Crew 2000 is a national Scottish charity established in 1992 by a group of community activists and peer educators. Crew exists to reduce harm, challenge perceptions and help people make positive choices about their use of psychostimulant drugs by providing non-judgmental, credible and up to date information and support. A skilled, diverse team of volunteer peer educators support and enhance the work of our professional staff team in Crew’s outreach, training and drop-in services. A team of qualified counsellors deliver our counselling service for people addressing psychostimulant drug use as part of the Edinburgh Alcohol and Drug Partnership Psychological Therapies Alliance.

Our response includes input from Mentor Scotland (Questions 8 and 9) and a Crew Social Media Survey April 2019 attracting 26 responses Age profile: 25-34 years: 23%; 35-44: 27%; 45-54: 38%; 55-64: 4%; 65+: 8%. Report written by Emma Crawshaw.

1. Recommendations: pages 1-2
2. Response to the Inquiry Questions: pages 2-11
3. References: pages 11-12

Recommendations:
1. Scotland should adopt an evidence-based approach to drug legislation and policy with robust evaluation of intended and unintended impacts, recognising that criminalisation of drugs and punitive approaches to people who use them are often the biggest barriers to getting help and that even the most expensive treatments as alternatives to imprisonment are more cost effective

2. People seeking help at the right time should be able to access reliable community-based drug testing and medically supervised injecting facilities which could help prevent immediate harms, improve access to services and reduce drug related deaths.
3. We strongly and urgently recommend that problematic psychostimulant drug use is included in the Information Services Division/NHS National Services Scotland definition of problematic substance use as soon as possible in order to reflect the changing patterns of drug harm in Scotland and ensure that research, budgets and services can be developed according to changing national needs.

4. We need to include the views and lived experiences of people affected by drug harms in developing legislation which is fit for purpose and which empowers the public to keep themselves safe.

5. Further devolved control of budgets and funding policy to increase resources to address drug harms and create the means to achieve:
   a. 5 year-funding for high quality treatment services based on sound evidence and effective approaches
   b. full cost recovery for voluntary sector drug services
   c. development of improved and more widely available treatment responses for people with psychostimulant drug use
   d. implementing the early education and prevention strategies outlined in the Rights, Respect, Recovery strategy.

6. Social policy should include a health inequalities impact assessment to consider the likelihood and severity of impacts on people who use drugs.

7. Controlled, de-criminalised, nationalised, well-regulated production of currently illegal drugs to remove drugs from criminal networks and address the concentration of more serious drug harm in areas of Scotland already experiencing poverty and deprivation, therefore reducing the risks of wider drug harms to young Scottish people experiencing poverty.

8. A Scottish working group should be established to draw on existing evidence of best practice in music festival and event welfare and set a minimum, multi-agency standard with specific reference to preventing and addressing drug-related harms from a health perspective.

1. **What are the unique drivers of drugs abuse in Scotland?**
   Crew would recommend the use of the term ‘problematic drug use’ rather than ‘abuse’.

**Drivers:**
Structural inequality and trauma:
- social dislocation, austerity, universal credit and other welfare cuts leading to poverty
- lack of education/opportunity
- adverse childhood experiences and living conditions, abuse, trauma and their effects on mental health – lack of services for young people.

Young people experiencing poverty and deprivation who also take drugs are more likely to:
- start drug taking earlier than their better-off peers
- take drugs in a more dangerous way
- experience dependence
- experience health problems
- experience unemployment and live where dealing drugs may be seen as a way to make money
- become involved in the criminal justice system and be imprisoned.

Markets and marketing:
- aggressive, competitive marketing using social media, the ‘clear’ and the ‘dark’ net.
- no separation in illegal drug markets between substances with very different risk profiles/effects, eg cannabis and heroin
- smart marketing, eg cannabis games online in which young people receive cannabis at a discount if they reach a location first after finding it via an online game.
- internet availability of benzodiazepines

Lack of appropriate service provision:
- lack of safe, medically supervised spaces to consume substances, and resulting poor harm reduction practice
- lack of stepped care services and person-centred approaches

Ideology and prejudice:
- historical emphasis on abstinence rather than recovery
- authoritarian prohibition approach
- moralistic rather than empirical or compassionate discourse
- lack of accountability from politicians and others for “disgraceful outcomes”.
2. **How is drugs misuse in Scotland different from the rest of the UK?**

Scotland’s Government recognises drugs and drug harms as public health as opposed to criminal justice issues, and Scotland’s rate of drug related death is 2.5 times higher than in other UK countries. Other differences identified by our social media respondents include:

- more use of and harms from benzodiazepine use
- concentration on intensive problems in policy rather than the wider spectrum of drug use
- cultural drivers and different attitudes towards the acceptability of drug use in Scotland compared to other UK countries
- lack of community-based drug testing trials such as those already conducted by the Loop in Bristol and Durham.

3. **To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?**

Prohibition under the 1971 Misuse of Drugs Act creates stigma, shame and fear of arrest, all of which hinder

- people’s ability to access help at the right time
- **harm reduction education and practical support**, which may be misunderstood as encouraging illegal activity
- research into the therapeutic potential of illegal drugs – licenses are available but they are prohibitively expensive
- the establishment of evidence-based harm reduction, such as **community-based drug testing and medically supervised injecting facilities** which could help prevent immediate harms, improve access to services and reduce drug related deaths.

Prohibition also increases the prison population, who may experience risker drug use in prison itself and find it harder to find work on release, compounding the effects of drivers of drug use such as poor mental health, poverty and deprivation.

4. **What is the relationship between poverty and deprivation and problem drug use?**

People with fewer resources are more likely to experience more and more severe harms from drug use than people who are better off, through having fewer choices in relation to their health, sub-standard housing and less access to education or work.

Poverty and deprivation are most closely linked to the most harmful kinds of problematic drug use and harm and least closely linked to recreational or occasional drug use and harm.

Young people experiencing poverty and deprivation who also take drugs are more likely to:
start drug taking earlier than their better-off peers
- take drugs in a more dangerous way
- experience dependence
- experience health problems
- experience unemployment and live where dealing drugs may be seen as a way to make money
- become involved in the criminal justice system and be imprisoned.

5. What role could reserved social security policy play in addressing problem drug use?
An opportunity to offer increased budgets and support, for example, more support for people using drugs problematically to link in to effective drug and health services rather than punitive practice for missed assessment appointments. Framing drug harms as health problems in social security policy could equip government and local authorities to respond more readily to the Scottish context and drivers of harm, especially income inequality and lack of opportunity. Reducing income inequality could address health inequalities by improving people experiencing poverty’s access to better housing, education, work, meaningful activity and healthier food.

6. How is the drugs market in Scotland changing?
“I have had various conversations with young people and support workers about the ease of using online to order drugs, both clear-net and dark. One conversation recently with young person whose friend is researching the dark net to look for options for alternative sources of regular medication for anxiety, due to concerns around impacts of Brexit.”

Crew Drop-in Shop Coordinator

“Social media sales – can buy anything from anywhere for less money – demand outstrips supply. Before, you had to know someone who sold drugs, now you just need a mobile phone.”

Everything that is banned becomes replaced with something else…. benzos and alcohol became more expensive so we see street benzos at an all-time high. The same will happen with gabapentinoids"

Crew Social Media Consultation

Technology: Access to illegal drugs is no longer restricted to “highly concentrated pockets of intense deprivation with multiple social problems” (1) in Scottish communities. The development of online technology has resulted in significantly increased access to a
greater number and variety of legal and illegal drugs since 2008 (2) many of which test higher for purity and UK purchase of drugs from the dark web has more than doubled from 12.4% in 2014 to 25.3% in 2017 (3).

In 2017, Afghanistan’s total area under opium poppy cultivation increased by 63% from the previous year as farming methods and technology have improved, in addition to many other factors such increased political instability and lessening engagement with the international aid community. This is despite opium poppy destruction having increased by 111% (4).

Advances in technology have not only expanded the online market and improved manufacturing methods, but have also allowed for the development and synthesis of hundreds of new drugs. Also, improved transport infrastructure and connectivity means we are working within an international drugs market, not a Scottish one.

**Trends and legislation:** When invited by the Home Office in 2015 to give evidence of potential risks and harm foreseen as a result of the introduction of the Psychoactive Substances Act 2016(PSA) and the removal of Novel Psychoactive Substances (NPS) from open sale, Crew identified serious potential impacts for people who had previously been taking NPS returning to traditional controlled drugs including heroin and other opioids (likely to have reduced tolerance thus at increased risk of overdose) and an increase in non-prescription use of medicines such as benzodiazepines, gabapentin and pregabalin. We also noted the risk that people having developed a taste for psychostimulant drug effects while using NPS might lead to an increase in people using psychostimulants like cocaine (5).

According to the United Nations, 2018 (6) Scotland has the second highest prevalence rate for cocaine use in the world.

Cocaine-related deaths in Scotland have increased more than 43 times (4,300%) from the 2000 total of 4 to 176 in 2017. 25% of people who lost their lives to drugs in 2017, 235 individual human beings, died from psychostimulant drug poisoning.

Cocaine purity is at its highest level for over a decade and prevalence among UK young people aged 15-34 is highest across Europe (EMCDDA Drug Report 2017; Police Scotland STOP Unit Bulletin 12/12/18).

We’ve seen consistent increases in people we support reporting cocaine, MDMA, Xanax, ketamine and LSD use 2016-18 (Crew Outreach/Counselling/Drop-in Surveys 2014-18) which is broadly consistent with wider trends across Europe (7, 8).

We note the UK Government’s report 25th March 2019 on the evidence of increased crack cocaine use in England (9).
Contributory factors identified in the report include:

- aggressive marketing by dealers
- easy access/availability of crack
- increase in county-lines activity
- less stigma associated with crack use

all of which have been reported to us anecdotally by treatment professionals and staff supporting people affected by drugs across Scotland.

Most NHS and voluntary sector drug services facilities in Scotland are focussed exclusively on opiates (heroin; methadone) and benzodiazepines (Valium; Xanax). Crew’s stepped care model is based on evidence of the most effective approaches to engaging with and supporting people who use psychostimulant drugs (10) and we offer training to professionals to equip them to respond more effectively to people presenting with problematic psychostimulant drug use or use of a number of different drugs (poly drug use).

Harms and deaths from psychostimulant drugs, such as MDMA, ketamine and cocaine may result from occasional, excessive recreational use, but also from routine and prolonged use. Psychostimulant drug use, however, is not included in the current official definition of problematic drug use used by the Information Services Division/NHS National Services Scotland. We strongly and urgently recommend that it is included as soon as possible in order to reflect the changing patterns of drug harm in Scotland and ensure that research, budgets and services can be developed according to changing needs.

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<td>473</td>
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<td>275</td>
<td>445</td>
<td>399</td>
<td>650</td>
<td>180%</td>
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<td>Amphetamine</td>
<td>25</td>
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7. How well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”.

The dark web could be seen as a logical or inevitable response to or result of current legislation:

“They do not even begin to touch the surface. It is impossible to police the market efficiently with such high demand and supply”

“where there is demand, people will supply”

“Not well at all, without decriminalisation and regulation drugs will remain dangerous”

“We must look to Europe and Portugal in Particular”

Crew Social Media Survey

8. Are any changes needed to the current regulatory landscape?

The Misuse of Drugs Act 1971 is not fit for purpose. The efficacy and benefit of capture and punishment is evidenced to be poor (11); the costs and harms of prohibition and the stigma this creates exacerbate and, it could be argued, outstrip the harms of both recreational and problematic use. We need to include the views and lived experiences of people affected by drug harms in developing legislation which is fit for purpose and which empowers the public to keep themselves safe.

Current legislation is seen as stigmatising and a barrier to accessing help in the first place as well as to providing achievable, evidence-based harm reduction.

People seeking help at the right time should be able to access reliable community-based drug testing and medically supervised injecting facilities which could help prevent immediate harms, improve access to services and reduce drug related deaths.

Arrests for smaller scale drug crimes increase the prison population and, it could be argued, divert resources from building infrastructure in Scotland which could improve housing, mental health, wellbeing, quality of life and education, all of which could reduce health inequality, drug use and harms from drug use.
Devolved powers leading to more control over funding/finances would also help with implementing the early education and prevention strategies outlined in Rights, Respect, Recovery, which would benefit Scotland in the long-run, as significant resources will be required over time to develop and implement consistent and effective prevention and early education strategies in schools which are already under significant financial pressure.

9. Are there other areas of reserved policy which is influencing the Scottish Government’s ability to address drugs misuse in Scotland?

Effective, evidence-based harm reduction at the heart of policy, rather than fear and judgement could create a conceptual and practical shift away from sub-optimal prescribing, away from prosecution for possession and break down barriers to reducing harm by enabling:

- Development of improved treatment responses to psychostimulant drug use
- medically supervised injecting facilities
- community-based drug testing.

De-criminalising drugs would make it easier for policy makers and professionals in both education and health sectors in Scotland to implement effective approaches to drug prevention and education with young people. Drug education falls within the Health and Wellbeing components of the Curriculum for Excellence. However, the stigma attached to drug use and drug users and the ‘taboo’ around talking about drugs that results from criminalization makes it difficult to implement effective drug prevention as part of school education. This is especially because it makes it hard for teachers and students to have open conversations that include a harm reduction component. Young people in England aged 11-18 are already indicating this to MentorUK/Mentor Scotland in focus groups. Given that Scotland’s issues with drugs are particular, this raises specific issues for Scottish young people within education, where there is a real need for effective drug education, including:

- reference to the local context
- critical thinking around social norms
- harm reduction
- developing resilience skills through effective dialogue.
This should be funded and supported to develop as an evidence-based and even more importantly evidence-producing part of the health and well-being curriculum. We should never wait until young people’s use is problematic before offering education, advice, support and help.

10. How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland?
The UK government has not prevented community-based drug testing which has gone ahead in collaboration with some local police forces and local authorities England, however this is not yet available in Scotland, which is bound to the same legislation but has a single, national police force.

The reserved Misuse of Drugs Act 1971 is cited as the reason for the delay in opening a medically supervised safer injecting facility in Glasgow.

11. Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?
“No but emergency services, other public bodies, third sector do where possible.”

Crew Social Media Survey

There is significant evidence for the likely effectiveness of and support for establishing medically supervised injecting facilities as a key action to reduce Scotland’s disproportionately high level of drug-related deaths, so rather than sharing what is already known by both governments to be best practice, it could be argued that a consistent approach to existing legislation is required.

12. Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland’s needs?
Further devolved control of budgets and funding policy could create the means to achieve full cost recovery for voluntary sector drug services – we can’t keep ‘pulling the rabbit out of the hat’ and subsidising public contracts when these are cut with a requirement to maintain the same level of service; this is neither sustainable or ethically defensible.

5 year-funding for high quality treatment services based on sound evidence and effective approaches would avoid the ‘race to the bottom’ and significant and detrimental administration costs engendered by tendering and re-tendering processes. Sufficient funding would make more evening and weekend appointments more feasible for services to provide, providing more people experiencing dangerously problematic drug use with more opportunities to get the right help at the right time.
With additional budget allocated to drug treatment and recovery services, and decriminalisation of currently illegal drugs for research, **improved responses** could be developed for **people using psychostimulant drugs problematically**.

**Broader impact analysis and reach for drug policy:** All social policy should include a health inequalities impact assessment to consider the likelihood and severity of impacts (nb likely to be unintended) on people who use drugs.

**Controlled, de-criminalised, nationalised, well-regulated production of drugs** would radically improve research into the risks, potential health benefits and use as medicines of substances which are currently illegal. Research licenses are currently expensive to the point of prohibiting important research projects into Alzheimer’s Disease, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder.

This could also remove drugs from criminal networks and address the concentration of more serious drug harm in areas of Scotland already experiencing poverty and deprivation, therefore reducing the risks of wider drug harms for young people experiencing poverty.

13. **What could Scotland learn from the approach taken to tackle drug misuse in other countries?**

Scotland should adopt an evidence-based approach with robust evaluation of intended and unintended impacts, recognising that criminalisation of drugs and punitive approaches to people who use them are often the biggest barriers to getting help and that even the most expensive treatments as alternatives to imprisonment are more cost effective (11).

The Portuguese approach of involving the criminal justice system of supporting, but most importantly not forcing, people into treatment rather than prison could reduce significant harm and save lives.

**Given clear emerging evidence of the efficacy of drug testing in reducing drug-related harms and increasing engagement with support services** in mainland Europe and England, Scottish local authorities, alcohol and drug partnerships and Police Scotland should trial community-based testing with integrated, good quality harm reduction support (13).

Sadly, there seems to be greater will expressed towards harm reduction projects in England such as community-based drug testing centres, despite a higher rate of drug-related deaths and evidence from projects like Global Drugs Survey showing a particular nature of drug use in Scotland (particularly among young people) (14; 15).
Criminalisation of drugs and aggressive approaches at music festivals and events can increase the risk of drug overdose, for example young people swallowing multiple pills if they fear an imminent, unexpected police search or sniffer dogs.

A mminimum standard for festival/event welfare with specific reference to preventing and addressing drug-related harms from a health perspective, such as those currently operating in Belgium, Germany and Spain should be established nationally as part of local licensing application requirements.

A Scottish working group should be established to draw on existing evidence of best practice in festival welfare and set this standard.

References:
2. Power, M 2013: ‘Drugs 2.0: The web revolution that’s changing how the world gets high’
5. Craik, V 2015: Crew written evidence to the Home Office consultation on the Psychoactive Substances Bill
11. UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters 2019 [https://www.unodc.org/documents/commissions/CND/2019/Contributions/UN_Entities/What_we_have_learned_over_the_last_ten_years_-_14_March_2019_-_w_signature.pdf]
12. Letter: Front of house drug testing by the Loop is essential in reducing future harm 2018 https://www.bmj.com/content/362/bmj.k3106.full
13. Claudio Vidal Ginéa; Mireia Ventura; Vilamalaa; Fiona Measham; Tibor; M.Bruntd; Alexander Büchelie; Carlos Paulos; Helena Valente, Daniel Martin; Bérénice Libois; Karsten Tögel-Linsj; Guy Jones; Alexandra Karden; Monica J.Barrattmno; The utility of drug checking services as monitoring tools and more: A response to Pirona et al, 2017 https://www.sciencedirect.com/science/article/abs/pii/S0955395917301226
1. What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?

Unlike there are ‘unique drivers’ as such – increased drug-related harm is currently a national and international concern. However, Scotland historically has a worse record with regards to all health outcomes compared to the rest of the United Kingdom, and this will be reflected, unfortunately, in drug-related harm also.

Many people have adverse childhood experiences and severe mental health issues and use drugs as a coping mechanism. The lack of services such as rehab clinics and longer waiting lists for opiate treatment is also a major factor. There is a lack of mental health provision for people with substance misuse issues, particularly during times of crisis.

The availability of substances, with certain areas “flooded with drugs available for sale” as well as the reduction in prices, drugs which were previously expensive to buy, are now being sold for much lower prices.

2. To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?

The constraints of UK-wide drugs legislation results in Scotland being less able to react dynamically to emerging threats and potential solutions that may be a particular priority to the population in Scotland compared to elsewhere in the United Kingdom.

The fact that Westminster won’t devolve drug laws to Scotland means we cannot set up safer injecting rooms. The Harm Reduction service reports that several individuals who access their service have asked when safe injecting rooms will be available as they are desperate to inject under supervision and have commented they ‘don’t want to use alone or die alone’. The feeling of this service is that staff would also be able to spend much more time engaging with individuals if they used safer injecting rooms and that Safer injecting rooms have the potential to reduce the prevalence of BBVs by giving facilitating access to BBV testing to individuals who are not engaged with any other service.

3. What is the relationship between poverty and deprivation and problem drug use? What role could reserved social security policy play in addressing problem drug use?

Poverty and deprivation are intrinsically linked to poor mental health and problematic drug use. 73% of people who died as a direct consequence of drugs in Tayside in 2017 lived in areas
that were in the two most deprived SIMD quintiles. People who develop problematic drug use and die as a result of drugs frequently experience multiple adverse events in childhood and adulthood and often have concurrent mental health issues. 74% of drug death casualties in Tayside in 2017 were known to have a co-existing mental health condition at the time of their death, most commonly depression (58%) and or anxiety (48%).

It has been shown that poverty and drugs misuse are frequently linked. Living in poor accommodation, suffering from ACES (Adverse Childhood Experiences) further increases the likelihood of firstly being in poverty and then the possibility of drug misuse. While Scotland has some (welcome) powers over benefits and employability programme provision, it does not have the levers required to make a sufficient impact. In particular it doesn’t have powers over Universal Credit (other than limited payment measures), conditionality and sanctions. If the ethos of the new Scottish Social Security Agency, treating those at its centre with dignity and respect could be replicated into UC then this would in itself be a significant measure in how we could deal with those living in poverty and also its additional impacts such as drugs misuse. While someone is actively engaging with a job centre then there is opportunity to make a real impact, build relationships and provide routes that will have an impact on whether they will find a way out of poverty. Once that engagement is lost then those that are also using drugs are often lost completely to any agency than can help, even the health or counselling services. It is vital that the causes of poverty are tackled at the earliest opportunity possible to have the biggest impact. The current mantra of work is the route out of poverty is unhelpful and also untrue. While it is a good route for many, equally the highest rising poverty figures (by more than 50%) are in relation to the working poor. When someone has complex needs including substance misuse then work is a long way off but the system is no longer geared to acknowledging that for some this is a simple fact and these barriers have to be addressed in a meaningful, long term way for any resolution.

Concerns were also raised by services of the current practice of providing lump sum back-payments of benefits, with no planning or involvement from services that could provide support. Examples being;

- £3000 + to a person who has experienced 20 non-fatal overdoses
- £19000 approx. to another who is now using broader range of drugs than before and is more vulnerable to financial exploitation by others

4. How is the drugs market in Scotland changing? How well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”. Are any changes needed to the current regulatory landscape?

The drugs market internationally is changing and this is, in part, driving the increased drug-related harm in Scotland. For example, the 2018 European Drug Report\(^2\) describes the

\(^{1}\) Drug Deaths in Tayside, Scotland. 2017 Annual Report
https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1&dDocName=prod_310127

increased production of cocaine in central and South America resulting in increased cocaine-related harm across Europe – Scotland, in this context is no different. The number of drug deaths where cocaine is involved has increased in recent years.\textsuperscript{3,4} Furthermore, a greater variety of substances are available (due to increases in the number of new psychoactive substances in recent years), and there is greater availability of diverted prescription medications such as gabapentinoids due to increases in gabapentinoid prescribing. Substances are therefore more available and affordable. In addition, substances are more easily accessible due to home production, for example in the case of etizolam, and through the internet (both the ‘normal’ web and the darkweb). The person with problematic drug use must be supported and drug-taking seen as a health concern and not a criminal concern. However, as in the Psychoactive Substances Act, there must still be a drive to restrict supply of substances and curtailing supply through the internet has to be a key priority in this area to address.

There is a rise in crack cocaine use however these individuals are hard to reach from a needle exchange perspective as they do not require paraphernalia to smoke crack. Many people believe smoking crack is better than taking heroin.

5. Are there other areas of reserved policy which is influencing the Scottish Government’s ability to address drugs misuse in Scotland?
Increasing drug related harm is a significant public health concern for the population of Scotland. The Scottish Government must be able to react quickly and appropriately to implement all evidence-based measures to address this public health priority.

6. How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland? Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?
It is imperative that best practice, information and policy outcomes is shared across all partner agencies, localities, regions and nations both within the United Kingdom and abroad. This is done sub-optimally at all levels currently.

The UK government’s policy tends to focus on prevention and the ‘just say no’ message which has no impact on existing heroin users and younger people who are exposed to drug culture and mental health issues or traumatic life events and are tired of seeing this message. A more proactive, radical approach is needed such as allowing people to make informed choices about drug use by allowing testing centres of drugs such as ecstasy, mdma, cocaine etc. It is possible that once people know that the drug they have purchased has toxic amounts of certain

substances in it or is not the substance they were expecting to find, they will dispose of the drug and choose not to take it. When drugs are seen as illicit they are sometimes more appealing. However if people can make more informed choices they are empowered to change their behaviour instead of being dictated to. Decriminalising drugs would remove the ‘gateway drug’ issue – for example a young person may start buying cannabis from a dealer and as a result is exposed to other drugs via the dealer, such as cocaine, crack or heroin. If drugs like cannabis were decriminalised this would remove this exposure risk. However alcohol is a major gateway drug as when individuals are intoxicated they are more likely to make poor choices and take illicit drugs when offered.

Scottish Government unable to make decisions that would address drugs misuse in Scotland, such as the implementation of safer injecting rooms and decriminalising of drugs. With regards to sharing best practice, there is research which shows other countries, e.g. Holland that has tried and tested methods which are resulting in positive outcomes around young people and drug use. It would be helpful if these findings could be incorporated into UK and Scottish Government policy.

7. Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland’s needs? Inevitably yes, for the aforementioned reasons. However, should further powers be devolved, the Scottish Government has to ensure that, in addition, appropriate resources are allocated to address drug misuse from a wider, holistic perspective in order to maximise any health and social gains from legislative change.

Scotland has the highest figures in the number of drugs death and high rates of poverty and deprivation. Devolution of powers would allow Scottish Government to make decisions and create policies which reflect what’s happening in Scotland and what’s needed to tackle this.

8. What could Scotland learn from the approach taken to tackle drug misuse in other countries? Options to consider that are implemented elsewhere:
- Improved harmonised monitoring of and timely reaction to emerging drug trends and associated health harm
- Supervised drug consumption facilities
- Increased support for people with non-opioid problematic drug use
- Improved access to residential rehabilitation

Safer injecting rooms – allowing testing centres – decriminalising drugs to allow their produce and distribution to be controlled and therefore safer.

We often hear about approaches taken from other countries to tackle drug misuse and whilst often talked about and highlighted, approaches are not adopted. Policy needs to be changed to reflect current needs, rather than continuing with policies that are known to be outdated or not fit for purpose.

April 2019
1. **What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?**

It is likely that there are no ‘unique drivers’ as such – as increased drug-related harm is currently a national and international concern. However, Scotland historically has a worse record with regards to all social circumstances, health and well-being outcomes compared to the rest of the United Kingdom, and this will be reflected in drug-related harm also. More specifically, issues relating to poverty and deprivation, high levels of vulnerability in terms of childhood and prolonged trauma and mental health, and high levels of domestic abuse are some drivers that could have an impact.

2. **To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?**

The constraints of UK-wide drugs legislation results in Scotland being less able to react dynamically to emerging threats and potential solutions that may be a particular priority to the population in Scotland compared to elsewhere in the United Kingdom. For example, the ability to test the impact of injecting rooms on a wider scale could be a positive measure in Scotland.

3. **What is the relationship between poverty and deprivation and problem drug use? What role could reserved social security policy play in addressing problem drug use?**

Poverty and deprivation are intrinsically linked to poor mental health and problematic drug use. They are also a factor in abusive and violent relationships which affect many women drug users. 73% of people who died as a direct consequence of drugs in Tayside in 2017 lived in areas that were in the two most deprived SIMD quintiles.¹ People who develop problematic drug use and die as a result of drugs frequently experience multiple adverse events in childhood and adulthood and often have concurrent mental health issues. 74% of drug death casualties in Tayside in 2017 were known to have a co-existing mental health condition at the time of their death, most commonly depression (58%) and or anxiety (48%).

We also know that poverty and deprivation affect people’s aspiration and the personal drive requires to recover from drug misuse.

The issue of the cyclical nature of adverse childhood experiences (ACE) should also be considered in this context. We know that many individuals affected by drug misuse have been subject to adverse early childhood experiences which continue to impact of their ability to recover.

4. **What role could reserved social security policy play in addressing problem drug use?**

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¹ Drug Deaths in Tayside, Scotland. 2017 Annual Report
https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1&dDocName=prod_310127
The best approach to this policy would be to devolve it to the Scottish Government and enable it to introduce specific measures that will be more supportive to the process of recovery from drug misuse. Universal credit often pose a real barrier to individuals who live chaotic and challenging lives.

5. **How is the drugs market in Scotland changing? How well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”. Are any changes needed to the current regulatory landscape?**

Drugs market internationally are changing and this is, in part, driving the increased drug-related harm in Scotland. For example, the 2018 European Drug Report\(^2\) describes the increased production of cocaine in central and South America resulting in increased cocaine-related harm across Europe – Scotland, in this context is no different. The number of drug deaths where cocaine is involved has increased in recent years.\(^3,4\)

Furthermore, a greater variety of substances are available (due to increases in the number of new psychoactive substances in recent years), and there is greater availability of diverted prescription medications such as gabapentinoids due to increases in gabapentinoid prescribing. Substances are therefore more available and affordable.

In addition, substances are more easily accessible due to home production, for example in the case of etizolam, and through the internet (both the ‘normal’ web and the dark web). The person with problematic drug use must be supported and drug-taking seen as a public health concern and not a criminal concern. However, as in the Psychoactive Substances Act, there must still be a drive to restrict supply of substances and curtailing supply through the internet has to be a key priority in this area to address.

6. **Are there other areas of reserved policy which is influencing the Scottish Government’s ability to address drugs misuse in Scotland?**

Increasing drug related harm is a significant public health concern for the population of Scotland. The Scottish Government must be able to react quickly, specifically and appropriately to implement all evidence-based measures to address this public health priority.

7. **How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland? Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?**

It is imperative that best practice, information and policy outcomes is shared across all partner agencies, localities, regions and nations both within the United Kingdom and abroad. This is done sub-optimally at all levels currently. We believe there is much room for improvement, including the sharing of areas where approaches haven’t worked and proposals for improvement.

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8. **Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland’s needs?**

Inevitably yes, for the aforementioned reasons. However, should further powers be devolved, the Scottish Government has to ensure that, in addition to setting up its own policies and approach, appropriate resources are allocated to address drug misuse from a wider, holistic perspective (including addressing the underlying cases of substance misuse) in order to maximise any health and social gains from legislative change.

9. **What could Scotland learn from the approach taken to tackle drug misuse in other countries?**

Options to consider that are implemented elsewhere:

- Improved harmonised monitoring of and timely reaction to emerging drug trends and associated health harm\(^5\)
- Supervised drug consumption facilities\(^6\)
- Increased support for people with non-opioid problematic drug use\(^6\)
- Increase focus on recovery by addressing the underlying causes (including greater focus on housing and employability)
- Improved access to residential rehabilitation\(^6\)
- There are also a number of Whole family Approaches progressed by organisations including Children 1st, Aberlour and Local Authorities’ Children& Families Services (including Dundee) that offer a joint response to the needs of children and parents and aims to keep families together.

April 2019


Glasgow City Alcohol and Drug Partnership (ADP) is a multi-agency group tasked by the Scottish Government with tackling alcohol and drug issues through partnership working. The ADP also fulfils the formal role of a Strategic Planning Group of the Glasgow City Health and Social Care Partnership (GCHSCP).

Membership includes Glasgow City Council, NHS Greater Glasgow and Clyde, Police Scotland, Scottish Fire and Rescue and Voluntary Sector Alcohol and Drug Agencies and three people with ‘lived experience’ and two family representatives. The ADP Strategic Group is chaired by Susanne Millar, Chief Officer Strategy & Operations/Chief Social Work Officer of the Health and Social Care Partnership.

Glasgow City ADP welcomes the opportunity to provide written evidence. This focuses on Scotland’s largest city, our challenges and our efforts to implement new innovative solutions in the form of Heroin Assisted Treatment and Safer Drug Consumption Facilities.

Executive Summary

- Scotland has a drug-related death rate 4 times that of England and Wales (see 1.4)
- Glasgow City is due to open a new ‘Heroin Assisted Treatment’ service in the autumn
- Glasgow City intends to open a Safer Drug Consumption Facility when legally permitted to do so.

1. What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?

1.1 The ISD report published in March 2019 estimated the number of individuals with problem drug use in Scotland ranged between 55,800 to 58,900. This represented an estimated prevalence rate among the population of approximately 1.62%. (1)

1.2 The report estimated that the number of individual experiencing problematic drug use in Glasgow was between 11,100 and 12,800; this represented 21.7% of the Scotland’s problematic drug users. The prevalence rate for Glasgow is 2.76%. (1)

1.3 This links in with drug deaths, showing that in Scotland in 2017 there were 934 Drug-related deaths, an increase of 8%. In Glasgow city there were 192 (a 12.9% increase on 2016) drug-related deaths which was the highest number ever recorded in the city. (2)
1.4 In England and Wales, there were 2,495 deaths registered in 2017. This equates to a mortality rate of 42.7 per million across England and Wales. By comparison the mortality rate in Scotland was 172.2 per million. (3)

1.5 During 2015, there was a substantial increase in new cases of HIV among people who inject drugs in Glasgow city. For twenty years the number of cases annually of HIV as a result of injecting drug use ranged from 1 to 10. In 2015 there was a dramatic increase to 48 cases. The outbreak is still ongoing with over 140 diagnoses to April 2019. (4)

1.6 During interviews with those affected by the outbreak, 83% reported injecting drugs in public places, such as alleyways, car parks, parkland, public toilets, and closes (communal entrances). These places may be chosen to provide shelter from the elements or access to water needed for injection. Privacy is also a big concern, with several of those interviewed saying they didn’t want the general public – particularly children – to witness them injecting. A rise in cocaine injecting in this population was also identified.

1.7 Data also suggests that between 400 and 500 people may be injecting drugs in public places in the city centre on a regular basis.

Research has identified four main health needs for people who inject drugs in public places:

- Addictions care and treatment
- Reducing the risk of blood-borne viruses, such as HIV and hepatitis
- Reducing the risk of other injecting-related infections and injuries such as abscesses, wounds, and blood clots
- Reducing the risk of overdose and drug-related death.

1.8 Despite ongoing efforts to address public injecting, it continues to cause significant health problems, as well as having a detrimental impact on the surrounding environment, communities and businesses. It is therefore evident that a new approach to public injecting is required.

1.9 The case for the two new proposed services has been developed in recent years and has been supported by the Glasgow City ADP and GCHSCP. The recommendations for Heroin Assisted Treatment and a Safer Drug Consumption Facility were developed under the headings of public health, recovery, Glasgow city communities and the economic case. (5)

1.10 The public health case for piloting the recommended services remains highly relevant. Glasgow city drug users have also experienced other injecting-related outbreaks in recent years such as Anthrax and Botulism and they remain at risk of future outbreaks. In addition, drug related deaths in Glasgow city have risen sharply in 2015 and 2016 and hospital admission rates for drug users have been rising in recent years. The profile of the public injecting population fits closely with those at most risk of drug related death and hospital admissions.

1.11 The proposed services will address public health needs by:

- Reducing the risk of blood-borne virus transmission and improving care outcomes for those already affected
- Reducing the number of injecting-related infections and injuries
- Reducing the risk of overdose and opioid-related death
- Addictions care and treatment for people who inject drugs in public places in Glasgow city centre
1.12 The Recovery system of care is well-developed for drug users, however data suggests that the city centre public injecting population do not seem to benefit. The population is characterised by severe and multiple disadvantage and present with complex needs, including homelessness, welfare issues, mental health problems, wider medical problems and frequent contact with the criminal justice/police services.

The proposed services have the potential to improve the recovery opportunities of this population by providing routes into early recovery for city centre drug users.

1.13 Glasgow city centre is a vibrant business and residential environment, however injecting, drug related litter and associated public nuisance has a detrimental effect on people living, visiting and working in the city centre.

The proposed services have the potential to have a positive impact on the city centre by:

- Improving the public amenity of the city centre
- Reducing the impact of public injecting on local residents and businesses.

1.14 There is a strong economic case as local data tells us that the costs to the health service associated with public injecting and its effects are significant. In Glasgow city, an exercise was undertaken to estimate service utilisation by people injecting in public places.

1.15 Between 2014 and 2016, 652 people were engaged with, including 350 injecting drug users for whom care data is available. This showed:

- 1587 Emergency Department attendances - a total resource use of over £200k
- 3743 acute inpatient bed days with a total resource use of over £1.5m
- 19 day case admissions with a total resource use of £9600
- Total resource use for all activity in acute hospitals totalled over £1.7m

1.16 One recent study estimated the average lifetime cost of HIV infection to be £360,000 per person. If this cost was applicable to the 78 new HIV cases in people who inject drugs in Glasgow for 2015 and 2016, this would translate to a lifetime cost of £28,080,000.

1.17 In NHSGGC, the average ‘medication only’ cost per patient receiving HIV treatment is £6,403 per year. For 78 cases, this would translate to an annual cost of £500k.

1.18 The balance of evidence from other cities suggests that safer drug consumption facilities are highly cost-effective and contribute to savings in health systems. Heroin assisted treatment has been shown to be more cost effective than oral methadone for the target population. By reducing the use of unscheduled care and crisis services, reducing in blood borne virus spread, reducing drug related offending, investment in a safer drug consumption facility and heroin assisted treatment services has the potential save public funds. (6)

2. To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?

2.1 Health is devolved to the Scottish Government. In Scotland, drug strategy comes under the auspices of the Health department. However the underpinning medicines and controlled drug legislation, including the Misuse of Drugs Regulations 2001 are reserved to the UK
parliament. Therefore key required levers to enable the full implementation of a public health based drug strategy are not available to Scottish and local government. This has inevitably hampered the development of an appropriate local response to identified public health needs in Scotland and in Glasgow.

2.2 In order to implement alternative approaches such as a safer drug consumption facility, and in order to render such a facility lawful, it may be necessary to obtain exemptions from specific sections of the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001. The question of whether or not to amend the regulations, or to give the Scottish Government power to amend regulations, in order to support the proposed SDCF would accordingly be a matter for the UK Government.

2.3 Glasgow city recognise that exemptions from offences under the 1971 Act would not on their own be sufficient – that exemptions from other laws including common law offences may also be required.

2.4 Proposals to implement a safer drug consumption facility have received approval at several levels in Scotland. Glasgow City ADP, Glasgow City HSCP IJB, Glasgow City Council and the Scottish Parliament support the proposals. Progress has been hindered by the absence of a legal framework in which to operate and the refusal of support by the UK Home Office.

3. What is the relationship between poverty and deprivation and problem drug use?

3.1 Poverty and relative deprivation are important drivers of health inequality; problem drug use is strongly associated with deprivation. Drug related harms are most noted in deciles 1 and 2. Work comparing mortality in Glasgow, Liverpool and Manchester has demonstrated an ‘excess’ of mortality in Glasgow city compared with the other cities. This ‘excess mortality’ cannot be explained by current indices of deprivation and is the focus of a major ongoing research programme. (6)

3.2 Life expectancy analysis shows that male life expectancy in the most deprived Glasgow city decile remained around 62 years, and did not improve from the mid-1990s until the mid-2000s. Male life expectancy at birth in the most deprived quintile did not rise and may even have reduced slightly between the early 1980s and 2000 – in the period 1981-85 the estimate of male life expectancy for the most deprived quintile was 65.3 years, while 20 years later in 1998-2002 this had dropped to 64.4 years. (6)

4. What role could reserved social security policy play in addressing problem drug use?

4.1 Relative poverty rates are higher in Glasgow city than in Scotland as a whole. Austerity measures in general, and the current implementation and extensions to welfare reform, are likely to exacerbate poverty locally and nationally. Further rises in relative and absolute measures of income related poverty are predicted across the UK. In Scotland, income-related poverty rates affecting children are predicted to rise sharply and increases in poverty are predicted for both working-age parents and non-parents. Poor households with children and poor working-age households are expected to be most affected by tax and benefit reforms. (6)
4.2 The UK Welfare Reform Act (2012) introduced sweeping and fundamental change to the welfare system. Key changes include the introduction of universal credit to replace a number of existing benefits including housing benefit and tax credits for people of working age. A benefit cap was also introduced limiting benefit payments to households based on the median earnings after tax for working households.

4.3 In 2012 it was anticipated that the welfare reforms will take more than £1.6 billion a year out of the Scottish economy. This is equivalent to approximately £480 a year for every adult of working age. Glasgow city faces the biggest loss; its residents can expect to lose in the region of £270m a year in benefit income, equivalent to £650 a year for every adult of working age in the city.

5. How is the drugs market in Scotland changing? How well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”. Are any changes needed to the current regulatory landscape?

5.1 The Drugs market is increasingly dynamic with a rapid growth in new psychoactive substances as well as new routes to market through the internet, dark web and social media. Concerning new drug trends include an increase in the prevalence and potency of many drugs in the market including cannabis, cocaine and benzodiazepine-type drugs alongside an increase in poly-substance use.

5.2 The internet and digital communication have significantly changed the drugs supply chain, from use of the internet and the dark web by bulk manufactures to the use of mobile phone technology by local suppliers. It has contributed to the accelerated pace of development and distribution of new substances and allowed markets to be reached beyond traditional geographic and socio-economic boundaries. This has required changes to how drug markets are controlled, particularly when UK legislation cannot be applied.

5.3 It is possible that they will disrupt traditional drug markets in the same way as online markets have disrupted the traditional markets for some legitimate commodities. For this reason, the systematic monitoring and assessment of the anonymous online ecosystem in the context of the overall drug market is necessary to support analysis to inform future policy and operational responses and to reduce the health and security threats.

6. Are there other areas of reserved policy which is influencing the Scottish Government’s ability to address drugs misuse in Scotland?

6.1 Glasgow city’s most pressing, over-arching problem is the scale and range of health and social inequality in the city. To a large extent, how inequalities are addressed nationally and locally will determine whether the wide disparities in social circumstances, opportunity and health across our population are reduce. The limited powers at the disposal of the local authorities do not provide sufficient tools for them to significantly impact on the root causes of poverty and inequality. Action from the UK and Scottish Government is also needed.

6.2 The UK government’s commitment to austerity measures, including their ‘welfare reform' policies is predicted to lead to higher levels of poverty.

7. How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland? Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?
7.1 Divergence is becoming evident between the Westminster criminal justice based approach and the Scottish public health and human rights approach to drug strategy. It is therefore difficult to make comparisons and to share best practice within different policy landscapes. Scotland and Glasgow specifically is being hampered from implementing evidence based policies in response to identified local need by legislation that is reserved to the UK parliament. A pilot of a supervised drug consumption facility would not only allow the city to respond to a pressing local need but the evaluation would provide evidence to potentially inform future developments for the rest of the UK.

7.2 The Scottish Government’s Programme for Government 2018 is supportive of proposals of which are in line with a human rights-based and public health-led approach. Controlled Drug legislation is currently reserved to the Westminster Parliament, and the Scottish Government will continue to press the UK Government to make the necessary changes in the law, or if they are not willing to do so, to devolve the powers in this area so that the Scottish Parliament has an opportunity to implement this life-saving strategy in full. (8)

8. Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland's needs?

8.1 Arguably, the devolved administration in Scotland does not yet have sufficient fiscal control over taxation and the benefits system to address income inequalities, but has been placing increasing emphasis on tackling health and social inequalities through initiatives such as Equally Well, the Keep Well programme, and it’s Ministerial Taskforce on Health Inequalities. The recent report from the Independent Adviser on Poverty has added a renewed call for action on specified priority areas including in-work poverty, the life chances of young people, housing affordability, as well as recommending a more progressive system of local taxation. (6)

8.2 The key messages in the Ministerial Task Force on Health Inequalities were that actions were required to address the fundamental drivers of social inequality, wider environmental influences and individual experiences. The review emphasised the need to prioritise a preventive approach and the requirement for political commitment and leadership at national and local levels. (6)

9. What could Scotland learn from the approach taken to tackle drug misuse in other countries?

9.1 Safer injecting facilities have been running since the 1980s with more than 90 worldwide. More than 100 scientific papers evaluating their impacts have been published showing:

- Reduction in public injecting and discarded needles
- Reduction in the sharing of needles and other injecting equipment
- Improved uptake of addictions care and treatment
- No increase rates of crime and anti-social behaviour
- Cost savings overall, due to reduced ill-health and health care usage.

9.2 Heroin-assisted treatment is already provided in a number of European countries and in a small number of specialist services in the UK.

A number of high-quality research studies in the UK and elsewhere have found:
• Improvement in people’s ability to engage/stay engaged with – addictions treatment
• Reduced criminal activity
• Improvement in integration into society – i.e. the ability to hold down a job or stable housing
• Better value for money because of the reduced demands on social care services and the criminal justice system. (5)

10. **Recommendations by Glasgow City ADP for action by the Government or others which you would like the committee to consider.**

• The UK Government should welcome the opening of a Heroin Assisted Treatment service in Glasgow city
• The UK Government should urgently amend or devolve the relevant legislation to enable the implementation of a pilot Safer Drug Consumption Facility in Glasgow city
• The UK Government should recognise the impact of wider social policy on deprivation, poverty and drug misuse

**Sources**

1. ‘Prevalence of Problem Drug Use’ ISD 2019
3. ‘Deaths related to drug poisoning in England and Wales: 2017 registrations’: The Office for National Statistics (ONS)
4. ‘Taking away the chaos’ The health needs of people who inject drugs in public places in Glasgow city centre: NHS Greater Glasgow and Clyde 2016
5. Glasgow Health and Social Care Partnership Integration Joint Board paper no.13 ‘Safer Drug Consumption Facilities and Heroin Assisted Treatment’ 15 02 2017
7. ‘The rise of in-work poverty and the changing nature of poverty and work in Scotland: what are the implications for population health?’ Glasgow Centre for Population Health: March 2013
8. ‘Rights, Respect and Recovery’ Scottish Government 2018
9. ‘Drugs and the darknet’:perspectives for enforcement, research and policy: EMCDDA/ Europol: Nov 2017

April 2019
Turning Point Scotland works with adults who are experiencing a range of support needs in relation to problematic drug and/or alcohol use, involvement in the criminal justice system, homelessness and mental ill-health. We work from the belief that people matter, that they are the experts on their support needs and that it is for us to work creatively with them and with partners to ensure that those needs are met.

We play a significant role in the delivery of treatment and recovery services across Scotland. Our range of services in Glasgow offer people a pathway from crisis, through residential rehabilitation and on into moving-on support. In Edinburgh we provide recovery focused support as part of the North East Recovery Hub and we are one of the main third sector providers working across Aberdeenshire. We have developed innovative approaches to support that integrates work around problematic drug and alcohol use with homelessness services (Housing First, Glasgow Homelessness Service) and with criminal and community justice services (218, Turnaround, Low Moss PSP Throughcare Service).

We welcome the opportunity to support the Committee in this inquiry.
1. What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?

1.1 The Scottish Government identified at least three broad categories of drug users for policy purposes – experimenters, regular users and problem users. Our work focuses on this third group; we are most interested in the drivers of problematic drug use.

1.2 There are a wide range of biological and social factors that influence whether or not drug use becomes problematic. Drivers are not unique to Scotland, but they appear to manifest and impact in a way that is different to the rest of the UK.

1.3 Drug use may be a response to physical or psychological trauma at any stage of life, although the significance of Adverse Childhood Experiences (ACEs) is increasingly acknowledged. “Adults who experienced four or more adversities in their childhood, were ... eleven times more likely to have used crack cocaine or heroin.”

1.4 People need access to good, evidence based education and information that enables them to make informed choices; our ability to do this is limited by the illicit nature of drugs and the stigma that surrounds them and the people who use them. This also presents a barrier to people seeking and accessing advice, support and treatment.

1.5 These are missed opportunities for prevention and early intervention that drive further and more problematic drug use. Despite strong efforts, we miss further opportunities by not responding quickly or effectively enough when people do try and access treatment and support. The latest figures on drug and alcohol waiting times in Scotland show an increase in the number of people waiting longer than six weeks to access treatment (14.3%, up from 9.4% in the previous quarter). At a service delivery level, we have seen funding concentrated on community day programmes while inpatient detox or rehab places are cut, reducing the range of treatment options available and limiting our ability to respond to people in crisis. Anecdotal evidence from Edinburgh shows an increase in families paying for private rehab places to enable loved ones to be admitted to a safe place quickly.

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https://www.gov.scot/publications/rights-respect-recovery/

1.6 Drug use itself is a key driver for so many other things; homelessness, poverty, inequality, involvement in the criminal justice system are all drivers of and driven by drug use and problematic drug use, and all combine to compound the effect of each issue. Our own analysis of the presenting issues reported by people accessing our support services shows the range of drivers at work\(^5\). The top ten issues reported were:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Presenting Issue</th>
<th>Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Drug Use: Non Injecting</td>
<td>1684 (57.0%)</td>
</tr>
<tr>
<td>2</td>
<td>Alcohol Use</td>
<td>1260 (42.7%)</td>
</tr>
<tr>
<td>3</td>
<td>Mental Health</td>
<td>1062 (36.0%)</td>
</tr>
<tr>
<td>4</td>
<td>Drug Use: Injecting</td>
<td>824 (27.9%)</td>
</tr>
<tr>
<td>5</td>
<td>Poly Drug Use</td>
<td>707 (23.9%)</td>
</tr>
<tr>
<td>6</td>
<td>Overdose/Risk of Overdose</td>
<td>676 (22.9%)</td>
</tr>
<tr>
<td>7</td>
<td>Medical/Physical Health</td>
<td>594 (20.1%)</td>
</tr>
<tr>
<td>8</td>
<td>Accommodation/Housing</td>
<td>486 (16.5%)</td>
</tr>
<tr>
<td>9</td>
<td>Hopelessness</td>
<td>444 (15.0%)</td>
</tr>
<tr>
<td>10</td>
<td>Legal/Criminal</td>
<td>437 (14.8%)</td>
</tr>
</tbody>
</table>

1.7 When substance use categories are excluded, the other issues affecting people are:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Presenting Issue</th>
<th>Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental Health</td>
<td>1062 (36.0%)</td>
</tr>
<tr>
<td>2</td>
<td>Medical/Physical Health</td>
<td>594 (20.1%)</td>
</tr>
<tr>
<td>3</td>
<td>Accommodation/Housing</td>
<td>486 (16.5%)</td>
</tr>
<tr>
<td>4</td>
<td>Hopelessness</td>
<td>444 (15.0%)</td>
</tr>
<tr>
<td>5</td>
<td>Legal/Criminal</td>
<td>437 (14.8%)</td>
</tr>
<tr>
<td>6</td>
<td>Social Functioning</td>
<td>426 (14.4%)</td>
</tr>
<tr>
<td>7</td>
<td>Homelessness</td>
<td>352 (11.9%)</td>
</tr>
<tr>
<td>8</td>
<td>Blood Borne Virus</td>
<td>333 (11.3%)</td>
</tr>
<tr>
<td>9</td>
<td>Self-Neglect</td>
<td>250 (8.5%)</td>
</tr>
<tr>
<td>10</td>
<td>Unemployment</td>
<td>187 (6.3%)</td>
</tr>
</tbody>
</table>

1.8 McCauley et al’s analysis of the recent HIV outbreak in Glasgow illustrates the range of factors driving problematic drug use that is in itself a driver of a major public health issue; “Glasgow has experienced a rapid rise in prevalence of HIV among its PWID population, associated with homelessness, incarceration, and a major shift to injection of cocaine.”\(^6\)

1.9 The Scottish Crime and Justice Survey 2017-18 illustrates the role played by deprivation and of crime as drivers of drug use. It showed that respondents from the 15% most

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\(^5\) Presenting issues recorded for people referred into each of our four substance misuse services between 1st January 2016 and 31st December 2018 – the Glasgow Drug Crisis Centre, North East Edinburgh Recovery Service (Community based support – urban), Aberdeenshire Community Recovery Service (Community based support – rural) and Turnaround (a criminal justice service covering 12 local authority areas).

\(^6\) [https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(19)30036-0/fulltext](https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(19)30036-0/fulltext)
deprived areas of Scotland are more likely to use drugs (10.4% reported that they had used drugs in the last 12 months, compared to 6.9% in the rest of Scotland). It also showed that drug use is higher among people who have been a victim of a crime (14.2% of people who identified themselves as having been a victim of a crime had used drugs in the last year, compared with 6.4% of those who did not identify themselves in this way).

1.10 One of the main ways that problematic drug use is different in Scotland than in the rest of the UK is the impact it has; as well as being the result of all the drivers already discussed we must also consider problematic drug use itself as a driver of other associated issues. We know that Scotland generally has poorer health outcomes than other areas of the UK and that Glasgow in particular fares significantly worse when compared to English cities of similar social and economic history (Manchester and Liverpool).

“It accounts for approximately 5,000 extra, ‘unexplained’, deaths per year in Scotland, and makes a substantial contribution to the other principal mortality ‘phenomena’ associated with Scotland in recent times: the lowest, and most slowly improving, life expectancy in Western Europe; the widest mortality inequalities in Western Europe; and the persistently high rates of mortality among those of younger working ages. After adjustment for differences in deprivation, premature mortality (<65 years) in Scotland is 20% higher than in England & Wales (10% higher for deaths at all ages); similarly, the excess for Glasgow compared with Liverpool, Manchester and Belfast has been shown to be approximately 30% for premature mortality, and around 15% for deaths at all ages.”

1.11 While the rest of the UK has seen a decline in HIV infection rates, Scotland has seen an increase; there were 228 newly diagnosed cases of HIV reported in Scotland in 2017, an increase of 15% since 2016, when the UK as a whole has seen a 17% decline in the same period.

Although the number of drug related deaths is rising across the UK, it is

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8 Ibid.

9 Glasgow Centre for Population Health (2011) Accounting for Scotland’s Excess Mortality: Towards a Synthesis
https://www.gcp.h.co.uk/assets/0000/1080/GLA147851_Hypothesis_Report__2_.pdf

10 Walsh et al. (2016) History, politics and vulnerability: explaining excess mortality in Scotland and Glasgow
Pg. 73
https://www.gcp.h.co.uk/assets/0000/5988/Excess_mortality_final_report_with_appendices.pdf

11 Ibid. Pg. 7


13 Public Health England (2018) Progress towards ending the HIV epidemic in the United Kingdom Pg. 18
rising at a much sharper rate in Scotland. The following extract is taken from page 47 of the official statistics on drug-related deaths in Scotland in 2017\(^\text{14}\) (emphasis added):

“So, the UK had a total of 3,299 drug-related/’misuse’ deaths (at all ages) registered in 2015, of which around 21% were registered in Scotland. As Scotland accounts for only about 8% of the population of the UK, Scotland’s drug-death rate (per head of population) appeared to be very roughly two and a half times that of the UK as a whole. The relevant calculations (which use the figures for all ages, not just for 15-64 year olds) are:

- **Scotland:**
  - 706 drug-related deaths registered in 2015;
  - population of 5,373,000 at mid-2015;
  - hence 131 drug-related deaths per million population in 2015;

- **UK as a whole:**
  - 3,299 drug-related/’misuse’ deaths registered in 2015;
  - population of 65,110,000 at mid-2015;
  - hence 51 drug-related/’misuse’ deaths per million population in 2015;
  - So the Scottish figure of 131 per million is very roughly two and a half times the figure for the UK as a whole of 51 per million.”

1.12 We are working within a profoundly complex set of issues that manifests differently in Scotland than in the rest of the UK. Our ability to tackle drug related deaths, the rise in new HIV infections and our general mortality rate is strongly connected to our ability to tackle problematic drug use. We must be allowed and supported to respond to changing patterns and types of drug use and to explore approaches that could work for us, here.

2. To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?

2.1 Many of the identified drivers are within the Scottish Government’s control. The way in which we respond to trauma, particularly Adverse Childhood Experiences,

\[^{14}\text{National Records of Scotland (2018) Drug-related deaths in Scotland 2017 Pg. 47}\]

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ensuring that all services are trauma informed, easily accessible and responsive, and taking a coordinated approach to tackling connected issues such as homelessness and mental ill health; these are all largely managed through devolved powers and we are seeing strong and positive action at the policy level to identify new, evidence based and creative approaches.

2.2 However, the UK-wide drugs legislation has been shown to prevent the exploration of innovative approaches.

2.3 The Glasgow Health & Social Care Partnership have set out a strong business case for the introduction of a safer consumption facility and heroin assisted treatment in Glasgow. Their proposal takes forward two of the main recommendations of a health needs assessment for people who inject drugs in public places in Glasgow. This was carried out in response to the sharp rise in the number of drug related deaths in the city and to the significant HIV outbreak, itself the latest of several outbreaks of serious infectious disease among people who inject drugs in Glasgow, including botulism and anthrax. Both the business case and the preceding health needs assessment were based on local data, a review of research evidence and stakeholder feedback from people with lived and living experience of injecting drug use and staff from relevant health and social services.

2.4 There is substantial evidence to show that this is an effective and efficient response to the identified health needs. The EMCDDA summarises this evidence: “... the benefits of providing supervised drug consumption facilities may include improvements in safe, hygienic drug use, especially among regular clients, increased access to health and social services, and reduced public drug use and associated nuisance. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting. These services facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime.” The following statement was made in an article focused on the lessons to be learned from the facility in Sydney, opened in 2001 – “In the more than 18 years since it opened, there have been more than one million injections supervised. In that time there has been 8000 overdoses – but there has not been one single death.”

15 Report by Susanne Millar, Chief Officer, Strategy, Planning and Commissioning / Chief Social Work Officer to Glasgow City Integration Joint Board (October 2016) Safer Consumption Facility and Treatment Pilot
16 NHS Greater Glasgow & Clyde (2016) Taking Away the Chaos: The health needs of people who inject drugs in public places in Glasgow city centre Pg. 5
17 CATO Institute (2018) Harm Reduction: Shifting from a war on drugs to a war on drug-related deaths
18 Adam Smith Institute (2019) Room for Improvement: How Drug Consumption Rooms Save Lives
19 EMCDDA (2018) Drug Consumption Rooms: an overview of provision and evidence Pg. 6
2.5 The Home Office have not been willing to consider an exemption or an amendment to the Misuse of Drugs Act (1971), although they have accepted the evidence in support of this approach\textsuperscript{21}.

2.6 Beyond this practical example, there are other, more subtle ways in which the legislative framework limits the effectiveness of our approaches in Scotland, but also across the whole of the UK. The illegal nature of drugs prevents open and honest discussion around the issue. It limits our ability to reach people with the high quality, evidence based education and information that enables people to make informed choices. The stigma around drugs and the people who use them creates a barrier that prevents people from accessing or engaging with support and treatment services.

2.7 There does not appear to be any political appetite at the UK level to review whether our legislative framework remains fit for purpose, but this may be what we need. We welcome the Scottish Government’s commitment to build an evidence base on the contribution and limitations of the Misuse of Drugs Act (1971)\textsuperscript{22}. We need a framework that is evidence based, that supports and enables the most effective approach to prevention and treatment and that allows us to respond and adapt to a changing drug market, changing patterns of use and changing health and support needs.

2.8 This question asks about the way UK wide drugs legislation affects the Scottish Government’s ability to address drivers of problematic drug use in Scotland. The committee must also consider how this legal framework affects the Scottish Government’s ability to respond to problematic drug use; to deliver effective harm reduction and treatment services, to encourage and support people in their recovery and, fundamentally, to try and keep people alive.

2.9 Dr. Roy Robertson makes an interesting comparison between the way we think about and respond to the most serious problematic drug use and how we manage other long term health conditions. "In many cases, drug use is a temporary phase and spontaneous recovery is common. For a minority, however, dependency on a drug, or more than one drug, is an enduring condition with ongoing and cumulative risks…We apply that basic principle, of preventing the most damaging consequences, to a lot of conditions such as diabetes, dementia or hypertension, where we’re managing symptoms and simply trying to mitigate the bad effects. It’s just that what we are talking about in this case is a condition with an illegal status, and serious stigmatisation. Drug users are marginalised and the most serious drug problems are associated with poverty and deprivation. I think managing addiction is like any chronic disease management, it’s

\textsuperscript{21} https://glasgow.gov.uk/index.aspx?articleid=22874
a condition some people have to live with, and it is something caring services can help with."²³

3. What is the relationship between poverty and deprivation and problem drug use?

3.1 We made reference to the findings of the Scottish Crime and Justice Survey 2017-18, with regards to the higher rate of drug use in deprived areas than in the rest of Scotland, in our response to Question 1. Evidence also tells us that deprivation is linked to a higher rate of health problems related to drug use; hospital admissions in 2015/16 were 14 times higher for people living in the 20% most deprived areas of Scotland than they were for those in the least deprived quintile²⁴. “In the most recent data, around half of

²⁴ SPICe Briefing (2017) Drug Misuse Pg. 14
patients with either a general acute or psychiatric stay in relation to drug misuse lived in the 20% most deprived areas in Scotland\textsuperscript{25}.

3.2 Our own analysis of referrals to our services showed that 81% of people referred to us live in an area that can be matched to the Scottish Index of Multiple Deprivation (SIMD), with a quarter coming from the top 5% most deprived areas in Scotland\textsuperscript{26}. The SIMD uses thirty-eight indicators of deprivation grouped into seven domains; although there is some regional variation, the largest proportion of referrals are for people living in the top 5% most deprived areas in relation to crime, education, employment, health, housing and income\textsuperscript{27}.

3.3 Although there are strong links between poverty, deprivation and drug use, these links are complex; it is important to remember that not everyone who is deprived or living in a deprived area develops problematic drug use. The four main factors that appear to drive these links are\textsuperscript{28}:

- Weak family and social bonds
- Psychological discomfort/personal distress
- Low employment opportunities
- Few community resources

3.4 The drivers listed here are clearly about so much more than income, but income, fairness and the role played by our social security system are key elements to tackling health and all other inequalities in Scotland.

“\textit{The existence of health inequalities in Scotland indicates that the right to health is not enjoyed equally. To address this we need to tackle/overcome the fundamental causes of health inequalities, prevent the impact that they have on the wider environment and reduce the effects they have on the individual life experience. This means that to be healthier, Scotland needs to be fairer. And it works the other way too. If Scotland is fairer, it will become healthier as more people are able to reap the health benefits associated with a fairer distribution of wealth, income and power.}”\textsuperscript{29}

\textsuperscript{25} Ibid. Pg. 15
\textsuperscript{26} Referrals to each of our four substance misuse services between 1st January 2016 and 31st December 2018 – the Glasgow Drug Crisis Centre, North East Edinburgh Recovery Service (Community based support – urban), Aberdeenshire Community Recovery Service (Community based support – rural) and Turnaround (a criminal justice service covering 12 local authority areas). There were 5140 referrals across these services included in the extract. Of these records, 4213 could be matched via post code to a data zone in the SIMD. This means that 81% of records could be matched to the SIMD.
\textsuperscript{27} Access is the one domain where the majority of people that we work with are from areas with a low degree of deprivation, because most of the people referred to our services are from areas classified as urban. This remains true in more rural localities like Aberdeenshire, although this area does have a greater proportion of referrals from areas in the top 10% most deprived in relation to access, reflecting the greater degree of rurality.
\textsuperscript{28} SPICe Briefing (2017) Drug Misuse Pg. 15
\textsuperscript{29} NHS Health Scotland (2016) Human Rights and the Right to Health Pg. 7
“...economic policies matter for population health. Widening inequalities in health are a consequence of more general widening inequalities across society, most notably measured in terms of income inequalities....making the reduction of income and wealth inequalities the central objective of economic policy is important. It is increasingly recognised that more equal distribution of income and wealth leads to wealthier, healthier, more resilient and democratic economies (even amongst bodies previously advocating a growth-first approach such as the Organisation for Economic Co-operation and Development (OECD) and the International Monetary Fund (IMF)).”

4. What role could reserved social security policy play in addressing problem drug use?

4.1 The social security system has a clear role to play in addressing financial poverty, one of the many drivers of problematic drug use. The Joseph Rowntree Foundation recommends that we reform Universal Credit to make it a poverty reduction tool, we prevent destitution and we ensure that benefit payments keep up with the cost of essentials in order to deliver a social security system that is effective and makes work pay. Our services report that the current waiting period for Universal Credit all but forces people into a debt that further traps them in the situation they are trying to move away from. We are seeing an increase in requests for food vouchers, food banks and a longer term reliance on what should be an emergency use.

30 Walsh et al. (2016) History, politics and vulnerability: explaining excess mortality in Scotland and Glasgow Pg. 76
https://www.gcph.co.uk/assets/0000/5587/Excess_mortality_-_Policy_recommendations.pdf
31 Joseph Rowntree Foundation (2016) We Can Solve Poverty in the UK Pg. 27
https://www.jrf.org.uk/report/we-can-solve-poverty-uk
4.2 A report by the Glasgow Centre for Population Health, NHS Health Scotland, the University of the West of Scotland and University College London on excess mortality in Scotland and Glasgow made a series of policy recommendations that relate to a range of areas, including our social security system.

“the social security system must ensure that all in society have sufficient income, and provide the basis from which people can develop their skills and provide for the needs of their families. This would involve increased levels of protection and less conditionality, such as would be the case with a Citizen’s Income. It will be important to use all opportunities offered by the partial devolution of benefits in the Scotland Act 2016, and to build on existing mitigation (e.g. on housing benefit changes), to protect geographical, equality group, and socioeconomic populations at greatest risk. If possible, this should include reversing the effects of UK government cuts and reforms (e.g. to tax credits, incapacity benefits, housing benefit and child benefits), thereby ensuring the provision of a more effective ‘safety net’ for the most vulnerable in society. In addition, there may be opportunities to change the administration and culture of (aspects) of the system to one that is centred around the needs of claimants.”

4.3 Turning Point Scotland are members of the Scottish Campaign on Welfare Reform. Together with a wide range of organisations that include Child Poverty Action Group Scotland, The Poverty Alliance, One Parent Families Scotland, Oxfam and the Scottish Trades Union Congress, we believe that our social security system should be reformed to reflect the five principles set out in our Manifesto for Change:

1. Increase benefit rates to a level where no one is left in poverty and all have sufficient income to lead a dignified life
2. Make respect for human rights and dignity the cornerstone of a new approach to welfare
3. Radically simplify the welfare system
4. Invest in the support needed to enable everyone to participate fully in society
5. Make welfare benefits work for Scotland

4.4 Specific ways in which the social security system could be improved for the people we support include:

- We need a system that is easier to understand, navigate and engage with – the current system creates confusion and the need for support from highly skilled professionals – this is both disempowering and stigmatising
- People need to know and be able to rely on their income if they are to make appropriate plans and budgets

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32 Walsh et al. (2016) History, politics and vulnerability: explaining excess mortality in Scotland and Glasgow Pg. 76
https://www.gcph.co.uk/assets/0000/5587/Excess_mortality_-Policy_recommendations.pdf
• Support with public transport costs would be a huge help in enabling people to navigate treatment, meet the requirements of the benefits system and to develop and maintain the positive social networks that facilitate and support recovery
• We need a more gradual stepped care approach to individuals in recovery returning to work or accessing further education and training, and a system that supports rather than hinders these steps. The system can be tricky to navigate. To reduce relapse. Initiatives like the Addiction Worker Training Project run by the Scottish Drugs Forum are hugely valuable, delivering an almost 100% success rate supporting people into work. Connections should be made between drug treatment services and the social security system so that resources can be invested in the development and widening of these initiatives to replicate this support in other professions

4.5 When I put this question to a group of people with lived experience of problematic drug and alcohol use, they described a lack of hope, expectation and aspiration across the board – among professionals delivering the social security system, communities, schools, the media and among people relying on the system. This limits what they feel they can do and what they are prepared to work towards, but also limits the ability of the system to help them move forward and the willingness of communities and employers to offer opportunities or to support them in their journey. They saw social security is just one part of a complex structure of support that is all supposed to help people make changes in their lives, but the services are too fragmented, all working in different ways, at different times and with different expectations of what people can/should be doing. It fails to understand the reality of people’s lives – assessments aren’t effective, physical impairments are poorly understood or dealt with and the understanding of mental health issues is even worse. Decisions are made on medical issues by people with no medical training/experience – we don’t make good use of input from medical professionals.

4.6 They made some suggestions on how we could move forward.
• The system has to be for all of us – we pay into it when we can and draw from it when we need to. We all need to believe in it and buy in to it
• Social security shouldn’t be just a financial safety net, the system should be designed and resourced to support us to make changes and move forward – and it shouldn’t stand alone. It has to be integrated into wider treatment, care and support pathways. This would co-ordinate support, ensure that the range of inputs complement each other, make effective use of the resources available and deliver better outcomes across the board
• We need a more personal approach, where professionals spend time with people to understand them, their circumstances, barriers and aspirations and to offer them or signpost them to the support that they need to move forward. We understand that working in this way takes much more time and resources but we believe that it would contribute to better decisions, reduced fraud and error and a more effective
delivery of social security resources. This should be a partnership, not just something done to us

- We need to measure the right things – we should expect people to be able to achieve real outcomes through working with a service, we should only be investing in services and approaches that can prove that they work

4.7 Fundamentally we need a system that is built on a human rights based approach. Our support services have reported that the online application process and the language used by DWP is hostile and inaccessible to people who are some of the most vulnerable in our society and who often have complex needs. There is anecdotal evidence that a large percentage of people dying a drug related death are on benefits; we must explore the ways in which the social security system can help us to tackle problematic drug use and also to reach those who are at most risk.

4.8 This is the approach that the Scottish Government have committed to take in relation to the additional powers devolved under the Scotland Act (2016)\(^\text{33}\) but we believe that the changes we want to see can be delivered in a reserved system if the will is there.

5. How is the drugs market in Scotland changing? How well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”. Are any changes needed to the current regulatory landscape?

“We are facing a potential supply-driven expansion of drug markets, with production of opium and manufacture of cocaine at the highest levels ever recorded. Markets for cocaine and methamphetamine are extending beyond their usual regions and, while drug trafficking online using the darknet continues to represent only a fraction of drug trafficking as a whole, it continues to grow rapidly, despite successes in shutting down popular trading platforms.”\(^\text{34}\)

5.1 Evidence gathered in our treatment and outreach services shows a rise in poly-drug use (particularly heroin, cocaine, benzos and alcohol) and in the use of benzos more generally, which have become cheap and readily available. A decline in the quality of


\(^{34}\) United Nations Office on Drugs and Crime (2018) Global Overview of Drug Demand and Supply: Latest trends, cross-cutting issues Pg. 1
\[\text{https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_2_GLOBAL.pdf}\]
heroin and cocaine becoming cheaper and more available are some of the drivers behind an increase in long-term heroin users, many of whom are on high doses of methadone and have been for some time, injecting cocaine and smoking crack. An analysis of the recent HIV outbreak in Glasgow found that the prevalence of cocaine injecting across the Greater Glasgow & Clyde area rose from 16% in 2011 to 50% in 2018, and from 37% to 77% in Glasgow city centre\(^\text{35}\); this shift was highlighted as one of the drivers behind the rise in new HIV infections.

5.2 This evidence is used to inform the development of our practice and our harm reduction approaches in particular, but we are also able to share this learning with partner agencies, including police, through local coordination bodies.

5.3 The clearest message we see in relation to regulating the changing marketplace is that effective communication, information sharing and a strong partnership approach is key, as is the ability to be flexible, responsive and able to adapt to what we are learning.

6. Are there other areas of reserved policy which is influencing the Scottish Government’s ability to address drugs misuse in Scotland?

6.1 We have already addressed the main areas of reserved policy that impact on the Scottish Government’s abilities in this area, namely the legal framework and the social security system.

6.2 A further, more overarching issue is the stigmatisation of people who are experiencing or who have experienced problematic drug use. The impact of stigma – both real and imagined – is increasingly recognised within public policy:

- The Scottish Government’s Drug and Alcohol Strategy highlights stigma as a significant barrier. “People who experience alcohol or drug problems, either through use or by association, often experience the most stigma in our society. Negative attitudes and stigma from society, from professionals within services, and self-stigmatisation, can be one of the biggest barriers to accessing treatment, community services and other activities. Stigma needs to be challenged across the sector and society.”\(^\text{36}\)

\(^{35}\) https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(19)30036-0/fulltext

• The final report from the Homelessness and Rough Sleeping Action Group included a recommendation that the “Scottish Government should launch, commission or be a partner in a public awareness campaign designed to tackle negative attitudes/stigma about homelessness and homeless people.” They also quoted advice from The Frameworks Institute to tell a ‘systems story’. “Instead of framing homelessness as a problem that affects individuals, emphasize its systemic causes and consequences. Doing so helps the public understand and support systemic solutions to homelessness, such as policies to pay workers living wages and incentivize the creation of affordable housing units.”

• The Scottish Government’s Action Plan in response to these recommendations included commitments to develop a lived experience programme that will help shape and deliver this Action Plan

• Stigma is explicitly acknowledged as an essential element of action around mental health in the vision that underpins the Scottish Government’s Mental Health Strategy. “Our vision for the Mental Health Strategy is of a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma.”

6.3 Anecdotally I have heard three accounts in recent weeks, from different parts of Scotland, where a person’s access to medical treatment and/or support was threatened, limited or denied as a result of (perceived) prejudice on the part of medical professionals, support staff and service delivery practices.

6.4 Tackling stigma does not fall neatly into any one reserved or devolved policy area; it is such a complex issue to tackle, no single action is going to work. We must all challenge ourselves, ask what it is that we can contribute towards making a change in the way we talk about and understand problematic drug use and the people experiencing it. We need to look to our own actions, our own language, our own policies and practices. We should work with people who have lived and living experience so that we can really understand the reality and importance of this issue and can learn from and guided by this experience.

6.5 We would like to see the UK Government, along with all devolved governments, make a clear statement of their commitment to challenge and tackle stigma and to lead by example. One of the most basic actions that we can take is to agree on language and terminology that does not stigmatise, that captures the social dimension of the issue rather than reinforcing ideas of individual weakness, failings or ‘otherness’. Talking about drug abuse or misuse plays on the ‘fault’ of the individual; if we talk instead about

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38 Scottish Government (2017) Mental Health Strategy 2017-2027 Pg. 7  
problematic drug use we are focussing on the problem that can be fixed rather than on the person who has failed. I’ve no doubt that you will see a range of language used in the submissions to this inquiry; the call for evidence itself used a number of different terms to describe the issue at hand. We would recommend that the Committee considers the guidelines produced by the Global Commission on Drugs Policy guidelines to help combat stigma\textsuperscript{39}.

6.6 We need a conversation about the standards we expect of ourselves, as agents working to tackle problematic drug use. Action actually needs to go much further than this to address the way in which problematic drug use and people who are experiencing or who have experienced this are represented in the media. The media plays a huge role in perpetuating and in challenging stigma; the very least we can do is to lead by example, to put a consistent message out there and to continually challenge stigmatising language and misrepresentation. We ask the UK Government to commit to using whatever power and influence it has to encourage change in this area.

7. How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland? Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?

7.1 We do not have direct experience that would allow us to assess how well this relationship works, although recent exchanges suggest that the answer to this question is – not very. We hope that best practice, information and policy outcomes are shared between the UK and Scottish Governments, and also with the devolved governments in Wales and Northern Ireland. We cannot comment on whether this happens or on how effective this exchange is.

7.2 The impression is of a very separate approach to this issue, where this relationship acts as a barrier to actually acting on best practice and information. Recent efforts to trial a safer consumption facility in Glasgow illustrate this barrier.

“We are sympathetic to proposals being pursued by Glasgow City Health and Social Care Partnership to pilot a safer drug consumption facility in the city centre….Drug legislation is currently reserved to the Westminster Parliament and we will continue to press the UK Government to make the necessary changes in the law, and if they are not willing to do so, to devolve the powers in this area so the Scottish Parliament has an opportunity to act and allow the facility to proceed.”\textsuperscript{40}


8. Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland’s needs?

8.1 We support further devolution of powers, not in support of further devolution in principle, but because it would allow us the opportunity to try and to learn from new approaches. At this point in time the existing relationship is acting as a barrier.

8.2 When we have been given the necessary power to do so, we have demonstrated our commitment to innovation. We were the first country in the UK to ban smoking in public places in 2005 and the first to introduce Minimum Unit Pricing in 2018. We have pioneered a creative, holistic and effective approach to tackling deaths from violent crime, another complex and multi-faceted issue that is both a driver of and driven by problematic drug use, that is now being replicated in London.

8.3 The reasons for Scotland’s difference, as outlined in our response to question 1 are complex and not easily addressed, but these differences support the view that we should be empowered to design approaches that will, or could, work for us.

8.4 It is clear that our approach to drug use and problematic use must be more responsive – to a changing demography, to an evolving drug marketplace and new patterns of drug use, to the people that we support, to public health issues and to evidence of best practice as it emerges. There is at least the perception that the Scottish Government is able to move more quickly than Westminster and could therefore be better placed to control the policy levers that dictate our ability to adapt.

8.5 To be clear, we are not calling for devolution for the sake of devolution. What we want is a policy framework that is effective in preventing problematic drug use and in responding when it does occur. A framework that is based on respect for the dignity and human rights of the people at the centre of it all, that is punitive when it has to be but prioritises finding the most effective response and remains focussed on enabling and delivering positive change. The current Scottish Government have demonstrated willingness to be innovative and try new things and have indicated a willingness to trial safer consumption sites; this all suggests that the devolution of further powers is the most likely course towards the policy framework that we need, but we are supportive of whatever arrangements would deliver this aspiration.
9. What could Scotland learn from the approach taken to tackle drug misuse in other countries?

**Lesson from Portugal**\(^{41}\): Accept what isn’t working and be brave in exploring evidence based alternative approaches

9.1 In 2001 Portugal introduced a radical new approach to tackling problematic drug use. The decriminalisation of drugs is probably the highest profile element of this approach but it is important to note that it was introduced alongside significant investment of public funding in treatment, prevention and harm reduction services. It was also set in a framework that introduced a new conceptualisation of drug use and the people who use drugs, demonstrated in the underpinning values. These include:

“‘Humanism’, for example, is the recognition of the inalienable human dignity of citizens, including drug users, and translates into a commitment to offer a wide range of services to those in need and to adopt a legal framework that causes no harm to them. ‘Pragmatism’ calls for the adoption of solutions and interventions that are based on scientific knowledge, while ‘Participation’ calls for the involvement of the community in drug policy definition and implementation.”\(^{42}\)

9.2 It is important to note that drugs were not legalised under this policy. Using or possessing any illicit drug without authorisation remains illegal, what changed was the response; it became an administrative, rather than a criminal, offence. When a person is caught in possession of an illicit drug, without authorisation, and the amount is no more than 10 daily doses (the details are set out in regulations), the drug is seized and the case is referred to the Commission for the Dissuasion of Drug Abuse (CDT). If they are in possession of more than this amount they remain subject to criminal prosecution.

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\(^{41}\) European Monitoring Centre for Drugs and Drug Addiction (2011)

\(^{42}\) Ibid. – Pg. 15
9.3 The CDT consists of a panel of 3 members, usually a legal expert, a health professional and a social worker, who hear from the offender, evaluate their situation and make a ruling on the offence. They have a range of disposals to draw from; they can issue a warning, ban people from certain places or from meeting certain people, or require a person to be at a certain place at certain times. They can issue fines but these are rarely used; the focus is on using the right intervention to enable that person to engage in treatment or otherwise move forward in their recovery. Essentially, the arrest is seen as an opportunity to use public resources to address the underlying causes of the offence, rather than to punish, stigmatise or further damage the person.

9.4 Attributing results this new approach is complex, as is problematic drug use itself. It is certainly clear that, as radical (and, in many cases, as laudable) as this approach is, it is not a panacea. However, a quick glance at the EMCDDA statistics for Portugal shows a positive trend, particularly in contrast with the UK\(^43\). The number of people dying from overdose has dropped from 94 in 2008 to 27 in 2016. The number of HIV diagnosis attributed to injection has also fallen sharply, from 493 in 2006 to just 30 in 2016\(^44\).

“... it is not possible to state definitively that any trends observed since 2001 have been caused by decriminalisation or the broader strategy. Nevertheless, the statistical indicators and key informant interviews that we have reviewed suggest that, since 2001, the following changes have occurred:

a) Reductions in reported illicit drug use among the overall population
b) Increase in cannabis use in adolescents, in line with several other European countries
c) Reductions in problematic drug users
d) Reduced burden of drug offenders on the criminal justice system
e) Increased uptake of drug treatment
f) Reduction in drug-related deaths and infectious diseases
g) Increases in the amounts of drugs seized by the authorities.”\(^{45}\)

Lesson from Ireland: We know so much more about drug use and problematic drug use than we did when our legislative framework was created; if this framework is to be effective it must be updated in line with the evidence and understanding that we now have.

9.5 Ireland shares much of the same context to its drug policy debate as we do in the UK; their Misuse of Drugs Act was passed in 1977 (the UK Misuse of Drugs Act was


passed in 1971), they also saw a big increase in the use of heroin, the growth of an injecting culture and the rise of HIV among injecting drug users in the early 1980s (particularly in Dublin), and in recent years they have seen a similar shift towards understanding drug use as a health issue rather than a criminal justice issue.

9.6 Where they now differ is in the high level support for a more evidence based response to drug use that takes them further along this path; support that has translated into legislative change. In 2015 Aodhán Ó Riordáin, the Minister in charge of the national drug strategy, announced that they would be introducing a safer consumption room the following year and that he was committed to the decriminalisation of possession for personal amounts\(^{46}\). The Misuse of Drugs (Supervised Injecting Facilities) Act was passed in 2017 and provides a legal framework for the introduction of these services; the location of the country’s first such facility was announced in March. The national drug strategy ‘Reducing Harm, Supporting Recovery’, also published in 2017, commits to establishing a working group to consider evidence on how other areas respond to the possession of small quantities of drugs; the group is expected to publish its report soon. The Ana Liffey Drugs Project has published a set of recommendations in partnership with the London School of Economics’ International Drug Policy Unit to support the efforts of this working group\(^{47}\).

**Lesson from Switzerland:** The general public must be able to see how our policy and use of public funds delivers for us all

9.7 Switzerland saw a huge growth in open drug use in its cities in the 1980s, presenting significant threats to public order and security and bringing with it an explosion of HIV. In 1986 Switzerland reported the highest rate of HIV cases in Western Europe. The official number was 3,252; for a country with a population of around 6.5 million this compared poorly with the UK, with the next highest rate of 2,600 and a population of around 56.6 million\(^{48}\). The highly visible nature of the issue ensured its place in the public consciousness and led to widespread calls for effective action.

9.8 In 1994 Switzerland defined ‘four pillars’ as the foundation of its national drug strategy, adding harm reduction to the already established pillars of policing, prevention and treatment. The legal status of drug use did not change; “drugs remain illegal and commerce and consumption are prosecuted. But an important new element was added: the principle that drug users who are unable to break the cycle of compulsive consumption continue nonetheless to have rights which address their specifically


marginalized status. The first of these is to stay alive\textsuperscript{49}. In this way, radical approaches to harm reduction were presented to the public as an integrated part of the established and accepted structure.

9.9 Their approach to harm reduction included needle exchange programmes, safer consumption rooms and heroin assisted treatment. These were radical ideas at the time, and even now, 25 years later and with a wealth of evidence to support them, remain controversial, yet the generally conservative Swiss public strongly endorsed this policy in a public vote in 2008\textsuperscript{50}.

9.10 Although this policy has faced strong criticism – at the time from neighbouring countries and the international community and more recently from those who believe the issue has been overly medicalised, failing to consider and act on the wider social drivers of problematic drug use – evidence shows that it has been effective.

“The success of Swiss drug policy can be encapsulated in a few significant numbers:

- The number of new heroin users declined from 850 in 1990 to 150 in 2002;
- Between 1991 and 2004, drug-related deaths fell by more than 50 percent;
- The country witnessed a 90 percent reduction in property crime committed by drug users; and
- The country that once led Western Europe in HIV prevalence now has among the lowest rates in the region”\textsuperscript{51}

**General lesson from the international community:** Policy change in name only is no real change

9.11 We must also learn from what has not worked in other jurisdictions. Chile and Poland have both taken a similar approach to Portugal and decriminalised possession of a small quantities of drugs (in 2005 and 2011 respectively), but they have not defined any threshold quantities in legislation, so people still face a criminal response. Argentina’s Supreme Court ruled in 2009 that drug possession for personal consumption should not be treated as a criminal offence, but as this has not been reflected in the legislative framework, people are still being prosecuted. The threshold quantities set under the decriminalisation approach in Mexico (introduced in 2009) and Russia are so low that many people are still prosecuted\textsuperscript{52}.


\textsuperscript{50} [https://www.academia.edu/4029433/The_Swiss_Four_Pillars_Policy_An_Evolution_From_Local_Experimentation_to_Federal_Law](https://www.academia.edu/4029433/The_Swiss_Four_Pillars_Policy_An_Evolution_From_Local_Experimentation_to_Federal_Law)

\textsuperscript{51} [https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-en-20160212.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-en-20160212.pdf)

\textsuperscript{52} [https://www.talkingdrugs.org/decriminalisation](https://www.talkingdrugs.org/decriminalisation)
A final message, if not a lesson as such from former UN Secretary General Ban Ki-Moon, who called on Member States, on International Day Against Drug Abuse and Illicit Trafficking in 2015, to “...consider alternatives to criminalization and incarceration of people who use drugs and focus criminal justice efforts to those involved in supply. We should increase the focus on public health, prevention, treatment and care, as well as on economic, social and cultural strategies.”

If you require any further information, please do not hesitate to contact me

Faye Keogh
Policy & Business Development Officer
April 2019

April 2019

1. **What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?**

Problem substance use is driven by personal experiences, for example ACES (adverse childhood experiences) or trauma experienced by adults, and social factors, for example deprivation. Personal and social experiences often occur together and lead to poorer outcomes overall for people’s health and wellbeing. From an island perspective, the sometimes insular nature of small communities can amplify these experiences.

Results from a public engagement exercise carried out in Shetland cited poor mental health as a key driver for substance misuse, by way of self medication. It is worth noting that until recently, Shetland had a consistently high rate of death by suicide.

2. **To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?**

As described above, personal, social and economic factors partly drive substance use, so it is imperative that legislation focuses on and tackles, for example, the protection of children and young people from harm, reducing inequalities and deprivation to enable better outcomes for all.

UK drugs legislation centres on criminalisation, which fuels stigma, creating barriers for those seeking support with their own substance use and for those who are affected by someone else’s substance misuse. A more health based focus would reduce stigma and promote inclusiveness of this vulnerable sector of society.

The lack of anonymity in rural communities can make it more difficult for people to seek support and can also make recovery and future prospects more challenging. There is also less choice of services in rural areas.

3. **What is the relationship between poverty and deprivation and problem drug use?**

The relationship between poverty and deprivation and poor health outcomes overall are well documented, as well as the relationship between poverty and deprivation and problem drug use.

In Shetland, there are not large areas of deprivation, rather there are pockets of deprivation scattered amongst otherwise fairly affluent areas, which can mean that the level of deprivation is sometimes fairly hidden. This creates difficulties for services who are trying to attract funding to tackle inequalities and deprivation and also created difficulties if specific targets/outcomes are set around postcodes.

Being in employment can be seen as a positive factor that aids recovery, but as previously mentioned, gaining employment in a small community where there is no anonymity can be challenging. Furthermore, gaining and maintaining employment whilst in treatment can also be challenging. This would be less challenging if problem substance use was recognised and treated as a health issue.
Inline with national trends, Shetland is seeing a substantial rise in cocaine use. Anecdotally, local cocaine use appears to fairly widespread and contrary to the drivers described above, is often centred in fairly affluent communities.

4. **What role could reserved social security policy play in addressing problem drug use?**

Again, if problem substance use was recognised and treated as a health issue and families were recognised as carers, the benefits system could perhaps be more flexible in supporting people affected by problem substance use.

5. **How is the drugs market in Scotland changing? And how well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”? Are any changes needed to the current regulatory landscape?**

In small communities, organised crime gangs can have a powerful and lasting impact on drug trends and online purchase of drugs is inevitable, as technology has made all goods more accessible.

Schemes that centre on alternatives to prosecution could be beneficial so as to not criminalise low level use, which may create further barriers to an individual’s future opportunities. It could also provide an opportunity for engagement with those who require support to address the root causes of their substance use. It is important however, that there is adequate legislation to protect vulnerable people from exploitation, as part of the drugs trade.

6. **Are there other areas of reserved policy which is influencing the Scottish Government’s ability to address drugs misuse in Scotland?**

We have no comment to make on this.

7. **How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland? Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?**

We have no knowledge base on this.

8. **Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland’s needs?**

Again, if we look at the drivers of problem substance use, further devolution of powers relating to poverty, deprivation and inequalities as a whole could be beneficial. The cost of living in Shetland is significantly higher than other parts of Scotland, yet this is often not reflected in the way that welfare payments or funding for service provision is apportioned.

Further devolution of powers within Scotland, including the Islands Bill, could allow increased local development of services to meet local needs. We would be wary of supporting centralised services which would not meet the needs of remote, rural and island populations.

In terms of service provision, it should be noted that in 2016/2017, the Shetland Alcohol and Drug Partnership received a substantial cut to its allocated budget cut from the Scottish Government; this
has had an ongoing impact on service provision, at a time when substance use appears to be on the increase.

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Addaction is the largest third sector provider of drug and alcohol services in Scotland. Every month we help more than 2,500 people turn their lives around through our network of 16 services nationwide. The majority of our services are direct access and recovery orientated, but we also have specialist projects for young people, people affected by HIV and hepatitis, individuals who have alcohol related brain damage and people who have a history of trauma. Our engagement team helps people who use our services to become more actively involved in their communities, and provides a bridge to the growing recovery network in cities and towns throughout Scotland.

- What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK? To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?

Historically Scotland has had substantially higher level of drug related deaths than the rest of the UK. In 2017, the most recent year we have available statistics, the rate of drug related deaths was more than double in Scotland (170 per million people) compared to England and Wales (66 per million people). One of the reasons for this is the considerably higher levels of opiate and benzodiazepine users within Scotland, reflected in the proportion of drug related deaths in which individuals were found to have opiate/opioids and benzodiazepines present. In Scotland it’s estimated that 1.62% of the population, or almost one in 60 people, are problematic drug users whereas the rate in England is approximately half that at 0.89% or one in 120 people (although the two countries include different substances the majority in both is made up of opiate users).

Most drug related policies are devolved to Scotland, such as responsibility for a national strategy and determining treatment commissioning structures. UK-wide drug legislation is unlikely to have a significant impact on the drivers of drug abuse, which are usually related to social policy issues and structural problems. However, it is likely to have a significant impact on the ability to support people with drug issues and providing effective harm reduction services and advice for individuals taking/considering taking drugs.

- What is the relationship between poverty and deprivation and problem drug use?

Overall drug consumption doesn’t increase with deprivation. For example, according to statistics the highest level of cocaine use is by those earning £50,000 or more.

However, research has repeatedly shown that deprivation is heavily correlated with problematic drug use. It is found to be associated with the sustained use of more harmful drugs, particularly crack cocaine and heroin, and drug related health and societal harms.
Deprivation is more likely to relate to a lower age of first use, progression to dependence, injecting drug use, other risky use, health and social complications from use.

In deprived areas there are more likely to be drug misuse risk factors, such as an unstable home, unemployment, school exclusions and adverse childhood experiences. It can be more difficult for individuals from deprived areas to overcome drug problems as they have less access to factors that support recovery such as meaningful employment and suitable housing.

Problematic drug use is often to do with structural disadvantages, limited opportunities, alternatives and resources, all of which are more common in deprived areas. For those who experience social exclusion and disadvantage prior to drug use, the onset of excessive drug taking in early adulthood may be a form of escape, a way to deal with the lack of resources available to the rest of society.

Drug related deaths increase in areas with the highest levels of deprivation. For example, the rate of deaths related to drug poisoning in England and Wales is about ten times higher in the most deprived decile than the least deprived decile. Unfortunately the same statistics are not available for Scotland.

One of the many reasons people we work with use drugs is to cope with underlying traumatic issues or forget certain circumstances and events in their lives. This is particularly the case for women. We have found from our services that people misuse substances to address the traumatic stress they experience – including self-medicating to escape invasive memories, or make traumatic relationships more tolerable. This usage can be heightened amongst certain groups, particularly children who face additional complexity in their lives, including; looked after children, those seeking asylum, those witnessing or involved in violence. This is also true of adults who experienced one or more of these issues as a child. People living in deprived conditions and communities are more likely to have experienced trauma in their lives.

People with multiple adverse childhood experiences (ACE) are more likely to develop substance issues, in part to manage the overwhelming emotional and somatic sensations associated with trauma. Children who experience four or more adversities are eleven times more likely to go on to use crack cocaine or heroin. The chances of developing a dependence on substances double if a child has also experienced sexual abuse or other forms of violence.

- How is the drugs market in Scotland changing? How well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”. Are any changes needed to the current regulatory landscape?

Trends in drug use are forever changing. Scotland is no exception to this. We carried out a survey of drug users in Scotland last year in order to get a better understanding of these
changes, in particular the extent of poly drug use (people who take multiple drugs) and the level of possible drug issues people have with drugs generally, whether or not people showing signs of dependence and are accessing support.

There are other regular Scottish drug surveys routinely carried out. However, they have relatively small samples sizes or focus solely on people in drug treatment. The results of this survey include responses of 8,518 individuals. To put this in context the most recent national drug survey in Scotland had 618 people take part who had taken substances within the last year and the 2018 Global Drug Survey had 1,300 respondents in Scotland.

Below are some of the headline figures from the survey. However, if helpful we would be willing to share more details and further statistics to the Committee.

● Substances

![Substances Chart]

More than 80% of respondents said they had taken cannabis in the last year and almost three quarters (72%) said they used cocaine/crack. Almost half (47%) reported using MDMA/ecstasy, more than one quarter (25%) of people said they had taken valium and a similar proportion (23%) said they had taken ketamine.

By comparison the latest Global Drug Survey found that 61.9% of respondents reported ever using cocaine, 51.7% having used in the last year. The most recent Scottish crime and justice survey in 2015/16 found that of the people who had taken substances in the past 12 months, 81% had taken cannabis, and only 30% cocaine and 22% ecstasy.

According to our survey over two thirds of people who took drugs in Scotland last year (71%) said they took more than one substance over that period. Generally we can see that very few people only took one substance. There is a multitude of interesting trends when breaking down polydrug use among different substances. For example, almost 40% of
people taking hallucinogens also took ketamine and a very similar number took hallucinogens and mdma.

On average people who used cocaine last year took three other substances. When we broke the results from our survey we found that just over one third of people who took cocaine also took MDMA and just less than one quarter also took ketamine. Three quarters of people taking valium last year took at least three other substances over the course of the year.

- Drug misuse and dependency

People responding to the survey were asked questions to determine whether or not they were showing signs of any issues with the substances they were taking. We found that more than two in five people (40.4%) had results suggesting they may have a significant problem and possible dependence with drugs, although this varied depending on the substance. Most worryingly two thirds (67%) of those said they had never received any sort of support or help.

Over 73% of Heroin and Methadone users displayed significant problems suggesting dependency. Almost half of people who had taken valium (46.6%), more than half of Xanax users, one third (32.2%) of cocaine users and 38% of ketamine users showed signs of significant problems.

- Image and Performance Enhancing Drugs
The number of people taking image and performance enhancing drugs (IPEDs) appears to be on the rise. They took 5 substances on average with a very high proportion of them taking cocaine (91%), cannabis (76%), mdma (65%) and valium (53%). When individuals taking IPEDs these were asked if they were able to stop taking the drugs when they want the majority said no. Unfortunately the majority also said they had never sought help or support.

● Conclusions

Our findings suggest that people who take substances in Scotland often take multiple different drugs over the course of a year. A substantial number of people taking substances are demonstrating signs that they might have issues with those drugs, that they might be negatively impacting their health and wellbeing. Unfortunately only a few of those people have looked for support.

It’s important that people are aware of their drug use and understand the damage it might be causing them and the best methods of minimising that damage. We need to encourage more people to come forward and look for that help and support though. People need to feel comfortable looking for advice, so there needs to be multiple options and tools available for them. That can range from traditional services to online support.

The more informed and up to date with drug consumption trends within Scotland the better advice we can prepare and harm reduction and treatment services we can put in place.

● Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland’s needs?

Scotland is prevented from introducing a completely unique approach to drug misuse due to UK wide drug legislation, such as the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016. This legislation precludes Scotland from controlling the schedule or classification of specific drugs as well as introducing certain policies or services that could be interpreted as breaching that legislation, most notably drug consumption rooms.

In 2015, an outbreak of HIV occurred among people who inject drugs (PWID) in Glasgow, with 50 new HIV cases reported in Scotland, which was more than double the average number of new HIV cases detected annually in the period 2006-2014. The proportion of people who inject drugs in Glasgow who testes positive for HIV increased by 1,000%. There is a general consensus among health professionals and local policymakers that a drug consumption room would reduce health related harms among people injecting drugs in Glasgow, including the transmission of blood borne viruses such as HIV and Hepatitis C. However, this has been blocked as the Lord Advocate believes a drug consumption room would breach the 1971 Act, which in effect is preventing an innovative and evidenced response to a public health crisis.
Although Scotland can introduce programmes such as heroin assisted treatment and drug testing facilities it can only do so through exceptions and licences granted through UK wide legislation. Therefore it does not have true control over them and their long term sustainability.

Addaction believes Scotland should have control to respond to unique and localised drug misuse issues in a progressive and innovative manner that is most likely to address the problem. There should be a comprehensive public health approach adopted to drug misuse, a move away from a position that often simply criminalises vulnerable individuals. Scotland should have the ability to formally introduce an approach such as this and not through informal, means

April 2019
UK Parliament Scottish Affairs Committee Inquiry:

Use and Misuse of Drugs in Scotland

Background to our submission

1. This submission is co-authored by the following NHS Scotland organisations:
   - NHS Health Scotland¹, which works to improve health and reduce health inequalities.
   - Information Services Division² (part of NHS National Services Scotland), which provides health information, health intelligence, statistical services and advice.
   - Health Protection Scotland³, (part of NHS National Services Scotland), which focuses on protecting the people of Scotland from infectious and environmental hazards.

2. We are submitting a single response because the three organisations above will soon join to form a new national public health agency in Scotland – Public Health Scotland. Public Health Scotland’s remit will include providing national leadership around tackling the harms associated with drugs in Scotland.

3. We welcome the opportunity to contribute evidence to the Committee’s timely and important inquiry into drug use in Scotland. Drug use disorders are the sixth leading cause of early death in Scotland⁴ and drug-related death (DRD) rates in Scotland are 2.5 times higher than in England, Wales and Northern Ireland.⁵ There are complex social, political and historical reasons for this, which we will set out below.

Executive summary

4. There is a significant body of evidence showing that poverty and deprivation are the main structural drivers contributing to problematic drug use in Scotland.

¹ https://www.healthscotland.scot/
² https://www.isdscotland.org/
³ https://www.hps.scot.nhs.uk/
⁵ National Records Scotland. Drug-related Deaths in Scotland in 2017. 2018
5. A combination of socioeconomic and political decisions created the context for the current problems with drug misuse in Scotland and therefore immediate and simultaneous action at a similar level is required to mitigate the likelihood of dying a drug related death (DRD) by those currently at risk, and prevent future generations from facing those risks.

6. Drug-related harms, and problematic drug use more generally, are commonly a symptom of wide levels of inequality.

7. We would welcome progress of the Supervised Drug Consumption Facilities Bill and for provision to be allowed to pilot a safer consumption facility in Glasgow City Centre.

8. Reserved social security policy could play a positive role in addressing problematic drug use in Scotland.

Response

Q1. What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?

Poverty, deprivation and inequality

9. Socio-economic disadvantage is one of the main drivers of drug use in Scotland. People who experience socio-economic disadvantage disproportionately also experience problematic drug use. Council areas with some of the most deprived communities in Scotland, such as Glasgow City (2.8%) and Dundee City (2.3%) have higher rates of problematic drug use than the national estimate (1.6%).

10. People who experience problems with their drug use are often amongst the most marginalised in society and can have multiple complex needs due to the circumstances in which they live.

11. International evidence confirms that poverty, deprivation and inequality are important drivers of problematic drug use, with countries with higher levels of inequalities experiencing higher incidence of drugs use. It has been argued that inequality can lead to psychosocial dislocation (characterised by...
among other things, erosion of social support networks, identity and purpose). For those who experience this most sharply, problematic drug use is a common occurrence. Therefore addressing wider social inequalities, for example in housing and employment, as well as tackling poverty, can play an important role in the prevention and mitigation of problematic drug use and associated harms.

12. While Scotland shares the negative impact of poverty, deprivation and inequality with other countries, there is evidence that there is a unique element to Scotland’s experience. Scotland has an ‘excess mortality’. This means that after adjusting for the main causes of poor health in society - poverty and deprivation - 5,000 more people die every year in Scotland than should be the case compared to England and Wales.

13. A study of the drivers of excess mortality in Scotland showed that the causes of Scotland’s excess mortality relate to a greater vulnerability to the main drivers of poor health as a result of UK economic and social policies since the late 1970s which have resulted in a widening of inequalities across the UK.

14. This makes Scotland, and Glasgow in particular, uniquely susceptible to the harms of inequality, psychosocial dislocation, drug use and, ultimately, DRDs. As Professor Sir Michael Marmot explains:

“...The causes of death with the biggest relative excess in Glasgow were drug-related poisonings, alcohol-associated deaths, suicide, and other external causes of death. These are all psychosocial in origin. They are what happens when people are disempowered, and have little control over their lives.”

15. Given that a combination of socioeconomic and political decisions created the context for the current crisis, immediate and simultaneous action at a similar level is required to mitigate the likelihood of dying a DRD by those currently at risk, and prevent future generations facing those risks.

16. Gains in life expectancy in Scotland has stalled in this decade; until now it has progressed without interruption since the Second World War. The change in trend is not due to a single age group or cause of death. However, the dramatic rise in mortality from DRDs particularly amongst those aged 35-55 years is one of the contributors and action to tackle these specific premature preventable deaths is crucial.

14 Fenton L, et al. Recent adverse mortality trends in Scotland: comparison with other high-income countries. 2019
Vulnerable (ageing) cohort

17. An age period cohort study\(^\text{15}\) published last year underscores this analysis, identifying a cohort who were particularly exposed to these historic harms. In 2017, 934 people in Scotland died a DRD. This was the highest number ever recorded and a more than a threefold increase since 2000.\(^\text{16}\) The increase is most marked in older age groups. There have been large increases in the number of DRDs among 35-44 year olds (from an average of 115 per year in 2003-2007 to an average of 267 in 2013-2017), people aged 45-54 (from an average of 38 to an average of 188); and people aged 55 to 64 (from an average of 10 to an average of 53), while there was a fall in the number of DRDs among people aged under 25.

18. Exploring the drivers behind this trend in DRDs in Scotland, the age period cohort study found that:

“The cohort effect identified here is consistent with exposure of young working-age adults to the changed socioeconomic context during the 1980s, an event which would have occurred primarily when young adults entered the job market and therefore earlier for those in the most deprived areas, and adds further evidence to this thesis. It seems likely that alcohol-related deaths, DRDs and suicide outcomes that contribute to Scotland’s ‘excess’ mortality could share a common causal pathway stemming from the changing social and economic policies of the 1980s.”\(^\text{ibid}\)

Different drug use patterns

19. There are different patterns of drug use in Scotland compared to elsewhere in the UK. While illicit opiate/opioid use is problematic across the UK, benzodiazepine use has traditionally been more common and crack cocaine use less common among people who use drugs in Scotland than in England. These distinctive patterns of usage form the basis of each countries’ definition of ‘problem drug use’.

20. Information from the Scottish Drug Misuse Database (SDMD) which collects data on clients entering specialist drug treatment\(^\text{17}\) shows that in 2016/17, opiates/opioids (e.g., heroin/morphine and methadone) were recorded as the main problem drug in 54% of assessments, with heroin the most commonly recorded drug (46%). Although benzodiazepines such as diazepam were


\(^\text{16}\) National Records Scotland. *Drug-related Deaths in Scotland in 2017*. 2018

\(^\text{17}\) Information Services Division. *Scottish Drug Misuse Database Overview of Initial Assessments for Specialist Drug Treatment 2016/17*. 2018
reported as the main problem drug in only 10% of assessments, consumption within the previous month was recorded in 32% of SDMD assessments.

21. Opioids or opiates suppress respiratory function and have been implicated in around 90% of DRDs in Scotland since 2000. In most cases where these drugs were implicated in death, they were consumed alongside other substances. The use of other drugs (principally benzodiazepines and alcohol) is widespread in Scotland and may further increase the risk of overdose and death.18

22. In Scotland, there is a longstanding issue with the concurrent use of opioids and benzodiazepines (drugs which are used to reduce anxiety and induce sleep). At high doses and when taken alongside opioids, benzodiazepines are a risk factor for DRD due to their respiratory depressant effects.19 ‘Street’ benzodiazepines such as etizolam and alprazolam (Xanax) are widely available in Scotland and have increasingly been implicated in DRDs since 2014. Benzodiazepines were implicated in 59% of DRDs in 2017.18

23. Gabapentinoids (gabapentin and pregabalin) are prescription-only medications licensed for the treatment of neuropathic pain, epilepsy and (for pregabalin only) generalized anxiety disorder. There is growing evidence that, because of euphoric effects at high doses (particularly if taken with opioids), gabapentinoids are increasingly being used by people with a drug problem. Potential side effects such as the reversal of methadone tolerance and respiratory depression mean these drugs are a risk factor for DRD. Gabapentinoids were implicated in around one quarter of DRDs in 2017. ibid In response to increasing evidence of harms related to their use, gabapentin and pregabalin were reclassified to Schedule 3 Controlled Drugs in April 2019.

Q2. To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?

24. The UK-wide Misuse of Drugs Act 1971 prevents the Scottish Government from pursuing their public health approach to drugs policy and from implementing evidence-based interventions to address the specific drivers of problem drug use in Scotland, notably around safer consumption facilities. This means the Scottish Government is prevented from pursuing the best possible health outcomes for people who are, or have been, drug users. It also means that people who are, or have been, drug users are prevented from realising their right to the highest attainable standard of health – a right recognised formally in

the UK since 1976 when the Government approved the International Covenant on Economic, Social and Cultural Rights.\textsuperscript{20}

Safer consumption facilities

25. A case in point is the inability of Glasgow City Health and Social Care Partnership to pursue plans for a safer drug consumption facility in the city. It would require a change to UK-wide drugs legislation to safeguard service users and staff from risk of prosecution under the 1971 Act. Therefore, despite a needs assessment\textsuperscript{21} finding that such a facility “is likely to have a positive impact on the most pressing health concerns affecting public injectors in Glasgow, and on the community as a whole”, the initiative has been unable to go ahead.

26. The Scottish Government stated in the Programme for Government 2018/19 and reiterated in their 2018 drug and alcohol treatment strategy\textsuperscript{22} that they are:

“… sympathetic to proposals being pursued by Glasgow City Health and Social Care Partnership to pilot a safer drug consumption facility in the city centre… we will continue to press the UK Government to make the necessary changes in the law, and if they are not willing to do so, to devolve the powers in this area so the Scottish Parliament has an opportunity to act and allow the facility to proceed.”\textsuperscript{23}

27. A Westminster Private Members Bill\textsuperscript{24} has been introduced to make provision for supervised drug consumption facilities and make it lawful to take controlled substances within such facilities in specified circumstances. We would welcome progress of the Supervised Drug Consumption Facilities Bill and for provision to be allowed to pilot a safer consumption facility in Glasgow City Centre. The Bill has drawn support from all political parties, with many supporters recognising that the status quo is failing to adequately respond to ongoing public health needs of people who inject drugs, in particular the estimated 500 people who inject public places in Glasgow City Centre.\textsuperscript{21}

28. The Adam Smith Institute recently published a report\textsuperscript{25}, which highlighted evidence of the effectiveness of safer injection facilities in harm reduction. The


\textsuperscript{21} NHS Greater Glasgow and Clyde. \textit{“Taking away the chaos”: The health needs of people who inject drugs in public places in Glasgow city centre}. 2016

\textsuperscript{22} Scottish Government. \textit{Rights, Respect, Recovery}. 2018


\textsuperscript{24} \textit{Supervised Drug Consumption Facilities Bill}

\textsuperscript{25} Adam Smith Institute. \textit{Room for Improvement: How drug consumption rooms save lives}. 2019
report has been met with cross-party support amongst MPs and cross-bench support amongst Lords.26

Decriminalisation

29. The Misuse of Drugs 1971 Act, which is wholly reserved, means that the Scottish Government cannot consider alternative regulatory approaches, such as decriminalisation, regardless of need or evidence of effectiveness. One pertinent example is evidence from Portugal27 that decriminalisation of drugs for personal use can be effective as part of a whole-system approach to tackling problem drug use:

“Portugal’s drug situation has improved significantly in several key areas. Most notably, HIV infections and drug-related deaths have decreased, while the dramatic rise in use feared by some has failed to materialise. However, such improvements are not solely the result of the decriminalisation policy; Portugal’s shift towards a more health-centred approach to drugs, as well as wider health and social policy changes, are equally, if not more, responsible for the positive changes observed.”

Q3. What is the relationship between poverty and deprivation and problem drug use? What role could reserved social security policy play in addressing problem drug use?

The relationship with poverty and deprivation

30. As detailed above, there is a significant body of evidence showing that poverty and deprivation are the main structural drivers contributing to problematic drug use and excess mortality.28

31. This includes the Scottish Burden of Disease Study, which found that the overall burden of drug use disorders is 17 times higher in Scotland’s most deprived areas compared with the least deprived.29

32. Information from ISD’s National Drug-Related Death Database shows that DRD prevalence is highest in the most deprived communities. Over half of people who had a DRD in 2016 (52%) lived in the most deprived neighbourhoods in Scotland (SIMD quintile 1), while only 3% lived in the least deprived areas

26 Adam Smith Institute. ASI plan unites MSPS from across Parliament. 2019
27 Transform. Drug decriminalisation in Portugal: setting the record straight. 2014
(SIMD quintile 5). The deprivation profile of DRDs has not changed since these data were first collected in 2009 (52% in SIMD quintile 1).\textsuperscript{30}

33. Information from inpatients and day cases admitted to Scottish general acute and psychiatric hospitals shows an increasing trend in drug-related hospital stays. In each year from 1996/97 to 2016/17, at least 50% of patients admitted to hospital in relation to drug use lived in the 20% most deprived neighbourhoods in Scotland (SIMD quintile 1), while approximately one quarter of patients lived in the next most deprived quintile (SIMD quintile 2).\textsuperscript{31}

34. Injecting drug use continues to be the most prominent risk factor for Hepatitis C virus (HCV) infection in Scotland, accounting for over 90% of infections. HCV diagnosis remains strongly patterned by deprivation with numbers of diagnoses highest in those most deprived and fewest in the least deprived.\textsuperscript{32} This is largely influenced by prevalence of problem drug use in Scotland (including injecting), which, as said, is also strongly patterned by deprivation.\textsuperscript{33}

The role of reserved social security policy

35. Reserved social security policy could play a positive role in addressing problem drug use in Scotland. Higher incomes mean people can choose alternatives to drugs to avoid or ameliorate psychological stress and better employment opportunities can make supplying drugs seem a less rational career choice.\textsuperscript{34} A social security system which offers adequate protection against destitution and hardship (in and out of work), combined with employment support to help people secure good work, could help.\textsuperscript{35}

36. However, we are concerned that the current reserved social security policy (including low levels of benefits, freezes and cuts, delays and errors, poor quality assessments, benefits sanctions and natural migration) has undermined an already inadequate welfare safety net. Rising employment and falling worklessness has not translated into improved mental health or lower levels of poverty. Current reserved social security policy thus risks undermining policies

\textsuperscript{30} Information Services Division. \textit{The National Drug-Related Deaths Database (Scotland) Report Analysis of Deaths occurring in 2015 and 2016}. 2017

\textsuperscript{31} Information Services Division. \textit{Drug Related Hospital Stays}. 2017

\textsuperscript{32} Health Protection Scotland and Glasgow Caledonian University. \textit{Blood borne viruses and sexually transmitted infections: Scotland 2017}. 2017

\textsuperscript{33} Information Services Division. \textit{Prevalence of Problem Drug Use in Scotland 2015/16 Estimates}. 2019

\textsuperscript{34} Shaw et al., \textit{Drugs and poverty: A literature review}. 2007

\textsuperscript{35} Taylor M. \textit{Good work: the Taylor review of modern working Practices}. 2017
to reduce problem drug use.\textsuperscript{36}\textsuperscript{37}\textsuperscript{38} Consideration should therefore be given to increasing the value of benefits.

37. A flexible, compassionate approach in the way the system engages with individuals in need is required in order to put the health interests of individuals first. The Welfare Conditionality Project demonstrates that personalised, constructive support (including substantive partnership working between Jobcentre Plus and other statutory and non-statutory agencies) is possible and can be successful. It also illustrates the counterproductive nature of more punitive approaches accompanied by a lack of substantive support, which can move people further away from the labour market and from recovery.\textsuperscript{39}

38. A more constructive arrangement is required to avoid people being sanctioned because of clashes between Work Coach appointments and drug treatment. NHS Lothian Health Board has developed a model to ensure that where people are expected to attend drug treatment this does not clash with their claimant commitment requirements. The aim is to avoid negative consequences for patients (either being sanctioned for missing a Jobcentre appointment or failing to attend drug treatment, with health and legal consequences). The model is dependent on good relationships being developed between Jobcentre Work Coaches and Drug Treatment Practice Managers. The model has not, as far as we are aware, been evaluated but it has been suggested this approach has prevented those attending drug treatment from being sanctioned.

39. In terms of employability support, the conclusions of Dame Carole Black’s review\textsuperscript{40} on the links between work and addiction for the Department for Work and Pensions found employment plays an important role in improving the wellbeing and self-worth of people with drug and alcohol addiction. The report recommends further exploration into ways people addicted to drugs and alcohol can be helped to find work, and improved joined-up working between work and health services.

40. Adjusting UK and Scottish statutory guidance and legislation to remove exclusions that stop problematic alcohol or other drug use being seen as a healthcare condition or disability would enhance access to recovery support and tackle a significant example of institutional stigma getting in the way of recovery:

\textsuperscript{36} NHS Health Scotland. Submission to Work and Pensions Committee Universal Credit natural migration inquiry. 2019
\textsuperscript{37} NHS Health Scotland. Submission to Work and Pensions Committee welfare safety net inquiry. 2018
\textsuperscript{38} NHS Health Scotland Submission to Work and Pensions Committee benefit sanctions inquiry. 2018
\textsuperscript{39} Welfare Conditionality. Social security in Scotland: final findings. 2018
\textsuperscript{40} Black C. Drug and alcohol addiction, and obesity: effects on employment outcomes. 2016
• Devolved: Remove the exclusion of alcohol or other drugs from the definition of ‘mental disorder’ under the Mental Health (Care and Treatment) (Scotland) Act 2003

• Reserved: Remove the exclusion of alcohol or other drugs from the definition of ‘disability’ within the Statutory Guidance to the Equality Act 2010.

Q4. How is the drugs market in Scotland changing? How well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”. Are any changes needed to the current regulatory landscape?

41. Heroin continues to be the most common drug injected in Scotland with over 90% of those interviewed as part of the Needle Exchange Surveillance Initiative (NESI) in 2017-18 reporting injecting it in the past six months. Reported injection of powder cocaine increased markedly from 9% in 2010 (n=217) to 29% (n=422) in 2017/18, with levels highest in NHS Greater Glasgow and Clyde (49%; n=286). Injection of ‘legal highs’ (i.e. Novel Psychoactive Substances (NPS)), associated with increases in severe soft tissue infections and HCV in parts of Scotland in recent years, was rare within the 2017/18 survey, reported by less than 1% of participants. A decrease in NPS injecting and related harms in Scotland has been associated with limiting availability and accessibility to such drugs through implementation of a Temporary Class Drug Order (TCDO) in the context of an infectious disease outbreak.

42. A major shift to injection of powder cocaine has been linked to a recent outbreak of HIV among people who inject drugs in Glasgow, the largest such incident in the UK for over 30 years. Between 2011 and 2018, HIV prevalence in Glasgow city centre rose from 1.1% to 10.8%.

43. There is evidence that cocaine use in the UK has increased in recent years due to a reduction in price and an increase in purity. Concurrently, cocaine-related harms (hospital admissions (stays) and deaths) have increased. Cocaine-related general acute stay rates doubled from 6 per 100,000 population in 2010/11 to 13 in 2016/17. Cocaine was implicated in between 5% and 10% of

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41 Health Protection Scotland, Glasgow Caledonian University and the West of Scotland Specialist Virology Centre. The Needle Exchange Surveillance Initiative (NESI): Prevalence of blood-borne viruses and injecting risk behaviours among people who inject drugs (PWID) attending injecting equipment provision (IEP) services in Scotland, 2008-09 to 2017-18, 2019


44 EMCDDA. European Drug Report 2018, 2018

45 Information Services Division. Drug Related Hospital Statistics. 2017
DRDs annually from 2006 to 2014. Since 2015, cocaine implication has increased significantly, reaching 19% of DRDs (176) in 2017.\footnote{National Records Scotland. \textit{Drug-related Deaths in Scotland in 2017}, 2018}

44. Data from ISD’s National Drug Related Death Database\footnote{Information Services Division. \textit{The National Drug-Related Deaths Database (Scotland) Report Analysis of Deaths occurring in 2015 and 2016}, 2017.} shows that the presence of diazepam at post mortem has decreased significantly since 2012, while the presence of various benzodiazepine-type Novel Psychoactive Substances (benzo-type NPS) has increased. The illicit manufacture and supply of these drugs and uncertainties regarding product type, purity and effect profile mean that the risks associated with consumption of unlicensed ‘street’ benzodiazepines such as etizolam and clazolam, may be higher than for prescribable benzodiazepines such as diazepam. These benzo-type NPS drugs appear to be more dangerous than diazepam, having been implicated in death in a higher percentage of DRDs where present.

45. Etizolam and diclazepam both became controlled substances in May 2017, almost one year after the implementation of the Psychoactive Substances Act (PSA) in April 2016. Neither of these two regulatory changes appears to have reduced DRDs or hospital stays associated with benzo-type NPS. These drugs have been associated with large increases in DRDs and are likely to be associated with the ongoing increase in stays in Scottish hospitals due to sedatives/hypnotics. Sedative/hypnotic-related general acute stay rates increased almost threefold from 5 per 100,000 population in 2010/11 to 14 in 2016/17. The percentage of stays involving sedatives/hypnotics increased from 4% (242) to 9% (739) over the same period.\footnote{}\footnote{ibid}

46. Gabapentinoid prescribing and presence among DRDs has increased in recent years. In 2016, of the 169 individuals who had a DRD and who had recently been prescribed these drugs, gabapentinoids were implicated in 73 (43%) deaths. Of these 73 DRDs, opioids were also implicated in 61 (85%) deaths. As a consequence of increasing evidence of diversion, misuse and harm, gabapentinoids became controlled drugs from 1 April 2019.

47. The rate of general acute hospital stays involving ‘other stimulants’ increased markedly from 5 stays per 100,000 population in 2010/11 to 12 in 2014/15, before decreasing to 8 in 2016/17.\footnote{ibid} The changing pattern of stays associated with ‘other stimulants’ is highly likely to have been associated with increases in the availability and use of stimulant-type NPS (for example, ethylphenidate) and the subsequent introduction of legislation to control their sale and supply (PSA 2016).
48. Whilst we cannot comment on the potential for regulating online activity, recent changes in legal frameworks appear to have had a limited effect on the illicit drug market in Scotland. The pattern of health harms associated with stimulants suggests a reversion to established psychostimulants (e.g. cocaine and ecstasy) as the sale and supply of stimulant-type NPS drugs was controlled by PSA 2016. In contrast, the introduction of PSA 2016 has not been effective at reducing the supply of benzo-type NPS in Scotland. There continues to be a strong demand for benzodiazepines and (as observed in relation to recent DRD drug implication patterns) more restrictive prescribing practices or more rigorous enforcement against these drugs will likely result in further unintended consequences as users transition to unlicensed benzo-type NPS or to licit benzodiazepines (e.g. alprazolam/Xanax) diverted from overseas markets.\

49. The recent evaluation of PSA2016 demonstrated mixed results of achieving intended outcomes. For example, while existing evidence suggests the PSA caused the prices of NPS to increase and their availability to fall; research also indicates a large-scale shift away from retailers to street dealers. Data also suggests shops and the internet remain important sources of NPS and it does not appear that the PSA has significantly disrupted darknet NPS activity (the UK as one of the leading dark web sellers of NPS both before and after the Act). Nor has the emergence of new NPS in the UK ceased following the introduction of the PSA.

Q5. Are there other areas of reserved policy which is influencing the Scottish Government’s ability to address drugs misuse in Scotland?

50. Given the structural drivers of drug use referred to above, all areas of reserved policy that influence the Scottish Government’s ability to tackle poverty and deprivation impact on their ability to address the misuse of drugs.

Q6. How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland? Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?

51. A number of knowledge-exchange collaborations exist such as The United Kingdom Focal Point on Drugs (UK Focal Point), to bring together the UK and Scottish Governments, along with the Wales and Northern Ireland. However, 

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while information is shared, it is not clear the extent to which this helps address the structural barriers to addressing drug misuse.

Q7. Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland’s needs?

52. Yes, for the reasons outlined above.

Q8. What could Scotland learn from the approach taken to tackle drug misuse in other countries?

53. A number of countries are taking new and alternative approaches to both the regulation of and treatment response to drug use. The health and social impacts of these approaches merit close investigation, review and evaluation to determine effectiveness and appropriateness for Scotland. This includes decriminalisation (such as the example from Portugal cited above), legalisation, liaison and diversion from criminal justice (taking a public health approach) and comprehensive treatment information.

54. International review-level evidence\textsuperscript{50} demonstrates:

- The quality of medically assisted treatment is crucial to improving outcomes and safeguarding the health of individuals with opioid dependence.
- Optimum dose is critical and retention in treatment essential to achieving positive outcomes.
- One size does not fit all. Treatment approaches and services need to be tailored to the individual to support them to stay in treatment, this includes choice in treatment options.
- Complex psychological and social barriers must be addressed to support individuals to access services.

Recommendations

On the basis of this evidence, and in addition to the recommendations made throughout this paper, our key recommendations are:

- Make the necessary changes to the Misuse of Drugs Act 1971 to enable the Scottish Government to pursue their public health approach to drugs policy (including the piloting of a safer consumption facility in Glasgow City Centre) or devolve the powers in this area.

\textsuperscript{50} NHS Health Scotland. \textit{Drugs-related deaths rapid evidence review}. 2017
• Address socio-economic disadvantage by providing adequate protection against destitution and hardship (in and out of work) along with employment support to help people secure good work.
• Recognise the unique aspects of Scotland’s experience of the negative impact of poverty, deprivation and inequality and work closely with the Scottish Government, and Public Health Scotland when it comes into being later this year, in order that an effective whole-system response can be made to problematic drug use in Scotland, and lives saved.

22 April 2019