Scottish Drugs Forum is a membership-based organisation delivering information, advice and support to the drugs field in Scotland in terms of both practice and policy development. This response is based on the results of a consultation with members regarding the issues raised by the Commons' Scottish Affairs Select Committee as part of their Inquiry on 'The Use and Misuse of Drugs In Scotland'.

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

*Note: The terms 'drug abuse' and 'misuse' are stigmatising and misleading. Most people are using products produced and supplied through legal or illegal sources for exactly the purpose for which they are intended. This term is based on a moralising attitude and a misunderstanding of substance use.

1.1

The drivers for substance use are different from the drivers for problem substance use. The drivers for problem use are personal and social. The **personal experience of adversity in childhood or adulthood** is a key personal driver for problem drug use. The Adverse Childhood Experience (ACEs) research explains some but not all of this. This finds linkage with **physical and sexual abuse and physical and emotional neglect, early and multiple bereavement and abandonment in childhood**. For adults the traumas may include **witnessing or being a victim of violence; bereavement; service in the Armed Services particularly in a combat zone; imprisonment** and **homelessness.** For many people with a drug problem there will have been personal experience of several of these adversities.

1.2

Although none of these experiences are unique to people in Scotland, it may be that Scotland has a higher rate of some or all of these issues than elsewhere. It is worth noting, for example, that **Scotland has a far higher rate of children being removed from parental care by the state and being brought up in care** than England. The extent and nature of the abuse uncovered by the The Scottish Child Abuse Inquiry should also be noted. It is also worth noting that it has a **higher proportion of people who served in the armed forces** than elsewhere.

1.3

Problem drug use is largely focussed on opiates (like heroin) and benzodiazepines (like Valium). It is worth noting that these two types of drugs numb feelings and emotions. It is

also worth noting that benzodiazepines are prescribed for anxiety. It is plausible to describe the use of these drugs as **self-medication**. If we include other depressants such as alcohol as potentially being used for a similar effect then we can see the extent of the demand for these types of drugs in Scotland and the significant number of people who develop substance use problems around this form of self-medication. The key drivers for this are **abuse and neglect in childhood** and **the experience of trauma across people's lifespan** and **lack of opportunities in terms of education, training and employment**. One might also include **marginalisation and stigma.**

1.4

To focus only on personal drivers is an error that can lead to a misunderstanding of the nature of the issue and then to inappropriate ineffective responses to problem substance use. People have always experienced adversity, so there must be social reasons why drug use became, for some people, the means of coping with this; why substance use has become an issue for wider society.

1.5

Key social drivers include relative **poverty and inequality**. Problem drug use is clearly closely linked to poverty. The work undertaken around The Glasgow Effect (unexplained low life expectancy caused by premature deaths in children and younger adults) has seen it postulated that the **economic changes 1960s-1990s** and the resultant **dispossession and social displacement** are a cause of this phenomenon. This is likely to be true for problem drug use also. Indeed problem drug use and drug-related deaths are a key factor in the causes of The Glasgow Effect.

1.6

It is worth noting that the areas with the longest history of problem drug use and the areas where it is most concentrated are in **impoverished communities in larger cities** (Glasgow, Dundee and Edinburgh) and in **Scotland's many de-industrialised towns and villages**.

1.7

It is also worth noting that the current pattern of use is a product of how Scotland has responded to this issue. There are many people with a drug problem alive today thanks to the early introduction of **needle exchange** and **opiate substitution therapies** in Scotland in the late 1980s and these becoming available across Scotland in the 1990s as well as through the delivery of the **national take-home Naloxone programme** in the 2010s. Otherwise many more people would have died through overdose or through health complications resulting from their drug use.

1.8

Culturally, Scotland may have some attitudes that explain the extent of drug use and the response made to problem drug use in Scotland. As regards drug use generally and certainly

problem drug use, Scotland often seems to have **a comparatively judgemental, moralistic and stigmatising cultural attitude.** This has been deeply unhelpful in developing an adequate response to problem drug use and to developing an effective means of prevention. It is tempting to explain this cultural attitude in terms of Scotland's religious traditions but one would need to contrast Scotland's attitude and resultant policy and practice to that of the Calvinist Netherlands or Catholic Portugal. It seems that Scotland's conservative attitude may have outlasted its religiosity.

1.9

The **leadership necessary to change attitudes** has been generally lacking in Scotland's civic and political communities. This may be because of **Scotland's deep social and cultural division** which means problem drug use is viewed as an issue affecting the poor and disempowered and therefore has not been prioritised.

1.10

There are significant differences in patterns of problem drug use in Scotland when compared to other areas of the UK.

- Problem drug use is more common than in the rest of UK
- Problem drug use involves polydrug use – the use of more than one substances in combination that carry an elevated risk of harm including overdose deaths
- Problem drug use is focussed chiefly on depressant drugs – alcohol, heroin and or benzodiazepines primarily
- In terms of responding to problem drug use, Scotland's rurality is an issue in dealing with a multi-faceted problem which may involve individuals receiving support and treatment from a range of services
- There is less of an ethnic dimension to drug problems.

1.10

Official estimates are that there **approximately 56000 people with a drug problem** involving opiates (principally heroin) and benzodiazepines (valium-like drugs) in Scotland. The estimated number of problem opiate users in England and Wales is just over 300 000. In Scotland, **polydrug use is common** and is the cause of the vast majority of overdose deaths. Also, **problem drug use is more depressant-focussed** than drug problems elsewhere in the UK. This is not to ignore the widespread use of cocaine. However cocaine and other stimulants are used far less problematically and result in far fewer deaths; although there is a recent worrying recent trend of stimulant use alongside depressant drugs by people with long-term drug problem.

1.11

In other parts of the UK there are ethno-cultural aspects to differences in drug problems between different groups and in different regions. This is far less apparent in Scotland. It is worth noting that services for specialist drug services for ethnic minorities have not developed as they have elsewhere in the UK although more generic health services serving

black minority ethnic communities have been developed, mainly in the voluntary sector. We are perhaps poorly placed to detect and respond to any problems that emerge within minority ethnic groups.

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

2.1

In the response to question 1 we identified the drivers in terms of demand as –

- Personal experience of adversity in childhood or adulthood
- Poverty and inequality
- Historic economic and social change

2.2

In terms of addressing these drivers, the Scottish Office, Scottish Executive and now The Scottish Government have used their powers to develop a range of policy and strategic interventions to address these issues.

2.3

At present, the Scottish Government has control over the entire health service and social care and all matters around the care of children and the protection of vulnerable children and adults. The Scottish Government has more limited control over Scotland's economy and the distribution of wealth and to address the effects of longer term social changes. In terms of drivers, the Scottish Government has valuable although not exclusive powers to stimulate the economy to create wealth, reduce income inequalities through taxation and other means and to redistribute income including by the creation of employability programmes.

2.4

The Scottish Government has limited controls over the benefits system though there has been some recent devolution in this area. However significant powers remain reserved to the UK Government. On balance, the Scottish Government have some control over addressing and reducing the drivers of problem drugs use.

2.5

It is worth noting that there are two obvious areas where Scotland may have taken significant control but has not exercised its powers. While the devolution of the powers exercised in the UK Misuse of Drugs Act (MoDA) is cited as key in developing an adequate response, there are anomalous interpretations of this legislation that cause significant harms in Scotland. For example – drug checking services are available in England and Wales. In fact the Welsh Government and NHS provide the most sophisticated off-site service. In Scotland these have not been supported by Police Scotland thus far, the belief seems to be that under the MoDA they are not possible.

2.6

Likewise, while the policing of the possession of drugs for personal use, illegal under MoDA, has been relaxed generally and the use of police recorded warnings for the possession of cannabis has been introduced, the possession of other substances is not dealt with in this way . This is anomalous and unhelpful and difficult to justify in terms of harms.

2.7

Also, similarly there was some surprise and disappointment when the Lord Advocate ruled that a drug consumption room could not be opened due to MoDA when much of the exemption sought already exists for the provision of needle exchange services for which policing arrangements and reassurance to staff, via a Letter of Comfort, have previously been made.

2.8

It now appears the only solution to allowing drug consumption rooms to operate in Scotland is for changes to the devolution settlement or to the MoDA itself to be made. There is a perception that this has resulted in the issue becoming something of a political football. This has been greatly disappointing to people who worked for its development and for those who may have benefitted from it and their families and friends. It is important to note however, that this development would only affect those people who were able to use the service – in the case of the Glasgow proposal this may have been around 500 people. Such a service is necessarily a very local service serving a small area.

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

3.1

As stated in question 1 there is a significant relationship between poverty and deprivation and problem drug use. Data on this include analysis of drug-related hospital admissions by postcode of residence; drug-related (overdose) deaths by postcode of residence. Also, of course there is the experience of drug treatment services in treating people with problem drug use. All this evidence suggests a link between the two. Poverty is a factor in developing problem drug use.

3.2

Once someone has a drug problem they also have more limited means to escape poverty. The chances of getting paid employment are affected across the whole spectrum of the experience – from problem drug use; being in treatment and in recovery. Even in abstinent recovery the chances of securing and maintaining employment are reduced. Having a criminal record, a lack of an employment history and the stigma of having or having had a substance problem all play a part in this. Of course paid employment is not a guarantee against poverty but not working almost guarantees it.

3.3

Poverty is also significantly connected with personal factors that increase the likelihood of problem drug use – adverse childhood experiences, poor engagement by or outcomes from education services; poor engagement by health services; being in care and being a care leaver; youth unemployment; early engagement by criminal justice services; imprisonment; homelessness.

3.4

Countries with very different policies in relation to drug use and drug problems have significantly fewer people with a drug problem per head of population than Scotland. Sweden has 8000 people with drug problems in a population of 10 million (double Scotland's population) Netherlands has 14000 people with a drug problem in a population of 17 million. The key reason for this appears to be greater levels of social cohesion, less inequality and poverty compared to Scotland.

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

4.1

There should be an adequate safety net for people who experience a substance use problem that offers both adequate financial support so as they can meet their basic needs and allow them to maintain contact with family and social networks. The system could accept the reality of their situation and work better to support people. There is also a demand that the system supports people across the spectrum of their problem – when they have a drug problem, when they are in treatment and recovery. Presently over-stretched families, partners and friends, other services and the public are helping people who could more effectively and efficiently be supported through the benefits system both in terms of their income and basic needs and in terms of recognition of their relationship to training and paid work.

4.2

Currently the DWP and the benefits system are viewed as ambivalent or unhelpful as regards people with drug problems. The system is viewed as unhelpful and unsupportive and often punitive. Any empathy or helpful support from frontline staff in DWP is regarded as personal and exceptional as staff are generally viewed as ill-informed or prejudiced and stigmatising. Staff clearly need to be trained and supported within the DWP to better serve people who have drug problems. They also need organisational support to ensure that they can deliver a flexible service that does not punish and harm the most vulnerable who find it difficult, because of the nature of their drug problem, to comply with a rigid appointment and sanctions system.

4.3

Workers in treatment and support services report that they spend a lot of time and effort on dealing with issues around benefits, particularly sanctions and avoiding sanctions, and on contesting decisions that very vulnerable people, including people newly in abstinent recovery, are 'fit to work'. This is viewed as an unnecessary and unhelpful burden and distraction from their own core work.

4.4

The system could allow more therapeutic work; could be more sensitive to the reality of people not being able to get or hold down work so not insist on people applying for large numbers of job every week or insist on daily presentations.

4.5

Portugal is held up as an example of the effectiveness of decriminalisation in reducing harm. Actually, decriminalisation was only part of the Portuguese approach. Accompanying changes to the treatment system to allow, among other things, easy access; changes to the

social security system; the development of employability programmes all combined to deliver an effective response.

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

5.1

For some decades the supply of drugs to people with a drug problem has been broadly consistent. It is important to note that most drugs are purchased by people with drug problems through 'traditional' means – street dealing and that the drugs supplied are opiates and benzodiazepines in the main. However, there are regular and consistent reports of on-going changes. Evolving recent developments of note are –

- The use of benzodiazepines by young people who are not (yet) identified as problem users.
- Increased use of crack cocaine and powder cocaine by people who have a long-term opiate based drug problem
- Increased supply and falling price of benzodiazepines (mainly etizolam) used in large quantities with alcohol and or opiates
- The possible emergence of fentanyl use currently on a very small scale and both by 'experimenters' and people who use heroin problematically. It is unclear in the latter case whether this is knowing use of fentanyl or whether fentanyl has been introduced in the street heroin supply.

5.2

Some of these changes are to do with changes in supply – sales through social media, through the dark web and through home delivery. These have expanded supply, the range of products available and how users engage with and perhaps perceive their dealer.

5.3

These changes have significant consequences for policing. In terms of legislation internet-based sales are illegal but may required specific legislation if they are to be policed – as may the 'dark web' more generally in terms of product sales.

5.4

However it is important to note that our experience based on reports from people with drug problems is that for the most vulnerable users – those with a dependence on street drugs - their supply route remains through the normal channels - street and community based dealers selling drug direct to users.

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

No

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

7.1

There is limited insight on this issue as, if they do work together, their joint work is done in a manner that it is not obvious or public. There is very little cross-border communication in terms of information about drug use or drug alerts in response to issues as they occur. Occasionally a Public Health England alert will be shared for example but there is no sharing of expertise to discuss the content or applicability of such alerts to Scotland.

7.2

There is a reluctance to share a vision in terms of policy – even when respective policies mirror each other. When both administrations were undertaking an abstinent recovery-focussed policy, for example, there was a keenness to emphasise that recovery in Scotland was not the same as was meant by recovery in England. Actually, in terms of the impact on the culture of services and the wider drugs field, there were clear parallels. England, however, followed the logic of this approach and this led to a 'payment by results' system where services were paid if people left their services 'drug free' and did not return for at least 6 months – a 'positive' outcome; this led to services being paid for outcomes that included death by overdose.

7.3

However, broadly, in terms of service culture and attitude it was difficult to discern differences between the English and Scottish approaches except that Scotland continues to have a far smaller proportion of people with a drug problem in treatment and consequently far higher rates of drug overdose deaths.

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

Given the link to poverty, the chief issue would be the devolution of any powers relating to the economy and the distribution of wealth and the Scottish Government capacity to provide an environment where there could be more wealth generated and where this wealth was more equally distributed.

8.2

However, in terms of responding to the needs of people with significant drug issues currently the powers are already largely devolved in terms of service design and delivery and offering support to this group of very vulnerable people.

8.3

As highlighted, Scotland can make significant progress with regard to drug law reform within the existing UK legislation. Where the present devolution settlement makes this impossible, Scotland should demand the devolution of these powers.

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

9.1

If we changed our approach and focussed investment wholly in evidence-based treatment and support interventions we could have treatment and support systems more like other European countries where drug use is far less likely to be problematic; people with problems are adequately supported and suffer and cause fewer harms to themselves and others. There are many personal tragedies involved in problem drug use but it is a national tragedy that Scotland has not dealt with this issue better. This is a long-standing issue.

9.2

In terms of decriminalisation of possession, as they have in several European countries, it is hard to justify the current law. Moving on this would be a significant move. In Portugal, this was accompanied by changes to the treatment system making access easier, to the benefits system and to employability services. Such a co-ordinated approach has been impactful there.

9.3

Scottish Drugs Forum undertakes work with various European partners and has often hosted European colleagues visiting Scotland on fact-finding visits. Frankly, sometimes it is uncomfortable to host people who express consternation at the system and response we have developed here and, most concerningly, at the physical state of people who have similar drug problems as the people they work with in their own countries but who enjoy far better general health. There are lessons here that we could learn.