Scotland Committee Inquiry: Use and Misuse of Drugs in Scotland
Written Evidence Submitted by Turning Point Scotland

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[1]. 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[2]. *"Adults who experienced four or more adversities in their childhood, were …eleven times more likely to have used crack cocaine or heroin"*[3].

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)[4]. 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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[1] Scottish Government (2008) *The Road to Recovery* Pg. 12
https://www.gov.scot/publications/road-recovery-new-approach-tackling-scotlands-drug-problem/

[2] The impact of ACEs is acknowledged in the Scottish Government's Drug & Alcohol Strategy 'Rights, Respect and Recovery', in their Programme for Government 2018-19 and covered in detail in Chapter 6 of 'Getting it Right for Every Child, Young People and Families.

[3] Bellis et al (2014) cited in Scottish Government (2018) *'Rights, Respect and Recovery'* Pg. 19
https://www.gov.scot/publications/rights-respect-recovery/

[4] https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2019-03-26/2019-03-26-DATWT-Summary.pdf

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:

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

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

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

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

[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

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)[7]. 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)[8].

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[9] and that Glasgow in particularly fares significantly worse when compared to English cities of similar social and economic history (Manchester and Liverpool)[10].

"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."[11]

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[12], when the UK as a whole has seen a 17% decline in the same period[13]. Although the number of drug related deaths is rising across the UK, it is

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[7] Scottish Government (2019) *Scottish Crime and Justice Survey 2017-2018: main findings* Pg. 117 https://www.gov.scot/publications/scottish-crime-justice-survey-2017-18-main-findings/

[8] Ibid.

[9] Glasgow Centre for Population Health (2011) *Accounting for Scotland's Excess Mortality: Towards a Synthesis* https://www.gcph.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.gcph.co.uk/assets/0000/5988/Excess_mortality_final_report_with_appendices.pdf

[11] Ibid. Pg. 7

[12] NHS National Services Scotland (2018) *Surveillance report: HIV infection in Scotland: Quarterly report to 31 March 2018* Pg. 7 https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2451/documents/1_hiv-infection-quarterly-march-2018.pdf

[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[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?

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759408/HIV_annual_report_2018.pdf

[14] National Records of Scotland (2018) *Drug-related deaths in Scotland 2017* Pg. 47
https://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/17/drug-related-deaths-17-pub.pdf

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, 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[15]. Their proposal takes forward two of the main recommendations of a health needs assessment for people who inject drugs in public places in Glasgow[16]. 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[17] [18]. 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."*[19] The following statement was made in an article focused on the lessons to be learned from the facility in Sydney,

[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* https://glasgowcity.hscp.scot/sites/default/files/publications/IJB_Meeting_20161031_Item_9.pdf

[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 https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf

[17] CATO Institute (2018) *Harm Reduction: Shifting from a war on drugs to a war on drug-related deaths* https://object.cato.org/sites/cato.org/files/pubs/pdf/pa-858.pdf

[18] Adam Smith Institute (2019) Room for Improvement: *How Drug Consumption Rooms Save Lives* https://www.adamsmith.org/research/room-for-improvement-how-drug-consumption-rooms-save-lives/

[19] EMCDDA (2018) Drug Consumption Rooms: an overview of provision and evidence Pg. 6 http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en

opened in is facility 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"*[20]

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[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)[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*

[20] https://www.theage.com.au/national/nsw/lessons-from-the-heroin-injecting-room-20190115-p50rec.html
[21] https://glasgow.gov.uk/index.aspx?articleid=22874
[22] Scottish Government (2018) 'Rights, Respect and Recovery' Pg. 19 https://www.gov.scot/publications/rights-respect-recovery/

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 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,

[23] https://www.holyrood.com/articles/inside-politics/choose-life-dr-roy-robertson-front-line-harm-reduction

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 quintile[24]. *"In the most recent data, around half of patients with either a general acute or psychiatric stay in relation to drug misuse lived in the 20% most deprived areas in Scotland"*[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[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[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[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.

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[24] SPICe Briefing (2017) *Drug Misuse* Pg. 14
http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_17-22_Drug_Misuse.pdf

[25] Ibid. Pg. 15

[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.

[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 classed 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.

[28] SPICe Briefing (2017) Drug Misuse Pg. 15
http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_17-22_Drug_Misuse.pdf

"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."[29]

"…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)."[30]

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

[29] NHS Health Scotland (2016) *Human Rights and the Right to Health* Pg. 7
http://www.healthscotland.scot/media/1276/human-rights-and-the-right-to-health_dec2016_english.pdf
[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

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[31]. 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.

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."[32]

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

[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

[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

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
- 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)[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?

[33] Scottish Government (2016) *Creating a Fairer Scotland: A new future for Social Security in Scotland* https://www2.gov.scot/Resource/0049/00496621.pdf

"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."[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 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[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?

[34] United Nations Office on Drugs and Crime (2018) *Global Overview of Drug Demand and Supply: Latest trends, cross-cutting issues* Pg. 1
https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_2_GLOBAL.pdf
[35] https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(19)30036-0/fulltext

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."[36]
- 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."*[37]
- 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.*[38]

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,

[36] Scottish Government (2018) 'Rights, Respect and Recovery' Pg. 13
https://www.gov.scot/publications/rights-respect-recovery/
[37] Scottish Government (2018) *Homelessness and Rough Sleeping Action Group: Final Recommendations Report* Pg. 18-19
https://www.gov.scot/publications/homelessness-and-rough-sleeping-action-group-final-report/
[38] Scottish Government (2017) *Mental Health Strategy 2017-2027* Pg. 7
https://www.gov.scot/publications/mental-health-strategy-2017-2027/

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 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[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?

[39] http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

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."[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.

[40] Scottish Government (2018) *Delivering for Today, Investing for Tomorrow: The Government's Programme for Scotland 2018-19* Pg. 73 https://www.gov.scot/programme-for-government/

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.

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

[41] European Monitoring Centre for Drugs and Drug Addiction (2011) http://www.emcdda.europa.eu/system/files/publications/642/PolicyProfile_Portugal_WEB_Final_289201.pdf
[42] Ibid. – Pg. 15

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]

<u>Lesson from Ireland:</u> 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 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 Ríordáin, 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

[43] http://www.emcdda.europa.eu/countries/drug-reports/2018/united-kingdom_en
[44] http://www.emcdda.europa.eu/countries/drug-reports/2018/portugal_en
[45] Gonçalves et al. (2015) *A social cost perspective in the wake of the Portuguese strategy for the fight against drugs* International Journal of Drug Policy, 26 (2015) 199–209, https://www.ijdp.org/article/S0955-3959(14)00231-X/pdf

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].

<u>Lesson from Switzerland:</u> 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 elements 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"*[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

[46] https://www.vice.com/en_us/article/4wbby9/ireland-drug-policy-narcomania-781
[47] http://www.aldp.ie/wp-content/uploads/2018/10/Not_Criminals_Report.pdf
[48] Open Society Foundations (2010) From the Mountaintops: What the world can learn from drug policy change in Switzerland Pg. 19 https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-en-20160212.pdf
[49] Beckley Foundation Drug Policy Programme (2009) *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law* Pg. 4 http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf Pg. 4

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[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"*[51]

<u>General lesson from the international community</u>: 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[52].

9.12 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*

[50] https://www.academia.edu/4029433/The_Swiss_Four_Pillars_Policy_An_Evolution_From_Local_Experimentation_to_Federal_Law
[51] https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-en-20160212.pdf
[52] https://www.talkingdrugs.org/decriminalisation

should increase the focus on public health, prevention, treatment and care, as well as on economic, social and cultural strategies"[53]

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

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[53] http://www.unis.unvienna.org/unis/en/pressrels/2015/unissgsm645.html