a	n/a	days of SU in the past month, as well as primary co-occurring disorder outcomes (e.g. depression, ADHD, bipolar disorder)	Low	downgrade for bias, inconsistency	Family medicine clinicians prescribing pharmacotherapy for mental health should be aware that additional interventions will likely be needed to address co-occurring SU.

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Vuilleumier	2022	Systematic Review	USA (x4 studies) Australia (x2) Canada (x1) UK (x1) US (x1)	No	In and outpatient	8 studies (435 participants)	Cannabis	Adults with a diagnosis of cannabis use disorder	n/a	any pharmacotherapy with medical cannabinoids, i.e., dronabinol, nabilone, nabiximols, cannabidiol or endocannabinoid modulators, as monotherapy or in combination with another medication, with or without concomitant psychotherapy.	n/a	n/a	reduction of cannabis use, maintenance of abstinence, reduction of withdrawal symptoms, reduction of craving, retention in treatment, safety, and tolerability.	Low	downgrade for imprecision, inconsistency	Cannabinoid receptor agonists, i.e., dronabinol and nabilone, showed only limited or no therapeutic potential in the treatment of CUD. In contrast, modulators of endocannabinoid activity, i.e., nabiximols, cannabidiol and PF-04457845, demonstrated broader efficacy which covered almost all aspects of CUD. Endocannabinoid modulation appears to be a promising treatment approach in CUD, but the evidence to support this strategy is still small and future research in this direction is needed.
Bahji	2021	Systematic Review	USA (x20 studies) Australia (x3) Canada (x1) Israel (x1)	No	In and outpatient	25 studies (1912 participants)	Cannabis	adolescents or adults (aged 15 years or older) with a confirmed CUD diagnosis using a valid diagnostic instrument (e.g., DSM-5 cannabis use disorder).	n/a	any pharmacotherapy delivered as monotherapy or augmentation, with or without concomitant psychotherapy.	n/a	n/a	Primary: reduction in cannabis use, retention in treatment Secondary: frequency of adverse events, discontinuation due to adverse events, abstinence, and reduced severity of CWS, CUD, or cravings for cannabis.	Low	downgrade for bias, inconsistency	some medications appeared to show promise for treating individual aspects of CUD. However, there is a lack of robust evidence to support any particular pharmacological treatment. There is a need for additional studies to expand the evidence base for CUD pharmacotherapy. While medication strategies may become an integral component for CUD treatment one day, psychosocial interventions should remain the first line given the limitations in the available evidence
Montgomery	2017	Scoping review	United States	no	N/A	22 studies, 7 on cannabis. (793 participants)	Cannabis	African American adolescents and adults with cannabis use	Not stated	Mixed, including Motivational enhancement therapy, cognitive behavioral therapy, contingency management, drug counseling, multidimensional family therapy, behavioral parent training	n/a	n/a	Mixed	Low	downgrade for inconsistency, imprecision	Preliminary evidence from a small number of studies (k 7) supports the use of Motivational Interviewing and Cognitive–Behavioral Therapy to treat cannabis use among African Americans, but not Contingency Management.

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Taylor	2018	Systematic Review	Australia (x24 studies) UK (x6) New Zealand (x2) USA (x1) Canada (x1) Netherland (x1)	yes	N/A	48 studies	Alcohol	People in NEPs (night-time entertainment precincts)	Not stated	Any intervention by a governing body or liquor authority to restrict access to alcohol	n/a	n/a	Mixed inclu: Assaults, injuries,	Very low	downgrade on inconsistency, imprecision	89% of studies looking at outlet density as the sole factor found that increased on-licence outlet density was associated with increased levels of crime and violence. Majority of reviews have shown that there is a strong empirical link between increased trading hours and increased levels of harm in NEPs. Most studies that examined lockouts alongside other interventions could not determine the unique impacts of each individual restriction, on their own lockouts do not appear to contribute meaningfully to alcohol-related harm in NEPs. The evidence supports the notion that higher prices reduce violence in NEPs. With proper implementation, patron bans could be an effective measure in NEPs. However, there is no empirical evidence of effectiveness. Drinks restrictions require more direct evidence of effectiveness in NEPs and a theoretical basis to explain their impact
Cameron	2012	Cross-sectional study	New Zealand	Yes	Manukau City, New Zealand.	n/a	Alcohol	n/a	Not stated	n/a	n/a	n/a	Police events and motor vehicle accidents	Very low	downgrade for inconsistency, imprecision	All three outlet density measures were significantly associated with a range of police events, but only off-licence density was significantly associated with motor vehicle accidents.
Cameron	2015	geographically weighted regression approach	New Zealand	Yes	North Island, New Zealand	n/a	Alcohol	n/a	Not stated	n/a	n/a	n/a	police-attended violent incidents	Very low	downgrade for inconsistency, imprecision	bar and night club density, and licensed club density (e.g. sports clubs) have statistically significant and positive relationships with violence

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Fitzgerald	2024	rapid non-systematic evidence review	Global	Yes	Policy interventions	78 studies	Alcohol	n/a	Not stated	policy options with potential to benefit public services and health, whilst avoiding or minimising negative impact on the hospitality sector. 1) pricing interventions 2) regulation of online sales 3) place shaping 4) violence reduction initiatives	n/a	n/a	n/a	Very low	downgrade for bias, imprecision	Interventions that raise the price of cheaper shop-bought alcohol appear promising as 'sweetspot' policies; any impact on hospitality is likely small and potentially positive. Restrictions on online sales such as speed or timing of delivery may reduce harm and diversion of consumption from on-trade to home settings. Place-shaping is not well-supported by evidence and experts were sceptical. Reduced late-night trading hours likely reduce violence; evidence of impact on hospitality is scant. Other violence reduction initiatives may modestly reduce harms whilst supporting hospitality, but require resources to deliver multiple measures simultaneously in partnership.
Guindon	2025	systematic umbrella review	Global	Unknown	population level policy	32 studies	Alcohol	n/a	Not stated	population-level policies to reduce alcohol use: 1) alcohol availability (introducing or increasing minimum purchasing age, restrictions on temporal availability, decreasing outlet density, government monopolization) 2) alcohol marketing (marketing self-regulation, advertising from government authorities, regulating the volume of advertising from alcohol	n/a	n/a	n/a	Low	downgrade for bias, imprecision	Consistent evidence that addressing alcohol availability was associated with lower alcohol use. Lack of evidence on the associations between alcohol marketing and alcohol consumption.

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Baldwin	2022	Systematic narrative review	Canada (x5) New Zealand (x8) Netherlands (x1) Australia (x5) USA (x3) Germany (x2) Denmark (x1) Sweden (x1) Finland (x2) UK (x1) Switzerland (x2)	Yes	n/a	31 studies	Alcohol	Infant and pre-schoolers (0 – 5 years), children (6 – 12 years), adolescents (13 – 17 years).	Not stated	Public alcohol supply reduction or control policies, including, but not limited to: price control, taxation, trading hour restrictions, outlet density restrictions, dry communities, policies preventing underage drinking, or MLDA.	n/a	n/a	1. Psychosocial wellbeing (i.e., emotional wellbeing) 2. Mental health related outcomes (i.e., symptoms or hospital presentations) 3. Physical health (i.e., rates of childhood abuse/maltreatment, teenage pregnancies, or emergency department presentations) 4. Anti-social behaviour (i.e., youth offending rates)	Moderate	downgrade for bias	the impact of increasing the availability of alcohol (i.e., through reducing the MLDA) or reducing the availability of alcohol (i.e., through increased taxation) varied depending on the policy, the policy environment, and the assessed outcome.
Killion	2023	Systematic review	Data from 44 studies internationally (mostly US and Australia)	No	Needle and syringe programmes	n/a	N/A	Unit costs of NSPs	Not stated	Needle and syringe programmes	Various by jurisdiction	Various by jurisdiction	Unit costs of providing NSP	Moderate		The total estimated spend for a high-coverage, comprehensive NSP across 68 countries with PWID size estimates is $5 035 902 000 for 10 887 500 PWID, 2.1-times higher than current spend.
Yeh	2023	Systematic review and meta-analysis	Multiple LMICs. 42 interventions from 35 studies	No	Needle and syringe programmes	56,751 across all studies	N/A	People who use NSPs	Not stated	Needle and syringe programmes	Various by jurisdiction	Various by jurisdiction	Needle sharing behaviours, HIV and STI-related outcomes (mix of individual and community level outcome measures)	Low	Downgrade on inconsistency	Random effects meta-analysis showed a significant protective association between NSP exposure and needle-sharing behaviors at the individual-level and community level. NSP exposure was also associated with reduced HIV incidence and increased HIV testing but there were no consistent associations with prevalence of bloodborne infections. Current evidence suggests positive impacts of NSPs in LMICs.
Lazarus	2018	Systematic review	5 studies from Germany, Switzerland and Spain	No	Prison needle and syringe programmes	1,276 across all studies at follow up	N/A	People in prison	Not stated	Needle and syringe programmes	Not stated	All programmes were officially trialled in prisons	Mixed including HCV prevalence, HIV prevalence, new infections, drug consumption, injecting-related abscess, needle sharing, HBV prevalence	Low	Downgrade on imprecision	The outcomes for which the studies collectively demonstrated the strongest evidence were prevention of human immunodeficiency virus and viral hepatitis. Few negative consequences from PNSPs were observed, consistent with previous evidence assessments.
Platt	2018	Systematic review and meta-analysis	28 studies, almost all Western countries	No	Community settings of needle and syringe programmes and OST, alone or in combination	6279 across all studies	N/A	People who inject drugs	Not stated	Needle and syringe programmes and OST either alone or in combination	Not stated	Not stated	Acquisition of HCV	Low	Downgrade on inconsistency	Opioid substitution therapy reduces risk of hepatitis C acquisition and is strengthened in combination with needle and syringe programmes (NSP). There is weaker evidence for the impact of needle syringe programmes alone, although stronger evidence that high coverage is associated with reduced risk in Europe.

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Fernandes	2017	Review of systematic reviews	13 reviews with 133 studies globally	Yes	Community NSPs (excluded prisons and consumption rooms)	Pooled numbers not stated	N/A	People who inject drugs	Not stated	Needle and syringe programmes	Not stated	Not stated	Prevalence/incidence of HCV and HIV, injecting risk behaviours	Low	Downgrade on inconsistency	We found that NSP was effective in reducing HIV transmission and IRB among PWID, while there were mixed results regarding a reduction of HCV infection. Full harm reduction interventions provided at structural level and in multi-component programmes, as well as high level of coverage, were more beneficial.
Kypri	2014	controlled before-and-after study	New Zealand	Yes	n/a	n/a	Alcohol	Young people aged 15 to 17 years and those aged 18 to 19 years. 20-21 year olds as control group	Not stated	Reduction of the alcohol minimum purchasing age from 20 to 18 years in December 1999	n/a	New Zealand legislation	counts of all individuals in each gender and age group who were admitted to hospitals in New Zealand between 12:01 am on Friday and midnight on Sunday with injuries caused by an assault	Very low	downgrade for imprecision	Lowering the minimum alcohol purchasing age increased weekend assaults resulting in hospitalization among young males 15 to 19 years of age.
Kypri	2015	controlled before-and-after study	New Zealand	Yes	n/a	n/a	Alcohol	Māori, young people aged 15 to 17 years and those aged 18 to 19 years. 20-21 year olds as control group	Not stated	Reduction of the alcohol minimum purchasing age from 20 to 18 years in December 1999	n/a	New Zealand legislation	the number of Māori in each gender/age group/period admitted to hospital between 00.01 Friday and 24.00 Sunday, with assault injury.	Very low	downgrade for imprecision	no evidence that lowering the minimum alcohol purchasing age increased weekend hospitalised assaults among young Māori. Inferences are compromised by lack of statistical power
Boniface	2017	Systematic review	Russia (x2) Finland (x1) Canada (x5) Poland (x1) UK (11) Australia (x4) New Zealand (x1) Scotland (x5) Ireland (x1) USA (x1) Worldwide (x3)	Yes	n/a	35 studies	Alcohol	Population level studies	Not stated	Any interventions or policies leading to changes in the minimum price of alcohol	n/a	n/a	the effect of pricebased interventions on alcohol consumption or alcohol-related morbidity, mortality and wider harms.	Very low	downgrade for bias, inconsistency, imprecision	Bradford Hill criteria for causality were satisfied. There was very little evidence that minimum alcohol prices are not associated with consumption or subsequent harms

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Falkner	2015	Survey	New Zealand	Yes	New Zealand population	115 participants	Alcohol	alcohol dependent clients (experiencing significant physiological withdrawal symptoms on alcohol cessation) admitted for medicated detoxification at an addiction service inpatient unit (IPU) between May 2013 and February 2014.	Not stated	n/a	n/a	n/a	Type and amount of alcohol consumed. Cost per day and cost per standard drink. Impact of price. Strategies to sustain alcohol use in the face of hypothetical price increase. Strategies used previously when no money was available.	Very low	downgrade for imprecision	Although the majority of our group would be financially impacted by an increase in the minimum price per standard drink, any potential impacts would be most significant in those buying the cheapest alcohol (who also drink the most), suggesting that minimum pricing may be an important harm minimisation strategy in this group. A minimum price per standard drink would limit the possibility of switching to an alternate cheaper product and likely result in an overall reduction in alcohol consumption in this group. Stealing alcohol, or the use of non-beverage alcohol, were seldom reported as previous strategies used in response to unaffordable alcohol and fears of such are not valid reasons for rejecting minimum pricing to reduce general population consumption.
Maharaj	2023	Systematic review	Canada (x5) Scotland (x3) Australia (x3) England (x6) Wales (x2) Northern Ireland, Ireland, South Africa (x1 each)	No	mixed	22 studies	Alcohol	mixed	Not stated	Minimum pricing policy of alcohol	n/a	n/a	primary: alcohol-related hospitalisation secondary: length of stay, hospital mortality and alcohol-related liver disease in hospital.	Very low	downgrade for inconsistency	Using the Bradford Hill Criteria, we inferred a 'moderate-to-strong' causal link that MUP could reduce alcohol-related hospitalisation.
Courtney	2025	Cross-sectional survey	USA (across 18 states)	No	n/a	5,360	Alcohol	General pop	Not stated	Expanded Direct-to-Consumer Alcohol Home Delivery Policies	n/a	Mixed across states: direct to consumer legislation	Alcohol Use Negative drinking consequences DTC measures	Very low	downgrade for indirectness, imprecision	adults living in U.S. states that expanded DTC policies had higher odds of using alcohol delivery, and using DTC alcohol delivery was associated with greater average drinks per week, greater frequency of monthly binge drinking, and more negative drinking-related consequences.

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Colbert	2021	International policy review and systematic literature review	United States Canada United Kingdom Ireland Australia New Zealand	Yes	Mixed	77 jurisdictions	Alcohol	Mixed	Not stated	Online alcohol sales and home delivery	n/a	Mixed	Age verification at the time of purchase. Age verification at the time of delivery. Third party delivery services. Delivery driver requirement to complete responsible service of alcohol training. Type of premises permitted to deliver. Alcohol types permitted for home delivery. Maximum quantities of alcohol permitted for delivery. Delivery trading hours. Mandatory information to be displayed on websites selling alcohol. Labelling of packages. Changes due to the COVID-19 pandemic.	Very low	downgrade for indirectness	Regulation of online sales and delivery of alcohol varied widely across the jurisdictions reviewed, but in most it does not meet the same standard as bricks-and-mortar establishments and may be insufficient to prevent youth access. We found that most jurisdictions rely on age verification occurring at the point of delivery. Our systematic review has demonstrated that compliance with age verification on delivery can be poor and has the potential to fail even when delivery drivers request identification from the purchaser.
Baandrup	2018	Cochrane Review	UK (x8) Denmark (x1) Italy (x5) France (x5) Israel (x4) (Spain, Mexico, France, Italy, Costa Rica, the Czech Republic, and Guatemala) (x1 study) Poland (x1) USA (x7) Japan (x1) Canada (x1) Netherlands (x2) Finland (x1) China (x1)	No	Outpatient	38 studies (2543 participants)	benzodiazepines	adults who withdraw from chronic benzodiazepine use	Not stated	pharmacological treatment versus placebo or no intervention or versus another pharmacological intervention	n/a	n/a	Primary: 1) Benzodiazepine discontinuation. 2) Benzodiazepine withdrawal symptoms 3)Serious adverse events. Secondary: 1) Benzodiazepine mean dose. 2) Insomnia. 3) Anxiety. 4) Comorbid substance abuse. 5) Non-serious adverse events. 6) Relapse to benzodiazepine use. 7) Discontinuation due to adverse events assessed only at the end of intervention.	Very low	downgrade for bias, imprecision, inconsistency	Found potential benefit of valproate at end of intervention and of tricyclic antidepressants at longest follow-up. Potentially positive effects on benzodiazepine withdrawal symptoms of pregabalin, paroxetine,tricyclic antidepressants, and flumazenil. Given the low or very low quality of the evidence for the reported outcomes, and the small number of trials identified with a limited number of participants for each comparison, it is not possible to draw firm conclusions regarding pharmacological interventions to facilitate benzodiazepine discontinuation in chronic benzodiazepine users.

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Indave	2016	Cochrane Review	USA (x13) Italy (x1)	No	In and outpatient	14 studies (719 participants)	Cocaine	people with cocaine dependence	Not stated	Antipsychotics vs placebo	n/a	n/a	Primary: 1) Dropouts from treatment. 2) Acceptability of the treatment. 3) Use of primary substance of abuse. 4) Results at follow-up. Secondary: 1) Compliance 2) Craving. 3) Severity of dependence. 4) Amount of cocaine use. 5) Psychiatric symptoms/psychological distress. 6) Withdrawal symptoms	Very low	downgrade for bias, inconsistency, indirectness	Antipsychotics reduced dropout. no significant differences for any of the other primary outcomes considered. At present, there is no evidence supporting the clinical use of antipsychotic medications in the treatment of cocaine dependence, although results come from only 14 trials, with small sample sizes and moderate to low quality of evidence.
Pérez-Mañá	2013	Cochrane Review	USA (x7) Sweden (x1) Australia (x2) Finland (x1)	No	Outpatient	11 studies (791 participants)	amphetamines	Adults with amphetamine abuse or dependence	Not stated	Psychostimulants vs psychotherapy or placebo	n/a	n/a	Primary: 1) Amphetamine use as mean (standard deviation negative urinalyses across the study 2) Amphetamine use as amphetamine concentration in hair analysis. 3) Sustained amphetamine abstinence. Secondary: 1) Self-reported amphetamine use. 2) Retention in treatment. 3) Amphetamine craving. 4) Depressive symptoms severity. 5) Anxiety symptoms severity. 6) Overall functioning. Secondary safety measures: 1) Number of participants who dropped out because of any adverse event (AE). 2) Number of participants who dropped out because of cardiovascular adverse events. 3) Number of participants who dropped out because of	Low	downgrade for bias, inconsistency	No significant differences were found between psychostimulants and placebo for any of the studied efficacy outcomes. Overall retention in studies was low. Psychostimulants did not reduce amphetamine use or amphetamine craving and did not increase sustained abstinence. Results of this review do not support the use of psychostimulant medications at the tested doses as a replacement therapy for amphetamine abuse or dependence. Future research could change this conclusion, as the numbers of included studies and participants are limited and information on relevant outcomes, such as efficacy according to the severity of dependence or craving, is still missing.

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Rahimi-Movaghar	2018	Cochrane Review	Iran (x9) India (x3) Thailand (x1)	No	In and outpatient	13 trials (1096 participants)	Opium	Management of opium withdrawal	Not stated	pharmacological detoxification treatment	n/a	n/a	Primary: 1) Completion of treatment. 2) Use of opium at the end of the detoxification programme. 3) Duration and severity of signs and symptoms of withdrawal, including patient self rating. 4) Nature, incidence, and course of adverse effects 5) Mortality rate Secondary: 1) Client satisfaction. 2) Use of other abusive substances. 3) Fatal or non-fatal overdose rate. 4) Relapse rate at follow-up	Very low	downgrade for bias, imprecision, inconsistency	clonidine was twice as good as methadone for completion of treatment. All the other results showed no differences between the considered drugs. Results did not support using any specific pharmacological approach for the management of opium withdrawal due to generally very low-quality evidence and small or no differences between treatments. However, it seems that opium withdrawal symptoms are significant, especially at days 2 to 4 after discontinuation of opium. All of the assessed medications might be useful in alleviating symptoms. Those who receive clonidine might experience hypotension.
Meader	2010	Cochrane Review	Mixed, not clearly stated	No	receiving formal drug treatment or not	35 trials (11,867 participants)	Cocaine Opiates	people who misuse cocaine, opiates, or a combination of cocaine and opiates	Not stated	psychosocial interventions designed specifically to reduce injection and/or sexual risk behaviour	n/a	n/a	at least one outcome measure of injection risk behaviour, sexual risk behaviour, or HIV seroconversion.	Moderate	downgrade for bias	There were minimal differences identified between multi-session psychosocial interventions and standard educational interventions for both injection and sexual risk behaviour. Although it should be noted there were large pre-post changes for both groups suggesting both were effective in reducing risk behaviours. In addition, there was some evidence of benefit for multi-session psychosocial interventions when compared with minimal controls. Subgroup analyses suggest that people in formal treatment are likely to respond to multi-session psychosocial interventions. It also appears single-gender groups may be associated with greater benefit.

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Gowing	2011	Cochrane Review	USA (x26) Australia (x3) Malaysia (x1) UK (x3) Multicountry (China, Indonesia, Thailand, Lithuania, Poland, Ukraine, Iran and Australia) (x1) Canada (x1) Ukraine (x1) Italy (x1) Germany (x1)	No	general primary health care, specialist drug and alcohol services or specialist infectious diseases services	38 studies (12,400 participants)	Opioids	opioid dependent drug users, the majority of whom were identified as injecting users, or with a recent history (last three months) of injecting drug use at the time of entry into the study. Studies involving participants using other injectable drugs in addition to opioids were also included.	Not stated	oral administration of full or partial opioid agonists for substitution treatment of opioid dependence	n/a	n/a	Primary: 1) sharing of injecting equipment 2) unprotected sexual intercourse. 3) high frequency injecting drug use. 4) frequency of condom use 5) multiple sexual partners. 6) providing sex in exchange for money or drugs. Secondary: 1) prevalence and incidence of HIV infection	Moderate	downgrade for bias	Studies consistently show that oral substitution treatment for opioid-dependent injecting drug users with methadone or buprenorphine is associated with statistically significant reductions in illicit opioid use, injecting use and sharing of injecting equipment. It is also associated with reductions in the proportion of injecting drug users reporting multiple sex partners or exchanges of sex for drugs or money, but has little effect on condom use. It appears that the reductions in risk behaviours related to drug use do translate into reductions in cases of HIV infection. The lack of data from randomised controlled studies limits the strength of the evidence presented in this review.
Hunt	2019	Cochrane Review	Australia (x6) UK (x5) Germany (x2) USA (25) Switzerland (x1) Denmark (x1) Ireland (x1)	No	Outpatient, hospital, community, jail,	41 studies (4024 participants)	Various	people with both severe mental illness and substance misuse	Not stated	psychosocial interventions	n/a	n/a	Primary: 1) leaving the study early. 2) Substance use: changes in substance use (alcohol or drugs, or both). 3) Mental state (mental health symptoms). Secondary: 1) adverse events. 2) Global state. 3) Social functioning. 4) Quality of life/life satisfaction. 5) Service use. 6) Homelessness. 7) Economic outcomes. 8) Compliance with treatment and medication	Low	downgrade for bias, indirectness	There is currently no high-quality evidence to support any one psychosocial treatment over standard care for important outcomes such as remaining in treatment, reduction in substance use or improving mental or global state in people with serious mental illnesses and substance misuse. Furthermore, methodological difficulties exist which hinder pooling and interpreting results. Further high-quality trials are required which address these concerns and improve the evidence in this important area.
Gowing	2017	Cochrane Review	USA (x14) Iran (x2) India (x2) Italy (x1) Australia (x1) Switzerland (x1) Israel (x1) UK (x2) Germany (x3)	No	In and outpatient	27 studies (3048 participants)	Opioids	Adults with opioid dependence	Not stated	Buprenorphine compared to methadone	n/a	n/a	Primary: 1) Intensity of withdrawal. 2) Duration of treatment. 3) Nature and incidence of adverse effects. 4) Completion of treatment. Secondary: engagement in further treatment	Moderate	downgrade for inconsistency	Buprenorphine is more effective than clonidine or lofexidine for managing opioid withdrawal in terms of severity of withdrawal, duration of withdrawal treatment, and the likelihood of treatment completion. Buprenorphine and methadone appear to be equally effective, but data are limited. It is not possible to draw any conclusions from the available evidence on the relative effectiveness of different rates of tapering the buprenorphine dose.

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Gowing	2016	Cochrane Review	Australia (x1) UK (x4) USA (x5) Hungary (x1) Germany (x1) Switzerland (x1) Italy (x3) Spain (x5) India (x1) China (x2) Taiwan (x1) Iran (x1)	No	In and outpatient. Prison (x1)	26 studies (1728 participants)	Opioids	People undergoing managed opioid withdrawal	Not stated	Alpha2-adrenergic agonist versus methadone	n/a	n/a	Primary: 1) Intensity of withdrawal. 2) Duration of treatment. 3) Nature and incidence of adverse effects. 4) Completion of treatment. Secondary: engagement in further treatment	Low	downgrade for bias, inconsistency	We found moderate-quality evidence that alpha2-adrenergic agonists were more effective than placebo in ameliorating withdrawal in terms of the likelihood of severe withdrawal. moderate-quality evidence that completion of treatment was significantly more likely with alpha2-adrenergic agonists compared with placebo. There were insufficient data for quantitative comparison of different alpha2-adrenergic agonists.
Mattick	2014	Cochrane Review	Iran (x4) Austria (x1) USA (x15) Sweden (x2) Norway (x2) Australia (x2) Italy (x2) Switzerland (x1) Malaysia (x1) Germany (x1)	No	In and outpatient	31 trials (5430 participants)	Opioids	People with opioid dependence.	Not stated	Buprenorphine maintenance at flexible doses compared to Methadone maintenance at flexible doses. OR Buprenorphine maintenance at high doses (16 mg) compared to placebo.	n/a	n/a	Primary: 1) Retention in treatment. 2) Use of opioids. 3) Use of other substances of abuse. 4) Criminal activity. 5) Mortality. Secondary: 1) Physical health. 2) Psychological health. 3) Adverse effects of medication.	Moderate	downgrade for bias	Buprenorphine is an effective medication in the maintenance treatment of heroin dependence, retaining people in treatment at any dose above 2 mg, and suppressing illicit opioid use (at doses 16 mg or greater) based on placebo-controlled trials. Compared to methadone, buprenorphine retains fewer people when doses are flexibly delivered and at low fixed doses. Methadone is superior to buprenorphine in retaining people in treatment, and methadone equally suppresses illicit opioid use.

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Zankl	2021	Cochrane Review	USA (x11) Iran (x1) Switzerland (x1) Scotland (x1) Australia (x1) Germany (x1)	No	Hospitals	16 studies (1110 participants)	Opioids	newborn infants with opioid withdrawal	Not stated	Mixed pharmacological	n/a	n/a	Primary: 1) Treatment failure: including failure to achieve control. 2) Seizures. 3) Neonatal and infant mortality. 4) Neurodevelopmental disability at 18 months' postnatal age or greater. Secondary: 1) Time to control of NAS. 2) Days admission to a newborn nursery. 3) Days hospitalisation. 4) Days pharmacological treatment of NAS. 5) Days to establishment of full sucking feeds. 6) Success of breastfeeding. 7) Postnatal growth failure (weight < 10th percentile at discharge) 8) Infant growth 9) Change of standardised growth. 10) Side effects occurring after	Very low	downgrade for bias, imprecision, indirectness	Compared to supportive care alone, the addition of an opioid may increase duration of hospitalisation and treatment, but may reduce days to regain birthweight and the duration of supportive care each day. Use of an opioid may reduce treatment failure compared to phenobarbital, diazepam or chlorpromazine. Use of an opioid may have little or no effect on duration of hospitalisation or treatment compared to use of phenobarbital, diazepam or chlorpromazine. The type of opioid used may have little or no effect on the treatment failure rate. Use of buprenorphine probably reduces duration of hospitalisation and treatment compared to morphine, but there are no data for time to control NAS with buprenorphine, and insufficient evidence to determine safety. There is insufficient evidence to determine the effectiveness and safety of clonidine.
Aspinall	2014	Systematic review and meta-analysis	12 studies (USA, Canada, Europe)	No	N/A	12,000 person years across studies	N/A	People who inject drugs	Not stated	Needle and syringe programmes	Various by jurisdiction	Not stated	HIV transmission	Moderate		Exposure to NSP was associated with a reduction in HIV transmission: pooled effect size 0 66 [95% confidence interval (CI) 0 43, 1 01] across all studies, and 0 42 (95% CI 0 22, 0 81) across six higher quality studies (according to the NewcastleOttawa tool).
Jones	2010	Systematic review	16 studies (USA, Canada, Europe)	No	Community NSPs (excluded prisons)	Over 5000 across studies	N/A	People who inject drugs	Not stated	Needle and syringe programmes, either alongside OST, different types of sites and settings, and with additional HR services offered	Various by jurisdiction	Not stated	Changes in injecting behaviours, BBV incidence and prevalence, entry intro treatment and healthcare utilisation	Low	Downgrade on indirectness	Based on 11 studies there was no evidence of an impact of different NSP settings or syringe dispensation policies on drug injecting behaviours, but mobile van sites and vending machines appeared to attract younger IDUs and IDUs with higher risk profiles. Two studies of interventions aimed at encouraging IDUs to enter drug treatment reported limited effects, but one study found that the combination of methadone treatment and full participation in NSPs was associated with a lower incidence of HIV and HCV. In addition, one study indicated that hospital-based programmes may improve access to health care services among IDUs.

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Des Jarlais	2013	Sytematic review	11 studies of LMICs who have high NSP coverage	No	LMICs	Not stated	N/A	People who inject drugs	Not stated	Needle and syringe programmes	Various by jurisdiction	Not stated	Changes in population level HIV prevalence	Low	Downgrade on inconsistency	While not fully consistent, the data generally support the effectiveness of NSP in reducing HIV and HCV infection in low/middle-income and transitional-economy countries. If high coverage is achieved, NSP appear to be as effective in LMICs as in high-income countries.
Davis	2017	Systematic review and meta-analysis	6 studies in US, Canada and Afghanistan	No	Community	2347 across all studies	N/A	People who inject drugs	Not stated	Needle and syringe programmes	Various by jurisdiction	Not stated	HCV seroconversion	Low	Downgrade on indirectness	The impact of NEPs on HCV prevention in PWIDs remains unclear. There is a need for well-designed research studies employing standardized criteria and measurements to clarify this issue.
Bouzanis	2021	Systematic integrative review	Canada	No	Various	Total not cited	N/A	People who inject drugs	Not stated	Various health programmes aiming to prevent and/or treat infectious diseases in PWID	Various by jurisdiction	Not stated	Various, including treatment initiation or adherence, mortality, testing, experiences of PWID	Low	Downgrade on indirectness	There are a variety of health programmes and services addressing the prevention and management of infections in PWID in Canada. Programmes and services should be expanded across geographic settings, healthcare settings and populations of PWID, specifically more marginalised PWID. Improving infectious disease care for PWID requires attention to social and structural barriers and inclusion of PWID in programmatic decision making.
Sauelle	2017	Cochrane Review	Australia (x1) Ireland (x1) Italy (x1) Scotland (x1) UK (x1) USA (x1)	No	Outpatient. Community pharmacy (x1)	6 studies (7999 participants)	Opioids	Patients with opioid dependence	Not stated	supervised dosing with a long-acting medication	n/a	n/a	Primary: 1) Retention in treatment. 2) Abstinence from unsanctioned opioid use. 3) Diversion (inappropriate use of medication by those for whom it has been prescribed) 4) Frequency of unsanctioned opioid use at the end of the intervention period. Secondary: 1) Adverse effects of medication. 2) Mortality or serious adverse event. 3) Severity of dependence. 4) Overdoses. 5) Craving. 6) Pain. 7) Aberrant opioid-related behaviours for prescribed opioid-dependent people.	Very low	downgrade for bias, inconsistency, indirectness	We found no difference in retention at any duration with supervised compared to unsupervised dosing or in retention in the shortest follow-up period. There was no difference in abstinence at the end of treatment and in diversion of medication. Uncertainty about the effects of supervised dosing compared with unsupervised medication due to the low and very low quality of the evidence for the primary outcomes

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McGovern	2021	Cochrane Review	UK (x1) Australia (x2) USA (21)	No	Outpatient drug and alcohol treatment, homeless shelter, child welfare services, community outpatient clinic	22 studies (2274 participants)	Alcohol and drugs	Parents who use substances	Not stated	Various psychosocial interventions	n/a	n/a	Primary: 1) Parental substance use Secondary: 1) Parental substance misuse. 2) Child welfare outcomes	Low	downgrade for bias, imprecision	We found moderate-quality evidence that psychosocial interventions probably reduce the frequency at which parents use alcohol and drugs. Integrated psychosocial interventions which combine parenting skills interventions with a substance use component may show the most promise. Whilst it appears that mothers may benefit less than fathers from intervention, caution is advised in the interpretation of this evidence, as the interventions provided to mothers alone typically did not address their substance use and other related needs.
Perry	2015	Cochrane Review	Not stated	Unknown	Criminal justice	14 trials (2647 participants)	Any drugs	patients with drug-using offenders. OR drug-using offenders	Not stated	(1) naltrexone in comparison with routine parole, social psychological treatment or both; (2) methadone maintenance in comparison with different counselling options; and (3) naltrexone, diamorphine and buprenorphine in comparison with a non-pharmacological alternative and in combination with another pharmacological treatment.	n/a	n/a	Primary: 1) self-report drug use. 2) biological drug use. 3) criminal activity. Secondary: 1) costs or cost-effectiveness	Very low	downgrade for bias, imprecision, indirectness	agonist treatments did not seem effective in reducing drug use or criminal activity compared to non-pharmacological treatment. Antagonist treatments were not effective in reducing drug use but significantly reduced criminal activity. When comparing the drugs to one another we found no significant differences between the drug comparisons (methadone versus buprenorphine, diamorphine and naltrexone) on any of the outcome measures. Caution should be taken when interpreting these findings, as the conclusions are based on a small number of trials, and generalisation of these study findings should be limited mainly to male adult offenders. Additionally, many studies were rated at high risk of bias.
Sheridan	2005	Cross-sectional survey	New Zealand	Yes	Needle exchange pharmacies	153 pharmacies	N/A	Pharmacies providing NEPs in NZ	Yes - in survey design	Needle exchange provided in pharmacies	Via the Government NSP funding	Legal in NZ	Service provision and barriers to service provision	Low	But plus 1 for lived experience involvement	The majority had not incurred problems such as violence or intoxicated clients in the last 12 months, although almost one third had experienced shoplifting which they associated with service provision. Training and improving return rates were identified as potential areas for further development.

Combined research and studies

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Hay	2017	Cross-sectional survey	New Zealand	Yes	Needle and syringe programmes	315 respondents	N/A	People who inject drugs	Not stated	Needle exchange (pharmacy and peer-based)	Via the Government NSP funding	Legal in NZ	Affective dysregulation, positive cognition, and information exchange	Low	No up or downgrade	We hypothesized that access to peer support would be associated with mental health benefits for PWIDs. Remarkably, the results of a multistep regression analysis revealed that irrespective of sex, age, ethnicity, main drug used, length of drug use, and frequency of visits to the NEP, the exclusive or preferential use of PBNEs predicted significantly lower depression and anxiety scores, greater satisfaction with life, and increased health-related information exchange with the service provider. These findings demonstrate for the first time an association between access to peer support at PBNEs and positive indices of mental health, lending strong support to the effective integration of such peer-delivered NEP services into the network of mental health services for PWID worldwide.
Rijink	2022	Qualitative interviews	New Zealand	Yes	Needle and syringe programmes	15 (PWID and staff)	N/A	People who inject drugs	14 interviews with PWID	Needle exchange	Via the Government NSP funding	Legal in NZ	Needs of PWID prior to and during disasters that may impact access	Low	Plus one for lived experience involvement	Access to NEP services is essential during natural hazard and human-generated disasters, as such NEP mobile outreach services and disaster resilience efforts should focus on maintaining service continuity for PWID during adverse times.
Noller	2020	HCV testing plus survey (used as a pilot)	New Zealand	Yes	Needle and syringe programmes	204	N/A	People who inject drugs	Peers conducted the testing and survey	HCV antibody testing within NSPs	Not stated	Legal in NZ	HCV detection and experience of prior HCV testing	Low	Plus one for lived experience involvement	Two hundred and four people were tested across the three sites. Of these, 131 (64.2%) tested HCV antibody positive (reactive) and by the study's conclusion confirmatory venepuncture testing (n=55) had produced 14 new diagnoses and seven people had commenced treatment. Additionally, the study successfully assessed clients' previous HCV testing rates and their knowledge of test results. Through the interactions involved in testing participants, needle exchange sta reported strengthened relationships with clients.

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Gibson	2021	Qualitative interviews	New Zealand	Yes	Needle and syringe programmes	5	N/A	Women who inject drugs (four women, one trans man)	Interviews with PWID	Needle and syringe programmes	Via the Government NSP funding	Legal in NZ	Gender as a determinant of stigma and NEP access, barriers to access for women who inject drugs	Low	Plus one for lived experience involvement	Stigma was an overwhelming issue affecting WWID which also acted as a barrier to their access of NEPs. The WWID in our study in terms of Goffman's original theorizing were "doubly discredited" as well as "precariously discreditable" due to their gender and injection drug using status. The participants keenly felt their stigmatized status through interactions with pharmacy-based needle exchange staff, perceiving that pharmacy staff viewed them as more contaminated than their male counterparts.
Horwitz	2012	Cross-sectional survey	New Zealand	Yes	Integrated hepatitis C clinic in Christchurch	120 clients	N/A	People with hepatitis C	Not stated	Integrated hepatitis C clinic	Study was funded by the CDHB, unclear how the intervention itself was funded	Legal in NZ	Client satisfaction, changes to lifestyle habits, Hep C knowledge, treatment intention, treatment status, referrals, experience with healthcare staff, access pathways.	Low	No up or downgrade	The findings point to the importance of integrated care in the community setting in providing clients with a positive experience of health care, which appears to increase their skills and desire to better manage their hepatitis C.
Potter	2025	Mixed methods	New Zealand	Yes	Needle and syringe programmes in Christchurch and Dunedin	survey n=57, PWID interview n=7, staff interview n=3	N/A	People who inject drugs plus staff	Co-designed with NEP staff	Needle and syringe programmes	Via the Government NSP funding	Legal in NZ	Experience of IRIDs and barriers to healthcare acces	Low	Plus one for lived experience involvement	IRIDs are a significant health risk in the Aotearoa injecting community and issues of stigma, discrimination and cost are significant barriers to healthcare.
Keen	2021	Economic evaluation	New Zealand	Yes	Needle and syringe programmes	N/A	N/A	People who inject drugs	Peer staff involved in study design and inputs	Needle and syringe programmes	Via the Government NSP funding	Legal in NZ	Economic costs and benefits	Low	No up or downgrade	For the year 2021, we estimate the NZNEP creates approximately $40 million in benefits, with approximately $6 million costs. These are shown in Table 4 and graphed below. We worked out that for every $1 in costs created by the NZNEP (both actual and social), the NZNEP creates $6.79 in benefits (including prevented future costs). Further analysis showed that the NZNEP creates $6.83 in benefits for every $1 of costs over the coming five years (2022 - 2026).

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Larney	2010	systematic review	Iran (x1) Australia (x2) Puerto Rico (x1) Canada (x1)	No	Prisons	5 studies (1036 participants)	Injected drugs	Incarcerated people who inject drugs	Not stated	Opioid substitution treatment	n/a	n/a	illicit opioid use, injecting drug use, sharing of needles and syringes and HIV incidence.	Very low	downgrade for bias, inconsistency, indirectness	Risk of heroin use was reduced by 62–91% across four studies reporting this outcome, and risk of injecting drug use was reduced by 55–75% in two of three studies reporting this outcome. Most importantly for HIV transmission, risk of sharing needles and syringes was reduced by 47–73% in the three studies that reported this outcome. This systematic review provides limited support for OST as a method for reducing injecting-related HIV risk behaviours among opioid-using inmates. However, OST can only be effective at a population level if available to the majority of heroin-dependent inmates.
Strang	2015	Systematic review + meta-analysis (Cochrane criteria applied)	Switzerland (Perneger 1998; n=51), Netherlands (van der Brink 2003; n=174 injected + 375 inhaled), Spain (March 2006; n=62), Germany (Haasen 2007; n=1,015), Canada (Ovideo-Joekes 2009; NAOMI n=226; 10%/n=25 injectable hydromorphone blinded), UK (Strang 2010; RIOTT n=127)	No	Outpatient; supervised clinics / RCT centers	~1,655 (375 supervised inhaled excluded from analysis)	Opioids / heroin (cf. methadone)	Opioid use disorder; heroin-injecting; unresponsive to standard treatment	Not stated	Safer supply: SIH (supervised; 2x daily + 1x daily methadone) vs Methadone only (?x daily; control) + some form of education or psychosocial support. No benzo allowed.	EMCDDA	Legal clinical prescribing or research frameworks	Retention in treatment, reduced illicit opiate use, mortality, 'drug use'/physical/mental health/other illegal activities.	Low	Moderate downgraded for indirectness - heavily entrenched PWOUD, generalises poorly to OUD at other degrees and NZ's landscape especially	COMPARED TO ORAL METHADONE: Retention in treatment (>in SIH); reduced illicit opiate use; mortality (< in SIH; n=16); some SAE (>in SIH), some improvements in 'drug use' / physical/mental health / other illegal activities @ 6-12 month follow-up. Favourable towards SIH over MMT. Highly variable outcome measures between studies; this review included primary outcome measures under supervised consumption only.

Combined research and studies

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Ferri	2011	Systematic review + meta-analysis (Cochrane Library)	UK (Strang 2010; RIOTT n=85), Canada (Ovideo-Joekes 2009; NAOMI n=226), Germany (Haasen 2007; n=1,015), Spain (2006; PEPSA n=62), Netherlands (2002; CCBH (A)) [<- THESE 5 POOLED FOR ANALYSIS], Netherlands (2002; CCHB (B) excl. due to inhaled RoA), Switzerland (Perneger 1998; n=51), UK (Hartnoll	No	Outpatient; mostly supervised clinics / RCT centers	2,007 (various n included in various comparisons for good reasons)	Opioids / heroin (cf. methadone or other OST)	Heroin-dependent individuals	Not stated	Safer supply: SIH (supervised; ?x daily + flexible methadone) + some form of education or psychosocial support. Side comparisons made for [any RoA] / [supervised/not].	Dept. of Epidemiology, ASLRME + Agency for Public Health (Italy), EMCDDA	Legal clinical prescribing or research frameworks	Efficacy, reduced mortality, acceptability, retention in treatment, reduced illicit substance use, improvement in health/social functioning, reduced criminal/carceral activity/outcomes	Low	Moderate downgraded for indirectness - heavily entrenched PWOUD, generalises poorly to OUD at other degrees and NZ's landscape especially	COMPARED TO METHADONE/OST/WAITLIST: Efficacy; acceptability; retention in treatment (> in SIH); reduced illicit substance use (> in SIH); mortality (ns < in SIH; RR=0.65 95%CI 0.25-1.69); improvements in health / social functioning (> in both groups, slightly > in SIH); reduced criminal/carceral activity/outcomes (> in SIH in single studies unable to be pooled); SAEs (> in SIH) @ 6-24 month follow-up (ONLY 12 MO INCLUDED). Favourable towards SIH over MMT. Highly variable outcome measures between studies; suitably compared / excluded for clarity, with in-depth description of differences.
Castells	2016	Systematic review + meta-analysis (Cochrane Library)	USA for all but 2: (Anderson 2009), (Dackis 2005, 2012), (Dursteler-MacFarland 2013), (Elkashef 2006), (Grabowski 1997, 2001, 2004a), (Kampman 2015), (Levin 2007, 2015), (Margolin 1995a, 1995b, 1997), (Mooney 2009, 2015), (Morgan 2016), (NCT00142818), (Perry 2004), (Poling 2006), (Schmitz	No	Outpatient	2,366	Stimulants / bupropion, dexmphetamine, lisdexamfetamine, methylphenidate, modafinil, mazindol, methamphetamine, mixed amphetamine salts, selegiline	Cocaine-dependent individuals (subgroup of cocaine+heroin dual-dependency maintained on methadone)	Not stated	Substitution: One of 9 drugs + some form of education or psychosocial support.	University researchers performed all studies with public funding, although eight of them also had additional private funding.	Legal clinical prescribing or research frameworks	Most commonly: Reduction of cocaine use, abstinence from cocaine, SAEs, retention in treatment	Very low	From Cochrane assessment	COMPARED TO PLACEBO: reduction of cocaine use (did not; very low quality evidence); abstinence from cocaine (~> in SST in some analyses, very low quality); safety (no SAEs, no difference cf. placebo) treatment (no difference cf. placebo, moderate quality) @ 6-24 week follow-up). Variety of secondary outcomes in some studies. Unhelpful pooling of substitute drugs with markedly different effects. Very low quality of evidence (massive attrition bias risk) for favourable outcomes cf. placebo; most quality evidence included indicated no difference in treatment retention. Best evidence in people with dual heroin-cocaine addiction. Did not improve cocaine craving or depression sx (handful of studies). Statistically significant: bupropion, dexamphet, mixed amphet salts (greater sustained cocaine abstinence cf. placebo), modafinil (reduced cocaine use), lisdexamfetamine (improved cocaine craving), dexamphet (greater sustained heroin abstinence in dual group) BUT studies too small for each drug to make conclusions.

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Siefried	2020	Systematic review	USA (53.5% / 23x), Iran (16.3% / 7x), Australia (9.3% / 4x), Malaysia (4.7% / 2x), Thailand (4.7% / 2x), Finland only (2.4% / 1x), Finland + New Zealand (2.4% / 1x), Iceland (2.4% / 1x), Russia (2.4% / 1x), Sweden (2.4% / 1x)	Yes	Outpatient (74.4% / 32x), inpatient (11.6% / 5x), mixed (9.3% / 4x), not reported (4.7% / 2x)	4,065	Pharmacotherapies (diverse x23) incl. dexamphet, methylphenidate, topiramate, naltrexone, bupropion, mirtazepine, etc. etc.	People with amphetamine/MA dependence or use disorder	Not stated	Substitution: One of 23 drugs (alone or + psychosocial support)	Government or academic (65.1% / 28x), pharmaceutical companies (funded or provided drugs in 23.3% / 10x), didn't state (9.3% / 4x), or no funding (2.3% / 1x)	Legal clinical prescribing or research frameworks	Abstinence, reduction of cravings, treatment adherence.	Very low	Extraordinary inconsistency of measures, underpowered studies	COMPARED TO PLACEBO (93% / 40x): Most commonly abstinence, reduction of cravings, treatment adherence. 55x disparate outcomes/measures = no meta-analysis. Underpowered studies, low treatment completion rates. Most favourable: stimulant agonists (dexamphet, methylphenidate), naltrexone, topiramate. Pull out NZ/Finland study!
Bahji	2018	Systematic review	Canada (Ovideo-Joekes 2009; NAOMI n=226; methadone n=111, heroin = 115), (Oviedo-Joekes 2016; SALOME n=202; hydromorphone n=100, heroin n=102)	No	Outpatient; supervised clinics / RCT centers	428 within scope	Opioids / heroin or methadone (or hydromorphone)	Opioid use disorder; heroin-injecting; unresponsive to standard treatment	Not stated	Safer supply: SIHH (supervised; up to 3x daily + flexible methadone) + some form of psychosocial + primary care support.	Academic / health authority	Legal clinical prescribing or research frameworks	Retention in treatment, reduction of illicit opioid use or other illegal activity, prevention of overdose / SAEs, days of street heroin use or days of past-month use of any street opioids	Low	Moderate downgraded in some domains for indirectness - heavily entrenched PWOUD, generalises poorly to OUD at other degrees and NZ's landscape especially. Large effect size for retention/illicit use for HAT, imprecision on SAEs	COMPARED TO METHADONE / OTHER AGONIST: [OJ/NAOMI 2009] retention in treatment (favours heroin 88% cf. methadone 54%); reduction of illicit opioid use or other illegal activity (favours heroin 67% cf. methadone 48%); Prevention of overdose/SAEs (favours methadone n=0 cf. heroin n=10 ODs and 6 seizures); [OJ/SALOME] days of streeet heroin use or days of any street opioids past 30 days (hydromorphone non-inferior); Prevention of overdose/SAEs (favours hydromorphone n=3 cf. heroin n=11) @ 12 mo follow-up. Mostly looked at other treatments, but 2x relevant to S(R)S
Carney	2020	Systematic review (Cochrane Library)	UK	No	2x general medical settings, 1x prison (male)	385	Opioids / dihydrocodeine	Individuals (15+) with less-severe opiate dependency (heroin, opium, morphone, codeine)	Not stated	Substitution: DHC compared to other OST (methadone or bupe) initially every 4 hr	Academic / government	Legal clinical prescribing or research frameworks	Primary: abstinence from illicit opiate use. Secondary: retention in treatment; other health and behaviour outcomes	Very low	Drawn from author's own assessment - methodological biases, massive attrition bias, indirectness	Low quality evidence of no sig. diff. cf. bupe or methadone for all. No blinding, significant attrition bias

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Dalsbø	2010	Systematic review (English excerpts)	2x Netherlands (n=174, n=256); 2x UK (n=96, n=127); 1x Switzerland (n=51); 1x Spain (n=62); 1x Germany (n=1,015); 1x Canada (n=251)	No	Not stated	2032	Opioids / heroin	Primarily heroin-injectors (1x smokers) with hx of chronic, long-term heroin or opiate addiction (many with failed attempts at traditional treatment)	Not stated	HAT vs. traditional OST (methadone, bupe)	Not stated	Legal clinical prescribing or research frameworks	Reduced mortality, retention in treatment, reduced use of illicit drugs, quality of life, SAEs.	Very low	Drawn from author's own assessment - hetereogeneous pops across studies, explicitly uncertain findings	Mortality; retention in treatment (all studies); use of illegal drugs; quality of life; SAEs (all but one study). Authors graded as very low quality; uncertainty is the conclusion
Ferri	2013	Systematic review (Cochrane Library)	Austria (Eder 2005, n=64; Giacomuzzi 2006, n =120), Australia (Clark 2002, n=11)	No	Outpatient	195	Opioids / morphine (slow-release)	Opioid-dependent people who respond poorly to other available maintenance treatments (though it's noted non of the studies imcluded people with a documented poor response to other maintenance??)	Not stated	SROM vs. traditional OST or no treatment	Academic / EMCDDA	Legal clinical prescribing or research frameworks	Reduced opioid use, severity of dependence, mental health/social functioning, opiate withdrawal, participant preference, reduction of cravings, reduction of depressive symptoms, physical complaints / anxiety symptoms, quality of life, SAEs, retention in treatment	Very low	Very small studies, inconsistent findings and small effect sizes between formats compared	Reduced opioid use (possibly favours SROM); severity of dependence; mental health / social functioning (both equivalent for SROM or favours comparison interventions); opiate withdrawal sx (favours SROM cf. methadone by >1/2); participant preference (7 of 9 preferred morphine in 1x study); reduction of cravings; reduction of depressive sx / physical complaints / anxiety symptoms (all favour SROM significantly); quality of life (favours OST or no difference); SAEs (favours comparisons cf. SROM); retention in treatment (no sig. diff. cf comparison interventions). Another study showing not enough studies to conclude anything
Pérez-Mañá	2013	Systematic review (Cochrane Library)	USA (>half of studies), Australia (Longo 2010, Sherer 2009), Sweden (Konstenius 2010), Finland (Tiihonen 2007)	No	Outpatient	791	Stimulants / various pharmacotherapies (dexamphetamine, bupropion, methylphenidate, modafinil)	People with meth(9x)/amphetamine(2x) abuse or dependence, mainly smokers (59%).	Not stated	Psychostimulants as replacement therapy	Academic only (8x) or with pharmaceutical industry funding (3x)	Legal clinical prescribing or research frameworks	Reduced ATS use, reduced cravings, sustained abstinence, SAE dropout.	Very low	Weak findings and severe attrition bias	Efficacy (no sig. diff. between any psychostimulant cf. placebo) measured as reduced amphetamine use (no mean diff.), reduced cravings (no mean diff.); sustained abstinence (no increase); SAEs/dropout (similar for stimulants cf. placebo). No different findings in any subgroup analysis. Poor retention in studies (50.4%). Results do not support use of psychostimulant medications as a replacement therapy.

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Gowing	2017	Cochrane Review	Australia (x1) UK (x4) Italy (x2) USA (x3)	No	In and outpatient	10 studies (955 participants)	Opioids	opioid dependent adults	Not stated	antagonist-adrenergic combination	n/a	n/a	Primary: 1) Severity of the withdrawal syndrome experienced. 2) Duration of treatment. 3) Nature and incidence of adverse effects. 4) Completion of treatment. Secondary: engagement in further treatment	Very Low	Indirect: It's really withdrawal management rather than safer supply. Drawn from author's assessment (Cochrane): downagraded for inconsistency and unclear comparative benefit.	Using opioid antagonists plus alpha2-adrenergic agonists is a feasible approach for managing opioid withdrawal. However, it is unclear whether this approach reduces the duration of withdrawal or facilitates transfer to naltrexone treatment to a greater extent than withdrawal managed primarily with an adrenergic agonist.
McNair	2023	Systematic review and meta-analysis	6x EU (Perneger 1998 (n=51), ven den Brink 2003 (n=549), PEPSA 2006 (n=62), Haasen 2007 (n=1015), RIOTT 2010 (n=127), TADAM Demaret 2015 (Belgium; n=74)), 2x Canada (SALOME 2016 (n=202), NAOMI 2009 (n=251))	No	Supervised clinical (outpatient)	2331	Opioids / heroin vs. OST	People with long-term heroin addictions	Not stated	HAT as safe(r) supply compared to methadone OST (or injectable hydromorphone)	Not stated	Legal clinical prescribing or research frameworks	Retention in treatment, reduced street drug use, health, social functioning.	Low	Moderate downgraded for indirectness - heavily entrenched PWOUD, generalises poorly to OUD at other degrees and NZ's landscape especially	Meta-analysis: Retention (significant effect for HAT across all studies pooled, 67-93%); street drug use (5 of 8 studies showed superiority to MMT; reduced by 13-47%); health (inconsistent findings, positive for HAT in 3 studies n=1626, no sig diff in 4x n=454); social functioning (only 3x reporting as an outcome, only Swiss showed sig pos effect). No sig. diff. in outcomes between studies offering (5x) vs requiring (3x) psychosocial interventions. Significant of different in retention in treatment widened for longer follow-ups (1-19% at 6-9 mo, at least 27% higher by 12 mo).

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Smart	2022	Review of RCTs	UK (UI-HAT, RIOTT), Switzerland, Spain, Netherlands, Germany, Canada (NAOMI, SALOME) for injectable HAT; Netherlands and Belgium for inhalable HAT	No	Supervised clinical (outpatient)	2427	Opioids / heroin	People with opioid use disorder, refractory to OST	Not stated	HAT as safe(r) supply compared to methadone OST (or injectable hydromorphone)	RAND Corporation - gifts from RAND supporters + operational income	Legal clinical prescribing or research frameworks	Reduction in criminal activity (primary), reduced illicit heroin use, reduced drug expenditures, employment and earnings, social functioning.	Moderate	Starting High, downgrade for indirectness (signficantly treatment-refractory population). Large consistent effect sizes for reduction of criminal activity and illicit use balances the author's admitted risk of methodologicla biases. Possibly a flag for review but feels reasonably balanced imo?	Primary: Reduction in criminal activity (sig. in all trials, 4x significantly larger for HAT cf. OST, OR = 0.45) esp drug/property-related (ORs = 0.14-0.9 for drug-related, 0.12-1.89 property-related); Mediators: reduced illicit heroin use; drug expenditures (3 studies - two with large differences 86-90% cf control!); employment and earnings (2 trials found improvement; only sig diff 'employment satisfaction' cf. MMT in Canadian trial); social functioning (4 trials found ~some improvement, only NAOMI signif. for HAT; very mixed measure across studies / proxies for days). Great wrapup of trials spanning 7 countries, 4 decades, 2427 participants. Feels weird to thank RAND but, thanks RAND. Excellent evaluation / summaries of the risks of biases across studies, tables of studies / measures / effects. Great inclusion of expenditure on illicit drugs / acquisitive crime.
Sharafi	2023	Systematic review + Meta-analysis	USA (Galloway 2011; n=60 + Thompson 2021 n=29-34 + Ling 2014 n=110), Sweden (Konstenius 2014 n=54 + Konstenius 2010 n=24), Australia (Longo 2010 n=49), Iran (Noroozi 2020 n=62 + Rezaei 2015 n=56), NA? (Tahonon 2007, n=34), Finland/NZ (Miles 2013 n=78-79)	Yes	Not stated	561	Stimulants / methylphenidate, dexamphetamine	People with ATS SUD	Not stated	Psychostimulants as replacement therapy, generally with some type of psychosocial support indicated	Canadian Institutes of Health Research; one author is supported by a variety of industry funding (not first/last)	Legal clinical prescribing or research frameworks	Reduced cravings at endpoint, reduced ATS use, SAE dropout, reduced cravings at early-stage, withdrawal, depressive symptoms.	Very low	Downgraded for attrition bias, heterogeneity, small sample..	Cravings at endpoint (significantly decreased by PPs SMD -0.29), reduced ATS use (non-sig., RR=0.95 by urineanalysis for all studies BUT sig RR=0.89 when biased studies removed, no effect self-reported), no differences detected for: retention in treatment (better with higher doses though), SAE dropout, early-stage craving, withdrawal, depressive symptoms. Probably the best summary of ATS safe(r) supply

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Martins	2021	Scoping review	Switzerland (8x), Canada (SALOME), UK, Spain	No	Supervised clinical (outpatient) OR take-home / home delivery OR inpatient OR opioid-naïve	705	Opioids / heroin	Treatment-refractory "patients" with heroin dependence	Not stated	Prescription of oral diacetylemorphine (solutions, tablets, capsules)	Financial contribution from DiAcetylMBV (Netherlands) - company does not produce heroin for oral admin.	Legal clinical prescribing or research frameworks	Highly variable. PK, PD, clinical efficacy/effectiveness, safety	Very low	Scoping review, wide variety of outcomes across heterogeneous populations / formulations. Industry funded risk of bias. Hypothesis-generating more than it is estimating effectiveness.	Based on all published data, it is unlikely that oral diacetylmorphine produces a substantial 'rush'. Prescription of oral diacetylmorphine might therefore be effective only for treatment-refractory patients with heroin dependence (i) as maintenance treatment for those who never injected or inhaled opioids; (ii) as maintenance treatment for those who want to switch from injection to oral administration of diacetylmorphine; and/or (iii) to reduce opioid withdrawal symptoms.
Noroozi	2021	Systematic review	Iran	No	Outpatient	148	Opioids / opium (morphine) extract	People with opioid use disorder (1x where only preferred opioid was opium, 1x unspecified)	Not stated	Prescription of oral opium tincture as maintenance	Not stated	Legal clinical prescribing or research frameworks	Sexual function (Kheradmand 2019), cognitive function (Wong 2020); not related to OUD	Very low	Sexual function has about 3/4 of F/A relevance to meaningful outcome measures	Sexual function improved significantly at week 12 with no differences between OT, bupe or methadone. Cognitive function improved on OT or methadone at 12 weeks but no significant differences.
Atkinson	2023	Programme evaluation	Canada	No	Outpatient	86	Opioids / hydromorphone	People with OUD	Client Advisory Committee met monthly for feedback + guidance	Prescribed safer supply, alongside comprehensive primary healthcare, case management, social supports.	Health Canada (Substance Use and Addictions Program; SUAP)	Legal clinical prescribing or research frameworks	Reduced risk of overdose and death, low-barrier to access in a community setting, connection with health / social care and harm reduction services, decreased harms associated with involvement in criminal activities related to substance use, retention in care.	Low	Observational, self-(staff)-administered, some PWLLE involvment but not convincing enough for upgrade afaict	Clients felt strongly that their risk of overdose had decreased since starting safer supply even if some were still using fentanyl. Self-reported 3mo ODs dropped from 50% to 15% (@ 6mo). 92% reported fewer or better side effects from using opioids than before. 52% stopped using street fentanyl, 26% decreased their use. Clients reported less or no withdrawal. 73% reported they were able to address a health issue for the first time, contact with a [social worker] up from 40% to 89% @ 6mo. 27% reported they had new / better housing. Clients reported decreasing or stopping involvement in criminal activities (3mo crime down from 44% to 19% @ 6mo). 80% retained in care (@ 12mo), 4% dropout due to death (all cause). 0% said quality of life had not improved - 85% more connected to healthcare, 81% more time to do things they want, 77% more money to do things they want, 88% greater sense of safety, 85% other things in my life have improved. Reported safer using (92% feels safer; 58% inject less often @ 6mo)

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Gomes	2022	Programme evaluation	Canada (Ontario, London)	No	Outpatient	82 matched to at least 1 control (303 controls)	Opioids / hydromorphone	People with OUD, at high-risk of harms / have experienced poisoning/overdose; comparison group (matched demographic / clinical characteristics not exposed to the program)	Not stated	Prescribed safer supply, alongside comprehensive primary healthcare, case management, social supports.	Ontario MoH and Canadian Institutes of Health Reseearch	Legal clinical prescribing or research frameworks	Primary: ED visits, hospital admissions, admissions for infections, healthcare costs. Secondary: MH ED visits/admissions, opioid-related ED visits/admissions, admissions for any SUD, opioid-related deaths.	Low	Observational, self-(staff)-administered, some PWLLE involvment but not convincing enough for upgrade afaict	ED visits decreased (-14 per 100 ppl; RR 0.69, nice), hospital admissions decreased (-5 per 100 ppl; RR 0.46), healthcare costs (ex. PCP/Rx; -$922/person; halved per person-year), no sig change in infection rate (-1.6 per 100 ppl non-sig; RR = 0.51). In comparison/unexposed group, no sig change to any primary outcome. Although additional research is needed, this preliminary evidence indicates that SOS programs can play an important role in the expansion of treatment and harm-reduction options available to assist people who use drugs and who are at high risk of drug poisoning.
Sprakes	2024	Programme evaluation	Canada (Ontario, Thunder Bay)	No	Outpatient	35 (+ 79 allocated to wraparound-only)	Opioids / hydromorphone & slow-release morphine	People with OUD, at high-risk of harms / have experienced poisoning/overdose, indigeneous (66% of n=35), partners of clients	PWLLE staff, PWUD advisory committee advising SSP Steering Committee, including program logic and evaluation methodology	Prescribed safer supply, alongside comprehensive primary health, psychosocial, harm reduction supplies (naloxone, pipes, condoms etc), wrap-around services addressing social determinants of health (incl. PCP, advocacy, transport, showers, breakfast/snacks)	Health Canada (Substance Use and Addictions Program; SUAP)	Legal clinical prescribing or research frameworks	Reduction in: withdrawal sx, overdoses, fentanyl use, incarceration, criminal activity, ER visits. Increase in: PCP engagement, immunisations, BBV care, chronic illness management, physical / mental health, sense of stability, social supports/community belonging, positive relationships with family / friends, connection to culture/identity, access to housing, food security, engagement in HR practices, knowledge/skills about substance use.	Low	Observational, self-(staff)-administered, some PWLLE involvment but not convincing enough for upgrade afaict	Reduction in: withdrawal sx (100%), poisonings/overdoses (77-92%), fentanyl use (80%), incarceration (100%), criminal activity (68% for those with existing), ER visits (50%), daily stress (34% reduced to every couple of days). Increase in: PCP engagement (68%), immunisations (51%), BBV care (100%), chronic illness management (68.5%), physical (54%) / mental (40%) health, sense of stability (43%), social supports/community belonging (43%), positive relationships with family (45.7%) / friends (20%), connection to culture/identity (20%), access to shelter/housing (86%), food security (37%), engagement in HR practices (100%), knowledge/skills about substance use (100%). Strongest outcomes in those in the program @>6mo. Median treatment time was 12mo for active clients (9mo overall). In addition to the program's main goals. Other risks reduced: polydrug use, injecting, acquisitive crime. Clients decreased (54.3%) or stopped (25.7%) fentanyl, decreased (51.4%) or stopped (8.5%) crack cocaine, or stopped (100%) using MA.
Haines	2023	Programme evaluation (qual)	Canada (Ottawa; 3x SSP sites)	No	Outpatient clinic / shelter/SCS / community health centre	30	Opioids / hydromorphone	People identifying as PWUD. No exclusion criteria. 20% identified as indigenous	Not stated	Prescribed safer supply	Health Canada (Substance Use and Addictions Program; SUAP)	Legal clinical prescribing or research frameworks	Reduced fentanyl use, overdose events, legal issues. Increased MH ratings, housing status, income source	Low	Observational - large effect sizes and relevance to peer-led service, but tiny sample and geographic range, no control group	Reduced fentanyl use (10pt -> 1.5pt), overdose events (28 (93.3%) -> 6 (20%)), legal issues (28 (93.3%) -> 12 (40%)). Increased MH ratings (1.75 -> 3.75 (0=very poor, 5=excellent)), housing status (8 (26.7%) -> 15 (50%)), income source (none into employment, but disability support from 12 (40%) -> 23 (76.7%)). Lots of nice misc qual/narrative findings too.

Combined research and studies

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Brothers	2022	Programme evaluation	Canada (Nova Scotia)	No	Hotel shelter (COVID-19)	77	Stimulants / MPH or lisdexamfetamine or dexampheta mine (n=31; 40%); Opioids / SROM (n=17; 22%) or hydromorph one (n=27; 35%); Benzos / clonazepam or lorazepam (n=6; 8%), alcohol (n=42; 55%), cigarettes (n=64; 83%)	People experiencing homelessness	Not stated	Prescribed safer supply to support14-day COVID-19 isolation	People who stayed at congregate shelters identified to have COVID-19 outbreaks were moved to isolation in hotels funded by the provincial government.	Legal clinical prescribing or research frameworks	AEs / overdoses, retention in isolation	Low	Observational, small sample - stunning effectivenss but also a very very niche application / context, indirect to non-pandemic settings	Six (8%) residents left against public-health orders - four returned soon after and remained (leaving n=2; 3% persistent discharges). There were zero (0) overdoses (over 1,059 person-days in isolation). Six records of intoxication (0.005 events/person/day). Three records of diversion (0.003 events/person/day).
Kalicum	2024	Programme evaluation	Canada (BC)	No	Unsanctioned compassion club	47	Stimulants / cocaine/crack , MA; Opioids / heroin	Eligible + user-group enrolled [members / people] who use cocaine, heroin or MA + in the Vancouver DTES, + at high risk of overdose.	Peer-led	Unsanctioned compassion club in Vancouver where members could purchase illicit drugs that had been rigorously tested to ensure quality and a lack of potentially fatal contaminants.	Buyer's club. Study: Canadian Institutes for Health Research Foundation Grant.	Unsanctioned / illegal	Any non-fatal overdose; involving naloxone admin	Low	Observational and very low generally (imprecision and indirectness to NZ) but solid upgrade for PWLLE design and delivery	Reduction in any non-fatal overdose (aOR=0.51); reduction any NFO involving naloxone admin (aOR=0.37). In this study, enrolment in an unsanctioned compassion club was found to be associated with reductions in any type of non-fatal overdose and non-fatal overdose involving naloxone administration. These findings highlight the need for ongoing research on safer supply interventions, as well as the potential of non-medicalized compassion clubs to complement existing safer supply programming and reduce overdose events.

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Kolla	2023	Programme evaluation	Canada (Ontario, London)	No	Outpatient	75 + 95	Opioids / hydromorphone (with/out slow-release morphine 'backbone')	PWUD	Program developed with input from people who use drugs (PWUD), peer staff	Prescribing safer supply in combination with comprehensive primary healthcare and social services specific to each individual client, wraparound support includes HR, BBV, diabetes education, nutrition services, housing support, assistance applying for social programs, counselling)	Health Canada (Substance Use and Addictions Program; SUAP)	Legal clinical prescribing or research frameworks	Changes 'since starting safer supply' (given for both 2022 and 2023 surveys): Decreased fentanyl use, decreased stimulant use, changing to lower-risk RoA for fentanyl or stimulants, reduced instances of overdose. Physical health, mental health, retention in care (80% in both years wewre contiunously / no break of >=4 weeks)	Low	Observational, self-(staff)-administered, some PWLLE involvment but not convincing enough for upgrade afaict	Decreased fentanyl use (49-53% decreased, 25-11% stopped), decreased stimulant use (59-63% decreased, 15-9% stopped), RoA for street fentanyl (actually injecting + smoking both went up; 17 -> 26% injecting, 59 -> 73% smoking) or stimulants (36-37% injecting and 63-62% smoking/snorting/eating), low rates of overdose (2022: 0 ODs past month, 8% past 6mo; 2023: 10% ODs past month, 15% past 6mo). Client preferences: Drug 33% fent, 32% hydromorphone IR, 23% heroin, 7% other hydro forms, 3% oxy, 2% suboxone, demerol etc.; RoA 37% inject, 35% smoke, 19% p.o., 6% path, 1% snort. Physical health (76-59% reported improvement), mental health (69-53% reported improvement)
Ledlie	2024	Scoping review	Canada	No	Outpatient	Varied per theme	Opioids / hydromorphone (with/out slow-release morphine 'backbone')	PWUD	Not stated	Prescribing safer supply in combination with comprehensive primary healthcare and social services specific to each individual client, wraparound support includes HR, BBV, diabetes education, nutrition services, housing support, assistance applying for social programs, counselling)	Canadian Institutes for Health Research Foundation Grant.	Legal clinical prescribing or research frameworks	Themes: opioid-related toxicities, infection complications, other clinical outcomes (e.g. hospitalisation), client-reported outcomes (e.g. crime), program access barriers, diversion, retention in care, healthcare costs	Low	Scoping review, really just synthesising the reviewed+grey literature so starting low. Great consistency across studies on toxicity reduction, retention and reduced criminal activity, longer follow-up would likely expand effect sizes but mostly they're really short interverntions (except LICHC).	Opioid-related toxicities (consensus across 8 studies: 0 fatalities, low or decreased occurence of NFO and fatal OD), infection complications (only LICHC; RR 0.51), other clinical outcomes (2x studies, 4x grey lit: sig diffs in ED/admissions, low deaths, improvements in other areas but not necessarily signif.), client-reported outcomes (decreased illicit fent, increased autonomy, less stigma, less anxiety / increased perception of safety, income/transport/food/clothing support, financial stability - still lots of unmet need. Consensus decrease in criminal activity), program access barriers (frequency, hours, observed dosing, difficulties with pharmacies/other HCWs, program capacity, lack of info, discontinuity of care, dose/potency), diversion (1x study; 3 of 27 clients rxed hydro), retention in care (5x PR/grey, high rates 77-94% @2mo, 9mo, 12mo, 17mo), healthcare costs (1x: signif. reduced). Only LICHC followed up to 1 year, no sig diff in ED/inpatient or fatal toxicity events.

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McMurchy	2022	Implementation evaluation	Canada	No	Outpatient	1355 at time (2 programs not yet commenced)	Opioids or opioids and stimulants	PWUD	Not stated	Safer supply	Controlled Substances and Cannabis Branch, Health Canada	Legal clinical prescribing or research frameworks	Program implementation for safer supply programs funded by CA SUAP pilot funding	Low	Observational, self-(staff)-administered, some PWLLE involvment but not convincing enough for upgrade afaict	6x SUAP programs delivering opioid SS alone (2 yet to come along at time of print), and 2 delivering both opioid + stimulant. None provided stimulants only. Having access to a safer supply has had tremendous immeasurable (and measureable) positive impacts on clients' lives. According to clients and staff, many are more positive and happier, and have better health outcomes, greater stability and improving relationships with family and friends. Some have secured housing and/or employment. Many have achieved their goals with the program, and others are working toward them. "I have achieved my goals with it. It works for everything I am looking for – every avenue that needs to be met." Clients are highly appreciative of having these services available to them. "It's surprising; I didn't think the government would provide this. We are addicts and not really a priority." "It's amazing, I never in my life thought I would have something like this."
Gomes	2025	Population-based matched cohort	Canada	No	Outpatient	856 + 856 (1,712)	Opioids / hydromorphone vs methadone	People commencing methadone OST or Safer Opioid Supply	Not stated	Safer supply	Canadian Institutes for Health Research and Ontario SPOR Support Unit	Legal clinical prescribing or research frameworks	Opioid toxicity, all cause ED visits, all cause hospitalisation, healthcare costs.	Low	Observational, self-(staff)-administered, some PWLLE involvment but not convincing enough for upgrade afaict	SOS and methadone were associated with improvements in health outcomes, including reduced opioid toxicities and health-care use, in the year after treatment initiation. The findings suggest SOS programmes play an important, complementary role to traditional opioid agonist treatment in expanding the options available to support people who use drugs.Opioid toxicity (signif. improvement -1.09 events per 100 ppl) in past month ODs; higher during commencement HR 2.83 cf. methadone, 1.16 for ED visit, 1.5 for inpt. admits), all cause ED visits (-8.85 per person year), all cause hospitalisation (-2.08 per person-year), incident infections (-0.68 per person-year), healthcare costs (-$91,699 per person-year). SOS less likely to discontinue treatment than methadone (0.62) @ 12mo follow-up.

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Miles	2013	RCT	New Zealand, Finland	Yes	Outpatient	79x randomised (41x NZ); 40x (21x NZ) to treatment, 39x (20x NZ) to placebo. Completed: 17x (10x NZ) treatment and 10x (4x NZ) placebo R U KIDDING LMFAO	Stimulants / methylphenidate	People with MA/amphetamine dependence, referred by SAS/CADS	Not stated	Replacement therapy	Authors are extensively employed as consultants / grant recipients for a wide variety of pharmaceutical companies.	Presumably legal but so embarassingly poor quality that it probably shouldn't have been	Primary: presence/absence of amphetamine/methamphetamine in urine samples collected twice weekly. Secondary measures included treatment adherence, alterations in craving scores and self-reported use. SE009c (SIPP webinar 20/Feb/26) retrieved as well.	Very low	This study sucks so much. Only PP trial that includes NZ, but in typical CADS fashion, doomed to fail from the outset. Concerta wrapped in candy is indirect to anybody it could possibly be applied to	ITT analysis (n = 79) showed no statistically significant difference in the percentage of positive urines between the methylphenidate and placebo arms (odds ratio: 0.95, 95% confidence interval: 0.83–1.08). However, there was a significant difference (P < 0.05) between the active and placebo arms in retention, the placebo arm displaying a significantly lower retention from 6 weeks that persisted until the end of the trial. Conclusions The trial failed to replicate earlier findings suggesting that methylphenidate was superior to placebo. The low retention rate confounded the ability to draw firm conclusions about efficacy. The higher retention rate was observed in the methylphenidate arm. Any replication of this work would need to consider alternatives to the rigid clinic attendance criteria, and consider an increased dose.
Yu	2022	Service report	New Zealand	Yes	NSP	Not stated - proportions used instead (only recorded numbers are 'service occasions' - any client #s are estimates and irrelevant to this citation	Various	PWID	Yes - kind of. NEST had stopped talking to peers in focus groups by this point (yeah there's a whole awful story behind that). But Jason was upstairs and the front counter staff mainly PWID peers across services.	NSP - irrelevant to safer supply really, just highlighting distribution of drugs injecting in the NZ setting	Health NZ	Legally sanctioned	Drug use by service occasion	Very low	Very observational and indirect to any actual effectiveness of the intervention	Just citing here as demonstration of the Aotearoa NZ injecting landscape
Maghsoudi	2021	Systematic review	Global (Australia, Europe, US) - 90 studies	Yes	Various drug checking services both off and onsite	Not stated	Various	People who use drugs	Not stated	Drug checking services	Various by jurisdiction	Various by jurisdiction	55 different outcome measures, mostly influence on behaviour and drug market monitoring	Low	Downgrade on indirectness	Drug checking services appear to influence behavioural intentions and the behaviour of people who use drugs, particularly when results from drug checking services are unexpected or drugs of concern.

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Giulini	2022	Systematic review	Global - 51 studies included	No	Various drug checking services both off and onsite	Not stated	Various	People who use drugs	Not stated	Drug checking services	Various by jurisdiction	Various by jurisdiction	Evaluation and implementation considerations	Low	Downgrade on indirectness	The services identified varied significantly in terms of testing methods, location of operation, primary goal, and the surrounding legal framework. The results suggest using multiple DC methods to be most beneficial. Further, DCS and the personalized interventions they provide can positively influence behavior change, minimize harm, and reduce mortality. DCS are a viable public health intervention that requires cross-sector support beyond the legal frameworks and testing methods.
Grace Rose	2023	Scoping review	North America - 29 studies included	No	Drug checking services	Not stated	Various	People who use drugs	Not stated	Drug checking services	Various by jurisdiction	Various by jurisdiction	Implementation and contextual factors for North American services	Low	Downgrade on indirectness	Technological considerations include the need for highly accurate, quantitative results which appeal to both populations of people with drug use disorder and recreational users. Accessibility of services was identiied as an important factor that may be impacted by the location, integration with other services, how the service is provided (mobile vs. ixed), and the hours of operation. Maintaining plausible deniability and building trust were seen as important facilitators to service use and engagement. Issues surrounding legality were the most frequently cited barrier by patrons, including fear of criminalization, policing, and surveillance. Patrons and stakeholders identified a need for supportive policies that ofer protections. Maintaining anonymity for patrons is crucial to addressing privacy-related barriers.
Whelan	2024	Thematic analysis	New Zealand	Yes	Community of people who use MDMA	14	MDMA	People who use MDMA	Yes, in research conduct	Drug checking services	Funded by NZ Govt	Legal in NZ	Participant views	Low	Plus one for lived experience involvement	Drug checking is a critical part of HR for MDMA, particularly to support informed behaviour.
Whelan	2024	Cross-sectional survey	New Zealand	Yes	Community of people who use MDMA	915	MDMA	People who use MDMA	Yes, in research conduct	Drug checking services	Funded by NZ Govt	Legal in NZ	Frequency of HR strategies and use of drug checking	Low	Plus one for lived experience involvement	53.3% of those who used drug checking reported changing behaviour in response. Lack of availability in some areas cited as a barrier.
Mayer	2026	Case study	New Zealand	Yes	Drug checking services	Not stated	Nitazene analogue	Service	Not stated	Drug checking services	Funded by NZ Govt	Legal in NZ	Process of identification and alerts	Low	No up or downgrade	Benefits of legalised drug checking in reducing drug related harm

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Brokenshire	2022	Cross-sectional survey	New Zealand	Yes	Festivals	390	Various	People who use festival drugs	Not stated	Drug checking services	Funded by NZ Govt	Legal in NZ	Use of drug checking, behaviour after drug checking, service awareness and use, reasons for use, barriers to use.	Low	No up or downgrade	Barriers to use included fear of reprimand and queue length, intention to use influenced by attitudes and social norms. Those with less drug use experience more likely to use drug checking.
NZ Drug Foundation	2025	Service use	New Zealand	Yes	Drug checking services	3213 samples checked	Various	People who use drugs	Not stated	Drug checking services	Funded by NZ Govt	Legal in NZ	Behaviour after drug checking, reasons for use / not using after checking.	Low	No up or downgrade	31% of people did not plan to take drug if it wasn't as expected, 39% would still take it, primarily because substance was "desirable" or because they hadn't taken it before. If still intending to take, would use other HR strategies including using with other people around and testing other drugs they are using.
McAuley	2015	Systematic review	USA (x4) UK (x4) Canada (x1)	No	Mixed	9 studies (1374 participants)	Opioids	PWUDs trained and supplied with naloxone	Not stated	Take home naloxone programmes	Study funded by NHS Health Scotland	Mixed	Primary : total number of peer naloxone administrations	Moderate	downgrade for inconsistency	Although the evidence base for THN is limited by evaluation design, the number of successful reversals and the lack of reported adverse events make a strong case for increasing delivery worldwide.
Tse	2022	Systematic review	USA (x5) Australia (x1) Canada (x1)	No	Mixed	7 studies (2578 participants)	Opioids	Mixed	Not stated	Take home naloxone	n/a	Mixed	Primary: change in heroin use associated with THN provision. Secondary: changes in other substance use (benzodiazepines, alcohol, cocaine, cannabis, or opioids other than heroin).	Low	downgrade for bias, inconsistency	no evidence that THN provision was associated with an overall increase in self-reported heroin use, or other substance use or increases in overdoses measured through emergency department. Instead, some studies showed a mean decrease in the days on which opioids were used, the quantity of opioid use, or the proportion of the population reporting use of opioids or other substances.
Chimbar	2018	Systematic review	Global (USA, Canada, UK, Germany). Numbers not stated	No	Mixed	9 studies	Opioids	People who use opioids	Not stated	Take home naloxone	n/a	mixed	mortality among those who abuse opioids.	Moderate	downgrade for bias	there is overwhelming support of take-home naloxone programs associated with decreased mortality among those who abuse opioids. As a result, there is an implication for a practice change that take-home naloxone programs should be more widely implemented throughout communities as a method of decreasing mortality associated with opioid overdoses.
Clark	2014	Systematic review	Global (USA, Germany, Canada, UK)	No	Mixed	19 studies	Opioids	People who use opioids	Not stated	Community-based opioid overdose prevention programs (distributing naloxone)	n/a	mixed	Mixed, articles included if they reported a training outcome and/or a report of overdose reversal rate, overdose fatalities, or another measure of overdose rate among program participants.	Moderate	downgrade for bias	The current evidence from nonrandomized studies suggests that bystanders (mostly opioid users) can and will use naloxone to reverse opioid overdoses when properly trained, and that this training can be done successfully through community-based opioid overdose prevention programs

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McDonald	2016	Systematic Review	Canada (2) USA (15) UK (4) UK and Germany (1)	No	Mixed	22 studies (13,891 participants)	Opioids (primarily heroin)	People experiencing opioid overdose	Not stated	Take home naloxone	n/a	Mixed	Overdose reversal after THN. Adverse reactions	Moderate	downgrade for bias	THN provision reduced fatal outcome of overdose among programme participants themselves, among fellow opioid users and in the wider community. The risk associated with THN programmes is relatively low, especially when the life-threatening nature of the emergency situation is borne in mind. There is no empirical evidence to support the concern that THN programmes might encourage heroin use.
Lewis	2017	Review	Not stated	Unknown	Community	Not stated	Opioids	nonmedical personnel adminstering naloxone	Not stated	take home naloxone	n/a	Mixed	Overdose reversal after THN administered.	Low	downgrade for bias, inconsistency	IN administration of naloxone allows medically untrained people to safely and effectively administer the medication with a substantial likelihood of success in reversing opioid-induced respiratory depression, if the overdose symptoms are observed. There is no need to learn how to administer an injection with aseptic technique, and the absence of a syringe needle eliminates the risk of needlestick injuries that could result in the transmission of infectious blood-borne pathogens. Thus, while THN programs have provided both syringes for IM injection or kits for converting syringes to nasal aerosol devices, and both treatment modalities appear to be similarly effective, there appear to be advantages to using the IN route of administration.

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Yousefifard	2020	Systematic review and meta-analysis	USA (x3) Australia (x2) Iran (x1)	No	pre-hospital	7 studies (726 participants)	opioids	People admited to hospital for opioid overdose	Not stated	Intranasal or intramuscular naloxone	This research was funded by a grant from Tehran EMS Center.	mixed	Success rate, onset of action and complications	Low	downgrade for bias, inconsistency	intranasal naloxone is as effective as intramuscular/intravenous naloxone in the pre-hospital management of opioid overdose complications. Intranasal naloxone aids in restoring the patients' spontaneous respiration and increases their consciousness level. The administration of intranasal naloxone was also found to cause no serious side-effects and all the reported complications were mild. Nevertheless, intranasal naloxone has a somewhat longer onset of action than intramuscular/intravenous naloxone. In addition, intranasal naloxone administration requires higher rescue doses compared to the other routes of administration. Overall, it seems that intranasal naloxone can be an acceptable substitute for the intramuscular/intravenous form in the management of opioid overdose in pre-hospital settings.
Bahji	2018	Systematic review	Netherlands (x1) Australia (x4) USA (x4) Canada (x2) Russia (x1)	No	Mixed	12 studies (2319 participants)	Opioids	Mixed, people experiencing opioid overdose or dependence	Not stated	pharmacological or nonpharmacological options for treating opioid overdose. Inclu naloxone, nalmefene, physostigmine, and naltrexone	n/a	mixed	reversal of suspected or established opioid overdose.	Low	downgrade for bias, inconsistency	naloxone, nalmefene, and physostigmine emerged as effective in treating opioid overdose, while naltrexone showed evidence in preventing opioid overdose. Opioid agonists were found to be effective in improving retention in treatment and in reducing illicit opioid use.

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Davis	2014	systematic legal review	USA	No	n/a	n/a	opioids	n/a	n/a	naloxone administered by emergency medical services	partially funded by the Robert Wood Johnson Foundation's Network for Public Health Law program.	53 legal jurisdictions within USA	n/a	Low	downgrade for bias, indirectness	While naloxone is the standard care for advanced life support and intermediate life support EMS personnel, few states permit its use at the basic life support level. We recommend that National Highway Traffic Safety Administration update the national Model Scope of Practice to include the administration of naloxone as a minimum psychomotor skill for basic life support personnel and that all states, territories, and the District of Columbia permit all properly trained EMS personnel to administer the drug under medical oversight. We also recommend research to determine appropriate standard EMS naloxone dosing and administration protocols. While naloxone is the standard care for advanced life support and intermediate life support EMS personnel, few states permit its use at the basic life support level. We recommend that National Highway Traffic Safety Administration update the national Model Scope of Practice to include the administration of naloxone as a minimum psychomotor skill for basic life support personnel and that all
Chung	2025	Cross-sectional survey	USA	No	Sterile syringe programs (2023 NSSSP; 2022 service data)	429 NSPs	Any smoked and injected probably	PWID/PWSD	Not stated	No intervention, just looking for associations between offering safer smoking supplies and service occasions / naloxone distribution	Arnold Ventures (philanthropic / NGO)	Lawful to distribute in some states but unfunded	Whether NSPs distributed safer smoking supplies; number of participant encounters; number of naloxone doses distributed.	Very low	Observational, downgrade for indirectness (engagement and naloxone rather than health outcomes) and imprecision (CI crosses the null)	Of the 429 SSPs included, 187 (44.1 %) distributed safer smoking supplies to participants. SSP organizational type, service delivery method, urbanicity, and regional Census divisions were associated with safer smoking supply distribution. Compared to SSPs that did not distribute safer smoking supplies, those that did reported more participant encounters (aRR= 1.62, 95 % CI: 1.19–2.20) and naloxone doses distributed (aRR= 1.26, 95 % CI: 0.91–1.74). 'Health' NSPs distributed pipes less often (aPR=0.51) than did community-based organisations. Conclusions: SSPs distributing safer smoking supplies had greater participant engagement and naloxone distribution. To maximize their full individual and population-level health benefits, SSPs should be supported technically, legally, and financially to implement safer smoking supply distribution for their participants.

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Eger	2026	Qualitative interviews with NSP staff	USA	No	Sterile syringe programs	41 NSP representatives (leadership 63%, frontline 22%, clinical/support 15%)	Crack, MA, opioids	PWID/PWSD	Not stated	No intervention, just looking for thematic associations around offering safer smoking supplies	US National Institute on Drug Abuse (NIDA) research grants	Unlawful to distribute for 55.6% of NSPs surveyed here	Determinants of adopting safer smoking equipment; new participant engagement from implementing safer smoking distribution; implementation challenges	Very low	Thematic analysis rather than an intervention	Fentanyl adulteration of unregulated drug supplies and the COVID-19 pandemic–drove the adoption of this intervention. Interviewees perceived that safer smoking equipment facilitated client engagement, expanded SSPs' reach into previously underserved communities, and promoted individual health by reducing the adverse consequences of injecting drugs. Barriers to implementation and sustainment included program staff and leadership concerns about limited evidence on the public healt benefits of safer smoking equipment, stigma and negative local attitudes, funding restrictions, and cost(particularly for glass pipes). Strategies to support implementation included incrementally piloting safer smoking equipment, partnering with diverse funders, and adapting services to navigate resource constraints. Nevertheless, limited funding and legal support hindered broader adoption, reach and sustainability. Conclusions: Implementation of safer smoking equipment represents a critical evolution in harm reduction programming
Fitzpatrick	2022	Quasi-experiment	USA (Seattle, Washington)	No	Sterile syringe programs	694	Heroin	People who use heroin	Peer-led service + concept	Implementation of a heroin pipe distribution program at an SSP	People's Harm Reduction Alliance + Drug Policy Alliance	Lawful to distribute in WA	Proportion of respondents using heroin; exclusively smoking OR injecting heroin; both injecting and smokig heroin; using heroin pipes obtained from that NSP; self-reported hospitalisation for pulmonary sequelae	Very low	Observational, downgrade for indirectness when applied to predominantly stim landscapes	he proportion of SSP clients who exclusively injected heroin was lower after implementation of heroin pipe distribution.Compared to pre-intervention behaviors, the proportion of respondents who exclusively injected heroin was lower after the start of heroin pipe distribution (32%, 80/251 vs 43%, 86/201, p = 0.02), while the proportion of respondents who both injected and smoked heroin was higher (45%, 113/251 vs 36%, 72/201, p = 0.048). Just under half (44%, 110/251) of respondents who used heroin during the post-intervention period used a heroin pipe obtained from the SSP, of which 34% (37/110) reported heroin pipe distribution had reduced their heroin injection frequency. Self-reported hospitalization for a pulmonary cause was not associated with using a heroin pipe. Randomized studies with longer follow-up are needed to investigate whether heroin pipe distribution reduces heroin injection and improves health outcomes associated with drug use.

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Reid	2023	Cross-sectional survey	USA (Seattle, Washington)	No	Seattle 2018 National HIV Behavioral Surveillance	555	Heroin, MA, crack cocaine	PWID	Not stated	Surveying prevalence / desire for / likelihood of changing injecting practices by safer smoking provision	National HIV Behavioral Surveillance with funding from a cooperative agreement with the Centers for Disease Control and Prevention	Lawful to distribute in WA	Access to free safer smoking equipment; impact of smoking NIROA on injecting frequency; interest in accessing safer smoking equipment; expectation of changed injecting behaviour	Very low	Self-report survey, downgrade for indirectness (intent rather than measured changes) and risk of biases. Useful prevalence/demand indicators but doesn't really speak to effectiveness	Among participants who reported prior year heroin (n = 495), methamphetamine (n = 372), or crack (n = 88) injection, 11%, 11% and 12% reported access to free safer smoking equipment, respectively. Of those with access, the proportion that reported that access reduced their injection frequency ranged from 12% to 44%. Among participants without access, 28% who used heroin, 45% who used methamphetamine, and 49% who used crack were interested in access. Of interested participants, a majority reported that they thought this access would reduce their frequency of injection
Harris	Unpublished	Mixed-methods quasi-experiment	UK	No	Drug treatment services and peer-led networks in three geographical areas reflecting different patterns of crack use and service provision	~700	Crack cocaine	PWUC	Peer-led (and informed)	- A SIPP crack pipe kit - Peer to peer harm reduction information - An e-learning module for drug treatment and harm reduction provider	UK National Institute of Health Research	Generally illegal in UK; developed and delivered in partnership with people who use crack (PWUC), police and service providers	Our primary outcome measure is decrease in crack pipe sharing in the past 28 days. Secondary outcomes include increased drug treatment presentations; reduction in injecting frequency; current acute injuries; homemade pipe use; and respiratory risk markers.	Very Low	Would tend to upgrade for peer leadership but downgrading these as they are entirely unpublished currently.	Systematic evaluation of safe inhalation interventions for PWUC is urgently needed in order to produce definitive evidence of their health and other benefits, and to allow for evidence-based program and policy decisions in the interest of public health. The SIPP intervention commences in June 2022.

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Harris	Unpublished	Descriptive survey	UK	No	Drug treatment services and peer networks in six geographical locations in England	727 surveys / 33 interviews	Crack cocaine	PWUC (past 28 days)	Peer-led	Crack equipment provision and workforce training intervention	UK National Institute of Health Research	Generally illegal in UK; developed and delivered in partnership with people who use crack (PWUC), police and service providers	Respiratory risk including from smoking crack cocaine	Very Low	Observational / feasibility study. Would tend to upgrade for peer leadership but downgrading these as they are entirely unpublished currently.	Respiratory symptoms, diagnoses and hospitalisations were commonly reported, at 60%, 36% and 19%, respectively. Qualitative data illustrate ingenuity of crack equipment practice, with participants fashioning pipes out of materials ranging from umbrella handles, through to tin cans and plastic inhaler cases. Ash and stainless-steel scourer were primarily used as suspension materials. Accounts of practice illustrate connections between materials used and respiratory harms, the latter exacerbated by poor living conditions and limited availability of supports. Conclusion: We evidence a high burden of respiratory harm among people who smoke crack in England. Stimulant inhalation equipment prohibition contributes to a constellation of respiratory risk, with use of unsafe materials and impoverished living environments exacerbating health harms among a highly marginalised population. There is a need to reorientate drug services to support safer crack inhalation practice and reduce respiratory risk. Legislative change can facilitate this
Sharpe	2026	Mixed-methods quasi-experiment	UK	No	Drug treatment services and peer networks in six geographical locations in England	3 sites intervention / 3 sites control - n=33 pax who use crack (2 formerly) + 17 providers	Crack cocaine	PWU(/ed)C, service providers	Peer-led	Crack equipment provision and workforce training intervention	UK National Institute of Health Research	Generally illegal in UK; developed and delivered in partnership with people who use crack (PWUC), police and service providers	Themes specific to contact and engagement with drug services relating to provision of safer smoking equipment + education for crack cocaine.	Low	Auto-low as it couldn't be an RCT (sites as case-control) but possibly would upgrade for PWLLE?	Results: Prior to intervention implementation, little adequate crack-specific support was identified. SIPP equipment provision facilitated increased contact and/or disclosure of crack use with services. Workforce training enhanced communication and relationship-building opportunities, enabling disclosure of additional need and commensurate provision or linkage to health and social supports. The capacity for contact to facilitate engagement was impacted by organisational and structural constraints, and for some populations barriers to access remain entrenched. Conclusions: Provision of crack inhalation equipment can facilitate new contacts with services among a highly marginalised population. Complementary workforce training helps to enable relationship building and engagement opportunity. Additional methods of provision, including through peer networks, are required to support people for whom barriers to service access remain.

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Harris	Unpublished	Mixed-methods quasi-experiment	UK	No	Drug treatment services and peer networks in six geographical locations in England	3000 monitoring surveys; 205 first-time service users (any drug service)	Crack cocaine	PWUC	Peer-led	Crack equipment provision and workforce training intervention	UK National Institute of Health Research	Generally illegal in UK; developed and delivered in partnership with people who use crack (PWUC), police and service providers	(1; SS009a): SIPP impact evaluation: pipe sharing, homemade pipe use, injecting any drug, ash as holder material when smoking crack, (2; SS009b): Factors around / resulting from SIPP: 1. Service engagement, 2. Peer expertise and collaboration, 3. SIPP kit acceptability, 4. Crack smoking risks and respiratory health	Very Low	Mixed-method/quasi-exp. - large effect sizes, peer-led codesign, direct relevance (albeit a slightly different substance class) to NZ but also unpublished (hasn't cleared reviewers yet) and non-randomised case-control allocation.	(1) Participants in SIPP sites engaged in safer practices when smoking crack in the last 28 days relative to participants in comparison sites: They were 35% less likely to use someone else's crack pipe, 75% less likely to use a homemade pipe, 50% less likely to inject any drug, 43% less likely to use ash to hold crack when smoking. On average over the past 28 days, relative to participants in comparison sites SIPP site, participants: Injected crack (with or without other drugs) 3.4 fewer days, Used homemade pipes 5.6 fewer days, Used someone else's pipe 3.0 fewer days. We also found that the implementation of SIPP had some effect on engagement with drug treatment services. Among participants at SIPP sites: There were 44% more new registrations, Participants visited a treatment service 2.9 times more. (2) 1. Service engagement: a. SIPP kits increased contact with services; b. SIPP kits + provider training increased engagement with services; c. Trusted engagement enables support provision. 2. Peer expertise and collaboration: a. Peer
Tapper	2023	Systematic narrative review	Canada (27x), 1 ea from Brazil, England, Germany, Indonesia, Mexico	No	Sterile syringe programs	~9,650 across all 32 studies	20x crack cocaine, 6x any drug smoked, 3x any illegal drug, 2x MA, 1 ea MA, heroin, 'opioids'	Various PWSD/PWUD	Not stated	Safer smoking equipment + education	Smokeworks Injection Alternatives	Countries where safer smoking materials are not banned	Self-reports on smoking as a form of harm reduction, sharing of smoking materials, delivery and utilisation of safer smoking services, preliminary efficacy of services, impact on health outcomes (1x)	Low	Mostly narrative of observational studies across wide range of substances and dimensions	Across studies, smoking drugs, as opposed to injecting drugs, were described as a crucial method to reduce the risk of overdose, disease acquisition, and societal harms such as police violence. Ten studies found that when people who use drugs were provided with safer smoking materials, they engaged in fewer risky drug use behaviors (e.g., pipe sharing, using broken pipes) and showed improved health outcomes. However, participants across 11 studies reported barriers to accessing safer smoking services. Solutions to overcoming safer smoking access barriers were described in 17 studies and included utilizing peer workers and providing safer smoking materials to those who asked. This global review found that safer smoking practices are essential forms of harm reduction. International policies must be amended to help increase access to these essential tools. Only one study directly assessed health outcomes, finding (n=1,718 PWSD) health issues (burns, sores, haemoptysis) declined by 18.5%.

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Eger	2024	Qualitative interviews	USA	No	Sterile syringe program	8 staff, 17 clients	Opioids	PWID	Not stated	Harm reduction narratives	NIDA	Legal research	Narratives around xylazine emergence and harm reduction	Low	No up or downgrade	Xylazine's emergence characterizes the current era of unprecedented shifts in the unregulated drug supply. We found that xylazine spurred important behavioral changes among people who use drugs (e.g., transitioning from injecting to smoking). Incorporating these experiences into early drug warning surveillance systems and scaling up drug-checking services and safer smoking supply distribution could help mitigate significant health harms caused by xylazine and other emergent adulterants
Syvertsen	2025	Qualitative interviews	California (USA)	No	Variety of community spaces including volunteer work in harm reduction services	195 (31% women, 60% "racialised groups", 53 interviews)	Opioids	PWUD	Not stated	Harm reduction narratives	NIDA	Legal research	Narratives around fentanyl exposure and harm reduction	Low	No up or downgrade	People using opioids were often initially unintentionally exposed to fentanyl through the heroin supply or prescription pills, but shifted to intentional use. People using stimulants attributed unintentional fentanyl use to adulterated methamphetamine, mistaking fentanyl for other drugs, and sharing smoking tools. Socially, fentanyl heightened overdose risk and fueled community stigma, while paradoxically instantiating forms of community care (i.e., overdose response, warning those experimenting with fentanyl). Conclusion: Our research calls for evidence-based education about fentanyl, expanded access to harm reduction services, including community drug checking and safer smoking supplies, and low-barrier drug treatment as part of broader efforts to promote community care.
Harris J	2020	Qualitative interviews	Northern Ireland	No	N/A	n=15	Opioids	People who smoke but do not regularly inject	Not stated	Harm reduction narratives	Not stated	Legal research	Narratives around opioid consumption	Low	No up or downgrade	Participants smoking and avoided injecting opioids due to perceptions of risk, of PWID (negative) and changing social contexts / normative beliefs / the market for heroin available to them.

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Kral	2021	Qualitative interviews	USA	No	N/A	n=395	Opioids	PWID	Not stated	Harm reduction narratives	Arnold Ventures	Legal research	Narratives around opioid consumption	Low	No up or downgrade	The number of days smoking fentanyl was associated with fewer number of injections (X2(2) = 11.0; p < 0.01). Qualitative interviews revealed that PWID's motivation for switching from injecting tar heroin to smoking fentanyl was related to difficulties accessing veins. After switching to smoking fentanyl, they noticed many benefits including how the drug felt, improved health, fewer financial constraints, and reduced stigma. Conclusion: Between 2018 and 2020, there was a shift from injecting tar heroin to smoking fentanyl in San Francisco. Reductions in injection of illicit drugs may offer public health benefit if it reduces risk of blood-borne viruses, abscesses and soft-tissue infections, and infective endocarditis.
Aaron	2008	Observational virological study	USA	No	Micro dept. (Columbia Uni); recruitment from community health clinic	38 patients with chronic + active HCV	Not specified ("self-reported intranasal drug use")	People with HCV	Not stated	Proof-of concept/plausibility	Not stated	N/A	Blood/HCV RNA transferrance on 'drug-sniffing implements'	Very Low	Observational - downgrade for small sample size, imprecision, indirectness.. Hard to pick one that dominates here.	Demonstrates virological plausibility of intranasal HCV transmission: confirmed blood and RNA in the nasal secretions of intranasal PWUD w/ HCV, and that HCV RNA is detectable on simulated-use drug-sniffing implements (straws inserted into the nasal passages of PWUD w/ HCV).

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Grund	2010	Review	Portugal	No	Broad landscape of substance use in general	N/A	Stimulants	PWUS	Not stated	Not an intervention	EUDA	N/A	Plausiblity / evidence surrounding BBV transmission on smoking implements	Very Low	Very general narrative point	HCV is also prevalent among non-injection stimulant users, with rates of 2.3–35.3 % among those who sniff or smoke stimulants (Scheinmann et al., 2007) and 2.3–81 % among crack smokers (Fischer et al., 2008) … other routes include oral sores and cracked lips from hot pipes ... Recent studies of cocaine smoking and HCV transmission have noted the collective use of glass smoking utensils (‘crack pipes’ or ‘stems’) as a potential risk factor. HCV is present in gingival fluid (Suzuki et al., 2005), nasal secretions (McMahon et al., 2004), saliva (Hermida et al., 2002), and crack pipes (Fischer et al., 2008), the last of which are frequently made of glass, metal or other materials that can get extremely hot, have jagged edges, and may break between clenching jaws. Oral sores and burns on lips can result from using these pipes (Ward et al., 2000; Faruque et al., 1996; Porter and Bonilla, 1993) and small blood droplets deposit on the stem of the pipe, possibly transmitting HCV to others with similar sores (Hagan et al., 2005). One study reported that up to 81 % of all
Fernandez	2016	Prospective cohort study (self-report survey + virological testing of LE-confiscated snorting utensils)	USA	No	UT Knoxville high-risk obstetrics clinic	189 pregnant people with HCV	Not stated	Pregnant people with HCV	Not stated	Not an intervention	Not stated	N/A	Self-reports of modes of transmission, drug use behaviours, sexual/tattooing exposures; virological presence on confiscated snorting utensils	Very Low	Observational, downgrade for indirectness (even within the same study - behaviours vs. detections are totally unlinked)	A total of 189 HCV-infected pregnant patients completed the survey, and no approached patients declined. Of these, 136 (72%, 95% confidence interval [CI] 65–78%) admitted to intravenous drug use, of whom 89 (65%, 95% CI 57–73%) reported sharing needles. Of the 178 (94%, 95% CI 90–97%) who admitted snorting drugs, 164 (92%, 95% CI 87–96%) reported sharing straws. The difference between the proportion reporting sharing of snorting utensils compared with the proportion sharing intravenous drug use utensils was significant (P<.001). Twenty-nine patients (15%, 95% CI 11–21%) reported snorting drugs and sharing straws but denied any other risk factor except sexual contact. Of the 54 straws confiscated by law enforcement authorities, 13 (24%, 95% CI 13–38%) tested positive for the presence of human blood.

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Scheinmann	2007	Systematic review	Global; Ireland (x1), PR China (x3), Switzerland (x1), Taiwan (x1), Belgium (x2), USA (x12), Brazil (x1), Occupied Palestine (x1), Saudi Arabia (x1), Italy (x1), Nepal (x1), Spain (x1), Netherlands (x1), UK (x1).	No	Various	n=20-722 per study included	Various	Non-injecting PWUD	Not stated	Not an intervention	NIDA	N/A	HCV prevalence range; association with utensil sharing	Very Low	Observational, downgraded for imprecision primarily	This systematic review examined the evidence on the prevalence of the Hepatitis C Virus (HCV) in non-injecting drug users (NIDUs) who sniff, smoke or snort drugs such as heroin, cocaine, crack or methamphetamine. The search included studies published from January 1989 to January 2006. Twenty-eight eligible studies were identified and the prevalence of HCV in these NIDU populations ranged from 2.3 to 35.3%. There was substantial variation in study focus and in the quality of the NIDU data presented in the studies. The results of our systematic review suggested that there are important gaps in the research of HCV in NIDUs. We identified a problem of study focus; much of the research did not aim to study HCV in users of non-injection drugs. Instead, NIDUs were typically included as a secondary research concern, with a principal focus on the problem of transmission of HCV in IDU populations. Despite methodological issues, HCV prevalence in this population is much higher than in a non-drug using population, even though some IDUs might
Shang	2023	Programme evaluation (peer-reviewed)	USA	No	Recovery program (Addictions)	375	Not stated	PWUD	Not stated	Safer rectal administration kits	NIDA, academic	Legal research	# kits requested and distributed	Very low	Very indirect	One-month post-implementation, 28% (40/141) of completed in-person visits had at least one kit request, and a total of 121 kits were distributed. Staff and clinicians found the program to be highly feasible, acceptable, and appropriate, and patient perceptions were positive (includes boofing kits; Cooker, lube, 3 mL vial of sterile saline, 1 mL syringe)

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Bardwell	2021	Qualitative interviews	Canada	No	(Women-only) Supervised Inhalation Site	32	Various	Women who attend a (women-only) Supervised Inhalation Site	Not stated	Gender-specific / inhalation-specific SCS	CIHR, NIH, NHMRC	N/A	Narrative synthesis	Low	Starting Low, indirectness is a risk BUT the directness of risks to femme PWUD cuts through that in my opinion to generalise well enough to NZ, no downgrade applied	Findings demonstrate the ways in which gendered social and structural environments shape women's daily experiences using drugs and the need for culturally appropriate interventions that recognize diverse modes of consumption while attending to overdose and violence. Women-only smoking spaces can provide temporary reprieve from some socio-structural harms and build collective capacity to practice harm reduction strategies, including overdose prevention. Women-specific SCS with attention to polysubstance use are needed as well as continued efforts to address the socio-structural harms experienced by women who smoke illicit drugs.
Prangnell	2017	Prospective cohort studies	Canada	No	Community SCS	1718	Crack cocaine	PWID	Not stated	Safer smoking equipment	NIH, Canada Research Chairs, various other academic	Legal	Proportion of pipes obtained from health services; rates of (self-reported) health problems associated with crack smoking; multivariate estimation of relationship between pipe acquisition source and self-reported health problems	Very Low	Observational, downgraded for indirectness (not least of which, smoking outcomes among a cohort of PWID)	proportions of those obtaining crack pipes only through health service points have significantly increased from 7.2% in 2005 to 62.3% in 2014 ($p < 0.001$), while the rates of reporting health problems associated with crack smoking have significantly declined ($p < 0.001$). In multivariable analysis, compared to those obtaining pipes only through other sources (e.g., on the street, self-made), those acquiring pipes through health service points only were significantly less likely to report health problems from smoking crack (adjusted odds ratio: 0.82; 95% confidence interval: 0.73–0.93).

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Shannon	2006	Prospective cohort study	Canada	No	Rock Users Group - wide variety of recruitment pathways including SROs	437	Crack cocaine	People who smoke drugs	Yes (VANDU/RUG authors included)	Safer smoking facilities (SSF)	Not stated	Illegal at the time of proposal	Willingness to use a SSF; covariates included PWID status, having pipes confiscated or broken by LEO, crack 'bingeing', smoking crack in public places, borrowing crack pipes, inhaling mesh materials due to rushing to smoke in public	Low	Observational / prospective and probably a little indirect to NZ, but good representation of PWLLE, not downgraded	Variables found to be independently associated with willingness to use a SSF included recent injection drug use (OR = 1.72, 95% CI: 1.09–2.70), having equipment confiscated or broken by police (OR = 1.96, 95% CI: 1.24–2.85), crack bingeing (OR = 2.16, 95% CI: 1.39–3.12), smoking crack in public places (OR = 2.48, 95% CI: 1.65–3.27), borrowing crack pipes (OR = 2.50, 95% CI: 1.86–3.40), and burns/ inhaled brillo due to rushing smoke in public places (OR = 4.37, 95% CI: 2.71–8.64). The results suggest a strong potential for a SSF to reduce the health related harms and address concerns of public order and open drug use among crack cocaine smokers should a facility be implemented in this setting
Lyu	2023	Commentary / Qualitative interviews	Berlin, Germany	No	Queer community drug use behaviours	N/A	N/A	People who engage in chemsex	Not stated	Not an intervention	Not stated	N/A	Narrative around relationship between chemsex and queer community	Very Low	Can't actually retrieve the full text - only citing in relation to the concept of 'chemsex' having an established link to Rainbow communities, I'm sure there's a better one out there but	The potential of sexualised drug use to enact the queer body is largely unaccounted for within the expert public health knowledges where ‘chemsex’ is produced as a predominantly cisgender gay male practice harmful to health. Underpinned by such logics, COVID-19 prevention measures in 2020–2021 limited urban nightlife, which can be thought of as a queer ‘intimate infrastructure’, restricting chemsex to the home. Such changes in routine afforded by public health emergencies provide a particularly clear glimpse into the emergent and situated production of queer bodies.
Chou	2017	Systematic review	Australia (x2) USA (x7) Canada (x1) Iran (x1) Finland (x1) Denmark (x1)	No	Out of hospital settings.	13 studies	Opioids	People experiencing opioid overdose	Not stated	naloxone administration (out of hospital)	This project was funded under contract no. HHSA290-2015-00009-I from the AHRQ, U.S. Department of Health and Human Services.	Not stated	mortality, reversal of overdose, recurrence of overdose, and harms.	Very low	downgrade for bias, imprecision, indirectness	Higher-concentration intranasal naloxone (2 mg/mL) seems to have efficacy similar to that of intramuscular naloxone for reversal of opioid overdose, with no difference in adverse events. Nontransport after reversal of overdose with naloxone seems to be associated with a low rate of serious harms, but no study evaluated risks of transport versus nontransport. Additional research is urgently needed to optimize administration of naloxone in out-of-hospital settings.

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Moustaqim-Barrette	2021	Scoping umbrella review	Europe (x12) Canada (x11) USA (x20) Australia (x2) Iran (x2)	No	Community settings.	47 studies	Opioids	n/a	Not stated	Take home naloxone in community settings	The authors acknowledge funding from Canadian Institutes of Health Research (CIHR) for the Canadian Research Initiative in Substance Misuse (CRISM) Implementation Science Program on Opioid Interventions and Services (OCC- 154821).	Mixed	Mixed, themes of provision, feasibility, acceptability, people transported and not transported to hospital, cost-effectiveness, improvement in knowledge immediately after training	Low	downgrade for imprecision, indirectness	majority of evidence syntheses related to naloxone evaluated the effectiveness of naloxone and THN programs in reducing opioid overdose mortality, examined optimal dosing or routes of administration for opioid overdose reversal, and documented barriers and facilitators to THN provision, feasibility and acceptability. Fewer evidence syntheses evaluated harms and adverse events related to naloxone administration, overdose response following naloxone administration, cost-effectiveness of naloxone distribution programs, and naloxone administration training strategies, and recommendations for policy and practice related to naloxone use and distribution.
Dietze	2019	Randomised clinical trial	Australia	No	Uniting Medically Supervised Injecting Centre in Sydney	197 participants	opioids	Clients of the center aged 18 years or older with a history of injecting drug use	Not stated	(1) intranasal administration of naloxone hydrochloride 800 µg per 1 mL and intramuscular administration of placebo 1 mL or (2) intramuscular administration of naloxone hydrochloride 800 µg per 1 mL and intranasal administration of placebo 1 mL.	funded by a grant from the New South Wales Department of Health Drug and Alcohol Services.	THN legal in Aus	Primary: need for a rescue dose of intramuscular naloxone hydrochloride (800 µg) 10 minutes after the initial treatment. Secondary: time to adequate respiratory rate greater than or equal to 10 breaths per minute and time to Glasgow Coma Scale score greater than or equal to 13.	Low	downgrade for bias, indirectness	This trial showed that intranasally administered naloxone in a supervised injecting facility can reverse opioid overdose but not as efficiently as intramuscularly administered naloxone can, findings that largely replicate those of previous unblinded clinical trials. These results suggest that determining the optimal dose and concentration of intranasal naloxone to respond to opioid overdose in real-world conditions is an international priority.

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Nielson	2016	Scoping review	Not stated, presume mixed	Unknown	Community	16 studies.	Opioids	n/a	Not stated	community pharmacy supply of naloxone	The National Drug and Alcohol Research Centre at the University of New South Wales is supported by funding from the Australian Government under the Substance Misuse Prevention and Service Improvements Grant Fund	n/a	Themes across included studies: Populations, supply systems, cost, perceptions, legal issues, training,	Low	downgrade for bias, indirectness	Provision of naloxone for bystander administration to prevent opioid overdose deaths appears increasingly feasible and warranted given the rise in rates of overdose deaths. Community pharmacy supply of take home naloxone warrants further development and consideration, in light of general support from the small number of pharmacists included in research so far. Barriers including cost and remuneration for community pharmacists' time, and how pharmacists may effectively identify and train naloxone recipients were identified in this review. In summary, some work has been done to lay the groundwork for larger scale implementation of naloxone supply in pharmacy.
Futterman	2004	Case study	USA	No	Public hospital - outpatient programme	N/A	Not stated	People who use drugs	Not stated	Integrated harm reduction and treatment programme	Public funded programme	Not stated	Not clearly described, but focus on patient and clinician acceptance	Low	Downgrade on imprecision	This integration has more positive effects than either model separately on the large problem of patient retention in substance abuse treatment. This integration is particularly relevant for its utility and acceptance in the public sector.
Denning	2001	Expert clinical opinion	USA	No	Addiction treatment services	N/A	Not stated	People who use drugs	Not stated	Integration of harm reduction principles into care	Not stated	Not stated	Not clearly described, but focus on practical strategies for HR implementation in treatment settings	Low	Downgrade on imprecision	Essential to implementing harm reduction is a recognition that, even for those who wish to become abstinent, this goal is difficult to achieve and maintain. We must acknowledge this and stop the practice of imposing punitive sanctions on clients who use drugs while in treatment. Exclusion or expulsion from treatment settings does nothing to reduce drug use and greatly increases the harm to the client. In conclusion, just as we need to respect diversity among our clients, staff must find a way to respect each others' ideas and concerns as we develop new ways to implement harm reduction in our work

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Taylor	2021	Expert clinical opinion	USA	No	Opioid use disorder treatment settings	Not stated	Opioids	Clients of an outpatient opioid use disorder treatment service	Not stated	Integration of harm reduction into treatment	Not stated	Not stated	Not clearly described, but focus on practical strategies for HR implementation in treatment settings	Low	Downgrade on imprecision	Incorporating harm reduction principles into primary care treatment settings can support programs in engaging patients with ongoing substance use and facilitate the delivery of evidence-based screening and prevention services. The objective of this narrative review is to describe strategies for the integration of evidence-based harm reduction principles and interventions into outpatient, primary care–based OUD treatment settings. We will offer specific tools for providers and programs including strategies to support safer injection practices, assess the risks and benefits of continuing medications for opioid use disorder in the setting of ongoing substance use, promote a nonstigmatizing program culture, and address the needs of special populations with ongoing
Dale-Perera	2017	Evidence review	Europe	No	Treatment settings	Not stated	Various	Not stated	Not stated	Integration of harm reduction and recovery goals	Not stated	Not stated	Goals and outcome measures	Moderate	No up or downgrade	Europe has led the world in harm reduction. Rather than focusing on old battles and a conflict-based approach to paradigms (e.g. harm reduction versus recovery), perhaps Europe can lead the way in developing a new integrated paradigm that recognises truly integrated systems of services with a range of goals for those with DUDs: a new paradigm that incorporates, without bias, a range of interventions and goals required to treat DUDs, from prevention of acute harm to management of chronic long-term DUDs to enabling people to overcome drug dependence.

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Pares-Badell	2020	Case study	Spain	No	Treatment settings	Not stated	Various	Clients of services	Not stated	Integrated harm reduction and treatment programme	State funded	Not stated, but appears to be legally provided by state	Not clearly stated, but focus on description of the integrated model and service access	Low	No up or downgrade	Preliminary evidence suggest the Barcelona model has maximized access to harm reduction services, has eliminated many common barriers to treatment and is temporally associated with a decrease in the number of overdose deaths. The integration of harm reduction and treatment services has increased access to both programs without increasing relapse
Krawczyk	2022	Survey	USA	No	Treatment and HR programmes	511 clients	Various	Clients of services	Not stated	Integrated treatment and HR services	Bloomberg Overdose Initative	Not stated	Health behaviours, service access, safety practices, overdose experiences	Low	No up or downgrade	To address the current and future crises, policymakers, payers, health systems and service providers should increase service integration opportunities, wrap-around funding, and support the spectrum of services related to the health of PWUD. Increased funding and attention to substance use as a part of holistic healthcare, with further investment and use of innovative and individualized client care models, can pave the way for a more effective and equitable service system that promotes the long-term health of people who use drugs.
Chang	2023	Qualitative	USA	No	Three integrated harm reduction and medical care sites	20 staff and providers	Various	Staff of services	Not stated	Integrated treatment and HR services	Not stated	Not stated	Implementation barriers and common practices of integration	Low	No up or downgrade	The interviews resulted in 8 main themes of integrated harm reduction medical care: 1) role of provider as both learner and informer; 2) pragmatic measures of success; 3) collaborative and interdisciplinary care teams; 4) developing a stigma-free culture; 5) creating a comfortable and welcoming physical space; 6) low-threshold care with flexible scheduling; and; 7) reaching beyond the clinic to disseminate harm reduction orientation; and 8) creating robust referral networks to enhance transitions of care.

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Boyle	2025	Clinical guidance	USA	No	Substance use treatment	Not stated	Various	Patients in treatment services	Not stated	Clinical guidance for non-abstinent patients in care	Guidance development funded by California Dept of Health Care Services	Not stated	Strategies for engagement	Low	No up or downgrade	To improve population outcomes, it is important to reach those who are not engaged in treatment and increase retention of those who do engage in care. To do this, treatment providers must proactively engage individuals in care, including those who are uninterested or ambivalent about treatment, and design services with the intention of increasing patient retention.
Wilson	2025	Co-design	USA	No	Intervention within hospital	14 participants	Various	People who use drugs who are hospitalised	Co-designed with people with lived experience	Harm reduction within hospitals	Not stated	Not stated	Intervention components and process	Low	Plus one for lived experience involvement	Participants conceptualized an intervention delivered by a THRIVE navigator who establishes rapport, identifies what if any goals the participant may have, offers information from a menu of harm reduction topics, and helps par- ticipants create a Wellness Plan focused on achieving their goals and overcoming likely barriers. The THRIVE navigator will then follow-up via weekly text messages. There were four additional themes that informed intervention content and implementation. These were related to the hospital being experienced as a hostile environment to PWUD; the value of health information being delivered by PWLE who can speak authentically; the importance of creat- ing a flexible participant-led intervention offering a range of content; and the importance of neutrality to building authenticity and attaining participant buy- in.

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Ganetsky	2025	Qualitative interviews	USA	No	Specialist treatment programmes for OUD	14 participants from within services	Opioids	Services	Not stated	Integration of HR principles and practices into treatment	Evaluation was funded by state	Not stated	Alignment of practices with HR principles	Low	No up or downgrade	Programs described integrating a range of harm reduction principles, including respect for autonomy, low-barrier treatment, and nonpunitive care, into their approach to care. However, several ongoing practices conflicted with these principles, including imposing attendance requirements, lacking an on-site provider to facilitate same-day medication initiation, and use of urine toxicology testing as a major marker of treatment success. Additionally, while many programs were engaging in some overdose prevention practices (e.g., naloxone distribution), few programs offered other risk reduction services.
Laitman	2014	Case study	USA	No	University	Not stated	Various	Students of Rutgers University	Not stated	Continuum of care for students with AOD concerns	Funded via the University	Not stated	Service engagement and motivations for change (NB. appears more geared towards recovery)	Low	No up or downgrade	College-age students present unique challenges in their substance use patterns. The ADAP staff has approached the development of interventions with the flexibility and openness to meet individual needs with special focus on seeking to incorporate evidence-based interventions appropriate for a college population.
van der Sterren	2023	Scoping review	Global	No	Outcome measures for AOD services	N/A	Various	N/A	The study aim was to explore how lived experience was incorporated into service outcome measures	Outcome measures for services	Various by jurisdiction	Not stated	How service outcome measures are developed, specifically lived experience involvement	Low	Plus one for lived experience involvement	Thirty measures—23 satisfaction and 7 experience—were identified. Sixteen measures reported some level of involvement by people accessing AOD services in their development, although, for most measures, at a relatively low level. This involvement increased over the time span of the review becoming more frequent in later years. Only four measures were developed for use in harm reduction-specific settings, and fewer than half reported undertaking analysis of underlying scale structure and constructs

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Perri	2026	Case study	Canada	No	Two services where clients were engaged in indicator development (day health program, and a safer opioid supply program)	54 participants across two projects	Various	People who use the services	Co-design	Co-design of outcomes and indicators for services	Not stated	Not stated	The indicators to be used for services and how clients were engaged in their development	Low	Plus one for lived experience involvement	In both projects, participants emphasized the importance of measuring social outcomes—like connection, self-care, and well-being—in addition to health outcomes. These projects show the value of a participant-driven approach to outcome indicator development that includes training and reflection.
Madden	2021	Evidence review	Australia	No	Residential AOD services	N/A	Various	Clients of residential services	Led by person with lived experience	Best practice for residential services	Review was commissioned by NADA	Not stated	Evidence for effective treatment models (NB. This included HR principles and integration)	Low	Plus one for lived experience involvement	In sum, despite the high utilisation of residential treatment settings, questions remain regarding their effectiveness. A lack of randomised control trials (RCTs), studies focusing on specific population groups and high attrition rates contribute to difficulty in establishing an evidence-basis, which is further compounded by heterogeneity in methodological and treatment approaches within the residential setting. The question of what works, and for who, requires further investigation.
Hawk	2017	Qualitative interviews	USA	No	HIV clinic	23 clients, 17 staff	Various	Patients of an HIV clinic	Interviews with clients to inform principles	Integration of HR principles to healthcare settings	Not stated	Not stated	Principles of integrated HR	Low	No up or downgrade	We defined six principles of harm reduction and generalized them for use in healthcare settings with patients beyond those who use illicit substances. The principles include humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination. For each of these principles, we present a definition, a description of how healthcare providers can deliver interventions informed by the principle, and examples of how each principle may be applied in the healthcare setting.

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Spackman	2025	Ecological analysis	Canada	No	5 health zones: North, Edmonton, Central, Calgary, South	n/a	Opioids	Canadian citizens, immigrants, and non-permanent residents	Not stated	Naloxone kit distribution	This project was funded by an unrestricted project grant from Canadian Institutes of Health Research, Funding Reference Number: 162066.	legal, available 'over the counter'	total combined monthly opioid-related deaths	Very low	downgrade on indirectness	every 10,000 kits in circulation was associated with a 23.9% reduction in opioid-related mortality. Previous analyses support the finding that naloxone kit distribution is associated with a reduction in opioid-related mortality; however, this is the first study to explore a program that is publicly available and not limited to those at risk of an opioid poisoning and their family or friends. The advantage of the CBN program's population health approach versus the more targeted approach is that it is less stigmatizing and is a simpler process to operationalize. Main limitations of this study is the lack of data on individuals.
Miller	2025	systematic review	USA	No	Emergency Department	10 studies	Opioids	Mixed, inlcu people with history of ED presentations for opioid overdose, opioid related visit, suspected nonmedical opioid use	Not stated	Assessing, monitoring, educating, giving tangibles	not stated	legal, available 'over the counter'	Primary aim: how different organizations in EDs implement THN and to what extent variations exist between intervention strategies. Secondary aim: identifying which measures and metrics are commonly used to assess the outcomes or effectiveness of THN interventions, what challenges or limitations affect THN interventions, and how authors identified success in implementation.	Very low	downgrade on indirectness	Each study used a strong evidence-based THN intervention and tailored it to best fit the needs of their facilities. Sites needed to adapt their technology to implement more efficient and approachable programs. Additionally, some sites face more political barriers than others do, affecting the goodness or fit of the intervention for each site. limitation of all studies to measure the health gained by the THN intervention is the lack of follow-up data from the program participants. Despite the general preference for intranasal naloxone, the cost of offering intranasal naloxone is too high for several implementation sites; therefore, intramuscular naloxone was chosen for their kits
Gariépy	2026	Systematic review	Canada	No	Community SCS	Geographic populations: health areas, other defined locales, whole province (Alberta)	Opioids	PWUD	Not stated	Supervised consumption sites	Did not receive any funding from agencies in the public, commercial or not-for-profit sectors (?)	Legal (fed exempt) sites	Population-level mortality in areas with or without safe consumption sites.	Very low	Quasi-exp./observational, starting low + downgrade for inconsistency across urban scales - possibly more of an analysis issue here but it is what it is, certainly noted by authors. Pop-level mortality significantly distal + biased by confounding here	4x quasi-experimental studies: No difference between areas with/without SCS within provinces; smaller urban areas showed some protective associations, inconsistent across studies. 2x observational studies: association found but with methodological limitations.

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Levengood	2021	Systematic review	Canada (n=16 studies), Aus (n=3), Spain (n=2), Norway (n=1)	No	Community SCS	Depends on the outcome, wide variety	Not stated	PWUD	Not stated	Supervised consumption sites	Health Canada, NIH, NIDA, various academic/hospital-based grants	Legal (fed exempt) sites	Reduction of overdose mortality, risk behaviours, drug-related harms, access to addiction treatment	Very Low	Observational studies and downgraded for imprecision	Good evidence for reduced OD M&M, decent evidence for accessing addiction treatment programs, poor evidence for reduced injection risk behaviours, varying low evidence for reducing crime / public nuisance
Kennedy	2019	Prospective cohort studies	Canada (n=2 studies)	No	Community SCS	811 (432 SIF, 379 non-SIF)	Not stated	PWID	Not stated	Supervised consumption sites	US NIH, CA CIHR, US NIDA	Legal (fed exempt) sites	Overall mortality (including off-site)	Very Low	Observational (Low), downgrade for inconsistency and cohort biases-> Very Low	SIF use inversely correlated with mortality (aHR 0.46; 95%CI 0.26 to 0.80)
Salmon	2010	Ecological analysis	Sydney, Australia (vs. rest of NSW)	No	Community SCS	20,409 ambulance callouts (proportion of total service occasions not given in abstract)	Opioids (primarily)	PWID	Not stated	Supervised consumption sites	Not stated	Legal (exempt)	Average ambulance callouts for opioid overdose in preceding 36-mo and 60-mo post-MSIC operning (ecological vicinity vs. NSW total with opening hours sub-analysis)	Low	Observational, comparator not randomised (natural experiment). Sub-analysis can't account for confounders / demographic biases. Somewhat indirect to NZ at minimum, though probably a bit less (considering Bartlett 2026) than CA studies.	burden on ambulance services of attending to opioid-related overdoses declined significantly in the vicinity of the Sydney SIF after it opened, compared to the rest of NSW. This effect was greatest during operating hours and in the immediate MSIC area, suggesting that SIFs may be most effective in reducing the impact of opioid-related overdose in their immediate vicinity.
Kerr	2005	Cross-sectional cohort study	Canada	No	Community SCS	431	Mixed / not stated (likely predominantly opioid)	PWID	Yes (derived from other scouting)	Supervised consumption sites	Victorian Department of Human Services, the Murdoch Children's Research Institute, and the Potter	Legal (fed exempt) sites	Self report syringe-sharing past 6-mo	Low	Observational and cross-sectional, confounding still likely despite adjustment, small sample (n=49 reported sharing). Relevant and effective enough to	Between Dec 1, 2003, and June 1, 2004, of 431 active injection drug users 49 (11·4%, 95% CI 8·5–14·3) reported syringe sharing in the past 6 months. In logistic regression analyses, use of the facility was independently associated with reduced syringe sharing (adjusted odds ratio 0·30, 0·11–0·82, p=0·02) after adjustment for relevant sociodemographic and drug-use
Milloy	2009	Meta-analysis (ish) + narrative	Spain (n=249; Bravo et al. 2009), Canada (Kerr et al. 2005, Wood et al. 2005, Wood et al. 2005)	No	Community SCS	1,262 pooled	Various	PWID	Not stated	Supervised consumption sites	Vancouver Coastal Health, Canadian Institutes of Health Research, Health Canada	Legal (fed exempt) sites	OR for syringe-sharing (various measure wording: 'sharing', lending', 'borrowing')	Low	Low-quality MA (non-Cochrane/PRISMA) as commentary. Narrow review comprised of observational studies. Large effect size on a narrow outcome and ranges are precise enough - no further downgrade applied.	Source - OR (95%CIs): Kerr et al. 2005 (Vancouver VIDUS, syringe sharing): 0.30 (0.11–0.82) Wood et al. 2005 (Vancouver SIF, syringe lending HIV+): 0.94 (0.00–7.90) Wood et al. 2005 (Vancouver SIF, syringe borrowing HIV-): 0.14 (0.00–0.78) Bravo et al. 2009 (Spain, syringe borrowing): 0.32 (0.14–0.73) cOR 0.31 (0.17–0.55) = 69% reduction (noice) in syringe sharing

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Potier	2014	Systematic review	Canada (n=30 studies) incl. the Wood & Milloy 2009 meta-analysis, Australia (n=1 study), Spain (n=1 study) + ~40 non-cohort studies across designs	No	Various	Depends on the outcome, wide variety	Various	PWUD	Not stated	Supervised consumption sites	Varied	Legal sites	Reduction of overdose mortality, risk behaviours, drug-related harms, access to addiction treatment	Very Low	Observational (Low), downgrade for inconsistency and cohort biases-> Very Low	Reduced mortality: zero deaths (7 studies), reduced equipment sharing (aOR=0.3) but demographic differences meant "greater" reuse (aOR=2.04) and public injection (aOR=2.79)
Mocanu	2024	Retrospective cohort study	Canada	No	Phone-based	331 unique callers (4,501 events)	Not stated	PWUD	Yes (service delivered by some kind of PWLLE)	Virtual overdose monitoring	Health Canada Substance Use and Addictions Program, Canadian Institutes of Health Research, and Grenfell Ministries	Legal	Use of phone services when physical SCS were available	Very Low	Observational (Low), downgrade for indirectness (not actually looking at mortality, just that they'd still use the thing even when physical site available)	30.2% of clients preferred NORS even when physical SCS/OPS were available
Rammohan	2024	Ēcological + spatial study	Canada	No	Regional (coronial)	787 overdose mortality events	Not stated	People who died from overdose	Not stated	Supervised consumption sites	Canadian Institutes of Health Research	Legal (fed exempt) sites	Overdose mortality (population)	Very Low	Observational (Low), large effect sizes but downgrade as super imprecise (ten-fold span RRs) -> Very Low	SCS (9 sites) decreased sig. (67%) in neighbourhoods within 500m of SCS (2.7 per 100k post-SCS cf. 8.1 per 100k pre-SCS; Rate reduction = 5.4; 95%CI 1.52 to 15.86). Effect lesser when comparing pre/post-SCS beyond 500m from the sites (RR=0.37; 95%CI -1.88 to 4.13) and city-wide (RR=0.99; 95%CI -0.01 to 5.46)
Lalanne	2023	Prospective cohort study	France	No	Hospitals with DCRs (2) or no DCR (2)	662 (238 DCR, 424 non)	Opioids or benzos	PWID	Not stated	Supervised consumption sites	French government	Legal sites	Injection equipment sharing, accessing HCV testing, OAT enrolment	Very Low	Observational (Low), inconsistency (many factors differ) between groups, non-randomised -> Very Low	Adjusted co-efficients: Lower risk of equipment sharing (-1.14 95%CI -1.91 - -0.36), reduced risk practices (probability 1% in DCR cf. 11% non-DCR), no sig. diff. for HCV testing or OAT enrolment
Milloy	2009	Meta-analysis	Spain (n=249; Bravo et al. 2009), Canada (Kerr et al. 2005, Wood et al. 2005, Wood et al. 2005)	No	Community SCS	Unspecified (>249)	Not stated	PWID	Not stated	Supervised consumption sites	Not stated	Legal (fed exempt) sites	Reduced HIV risk behaviours (sharing of injecting equipment)	Very Low	Observational (Low), indirectness and imprecision -> Very Low	Effects (OR of sharing/lending/borrowing equipment) ranging 0.14-0.94 (pooled estimate: 0.31 95%CI 0.17-0.55)

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Marshall	2011	Retrospective cohort study	Canada	No	Community SCS (x65)	209 decedents	Not stated	PWID	Not stated	Supervised consumption sites	Vancouver Coastal Health, Canadian Institutes of Health Research, and the Michael Smith Foundation for Health Research	Legal (fed exempt) sites	Overdose mortality (population)	Very Low	Observational (Low), indirectness and imprecision -> Very Low	~35% reduced mortality in surrounding areas
Matskiv	2022	Retrospective cohort study (NORS data) + narrative review	Canada	No	Phone-based	222 unique callers (2,172 events, 53 SAEs)	Opioids (75.7%), Cocaine (8.9%), MA (7.4%)	PWUD	Yes (service delivered by some kind of PWLLE)	Virtual overdose monitoring	Health Canada	Legal	Intervention in adverse events (overdose reversal)	Low	Observational (Low), potential PWLLE upgrade?	No deaths after any of the SAEs / callouts (only 2 were false alarms)
Bartlett	2026	Retrospective cohort study	Australia	No	Community SCS	Not stated in abstract - service occasions 2001-2024	Opioids and / or amphetamines	PWID	Not stated	Supervised consumption sites	Not stated	Legal (exempt)	Proportion of injections opioid vs amphetamine vs both; Overdose risk by drug type; Incidents of challenging behaviour	Very Low	Observational, no control/randomisation. Assessment based on abstract only - unable to obtain full text by time of draft submission	Amphetamine injection prevalence increased from 2% (2002-2011) up to 50.1% (2024); exclusively amphetamine 8.9% (2001) -> 43.9% (2024, both 5.6% (2001) -> 33.2% (2024). Injectors of both had a lower risk of overdose cf. opioid-only injectors (aOR 0.64 95%CI 0.54-0.75); "Incidents of challenging behaviour appear unrelated to amphetamine injection."
Perri	2023	Qualitative interviews	Canada	No	'Drug spotting' (phone / informal) both spotters and 'spottees'. Pandemic-specific (interviews conducted Aug-Nov/2020)	30 total (14 spotter, 9 spottess, 7 both) - 20 PWUD who provided or used informal, and 10 (PWUD or not) who provided or used a formal service.	Various	PWUD (accepts non-PWID cf. certain SCS)	Yes (participants / providers - mostly anyway)	Drug-spotting (informal / org-based)	University of Toronto, CanHepC	Legal	Narratives around 'drug spotting'	Very Low	Observational, self-reported, significant downgrade for indirectness (CA, pandemic) to general conclusions	highlights varying benefits and limitations of organizationbased and informal spotting, concluding that both have a role in mitigating existing harms faced by PWUD. Factors raised by study participants such as the persistent and cross-cutting role the criminalization of drug use plays in facilitating inaccessibility to and fear of existing harm reduction services must be considered in future program development. Future research should focus on the role of spotting in contributing to and/or mitigating risk environments for PWUD. In addition, further attention is needed to understanding how the different modes of harm reduction service delivery (e.g., in person, remotely on the phone, or through a mobile app) can be integrated and serve groups of people in varying contexts with diverse needs. Moving forward, scale up and evaluation of spotting services – both organization based and informal – will help to understand how to provide overdose response services for PWUD who are socially isolated, distant from harm

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Kerr	2025	Grey literature (HRI review)	Global	No	Community SCS	N/A	Primarily opioid, some stimulant	PWUD	Yes	Supervised consumption sites	N/A	Across jurisdictions - generally legal, but applies to unsanctioend as well	N/A (review of various services models, evidence quality, policies)	Low	Review (and grey lit at that) - assessment derived from WHO 2025. PWLLE upgade probably worthy but sort of neither here nor there	It be what it do (mostly re: pre-2010). It's a review, notably includes 2025 Uniting MSIC stats (uncited; as per this field): >22,000 referrals, 1.38M injections, 11,205 overdoses successfully managed without a fatality. Mainly pulled here for narrative / Uniting MSIC stats.
Wood	2006	Programme evaluation (peer-reviewed collection of 8 sub-studies, all prospective cohorts)	Canada	No	Community SCS	Various per outcome (n=several hundred or >1k)	Mainly opioids, cocaine	PWID	Not stated	Supervised consumption sites	Health Canada	Legal (fed exempt) sites	Characteristics of people using the SIF; heroin vs. cocaine use; recent overdose stats; public injecting; publicly discarded syringes; injection-related litter.	Low	Aggregate of observational studies, decent direct effects no downgrade applied	Public order: predicted daily mean publicly discarded syringes 11.5 (95%CI 10-13.2) -> 5.4 (4.7-6.3); injection-related litter 601/day (590-613) -> 310 (305-317); public injecting 4.3/day (3.5-5.4) -> 2.4 (1.9-3.0) all approximately halved over 6-wk pre / 12-wk post. HIV risk: SIF use independently associated with reduced syringe sharing (aOR 0.30, 95%CI 0.11-0.82). Addiction treatment: weekly facility use (aRH 1.72, 95%CI 1.25-2.38) and on-site counsellor contact (aRH 1.98, 95%CI 1.26-3.10) independently associated with faster entry to detoxification. Overdose: ~1.3 per 1000 injections; 60% managed without ambulance call, naloxone administered in ~30%; zero fatalities to mid-2006. No detected increases in drug-dealing, drug-acquisition crime, relapse rates, or new injection initiation
Perri	2022	Commentary	Canada	No	Phone-based	N/A	Various	PWUD	Yes	Virtual overdose monitoring	None	Legal	Narratives around 'drug spotting'	Very Low	Not an intervention, indirectness doesn't really even apply but it's still there in a pandemic-specific paper; gender considerations reach beyond the pandemic tho	This commentary aims to identify how virtual and remote delivery of substance use treatment and harm reduction services can be gender-responsive. We highlight the role gender transformative services play in meeting the unique needs of women and gender-diverse people who use drugs both during and after the COVID-19 pandemic
Cortina	2018	Cross-sectional cohort study	Canada	No	Hypothetical safer inhalation spaces	539	Crack cocaine	People who smoke stimulants	Not stated	Hypothetical safer inhalation spaces	NIH, Canada Research Chairs, CIHR	N/A	Willingness to use an in-hospital supervised inhalation room, various covariates therein, motivations	Low	Hypothetical / behavioural / intentions. Well powered and reasonably direct/relevant to NZ pop.	n=320 of 539 (59.4%) willing to use an in-hospital SIR (useful both ways) + Difficulty accessing new crack pipes was significantly and negatively associated with the willingness to access an in-hospital SIR (AOR = 0.51; 95% CI 0.30-0.86)

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Bayoumi	2008	Cost-effectiveness modelling	Canada	No	Community SCS	Regional population in theory, estimated PWID ~7k (range 3-20k)	Various	PWID	Not stated	SIF influence on HIV/HCV transmission, treatment referral, associated costs	No external funding	Legal	HIV cases averted; HCV cases averted; LYs gained; net cost; cost-benefit ratios across a range of modelled parameters / increments of uptake	Low	Modelling study - well designed for what it is but authors note significant limitations including exclusion of overdose prevention as a modelled benefit. Having said that, that's exactly the basis of NZ's NEP funding at the commissioning level (HIV/HCV) - could be argued that's a directness factor for NZ ha ha..	Focusing on the base assumption of decreased needle sharing as the only effect of the supervised injection facility, we found that the facility was associated with an incremental net savings of almost $14 million and 920 life-years gained over 10 years. When we also considered the health effect of increased use of safe injection practices, the incremental net savings increased to more than $20 million and the number of life-years gained to 1070. Further increases were estimated when we considered all 3 health benefits
Andresen	2010	Cost-effectiveness modelling	Canada	No	Community SCS	Various modelled per outcome	Various	PWID	Not stated	SIF influence on HIV transmission + prevention of overdose death	Not stated	Legal	HIV cases averted; overdose mortality prevented; societal benefits thereof; programme costs/effectiveness/benefit ratios	Low	Modelling study - directly addresses mortality but no up or downgrades applicable here	Through the use of conservative estimates, Vancouver's SIF, Insite, on average, prevents 35 new cases of HIV and almost 3 deaths each year. This provides a societal benefit in excess of $6 million per year after the programme costs are taken into account, translating into an average benefit-cost ratio of 5.12:1
Jozaghi	2014	Cost-effectiveness modelling	Canada	No	Community SSF	N/A	Crack cocaine	People who smoke stimulants	Yes - both in delivery and this modelling	Safer smoking facility	Vancouver Coastal Health (ironically in this case - they pulled funding for the site)	Unsanctioned at the time of study	HCV cases averted; operational vs. prevented HC costs; sensitivity across various pipe-sharing frequencies modelled	Low	Modelling study - indirect to any sanctioned site where costs would likely be higher. Strong element of peer leadership in service delivery, study design, data representation at least.	DTES SSF's benefit-cost ratio was conservatively estimated at 12.1:1 due to its low operating cost. The study used 70% and 90% initial pipe-sharing rates for sensitivity analysis. At 80% sharing rate, the marginal HCV cases prevented were determined to be 55 cases. Moreover, at 80% sharing rate, the marginal cost-effectiveness ratio ranges from $1,705 to $97,203. The results from both the baseline and sensitivity analysis demonstrated that the establishment of the SSF by VANDU on average had annually saved CAD$1.8 million dollars in taxpayer's money

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Viste	2003	Observational (retrospective)	Canada	No	Phone-based	6528 completed calls (3994 for supervised consumption)	Mainly opioids, followed by cocaine, MA, or some combo thereof	PWUD	Yes (service delivered by some kind of PWLLE)	Virtual overdose monitoring	Health Canada Substance Use and Addictions Program, Canadian Institutes of Health Research, and Grenfell Ministries	Legal	Service utilisation; caller demographics / drugs used, overdose event characteristics / outcomes	Low	Observational, retrospective, no controls. No further downgrade. Has some PWLLE component to the service delivery which is notably valuable	Of the 6528 completed calls on the line, 3994 (61.2%) were for supervised drug consumption, 1703 (26.1%) were for mental health support, 354 (5.42%) were for harm reduction education or resources, and 477 (7.31%) were for other purposes. Overall, there were 77 (1.18%) overdose events requiring a physical/ in-person intervention. Of the total calls, 3235 (49.5%) were from women, and 1070 (16.3%) were from people who identified as gender diverse. Calls mostly originated from urban locations (n=5796, 88.7%) and the province of Ontario (n=4137, 63.3%). Odds ratios indicate that using opioids (OR 6.72, CI 95% 3.69–13.52), opioids in combination with methamphetamine (OR 9.70, CI 95% 3.24–23.06), multiple consumption routes (OR 6.54, CI 95% 2.46–14.37), and calls occurring in British Columbia (B.C) (OR 3.55, CI 95% 1.46–7.33) had a significantly higher likelihood of a drug poisoning. No deaths were recorded and only 3 false callouts had occurred. The overall drug poisoning
Freeman	2005	Mixed methods evaluation/modelling from natural experiment	Australia	No	Community SCS	N/A	Various	N/A at the outcome level (local population not specifically clients)	Not stated	Supervised consumption sites	Not stated	Legal	Recorded theft/robberies pre-/post-MSIC; drug-related/total loiitering counts around MSIC; drug-use/supply offences around Kings Cross; perceptions of changes in community	Low	Quasi-exp./observational, no downgrade applied	There was no evidence that the MSIC trial led to either an increase or decrease in theft or robbery incidents. There was also no evidence that the MSIC led to an increase in 'drug-related' loitering at the front of the MSIC after it opened, although there was a small increase in 'total'

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Bowring	2026	Cost-effectiveness modelling	Australia	No	Community SCS	Modelled pop of 1,500 PWID + 33,600 NIROA PWUD	Modelled separate classes of opioid / non-opioid (and by different routes)	PWUD	Not stated	Supervised consumption sites	ACT Health, ANU, Burnet	Legal	Health outcomes; overdoses/related deaths;injection-related injuries; HC/societal costs averted; BCRs per intervention; contingency for increased OD mortality modelled	Low	Strong modelling design but still a case of "we drew lines that went up/down". No downgrade applied.	Compared with no coverage, the current package of harm reduction interventions was estimated to cost $24.6 million over 2026-2030 and avert 454 (24%) opioid and 20 (0.2%) non-opioid overdoses, 70 (28%) overdose-related deaths, 215 (17%) emergency responses, 552 (117%) hepatitis C infections and 199 (9%) IRIs. This corresponds to $250.1 million in economic benefits [benefit-cost ratio = 10.1, 95% confidence interval (CI) = 7.9-12.4]. Benefit-cost ratios for scaling up take-home naloxone [16.4 (5.0-27.9)], opioid agonist treatment [10.2 (5.6-15.3)], technological interventions [3.5 (0.0-15.7)], drug consumption room/s using medialised [1.9 (0.6-3.9)] or nurse/peer-led model [2.7 (1.2-4.4)], safer opioid supply [1.5 (0.8-2.6)] and needle-syringe programs [1.4 (0.7-2.6)] were favourable. The benefit-cost ratio for drug checking was 0.3 (0.0-6.2) but increased to 14.0 (0.1-29.6) under changed drug market conditions.
Rioux	2023	Cost-effectiveness modelling	Canada	No	Phone-based	Monte-Carlo simulation based on characteristics and outcomes from 5,159 actual calls to NORS	Various	PWUD (NORS service users)	Not stated	Virtual overdose monitoring	Health Canada Substance Use and Addictions Program, Canadian Institutes of Health Research	Legal	Cost-benefits from overdose/HC costs averted vs. operational cost; modelled BCRs over service span; modelling across various mortality rates in its absence; per-overdose HC cost savings	Low	REALLY GOOD.. modelling. No downgrade applied	Over the total funded lifespan of the program, and using a Monte Carlo estimate, the benefit-to-cost ratio of the NORS program was 8.59 (1.53–15.28) per dollar spent, depending on estimated mortality rates following unwitnessed overdose and program operation costs. Further, we conservatively estimate that early community-based naloxone intervention results in healthcare system savings of $4470.82 per overdose response. Conclusions We found the NORS program to have a positive benefit-to-cost ratio when the probability of deat following an unwitnessed overdose was greater than 5%. // BMR'S COMMENT: Putting the thought here bc I don't think I'm mentioned it anywhere in the report - Virtual Overdose Monitoring Services (VOMS) is possibly the funniest abbrev. I've ever seen or will see in this life or the next

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Milaney	2021	Survey	Canada	No	Alberta	432 survey respondents	Opioids	PWUD	Not stated	Observational study of housing associated with hospital access (as a study of integrated care)	State funded	Not stated	Hospital use as a function of housing instability	Low		Results highlight the importance of concurrently addressing housing instability alongside the provision of harm reduction services such as safe supply and supervised consumption sites.
Ritter	2018	Discussion paper	Australia	No	N/A	N/A	All illegal drugs	N/A	Not stated	Decriminalisation	N/A	N/A	N/A	Low		Description of four decriminalisation models with pros and cons.
Hughes	2019	Discussion paper	15 alternative approaches globally	No	N/A	N/A	All illegal drugs	N/A	Not stated	Decriminalisation	N/A	N/A	N/A	Low		Description of six decriminalisation models with pros and cons.
Hughes	2007	Policy evaluation	Portugal	No	population level policy	N/A	All illegal drugs	N/A	Not stated	Decriminalisation	Govt funded in Portugal	Law changed in Portugal	Drug use, drug-related disease, crime	Moderate		The statistical indicators suggest that since the decriminalization in July 2001, the following developments have occurred: • Increased use of cannabis. • Decreased use of heroin. • Increased uptake of treatment. • Reduction in drug related deaths
New Zealand Drug Foundation	2025	Discussion paper	New Zealand	Yes	population level policy	Informed by 442 survey responses and 31 workshop participants	All illegal drugs	N/A	Yes, in survey and focus groups	Alternative policy approaches	N/A	N/A	N/A	Low	Plus one for lived experience involvement	Recommendations for improving drug law in NZ
Smith-Bernardin	2022	Scoping review	32 studies globally	No	Managed alcohol programmes	Total not cited	Alcohol	People with harmful alcohol use	Not stated	Managed alcohol programmes	Various by jurisdiction	N/A	Health, quality of life, alcohol consumption, housing retention, service use	Low	Downgrade on imprecision	Based on a harm reduction approach, MAPs offer a promising, targeted intervention for individuals with severe AUD and experiencing homeless-ness.
Magwood	2020	Review of systematic reviews	30 systematic reviews	No	Community	Total not cited	Alcohol and opioids	Homeless populations	Not stated	Managed alcohol programmes, supervised consumption, pharmacological interventions for opioid use disorder	Various by jurisdiction	N/A	Mortality, morbidity, substance use, mental health, access to care, retention in treatment	Low	Downgrade on imprecision	Supervised consumption facilities reduce overdose and improve access to care, while pharmacological interventions may play a role in reducing harms and addressing other morbidity. High quality evidence on managed alcohol programs is limited.

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Brooks	2018	Systematic review	42 studies	No	Community and hospital settings	Total not cited	Alcohol	People with harmful alcohol use	Not stated	Managed alcohol programmes either in hospital or community settings	Various by jurisdiction	N/A	Both health and social outcomes	Low	Downgrade on inconsistency	Forty-two studies met review inclusion criteria. Twenty-eight examined the administration of alcohol to hospital inpatients, with most reporting positive outcomes related to prevention or treatment of alcohol withdrawal. Fourteen studies examined MAPs in the community and reported that they help stabilise drinking patterns, reduce alcohol-related harms and facilitate non-judgemental health and social care
Thompson	2025	Evaluation	Australia	No	Residental managed alcohol programme in South Australia	analysis of 21 clients	Alcohol	Aboriginal Australians experiencing homelessness and alcohol dependence	Not stated	Managed alcohol programme in a residential setting	Govt funded	N/A	Culture, medical support, system navigation, housing, capacity, resilience, social connectedness	Low	No up or downgrade	The South Australian MAP provided various interconnected short-term benefits relevant to people experiencing homelessness and alcohol dependence in general and Aboriginal peoples additionally experiencing the on-going impacts of colonisation in particular. This evaluation supports international literature on the value of MAPs as an effective harm reduction approach to co-occurring homelessness and alcohol dependence and strengthens evidence for the feasibility, acceptability, and benefits of MAPs in Australia.
Purcell-Khodr	2020	Systematic review	Australia, NZ, US, Canada	Yes	Primary care	Total not cited	Alcohol	First nations people with unhealthy alcohol use	Not stated	Brief intervention, ambulatory withdrawal management, relapse prevention medications, cultural therapies	Various by jurisdiction	N/A	Treatment accessibility and acceptability, effectiveness, implementation	Low		Research evidence on how best to care for First Nations peoples with unhealthy alcohol use is lim-ited. Trials of naltrexone and disulfiram presented promising results. Cultural and bicultural care were perceived as highly important to clinical staff and clients in several studies. More effectiveness studies on the full scope of alcohol treatments are needed. Greater community participation in research and more transparent reporting of this in study methods will be key to producing quality research that combines scientific rigour with cultural appropriateness.

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Patton	2022	Qualitative interviews	UK mainly (sub-sample including England, Scotland, Belgium, Netherlands)	No	Community (post-treatment recovery)	n=30 (half and half male/femme)	Diverse AOD (not stratified)	People in recovery	Not stated	Recovery capital (observational / framework)	NIHR	N/A	Qualitative themes re: pains of recovery (push factors) and recovery capital (pull factors) across recovery phases	Low	Qualitative; well conducted but small sample	Pains of recovery rarely drive positive change on their own. "pull factors" (recovery capital) are accrued via relationships, identity, meaningful activity as primary drivers. Recovery capital cannot accrue or sustain without managing (reducing/eliminating) negative recovery capital, particularly in early recovery. Calls for structural/systems-level transformation alongside individual strengths-based plans.
Heo	2023	Cross-sectional survey	USA (South Carolina)	No	Rural community (gen pop)	n=338	Opioids	People with OUD	Not stated	Attitudinal survey re: HR & recovery services	Not stated	N/A	Harm Reduction & Recovery Support Score (HRRSS, composite); demographic and attitudinal predictors	Low	Observational cross-sectional, no comparison group; adequately powered for stated effect; downgrade for indirectness (attitudinal outcome rather than behavioural/health)	Mean HRRSS 4.1 (SD 2.3) = low community support overall. Strongest predictors of higher HRRSS (after adjustment): agreement that OUD is a disease (adj diff 1.22, 95%CI 0.64–1.80) and that MOUD is effective (adj diff 1.11, 95%CI 0.50–1.71). Younger and employed respondents had significantly higher HRRSS. Authors argue community-level education on the disease model and MOUD effectiveness is foundational to building in/tangible social capital for HR.
Best	2020	Mixed-methods programme eval	UK	No	Peer-led recovery (community, hospital, prison settings)	Various across case studies	Diverse (AOD)	People in / entering recovery.	Yes (peer-led org, PWLLE in intervention context + co-authors)	Peer-based recovery support (Asset-Based Community Development + assertive linkage; hub-and-spoke model)	Not stated	Legal (NHS-adjacent)	Engagement and uptake; descriptive recovery-capital indicators across three case studies	Very Low	Observational case-study design, no comparison group; descriptive only; downgrade for indirectness and risk of selection bias	Three case studies: (1) acute-hospital partnership for co-occurring SU/MH, (2) recovery residence linking high-risk individuals to hubs, (3) prison-reentry resettlement via 'Behavioural Health Companions'. Authors describe peer-led engagement as the mechanism: "spark of hope through connection" preceding recovery-capital growth. Community recovery capital framed as a measurable property of organisations (quantity/quality of community relationships).
Jowett	2021	Qualitative interviews + thematic analysis	New Zealand	Yes	Mixed AOD services / community (interviews with NZ-based AOD professionals)	n=8	Diverse (alcohol, amphetamines, opioids, cannabis, MDMA, LSD, pharms incl. temazepam)	NZ-based health & social-service professionals with personal AOD addiction & recovery experience	Not stated	Observational/exploratory (barriers & contributors to recovery in Aotearoa)	Not stated	N/A	Qualitative themes: nine across barriers and contributors to recovery	Low	Qualitative, small NZ-only sample, high relevance and transparent thematic methodology; lived-experience research design adds credibility but not heaps	Nine themes split across barriers (stigma, including internalised; peer-role stigma in workplace; systemic gaps in school AOD education, welfare/housing, the AOD sector itself, criminal justice, funding models, women's services) and contributors (self-defined recovery & redemptive self; therapeutic relationships especially with PWLLE professionals; career progression; community & gender-specific supports). Authors conclude barriers are systemic and preventable, advocating for greater use of PWLLE practitioners and stronger social-work role in AOD.

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Kennedy	2019	Qualitative interviews	Canada (Vancouver DTES)	No	Overdose prevention sites (x4)	n=72 across 4 OPS	Opioids mainly	PWUD @ DTES OPS, unstably housed in particular	Not stated	Peer-staffed OPS (SCS-adjacent / low-threshold model)	CIHR, NIDA, Canada Research Chairs programme, Michael Smith Foundation for Health Research	Sanctioned' but legally distinct from federally-exempt SCFs at time of fieldwork	Qualitative themes: peer worker capacities, service engagement, harm-reduction outcomes, burnout / sustainability	Low	Mixed-methods design with strong methodological rigour and triangulation. Well conducted, but transferability limited to similar high-acuity overdose-crisis contexts	OPS operation was contingent on peer workers; peers' existing capacities (e.g., overdose response, rapport, low-barrier engagement) recognised as valuable. Peers enhanced comfort and engagement and enabled communication that fostered HR practices and health benefits. However, minimal financial compensation and the emotional toll (grief, lack of organisational supports) contributed to burnout. Authors call for formalisation of peer roles with adequate pay and workplace supports.
Bardwell	2019	Qualitative interviews	Canada (Vancouver)	No	Emergency shelters (SCS)	24	Opioids / stimulants	PWUD (low-barrier emergency housed)	Not stated	Peer-led shelter-based witnessed injection / overdose-response programmes	NIH/NIDA, Canada Research Chairs, Michael Smith foundation	Legal (as overdose emergency-response programmes)	Qualitative themes: peer support development, safety, peer vs non-peer staff dynamics, informal peer overdose response	Low	Small sample at two shelters in a specific city/crisis context; transferability limited but methodology is sound and triangulated	Four themes: peer support developed through relationship-building and trust; shared lived experience created safety using in front of peer workers; peers preferred over non-peer staff due to nominal power dynamics and prior negative experiences; peer roles informally routinised across resident social networks, fostering collective overdose-response obligation. Authors call for scaling formal + informal peer roles in shelter-based HR.
Best	2023	Narrative / conceptual review	USA / UK	No	N/A (review)	N/A	Diverse AOD	People in/seeking recovery (review)	Not stated	N/A (conceptual review)	NIH/NIDA; potential CoI as Best = director of 'Recovery Outcomes Institute;	N/A	Narratives across four areas: conceptual development, empirical measurement, application in treatment/continuing care, dissemination to policy/practice/LE groups	Very Low	Conceptual narrative review. Significant authority on Recovery Capital but not empirical	RC is conceptually rich but empirically under-developed: heavy reliance on self-report questionnaires, no agreed cross-population measurement, unsystematic translation. Authors propose four priority areas including formal collaboration between academia, practitioners and experts-by-experience (PWLLE?) worldwide to develop RC "in an empirically-driven and culturally appropriate manner" and testing applicability at individual, organisational, and societal levels

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Lancaster	2015	Policy analysis	Aus + UK	No	Policy docs	Two reports	Diverse AOD	N/A (policy)	Not stated	N/A (policy analysis)	Not stated	N/A	Four problem-representations": people who use drugs as 'problematic users', as responsibilised individuals (UK) / patients (Australia), as conditional citizens (worthy only via "treatment/recovery")	Low	Qualitative critical policy analysis; well-conducted with decent transparency; downgrade for limited generalisability beyond the two analysed texts (though the analytic framing is broadly applicable)	Both reports illustrate PWUD via overlapping 'problem representation' that constrain alternative understandings: drug users as inherently problematic (limiting recognition of stable/non-problematic use); responsible individuals or patients; citizenship as conditional on treatment/recovery (silencing the rights and 'worth' of people who continue using). Authors argue these shape policy in ways that risk displacing harm reduction. Strong critical resource for the "Understanding HR" section
Harris	2026	Editorial / commentary	UK	No	Research practice (academic + community)	N/A	Diverse (but mainly crack cocaine)	Not statePWUD (marginalised and criminalised esp.)	Yes - author as a researcher + community member	N/A (principles for research / collaboration)	Not stated	Unlawful but exempted by agreement with police	Five principles for collaborative research with PWUD; reflection on infrastructure (e.g., representative organisations tied to HIV/HCV funding in AU/CA, absent in UK)	Very Low	Editorial / methodological reflection rather than empirical study; high practitioner/community authority through positionality and case-study illustration	Describes shift from 'whether' to 'how' to collaborate with PWUD. Five principles: recognise expertise of LE; build long-term relationships of trust, respect, mutual value; provide infrastructure and reimbursement (fund it); build flexibility and contingency into design; build capacity reciprocally. Highlights structural asymmetry: Aus/CA representative orgs sustained by public-health mandates vs UK reliance on personal networks (heightening tokenism risk). Case studies illustrate practical strategies (peer expert groups, dissemination funds repurposed for co-development, exit strategy planning)
Collins	2019	Commentary	USA + Canada	No	N/A (commentary)	N/A	Opioids / stimulants	Women, transgender / NB people, two-spirit	Not stated	N/A (commentary)	Not stated	N/A	Argument for moving beyond gender-neutral overdose response; review of differential gendered harms; calls for intersectional, gender-responsive HR	Very Low	Commentary; not empirical. Synthesises existing evidence but introduces no new data	Women were ~30% of US and ~23% of Canadian fatal overdoses; US fatal overdoses rose 260% in women aged 30–64 and ~500% in women aged 55–64 between 1999–2017. Gender-neutral framings obscure specific vulnerability (gendered violence, HIV/HCV, injection-related harms) compounded by racialisation, criminalisation, and other intersecting marginalisations. Authors call for attention to gender diversity and intersectionality in overdose response, including gender-responsive HR services

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Te Pou (Baxendine)	2025	National outcome report	New Zealand	Yes	Community AOD services (Health NZ districts + NGOs)	26,440 service occasions, 9,804 ADOM treatment starts; 1,337 matched pairs (treatment start/end)	Diverse - mainly alcohol, some other drugs	People accessing community AOD services (36% Māori in this cohort cf. ~16.8% in gen. age-matched pop)	Not stated	N/A - outcomes from surveillance / reporting	Te Pou	N/A	Substance-use change (days used past 28 days; standard drinks per drinking day); lifestyle and wellbeing domains; client-perceived recovery progress measured at treatment start vs treatment end	Low	Outcome-measure report (not RCT). Coverage uneven: only 37–39% of NGO/Health NZ episodes have valid ADOM collections, some districts not yet reported. Matched-pairs are still not very representative of all clients (clients with treatment-end data tend to be more engaged). Descriptive only, no comparison condition. Conservative interpretation made here	Routinely-collected national data showed medium-to-large reductions in substance use and improvements across most lifestyle/wellbeing and self-perceived recovery criteria for those completing both treatment-start and treatment-end ADOMs. Alcohol is the dominant main substance of concern (59%) and a major secondary concern even where another drug is primary. Māori are over-represented among service users (36% of treatment starts) relative to general population proportion. Useful NZ grey-lit evidence that current community AOD services produce measurable positive change for those engaged through to treatment end, while acknowledging significant data gaps
Doncliff	2025	Practice narrative	New Zealand	Yes	N/A (clinical framing)	N/A	Diverse AOD	People with SUD	Not stated	N/A - explains applying RC in NZ clinical settings	N/A	N/A	N/A (descriptive re: recovery, recovery-capital domains (social/physical/human/cultural/community capital), and negative recovery capital)	Very Low	Practitioner narrative review with explicit editorial review (O'Brien) but no systematic methodology; clinical-framing piece rather than empirical evidence.	NZ clinical framing of Recovery Capital linking to harm-reduction principles and notes that recovery capital is embedded in the NZ Ministry of Health's OST guidelines. Describes five RC domains (social, physical, human, cultural, community), contrasted with negative recovery capital / pains of recovery (citing Patton 2022). Positions clinician role as resource-broker across the recovery journey, emphasises non-linear/individualised recovery, and notes that both harm-reduction and abstinence approaches both operate in NZ AOD services.