HOUSE OF COMMONS

Scottish Affairs Committee

Oral evidence: Problem drug use in Scotland, HC 1997

Tuesday 4 June 2019

Ordered by the House of Commons to be published on 4 June 2019.

Watch the meeting

Members present: Pete Wishart (Chair); Deidre Brock; David Duguid; Christine Jardine; Ged Killen; Danielle Rowley; Tommy Sheppard; and Ross Thomson.

Emma Harper MSP, David Stewart MSP and Brian Whittle MSP were in attendance.

Questions 108 - 170

Witnesses

I: Vicki Craik, Crew 2000; Dr Iain McPhee, University of the West of Scotland; Dr Neil McKeganey, Centre for Substance Use Research; and Dr Angus Bancroft, University of Edinburgh.

Written evidence from witnesses:

– Crew 2000

Examination of witnesses

Witnesses: Vicki Craik, Dr Iain McPhee, Dr Neil McKeganey and Dr Angus Bancroft.

Q108 **Chair:** Can we welcome you all very much to the Scottish Affairs Committee to help us in our inquiry into problem drug use in Scotland? Today we are looking into routes into problem drug use. We are grateful to all of you for coming down from Scotland, I believe, today. Just for our record, please state who you are and anything else by way of a short introductory statement. We will start, as is traditional, from left to right. Dr McPhee.

Dr McPhee: My name is Dr Iain McPhee. I am a senior lecturer at the University of the West of Scotland, specialising in drug use and addiction. My research focuses on hidden drug use and the associated stigma. I worked in the treatment field delivering psychological interventions prior to becoming an academic and I am currently a consultant expert witness in legal cases and High Court and Sheriff Court.

Vicki Craik: Good afternoon. My name is Vicki Craik and I work for a drugs harm reduction charity called Crew. Crew was established in 1992 in response to the emerging Ecstasy scene and today we are still one of the only organisations in Scotland that focuses on psychostimulant drugs. We produce information, advice and support for anyone looking to make more positive choices about their drug use.

We do these things through a drop-in centre, through outreach at events and festivals and through our one-to-one drug counselling. My role specifically at Crew is to focus on emerging trends and training, and I train frontline workers across all 32 local authority areas in Scotland in order to improve their knowledge and confidence on drugs and drug trends.

Chair: I am grateful and thank you once again for allowing the facilities at Crew for the launch of our drug policy inquiry a few weeks ago. We were very grateful for that.

Vicki Craik: You are welcome.

Dr McKeganey: I am Neil McKeganey. I am a sociologist. Since the early 1990s, my research centre—initially at Glasgow University, but then subsequently independent of Glasgow University—has carried out research on the nature and extent and consequences and the effectiveness of policies designed to tackle the issue of drug abuse in Scotland. My research colleagues developed the methods for estimating the size of problem drug use in Scotland and we have carried out research on factors associated with young people's use of illegal drugs. The vast majority of that work is based in Scotland, although we have carried out research for the Department of Health, looking at the

effectiveness of treatments designed for prisoners with serious drug problems.

Most recently, the work of my research centre, which is now a private research centre, has been tasked with assessing the public health impact of alternatives to combustible tobacco products and to address questions that the US Government's Food and Drug Administration has identified as key in determining whether or not e-cigarettes and other electronic nicotine systems are an effective alternative to combustible tobacco products and a means to reduce some of the tobacco-related health harms.

Dr Bancroft: I am Angus Bancroft. I am a lecturer in sociology at the University of Edinburgh. I research dark-net drug markets, illicit markets and online communities of drug users. I have also led research into the impact of parental drug and alcohol misuse on children.

Q109 **Chair:** I am grateful. Just before we proceed, I think it would be useful to tell you—or anybody who is observing our proceedings today—that we are most grateful for being joined by three of our MSP colleagues from the Health and Sport Committee in the Scottish Parliament, namely Emma Harper, David Stewart and Brian Whittle. They are all more than welcome. I know that they have been doing some work on drug use in Scotland, which is a welcome addition to the work of this Committee. We are doing a couple of sessions with our colleagues in the course of this inquiry.

We will get started. This is a session that we have described as routes into drugs. Perhaps just as an opening question, maybe you could give us your views about why some people get caught up in problematic drug use and why others do not. We see figures like 10% of people, possibly it becomes a bit of a problem issue for them. We have received numerous pieces of written evidence that suggest issues like trauma, stigma, social deprivation and mental health issues seem to be gateways into problem drug use. We have you all here today and we are interested in your views, so perhaps you could tell us what you believe are the primary routes into problem drug use in Scotland. We will start left to right again, so we will start with you, Dr McPhee.

Dr McPhee: Thank you for that. There appear to be various risk factors for experimenting with drugs leading to problematic drug use, but the evidence does not support the assertion that drugs in and of themselves and exposure to them necessarily leads to drug problems. The reason we know this is that when we produce surveys—and the one in Scotland, the Scottish Crime and Justice Survey—they indicate that problematic drug use is relatively rare in the general population.

The estimate is that one in four Scots, when asked, "Have you ever tried drugs?" say yes to that question. However, one in 15 say that they have used drugs in the previous 12 months and one in 28 say they have used drugs in the last month. What that and other evidence suggests to us is

that trying drugs is not necessarily one of the major routes into problematic drug taking. Exposure to drugs, so-called addictive drugs, has to be combined with additional risk factors to become problematic.

You mentioned some of the risk factors in your introduction there, which are marginalisation and equality deprivation, perhaps adverse childhood experiences. One of the things we know about problem drug users—and they are a much-studied population—is that research informs us that they are experienced in inequality from a very young age. All of these additional risk factors—living perhaps in an area of deprivation, being exposed to drugs and perhaps managing adverse social and psychological situations—may predispose them, but exposure to drugs in and of themselves does not appear to be the major route into problematic drug use.

There are additional routes, and some ex-users in recovery do mention that perhaps access to prescription medications is a route into problematic drug use.

Chair: We will come on specifically to that, if that is okay. I am conscious that this is a rather large panel and you can see there are quite a lot of us today so I am going to appeal for brevity and to-the-point responses from all of you, if that is okay. Ms Craik.

Vicki Craik: At Crew we have a slightly different point of view on what problem drug use means. The official definition focuses on the use of opioids and the illicit use of benzodiazepines and we do not deal with either of those drugs at Crew. Our main drugs are cocaine and cannabis, Ecstasy and ketamine. If you go just by the official definition of problem drug use, that means the thousands of people that we speak to each year do not have a problem. For me, problem drug use is not so much people who do not have a problem or do; it is more a spectrum of harm. A lot of the time, by the time we come to deal with problem drug use in the case of public injecting or overdose, to me that person is more at a crisis than having a problem. We see lots of people experiencing problems, but it depends on what end of the scale.

The most serious problems are normally caused when the individual has some kind of trauma and they are more likely to develop problematic drug use the more often they take drugs, the larger doses they take, and the longer the period of time they take drugs. They are the individuals that are most at risk of developing a long-term problem.

Dr McKeganey: Our understanding about routes into problem drug use in Scotland is principally to do with the development of serious drug problems, particularly around heroin and benzodiazepines. That is the area where we have had most success in trying to understand the growth of Scotland's substantial and serious drug problem. It is unquestionably the case that there is a range of risk factors, which you have already alluded to, which I think predispose the escalation of an individual's drug problems. Where use occurs alongside these known risk factors, there is

a greater likelihood that the individual will progress from initial use to repeated use and then problematic use.

However, I would also say that drug problems in our communities have attained a certain self-perpetuating momentum now, so you do not have to have these traditionally conceived risk factors to experience an immersion into a drug-using culture. The momentum that has grown up in some communities has meant that there are individuals who do not have these risk factors who get swept up in an escalating drug problem.

One needs to understand the way in which drug problems in Scotland and elsewhere rapidly change. Many of our understandings are of a problem that started in the 1980s, when heroin became a notable problem in Scotland. We still do not really understand the growth of the new psychoactive substances and the way in which problems can arise from the use of those substances, which are not about addiction as it is classically conceived: they are about the serious adverse psychological and physiological effects of these new substances. That is changing and will change our understanding of what problem drug use actually means and how it can be most appropriately targeted.

Q110 **Chair:** Just to clarify, your view is that problem drug use may emerge without a predisposition to some sort of addiction; you are saying that problem drug use may emerge just by the simple process of consuming drugs.

Dr McKeganey: Yes. We tend to think of problem drug use in a very narrow way, associated with addiction and principally involving heroin and benzodiazepines. I think that the notion of problems associated with drug use has expanded in the incidence and prevalence in Scotland, but our understanding has not increased commensurately.

Chair: I know we will want to come back to some of these issues, so thank you for that. Before we conclude opening remarks, Dr Bancroft.

Dr Bancroft: As well as looking at drug problems themselves, we should look also at the kind of problems that people are trying to solve with drugs when they use them and which may lead them to become particularly problematic. I think this is the case with problematic use of new psychoactive substances, but what we might think of as more traditional problem drugs as well—community trauma, social trauma, personal trauma, overlaying problems of deprivation, isolation, and other kinds of social disruption that people suffer.

The opposite side of the coin is also important: the kind of resilience that people display, even when exposed to problems. It is not all simply a story of pathology. People can mature and grow out of potential problem exposure. Most people who try drugs or are exposed to them do not end up with drug problems. Even most people in very adverse circumstances also show resilient outcomes. We also have to think about the kinds of

futures that there are for them and how we can make them into concrete, realised futures that will support them out of different problems.

Q111 **Chair:** A last general question from me. Are there particular reasons or different reasons why people might turn to illicit drugs or to self-medicate? What is your understanding about the links to that, apart from what you have already described as a route into problem drug use? We will start with you, Ms Craik.

Vicki Craik: A lot of people at Crew will take drugs because they have a positive effect, because they enhance life, because they enjoy it and they enjoy the experience of taking them, rather than necessarily self-medicating for a particular issue. We do not see a lot of people self-medicating in that respect. Obviously with opiates they are a painkiller, so they will numb the physical and psychological pain that somebody is in, but a lot of the psychostimulant drugs, they just make you feel a bit happier, so maybe they are just medicating to make life a bit more enjoyable, at least in the early occurrences.

Q112 **Chair:** In your view, Dr McKeganey, why do people turn to illicit drug use? What are the underpinning reasons?

Dr McKeganey: In many instances, people are curious. They obviously are well aware of the availability of different substances. They are much less cautious now than in the past. Surveys have shown that there is a willingness to use substances when the individuals do not necessarily even know what those substances are.

Over the last 15 or 20 years, there has developed an openness to experimentation with drug consumption, tempered rather less than one might hope by concerns about the potential health risks. There has been a cultural growth in a willingness to use substances and to explore those substances. Many drugs are named with terms that make them quite appealing, but clearly do not emphasise their harm. From an advertiser's standpoint, they are quite attractive. That is what we have seen in the last 15 or 20 years, the growth of substances where there is a curiosity; they seem interesting. People talk about the pleasure that is associated with at least the initial use of them. That is in a sense what I meant about drug use becoming self-perpetuating now.

Dr McPhee: It seems to me that the way the question is asked assumes that one of the major reasons why people use drugs is that they are self-medicating because they may feel anxious or unable to cope with life on life's terms. But if we look at adult drug users, the vast majority of them, if we do not look at the clinical population but look at the pathological population who make up the bulk of the problem users and contact the services, many of them are risk aware. They know exactly what it is they are taking and they tend to create informal networks that inform each other, because going through Government-funded websites like Talk to Frank and Know the Score tend to be anti-drug information, rather than information about how to take drugs safely.

We also have to recognise the impact of great social upheaval, which is part and parcel of the great "isms"—individualism, globalism and corporate capitalism and so on—insofar as there are historical precedents for what happens when there is great social upheaval. We only have to look at Hogarth's classic engravings from the 18th century, Beer Street and Gin Lane, to see the impact of a new substance being introduced to a culture, where beer was seen as something normal and in many ways safer to drink than contaminated water and it was seen as something for optimal health. In comes a new drug called gin, which is very powerful in relation to beer or ale, and Hogarth classically demonstrates the thinking of this time, that exposure to that substance leads necessarily to infanticide, to degradation and death.

We have to look at the societal factors and forces that impact on why people choose to self-medicate and why they may choose to use particular drugs. We also have to recognise that being risk aware, risk assessors, many drug users use drugs because of the functional use: stimulants to stay awake and alert; analgesics and depressants to make them feel less anxious and get to sleep; hallucinogenics perhaps to explore difficulties in living.

Chair: We might explore Hogarth further with you in the course of this session. Dr Bancroft.

Dr Bancroft: As well as the functional and self-exploratory uses of drugs, some people take up drugs because it gives them status and meaning in their lives and some people enter the drug-dealing economy because of that, because through it they may have access to resources and recognition by others that they would not have otherwise. That can be a kind of reward in itself; it does not simply come from the drugs.

There can also be factors pushing them in terms of say employment, pressures of work and study that will encourage particularly the use of so-called smart drugs or study drugs. There can be situations where using drugs can be a rational choice for people.

Chair: We have a couple of supplementaries before we move on to Emma Harper. First Tommy Sheppard and then David Duguid.

Q113 **Tommy Sheppard:** I want to ask a supplementary in the middle of something that was being said there. I am keen to try to understand what poverty does in terms of driving people to drugs: whether that is a primary driver or whether it is just coincidental, in the fact that you are more likely to be poor or if you have other reasons that are driving you to drugs.

Looking at the evidence for hospital stays, for example, there is a direct correlation between the level of the deprivation and the number of people going into overnight hospital stays. What is your own view? Is there any reason why being poor means that you would be more likely to turn to drugs or is just because you are poor, you are more likely to be depressed about stuff or you are more likely to have other factors in your

life and they become the drivers for drug use?

Dr McPhee: One of the things that interests me about the explanations that you have given for the social determinants of health and how they impact most negatively on the poor and people living in areas of deprivation is that the 1998 report "Drug misuse and the environment" by the Advisory Council on the Misuse of Drugs stated that poverty and deprivation are corrosive influences that impact not only on individuals' quality of life, but on how they are perceived by others in their community and how they are perceived by the police, by the NHS and by social workers. In many ways, the stigma associated with being a drug user, the way in which they are treated, and the way that they see themselves being treated in services, all exacerbate the drugs issue.

It is not necessarily that poverty in itself causes problematic drug use. It is a major risk factor for poor outcomes in health and it is also a major risk factor for problematic drug use and a barrier to achieving recovery, however that is defined.

Vicki Craik: With regard to poverty, we find that a lot of people that are living in poverty, who are not well off financially may also lack social structures in place, which are a protective factor. They may lack employment or have difficulties with housing that lead them to developing a drug crisis quicker than those who do not live in poverty, who have better relationships around them, who have the protectiveness of employment, of secure housing and education.

What we find is that children who are born into poverty, as they grow up, are more likely to start experimenting with drugs. Research has shown they are more likely to take drugs in a dangerous way, and that they are more likely to experience problems and dependence with drug use. When people are brought up in poverty it leads to the snowball effect of drugs. If the people around you are taking drugs in a problematic way, you are also likely to take them in a problematic way. It is more about the lack of protective factors that people have around them that leads into problem drug use.

Dr McKeganey: In relation to Scotland's heroin problem, there is an unquestioned and powerful connection between that problem and poverty, communities that we used to describe as socially excluded, people who feel that they have very little to benefit from or investment in the wider society, who feel rather left behind, where there are many young people without gainful employment, with inordinate numbers of hours unfilled.

In those circumstances, heroin use has found a rich environment for dispersal and use. That is what we have seen. We have seen many of our characteristically defined addicts concentrated in areas of extreme poverty. I do not think it is easily explained in terms of individual psychopathology. In those communities serious drug abuse has proliferated in the absence of many of those other structures elsewhere

that might have made the growth of those problems rather harder to occur.

However, I would also say that Scotland's drug problem is evolving. As it still is evolving, there is a less close connection to poverty and social exclusion as it is typically traditionally described. Cocaine use, the new psychoactive substances, the pattern of use of those drugs is no longer concentrated in some of the poorest communities in Scotland.

Dr Bancroft: There is quite a strong social gradient in drug use population-wise. As well as looking at poverty itself, we should also look at the structure of poverty, not simply the lack of resources, but rather a lack of social capital or other kinds of support—the inability to get credit, for example. These factors can all affect the kinds of assets people can draw on and they can mean that a drug problem that might be costly in one circumstance becomes catastrophic in another, so it hugely increases the impact of drug problems in those groups.

Chair: I am conscious that we are still on our first question, and we are going to try to make a bit of progress, so do not all feel that you have to give us the benefit of your particular views on each and every single question. If you feel it has been covered, we can move on. We want to make the best use of the time that we have available with you this afternoon. David Duguid.

Q114 **David Duguid:** I was going to make the same suggestion and target my question to Dr McPhee, if that is okay.

In your opening statement, you talked about the risk factors and how merely drugs being available or people's experimentation with drugs alone have to be taken into account along with all the other risk factors. You specifically talked about poverty, inequality, deprivation and other social factors. Is there a distinction to be made between those factors that would lead someone to take drugs in the first place and then therefore become problematic and those other circumstances, where people—maybe just almost culturally—experiment with drugs and those factors leading to problems, rather than for some others, were it does not lead to problems? Is there a distinction to be made as to whether it is a driver or something that enhances the problem? Is there a distinction to be made between whether risk factors are drivers or factors that exacerbate the problem?

Dr McPhee: Are you asking whether the drugs themselves are the major risk factor or whether it is something to do with the individual?

Q115 **David Duguid:** If we accept that there are various social factors that can lead to someone becoming a problem drug user, is it those factors that drive the person to drugs or are those factors combined with the fact that many young people find themselves in a situation of curiosity or what have you that leads them to experiment? Whereas many people of all ages, I guess, would experiment and not take it any further, do social factors make some people more liable to become problem drug users?

Maybe I am being a bit clumsy with the question. I am trying to find out if there is a distinction to be made between social factors driving people to drugs and the fact that some people try drugs on top of those social factors that make the problem worse.

Dr McPhee: One thing we have to make clear is that there do not seem to be any individual pathological or psychological factors that we can use as predictive factors to determine who will develop a drug problem. But if we look at the use and misuse of alcohol among young people in Scotland, they invariably learn the rules for drinking from their peers—sometimes from kinship networks, but mainly from their peers. We have an idea—and this is culturally transmitted—that alcohol is to be used for almost immediate intoxication and that alcohol is not necessarily to be used for social enjoyment and enhancement of a meal, which it may in other, for example, Mediterranean cultures.

When it comes to risk factors for drugs, there do not seem to be any individual factors. There do seem to be protective factors. With regard to drugs education, what we find is that there are some ways in which people can manage and negotiate risks that are associated with affluence and education, and which appear to be absent among children who may have poorer experiences of parenting and poorer experiences in terms of their life chances and life experiences. These appear to be additional risk factors, but they do not necessarily in and of themselves lead to problematic drug use.

We also have to remember that the vast majority of drug-taking is short-lived experimentation, which does not necessarily lead to longer-term problems. I have to reiterate that exposure is not the prime causal factor in any problematic drug-taking. Does that answer your question?

David Duguid: I think so, yes.

Q116 **Emma Harper:** Good afternoon, everybody, especially Professor McPhee, who was my professor when I studied alcohol and drugs at the University of the West of Scotland. I am interested in when drugs become problematic. You mentioned alcohol, because alcohol is legal, as opposed to other drugs that are illicit. Do people take many drugs, lots of drugs? Do people sequester and only go down a path of heroin and cocaine, either/or kind of thing? When does it become a problematic issue when people are taking drugs?

Dr McPhee: Are you directing this question at me?

Emma Harper: Everyone, if they choose.

Chair: Anybody who wants to answer, but I think that was directly to you, Dr McPhee.

Dr McPhee: One of the things that is interesting to me is that we tend to play down and negate the impact of societal reaction and the impact of the Misuse of Drugs Act, which criminalises the possession of certain

commodities, these drugs we call "control drugs", and we have this classification system. By criminalising the drug-taking, we automatically make it a problem. In doing so, we increase stigma and discrimination and we also demonise users for experimenting, because we fear that that experimentation will become problematic.

The risk factor of using drugs in combination, does that necessarily lead to problems? As Vicki mentioned, the problem drugs for our service users appear to be benzodiazepines, opiates and alcohol. The drugs that do not seem to be causing a problem are the drugs that are still surveyed for, but they do not necessarily lead to problems. They are cocaine, MDMA, amphetamines and other stimulant analgesic and psychedelic drugs.

These drugs do not necessarily, in and of themselves, lead to problems. What appears to lead to problems are the additional risk factors that we have already discussed, which are the climate of moral and legal censure, our legal system, the way that we charge social work to minimise the impact of child neglect, and other educational benefits and welfare structures, which all stigmatise and demonise drug users—perhaps unintentionally.

Vicki Craik: On that note, with regard to drugs like cocaine not necessarily causing problems, I think the problems that they do cause are underrepresented because we do not have the mechanisms in place to collect data on them. We do not have the services available for people to go to. Therefore when we regard cocaine as not causing problems, that is inaccurate. Now that we see an emergence of cocaine being used across the board, it is causing quite catastrophic problems for some people that are just not captured. For me, problematic drug use occurs when the disadvantages, the side-effects of the drug, outweigh the advantages that the person is getting from it.

Dr Bancroft: I would say that in terms of addiction, you can see how repeated and regular use of a substance, and increasing tolerance, can create a situation of addiction. There you have frequency, rapidity and the increasing quantity being in a sense the steps to develop the problem of drug addiction, but of course the problems associated with drug consumption are only partially about addiction.

If you are injecting— even for the first time—a substance that is full of impurities, you can acquire serious physiological harm associated with those impurities present in the drug that you are injecting. It is clearly not about addiction, but about the actual substance that you are introducing into your venous system.

There are drugs that are associated with psychological harm that can occur from a single instance of use. Again, it is not about addiction, it is about the disproportionate impact on one's sense of identity and thought processes that can arise from ingesting a substance that has been designed with multiple constituent chemicals, the human health impact of

which we do not fully understand. The routes to problem use are multiple and varied.

Chair: Thank you. Unless you have a pressing contribution, we will move on. Ross Thomson.

Q117 **Ross Thomson:** Before I ask the particular question I was going to ask, what you have just touched on is the subject of one of the very first questions I asked when we had this inquiry, which was about trying to understand what a clear definition of problematic drug use was.

There does not seem to me to be one definition because there will be differences of opinion. Some would say if it is the sort of heavy dependency where you cannot function without using drugs, that makes it problematic, but my view would be that using a substance every weekend potentially just to see yourself through a house party could be problematic. Also that one instance where Leah Betts took one ecstasy pill and lost her life, that could be problematic. Am I right? Is there no clear definition of problematic drug use? Because that is one thing we just do not seem to have managed to have nailed down yet.

Dr McKeganey: I would agree with you. I think the definition has tended to be driven by what we can measure easily. We have the techniques to measure the number of problem heroin users and I think that has shaped the language to an extent; we have thought of that being the problem, but that is only one feature or one facet of the problem. There is no single appropriate or inclusive definition of problematic drug use.

Dr Bancroft: It is important to separate acute problems from problems. As you mentioned, an adverse reaction to a pill like Ecstasy, of course, is important, but is an acute risk in a context of generalised recreational use versus the kind of use that separates people from a recreational culture, from other kinds of social and work relationships, that is quite distinct.

Q118 **Ross Thomson:** We took evidence just the other week from people who had lived experience of using drugs. One of the witnesses said that her first exposure to it genuinely was on the party scene or going to house parties. The two drugs were ecstasy and then cocaine. She then found herself using drugs more regularly and in a situation where she was using harder substances. For me, that sort of fitted in with an argument that has been made a number of times about gateway drugs, using things that eventually get you on to other substances. From your professional experience, what is the evidence around people who use drugs recreationally and then develop a problem later on in life?

Dr McPhee: One of the things we need to remember about the so-called gateway theory is that we tend to take a person with a problem and then work backwards and look at their life history and their drug career in that sense. The gateway theory, if it has any predictive validity, is that we should be able to interview 100 cannabis users and see, "Do you intend to use opiates?" and of course the answer would invariably be no. But if you interview 100 problematic heroin users and asked if they have ever

used cannabis, then invariably the answer and the direction of causality would be yes, they have used it.

But to erroneously suggest that that is a prime causal factor, that cannabis leads necessarily to heroin, is inconsistent with the evidence. It may well be that when we hear evidence from people with lived experience, yes, they can authoritatively speak about their own personal experiences, but it does not necessarily mean that these atypical experiences can be generalised to the experience of every person who is exposed to drugs. I must not minimise the dangers associated with taking any drug whatsoever.

Vicki Craik: I agree. We also shy away from using the term "hard drugs" or "soft drugs". It depends on a number of factors: it depends on how the individual is taking a drug, how often they are taking it, and how risky their use is overall, because all drug use can be risky; it just depends on the dose.

Q119 **Ross Thomson:** On this gateway theory, I and other members of the Scottish Affairs Committee were in Canada just the other week, where we wanted to look at—just making that plug again—the approaches that are taken there, because, as you may be aware, Canada has just legalised or decriminalised cannabis. Is it legalise or decriminalise? Legalise, right.

Speaking to some of the Canadian politicians there, they said, "No, we are taking it out of the hands of criminals". They are talking about it being a boom industry, jobs created. But when I was in Toronto just before the end, it was interesting to see one of these new stores just opening—it was called Tokyo Smoke or something—but at the same time seeing billboards had been placed around it saying, "Keep our kids drug free" and a Government campaign to try to make kids aware of the dangers of trying it.

My position with the politicians was in legalising it and therefore increasing exposure—would that not increase the risk of this gateway pattern? I might be completely wrong, but as something becomes more readily available, as we have seen with alcohol and other things, is there not a higher risk of people potentially progressing on to something else? I would be keen to hear your thoughts.

Dr McKeganey: I would say that in a situation where drugs are legalised or decriminalised, inevitably there will be an increase in use. I say "inevitably" because those who were inclined to use those substances when they were illegal will clearly continue to use them when they become legal and those who were disinclined to use them when they were illegal will be more inclined to use them if they become legal. An expansion in terms of population level use will unquestionably follow over time the policy of legalisation.

Equally inevitably, because of the expansion in the sheer amount of use, there will be an increase in the number of problems associated with that use, which is clearly not to say that everybody who previously would not

have used a drug when it was illegal is then going to use the drug. It is also not to say that all users will experience problems, but the sheer increase in use in terms of drug prevalence at a societal level will generate, in my perception, an increased range of problems.

Chair: We will come to Dr Bancroft now, but we will come back to these issues because that is not exactly the evidence that we have secured from the international examples of innovation when it comes to decriminalisation and legalisation, and I am certain that the Committee will want to discuss that further with you. Dr Bancroft, did you want to come in?

Dr Bancroft: Simply to say that increased use under legalisation might be a problem or it might be useful if it separates that market from a more problematic market and cuts out the tendency to move on to other drugs. One issue in the way in which people move from, say, Ecstasy to cocaine to an opioid will sometimes be that the person selling it also has that other drug for sale, so they are in the same place and they are available or they have other kinds of connections through that. One possibility for legalisation might be to separate that. Of course we will see from those examples.

Q120 **Brian Whittle:** Quickly, I think you will probably find that some of the panel would disagree with your analogy that it would potentially increase drug use, but I am more interested around what our goal is. If our goal is to eliminate the use of potentially harmful drugs, legalising it will not achieve that goal. I do not know whether you want to comment on that.

Dr McKeganey: As you are looking at me, I will respond. My views are not necessarily widely shared, but I do think that at the forefront of policy in this area should be a commitment to reduce the scale of our drug usage in Scotland in all its various forms. I do not entertain a notion that with the right policy options being implemented Scotland will ever be drug free, but I do think that policy in this area should principally be driven by a commitment to reduce the extent of our drug problem, because that will deliver benefits associated with reduction of harm.

If one seriously reduces the scale of the use of these substances, then many of the harms associated with that use will similarly reduce in prevalence. I do feel that that should be the appropriate principal aim of policy and I have argued for many years that all our policies in relation to drug use should first—not solely, but principally—be interrogated in terms of whether they are designed with a realistic prospect of success to reduce the scale of our drug problem.

Dr McPhee: To achieve a drug-free world was one of the stated aims of the United Nations and also one of the stated aims of the UK Government in trying to, if not reduce, then eliminate problematic drug use. To try to eliminate all drug use seems to me to be against how human beings seem to wish to interact with each other and their environment. I assume you are not talking about pharmaceutical products and I assume you are

not talking about alcohol, tobacco and over the counter medicines, but that you are merely talking about those drugs controlled within the Misuse of Drugs Act 1971.

Q121 **Brian Whittle:** The reality is that we will not eliminate drug use, but if we look at that as over the horizon and far away, but nonetheless as an aim and a target—what I am asking about is if the target is to try to reduce it to the lowest possible level, whether legalising it will not allow that to happen.

Dr McPhee: That assumes that a drug-free world is not only achievable but is in many ways desirable. While I agree that we should be minimising the risk to young people—with that, I wholeheartedly agree—free-thinking adults who have cognitive liberty and human rights should be able to exercise their abilities to choose whatever commodity they use, but the Misuse of Drugs Act makes possession of certain commodities illegal.

The Misuse of Drugs Act, in and of itself, appears to be unfair, unjust and unworkable and seems to impact—perhaps unintentionally, but because of the concentration of police targeting drug users—our most deprived and unequal communities. That in and of itself seems to me to be incompatible with social justice.

Q122 **David Stewart:** Dr McPhee, if I could ask you a very quick point, I am very interested in what political levers we can use, irrespective of which Parliament we are in. If I can take two examples that have worked, one was the smoking ban, which at the time you will recall there was a lot of anxiety about, particularly from publicans, and now it is accepted. That has made a huge difference.

The other one is still to be proved, but I personally support it, and that is minimum unit pricing. I think in the long term that will see a reduction in alcohol abuse in Scotland and beyond. There is no magic bullet in this argument, but is there an equivalent in extreme drug use that we could use as some sort of analogy for either of these two examples?

Dr McPhee: It seems to me that those two examples you have given, minimum unit pricing and its impact on the use of some alcohol, particularly cheap alcohol—white cider I am thinking of, which probably has never seen an apple and is in many ways just a mixture of chemicals—and the ban on smoking in public places, are perfect public health initiatives, which the Scottish Government have enacted and demonstrate that they can be evidence-informed and evidence-driven when they are making policy. But it seems to me that unless we tackle the reserved power, which is the Misuse of Drugs Act 1971, we cannot make an impact on the rates of problematic drug use, which are very high in Scotland, and the shocking rates of drug-related death.

Q123 **Danielle Rowley:** This is on the back of what we have been discussing and before I come on to my main question. We heard there about whether legalising certain drugs would increase use, but I think it is much

more useful to look at whether you think legalising certain drugs would have a reduction in misuse and in harm. A quick answer, if that is okay, on whether you think it would reduce harm.

Dr McPhee: Yes, I think it would reduce harm.

Vicki Craik: Yes, I agree.

Dr McKeganey: No, I do not think it would reduce harm; I think it would most likely significantly increase harm. The breadth of that harm is what I am talking about at a population level, where you would very probably see a notable increase.

For example, at the moment heroin is a drug that is rarely used in population terms. There are many people who would not use heroin and perceive it as a dangerous drug, an illegal drug, the use of which could lead to serious adverse consequences, in part to do with its illegality. I think if heroin were legally available in Scotland, one would see an increase in its use for the reasons that I have said: those who use it when it is illegal will continue to do so and some of those who do not use it because it is illegal will initiate such use. Correspondingly—not in a one-to-one relation, but correspondingly—one would see an increase in problems associated with that.

Chair: Danielle asked for a quick yes/no round there, but I am grateful for your additions to that. As long as it is very quick.

Vicki Craik: It is. I just want to counter that point. It depends on how we do it. If we just legalise drugs into a free market, the chances are that harm will increase. If we do it in a very controlled, structured way with education and treatment programmes in place, then it might have a different outcome.

Chair: Dr Bancroft did not get a chance for his "yes/no" on that one.

Dr Bancroft: I agree very much with what Vicki said. It is the kind of legislation, the kind of regime that we have that matters. We have a regime at the moment. It is a choice between different ones.

Q124 **Danielle Rowley:** We have heard anecdotally from witnesses about the use of prescription medication, legitimately prescribed for medicinal purposes, and how that leads on to problem drug use. Dr McPhee, I think you were going to lead on to that in one of your earlier responses. Do you think that there is a connection there and how prevalent do you think it is?

Dr McPhee: I do think there is a connection. When we listen to people with lived experience, their experience with prescribing has been an issue for them, but we must be careful that we do not unnecessarily demonise the people who are prescribing these particular medications because some of the medications can be extremely helpful, and suggest—and perhaps suggest the intervention leading from it—that if prescribers are

the root source of problematic drug use, we must put them under greater surveillance.

I am talking about the incidence of what has become known as the fentanyl problem in the United States.

One thing we can certainly say for sure is that while there was an increase in prescribing this particular analgesic, the main cause of the problems of people seeking drugs on the dark web and seeking drugs beyond their prescribers—from the street, for example—is the fear that doctors had of losing their licences and the fear of addiction, which had been instilled in them in their training. They would see people becoming dependent on fentanyl, for example, and then quickly stop prescribing it, leaving these people with no route of coming to terms with the abrupt withdrawal of their preferred drug or the drug that they had become dependent on, forcing them to go elsewhere and creating the problem that prescribers had tried to prevent. In many ways intervention can exacerbate problems and may be something that is a cause of greater problems.

Dr McKeganey: The experience in the US is salutary here. We have seen a situation of the growth of prescribed pain medication. No doubt each time it is prescribed appropriately and justifiably, but the consequence of that has been the growth of serious patterns of addiction with major adverse health consequences, as a result of which I think there will be a reassessment of the appropriate way in which opiate-based pain medication should be made available.

Chair: Our trip to Canada was very salutary when we learned of the difficulties with fentanyl and carfentanil, which account for so many of the opioid problems that they have experienced in North America just now, and the strength of it. When it was described to us, I think it shocked the whole Committee, didn't it? We saw everybody's heads shaking. We did visit the drug consumption facilities in Montreal, but that was my impression. Ged Killen.

Q125 **Ged Killen:** This question is for Dr McPhee as well. Are there different risk factors for people who are using drugs for medicinal purposes leading into problematic drug use or is it the same as for others in terms of ACEs and all the things we have discussed already?

Dr McPhee: I would have to make an assumption and suggest that that is just one route into problematic drug use. It seems to me that, yes, having access to a particular type of drug and that becoming a problem, if people are experiencing difficulty in cutting down or swapping, then by definition we can classify that as an addiction or dependence and it becomes very difficult for that person to cut down. And they may have additional risk factors. But to suggest that the exposure to prescription medications in and of itself is the causal factor in developing the problem I think is at odds with the evidence.

There are manifold factors, including the prescribing, but other risk factors, perhaps immediately stopping rather than asking the patient or client, "What is it that you need? What is it you want? How can we best help you?" rather than just, "I am frightened of losing my medical licence. You are no longer my patient". That in and of itself, I think, is problematic. We must remember and learn from the experiences in the United States.

Q126 **Ged Killen:** On that, do you think that that is the reason why we have not seen cannabis being prescribed in this country, given there has been a real change, but we are still seeing people having to bring it illegally into the country? Is it fear of that leading to some sort of addiction and it having an impact on their licences?

Dr McPhee: Yes, I think that is one issue, although in my understanding I think GPs are allowed to prescribe cannabis.

Q127 **Ged Killen:** They are allowed, but we are not seeing the prescriptions: that is the point I am making. It has not led to that.

Dr McPhee: Yes, but there also is the spectre of the Misuse of Drugs Act and possession of this particular commodity being illegal, although Police Scotland practices have generally been very good in respect of cannabis, insofar as the way that they are policing cannabis possession at the moment is to not necessarily treat it as a criminal issue, but to treat it as a civil issue and record that incidence of possession without necessarily putting that consumer through the criminal justice system.

Q128 **Tommy Sheppard:** I want to make a comment. I know we are supposed to ask questions rather than make comments, but I could not help reflecting on the debate we have just had about whether the use of the law has any relation to the level of use of a product. I would point out that we have dramatically reduced the level of consumption and use of tobacco, which is an extremely dangerous drug, without anyone suggesting that we should apply the criminal law to prevent users using it.

I say that to take us into this debate about the relationship between various strategies, particularly the fact that in recent years the Scottish Government, and arguably the UK Department of Health as well, have done an awful lot to try to relocate dealing with this problem within the field of health and health policy. But of course the legal framework remains that this is a criminal justice matter by and large. We have had evidence from people with lived experience and from various organisations. We are probably just a third of the way through our inquiry, but we have had a lot of evidence that suggests that criminal justice sanctions themselves can exacerbate the problem for individuals. We have had testimony about people who have become addicted to hard drugs, however you might perceive it, because they began using in prison.

Can you guys give us any evidence that would shed light on that—that

either the very fact of criminalisation or the way in which it is applied is counterintuitive and is exacerbating problems rather than reducing them?

Dr McPhee: One thing I can comment on is the research I have carried out with treatment populations. The impact of criminal sanctions where people have been processed as an offender under the Misuse of Drugs Act and that offence is disposed of by a fine—when someone is in poverty and in addition they have to maintain their regular drug habit and the other things that they must do, such as pay their rent and other bills—the fine causes them great hardship. The imposition of the Misuse of Drugs Act there can exacerbate the problem.

We also have to remember that in some of the bureaucracies that we set up, which are in many ways underpinned by the stigma driven by the criminalisation of drugs, we often see drug users first as criminals to be processed rather than people requiring care and compassion. I think we can learn a great deal from other countries that have dismantled the criminal justice apparatus.

Dr Bancroft: We have been talking so much about this issue as a health and welfare issue and so on, but yes, it is a criminalised activity. Criminalisation can exacerbate acute harms and it can make people turn to more dangerous kinds of use, particularly if policing disrupts a localised market. It can create more problematic forms of use simply because of the need say to consume more quickly, or to use less reliable sources and so on. Certainly I think the evidence is that treating drug use as a public health issue is going to be important and policing can be part of that; we can police for public health.

Q129 **Chair:** I think you suggested a harder approach for the criminal justice side of things, Dr McKeganey. Could you tell us exactly how that would constitute itself, what it would achieve for us?

Dr McKeganey: I do agree with you that the use of the criminal law can result in adverse consequences for those who are caught up in it. If as a result of some transgression one ends up in prison and acquires a drug problem because of the preponderance of drug use in prison, that is a set of circumstances that we should be rightly seriously concerned about and that none of us could feel at all positive about. However, that does not lead me to offer the view that criminal justice sanction is the cause of the problem here. I think the problem there is our failure to stop drugs from getting into prisons. I do not believe it is the failure of the drug laws that is the problem here.

I do think that at a societal level it is really important to have a criminal justice sanction against those activities that one is trying to discourage, to signal very clearly that engagement in those activities could have serious adverse consequences for the individuals involved. I also think that in relation to those individuals who use those substances or initiate those actions, irrespective of those criminal justice sanctions, it will have a different impact or possibly no impact, but in relation to those

individuals who do not engage in those actions because of the criminal justice sanctions, the criminal law is efficacious.

One of the reasons we see heroin use at a very low level in population terms, relative to smoking and alcohol consumption, is in part because we have had a clear criminal justice sanction associated with the transactions involving those substances. I think at a societal level the criminal justice law is very, very important.

Q130 **Tommy Sheppard:** Are you suggesting that there are a significant number of people in this society who would use heroin, were it not for the fact that it is illegal?

Dr McKeganey: Yes.

Q131 **Tommy Sheppard:** Has anyone done any research to quantify that: opinion surveys or—

Dr McKeganey: Yes, I do think that. I think heroin, at least initially, is a very pleasant drug to take. If it were legally available in some of our communities that we referred to at the start of this session, where there is extensive and longstanding marginality and exclusion, I think the availability of heroin in those communities would lead to a very substantial—over time—increase in the use of that substance, because use of that substance, at least initially, is very pleasurable. That anxiety should, rightly, lead us to be very cautious about going down the road of initiating policies, the consequence of which is that these drugs become more available.

The experiences with alcohol and tobacco are precisely that: that once these substances are legal and once the commerce associated with the legal industry starts to gain momentum—as we are seeing in some of those states in the US that have legalised cannabis—where we are seeing a profit motive, we are seeing large investments, we are seeing major companies creating the industry of cannabis production and sale. That I think is a very real risk that we would face if we instituted similar policies in the UK.

Chair: I have supplementaries, but I just wanted to make sure that—

Vicki Craik: I would just refer to my previous point: that I do not think anyone is advocating a legal free supply of heroin. It would be done in a very strict controlled environment. But yes, criminal sanctions do produce injustices.

Chair: Thank you for that. The comments from Dr McKeganey have solicited a number of questions, starting with David Duguid, David Stewart and then Emma Harper.

Q132 **David Duguid:** A very specific issue related to the criminal justice system, particularly in my constituency and probably elsewhere in Scotland. My constituency is Banff and Buchan, which includes Peterhead and Fraserburgh. You have probably become aware of Fraserburgh in

particular in recent years.

My local police area commander tells me that one of the biggest problems he faces is the act of cuckooing. As I understand it, these are out-of-town dealers taking advantage of vulnerable people and using their homes as part of their supply network. Very often, before the police get involved, they have gone on to someone else and the person left behind, who has maybe been left with a stash of illegal drugs or has been reported in some other way, is being left to face the criminal charges. Is there anything that can be done to protect those particular vulnerable people in our society?

Dr McPhee: I think what you are referring to is known in England and Wales as county lines dealing; it may well be known as cuckooing in your part of the north-eastern Scotland. For me, the reason why the drug markets are so attractive to organised and semi-organised criminal networks is because of the Misuse of Drugs Act and the fact that there is a demand for these substances and in lieu of the state or other corporate interests being involved, whether that is decriminalisation or legalisation, this demand will be satisfied.

I also have to be aware that police commanders, like the person in your constituency, are also demanding resources to be given to them in order for them to make an impact and police the Misuse of Drugs Act. While I am not suggesting that cuckooing or county lines dealing is not occurring, I do think the incidence of it is perhaps overstated in order for the police to attract resources to them.

Q133 **David Duguid:** I understand what the county lines issue is; that is not what I am talking about. I am talking about cuckooing, which is the act of a dealer syndicate, if you like, taking over a vulnerable person's home and using that as a base of operations, like a cuckoo does with other birds' nests, and of course that vulnerable person being left behind to deal with the criminal charges when the syndicate has moved on. Across the panel, is there is anything in any of your research that has looked at ways of addressing cuckooing?

Dr McKeganey: No, but I think we understand more about the nature of vulnerable communities and vulnerable households in circumstances where drug use and drug dealing is widespread. But instances such as your police commander described are—

Chair: We will be speaking to law enforcement, David, if that helps you, because this is routes into drugs that we are dealing with today, and I know that there are particular issues around that that we need to explore properly. We will have law enforcement in and I am pretty certain you will have ample opportunity to put that.

David Duguid: I was focusing on the vulnerability of certain people that get pulled into the regime, as a route into it.

Chair: Does anybody have any views on that? All right. David Stewart.

Q134 **David Stewart:** Could I raise just a couple of points with Dr McKeganey? You made some very interesting points in your statement about drug use in prisons. We all of course realise the important role that methadone plays in prisons, but you were arguing, if I understood your evidence, that there is a problem in that it can make drug use post-release a particular issue. There is a strong argument for a clear review, for an exit strategy, which I think is also important, and prescribing for short time periods only. Could you amplify that? They were some quite interesting—perhaps also controversial—comments on that issue.

Dr McKeganey: In Scotland and England, we have a serious problem of drug-taking in prisons. I think we have inadequate provision of health services within our prisons. I do not think we can be confident that we are doing as much as we need to do to meet the health needs of prisoners who either go into prison with a problem of drug addiction or drug usage or acquire that problem while they are in prison.

There is almost, dare I say it, an acceptance of the inevitability of drugs being available within prisons. I think many people who are on the outside are exasperated at what they see as an evident failure to stop drugs getting into prisons and they cannot see how, with an environment that is controlled to the degree in which a prison is, it can be impossible to reduce the flow of drugs.

I think short-term sentences that result in individuals going into prison for a short period of time and being exposed to an embedded drug problem is something we need to be rightly concerned about. I hope I am not trespassing on areas that this Committee will get into elsewhere. I might be, mightn't I?

Chair: Yes, we will be looking at that specifically.

Dr McKeganey: But I do think short-term sentences become deeply problematic in a situation where you have to ask yourself, "What is that individual going to be exposed to when they into prison?" Prisons are failing to tackle the problem of illegal drugs getting in and I think different policies to address that problem need to be considered. I do think we need a review of exactly what is happening within our Scottish prisons with regard to illegal drugs.

Q135 **Chair:** Prisons are really important, because from our witnesses with lived experience, we also heard quite a lot about the personal experience of those who had been through the criminal justice system. I have a prison in Perth. I have spoken to several governors and they have said they would need a facility comparable to Robben Island in order to try to stop drug use in prisons. Even with that, they told me it was unlikely they would be able to stop drugs coming into the prisons.

Is it not the case that prisons are designed for punishment, incarceration, the deprivation of liberty? The prime focus in the facility is not rehabilitation, recovery and health interventions, so how is it possible therefore to have prison facilities—when there is a demand from the

public that it does that one function—that service problem drug users?

Dr McKeganey: It is an extraordinarily difficult conundrum to resolve. I do not think it is tenable to say that prisons are only now about punishment or should only be about punishment. Drug use is so overlaid with criminality and is a factor associated with the reason why individuals are in prison in the first place, but a substantial proportion of the prison population absolutely need optimum treatment services made available to them within prison. How you deliver that within a custodial institution, which to an extent is focused on punishment, is a difficult challenge, but I do not think it is one that we can afford to fail, given its difficulty.

Chair: I know we are going to be looking at this further. As I said, we will be discussing it with some representatives of criminal justice in Scotland. Emma Harper.

Q136 **Emma Harper:** I want to pick up on what Tommy Sheppard said about deregulation and legalisation, that kind of aspect. If we support people to have access to clean needles, drugs we know the pharmacological purity and the doses of—if you are buying something online at the moment and you do not know if that Xanax is Xanax—wouldn't deregulation or legalisation have better processes to monitor and get folk to access the right treatment that they need to support them through their mental health challenges, their adverse childhood experiences and instead of trying to deal with them through the prison system, we deal with them through a public health system by better regulation, not making the Government the drug dealer, but a regulation process that supports people? Wouldn't that be the better pathway to take?

Vicki Craik: Yes, Crew would support decriminalisation for a start. Regulation of the drug market would reduce the harm associated with the fact that the substances are unknown, that they are very variable. Profits that are made from any sale of drugs though should be reinvested back into harm reduction, through information and education, back into our healthcare system, in order to reduce overall the harm arising. But it is about doing it in a specific regulated way. Transform, the drug policy foundation across the UK, has very good project proposals on how they would do that.

Chair: We are conscious that we are barely at the top of the questions that we have designed to ask you. I know that Christine and Ged want to come in. We will take these and then we will move on. Christine Jardine.

Q137 **Christine Jardine:** Going back to something Dr McPhee had said when we were talking about legalisation and decriminalisation, do you think the key in that, whether you call it decriminalisation or legalisation—and there are differences, I know—is the fact that it would then be regulated and you would have some sort of state oversight of the availability of drugs? How important do you think that regulation aspect would be?

Dr McPhee: As Vicki alluded to, Transform, using international evidence, has created frameworks that take the regulation of drugs outwith the

hands of criminals. I agree with what Emma was proposing insofar as the current situation of our organised criminals and others making drugs available. They are themselves the vendors, and they can make available commodities and of itself, as a public health measure, reduce harms to drug users.

What we have at the moment, yes, you are correct about that. Users, when they choose to use a particular commodity—unless it is a prescription, an over-the-counter medication or a legally available drug like tobacco, nicotine or alcohol—may have no idea what it might be. Yes, if we are truly committed to reducing harm through a public health framework and challenging the criminalised elements, which stigmatise and discriminate against users, then we should be regulating and controlling and not leaving it to the hands of people who care very little about the consumers to whom they are the main vendors.

Q138 **Ged Killen:** On that same point about regulation and people having knowledge about what it is that they are using, in Canada one of the things that we heard was that there still is an illegal market in cannabis because it is far cheaper than going to one of these outlets to buy whatever is available there. How do we avoid a situation where you regulate and people know what is in these drugs, but there is still a stronger version available on the black market that they would rather take? This kind of overtakes the methadone programme by just becoming the latest thing that is on offer from the Government, which I think is a good thing, but how do we stop that illegal market just coming in there anyway and providing something extra?

Vicki Craik: One of the reasons why people in Canada are still turning to the black market is that legitimate vendors are struggling to meet the supply and therefore are often out of stock when people are going to buy. I would advise that a lot of money should be invested into law enforcement. We are in a situation in Scotland where our police just do not have the resources to effectively implement the Misuse of Drugs Act all the time. If we were to regulate drugs, the police would have more resources and investment to target anything that fell outwith our regulatory framework.

Ged Killen: I am quite interested to hear Dr Bancroft's view on that.

Dr Bancroft: It is certainly what users want in terms of information. They want to be able to buy drugs in a way that is non-stigmatising, is respectful to them, where they have knowledge about what is in that drug and the likely effect on them, which is part of why some turn to the dark net for a drug purchase.

You will never have a situation where we have a perfectly functioning market, whatever it is. I suppose the aim of harm reduction is not as an end in itself, but rather it is to make other things happen around it. It is to bring people into situations where they can be given access to other kinds of services they might need, where problems can be identified,

where other supports can be involved, where they can be informed. In that sense, the function of a decriminalised or a legal market might be to do that, so that might be the purpose of it.

I think we will never have that situation where people are not turning to other sources, partly because the illegal market is quite well-developed and is very responsive to users' needs. For example, in Glasgow you can get cocaine very quickly—quicker than ordering a pizza, according to the Global Drug Survey. The market is highly responsive and that is what people look for.

Q139 **Chair:** Could I turn the discussion almost on its head? We are intrigued that we have Dr McKeganey with us today; we are very grateful for you coming along. We were finding it very hard to get people on to this Committee who promote an abstention approach when it comes to illegal drug use. I am maybe unfairly characterising your views about all of this. I just want to know how effective they have been in the past. We all know about Just Say No. I was on the campaign committee of Scotland Against Drugs back in the 1990s—and I know David Stewart will remember this—where Alex Salmond and Donald Dewar had their baseball caps around the wrong way to try to ensure that they were down with the kids. Is there any evidence at all that a hard, abstentionist, Just Say No approach has any sort of success?

Dr McKeganey: The principle of abstinence here I think is an important one. There are different aspects to it. In relation to treatment, for example, when my colleagues and I surveyed one in 12 of all drug users initiating treatment in Scotland some years ago, we asked them, "What do you want to get out of treatment? What is the reason you have come to treatment? What is the thing that you want to achieve from treatment?" Overwhelmingly—

Q140 **Chair:** With due respect, treatment is really interesting and fascinating. What I am asking you is when these campaigns are initiated, like campaigns I was part of—and I have to conclude that I did not see any dramatic results in the uptake and kids taking less drugs—do you have any evidence that these general political community abstinence Just Say No campaigns have any impact whatsoever?

Dr McKeganey: No, I do not think that there is good evidence in relation to Just Say No campaigns, but I would not regard the Just Say No message as the acme of what one should be trying to foster.

Q141 **Chair:** What about "war on drugs", because that was the big theme that we—

Dr McKeganey: I think that "war on drugs" is just a linguistic device used to attack individuals who put forward a case for a role for criminal justice sanction. We do not have a war on drugs in Scotland; we haven't had for many, many years. We do not have a war on drugs more broadly in the UK either. It is a mythologised notion, which is just used to poke

fun at individuals who are advocating some role for criminal justice sanctions.

Q142 **Chair:** Could you tell us how an abstinence approach would be designed and how you would see a high optimal approach that would have that at its core? You have obviously looked at this for years and years, you are very critical of harm reduction approaches and you feel that they do not work. What in your view—

Dr McKeganey: I cannot remember the last time in Scotland that I saw a national media campaign targeting the issue of drug problems. I cannot remember when the last one was. I think that we have largely ceded the ground there and accepted the inevitability of drug use in Scotland. We have not had a national campaign focused on reducing the incidence and prevalence of drug usage. We have not had it in the media. I think that our school programmes are ad hoc. They are not well evaluated. They are not well co-ordinated. The actual placement of anti-drug campaigns or programmes within schools I think is far too much a matter of happenstance. There is no systematic programme in Scotland.

Q143 **Chair:** I am interested. Does anybody across the panel have any evidence that these types of campaigns or approaches with abstinence at their core have had any real impact or effect or have done anything about drug use?

Vicki Craik: The Scottish Government published a report called "'What Works' in Drug Education and Prevention?", and overall it concluded that the Just Say No approach is ineffective at reducing drug use and drug harm within young people.

Dr McPhee: Cleary, echoing what Vicki is saying, any fear arousal messages, which try to instil fear in young people to act as an inoculation against future risk, "Don't take X substance because Y will happen", are also ineffective.

I must also, I think, counter Neil's assertion. While I do not disagree with many of the things that Neil is saying, in the mainstream media it seems to me when I put on terrestrial TV I can see constant anti-drug messages on TV and also when I access mainstream media in newspapers and online, cops with cameras, border patrol. All of these tend to demonise drugs and drug users and, in particular, drug dealers.

The message may not be formal in a national population-targeted Government campaign to educate the public about the dangers of drugs, but they are insidious and consistent in terms of how mass media disseminates this product, which is for sensationalist purposes, which demonstrates that if you take drugs X will happen, that border patrols are there to constantly keep drugs away from our young people and that if you are dealing or using drugs the police will target you. These programmes, it seems to me, are consistently giving a particular type of

message about the dangers of drugs. No one is evaluating their efficacy and I wonder what their purpose is, other than entertainment.

Q144 **Chair:** Thank you. Did you want to come in, Brian, on that one?

Brian Whittle: I think that I could ask my question next because it is relevant to what is currently being discussed, if that is okay with you, Chairman.

Chair: Please, yes, of course.

Q145 **Brian Whittle:** You have brought education into this discussion, which in my view is the absolute key and the core of how we will tackle the issue of drugs here. We have talked about education around things like the Just Say No campaign, and I think that it is important in the preventative agenda to have our kids understand the potential outcomes of taking drugs.

There has been a lot of anecdotal evidence that especially within deprivation it is lack of access to opportunity. It is lack of access to things like sport, art, drama, music and things that could create a passion and a purpose around a young person's life and in that in itself could help to tackle the issue. There is Street Soccer Scotland. I am sure you are aware of the homeless soccer and the impact that that has had around sport, the impact that Centrestage has had by using music, Catalyst in using art. That has given a sense of purpose and resilience and confidence that has been missing from that early life.

We talk about ACEs, the adverse childhood experiences, but I would like to talk about PACEs, which is creating positively affecting childhood experiences. Is that not the direction of travel when we talk about trying to tackle drugs? We need to go all the way back and when we talk about education, that is where we need to be?

Dr McPhee: Embedded within that, what we used to call "diversionary activities", is where this is to be targeted. Is this to be targeted to young people as a primary prevention to act to prevent or at least delay the onset of drug taking, or is this to be targeted at drug users who are already experienced and perhaps as a secondary prevention to stop their current use becoming problematic?

If I think about the research that was carried out by Bruce Alexander—and some of the research is really interesting—in his earliest research he looked at something called "Rat Park", where the belief was that simple exposure led to problematic drug taking. That was rats in isolated cages would press a lever and take drugs until they would be exhausted or die. When he put these rats into an environment that was rich in stimulus and they had things to do other than taking drugs, which was engage in play, engage in sex, take food and have an environment that was clearly advantageous to social functioning for these rats, he found that they would prefer other activities rather than taking drugs.

It seems to me that if we limit the life chances of some of our young people, then necessarily these risk factors could lead to drug trying and this drug trying becoming a problem. But providing these diversionary activities in isolation without other credible advice and information, which is not descending into a Just Say No or becomes anti-drug, while interesting and useful would not necessarily act to prevent or at least delay the onset of drug taking. As secondary preventions I think that the evidence is interesting but not conclusive about how useful they are.

Q146 **David Stewart:** I will say sport because that is my particular area of expertise. If you allow a young person or any person to attach an importance to a specific activity, say in sport, an ability to participate in that will be impaired by drug taking, by alcohol and by smoking, so there is a behavioural driver there. Because they want to be better in that particular area, there is a behavioural driver that says, "I need to stop doing that".

Last week I took that evidence from the chap who runs the homeless football, Street Soccer. That is what I am driving at: if we can create an environment where whatever activity they happen to be involved in is important to them, it then drives a behaviour that says it will be impacted negatively by these kinds of activities. That is really what I am driving at.

Dr McPhee: I think that that is laudable as an intervention. We know that people for whom drug use does not become a problem have other overriding interests rather than just seeking pleasure or solace in drug taking. Yes, I agree with you. Some people who have lived experienced are excellent at providing alternative diversionary activities, which can be life enhancing and can be a pathway out of problematic drug taking. Of that, of course, we should be supporting initiatives like this, but whether they can be rolled out and act as an inoculation against future risk I am unsure.

Dr McKeganey: I agree with what you are proposing. I think that it is hard to imagine a country that cares more about football than Scotland. From wherever one stands on the spectrum, I think that is true. I do think that, unwelcome and burdensome as it may be, all our football teams of national prominence should be engaged in this activity of drawing young people in, showing them the benefits of physical fitness, the way in which fitness can be depleted when one gets involved in drugs, and taking on that role way beyond their responsibilities as football players.

Because football is so fundamentally important to Scottish culture, I do think that we have underutilised and they have underperformed in terms of the social responsibility that football teams should have with regard to enhancing the health and welfare of the population in their local area. That is an initiative that is much bigger than one or two celebrity footballers articulating a drug-free lifestyle. It is opening up our football stadiums, et cetera.

Chair: Association football has probably been kicked around enough in this Committee, unless Emma has a question on that.

Q147 **Emma Harper:** No, it is a supplementary. Education might work for young folk, but there is a cohort of people who have been taking drugs for 20 and 30 years who now have HIV and hepatitis. The suggestion by Glasgow to bring in safe consumption facilities means that people get access to healthcare professionals, HIV testing, hepatitis testing and somebody who cares about them. That is one of the ways that we get access to the people who are suffering from harm right now. These are the folk who have been taking illicit substances for 20 or 30 years.

Dr McKeganey: If our services' best route to get to those people is through creating an environment where illegal drugs can be used, then those services are utterly failing. Those services should be working assiduously to contact these people in those communities where drug use and drug problems have proliferated. The idea that the only route to those disenfranchised, marginalised, adversely health-harmed individuals is to create a setting where they can use illegal drugs to me is completely fanciful. It is an abrogation of the responsibility of those services to deliver their input within communities. I cannot accept that the only route for our services to contact the individuals who you have rightly described in multiple need is to create a situation, a setting, where people can use illegal drugs.

Q148 **Chair:** We actually visited a drug consumption room in Canada last week. It was only Ross and I who were there and we probably have different views and impressions about that experience. For me, I was knocked out by what was available to people. Well, not "knocked out"; I will say highly impressed.

I am interested in the rest of the panel's view because drug consumption rooms will be a feature of this inquiry. What we found was problem drug users being able to consume very dangerous drugs that were probably contaminated with fentanyl, which was causing great concern to the people who ran the centre, under a safe environment while being exposed to a wide range of other services to encourage them to treatment, psychological services, medical services and counselling services.

I do not know what it is about how that would not work in Scotland where people are going to get the opportunity to seek the treatment and help that they need to secure in order to do it. Other than that, you just leave them in the streets. I do not know if anybody else has a view about this. This is a really important issue for us and it is something that we will want to revisit again in our inquiry.

Dr McKeganey: I do not think that the choice should be just leaving them in the streets or providing a drug consumption room. If you are genuinely proposing that the choice here is between leaving them in the streets and leaving them in a situation of health harm and neglect or providing a drug consumption room, then we have completely

misconstrued and misconfigured our treatment services in which we have invested hundreds of millions of pounds over a number of years. If that truly is the choice that one faces here, then we are in a much worse situation.

Q149 **Chair:** What I do not understand, Dr McKeganey, is where it is going wrong in offering a treatment and a service to people who have real difficulties and who have obviously come forward in order to seek assistance. All these things will happen anyway but obviously it is not having an impact, as you have rightly—

Dr McKeganey: I do not think it is the responsibility of services to facilitate drug consumption. I think that is where we would disagree.

Chair: We have a number of people who want to contribute to this. We will let Ross in because he was there with me that day, and then we will have Brian and Emma.

Q150 **Ross Thomson:** You are right that I suppose we did come away with slightly different perspectives, and perhaps this is something that we could look at as part of the debate in the UK.

When I went to the consumption centre, I expected to find, as had been intimated, more people being referred through to different services for help and support, whether that is mental health, whether that was to end their addiction, whether that was to do with sexual health—whichever it was. But when you looked at the numbers, out of the 800-odd people who had gone through the centre, of there being about 15,000 transactions, only 120 or so were actually referred on to another service for help.

I and others could not understand how that was so low because you would have thought there would have been conversations happening all the time with people who were coming in to inject, but they did not view that as their particular role. They thought they are there to provide a safe space but not there really to help people to end that particular addiction or go on to something else.

I do not know if that is something that, should that ever happen in the UK, we maybe look at a more proactive approach in terms of not just managing the addiction but helping people to end it. Maybe that was more a comment to the Chair's point than a question, but that was the figures that we had.

Chair: I have some clarity on the figures because I have just been presented them from—

Ross Thomson: Do you have the presentation? Yes.

Chair: There were 513 people who presented to the service; 250 were referred.

Ross Thomson: The top figure, the high thousands, is the number of transactions. Then there is the however many hundred-odd.

Chair: It is 513 people. It was 14,000 referrals, 513 individuals with 250 referrals further on for treatment, support and service.

Ross Thomson: That is very low, and they admitted that. If you have the notes from the meeting, they admitted it was low.

Chair: I am just giving you the figures that we have from the centre. Thank you for that.

Q151 **Brian Whittle:** The subject of these centres has gone around in the Scottish Parliament just the same as it is going around here. We have already had a debate on this. Where I have an issue here, and I am with yourself, is that they seem to be this panacea or this silver bullet that everybody starts to talk about. What happens in rural areas? What is the catchment area for one of these treatment centres?

Would the investment required into that be better spent, for example, investing in third sector organisations that have already proven to be successful? Are we utilising all the tools and levers to the best advantage? Although there is a legitimate debate to be had here, my feeling is that there are a lot of other levers that are not being pulled while we discuss this. Does the panel think that these centres are the best use of our resource?

Vicki Craik: I would argue: why don't we pull all the other levers as well as a drug consumption room? Ideally, the best way to reduce problem drug use is to reduce drug taking, so it starts with prevention and education. We need to invest in that. If we did invest in a drug consumption room that referred people, we would need to have appropriate services, so we need to invest in our services as well.

There are currently 90 drug consumption rooms in operation. Rather than saying we are spending money on this, we should say it is about a cost-saving investment. The Scottish Community Safety Network has a toolkit where we can calculate how much a drug consumption room would save us as a society rather than it being an outgoing cost. With a lot of things in drug use, the more we invest into the services the less we have to spend to react to the problem drug use.

Dr McPhee: It seems to me that, yes, I agree, there is no magic bullet to addressing what has become known as the drug problem in Scotland. There should be a whole range of treatment and help available, whether that is through specialist NHS services like safer injecting facilities or heroin-assisted treatment, but also made available through perhaps bodies like the Scottish Recovery Consortium and people there giving care and compassion and lived experience to help people address the very real issues of their problematic drug use.

Yes, I think that a whole range of services could be made available. I agree with Vicki; we should not necessarily just focus in or fetishise how much it has cost but longer term think about how much this is actually saving us in terms of prevention of future harm.

Q152 **Emma Harper:** Safe consumption facilities are not just about supervising injecting: they are about access to a shower, a phone, social care and housing, and putting the third sector in the same building. In Portugal, we did not see an increase in the number of drug users just because we decriminalised it. I am interested in looking at all of the above approaches. It is not a panacea. It is about how we target folk who are normally shooting up in an alleyway who now we can protect from overdosing and losing their life when they still have weans and a partner at home. It is about supporting and engaging. Wouldn't that be a better approach in order to address our huge issue that we have in Scotland?

Dr McPhee: I do not think that we should ever forget that the greatest impact of what we are trying to do at the moment—clearly, if we look at our rates or prevalence of problem drug taking and our high incidence of drug-related death—is that what we are doing is not working and that overwhelmingly what we are doing at the moment, perhaps even unintentionally, is impacting greatest on the poor.

To pick up on your point about Portugal, yes, Portugal did several things as well as dismantle their criminal justice apparatus. They also made treatment available based on the savings that would be made when the police were asked to do other things. They also altered their benefit welfare system and their routes into work for people with problems. There is a whole host of things that have to be done in addition if we truly want to address this as a health issue rather than a criminal issue.

Chair: Thank you. We really have to move on from that, but thank you for that. It was a really interesting conversation about this, which is becoming an increasing feature of this inquiry.

Q153 **Deidre Brock:** Earlier, one of you mentioned smart drugs and I think also described it as a study drug. I wondered if you could talk us through what those are, who uses them, and certainly what risks are attached to them. We would very much like to hear about that.

Dr Bancroft: I think that I mentioned that, but other people can come in. Smart drugs or study drugs are a class of pharmaceuticals that are used for the purposes of supporting work or focusing on study, drugs like methylphenidate, Ritalin, Adderall, drugs, for example, indicated for attention deficit hyperactivity disorder and narcolepsy. They are effectively used to keep a person awake and focused on the task they are doing.

They are fairly normalised among the student population. As with many drugs, people often think they are in more widespread use than they are. They think their peers are using them much more than they actually are. None the less, there is an expectation that that is normal and expected. Many of the drugs are bought over the internet, the dark net but also the open internet, and off prescription. People will have access to them because they are prescribed them.

There are a number of problematic side effects, some of which stem from the actual effect of the drug itself. People will forget to eat or drink because of the effect the drug has. There are certain myths about them, that they enhance performance, but they do not. They are often used to cope with other issues, overwork, conflicting problems people have, and sometimes the effect of other drugs they are taking.

Q154 **Deidre Brock:** Okay. You mentioned the risk of people forgetting to eat or drink. What other risks are there attached to that?

Dr McPhee: It seems to me that we also have to look at the impact of the marketing of these commodities, particularly on the internet. Primarily, as Angus mentioned, among the student population and other populations who are making risk-aware choices, they are tending to gravitate towards stimulant-type drugs like methylphenidate and Adderall and also drugs like modafinil, which also act to stimulate the central nervous system.

The danger with any stimulant drug use is that it is a bit like having an advance from your bank. That excess withdrawal, that overdraft, has to be paid back. Any gains in terms of ability to stay awake in order to study more—the findings are not great about divergent thinking, creative thinking and remembering what you have studied, so there does not appear to be anything supporting the use of these drugs other than that they act like stimulants. Like all stimulants, the negative consequences are rest, recuperation and at very high doses drug-induced psychosis, which we have to remember is drug-induced psychosis and not necessarily something that is fixed and permanent after it occurs.

Q155 **Deidre Brock:** Is there any evidence to suggest that the use of those smart drugs then leads on to problem drug use later on?

Dr McPhee: I do not think there is any evidence to suggest that would be a gateway to problematic use, but we certainly need more research on something like this.

Q156 **Chair:** My question is to Vicki and it is about new psychoactive substances. I think that you gave us that in your contribution and in your written evidence. What are the new ones that are around just now in the market? Who is it that uses them?

Vicki Craik: The market for NPS has changed significantly. When I started at Crew, I was the new psychoactive substances co-ordinator and now I am the emerging trends co-ordinator, so I think that shows that we have moved away from the market of NPS. We do have specific pockets of use in Scotland.

The main problematic use of NPS is with your synthetic cannabinoid receptor agonists and that is in use within the prisons, mainly because they are more difficult to detect and they are more potent than traditional drugs are. We also have the emerging issues of synthetic opiates, which are drugs like fentanyl and other synthetic versions of that. We also have

a group of NPS, vaguely termed NPS, which are unlicensed benzodiazepines. This includes drugs that were previously legal and sold in shops like Etizolam that have now entered our mainstream drugs market. Although they are now a class C drug, they are used quite widely. We have seen quite a change in the NPS market in the last couple of years.

Q157 **Chair:** Is there much evidence of fentanyl coming into the Scottish marketplace just now? I know that Xanax has always been a feature of particularly the heroin issue here, but is there any evidence that fentanyl has made its way to Scotland?

Vicki Craik: It is in Scotland, yes. There is very little evidence to suggest whether it is used on purpose or whether it is laced with other drugs. If you look at the drug-related death figures for it, they are much smaller than deaths with traditional opiates and with benzos. It is not a great concern at the minute but it is in circulation and it is something that we should be mindful of in the future.

Dr McPhee: Just to follow on from what Vicki was saying, in my work as an expert witness I have seen over the last year and a half an increase in the police seizures of Etizolam and, in particular, the dangers that users have in accessing this particular drug on the street, particularly in the Glasgow area. They call these Baby Blues and the reason why the blue colour is so symbolic is that traditionally 10 milligram diazepam and temazepam were the drugs of choice of people whose drugs of choice were central nervous system depressants.

The danger with Etizolam is with the inconsistency in its purity and potency. Accessing these drugs from the internet and accessing them from street vendors, the danger remains of not knowing the potency of these drugs and consuming them, like a 10 milligram-diazepam or a 10-milligram temazepam, and the overdose and perhaps impact on drug-related deaths that happens. How we police this, how we regulate and how we minimise the impact of this drug I am unsure.

Chair: Thank you for that. I am very conscious that we have had you here for almost two hours and I do not want to detain you any further, so we will move on.

Q158 **David Duguid:** Just quickly, how effective has the Psychoactive Substances Act 2016 proved at reducing supply and use of these legal highs?

Vicki Craik: Crew published an annual report that analysed the Act and was cited by the Home Office in their conclusions. The aim of the Psychoactive Substances Act was to remove NPS from open sale and it has been successful in achieving that. There were around 150 shops in Scotland and the legal high trade or the NPS trade within that has almost been eradicated. That is not to say the harms from the drugs have been eradicated or people have not switched to other substances, but certainly you cannot buy them in shops anymore.

I have a quick point on fentanyl because I know people will pick me up on it. A lot of people will not class it as an NPS but there is a class of NPS called synthetic opioids, which are emerging within the European drugs market. We should be aware of that rather than the word "fentanyl" itself.

Q159 **Chair:** I think that we have seen a lot of drugs deaths in the north of England linked to fentanyl, exactly as you have—

Vicki Craik: Yes, and there are lots of similar opioids that might be classed as an NPS that are certainly new and emerging.

Chair: Okay, thank you. That then brings us to Christine Jardine.

Q160 **Christine Jardine:** We have touched on this before, but could you briefly give us a summary of the methods of early intervention that we have in Scotland to identify and address potential cases of developing problem drug use, to spot it happening in individuals? What early interventions do we have?

Vicki Craik: In my opinion, early interventions are very few and far between and it very much depends on certain areas. We find that a lot of it is in response to something. Schools will contact us in response to an event happening rather than there already being a programme in place. There is no overall standard national curriculum for prevention as far as I am aware.

Q161 **Christine Jardine:** Do you think that there is a need for something in the national curriculum?

Vicki Craik: Yes, undoubtedly. We speak to our children about everything else in society and when it comes to drugs we say nothing. They learn from the internet, their peers, un-credible sources of information. There really needs to be a focus on drugs education embedded within the curriculum for excellence.

Q162 **Christine Jardine:** Do you think that there are specific barriers to preventing more early intervention and more effective early intervention apart from the one you have just mentioned?

Vicki Craik: Lack of resources is one. The stigmatisation and the fact that it is illegal means people are hesitant as to how we address it. A lot of people are scared they might be promoting use, especially since there are no national guidelines. I do think that there is a hesitancy as to what the best practice is and direction should come from top down for that.

Christine Jardine: It is interesting that we come back again to the stigma and the potential for a criminal record if you get involved or do anything to help. It is interesting that we keep coming back to the same thing. Thank you.

Q163 **Emma Harper:** I am interested in issues around online markets. How does that affect the availability and the range of drugs available? Deidre Brock mentioned the dark web and in your submission, Dr McPhee, you

talked about access to drugs through the dark web means it is possible to access a pure, unadulterated substance from trusted vendors. Then there are also the no-name drug dealers that are selling you something that you think is Xanax but it is completely not, so you do not know the dose. Are there issues around online purchasing that make it difficult for us to address this?

Dr McPhee: I will defer to Angus on this, who is the noted expert, but just to comment on my own submission, that was a PhD student who I supervised to completion, Dr Kieran Hamilton, and his research looking at risk-aware online communities. He asked them, "What was your motivation for purchasing new psychoactive substances or drugs that come under that label?" It seemed in his sample that one of the prime drivers was access to a purer quality product. Street drugs were no longer providing the type of experience that the users were seeking, whether that was stimulants, analgesics or hallucinogens. They also wished to minimise the impact of being prosecuted under the Misuse of Drugs Act. They were also able to rate and view. In all online marketplaces there is a rating system where unofficially you as a vendor and supplier can be rated, even within the dark web, about how reliable the product is and how good the product is once it arrives.

This sample that he accessed may not be typical insofar as the people he accessed were risk-aware online communities, his own term that he has coined. That does not necessarily mean that that was a motivation for accessing drugs on the dark web, and the reason they used the dark web, The Onion Router or Tor browser in particular, was to try to minimise detection by state surveillance agencies.

Dr Bancroft: I can add a little bit more to that as well. What Iain said is absolutely correct. The attraction of the dark web is the level of information and predictability in terms of purchase. It only really serves a minority of the drug market. Most users are very well served by the face-to-face market. Some people tried the dark web and moved back to the face-to-face market simply because of that; they find it more convenient.

What it has done is it has increased the repertoire available to people so that they can try a bigger range. They can try with greater knowledge because there are trip reports about what the effect of the drug is. It has also changed the last mile supply. A lot of people on there are not consumers, they are actually dealers who will buy to then supply the drug locally. It has changed the supply chain somewhat and it has changed the amount of information available to people.

Mostly, the drugs being bought are so-called recreational drugs, MDMA, cannabis, stimulants and so on, but there is definitely a group of people who are buying more problematic drugs such as benzodiazepines and opioids on the dark net. One of the attractions is that they can know what they are getting and it is more reliable than a street dealer for them. That can be one of the reasons why they are doing it, but there are problems. People will sell very high-strength Xanax as regular strength. That can be

very addictive and very dangerous as well. Broadly, they seek predictability and that is where they can get it.

Q164 **Emma Harper:** It is not just the dark web; it is also Facebook and Instagram where people are using the internet as a means to purchase.

Dr Bancroft: Yes, in fact, many drug deals are taking place through social media.

Chair: Just before we come to you, Brian, I know that David wants to ask a question. He is getting a note delivered to him as we speak, which I am sure will be legible.

Q165 **David Duguid:** Yes, I got that; thanks for that. It was just a question that was going to be asked by Mr Sheppard earlier but he left so we missed it, and I was hoping to come back in on that. It was about the more traditional means of supply and distribution of drugs, before we got on to the internet and online purchasing.

As I mentioned earlier, historically there was a widespread drug problem in the north-east of Scotland, in my constituency in particular, Peterhead, Fraserburgh. That has improved in recent years, but the police, as I mentioned earlier, have been making fairly high-profile arrests recently where class A drugs are concerned. It appears that out-of-town dealers, not just from the central belt in Scotland but further afield in England and Wales, are using these more rural communities.

Dr McPhee, you suggested earlier that this was perhaps something that the police were—I do not want to paraphrase; I do not think you used the word "exaggerate", but I think that you were suggesting that this is something that the police were saying to try to get more resources. Is it not the fact that the resources are so thin on the ground in these rural communities that makes these places a target for out-of-town dealers for these so-called cuckooing or county lines operations?

Dr McPhee: It does seem to me that, yes, there is a role for particularly policing in protecting vulnerable individuals from cuckooing, where organised criminal networks target someone, use their premises, move on and leave them to realise the negative consequences of this.

When it comes to the availability of drugs and why drugs are made available and the motivations for why people are making drugs available, the research suggests that there is no clear distinction between dealers and users, at least at the street level. What you seem to be mentioning is organised criminal networks and, of course, these organisations and networks are going to move in where there is a profit to be made. The reason why there is a profit to be made is that there is the demand for these products. How do we reduce the demand? We have already discussed this. This appears to be extremely difficult, if not impossible. Therefore, we have to consider other ways of making drugs available that do not necessarily involve organised criminals being the illegitimate vendors of these commodities that the people wish to purchase.

Underpinning all of this is your discussion with that senior police officer that the availability of drugs in and of themselves is the causal factor in drug problems, and I am not sure that that necessarily is the case. I think that there is a range of risk factors that lead to drug problems, and availability, which the police tend to concentrate on, is not necessarily the prime causal factor for problems.

Q166 **David Duguid:** Would it be over-simplistic to ask whether these operations, whether it is cuckooing or online availability of drugs through the dark web, et cetera, are just satisfying an existing demand or actually exacerbating the problem?

Dr McPhee: It is hard to say, but if we look at when you make available something that is not controlled or deterred using a criminal justice sanction, then yes, you will probably have a spike in drug trying, but that may normalise in the same way that we have seen in countries that have not only decriminalised but legalised. Yes, there are corporate influences, yes, there may be a sharp spike in use, but it may level out and people may no longer wish to use them. There may be other things that they wish to engage in.

As I keep reiterating, the drugs in and of themselves and their availability are only one part of the range of risk factors that must be in place in order to create a drug problem. It is not the drugs in and of themselves. I must also reiterate that I am not suggesting in any way, given this evidence, that drugs are not dangerous. I am merely stating that they are not the prime causal factor for problems.

Q167 **David Duguid:** Does anyone else on the panel want to comment on that supply and demand or supply and distribution issue?

Vicki Craik: Just a quick note, going back to new psychoactive substances when they were legal and they were sold in shops, that evidenced the fact that the availability of the substances did cause problem drug use, especially in areas around where the shops were located. If you are looking at a model of legalisation, then that is certainly not one to follow. I think that we can learn a lot from the situation we had with new psychoactive substances when they were legal.

Q168 **Brian Whittle:** Just taking that a little bit further, now with the internet there is obviously the potential to access a global marketplace. I wonder what the panel think about the availability and prevalence of the so-called smart drugs and what we can do to try to combat that.

Dr Bancroft: What we can do to combat the availability of smart drugs, is that the question?

Brian Whittle: Yes, especially access through the internet, the prevalence on the internet.

Dr Bancroft: Yes. Broadly speaking, ultimately most access is local. Most people buy off somebody they know. Most supply, particularly of smart

drugs, is social supply. It exists within peer networks even if that person is buying a load off the internet or off the dark web and then distributing it.

In terms of managing that, one way is for education information to follow that and to happen at that level. People have to be made aware of the risks and the fact that smart drugs are not a great cure for having not had time to study throughout your semester. They will not give you a leg up over anyone else. It is also being aware of the reasons why people are being pushed into it. For example, workers in the gig economy often turn to these kinds of stimulant drugs because they have very long shifts that are very split and unfocused. Being aware of the kinds of risks that people are pushed into through, say, their employment patterns as well I think is very important.

Q169 **Chair:** Thank you. We have detained you for up to two hours. We thought that would be the case given that we have extra members with us from the Scottish Parliament. We are very, very grateful for your time. That was a fascinating session and it is great to hear a range of different views about some of these issues.

If there is anything else that you could usefully contribute, please get back to us. I will end as I usually do in these sessions, given we have a range and variety of experts on this. If there was one thing that you could do to address problem drug use in Scotland, what would that one thing be? I do not need a "War and Peace" version to support it, just what you think that would be and perhaps a short statement of why. We will start with you, Dr McPhee.

Dr McPhee: I want to qualify this by saying that the research would suggest that even among problem users, chaotic use is but one part of a whole pattern and range of patterns of drug use and not necessarily an inevitability through a drug-using career. Users, particularly in my own research, can have periods of chaos, periods of abstinence, and periods of controlled use. These can be fluid; they do not appear to be fixed.

My recommendation is quite simple. I think that members of the Scottish Parliament can debate and legislate on a whole range of agencies that impact and can be used as interventions in relation to drug use and problematic drug use, yet they have no say on the United Kingdom Misuse of Drugs Act. I believe that the Scottish Parliament does need not only to debate but to perhaps revisit the UK Misuse of Drugs Act.

Vicki Craik: I would recommend that the definition of problem drug use is redefined to encompass all drugs and, therefore, we expand our research, our evaluation and our services to meet this new definition.

Dr McKeganey: I would say that as a Committee you should set your sights higher than the creation of drug consumption rooms. I would encourage you to foster the development of recovery centres across Scotland. I say that because part of the reason why Scotland has a drug

problem of the scale that it been the failure of Committees such as this in times gone by to follow the evidence as opposed to following what they think is a really good idea that needs implementation.

One of the bits of evidence that has been consistently ignored is surveys of drug users themselves have said that what they want is services to help them recover, to get off drugs. I think that this Committee and other similar committees have failed to give due weight to those views and that we should have a network of recovery communities well funded in Scotland. That is what we should be doing, not setting up a network—it will inevitably become a network—of centres where people can use illegal drugs.

Q170 **Chair:** One thing that this Committee has been very careful to do is go to people with lived experience. We have already had two sessions with them and we will be having further sessions, so your advice is very well taken. Please be reassured that we will be seeking to discover that and find out what those stories are and what that advice is. Dr Bancroft?

Dr Bancroft: I think that the most effective interventions are those that are trusted by users themselves and which they have a voice in. I think that for grounding, the voice of current problem drug users is absolutely vital.

Chair: Thank you all for your advice, as always when it comes to these sessions. We have really enjoyed you coming along today. If there is anything else that you could usefully contribute, please get in touch with this Committee.