

A Drugs Strategy for Scotland

Scottish Drugs Forum's response to the proposal announced in

A Nation with Ambition: The Government's Programme for
Scotland 2017-18

to refresh Scotland's existing drug strategy

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A Drugs Strategy for Scotland

1 Introduction

This response has been prepared by Scottish Drugs Forum (SDF) and is informed by discussions with SDF members and other stakeholders across Scotland including those attending four SDF member events hosted in late 2017. This response has also been informed by a range of other SDF activity undertaken over recent years, in particular work in relation to people with a drug problem aged 35 and over¹ and work on drug-related deaths². The response also draws on the Essential Care report³, The Expert Review of Opioid Replacement Therapy⁴ and Drugs-Related Deaths Rapid Evidence Review⁵ conducted by NHS Health Scotland.

Scotland's current drug strategy, The Road To Recovery⁶, is ten years old and, while it has had some success, it has failed in preventing or reducing drug-related deaths and other significant harms. In the face of this, there is a proposal to refresh the current Road To Recovery strategy. In this response, we describe a drugs strategy that meets the challenge Scotland faces – a drugs strategy for Scotland.

2 The scale and nature of the challenge

Scotland faces

Scotland has one of the highest rates of problem drug use per head of population, if not the highest, in Europe⁷. The number of people with a drug problem in Scotland has remained almost stable in recent years⁸; this means that the number of people developing a drug problem is approximately equal to the number of people moving on from problem drug use plus the number of people dying.

The research and latest official statistics show that

- Scotland has 61,500 people with a drug problem⁸ involving opioids and / or benzodiazepines
- Present NHS projections are that this population will be of a similar scale in 2027⁹
- While the number of children and young people in Scotland using drugs seems to have reduced¹⁰, recent research shows the number of young people using drugs in a way that is potentially harmful is increasing¹¹
- 'Drug use disorder' was the 8th most common cause of disease burden, i.e. premature death and years lived with poor health, in Scotland in 2015 – higher than dementia or diabetes¹²
- More people are dying through drug overdoses than ever before (867 in 2016) and the number of people dying through an overdose has doubled in the last 10 years¹³
- There is an uncontained outbreak of HIV amongst people who inject drugs in Greater Glasgow¹⁴.

A public health emergency has been declared and emergency measures implemented elsewhere, for example in British Columbia, Canada, in the face of less troubling circumstances than we currently face in parts of Scotland¹⁵.

Despite the toll in terms of death and ill health, only 35-50% of people with a drug problem are in specialist treatment at any time¹⁶ and there is evidence that many people are regularly dis-engaged from and subsequently re-engaged by treatment¹⁷. This means that people are not engaged in effective treatment for long enough to benefit from it or the protection it offers against overdose death.

Problem drug use is concentrated within our most deprived communities, even more so than problem alcohol use¹⁸. Poverty and inequality are key drivers for the emergence of problem drug use and its continuation¹⁹. For many people with a drug problem this background was the setting for a childhood and youth marked by adverse events and circumstances. The accumulation of adverse childhood experiences (ACEs) is closely associated with problem drug use in adulthood²⁰.

Stigma remains a significant issue for people with a drug problem in all settings including treatment and recovery. For the vast majority this is a stigma compounded by other stigmas including stigma associated with poverty. Stigma is a significant barrier to making an effective response to Scotland's drug problem and therefore, must be addressed by an effective drug strategy for Scotland.

Our current strategy, levels of resource and commitment are inadequate to meet this challenge. This should be a political and national priority.

3 The basis for a drugs strategy for Scotland

Internationally, drug strategies often reflect ideologies and mistaken assumptions about the causes and nature of problem drug use. A new drugs strategy is an opportunity for Scotland to adopt a world-leading approach to problem substance use that is based on human rights and on evidence of effectiveness.

A drugs strategy for Scotland should be based in seven principles and understandings:

- 1 Human rights as defined in the European Convention on Human Rights and particularly, in the context we find ourselves in Scotland, the right to life and the duty of the state to prevent foreseeable loss of life²¹ and in the World Health Organisation's Right To Health²²
- 2 The Health and Social Care Standards²³
- 3 The evidence of the root causes and drivers of the problem – adverse personal circumstances and experiences, health inequalities and social inequalities including poverty
- 4 The evidence of effectiveness for the full range of interventions and measures without recourse to ideology, prejudice or stigma
- 5 A commitment to the dedication of adequate resources and means to deliver the strategy
- 6 Adequate means to measure the effectiveness of the strategy including in terms of a reduction in deaths and other drug-related harms and of recovery, defined as progress in an individual's quality of life
- 7 A cross-cutting and joined-up approach from Government and in the development of national and local responses.

4 A summary of this response

A fundamental change of approach based in evidence is required. The evidence of the scale and nature of the challenge Scotland faces in preventing and responding to problem drug use is clear. We cannot shirk from recognising and addressing the key drivers of this phenomenon – poverty, inequality and adverse events and circumstances, particularly in childhood. Many people with a drug problem are victims of circumstances and events which the state and others have failed to prevent and to which the state have failed to provide an adequate supportive response.

Equally we have to acknowledge the reasons we have struggled to address problem drug use. We have previously framed this as a criminal justice issue. Now that we recognise that it is more accurately framed as a health issue, we also need to acknowledge that it is a social issue in which stigma is key. Stigma affects people with a drug problem every day. Stigma can stop people engaging with services and from fully benefitting when they do engage with services – both drug services and mainstream services. Stigma also affects services themselves in terms of the resources they are allocated and in their joint work with mainstream services. People with a drug problem are marginalised within society, as a result, so too are the services that work with them.

Many people with a drug problem suffer huge physical and mental health harms and drug overdoses alone are causing an average of two or three deaths every day in Scotland. This response recommends seven evidence-based measures which, if implemented, will drastically reduce these harms. These would ensure that people had less harm from which they have to recover.

The capacity of drug services is inadequate, resulting in an inadequate level of engagement with the population they should serve. This means that less than half the people with a drug problem are in treatment. Everyone with a drug problem should have access to health services. For this engagement to protect people from death and other drug related harm, they need to stay engaged. This response includes proposals for a target for the proportion of people with a drug problem who are engaged with drug services and for the proportion of people engaged with drug services who stay engaged with drug services. This response also recommends five evidence-based service developments which would greatly improve the effectiveness of specialist drug services.

This response identifies the need for significant cultural changes in the way services are planned, commissioned, managed and delivered and in accountability in these processes. People who have a drug problem and the services that work with them should not be left behind in the drive to change the way public services are delivered and delivering effectively to this group should be a measure of the effectiveness of these changes. This response makes five recommendations for service system change which will change the relationship between people with a drug problem and specialist drug services and the quality of service delivery.

To make progress with the issues which impact on their quality of life and drug problem, people should be able to engage with high quality services that can work jointly to support them. This response makes recommendations about how seven areas of common concern to people who have a drug problem could be addressed by service innovation.

The response also makes suggestions on how families and children may be better supported.

The response also acknowledges and describes the role of legislation, the criminal justice system and policing in improving our responses to problem drug use.

A drugs strategy for Scotland is largely focused on the main causes of harm - including death - and on the 61,500

people with a drug problem relating to their use of opiates and or benzodiazepines. It should be borne in mind that there are other people with a drug problem and other drugs of significant concern. These are mentioned in terms of prevention and of future challenges.

5 Preventing problem drug use

A drugs strategy for Scotland should have two approaches to prevention – a long term strategic approach and an educational approach.

Strategic prevention activity should focus on the drivers of problem drug use by reducing inequalities and poverty, increasing opportunity for all and maintaining a focus on vulnerable children and young people, particularly relating to adverse childhood experiences.

This work, where it currently exists across Government policy and activity²⁴ should explicitly be linked to a drugs prevention strategy in a drugs strategy for Scotland. This would include -

- How the Government delivers a welfare system based on dignity, fairness and respect to alleviate the disastrous impact of welfare reform on people including people who have a drug problem
- How the Fairer Scotland Action Plan works to prevent problem drug use and for people who have a drug problem
- How Government's funding for a range of organisations working to reduce poverty and promote social justice works to prevent problem drug use and achieves these ends for people who have a drug problem
- How the Government adviser on poverty and inequality's work can contribute to the prevention of problem drug use.

A drugs strategy for Scotland should acknowledge that an early indicator of later problem drug use is a childhood spent in care and/or a childhood that features neglect and / or abuse. Across Government there should be a commitment to improving the care of looked after and accommodated children and young people who have been looked after and accommodated.

Government should also re-commit to the prevention of abuse and neglect and other adverse events and circumstances in childhood and to support children and adults who have survived these events and circumstances. Government should include the prevention of problem drug use as an aim of activity in these areas and as a measure of success.

This includes the development of adequate mental health services for children and young people who have suffered adverse childhood experiences including bereavement, parental imprisonment, parental problem substance use, or witnessing domestic violence. It also includes the training and development of the workforce working with people affected by adverse childhood experiences in terms of their understanding of, and response to, drug use and its causes and the development of trauma informed practice and environments.

Prevention activity that involves educational approaches should be developed from the evidence of what works including the recent work on establishing the evidence base for such activity²⁵. Ineffective practice and practice that actively causes harm - which occurs especially in schools and youth work settings - should be abandoned.

Evidence-based approaches have to make their way into individual schools and classrooms and to other settings where children and young people can participate. It is therefore necessary to consider how this is achieved and how the development and distribution of ready-for-use resources might best be undertaken. Leaving this education to local arrangements, at authority and school level for example, has produced many examples of practices evidenced to be ineffective or damaging.

A drugs strategy for Scotland should

- Address the root causes of problem drug use – inequalities including poverty
- Commit to preventing the adverse events and circumstances that characterise the childhoods of many people with a drug problem
- Commit to better supporting children, young people and adult survivors of adverse circumstances and events
- Commit to the provision of adequate mental health and support services to people who have suffered adverse circumstances and events in their childhood and early adulthood
- Ensure workforce development for people working with people at raised risk of developing problem drug use to improve their understanding of, and response to, drug use
- Ensure evidence-based drugs education that equips people, particularly young people, with both knowledge and skills.

6 Reducing harms

Harm reduction involves ensuring people survive drug use and minimising what people have to recover from. Harm reduction is therefore a key part of a drugs strategy for Scotland.

In the circumstances in which we find ourselves, ensuring the physical survival of people who use drugs is a legitimate primary aim of a drugs strategy for Scotland. Reducing the harmful consequences of drug use will protect life by preventing fatal consequences and allow people the potential for a fuller recovery.

The narrower context of overdose deaths should be a focus of a drugs strategy for Scotland. Overdose deaths are preventable. Each overdose death could have been avoided and so it is inappropriate to set any other target than zero for overdose deaths. Some of the measures that would deliver this are described in the following pages.

Scotland's drug strategy should acknowledge the need for harm reduction services, the role of such services and the contribution they make to the overall strategy. The strategy should commit the Government and local service providers, commissioners and planners to ensuring the provision of quality services that are accessible and acceptable to people at risk of harm and achieve harm reduction and public health aims. The measures which can reduce drug-related harm are set out in the following pages.

A drugs strategy for Scotland should

- Ensure that people with a drug problem -
 - Survive drug use
 - Experience minimum possible harm
- Acknowledge that all drug overdose deaths are preventable and therefore aim to reduce fatal overdose deaths to zero
- Outline the rationale and the means by which people who use drugs and people with a drug problem, their communities and wider society are protected from harm through the provision of the following measures -
 - Drug checking
 - The provision of sterile injecting equipment
 - The supply of take-home naloxone
 - The provision of wound care services
 - Eliminating HIV and hepatitis C as public health concerns
 - The provision of drug-consumption rooms
 - Ensuring the sexual and reproductive health of people with a drug problem.
- Outline the rationale and the means by which the proportion of people with a drug problem who receive treatment and care is maximised. This includes describing the means by which innovations in services may be delivered, including –
 - Developing outreach services

- Reducing delays in access to evidence-based treatment
- Improving the quality and acceptability of the treatment and care experience and building a therapeutic relationship
- Increase the number of GP primary care services working with people who have a drug problem.

Measure 1: Drug checking

Considerable harms are caused by the quality of street drugs. Adulterants and contaminants can be present but the greatest risk from an individual supply is that either the drug is not what it professes to be and / or is in fact a mixture of drugs. Testing samples can quickly inform users if this is the case as well as indicating the strength of the drug. There is evidence that once users are made aware that a supply is potentially dangerous, many avoid using it.²⁶

Elsewhere effective measures have been taken to address this issue²⁷ It is disappointing that no progress has been made in Scotland, unlike elsewhere in the UK on the issue of drug checking. The Welsh Government and Public Health Wales have for years funded WEDINOS – a service that allows for the checking of drugs. This system is effective in removing some of the most dangerous drugs from the Welsh and wider markets. It also deters people in supplying the most dangerous street drugs on the Welsh market in the first place. Previously the provision of such services in Europe and not in the UK meant that some of the most dangerous drugs were ‘dumped’ in the UK market.

Also on-site testing at venues and events where people are likely to be using drugs – including large entertainment events and festivals - has been undertaken in the rest of the UK. This provision should be developed in Scotland.

A drugs strategy for Scotland should

- Commit the Government and public health in Scotland to developing a Scottish service similar to WEDINOS
- Commit the Government, Local Authorities and Police Scotland to work with third sector organisations and the relevant private sector agencies in the arts and entertainment field to ensure the provision of on-site testing.

Measure 2: The provision of sterile injecting equipment

Basic harm reduction provision should be available to all who need it. For people injecting drugs, this includes the provision of **injecting equipment provision** (IEP) services operating to the standards outlined in the national Guidelines²⁸. In this context, it should be noted that official estimates of the rate of provision of injecting equipment per person who injects drugs in Scotland is 77 per year²⁹ and the World Health Organisation (WHO) target in order to adequately address the risk of blood-borne virus transmission is 200.³⁰

A drugs strategy for Scotland should

- Commit Health Boards to ensuring the provision of injecting equipment through services which, as a minimum, meet the national guidelines
- Introduce a target to increase the provision of injecting equipment to the WHO target
- Commit the Government, NHS and Scottish Prison Service to ensuring adequate IEP services in Scotland's prisons.

Measure 3: The supply of take-home naloxone

The supply of take-home naloxone to people at risk of opioid overdose or others likely to witness an overdose is a crucial element of Scotland's response to opioid use. Scotland's drug strategy should commit the Government to the continued gathering of statistics on supply and to encouraging an increase in supply with a target for people using prescribed and non-prescribed opiates and opioids.

In line with the World Health Organisation's guidelines³¹, those likely to witness an overdose include -

- People at risk of an opioid overdose, their friends and families
- People whose work brings them into contact with people who overdose (health care workers, police, emergency service workers, people providing accommodation to people who use drugs, peer educators and outreach workers)

This target for supply should also apply to the prison estate.

As well as being provided to people when they are released from prison, naloxone should be held by staff in all of Scotland's prisons and be available for prison officers to use in the case of suspected opioid overdose.

A drugs strategy for Scotland should

- Commit Health Boards to a naloxone supply target that reaches 90% of the population identified as being at risk of opioid overdose
- Commit the Government, NHS and Scottish Prison Service to ensuring the supply of naloxone to all prisoners tested positive for opioids on entry to prison or during their stay in prison or who have a history of opioid use. Commit the Government, NHS and Scottish Prison Service to ensuring that naloxone is available to prison officers working in all of Scotland's prisons to be used in the event of an opioid overdose in prisons.
- Commit the Government, NHS and Police Scotland to ensuring that naloxone is available to police in emergency response vehicles across Scotland to be used in the event of an opioid overdose.

Measure 4: The provision of wound care services

Wound care and other early intervention services for people who inject drugs are crucial interventions in reducing harms that can have serious consequences requiring surgery and hospitalisation including amputation and also death. A commitment to the local provision of these services should form part of a drugs strategy for Scotland.

A drugs strategy for Scotland should also commit the Government and other stakeholders to learning the lessons of outbreaks of bacterial infection by implementing the recommendations made in the anthrax outbreak report³² and other outbreak reports.

A drugs strategy for Scotland should

- Commit Health Boards to the provision of adequate and suitable wound care and other services for people who inject drugs.
- Commit the Government to working with local NHS Boards and other stakeholders to provide health-board area reports that account for progress on the recommendations of outbreak reports including the Anthrax report and action planning to make changes and improvements not already implemented.

Measure 5: Eliminating HIV and Hepatitis C as public health concerns

Blood-borne viruses (BBVs) remain a serious threat to health and life for people injecting drugs in Scotland. The prevention of BBV transmission and the treatment of BBVs should be central to the strategy.

The outbreak of HIV in Glasgow is uncontained and has spread to neighbouring areas. Scotland's drug strategy should focus on BBV infection prevention and describe the importance of local vigilance against similar local outbreaks – through IEP service provision and through routine testing. The strategy should include targets for blood testing people who are injecting drug users or have been injecting drug users for BBVs including HIV.

The importance of BBV treatment as a means of prevention should be stated within Scotland's drug strategy and commitment should be made to increasing rates of treatment. The strategy should commit Scotland to achieving the WHO 90-90-90 target for HIV for people who have injected drugs. This means that 90% of all people living with HIV who became infected through injecting drug use will know their HIV status; 90% of all people with diagnosed HIV infection who became infected through injecting drug use will receive sustained antiretroviral therapy and that 90% of all people who became infected through injecting drug use and are receiving antiretroviral therapy will have viral suppression.

The provision of pre-exposure prophylaxis (PrEP) to people at risk of HIV through injecting drug use has the potential to protect individuals and to contain local outbreaks. National and local public health bodies should work to ensure that PrEP is deployed appropriately for people who inject drugs and are at risk of HIV infection through sexual transmission and through the sharing of injecting equipment.

In 2016, the World Health Organisation's first ever Global Hepatitis Strategy was adopted by 194 member states, including the UK. The strategy includes a goal of eliminating viral hepatitis by 2030.

Given the new drug treatments for HCV and their effectiveness, there is an argument that everyone with HCV should be treated. This will be beneficial to the individuals and as a wider prevention measure. There are countries piloting this approach and in Tayside this is being researched. The aim is to reduce the pool of people with HCV so that new infections are reduced to low levels. Scotland is due to launch its hepatitis C elimination strategy in 2018.

Hepatitis B vaccination amongst people who inject drugs is high, and diagnoses are low. A drugs strategy for Scotland should commit to continued effort to maintain this standard, and improve in areas where needed.

A drugs strategy for Scotland should

- Commit Health Boards to meeting the WHO 90-90-90 target for HIV amongst people in Scotland who inject drugs or have injected drugs
- Commit Health Boards to meet the WHO Elimination of hepatitis B and C as a public health concern by 2030

- Commit the Government and national public health agencies to take appropriate action to assess and, if efficacious, enable the supply of PrEP for people who are at risk of HIV infection through injecting drug use
- Commit the Government to monitoring the outcome of the work on treatment as prevention being researched in Tayside and to nationally implement such provision if this approach is proved to be effective.

Measure 6: The provision of drug consumption rooms

In areas with high levels of public injecting or in the event of a public health emergency related to injecting drug use, the provision of drug consumption rooms is an evidenced response.

Proposals for these in Scotland have been thwarted by the Lord Advocate's interpretation of the law and by the UK Government's refusal to devolve part or all of the powers that framed the Misuse of Drugs Act (1971) or amend the Act. A drugs strategy for Scotland should commit the Government to exploring practicable measures by which the provision of drug consumption rooms may be made under an interpretation of existing legislation.

A drugs strategy for Scotland should

- Commit the Government to support and work with local health boards and other stakeholders to develop drug consumption rooms where evidence suggests that they would address public health and other issues.

Measure 7: Ensuring the sexual and reproductive health of people with a drug problem

The sexual and reproductive health of people with a drug problem should be a priority. There is an opportunity to demonstrate a joined up approach by ensuring the drugs strategy is aligned with and cross-references with the Government's sexual health and BBV framework.

Sexual and reproductive health services have struggled to engage with people with a drug problem. These services can lack confidence in discussing issues around drug use and consequently women with a drug problem are often not effectively engaged by the services and are inadequately supported and empowered around issues of fertility. Their chances of having "pleasurable and safe sexual experiences, free of coercion, discrimination, and violence" (from WHO definition of sexual health) are greatly reduced. Drug services can lack confidence in discussing issues around sexual and reproductive health with their service users and consequently the sexual health of men and

women with a drug problem is not generally prioritised by these services. Any discussion is likely to focus on the absence of disease, dysfunction, or infirmity and there is unlikely to be discussion around physical, emotional, mental and social well-being in relation to sexuality.

Improved joint working between drug services and sexual and reproductive health services should be a priority. Service planners and commissioners should consider how to enable better joint work between services.

A drugs strategy for Scotland should

- Commit local health boards to ensuring that women with a drug problem are adequately supported to have control over their own fertility and have access to reproductive health services and to effective, appropriate contraception, including Long Acting Reversible Contraceptive (LARC)
- Ensure that people with a drug problem have good sexual and reproductive health and have access to information and support which provides a positive and respectful approach to sexuality and sexual relationships and to them as individuals who have a drug problem.

7 The role of Opioid Replacement Therapy (ORT)

Scotland's drug strategy must give appropriate focus to people with a drug problem involving opioids.

The benefits of ORT

As one of the most researched treatments in medicine, the benefits of ORT are well evidenced, as was confirmed in the Government-commissioned review. For individuals, ORT offers significant benefits including -

- A reduced risk of overdose death
- Reduction in infections and conditions associated with injecting drug use including BBVs, as well as injecting wounds, and deep vein thromboses which can lead to amputation and death
- Reduction in the acute and chronic health issues that arise from the use of adulterated and contaminated street drugs
- Improved general health
- Being able to develop a day to day lifestyle that is not centred around acquiring money, acquiring drugs and using drugs.
- Not having to spend a significant part of their income on street drugs; for many this means ceasing their involvement in crime
- Being able to move away from a social network largely focused on drug use.
- Establishing a positive relationship with a health services which may be a platform for more positive engagement around other issues they may face.

The wider benefits include -

- A reduction in the use of acute services including A&E
- A reduction in unplanned hospital admissions
- A reduction in drug-related crime – possession and supply
- A reduction in acquisitive crime to fund drug use
- A reduction in the profits of organised crime
- A reduced risk to public health through preventing blood-borne virus transmission and other risks.

In summary, ORT can reduce harms for people with an opioid drug problem, improving the likelihood of their recovery and the quality and extent of that recovery; it can reduce the harms to other people impacted by their use and deliver significant public health and other outcomes. These and other evidenced benefits are sufficient to justify ORT and investment in high quality ORT for everyone who could benefit from it.

As families and friends of people who have a drug problem know - despite huge personal commitment, effort and sacrifice - abstinence cannot be imposed or induced in people with a drug problem. Although many people who have a drug problem may be abstinent for periods of time, relapse into drug use is common. However, many people do go on to eventually maintain abstinence.

To task services with the aim of imposing or inducing abstinence in people with a drug problem is inappropriate and impracticable. This approach is based on a misapprehension of the nature of a drug problem – a key feature of

which, for many people, is uncontrolled use. It also presumes a level of motivation on the part of the person with a drug problem, a key feature of which is a lack of motivation to change. It is also based in a notion that services should do things to 'their service users' rather than work with people and is therefore a poor basis for a therapeutic relationship or the empowerment of people to address the issues they face.

Abstinence is a state or a condition and is not an end in itself. Treatment services should be working to develop a therapeutic relationship with people with a drug problem and to support and empower them to address the issues they face.

Abstinence should be an option for people who have a drug problem but it should not be the measure of the success of services. Making abstinence the goal of treatment simply does not allow services to meet the person in the midst of their drug problem on the terms and in the circumstances in which they find themselves.

In terms of measuring the success of an intervention, or of a drug policy, abstinence is a narrow and sometimes irrelevant measure. The measure of a successful policy or intervention is the avoidance of harms that would otherwise have occurred (to the person using drugs and those affected by their drug use) and the quality of life of the person who has had a drug problem and those affected by their use.

A drugs strategy for Scotland should

- Clearly state the benefits of ORT and unambiguously support the development of high quality, accessible and acceptable ORT services for anyone with an opioid drug problem
- Make clear that the aim of ORT is two fold –
 - To reduce the harms associated with problem drug use so that the extent of potential recovery can be maximised
 - To serve as a platform from which a person can be supported to address other personal issues and circumstances that limit the quality of their life and therefore their recovery.

The 80% engagement target – Ensuring all who can benefit from ORT are engaged with services

A key goal of the new strategy must be to increase the proportion of people with an opioid drug problem who receive drug treatment and care. The number of people in treatment currently is estimated at between 35% and 50%³³. A step change is required. A drugs strategy for Scotland should commit to a target of having 80% of people with an opioid drug problem in ORT so as to ensure they survive and to reduce the harms they and others experience as a result of their drug use.

A drugs strategy for Scotland should

- Set a target for the proportion of people with an opioid problem receiving treatment of 80% of estimated prevalence.
- Ensure local health and care planners and commissioners are tasked with working with providers to create a local plan to deliver this target within three years
- Ensure the delivery of this plan is monitored by Government.

The 80% retention target – Ensuring all who can benefit from ORT receive effective treatment

To be effective in reducing deaths, people must stay in ORT for at least 12 months. To develop a therapeutic relationship and engage with the range of services that may help address the issues that caused their drug problem or are a consequence of their drug problem - will take considerably longer for many people.

Currently, there is evidence that people are engaged and disengaged by services sometimes in a matter of weeks. This is partly caused by a service culture in which people are denied treatment for not complying with appointment times, for using drugs or for being poorly motivated. These 'behaviours' are all symptomatic of problem drug use. A cultural change is needed so that when people present at a service and seek support to manage issues in their life, including their inability to manage their day-to-day life, their behaviour is understood and they are supported and empowered to address issues rather than sanctioned.

Some of this service behaviour is a consequence of the HEAT (Health Efficiency, Access and Treatment) target for getting people who present for treatment into treatment within three weeks. This was introduced to improve access to drug treatment but has not been resourced adequately to expand the capacity of the service system and so a 'churn' of people entering and leaving the service is the only way to achieve the target. This can be avoided through adequate resourcing of services. (See section 17 - Making it work).

A drug strategy for Scotland should set a target for retention in treatment of 80% of people for each year.

A drugs strategy for Scotland should

- Set a target of retaining 80% of people in ORT treatment in a year
- Ask local service planners and commissioners to work with health and care providers to create a local plan to deliver this target within three years.
- Ensure the delivery of this plan should be monitored by Government.

The service developments required to meet the 80-80 targets

The 80% treatment and the 80% retention targets will be met through the evolution of services and service systems that are fit for purpose and have the capacity to engage some of Scotland's most vulnerable and marginalised people. This requires leadership and the vision of a Scotland determined to address the needs of this group; improve their lives to their benefit and to the benefit of their families and communities.

Five service developments are required to achieve the goal of ensuring all the people who can benefit from effective treatment receive it. Below are the service developments required to increase the number of people who receive treatment and ensure that the treatment is effective.

Service development 1: Develop outreach services

Outreach can help ensure that people are supported to engage with services appropriate for them. Outreach can also quickly re-engage people who have recently dropped out of treatment and care. The need for this service will be reduced if services can attract and retain people to treatment, however, the provision of outreach will still be required.

Service development 2: Reduce delays in access to evidence-based treatment

In Scotland, people have to wait for health treatment. For many people this can involve inconvenience as well as anxiety and even pain and suffering. However, for people with a drug problem it can result in disengagement and a failure to engage for months and or years, meaning that they are involved in years of harms to themselves and to others. Lack of motivation to change is a key indicator of problem use and so waiting times mean no treatment for many people. The three week wait is largely being met however what is evident from the data is that this is primarily for structured support rather than ORT and the data masks lengthy waits for ORT – six months or more in some areas.

The current three week HEAT target is appropriate for some people engaging with drug treatment. However, it is not appropriate for people with an opioid problem. There should be a specific waiting time for access to ORT for people with an opioid problem. This should be shorter than three weeks and, for the most vulnerable, less than 48 hours.

Service development 3: Improve the quality and acceptability of the treatment and care experience and building a therapeutic relationship

Good quality services attract people to use them and reduce the need for outreach and other activities. Means of increasing the acceptability of treatment for people with drug problems are similar to those for other groups receiving health and social care. We need a range of treatments, and treatment regimes, to understand their suitability for individuals and to work with the person to find the treatment most suited to them. In this regard, people with a drug problem are similar to any other group and yet all of this is largely undeveloped in the area of drug treatment.

ORT should be delivered according to evidence-based practice and good practice guidance. A range of therapies should be widely available and considered for each person on ORT morphine and Patients should be actively engaged and involved in this process. This may involve advocacy (see section 8 - The Quality of Specialist Treatment and Care Services).

A risk-averse default that means the majority of people are treated with the maximum level of supervision and control in terms supervised dispensing has developed. This is disempowering for some people who would benefit from a more flexible approach which would better allow engagement with other services - including employability - and be further involved in meaningful occupation.

Guidance on the development of more flexible treatment regimes should be developed. There is a need to better target different regimes around ORT including take home and supervised dispensing of ORT. Individuals should be able to switch between different regimes to be best supported with the issues they face and the opportunities they have in terms of engagement with family, meaningful occupation and employment.

Service development 4: Increase the number of GP primary care services working with people who have a drug problem

The capacity of existing specialist treatment services is inadequate. Existing specialist treatment services can be under considerable pressures that affect service quality and their ability to retain people in effective treatment. While specialist service provision could be expanded and there are opportunities in terms of improving efficiency; a step change is required. The only practicable means to double the capacity of the healthcare system to engage people with an opioid drug problem in ORT is to normalise the relationship between primary care services and people with a drug problem.

People with a drug problem are often disengaged entirely from primary care. This means that they receive their drug treatment through specialist services only and often means that they receive a reduced or non-existent service around their other healthcare needs. This is not the basis for making a recovery in terms of health and well-being. This variability has developed over 30 years, with excellent GP engagement, participation and involvement in some

parts of Scotland and virtually non-existent in others.

Where it exists, GP resistance to engaging with people with a drug problem has to be challenged and GPs need to be supported in sharing the care of patients with a drug problem with specialist services.

Service development 5: Increase the range of prescribing options

There remains a significant issue with the provision of patient-appropriate prescribing. Prescribers and patients should be working together to find a form of ORT that is effective and appropriate for them. People should be able to move from one prescription to another as they progress or when they encounter issues with their prescribed medication. In other words, this NHS patient group should be engaged and treated like any other patient group. So a full range of substances should be options for all individuals – methadone, buprenorphine, slow release morphine and diamorphine. There is also a need to explore the potentials of other substances prescribed elsewhere in Europe including long acting medications that would not have to be dispensed daily. These would give patients more freedom to address issues they may have or to meet family commitments or to work, for example. They would also remove some of the pressure from services.

The ‘street valium’ and other markets are a significant hazard and a cause of growing concern. The prescription of benzodiazepines to people who are dependent or use these substances should be considered.

These five service developments will improve engagement; however, services - and the proportion of people with a drug problem who are engaged with them - would be transformed by a clearer vision of the purpose of treatment and care services. This includes physical survival of problem drug use, a reduction in harms from which people have to recover and to provide a solid base for people to identify and address the issues they face in their life across a full range of measures. This should not be restricted to immediate crises over homelessness and debt or injecting site infections, for example, but long term issues including experiences of trauma, physical and mental health, social isolation and employability.

A drugs strategy for Scotland should state clearly that the purpose of treatment services is to

- Ensure that people survive their problem drug use
- Reduce the harms from which people have to recover
- Provide a solid base for people to identify and address the issues they face in their life across a full range of measures.

8 The Quality of Specialist Treatment and Care Services

The quality of services will be improved through investment and service developments required to meet the 80-80 targets described in the previous section.

However, a drugs strategy for Scotland should ensure services quality so that engagement with drug services is the basis for addressing other issues and making improvements in people's quality of life. This section describes how workforce development, changes in service configuration, effective local planning, the involvement of people who use services and the development of advocacy services can ensure that more effective services are delivered.

Service system change 1: The configuration of specialist treatment and care services

The configuration of services is an issue that should be addressed through a drugs strategy for Scotland. One obvious issue is that in some parts of Scotland there are some very large NHS specialist services which understandably struggle to deliver person centred care given the high number of people they seek to serve. There are significant benefits to be gained in moving to a more localised model that would improve uptake with wider health provision and wider holistic support services.

A drugs strategy for Scotland should

- Ensure local service planners and commissioners work to develop units of care on a scale that deliver localised person centred care and are adequately networked with mainstream generic services including health services and other services that support people in improving their quality of life.

Service system change 2: Local planning, commissioning and accountability

There is an anomaly in many parts of Scotland that means that local service planners and commissioners have control and scrutiny over the services delivered by some service providers, for example third sector services, in terms of the role of the service, how it is delivered, its aims, targets, outputs and outcomes and joint working with other agencies; however, they have no such control and scrutiny over other service provision, for example that delivered by the NHS.

This makes overall service planning and the development of systems of care very difficult and means that there is no coherent chain of local accountability.

A drugs strategy for Scotland should

- Ensure that specialist services in both the statutory and third sectors have a service specification and agreement with local service planners and commissioners that provides transparency in terms of their aim, role, outputs, outcomes and capacity regarding accountability arrangements.
- Ensure local service planners and commissioners have scrutiny over all of the specialist drug services in their area and ensure that there is a shared local understanding of the aim, role, outcomes, outputs and capacity of these services and how they work with generic health and other services.

Service system change 3: Workforce development

Services will be improved if all frontline staff have the knowledge and skills to optimise drug treatment and to use treatment as the basis for improving people's quality of life by addressing the issues that are the cause or the consequence of their drug use.

Staff in generic services require the knowledge and skills to be able to work with people who have a drug problem so as they can improve their quality of life.

A drugs strategy for Scotland should

- Commit the Government to a workforce development strategy to ensure the specialist workforce is equipped to deliver a quality service that provides high quality effective treatment. This should serve as the basis for engagement with services and other means to improve the quality of life of people with a drug problem.

Service system change 4: Involving people with a drug problem in developing services

The involvement of people who use services in service commissioning, planning and evaluation is key in the development of quality services. The experiences and opinions of people who use services, or who might benefit

from using services, should help inform all stages of planning, commissioning, development and evaluation of services.

It is important to include the most marginalised groups within this process. The voices of the most vulnerable and marginalised are often not readily available to planners and commissioners of services. Commitment and innovative practice are required to ensure that these voices are heard. Existing commitments, for example, from the NHS to involve the public in decision making often do not extend to people with a drug problem. A more proactive and committed approach is required. There is a huge challenge to empower, what is largely a very marginalised and disenfranchised population. A range of models should be used to support this.

A drug strategy for Scotland should commit national and local service planners, commissioners and management to active involvement of people who use services or may benefit from services in their processes and service development and actively involve the opinions and experiences of the most marginalised within these groups.

A drugs strategy for Scotland should

- Commit the NHS and other services, services planners, designers and commissioners to engaging with people with a drug problem
- Ensure that the experiences and opinions of people with a drug problem, including the most marginalised are given due influence developing appropriate services that are based, where possible, in evidence of effectiveness.

Service system change 5: Advocacy

Advocacy services help people to engage with services and ensure that people receive the services to which they are entitled. Advocacy can also help improve services as in making changes to accommodate people who may otherwise be excluded services make changes that can benefit service users more widely. There are real opportunities for services and staff to develop in ways that more readily include and support people. With a group as disenfranchised as many people with a drug problem, advocacy has huge potential to empower people and drive change in service systems.

All people with drug problem should have access to skilled advocacy services which have the appropriate knowledge and understanding of substance issues to be able to support people to challenge service practice. People with a drug problem themselves should be made aware of their rights and how, if necessary, they are to be supported to assert these. There is a potential for peer supports in this regard.

A drugs strategy for Scotland should

- Commit to the development of local independent advocacy provision to help those who are not engaged, or not fully engaged, with specialist services to receive the services to which they are entitled to
- Commit service planners and commissioners to using the learning from this work to improve services, thus reducing the need for advocacy in the longer term.

9 Recovery

Recovery involves people making progress and improving their quality of life. By helping improve quality of life and maximising what people can recover to - wider supports provided through non-specialist services can contribute to people's recovery.

Specialist drug services have a limited role and are dependent on other mainstream generic services in working with people who have a drug problem to make progress across a range of domains.

Improving joint work with mainstream generic and non-specialist services

The development of effective systems of treatment and care is dependent on joint working between specialist treatment and care services and mainstream generic services.

The wider support required by individuals may include engaging with a range of services dealing with issues including housing, debt, employability, physical and mental health and isolation and loneliness.

The development of effective systems of treatment and care is sometimes stunted by mainstream generic services attitude and behaviour with regard to people with a drug problem. Access to wider services and support can often to be limited and impacted on by the attitudes of these services towards people with drug problems. Eliminating stigmatising attitudes in the wider support services is crucial to ensuring people receive appropriate and effective support. In these service settings there is a need to adopt a rights-based approach where discrimination is challenged and viewed as unacceptable.

A drugs strategy for Scotland should

- Task local commissioners, planners and managers to map and audit local non-specialist services that might support local people with a drug problem in improving their quality of life and to measure their current capacity to do such work
- Task local commissioners, planner and managers of services to establish joint working to improve this capacity and the quality of engagement of non-specialist services with people with a drug problem
- Commit the Government in taking a lead in national action to reduce stigma experienced by people with a drug problem including by the approach and value base evident in its drugs strategy and the language, tone and attitude adopted in promoting the strategy
- Task local service planners and commissioners and stakeholders to work together to reduce stigma and remove this barrier to joint working between services.

Housing and homelessness

Problem drug use is a cause of and is caused by insecure housing and homelessness. In terms of motivation, seeking help and engagement with services offering treatment and other support, homelessness is a barrier to people making progress in their lives. Housing policy is therefore an important facet of an effective strategy response to problem drug use. A drugs strategy for Scotland should articulate with national housing and homelessness policies.

Housing First, whereby accommodation and necessary support to maintain a tenancy are provided without condition as to the person's substance use should be further developed across Scotland.

Scotland was an early adopter of this provision, in UK terms. The first project opened in 2010. However, there are still only a few such projects in Scotland. In 2009, the Government's own advisory group recommended this approach and there are extensive projects in other parts of the UK including a project that covers the whole of Merseyside.

A drugs strategy for Scotland should

- Explicitly support the further development of Housing First provision in Scotland so that it is the default offer to people with a substance use problem affected by homelessness.
- Ensure reduction in demand for Housing First by further committing to the provision of adequate housing support to ensure that people with a drug problem are adequately supported to maintain their current housing.

Registered social landlords (RSL) and support services should ensure that adequate support rather than eviction is the default offer to tenants with a drug problem who are in rent arrears, identified as being involved in 'anti-social behaviour' or other circumstances that lead to eviction. These evictions are part of RSL response to Government agendas around 'anti-social' behaviour and rent arrears. There is a clear need to think through unintended consequences of policy and the costs to public finances.

A drugs strategy for Scotland should

- Commit the Government to work with local authorities and others to ensure that the default offer from registered social landlords and support services is to adequately support rather than evict tenants with a drug problem.

Education, training and personal development

For many people with a drug problem, education, training and opportunities for personal development are key to making progress and moving on. There should be funding for this work from existing mainstream providers who should be inclusive of people with a drug problem and in recovery.

Funding for this work should be dependent on measures of success; including soft indicators of people making progress in their lives and perhaps towards 'meaningful occupation' rather than moving into paid employment. In this context, treatment and care services should be working with local partners to ensure the provision of opportunities as part of people's recovery.

Local recovery communities provide a basis for some activity in this area for some people. However, future focus should also be on how colleges, local training providers and others work with people with a drug problem or who are in recovery and the services they are engaged with. There is a need to adopt a rights-based approach to training and education where discrimination is challenged and viewed as unacceptable.

A drugs strategy for Scotland should

- Commit local service planners and commissioners to work with local providers to ensure that there are effective links between services so that people with a drug problem, and those in recovery, are adequately supported with regard to their education, training and personal development. Where there are gaps in provision, innovation should be encouraged.

Employability and volunteering

For some people, education, training and personal development enable them to move towards employment. Employability work and volunteering can play a role in this.

For some people, a move into paid employment is provided through intermediate labour markets (ILM) which allow people to undertake paid work while learning and receiving certificated training. The outcomes for people in recovery - in terms of the number of people gaining paid employment - are very good. A range of intermediate labour market programmes should be developed and supported which recognise the significant barriers to employment for this population and also the huge potential that exists within this population and the contribution employment makes to the quality of life.

There is potential for support for people who have a drug problem to be a key focus of existing employment and employability services; including Fair Start Scotland.

A drugs strategy for Scotland should

- Commit local stakeholders to supporting the development of ILMs for people in recovery
- Commit the Government to reporting on the number of people with a drug problem and in recovery benefitting from existing national employability services and to increasing this number.

Some people in recovery work in the delivery of peer education and support and harm reduction measures. There are good practice models of the delivery of harm reduction measures by people in recovery which are of benefit to them through the provision of work experience and employment. The Glasgow peer naloxone training and supply is a useful model of the potential for such work, as are other models across Scotland.

A drugs strategy for Scotland should

- Commit local stakeholders to creating opportunities for people with a drug problem or in recovery to work, including, but not limited to, in peer roles.

Income maximisation and financial inclusion

There is a need for welfare rights advice to be provided to people with a drug problem or with a history of substance problems who are in receipt of social security. Existing services are not necessarily designed to work with this group. Local ADPs should map such services and engage with them regarding provision to people with a drug problem.

There are models of specialist drug services and other services for marginalised groups (e.g. homelessness services) which host welfare rights services to maximise income for their clients. Clearly there is role for debt advice and credit unions in working with people with a drug problem at all stages in their recovery.

A drugs strategy for Scotland should

- Task specialist drug services to work with local services including credit unions, welfare rights services and others to deliver to people with a drug problem and in recovery.

Physical health

The underlying physical health conditions of people with a drug problem need to be identified and treated appropriately.

Generally, the physical health of people with a drug problem is poor and their engagement with mainstream medical services is poor.

People with drug problems are over-represented in attendance figures at A&E; amongst unscheduled hospital admissions and in self-discharging from hospital. Together, all of this means that their health issues are not always identified and they are often diagnosed when well progressed and the cause of a health crisis or acute problem and diagnosis and treatment are provided through the most expensive medical services. There are significant financial savings to be made in identifying and addressing health issues in more appropriate settings and in reducing A&E attendance and hospital admissions.

It is also worth noting that people with a drug problem often have low expectations of their own health and expect to be in poor health, so do not proactively engage with services.

Routine screening is part of the answer to this. For people in drug treatment routine screening for COPD, diabetes, liver function, etc. would ensure that some of the health issues that can be envisaged in this group could be identified as they are with other patients.

People who have injected drugs should be tested for blood borne viruses and people who continue to inject drugs should be tested every three months.

Specialist treatment services need to work with mainstream health services or develop their own capacity to undertake this work. General practice is a potential resource to meet this need.

A drugs strategy for Scotland should

- Task specialist drug services and GPs with ensuring that people with a drug problem in their care receive routine health checks and tests.

Mental health

Poor mental health is a cause and consequence of problem drug use. In this sense, many people with a drug problem initiate their drug use as self-medication for their mental health issues, or their drug problem evolves and becomes, at least to some extent, a matter of self-medication for mental health problems. The use of opioids and benzodiazepines is clearly connected with their effect in terms of addressing anxiety and distress. The high prevalence of problem use of these substances - rather than stimulants like cocaine - is a consistent and particular characteristic of drug use in Scotland.

The identification of a mental health problem and, if possible, diagnosis and treatment, can be crucial in people making progress in their lives. Yet there is surprisingly little mental health service involvement with people with a drug problem. Drug use, including being on medication for drug use, is a criteria to exclude people from mental health services.

IJBs should ensure that mental health and addictions services work effectively together at operational and strategic levels in order to better identify and meet the needs of people with a substance problem. This work should include but not be limited to building the capacity of addiction services to work with people with mental health problems. The Glasgow Trauma Service is a model for how this could be developed.

As well as diagnosis and treatment for mental health issues, there are other means to improve mental health. These include identifying issues with people and supporting the development of coping mechanisms that deal with symptoms other than drug use. There are issues for many people with a drug problem with disordered sleep patterns and self harm, for example. Services working with people with a drug problem should work with ADPs so that they are aware of supports in their local area for these and other mental health issues.

Those planning and commissioning services should ensure clear referral pathways and joint working protocols between drug and mental health services.

A drugs strategy for Scotland should

- Task local service planners and commissioners with ensuring joint work between specialist treatment services, GPs working with people with a drug problem and mental health services and ensuring that there is adequate capacity in mental health services for this work.
- Task local service planners and commissioners with building the capacity of services working with people with a drug problem to understand mental health issues, particularly trauma, and to work with people affected in a psychologically informed approach.
- Task local service planners with mapping mental health related services and encourage joint working and referral pathways between these and specialist drug services.

Social networks

Social isolation is a significant issue for some older people with a drug problem and for some people in recovery. Local partners should consider how they can develop appropriate support to reduce isolation and loneliness amongst people with a drug problem, particularly older drug users, and where appropriate develop meaningful productive activity programmes.

At a national level, the loneliness and social isolation strategy should co-ordinate with the drug strategy for Scotland. Service planners and commissioners should consider this issue and how to improve social networks of people who have a drug problem or are in recovery.

A drugs strategy for Scotland should

- Task local service planners with mapping opportunities for developing social networks for people at all stages in recovery or problem drug use and in ensuring that these are known to all services
- Task specialist drug services with identifying social isolation in people using their services and ensure that there is joint work and referral to services or groups that may help.

10 The role of families

Having a family member with a drug problem has a huge impact on family life and relationships within the family. Families need to be adequately supported to protect their own health and wellbeing and, where appropriate, to contribute to the support and care of their family member with a drug problem.

The families of some people with a drug problem are closely involved in their support and care. Family engagement with services involved in the treatment and care of a family member is a complex issue. Issues over the person with a drug problem's right to privacy and confidentiality and to make decisions for themselves can bear on the degree and nature of family involvement.

There is also the issue of the extent to which the family have the capacity to support and care and whether this is therapeutic for the person with a drug problem. It should not be presumed that the family does not have the capacity to care and support or that such a relationship will not be therapeutic. Services have to consider with the person they are working with, the role of their family in support and care and the extent to which maintaining and building relationships with family members contributes to progress in terms of wellbeing. This consideration may change as circumstances change and so should be reviewed.

There are various means by which services can develop family-informed practice. Families often are the first to realise that someone has a drug problem. When this is raised with services, it is reasonable that they should receive a positive response, even if the service is unable to intervene or offer further support at this stage. Likewise families may be able to contribute to assessments and to treatment regimes. This should be considered although the person with a drug problem is the final arbiter of this. It may be that, as in the mental health field, advance statements could help make the intentions of a person with a drug problem, whose decision-making is impaired, clear in this regard.

A drugs strategy for Scotland should

- Commit the Government and local service planners to providing adequate supports to families affected by a person's drug problem to support and promote their health and well being
- Commit specialist drug services to consider the role that family and other social networks play or may play in supporting and promoting the well being of people with a drug problem with whom they work
- Commit specialist drug services to considering the role that advance statements may play in the longer term support of people with a drug problem, especially if they also have a mental health diagnosis.

11 Children

This area of work is closely linked to the prevention agenda, particularly with regard to the risk of children with parents with drug problems developing problems themselves.

Adult specialist drug services need to work more closely with children's services. This may be best achieved through appropriate co-location and through training and network events that encourage and facilitate joint working.

Too often, parents with drug and alcohol problems report that assistance is only available at the point of crisis. Help and support needs to be available much earlier to families experiencing problems and should be available consistently and, potentially, over a long period.

Such support will lead to better care of children, earlier identification of those children at significant risk and reduce the likelihood that children will require compulsory measures of care.

A drugs strategy for Scotland should

- Clearly link activities that support the children of parents with a drug problem to the prevention of problem drug use
- Task services with identifying and meeting the support needs of families requiring assistance
- Ensure there is a shift from a crisis-based perspective to a supportive relationship with vulnerable families; achieved through services making earlier interventions.

12 Criminal justice

The criminal justice system should provide means to get people the help they need to address their problem drug use and so reduce their involvement in crime.

Diverting people involved in drug-related crime away from the criminal justice system wherever possible is beneficial to the individuals, delivers better outcomes and saves costs within the criminal justice system; including costs of the Crown Office Procurator Fiscal Service (COPFS), the courts, legal aid and the Scottish Prison Service. There is good evidence for this - and the argument is broadly accepted - but practice is inconsistent and, for large parts of Scotland, arrest referral schemes and alternatives to custody are underdeveloped.

There are a number of potential interventions that should be in place including arrest referral schemes, alternatives to prosecution programmes and alternatives to custody models.

Arrest referral

These schemes are designed to deliver a referral service to a specialist service at the point of arrest. These can operate as well-resourced programmes or simply a card providing information to the arrested person on local services. The better resourced programmes would allow for service engagement while the person is in custody. While not designed as an alternative to prosecution it may lead to a better and informed disposal either by the COPFS or the courts. The main purpose however is to engage with an individual in order to encourage uptake of harm reduction and treatment services.

Alternatives to prosecution are underdeveloped in Scotland. The better models which have existed in Scotland have been those which have provided a specialist drug and alcohol service to the COPFS. This would allow, with appropriate protocols being in place, for the specialist services and COPFS to discuss specific cases of individuals and agree that justice may be best served by not proceeding with a prosecution, provided the person agrees to certain conditions. In most cases this would be to attend a service for an agreed minimum period of time.

Court disposals

Clearly there are a range of disposals available to the courts depending on the severity of the offences. Alternatives to custody programmes have been in place for many years, most notably Drug Treatment and Testing Orders (DTTO), which were established across Scotland in 2005 following pilots in Fife and Glasgow. These are orders whereby a person can be sentenced to a DTTO. These are non-custodial treatment orders which can be up to three years in length. The person must participate in treatment and other supports and their progress is monitored to ensure compliance.

Other disposals might be a community pay back order with a condition of drug treatment.

A drugs strategy for Scotland should

- Seek to develop a coherent, consistent, evidence-based and practicable approach to people who use drugs in terms of the law and the criminal justice system
- Ensure that well resourced arrest referral exists across Scotland
- Ensure that alternatives to prosecution programmes are in place
- Ensure that DTTOs are appropriately utilised and of consistent quality.

13 Policing, the law and drug use

Police role in event of overdose

People who are using drugs or who have other reasons to not want to engage with police are reluctant to seek help from emergency services in the event of witnessing a drugs overdose. A delay in calling for emergency help or people leaving the scene who may otherwise have helped a person who has overdosed is a threat to that person's life.

For this reason, police treating the scene as a crime scene is an inappropriate first response to a suspected drugs overdose. Elsewhere, including in Canada, a 'good Samaritan' approach means that anyone, including a person using illicit drugs, can ask for an emergency response and be encouraged to stay with an overdose casualty until help arrives as they know that they will not be treated as a suspect and will not be investigated for petty offences as the priority is assistance to the person who has overdosed.

In Scotland this should be considered as a national Police Scotland protocol. Police would not seek to investigate or enforce other matters at the scene of an overdose. The clearest indication of this immediate priority would be that police responding to an overdose would have possession of a naloxone kit and be trained in its use.

A drugs strategy for Scotland should

- Commit the Government, Police Scotland, The Scottish Fire Service and The Scottish Ambulance Service to creating a joint protocol on the emergency response to a suspected drugs overdose that ensures that the priority of first responders is always and solely the well-being of the person who has experienced a suspected drugs overdose.
- Ensure police practice is developed to solely prioritise the well-being and safety of a person who overdoses and not to investigate or enforce the law in the immediate scene of a drug overdose.
- Ensure police and the fire service have naloxone available to them and are trained in its use.

The policing of drug possession

The policing and prosecution of people for possession of small quantities of drugs for personal use costs a lot of police time and resources, as well as the resources of COPFS and others. It also affects the relationship between people who use drugs and the police, and the relationship between people who do not use drugs, especially young people, and the police.

In late 2015, Police Scotland announced they would change their approach to possession of cannabis for personal use from January 2016. This involves the use of Recorded Police Warnings. Official figures show officers handed

out a total of 5,827 Recorded Police Warnings (RPWs) in 2016/17, equivalent to roughly a fifth of all drug possession charges.

This practice has proved practicable and effective for over two years and it should now be extended to cover drug possession for personal use.

A drugs strategy for Scotland should

- Commit to the introduction of a RPW system for all cases of possession of drugs for personal use.

14 Drugs legislation

Drugs are controlled in the UK under the Medicines Act (1968), The Misuse of Drugs Act (1971) and The Psychoactive Substances Act (2016). All of this legislation is reserved to Westminster.

It should be noted that -

- Some of the content of this legislation is the means by which the UK meets its international treaty obligations, including the UN conventions that form the basis for the control of drugs in over 180 states
- The vast majority of evidence-based interventions, some completely lacking in Scotland e.g. heroin assisted treatment, and others underdeveloped e.g. moving people from the criminal justice system to treatment, can be undertaken under the current legal framework at UK and Scottish levels
- Other jurisdictions within the UK, equally confined by the terms of the Misuse of Drugs Act and other UK legislation, have been able to innovate services, for example drug checking services. The joint support of police, local government and, in the case of Wales, national government seems to be crucial
- Even in Scotland, innovations have been possible including the deployment of Recorded Police Warnings for possession of cannabis for personal use from January 2017.

Recently, The Lord Advocate advised that a drug consumption room would be illegal and undeliverable due to, amongst other matters, the terms of the Misuse of Drugs Act. This has led to requests to devolve drug control and other related matters to Scotland.

It is timely to ask what Scotland would do with the powers that may be devolved. Public discussion can begin immediately. An inclusive, respectful public discussion seeking insight into the challenge and possible practicable responses and the evidence for these should be initiated and this should include discussion of whether and how drugs are controlled in Scotland.

A drugs strategy for Scotland should

- Commit the Government, Police Scotland, The Scottish Fire Service and The Scottish Fire and Rescue Service to contribute to a public debate on practicable evidence-based responses to drug use and to problem drug use. This would include how drugs are controlled in Scotland and how the state should best be involved with people who have a drug problem; identifying whether the powers to achieve this are within the control of the Scottish Government; seeking the devolution of any such powers that are not devolved and do not serve to meet the UK's international treaty obligations.

15 Empowerment, changing cultures and attitudes

The Global Drug Policy Commission has published an authoritative and highly readable report that neatly summarises much of the impact of prejudices on people who use drugs and in impeding responses to problem drug use.³⁴ This document could serve as the basis for a new and world-leading approach in Scotland. Central to this is addressing stigma.

Stigma and discrimination result in people with a drug problem often being treated in ways that would be viewed as unacceptable for other populations in society. The attitudes, beliefs and values held towards people with a drug problem, result in behaviours towards them in public, service and even family settings which are unhelpful in supporting people to address their problems - including their drug problem.

Stigma contributes significantly to Scotland's drugs problem and also significantly hinders our response to the challenge of problem drug use.

Drug use is stigmatised; having a drug problem carries additional significant stigma; treatment is often stigmatised; being a person who has had a drug problem in the past is also often stigmatised. Thus forms of stigma haunt people across their whole engagement in drug use, their treatment and recovery.

Stigma is a significant reason why people have difficulties reaching out for help, engaging with services and other forms of support which they need and to which they are legally entitled to including, for example, housing and health services. It also hinders the provision of services, as services and their interventions, including medical treatment, is itself stigmatised.

Stigma is a key driver of alienation and exclusion, from family and other social contacts as well as employment and education.

Stigma is a cultural phenomenon which we cannot wholly control but which we can influence. There is a need to challenge stigma at all levels and at all stages. One way to begin challenging stigma is to clearly state the intention to do this, to have a positive and coherent strategy on drug issues generally and to foster a respectful public discourse on drug issues that eschews the language of prejudice so often adopted in public and political discourse. If public discourse can be based on fact and evidence rather than ideology and prejudice, this would also help.

Consistency should be applied by Government, NHS, local authority and commissioned third sector organisations as to acceptable and unacceptable language. As a first step, terms like 'addict', 'clean', 'abuse' and 'misuse' should be challenged and removed from the discourse in services.

Developing an evidence-based response to problem drug use is hugely impeded by the stigmatisation of evidence-based responses and particularly ORT with methadone. While it is important that poor practice is challenged, for years the terms of debate and discussion around methadone in Scotland has often exposed prejudices and stigmatising attitudes to people with a drug problem. This needs to be challenged. There is a clear role for Government and the national strategy to take a lead role here.

Another means of challenging stigma is to ensure people with a drug problem are adequately supported and empowered. The measures to ensure that people using services are involved in planning and delivery of services

and the development of advocacy (described in Section 8) form part of the activity to empower people with a drug problem.

Training and awareness raising has potential to create a human resource that could challenge stigma.

A drugs strategy for Scotland should

- Initiate and promote a respectful public discourse on drug issues that eschews the language of judgement and prejudice
- Ensure training on stigma is part of the induction programme for all staff commencing work in specialist drug and alcohol services
- Ensure all service managers receive training on stigma
- Ensure materials are available so that people know how to identify and challenge stigma
- Ensure a national programme of training for other professional groups that have significant contact with people with drug problems
- Commit NHS Scotland to de-stigmatising the medical treatment of people with a drug problem through its communication with the public and through the media.
- Ensure inappropriate and stigmatising terms like 'addict', 'clean', 'abuse' and 'misuse' are removed from the discourse in services.

16 Future-proofing a drugs strategy for Scotland

A drugs strategy for Scotland should focus on the main causes of drug-related harm - including death. It is appropriate therefore that the focus is on opioid and benzodiazepine use. However, the strategy must also take account of emerging trends in substance use and groups of people who are particularly vulnerable.

Recent work on trends of drug use in the following vulnerable populations suggests that a better understanding of the issues and how harms might be reduced is required -

- Men who have sex with men and particularly men involved in chemsex
- People who use image and performance enhancing drugs, particularly steroids and those who inject drugs
- People involved in prostitution
- Vulnerable young people including people who have been looked after and accommodated.

A drugs strategy for Scotland should

- Commit the Government to work with partners to monitor and research trends in drug use and emerging issues with vulnerable populations
- Commit local planners to develop and maintain local trend monitoring groups and to implement services based on local needs.

17 Making it work

Paying for the strategy

Scotland spends significant resources on responding to problem drug use, Given the scale and nature of the challenge Scotland faces this is inevitable. An effective drugs strategy is going to demand significant resourcing.

However, there is a significant decision to be made in terms of resources. Recent work by ISD has projected future service use by people with a drug problem in terms of unscheduled hospital admissions alone that indicate the huge potential saving available to invest in interventions that prevent these costs.

In simple terms, responding to Scotland's drug problem has been and will be expensive. We have little choice in that. However, there is a crucial choice to make – do we continue to respond reactively and pay for the cost of unnecessary accident and emergency attendances, unplanned hospital admissions, HIV and viral hepatitis treatment costs, policing costs, courts costs, legal aid costs, prison stays, drug-related crime, to name a few - OR - do we invest in services that respond proactively to the problem, reduce harm, respond to the immediate crisis and then engage people to identify and address their underlying issues and problems - including their mental and physical health, having a home, having an income, having some positive activity to engage in and having a useful supportive social network of people around them.

When the full spectrum of needs is properly viewed, we can see that people with a drug problem have the same needs as everyone else and these should be addressed through generic services and the same means as the rest of the population. The specialist support is only required in terms of identifying needs and ensuring these are addressed through mainstream provision.

Responsibility for the overall delivery of the new strategy rests with Government and the local planning structures – Alcohol and Drug Partnerships which report to Integrated Joint Boards for Health and Social Care. However, delivery will involve the full range of mainstream services used, or which could be used, by people with a drug problem to improve their health and wellbeing and wider quality of life. All this would be helped by family and community supports of people with a drug problem and by a Scotland-wide commitment. This is a national challenge and should be a national priority, for which an adequately resourced response is required. A drugs strategy for Scotland should represent that commitment to some of Scotland's most marginalised and vulnerable adults.

Measuring success

There must be clarity regarding the key outcomes Government wants to deliver and how these are to be measured. Key outcome measures should be –

A reduction in fatalities

Measures would include -

- A reduction in fatal overdose deaths
- A reduction in suicides amongst people with a drug problem

- A reduction in people with a drug problem dying from hepatitis C-related conditions
- A reduction in people with a drug problem dying of HIV-related conditions.

Improvements in physical and mental health

Measures would include -

- Increased engagement with health services
- Improvements in individuals' health and well being
- Increased engagement with mental health services
- Improvements in individuals' mental health and emotional well being
- Fewer new transmissions, as well as late diagnoses, of blood borne viruses and other infections associated with injecting drug use.

A reduction in harmful substance use

Measures would include -

- A reduction in substance use
- A reduction in poly-substance use
- Transitioning to less hazardous forms of substance use

A reduction in homelessness and insecure housing

Measures would include -

- The numbers of places available through Housing First
- Fewer evictions of people with a drug problem
- More housing support to people who have a drug problem
- A smaller proportion of homelessness presentations by people who have a drug problem
- A smaller number of homelessness presentations by people who have a drug problem
- The extent of the coverage of housing first provision.

Other measures may include increased meaningful occupation; reduction in offending; improved self-care and nutrition; improved relationships with others and social networks; a maximised income, access to debt advice and financial inclusion; improved parenting and relationship with children, if appropriate.

For many people with a drug problem this will be achieved through:

- Increased engagement with drug service
- Improved retention in drug services
- Increase engagement in wider supports
- Improvements in person-centred care

In terms of measuring the success of the strategy and ensuring that it is addressing any emerging issues, the Minister and the Government should be advised appropriately by those expert in the sometimes complex issues which are

involved. Experience shows that such structures, now in their third iteration under the devolved administration, need to be robust, stable and properly designed. A drug strategy for Scotland should commit the Government to developing a single such entity. The appointment of the independent chair of this body should be made under the system regulated and monitored by the Commissioner for Ethical Standard in Public Life in Scotland.

A monitoring and evaluation framework should be developed that covers all the commitments made in the strategy and the means by which these will be delivered. The monitoring of progress should include obtaining the views of those receiving services and their view on the extent of quality improvements including progress on improving person-centred care.

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