

Scottish Affairs Committee

Oral evidence: [Problem drug use in Scotland](#), HC 1997

Tuesday 7 May 2019

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Members present: Pete Wishart (Chair); Deidre Brock; David Duguid; Hugh Gaffney; Christine Jardine; Ged Killen; Paul Masterton; Tommy Sheppard; Ross Thomson.

Questions 1 - 56

Witnesses

I: Professor Catriona Matheson, University of Stirling; Dr Emily Tweed, University of Glasgow; Dr Andrew McAuley, Glasgow Caledonian University; and Dr Tessa Parkes, University of Stirling.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Professor Catriona Matheson, University of Stirling; Dr Emily Tweed, University of Glasgow; Dr Andrew McAuley, Glasgow Caledonian University; and Dr Tessa Parkes, University of Stirling.

Q1 Chair: We welcome you all to our first session into problem drug use in Scotland. We are looking forward to discussing these issues with you. For the record, please say who you are, who you represent and anything by way of a short—with an emphasis on “short”—introductory statement. We have lots of questions to get through, and we want to get through as much as we possibly can. We will start with you, Dr Tweed.

Dr Tweed: My name is Emily Tweed. I am a clinical lecturer in public health and honorary speciality registrar. I am based at the MRC/CSO Social and Public Health Sciences Unit at the University of Glasgow. I am a public health doctor by background and previously I have been involved in projects looking at the health needs of people who inject drugs in public places in Glasgow city centre and at the reasons for an increase in drug-related deaths among women in Scotland in recent years.

Professor Matheson: I am Professor Catriona Matheson. I am a professor of substance use at the University of Stirling, which is a relatively new appointment. Before that, I worked at the University of Aberdeen for 20-plus years, researching drug use and services for drug users, the health service response. My background is originally as a pharmacist but also in public health and in health services research.

Dr Parkes: Good afternoon. My name is Dr Tessa Parkes. I work at the University of Stirling. I have about 20 years of experience in doing social services, social health research. I have worked as a service provider. I have worked in England and Canada as well as Scotland. I think it is important to say that I will speak from the academic evidence, but I will also be informed by service provision in the different roles that I have had. Thanks for inviting me today.

Dr McAuley: My name is Andrew McAuley. I am a senior research fellow at Glasgow Caledonian University and principal scientist at Health Protection Scotland. My work mainly involves people who inject drugs and the harms related to injecting drugs in Scotland, particularly in relation to blood-borne virus and overdose. I have worked in the field locally and nationally for over 15 years now. I am delighted to be welcomed to this Committee.

Q2 Chair: Thank you for being so helpful and concise with your opening remarks. To get things started and to be of help to the Committee, could you tell us what, in your view, problem drug use is? In your response, tell us how badly it does impact and affect Scotland.

Dr Tweed: I think it is important to make the distinction between a quite narrow technical definition of problem drug use that is often used and the



broader sense in which the Committee might be interested. The technical definition is the one used in official statistics to estimate how common problem drug use is in Scotland. That definition focuses on the problem use of opioids and benzodiazepines. But there is a broader issue about problem drug use that encompasses other drugs as well and I think it is important that the Committee makes the distinction between problem drug use and any use. The vast majority of people who use drugs will do for a short time without any harms, but I think that the focus of our work and our discussions today should be those people who experience problems from it. I don't know if anyone else wants to come in on definitional issues.

Dr McAuley: I think Emily has captured that nicely. We very much focus on the problem side of things because we feel that that is the area where we can make the most gain from policy and practice change. There is a disproportionate amount of harm suffered by the individuals who engage in problem drug use in comparison to the wider population who may be using drugs but not reaching that level of harm. That is demonstrated in the epidemic levels of drug-related deaths and other drug-related harms we have in Scotland that are very visible, not just to the population but from the statistics and the evidence.

Q3 **Chair:** I am going to go straight to drug-related deaths. Professor Matheson, could you help us by explaining why you think there is a particular issue in Scotland? We have seen all the headline figures recently, that they expected over 1,000 deaths in 2018, that they are two and a half times the level of the rest of the UK. In your view, what is going on in Scotland that this is happening here?

Professor Matheson: There are a number of aspects to that, several strands to the rise in drug-related deaths. We have an ageing cohort of drug users who started drug use in the late 1980s and who are now in their middle age, but they are ageing prematurely. I know this is something we may have covered later but it is very relevant to this point. They are ageing prematurely, so they have multiple comorbidities, other health problems and, importantly, mental health problems as well. We asked for all health problems, mental and physical. Mental health support came out as the most important issue for people and 95% of the drug users we interviewed, who were over 35, mentioned that they felt they suffered from that. We have this cohort that also suffers from premature normal ageing conditions such as respiratory disease and cardiovascular disease. They are physically and mentally more vulnerable.

We have other particular issues in Scotland with benzodiazepine use that has come to the fore quite recently, in the last three or four years. When benzodiazepine is thrown into the mix of other drugs like opiates and alcohol, it becomes a lethal concoction because you get respiratory depression, which you do from opiates but benzodiazepines compound that effect. We have all of those things. We also have issues around



social support and trauma. There are many other aspects to it, but one of my colleagues might want to come in.

Q4 Chair: What struck us in the written evidence was the focus that we had in repeated submissions about childhood trauma as being a push factor when it comes to this, whether that is to do with emotional neglect or abuse. Is there any reason why that should be a bit more prevalent in Scotland and why we have this? I am not hearing any clear detail about why there is a specific difficulty issue in Scotland. Can anybody help with that one?

Dr Tweed: You are absolutely right that what we often call generally adverse childhood experiences are a risk factor for later problem drug use. That might include neglect, physical, sexual, emotional abuse, but also things like having a parent in prison, having a parent with mental health problems, domestic violence within the home. These adverse childhood experiences—you might hear them called ACEs—have risen up the agenda in recent years and there is a lot of awareness of them. They are much more common among people who experience problem drug use than among the general rest of the population. We identified that as a factor in the work that we did looking at women who experience drug-related deaths.

On whether it is a particular problem in Scotland, there was a piece of work done recently by colleagues in Glasgow—Michael Smith and colleagues—that looked at whether it was more common in Glasgow and the west and centre of Scotland and Scotland in general and whether that could contribute to, for instance, the excess mortality that we see in Scotland. They found that some forms of adverse childhood experiences did appear to be more common, such as having a parent in prison, having a parent with substance abuse, experience of domestic violence within the home, but other forms, particularly on self-reports and surveys, were not any higher. They concluded there was a bit of a mixed picture in what the evidence says about whether adverse childhood experience is more common in Scotland.

What we do know that is really important about adverse childhood experiences is, to set them in the wider context of the social processes and drivers, they are very closely linked with poverty, deprivation and inequality. I think it is important that we see poverty and deprivation themselves as adversity, particularly in childhood, and that we don't forget that context.

Q5 Tommy Sheppard: Can anybody hazard a guess as to what proportion of use of illegal drugs ends up being problematic? My interest in asking this is to try to get some sort of handle on, for want of a better word, the scale of the market in illicit drugs. Is it 1%, 10%? I have known an awful lot of people over the years who have used drugs that are illegal, and they have done so without any harm to themselves or others and it has not been a problem. What is the scale of the problem? Also, could you suggest why? Is it because of other factors that we will come on to, like



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the ACEs or social factors, that some people develop a problem and others don't or is there something else at play in who will develop problematic use?

Dr McAuley: I will take your first question about the size and scale of the prevalence of problem drug use. In the studies conducted every few years on this, using scientific methods to estimate the size of the population, the prevalence of problem drug use in Scotland is currently 1.6%. That equates to roughly 60,000 people under that tight definition of problem drug use, problematically using opioids and/or benzodiazepines. That prevalence rate has not changed much over the years. It has remained largely stable.

Q6 **Tommy Sheppard:** That is 1.6% of the population?

Dr McAuley: Yes.

Q7 **Tommy Sheppard:** What percentage is that of all people who use drugs?

Dr McAuley: Traditionally, that is not the way it is estimated. We do not follow up people in cohorts of everybody who has tried drugs because of the challenges in ascertaining everybody who has ever tried and who goes on to problematic use. It would take quite a difficult cohort longitudinal study to do that. What we tend to estimate is the people who are most at risk and these are the people who are the ones contributing most to harm levels, health services, social services and the like.

The key point there is that it links in with what Emily has just said about whether adverse childhood experiences are more prevalent in Scotland than they are in other parts of the UK or Europe. They are prevalent in people who experience problematic drug use and Scotland is known to have very high rates of problematic drug use. Our rates of problematic drug use are much higher than they are in other parts of the UK or even in Europe. That is why we see significant levels of harm because it correlates very strongly. If you have large populations of people using problematic drugs, you will have large numbers of drug-related deaths, drug-related infections and so on. There is a very direct correlation there.

Dr Tweed: One of your subsequent questions was about the relationship between problem use and use more generally and whether social factors play any role in that. We do see a social gradient in both use in general and problem drug use, but the gradient is much steeper for problem drug use and drug-related harms, so the inequalities are greater when it comes to problem drug use. That is partly about the forces behind that in terms of limited opportunities, sense of disempowerment, exclusion, but also about what we might call recovery capital or things that support people, such as housing, good work, being able to navigate the system. Those are some factors that mean that use by more advantaged people might not translate or subsequently develop into problem use or into harms.

Q8 **Ross Thomson:** The question I am going to ask is very similar to the



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question Mr Sheppard asked. In your opening remarks you mentioned the focus being on the problematic drug users but across the wider population there are those who use without harm. Just so I am clear in my head of what we are talking about, what is your definition of a problematic drug user? Of those you deal with who are problematic users, what proportion would start off as somebody who took it infrequently, started off, I take it, without harm, then it becomes a bit more habitual and then becomes problematic? I know that is not for anyone, but what sort of proportion would start off as taking it at a party on a night out and then it becomes something that is a bit more problematic?

Professor Matheson: It is a really difficult question to answer. I think you are asking the same question. That sounds like an easy question or I could see you would want the answer to that, but it is actually a very difficult question to answer. For the reasons Andy explained, we don't follow up people who occasionally use drugs. The other source of information we have on that is population surveys where you do a snapshot of the population and say, "Have you used any of these drugs?" Things like cannabis always come out the highest, but what we can't do is link that very easily to how many people develop problematic drug use. It is different substances and different patterns of use, so that progression is very difficult to express in a percentage, unless anybody has come across any research. I think it is something that has been a challenge in this field.

Q9 **Ross Thomson:** Again, it may sound like a very simple question, but would you determine someone who is problematic as someone who genuinely cannot function without substance or—

Dr McAuley: We use this definition because it is sometimes helpful to have a number to work with when you are planning services or research in that way, but obviously our work goes beyond that. It does not just focus on everybody who is problematic using opioids and/or benzodiazepines. For example, cocaine has seen a major shift in Scotland over the last couple of years and there are large bodies of work that we are all involved in, focusing particularly on the group in Glasgow who are injecting cocaine at the moment. Those definitions are used specifically for a purpose and it is very difficult, as Catriona said, to measure everyone at a point of starting and how they transition at that point. It is purposeful to have a definition that is as tightly framed as that, but it is also prudent to review that definition over time to make sure it is capturing changing trends in the population.

Q10 **Ross Thomson:** We were talking about there are factors behind drug use and particularly deprivation and poverty. Some of the things I have been reading about recently—I don't think there is a question about this later on—is middle class drug use. Is that a growing problem in Scotland as well? It is not just those who experience deprivation or poverty, but you now have an area where middle class is becoming a bit of growing issue where people are using it recreationally. I don't know. It is something that I have read about more recently.



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Dr Tweed: We have highlighted the limitations of the data that we have in relation to drug use. It is a very difficult problem to gather evidence on, as I am sure we will come back to. What we do see from things like the Scottish Crime and Justice Survey, which is done intermittently, is a clear social gradient in use and an even steeper social gradient in harms. I am not aware of any evidence that points towards a growing problem among the middle classes.

Q11 **Hugh Gaffney:** How can we measure this then? It is all walks of life. They are making it a social thing as if it is the bottom of the pile, but it pervades through every walk of life. Why aren't we using court figures, for instance?

Dr McAuley: Ironically, Scotland has some of the best drug data anywhere in Europe if not the world. Our surveillance data is very good, but it does tend to focus on the more harmful aspects of drug use because that is where a lot of these people present, whether it is in hospitals, prisons, police cells, social work reports. A lot of these sources are used to triangulate to get an idea of the size of these populations. Similarly, we are involved in studies that go every two years into needle and syringe exchanges and interview people in those to get an ascertainment of that side of the population. To look at the whole population of people using you would be thinking more of a census type study, but you would be looking at a large chunk of the population who are using drugs in a way that is not going to get them into any difficulty, whether it is harm related to health or to criminal justice. That is why we tend to focus on the people who are experiencing the most problematic aspects of drug use.

Q12 **Hugh Gaffney:** I hope that we will get better figures, but 1.6% seems very low for a big problem in Scotland with drugs, so maybe during the process we will get there.

Dr Tweed: I wanted to pick up on your point about all walks of life, and it is true. Drug use and problem drug use does affect people from all walks of life, but we see it is about the preponderance. The percentage, that prevalence, will be higher among people from more deprived areas. That is not to say that people from the middle classes or the most advantaged groups won't have problems with drug use. It is just about the preponderance and that distribution; the harms and prevalence of problem drug use will be higher among people from less advantaged backgrounds.

Dr Parkes: It is more challenging for people who experience problem drug use if they are criminalised in the criminal justice system to manage to pull out the recovery capital or the social resources to try to mitigate some of the harms. While drug use is a phenomenon across all social classes, all genders and all ages, the harms, and particularly the risky harms that the panel have just spoken about, are graduated. Some of the protective factors that we know through, for example, being brought up



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in a secure and safe house and family environment are not always in place for people who end up in risky situations with their drug use.

As well as childhood abuse that Emily has just talked to, I wanted to mention that adult abuse is also very prevalent for people who end up with mental health problems, which I know the Committee is interested in, and domestic violence and domestic abuse. We know that commonly intergenerational effects are important for people. Children might be affected by adverse childhood experiences but then they might go on to experience very adverse effects as adults, such as domestic abuse, incarceration and survival sex work, most commonly for women.

Also now it is more common for people who have problem drug use to be retraumatised in a number of ways. Prison and incarceration is one way, a criminal justice approach, you could argue. It has been evidenced that sanctions and negative personal sanctions disrupt people's ability to come for help and to be able to leverage family and friend supports. They go under the radar and are harder for us as health service providers, social service providers and friends and family members to bring back. It is important to recognise that services must be very conscious of not retraumatising and our policy must be really careful not to retraumatise people.

People witnessing fatal and non-fatal overdoses is prevalent in Scotland now, so while we talked about a small number, actually the impact is huge, and we would say it is very much a public policy priority to resolve.

Q13 Chair: Can I come to trying to identify some of the trends within problematic drug use and some of the trends within drug-related deaths? I don't know who it was who touched on the over-35s, and you might want to refer to that again. In the written evidence we have also seen that there has been an increase in drug-related deaths among females and maybe that is something you want to touch on. I think it was Dr McAuley who mentioned the increased prevalence of injecting cocaine, which is something we have identified particularly as a problem in Glasgow. Are these the main trends that we are seeing in problem drug use? Is there anything that we have missed? Talk us through your views about what we are having.

Professor Matheson: I mentioned we have this older cohort. There is the element that people are ageing. The drug-related deaths have increased in the older age group. The average age of a drug-related death has gone up, so that indicates a cohort type effect and it ties in with the health issues and the comorbidities that go along with ageing and premature ageing. I am talking about other illnesses—respiratory disease, circulatory disease, chronic pain—for which people can be getting prescribed, and depression. People can be being prescribed many medications and self-medicating as well, and that is important to highlight here because benzodiazepines are evident more recently in the drug-related deaths.



Benzodiazepines are used as a sedative and also to help sleep. We know from interviews and work on older women who have had drug-related deaths or older women who are at risk that they like their benzodiazepines and they are harder to get prescribed so they may buy them on the street. These are factors that may well play, and they are self-medicating by buying street drugs because they know that in their environment, it is not unusual to them, alongside prescribed medication to cope with all the other health issues that are going on.

Q14 **Chair:** Can we address some of the issues about female—

Dr Tweed: Yes, absolutely, and I want to add to what Professor Matheson has said about the ageing phenomenon. That is partly related to the fact that we see an overall decline in self-reported drug use over time and particularly fewer young people initiating injecting drug use. That is a success story in many ways, but it does mean that we see the ageing phenomenon in the existing population of people who inject drugs. My point of view from the piece of work that we did about women who die from drug-related deaths is that we need to understand ageing in quite a nuanced way. When we think about ageing we maybe think about inevitable age-related decline that cannot be fended off, but what we were seeing was premature ageing due to life circumstances, this increased prevalence of treatable physical and mental health conditions. Age is a proxy for other changes in life circumstances, like increasing social isolation, bereavements in social networks. When we talk about ageing, we want to emphasise that there are still many points for intervention. It is not about inevitable age-related decline. Age is also a proxy for these other forces.

It is not just about people ageing now. It is also about being a particular age at a particular point in time. There is evidence from NHS Health Scotland of this cohort effect, which is about the phenomenon of being a particular age at a particular stage of history. What they found was the people who are dying now of drug-related deaths were predominantly young men from deprived areas who came of age during the 1980s. That is predominantly who we see the drug-related deaths occurring among and so it is about being at a particular stage of your life at a particular point in history with all the surrounding social and economic conditions that are happening there. I would be happy to expand on the female drug-related deaths.

Q15 **Chair:** We will leave that because I am keen to get a few other views from the panel, if there is anybody else who wants to contribute.

Dr McAuley: On the point about trends, we do see some key differences in trends over the last few years. The shift in cocaine has been one of the most major trends we have seen. Particularly in west and central Scotland at the moment, there has been a huge shift towards the injection of cocaine over the last few years. We have seen that playing out into key ways. One is that we have found it to be the main driver of the HIV outbreak that is occurring among people who inject drugs in



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Glasgow city centre at the moment. We also see a massive increase in cocaine-related deaths within the death statistics. That massive shift towards powder cocaine injecting plays out in both the harms and the death statistics.

As has been mentioned, we have also seen the change in benzodiazepine use. Benzodiazepines were always present in drug-related deaths, but their involvement was capped at almost a certain level because it was largely related to a diazepam market whether prescribed or illicit. But that street benzodiazepine market has changed massively in the last few years towards drugs such as etizolam or alprazolam, which are much more toxic benzodiazepines. They are often 10 times as strong as the diazepam that people would be used to taking. They are often marketed to look like diazepam tablets, so they look the same, smell the same and are branded exactly the same as diazepam tablets. People are often taking these medications on the street unknowingly. We are talking about taking them not in ones and twos but in handfuls. They are taking these drugs on top of their normal level of heroin, alcohol, methadone or whatever, putting people much more at toxic risk of overdose and that has really been played out in the statistics over the last few years. We have seen a massive jump in the involvement of benzodiazepines in drug-related deaths to over the 50% mark.

One other thing I would like to add about prescribed medications is in relation to gabapentinoids. We have seen a huge increase in the involvement of gabapentinoids in drug-related deaths over the last couple of years. That is potentially related to the changes in diazepam prescribing where people are seeking alternatives to take drugs to enhance the effect of their opiates, heroin or methadone.

Professor Matheson: There are a couple of points that I want to make in relation to the trends and older people that we did not mention earlier. One is about social isolation and many older drug users are living alone now. Often that is a deliberate choice to try to get away from things. Social isolation plays into this and people may be more likely to take risks and if they do there are fewer emergency services and things like naloxone that is a very useful antidote but can't be used if you are overdosing on your own. That is one thing. The other is the role of trauma in risk taking and maybe taking slightly more risk or being a bit more ambivalent about whether you do ever die when you are taking a substance.

Dr Parkes: In addition to the points that have just been made by Andrew, it is important to say that some service responses about fears of prescribing benzodiazepines have led to physicians taking people off prescribed medications. As part of the committee work that I do, I have spoken to people where that has happened and they have told me that their GPs are no longer able to prescribe and they have been forced to go and ascertain street and impure and illicit benzodiazepines and were talking about the recovery, which has been substantial, maybe years and



years worth of recovery. They are also HIV positive and they will be on other forms of drugs. There is all of that recovery and all of that instability for them and their friends and family, because if they were caught buying illicit drugs they would be involved in the criminal justice. It feels like sometimes service responses, whether wittingly or unwittingly, can exacerbate harms in pushing people into street drug use.

- Q16 Tommy Sheppard:** Continuing on the theme, to explore more about the drivers at play that lead people to take drugs in the first place and in particular the drivers where it ends up being problematic, we have talked about mental health, poverty, trauma. In this sort of environment, we are very much cocooned from some of the horrors that people experience in their daily lives, but we are all MPs, we all do surgeries and we all have an inkling of some of the levels of despair and desperation that some people face. It is not a big leap—for me anyway, I don't know about colleagues—to understand why people would self-medicate and try something to get out of the situation that they are in. What I am keen to explore is why that becomes problematic for some people and for others it doesn't. Put it another way, if we could get rid of poverty and inequality and if everybody could afford access to quality controlled drugs and stimulants, would we still have the type of problem we have or not? How much of this is to do with society and how much is to do with drugs?

Dr McAuley: I think it is clear that poverty and deprivation are the main structural drivers of problem drug use in Scotland. The evidence is overwhelming in relation to that. If you can control the poverty and inequality side of it or if you can narrow the inequality gap, you will certainly go a long way to addressing that. It takes much larger forces to impact on income, wealth, housing, employment, but these are the structural forces that created the problem drug use cohort in the first place, and these are fundamentally the things that will address it in the future.

Dr Parkes: We might come to the Portugal approach a bit later. Their whole system approach was not only to decriminalise drugs, so that is possession and use, but also to put in place welfare reforms. They brought in not only expanded harm reduction and treatment but also an administrative response and minimum wage. They basically reformed the system around humanity, pragmatism and participation. Those are things that they have been able to track for 15 years, so we have some evidence that by doing that—and there is evidence that suggests that it was largely or in part hard to pull apart the separate pieces—it did not increase use and has led to reductions in use across the board, not only problem drug use but also use. It has not expanded use. What we can see is that enhancing social and economic supports can go some way towards alleviating not necessarily drug use and experimentation but problem drug use because people are no longer excluded from society.

The major thing that the Portuguese proponents and advocates now say 15 years later is that the impact was on stigma, that people now felt that



they had a voice to be able to raise their own expression of needs and fully participate in society. There is a connection about not only welfare reform and protection of social and economic rights and human rights but also about participatory processes.

- Q17 Tommy Sheppard:** Can I throw something else in the mix? To what extent is prohibition itself a problem in the sense that organised crime controls the price structure, what you have to pay for it, so they are very expensive. If you are in poverty, that is a problem. They also control the supply, what you actually get. I have read that people deliberately develop products with addictive properties so that people will keep coming back for more. Of course, because it is illicit, the method of drug consumption itself, injection or whatever, becomes problematic. I am asking generally, are those factors at play in Scotland? With Portugal or anywhere else, can you point to comparisons where there is evidence for prohibition itself being part of the problem?

Dr McAuley: The UK adopts a prohibition-based policy structure. Drug use is criminalised in the UK and part of the reason we are here is because of that policy, rightly or wrongly. Drug-related harm is very significant in Scotland and it is within the context of a prohibitionist criminalisation-based policy. That narrative allows people to take drugs in a way that is hidden, so people are often doing it in a way where they are worried that they may get in contact with the police, which often engages them in a lesser behaviour, where it is with organised crime and there are other levels of crime. People are often punished for their drug use. They end up in the prison system, which exacerbates the risk for a whole host of other things and continuing their drug use as well.

A lot of the prevention mechanisms we have put in place to try to prevent the harm related to drugs, whether it is things such as needle and syringe exchange—a good example of that is that people interviewed as part of the HIV in Glasgow reported that they were unwilling to carry fresh equipment on them about the streets in case they were stopped by the police and sent for further charges in relation to that so people were reusing their equipment or sharing their equipment, putting them at risk of other drug-related harm. There is certainly evidence that the wider context of prohibition and criminalisation in the UK at the moment is contributing to harm in that way.

Dr Tweed: To expand on what Andy said about the local experience in Glasgow, as part of the work that we did on public injecting we found that the act of public injecting in closes, alleyways, car parks and so forth was partly because people were coming into Glasgow where the markets are to buy their drugs and they were very reluctant to travel in possession of drugs. They were injecting them very close to where they were buying them in the local drug markets. People were injecting in public because they were living in hostels or temporary accommodation because of their homelessness and they knew that they would get kicked out of their accommodation, they would lose their housing if they were found to be



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using drugs in that situation. People were going out and using in public places because of that. People were rushing use in public places for fear of getting caught and rushing use was increasing the risk of overdose.

We see a broad evidence base from across the world about some of the potential harms of a criminalisation approach with criminal records and the effect that that has on people's lives, stigma, which has already been alluded to, people's willingness to access harm reduction and treatment. We very much see that playing out locally as well.

- Q18 Ross Thomson:** The reason I asked about the middle class use earlier on is that I represent Aberdeen and we have seen some growing issues. There has been an increase in drug-related crime in Aberdeen over the last year. The police have recorded 194 incidents pertaining to supply of illegal substances between April and September compared to 172 the previous year. We have seen more reports. In February two men were in court with drugs valued up to £70,000 in their possession and a couple of months ago two men were arrested with £1 million worth of Ecstasy in their possession. To try to understand that, Aberdeen is a very affluent city because of oil and gas, and we know that groups will travel up from areas like Wolverhampton and so on to supply. Do you think in that context, given the discussion you have had with Mr Sheppard, it is slightly different, a different type of user? Would that be right or is that totally wrong?

Professor Matheson: I live in Aberdeen and I have children of an age, in their late teens, early 20s. I hear from them about drug use. It is fairly prevalent. It is what I would describe as experimental drug use and that is in the middle classes. The other thing that we see is quite a lot of steroid use. That and cocaine use is something we may need to prepare for in the future. All of these things are definitely there in the middle classes, there is no denying it. It may be that they are more in the middle classes now than in the past and it may be in time there will be a percentage of this group who will go on to have more problems, but at the moment they are not emerging as problems in health and the extreme problem of drug-related death.

Dr McAuley: The key point is that the middle classes are less exposed to the factors that are more likely to lead them towards problematic drug use, the catalyst people on the panel have been calling it, whether it is income, employment, stable housing, adverse childhood experiences; the middle classes are much less exposed to those factors and these are the factors that are more likely to drive people in the more deprived communities into problematic use.

Dr Parkes: There are other things like the deaths of despair that have been written about. It is not just drug use. It is also particularly male suicide but suicide and the difficulty in sometimes discerning what is a suicide and a drug-related death because of loss of hope.

- Q19 Chair:** I also represent a prosperous area. I would be loath to call it



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middle class but certainly Perthshire would be classified as a relatively prosperous area. It is also a large rural area. What we have heard from some of the evidence that has been submitted to us is that there is a distinct issue when it comes to rural areas, whether that is service provision or further complications with isolation. We were particularly struck by the evidence from NHS Shetland who told us that the characteristics of problem drug use in rural Scotland is quite pronounced and very different. Do any of you have any views about that that you could help us with?

Professor Matheson: I have done some work with colleagues in Shetland on this issue. We have mentioned stigma in passing, and maybe we will come to it a bit more, but stigma is associated with being a drug user. If you live in a rural community where everybody knows everybody else and you may be trying to hide your drug use, it becomes much more difficult. You can't necessarily use treatment services because they may be too far away, so you may be relying on your local GP practice, which will be small and local and the people working in it will be your neighbours. There is that added level of not being able to hide if you do want to hide, so being fearful of being judged by people who are your neighbours and go to school with your kids as well as being a friend and there is that judgment. There is also the issue of the cost of travel and the time to travel. If you are in Shetland and you want to travel to Lerwick to a drug treatment centre, that is a whole day potentially. There is a cost associated with that, which people don't necessarily have. Those are the added challenges of rural communities and not just in Shetland; rural Aberdeenshire also has these problems.

Dr McAuley: I think it is important to highlight that a lot of the problems we see within dense urban populated areas, we see in rural communities as well. One of the studies we manage is the Needle Exchange Surveillance and we cover all of mainland Scotland and interview people injecting drugs as far north as Fraserburgh and as far south as Newton Stewart. We cover lots of rural communities as well as more city-based or town-based communities. Drug use at that problem level is all across Scotland. It is not just concentrated in the major cities, which sometimes the narrative gives the impression of.

Q20 **Chair:** Before we move on, I would like to pick up something that has come out of the evidence so far and it is about intravenous drug use. One of the big successes was in the 1980s in Edinburgh where the prevalence of HIV and the link to shared needles was dealt with effectively—probably the most demonstrable impacts of a public health programme. Why are we still having issues with cocaine in Glasgow? We don't have to deal with this now, we have had the experience with this, and the fact that we are still seeing issues to do with it 20, 30 years later must be really worrying.

Dr McAuley: It is remarkable that HIV has reemerged in a country like Scotland that has had effective prevention for over 30 years since the Dundee and Edinburgh epidemics of the 1980s. I was part of the team



that analysed and published the data on that, and we have seen Glasgow experiencing an HIV outbreak since 2015. It is a very complex outbreak involving people with a lot of complex issues such as homelessness, with a huge shift to cocaine injecting at the same time. That has compromised a lot of the harm reduction that is already in place to try to prevent it. The health board has been very successful in realigning their treatment services to get people on to treatment but the dynamics of the outbreak itself require new additional responses that have been demonstrated to be effective in other parts of the world that have experienced similar type of outbreaks.

Vancouver is the obvious example. It had an outbreak in the 1990s despite the presence of harm reduction and opiate substitution therapy there. It was there that the drug consumption room was implemented to try to help to contain the outbreak at that time. With Scotland's infrastructure, there was probably a bit of complacency about HIV being effectively prevented for so long that people were taking their eyes off the ball and did not expect it to come back, but it has come back in a very big way.

Dr Parkes: I think it is important to also say that there is very good guidance about how those kinds of services, needle exchanges and ORT, opioid replacement therapy, medically assisted treatment, need to be delivered and that is not always the case anywhere in the globe, having done quite a bit of work in Canada and looking at global approaches to methadone maintenance treatment. But in Scotland we need to do more about low threshold access, making it really easy for people to get in. We also need to do much more about effectively retaining people in treatment, and by treatment I mean ORT but also the broader elements of optimised ORT, which is psychosocial supports, counselling, working alongside families, recovery supports in the community, mutual aid, peer-led work. We need to do more work on low threshold access with treatment and also quality of care. There are global findings, but our rapid evidence review that Health Scotland led reminded us all that there is still a way to go with our treatment service delivery as well.

Q21 **Ged Killen:** Good afternoon. We have heard from Scottish families affected by alcohol and drugs that online and digital marketing and purchasing has facilitated easy access to drugs, including via mobile texting and apps, websites and social media. Has the internet affected the supply and accessibility of drugs?

Dr McAuley: We have discussed this question. In the data that we see there is no obvious impact of internet sales or availability on the market that we see. There was a suggestion that people were using the internet to import illicit street benzodiazepines but there has been evidence recently that a lot of that production has been happening within Scotland itself. Police Scotland was involved in a large operation in a pill-pressing plant in Paisley, I think, at the tail end of last year. A lot of the internet illicit market has been linked to the Psychoactive Substance Act that was



passed in 2016, which took a lot of the availability of the drugs that were being imported, the so-called legal highs at the time, away from street-based vendors and potentially on to the internet market.

But certainly in my work—I can't speak for the rest of the panel—I don't see a huge impact of internet availability on the market yet. That may change over time demographically because, as we have said, the people using drugs problematically in Scotland are of a certain age. As young people come through and transition, perhaps they will be more exposed to the internet in that way and more familiar with using it, but it is not something we see at the moment.

- Q22 **Ged Killen:** In the evidence that Scottish Families Affected by Alcohol and Drugs gave, they said that individuals have been proactively pursued by dealers using mobile phone numbers that can be changed or social media accounts. If there is not a market, is it on an individual basis? Are you seeing anything like that?

Professor Matheson: You are probably getting good evidence from there. It is not something that we have particular expertise or ongoing research in or any evidence we can add to that, other than we know it will be more of a problem in the future and being prepared for that is obviously very important.

- Q23 **Ged Killen:** Does anyone have any experience of social media having an effect on social attitudes about the acceptability of drug use?

Professor Matheson: It has the opposite effect, certainly. We do know that. We know that media coverage can play into the stigmatisation of drug users. Ideally, you would think it could work the other way, that if media were to have a slightly different take on things it could reduce stigma of people who are affected by drug use. I don't know if anybody else wants to expand.

Dr McAuley: I am not aware of any studies that are reinforcing that point at the moment. There is a lot of evidence to suggest that print media perhaps in the past and in the way drug users are portrayed reinforce the stigma and there is nothing to suggest that would not be played out as within social media as well. I know there is a lot of work looking into guidelines for media outlets to try to help reduce the levels of stigma towards people who use drugs.

- Q24 **Ross Thomson:** What would you say are the main differences between criminal justice and public health approaches to problem drug use?

Dr Parkes: I will take that question. Thank you. We have already covered some of the criminal justice material. It is a focus on supply and prevention, on policing and law enforcement. It does not address the harm specifically that we have been speaking about today. It does not view the consequences of prohibition. Some academics argue that prohibition and criminalisation cause many if not most of the problems and some of the experiments across the globe can be learnt from in that



respect. The public health approach, to the contrary, supports the harms and harm reduction very specifically. They actively support harm reduction.

Harm reduction and public health very much go together and many of our international and national bodies such as the WHO, the Royal Society for Public Health, the British Medical Association, the Royal College of Physicians have come out, some quite recently, very much in favour of a public health harm reduction approach to drugs. They are starting to be much more critical and see themselves as advocates for healthcare and health treatment and the social reform that they are hoping to see.

Did you want to come in on that, Emily, because you had some other points?

Dr Tweed: To review what you have said already, as a public health professional what I would see as the key values of public health are that it is evidence-informed, that we look at the social context in which processes are taking place and we particularly focus on tackling avoidable inequalities, and that we look at balancing benefits and risks.

From a criminalisation point of view, public health approaches differ in that they don't preclude the use of criminal justice as a means to an end. Under a public health approach, there would still be enforcement around manufacture, supply and import. That is still likely to be important, but it is really about focusing on the risks to individuals and to communities and how those can be most effectively reduced based on the evidence. That is about the integration of what we see as effective harm reduction approaches as well as a broad definition of recovery that sees where people are at and supports them in that journey.

I would say that the goal of public health is not about the elimination of all risks. We recognise that drug use over time has been a feature of most human societies. What we are focused on here is reducing harms and public health is about balancing benefits and harms in a way that improves population health and reduces inequalities. I would see a public health approach as guided by those values.

Q25 **Ross Thomson:** On that point of the balance, you will know *The Press and Journal* up in Aberdeen. The main story today talks about the George Street part of Aberdeen, which is split between my constituency and Aberdeen North. The residents in that particular community are saying that they are at crisis point with the issues associated with drug use and drug selling. They say that people have now moved out of the area and they have been calling for more police prominence in the area because of the things associated with antisocial behaviour and other consequences. Do you think some of that would be mitigated with a purely public health approach for those residents and the community or is it getting the balance right between a public health approach to help people who are addicted to these substances or involved in these substances and also the public enforcement approach to help to deal with issues of antisocial



behaviour or anything else that comes with it? To give those residents an answer, what is it?

Dr Tweed: I am not familiar with the situation in Aberdeen so I can't comment on that case in particular. I think it comes back to my point about the fact that a public health approach does not preclude the use of criminal justice approaches more broadly, but in particular the distinction is about how we approach an individual who has problem drug use. A public health approach would move away from criminalising that individual with the stigma, the criminal record, the potential impacts of prison on that person, and would very much focus on how we can help that individual with treatment and harm reduction. But as I say, a public health approach would not preclude, for instance, looking at the broader markets, the organised groups that might be involved in the supply, that whole context.

Echoing the point I made earlier about societal context that we are always banging on about in public health, it is about what are the drivers that have led to that situation arising in that particular locality; what are all the different factors at play, with individuals, within communities, within the region, within society more broadly.

Q26 **Chair:** When you look across the range of Government policies and approaches, how would you summarise the balance between the criminal justice element and the public health element to that? I think somebody mentioned that the United Nations describes drug-related criminal justice policies as “ineffective in reducing drug trafficking or addressing non-medical drug use and supply”. We are decades on from what was described as the war on drugs. I am trying to get a sense of where the trends are in the approaches and how the criminal justice side of that is balanced against some of the more public health approaches. What would you feel we need to do to try to get the right balance? Maybe that is one for you, Dr McAuley.

Dr McAuley: I think there is a growing consensus that the war on drugs or the criminalisation approach, not just in the UK but in other countries, has largely failed. There is a movement—Portugal is the key example that a lot of people cite but there are other examples. In Scotland we have cannabis legislation now, so personal possession of small amounts of cannabis is no longer punished in the same way as it was before. There is an increasing acceptance among global leaders that the criminalisation approach has not worked, as demonstrated in the sheer levels of problematic drug use and harm that we see in the UK and abroad. That is where the public health approach offers a potential solution that bridges some aspects of the enforcement approach but with a much more human rights-based public health approach that looks to reduce the risk at an individual level but also at a community level.

Dr Parkes: Portugal's approach was targeting problem drug users, so it was an administrative approach to people who were significantly at risk. They still have other sanctions for people who are supplying. It is



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decriminalising drugs for personal use. One of the findings from the Portugal work shows that relationships between communities and police have improved, which I think relates to one of the points that has just been made here. It is not polar opposites. They can be in combination and the reason why so many people look to Portugal is because they did many things and they have also done some rigorous, including independent, evaluations and shared their findings very broadly. Each country needs to be able to feel free to adapt the learning from public health approaches to their own local problems and create novel and innovative—

Q27 **Chair:** Do you feel that in both the UK and Scotland we are getting that balance about right or is it tilting in one way or the other? No, you are shaking your head.

Professor Matheson: Our prisons are full of people who have a drug problem. I think that is a basic fact. Look at our prisons that are full of people who are there for a lot of fairly minor drug offences and they are in and out all the time. That has a cost, of course. When Portugal looked at the societal costs associated with their new programmes, it looked at prison costs, health costs. There has been an 18% reduction in costs overall to society as a result of their approach. People are not getting off without some form of—calling it decriminalisation just means they don't necessarily end up in jail, but they will have something like they may need to do community service or go into treatment. It is an opportunity to intervene with treatment for people. There is an intervention there. It is just not putting them in jail.

Dr Parkes: Importantly, it is voluntary. There is no compulsory nature. That is because I think the Portugal model was very much about reducing shame and stigma and encouraging people into treatment and they know that punitive approaches don't do that.

Dr Tweed: You asked how we characterised the response and we have seen that the UK drug strategy from 2017 takes very much what I would characterise as a criminal justice approach. There is little or no mention of harm reduction for drugs within that strategy. It equates recovery quite narrowly with abstinence and it talks about having a vision of a drug-free society. In Scotland the Road to Recovery was quite a recovery-focused strategy, as the name suggests, with quite a narrow focus on recovery. We are seeing some encouraging signals with the new drug treatment strategy that makes positive noises about things like inequalities, ACEs and mental health and diversion, but it is yet to be seen how that will play out in practice.

Q28 **Paul Masterton:** Thanks very much, panel. Apologies for being late and also apologies for having to leave shortly to go back down to the Chamber.

I am interested in this idea about trying to find a balance between the two, because it does seem to be one of the difficulties. We are dealing



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with very different kinds of substances and often very different types of users. It seems like some of the criminalisation work on legal highs, which is at the other end of the threshold, appears to have been quite successful in reducing deaths, but there is a very different approach needed for the very problematic users that I see if I go into Glasgow at the weekend on a Saturday night out. I wonder if sometimes in the conversations that we have about drugs we look at it as if we are dealing with one big problem where everybody is the same and it needs one approach to deal with all drugs as a whole and what we need to do in how we approach them is to be breaking it down much more into the different types of users, what has led them to their drugs use and even what drugs they are using.

Dr McAuley: I think a public health approach exactly does that. It looks at the drivers of drug use at the outset, but it also looks at the potential responses to people who have got themselves at that problematic end of the spectrum. It also looks at the more community side of things, the whole population and how the public health approach can benefit not just the individuals using drugs but perhaps the businesses or the residents in areas where public drug consumption is very visible, and looks at solutions to address that. The public health approach is not absent from any enforcement aspects and certainly the new Scottish drug strategy describes it as a public health approach to justice. It very much sees the criminal justice setting as part of the solution and that includes places like police custody and prison. That can be part of the response to helping individuals in that way.

Q29 **Paul Masterton:** I know that this inquiry is about the use and misuse of drugs, but I sometimes worry that you often end up talking very much about the use and very little about the supply. Do you think that the move towards a more public-health-facing approach around use, that would shift the criminal justice argument back on to the suppliers? Because I suppose it is very easy to say that the user is the criminal problem, whereas if you free that space up a little bit, it drives you back into looking more aggressively at the supply chain in terms of the criminality.

Dr Tweed: That is exactly what was done in Portugal. At the same time as decriminalising the use of drugs for personal possession and investing in treatment and so forth, they increased their enforcement at those higher levels of the supply chain. Again, it illustrates that it is not mutually exclusive and that was one of the factors that contributed to it being seen as a success in Portugal.

Q30 **Hugh Gaffney:** On legislation, does reserved drugs legislation impact on the Scottish Government's ability to respond to the problem of drug use in Scotland?

Professor Matheson: It does. There is a very specific example that has come to the fore recently of course around safer injecting, safe consumption rooms. We Are Scotland would like to address this problem,



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particularly in Glasgow, around street injecting and the HIV outbreak that we have mentioned. The Misuse of Drugs Act 1971, it is old, but it has something very specific in there that makes that not possible. That is if you work in a premises or you go to a premises where you know there are illegal drugs being used, that in itself is a criminal act, so staff that work supervising an injecting facility, for example, would be breaking the law. That is a very specific example that has been a major barrier to moving forward with an intervention that is much needed.

Dr Tweed: I want to add to that. In policy areas that are devolved to the Scottish Government like alcohol policy and smoking, we have seen that Scotland has a history of public health innovation. We introduced minimum unit pricing, we were the first country in the UK to introduce the smoking ban, and I guess that illustrates the potential of devolution to respond to local needs. At the moment we have very clear evidence, a very compelling case of local need in the form of a safer drug facility in Glasgow to address some of the individual and community harms associated with public injecting, but the Scottish Government does not have the levers to address that. We also need to think about the reserved policy areas that we have been talking about that impact on the drivers that we have been discussing in terms of income, wealth, socioeconomic inequality and child poverty and good work.

Q31 **Hugh Gaffney:** On the Scottish Government, Monica Lennon, the health spokesman for Labour, she says the Misuse of Drugs Act 1971 is not fit for purpose. Would you agree with that?

Dr McAuley: Yes. It is a classification-based Act, it not based on any evidence related to harms. It is long overdue for review and renewal.

Professor Matheson: As a pharmacist, I will say that the Misuse of Drugs Act covers a lot. It is very clear for how pharmacists and prescribers manage drugs, what they have to do. It is clear to the police, so it not necessarily problematic. It is not the whole Misuse of Drugs Act that is the issue. A lot of that is very good in determining how drugs are managed within hospitals, pharmacies, the supply, all that kind of stuff, so do not forget that, but there are very specific problems with it that are out of date.

Chair: I want to come to drug consumption. We have a couple of questions and I think Christine is first.

Q32 **Christine Jardine:** You have touched on drug consumption rooms there. Could you tell us a little bit more about the research that has been done on whether or not they are effective?

Dr Tweed: The first drug consumption facility was introduced in Switzerland over 30 years ago, so we have three decades of evidence. There are now around 100 facilities in a number of countries worldwide, so France, Spain, Germany, Denmark, Canada, Australia, and there will be others that I am forgetting. We have lots of international examples to draw on and some of the best-evaluated of those are Canada and



Australia, as well as evidence from elsewhere. When we did the piece of work in Glasgow looking at local need and particularly in relation to public injecting, we saw there was good evidence for their effectiveness and the particular problems that we were seeing. That evidence is endorsed by the Advisory Council on the Misuse of Drugs here in the UK and also the European Monitoring Centre for Drugs and Drug Addiction.

What these facilities are able to do is they are able to reach people most at risk of drug-related harms and they are able to reduce the sharing of injecting equipment, which is the biggest risk factor for blood-borne viruses like HIV. They reduce levels of public injecting and drug-related litter, so there are important benefits there for the local communities as well. They appeared in both Canada and Sydney to improve people's uptake of treatment and improve people's access to treatment, because these are not just places where you inject your drugs; they also have close links with treatment services and with wider services around housing, welfare and so forth.

What was interesting was that there was no apparent increase in crime or antisocial behaviour in the vicinity of these facilities and that public opinion tended to improve either the closer you were to the facility or the longer that it had been in place. From a societal point of view also, we see in Canada and Australia these facilities were cost-saving, so although they require quite a substantial initial investment of money, they saved the health service money because of the averted blood-borne virus infections and overdoses. Those were quite conservative assumptions they used in looking at costs. They did not look at other forms of health harm and they did not look at other societal impacts. That is the evidence that we see from elsewhere.

Q33 Christine Jardine: I was going to ask you about the other countries, but one of the other things I was going to ask was whether there are organisations or whether any of the organisations in this country who deal with people who have problems with drug misuse—I am thinking about organisations like the Salvation Army—have they expressed any opinion or put forward any suggestions as to whether or not they think this could work or if there is a halfway house or something else even further on?

Dr Tweed: As I think was recorded in a number of the evidence submissions, there is a huge amount of professional and third sector support for these proposals in Glasgow. From a third sector point of view, I believe the National AIDS Trust, the Hepatitis C Trust, Waverley Care, Turning Point Scotland have all lent their support to this and I am sure there will be others that others can chip in with. Also from a professional point of view, they are supported by the British Medical Association and the British HIV Association, so they do have that support. What is important about that is people recognise the context in Glasgow.

I have described the evidence internationally, but certainly the work that we did on the health needs assessment and Andy's work on the HIV



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outbreak has demonstrated that we do have a population of people who have very complex needs, who are injecting in public and are either involved in the HIV outbreak or are at very high risk of HIV, for whom this will offer a benefit. We did a survey on needle exchanges in the city centre and 79% of people attending those needle exchanges would use a facility like this and 74% of them said they would use it every day.

There is also a need in terms of the community benefits and of the local residents and businesses that are affected by public injecting.

Q34 Christine Jardine: One other thing I was going to ask, to go back to Mr Gaffney's question about the legislative framework, what would you say to the suggestion that what we need is for the UK Government to make a special case for a pilot in Glasgow to look at the situation nationally, right across the UK, rather than only in Scotland?

Dr Tweed: I would absolutely support that. Andy, you wanted to come in as well.

Dr McAuley: Yes. Certainly that is what the Glasgow Health and Social Care Partnership have asked for and that is what was requested, but that has been denied repeatedly by the Home Office. It is important to acknowledge Glasgow's case for a drug consumption room is arguably the most compelling case for a drug consumption room Europe has seen, not just the UK. If you look at the most recent one that was opened in Paris, the case that that was built on was nowhere near as compelling as Glasgow, if you think about the HIV outbreak, the drug death epidemic, largest botulism outbreak Europe has ever seen. There is a whole host of reasons why Glasgow is a perfect case for the UK's first consumption room.

I would also like to point to precedent for licences being granted for things that have been done. The Home Office did grant a licence recently for drug-checking services in Weston-Super-Mare, an Addaction service there, so there is precedent for the Home Office shifting the position to allow illegal drugs to be kept onsite at a drug treatment service. If Weston-Super-Mare can be granted a licence to innovate, surely Glasgow can be granted the same licence to do that.

Dr Tweed: If I can pick up very quickly on your point about pilots, we do see the end benefits in other countries. We expect those to be transferred to Glasgow, but it is important to evaluate that. The proposals that have been put forward include a robust evaluation framework. Andy and I have been involved in work to plan that evaluation and it is essentially ready to go if the facility were to be introduced, so it is important that is evaluated to make sure we see those benefits in Glasgow.

Chair: I am conscious we are trying to get the best out of you, and we are running out of time quickly, so if you could be a little bit more concise with some of your answers, fascinating though your evidence is, and we will get through a number more of these questions. Deidre Brock.



Q35 Deidre Brock: Can I ask what you make of the UK Government's arguments against consumption facilities in Glasgow or at least one consumption facility? Some of those concerns the Home Office indicated were about law enforcement, ethical quandaries for medical professionals and the risk that users would travel long distances to use the room. What are your thoughts on those arguments?

Dr Tweed: In terms of challenges for the police and law enforcement, in other countries where this has been introduced that has been addressed through very close partnership working between police and organisations of these facilities. Often the police are involved in the board or the leadership committee and certainly in Glasgow, there has been very close working with Police Scotland and with Community Safety Glasgow. In terms of ethical objections from medical professionals, as I noted, the British Medical Association and the British HIV Association support these proposals and certainly there is a lot of local support from professionals that we have seen. Andy, did you want to come in?

Dr McAuley: Your last question I think was about the honeypot effect, about attracting people towards the service. There is no evidence of that happening in any equivalent services worldwide, largely because people who inject drugs inject drugs very territorially, where they source their drugs. There is not a known kind of migration to different spots. That is not something we expect to happen with the Glasgow facility. It would be put in place very much where the hotspot of public injecting is in the east side of the city centre. But again, that is very much the sort of thing that we would study as part of an evaluation of the service.

The one thing about the police I would also mention, there are a number of police and crime commissioners across the UK on record as supporting drug consumption rooms. I am thinking about people in those positions in Cleveland, Durham, the West Midlands and Wales. There are a number of people in those offices who are on record as supporting not just the Glasgow facility but similar facilities elsewhere in the UK.

Q36 Deidre Brock: What about the suggestion there would be ethical quandaries for medical professionals? Is that—

Dr McAuley: I do not see what the ethical quandary would be there. They would be providing an evidence-based intervention. They would also be ethically addressing people at their point of need, reducing people's likelihood to come to harm, so I cannot see that being a barrier.

Q37 Tommy Sheppard: Can I come back to decriminalisation? We were talking about this earlier. We have to write a report at the end of this process, which might well be the autumn before we get there, so I wonder if I could invite you to be explicit in your advice to the Committee. Based on what you know and the evidence you have seen, would decriminalisation have a beneficial effect upon the problem in Scotland? If so, how?



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Dr Parkes: Certainly the evidence that I have seen and am aware of and all the work I have done make me believe that we should be decriminalising personal drug use and possession, so yes in response to that question. My colleagues can elaborate on the difference that will make.

Dr Tweed: I would agree that if it is implemented as part of a whole-systems approach in the way that they did in Portugal, which looks at multiple fronts, including treatment and the social circumstances that people look at, decriminalisation can contribute to reductions in harm and should be supported.

Professor Matheson: I would agree as well, absolutely. The evidence is very strong, but it is not decriminalisation on its own, it is part of this treatment and care package and joining up the drug policy with the social care policy and that will work. That is a challenging bit, but that is where you need to be looking.

Q38 **Tommy Sheppard:** Four out of four?

Dr McAuley: I would agree wholeheartedly, yes.

Q39 **Tommy Sheppard:** What do we say then to the Home Office, which says that decriminalisation would send out the wrong signal and would be seen as public policy encouraging problem drug use?

Dr McAuley: I would say to the Home Office that you could argue that there are lots of policies in place. I have been asked this question a number of times, whether decriminalisation or drug consumption rooms facilitate illegal behaviour, but we already have needle and syringe exchanges in every town and city all across the country. They are there in the acknowledgement that people are going in there to get sterile injecting equipment to go and use drugs, typically purchased illicitly. They are not going to get stuff that has been prescribed by their doctor. There is already an acknowledgement in society that people are engaged in drug use that is illicit and we have these interventions in place to reduce levels of harm. Things like decriminalisation and drug consumption rooms are logical extensions to that harm reduction environment, to change to an evolving dynamic of what drug use is like in the UK nowadays.

Dr Tweed: I would absolutely echo that. I would also question the message sent out by our existing system, which is that, first, we are failing to implement evidence-based solutions, which we fully expect to reduce harms among a very disadvantaged section of society.

Also, as Andy has alluded to, the classification system under the Misuse of Drugs Act does not reflect harms. There is some evidence from work that the Royal Society of Public Health has been doing that people have very little faith in it because they see it as sending the wrong message. It is also important to note that with decriminalisation, as it has been implemented in places like Portugal, possession is still illegal, and that it



is just the sanctions that are different. People are not receiving criminal penalties in the form of imprisonment; they are receiving civic or administrative penalties in the form of diversion to treatment.

- Q40 Tommy Sheppard:** I wanted to ask a little bit more about Portugal, where they decriminalised, so you do not go to jail for possession, but it is still illegal to supply and market certain substances. Does that leave the market in the control of organised crime then? Do they determine price, content, marketing, recruitment of people, of pushers and all the rest of it? Is that all in place in Portugal or has the effect of decriminalisation of possession undermined all of that?

Dr McAuley: It is just the size of the market. It has certainly not increased the size of that market, which is a lot of what people perhaps thought the unintended consequence of decriminalisation or a more extreme form of legalisation would cause, that there would be much more people using drugs and much more people experiencing levels of harm. The evidence from Portugal is the exact opposite. There are fewer people using drugs problematically and a massive reduction in levels of harm among those that are. The evidence is clear that it works.

- Q41 Hugh Gaffney:** Sticking with Portugal, the examples it sets down, has that also helped the public health outcomes of the problem drugs?

Dr McAuley: Yes. There are lots of different indicators you could point to, but the two biggest that are rolled out are the drug-related death rate and the HIV infection rate. Their HIV infection rate was over 50% before this policy came in. It is now less than 10%. That is a clear indication of how successful it has been for people who inject drugs. Their drug-related death rates are among the lowest in Europe. Now, obviously acknowledging there are issues of comparison with their data, but Scotland is at the top of that spectrum; Portugal is near the bottom.

- Q42 Chair:** Grateful. A lot of the written evidence we have had in this inquiry also says that the Scottish Government could do more with its existing powers. I think we are all very clear about the distinction of powers. The legal aspects of things such as criminalisation and legality are all reserved to Westminster, but the Scottish Government have a whole range of powers in the suite of arrangements of powers that they could refer to when they want to go ahead with any sort of policy. We know rights, recovery and respect is the policy that is underpinning the Scottish Government's approach. Do you think the Scottish Government could do more with the powers it has?

Dr Parkes: It is difficult to answer. In terms of the most substantial levers that we have talked about, including socioeconomic, they do not have all the levers to do so. They do not necessarily have the taxation to do that welfare employment in the economy. I do want to preface my comments by saying that.

However, the new policy is saying many of the right things. It responds to many of the things we have talked about, the drivers and trends and



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also in terms of targeting sub-populations, which I was not able to say earlier. There are lots of good work and lots of good developments: the National Naloxone Programme, the plans for heroin-assisted treatment, the ORT reviews, the “Staying Alive” report, the older drug user report. They have commissioned a lot of the work that we have been able to speak about today. There is the Quality Principles, the NESI work and the drug-related deaths database work. However, of course there can be more done. It is a complex problem. Harm is increasing. We would say it is an emergency-level requirement for policy and practice to act.

It is early days. The new strategy was only published a few months ago, in late 2018. There are plans for evaluation, which are very important to see. We do not have the action plan yet in the public domain. We hope to be working towards that. The public sector reform that was put in place to try to deliver what we were talking about in terms of community needs is still in its very early days in terms of Health and Social Care Partnerships and community partnership structures.

There is a need for more inspection and quality monitoring in Scotland of all services, not just third-sector services; that is something I would like to see in the context of attempts to drive up the quality that we talked about earlier, retention, quality and access that can be improved. I also think there is a need for more and better national co-ordination of drug death reviews in Scotland. Those would be the things for me. I do not know if my colleagues want to add anything.

Q43 Chair: I am interested in the heroin treatment centre that is to be established in Glasgow this year. Obviously the Scottish Government have the powers to put that forward. Will this make any sort of difference? Is this the sort of thing that you believe the Scottish Government can do more of with the powers that are available to it?

Dr McAuley: It is important to acknowledge that the heroin-assisted treatment service that will open in Glasgow in the autumn is being driven locally by the health board and the Health and Social Care Partnership. It is not a Scottish Government initiative. The Scottish Government endorsed what is going on there, but these services come from the ground up, they respond to local need, so there has been nothing stopping heroin-assisted treatment in the UK for as long—

Q44 Chair: It can happen anywhere in the UK?

Dr McAuley: It can happen anywhere in the UK as long as there is a local need and there is resource to fund it, because they are very intensive and expensive services. The doctors required are licensed. They only changed the laws in 2012, where the licensing application scheme was devolved to Scotland, but it is a UK-wide service.

Q45 Chair: Another thing is the drug-checking service here. I think you mentioned it was Weston-Super-Mare, which I think is new to us in this Committee. We did know that facility was available and that it was



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ongoing in England. I believe Wales is doing something with this too. Is that within the powers? Obviously it would be if it is in England and Wales. Do you think there is a case for Scottish Government or one of the health boards to go down this route too?

Dr McAuley: The service you mentioned is called the WEDINOS. I will not go through what the acronym is, but it is basically a drug-testing service, so anybody in the UK can send a sample to WEDINOS and it will be tested for you and your result will be sent back to you. So for whatever purpose you want your drugs tested, whether you are a clinician, whether you are a festivalgoer or whatever, however you want to describe this service, anybody in the UK can access it. I have been in touch with them recently ahead of coming here and they do receive samples from Scotland. They do not receive lots of samples from Scotland and it is not a service that I see promoted well in Scotland, whether within drug treatment services or elsewhere, so perhaps it could be promoted better in Scotland. Whether a WEDINOS-type service in Scotland that is more localised and more visible to people would be of benefit, possibly, yes, but I would like to see the existing service promoted better and used in that way.

Q46 **Chair:** Those are two very good examples of harm reduction measures that can be put in place very easily and conveniently by the Scottish Government and health boards. Are they the sorts of things we should be doing more in Scotland?

Dr Parkes: I do not think we were able to do the drug checking in Scotland up until now. That was certainly our understanding, that it is not within the Scottish Government's powers. Andy, correct me if I am wrong.

Some of the other things that we have just spoken about that are next week we are having international researchers speak at a Drugs Research Network event in Dundee about lots of things around drug-related deaths. One of those things is drug checking and drug testing. In areas of British Columbia, where they have a huge epidemic of drug-related deaths, they are now doing a lot of drug testing and drug-checking work, and they are going to be talking with a Scottish audience about their experiences of doing that. We have just sold out that event. There is a lot of interest in coming to that from all geographic areas of Scotland. It is very much something that we want to learn from and to do. I do not see why we would not be able to do it if we had the powers, but my understanding is we do not.

Professor Matheson: I was just going to make a point about heroin-assisted treatment and why that can be done in other parts of Scotland and why it has not been done. Part of the reason is because the treatment services have been struggling to do what they are doing at a basic level, due to financial cuts. Some of that money has now been reinstated, but they have been struggling to maintain a level of prescribing methadone and buprenorphine as fairly basic services.



Developing a new system like heroin-assisted treatment does take a bit of effort and investment in time to get it up and running. They have not had the capacity to do that.

Dr McAuley: It is a very specialist service for a very small number of individuals who have failed conventional therapy—methadone and buprenorphine treatments—multiple times. Heroin-assisted treatment is made available to them. It is very intensive, twice a day, seven days a week.

Back to your point about what the Scottish Government could do better, a few people have mentioned it, but treatment is the most protective factor against drug-related death and treatment—opiate substitution therapy, through methadone or buprenorphine—is within the gift of the Scottish Government, and Scotland performs poorly in that. We only have about 40% of the problem drug use population in treatment at any given time. We perform poorly compared with our European counterparts and the retention rates for those who are in treatment are also poor in comparison. There have been numerous reviews of the OST system in Scotland over the years, which have not been able to make any specific impact in that sector. That is something that is of immediate concern and something we should certainly be focusing on.

Q47 **Tommy Sheppard:** Can I ask a supplementary on that first? Does Scotland perform poorly in comparison to the rest of the UK as well?

Dr McAuley: It is interesting that this has come up through the evidence submissions. I have seen certain figures quoted in the evidence submissions. I would not like to comment on that until I see the different data sources—where they have come from and how they have been generated. I can only comment on the 40% Scottish figure because I know where that has come from and I have compared that with data from a number of other comparable European countries, particularly countries in Scandinavia. There has been an English figure quoted in one of the evidence submissions that I am not familiar with, so I do not feel it is right to comment on that.

Q48 **Tommy Sheppard:** Regarding treatment, from stuff I have read previously, I believe that part of the problem about treatment is that if there is a presumption of curing people, then you take them through a process of treatment and that the objective of it is to get them out of the system and get them out of treatment, so that is seen as a result, whereas in other contexts, some people would argue that you can keep people in treatment indefinitely and that is going to lead to a better outcome than basically trying to send them out, saying, “Problem solved”.

Dr McAuley: It is not a one-size-fits-all approach to treatment. Goals should be identified by the individual who is being treated in collaboration with their clinician. It should not be that abstinence is a goal for everyone, because abstinence might not be an achievable goal for



everyone. For some people it is just stability and there are many people who function—if I can use that crude term—in terms of employment and housing who are on a daily OST script. They are just maybe not that visible to the public. The treatment goal should be very much led by the individuals themselves.

Professor Matheson: We have been tied up for too long in Scotland, in England, with that argument about recovery and being abstinent compared to being on a long-term opiate treatment script. We need to move on from that. We need to accept that there is very good evidence over decades now that opiate replacement treatment is effective at reducing drug use, reducing mortality, reducing criminal activity and improving social functioning. That is clear and it should not be debated. It is very much not about focusing on abstinence; it is about getting stability in somebody's life and it is to be hoped that that will eventually lead to abstinence, but there is a long process that may need to take place in the interim.

Dr Parkes: Something we have not covered is the subject of a recent paper around cycling in and out of treatment. The rapid review that Health Scotland did showed that people are particularly vulnerable to drug-related deaths immediately leaving ORT treatment or abstinence-focused treatment such as rehabilitation or prison. The four weeks coming out of treatment is one of the most vulnerable periods, and also for dose variability, so going up and then back down.

What you sometimes see in services is that people do not manage to co-operate, they miss their appointments and we have heard about "three strikes and you are out"—people have to go through all the high-barrier stages to get back into treatment. We know that does not work. We should have not only easy access in, a low threshold to care, but also easy re-entry back into services so that we do not have this dose variability, which puts people at risk. Treatment is protective, but it needs to be high-quality treatment that people want to be engaged and involved with and that does not have so many personal sanctions that mean they are in and out on various doses.

Treatment also needs to be optimised treatment, which is what the evidence-based guideline states. Quite a lot of treatment is not optimised in that way, so people are topping up on top. That has been in the literature for decades and decades. We know what we need to do, and we need to be doing it better.

Dr Tweed: I agree.

Q49 **Tommy Sheppard:** The question I was supposed to ask was about the powers of the Scottish Government and the debate about potential devolution in the future. I think everyone has said the 1971 Act, if we put it kindly, needs to be reviewed. What can you tell us about the debate about the legislative framework for overseeing drug policy and classification in use, and whether that should be devolved to the Scottish



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Government? Are there benefits to that and what evidence do we have internationally within big states of regional differentiation of policy?

Professor Matheson: It is tricky, because the Misuse of Drugs Act does not just cover criminality or being in possession of small amounts of drugs; it covers so much more. It covers the whole framework, as I mentioned earlier, around controlled drugs that are being used for pain and how those are managed and supplied. That is the challenge, I would say, because at the moment it is a whole big piece of legislation that covers a lot. If some of that could be reviewed or some of it could be devolved, that would be ideal.

Dr Tweed: I come back to that earlier point about devolution as responsive to local needs. I suppose that is the advantage, but one of the disadvantages is that you might create inequalities between different areas of the UK. Certainly, as Andy has alluded to, there are likely to be other areas of the UK that might benefit from, for instance, safer drug consumption facilities or from a review of the classification system more broadly. Devolution might lead to positive changes in Scotland, but we think we need to acknowledge that the rest of the UK is also experiencing a lot of similar problems. Of course it would also depend on how any Government was minded to use those powers.

Q50 **Hugh Gaffney:** Are the UK and the Scottish Governments, working together to address this drug use? Is it working?

Dr McAuley: It is an interesting question for us, because we are not privy to that level of collaboration, but we do see examples of it, the advisory level work that we do or the research level work we do. A good example of that is the Focal Point initiative. Each of the UK Administrations is represented on what is called a UK Focal Point. It is a joint UK public health surveillance for drugs, which is linked into the European centres in that way. A lot of the work we do is public-health-type research and that is a good example of that. As for how the UK and Scottish Governments are working day-to-day in this area, I certainly am not privy to how closely they are linked.

Professor Matheson: My impression is that they are not working together.

Q51 **Hugh Gaffney:** You do not feel you are getting the full support from either the UK or Scottish Government. Is one better than the other?

Dr McAuley: That is a different question. So is the question about how much support we get in our work from the Scottish Government. Certainly the Scottish Government are involved in a lot of the stuff that has been described today, whether it is evaluation of existing programmes like the National Naloxone Programme in terms of funding that at the outset and putting an infrastructure in place to allow that or whether it is endorsing some of the more recent innovations such as the safer drug consumption facility in Glasgow. It is helpful to have cross-party support in Scotland for those initiatives. The most obvious example



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recently would be the drug consumption room. We have not seen the same support for that at a UK level, but because of the nature of health policy being devolved in Scotland, most of our work is with the Scottish Government.

- Q52 **Chair:** On that point, is there a sense that there is a growing political consensus about the approach to drugs issues or is there a Right/Left divide when it comes to criminal justice versus a health approach? What I am beginning to sense, particularly in the work of the Scottish Parliament, is that there does seem to be a degree of consensus on the one approach, which is mainly around a health agenda approach. Would I be right in that assessment? I am seeing everybody shaking their heads. Maybe somebody could address it.

Dr Tweed: Certainly in relation to the safer drug consumption facilities, there is cross-party support across the Scottish Parliament. I am not sure about the extent to which that applies more broadly to the debate about criminal justice versus public health approaches. I do not know if anyone else wants to pitch in on that one.

- Q53 **Chair:** We do a bit of joint work with our colleagues in the Health Committee in the Scottish Parliament—us attending their sessions and some of them attending our sessions—so we are hoping to join this up a little bit more. If you have any advice for us about how we approach that, it would be very useful. I sense that that consensus across the political communities is beginning to emerge, but you still see the odd little bit about prohibition, about abstinence and that it is all about criminal justice.

Dr McAuley: It is healthy to have a range of views and opinions, but in relation to Ireland and Scotland, drug use is probably more visible now—whether it is on the streets or whether it is in the media—than it has perhaps ever been, so I think that has helped a growing consensus at a political level.

I would also say that there are examples from Westminster. There was a Select Committee last year that had cross-party support for the consumption-room proposals. There was consensus in the House of Lords from all parties for some of the things that have been put forward, so cross-party support is not located just in Scotland; we have seen evidence of it here in London as well.

Chair: We obviously have a consensual approach in this Committee. Deidre Brock.

- Q54 **Deidre Brock:** I want to ask about the way social security and welfare is currently delivered by the DWP. NHS Health Scotland said in a submission to the Work and Pensions Committee: "We are concerned that the current reserved social security policy (including low levels of benefits, freezes and cuts, delays and errors, poor quality assessments, benefits sanctions and natural migration) has undermined an already inadequate welfare safety net ... Current reserved social security policy thus risks



undermining policies to reduce problem drug use". Could I ask for your views on that?

Dr Tweed: I would like to applaud the work done by NHS Health Scotland in this area, because they have been doing a very rigorous programme of work on the relationship between welfare reform and health, so absolutely, as they say, social security is an important determinant of health, partly because it has such a big influence on people's incomes and that in turn influences their health, but also people's interactions with the system and the way that system works. Certainly from the work that we did on women dying from drug-related deaths and why that has increased in recent years, the intersection between being female and being someone who uses drugs was a vulnerability within the welfare system; we know that austerity and welfare reform have had a greater impact upon women.

We also know, as Health Scotland has alluded to, that austerity and welfare reform has particular impacts on people who use drugs because they use public services, they often have precarious circumstances, needing support from benefits. Women are at the intersection of those harms and certainly the feedback, both from our professional stakeholders and from the women with lived experience, was very powerful in identifying that as a potential factor in the increasing drug-related death seen among women in recent years.

Q55 Deidre Brock: I suppose uncertainty about finances—you mentioned stability and how important that was in terms of trying to get recovery—something like that would be very much affecting people.

Dr Tweed: I would also like to point to another piece of evidence that the Committee may be interested in, which is a large project on welfare conditionality, funded by the Economic and Social Research Council and carried out by a number of universities. It found that a lot of the welfare reforms in recent years have been ineffective in getting people into the labour market and progressing them and that sanctions have been having very negative effects on health, particularly among people with mental health and substance use problems. In their conclusions, they felt that a lot of those sanctions were moving people further away from recovery.

We were just speaking about consensus. I think there is very much a consensus within the academic community and the health community about the harmful effects that this is having on people.

Q56 Chair: It has been a fascinating session, thank you very much. I will ask a little mischievous question at the end here, just so you can help us properly with our report and recommendations.

If there was one thing that you feel that we, as a Westminster Committee, should recommend—I think it would be to the Home Office—on this particular issue, what would that one thing be? We will start with you, Professor Matheson.



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Professor Matheson: Thinking of the drug-related deaths situation, I think we should be declaring a public health emergency, absolutely. This is not just a problem for Scotland. It is much more acute in Scotland, but drug-related deaths are also increasing across the UK. I think that is the type of response we need. This is an emergency situation and we need to do something now. We cannot wait for legislation changes several years down the line. That is going to be too late for a whole generation of people at risk.

Dr Tweed: I echo what Catriona has said, but would also say that we have been talking a lot about the social determinants of problem drug use and the social drivers of that and I would see it as an absolute priority that the UK Government act to reduce poverty and inequality and to reverse a lot of the recent policy decisions that have made those factors worse for people.

Dr Parkes: The recommendation I would wish to make would be to decriminalise personal use of drugs.

Dr McAuley: I would support all three of the recommendations, but on top of what has already been said, I would like to see legislation, or something done to facilitate Glasgow to allow the piloting of a safer drug consumption facility there.

Chair: That is all very helpful. You have this inquiry off to a flying start and we are very grateful for your contributions today. As always, if you feel there is anything else that you could usefully contribute to this inquiry, please get in touch. I am pretty certain we will be coming back to several of you anyway in the course of the next few weeks to secure further assistance with this inquiry, but for today, thank you for coming down to London and helping us with this inquiry.