

## Scottish Affairs Committee

### Oral evidence: Problem drug use in Scotland, HC 1997

Tuesday 18 June 2019

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Watch the meeting

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

Questions 171-238

#### Witnesses

[I](#): Dr John Budd, Edinburgh Access Practice, Norma Howarth, Signpost Recovery, Patricia Tracey, Service Manager, Turning Point Scotland, and Iain Clunie, SMART Recovery.

[II](#): Elinor Dickie, Public Health Intelligence Adviser, NHS Health Scotland, and Dr Saket Priyadarshi, Medical Director for Addictions, NHS Greater Glasgow and Clyde.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

## Examination of witnesses

Witnesses: Dr John Budd, Norma Howarth, Patricia Tracey and Iain Clunie.

Q171 **Chair:** Welcome to the Scottish Affairs Committee, where you are here to help us with problem drug use in Scotland. Welcome to the new set-up in the Committee. This is an experiment to see how all this works with new technology and resources available to us. It is as unusual for us as it is for you. Just for the record, would you state who you are, who you represent and make anything by way of a short introductory statement? We will start, as is traditional, by going from left to right.

**Dr Budd:** I am John Budd. I am a GP. I work in Edinburgh with people who are homeless, and I am employed by the NHS.

**Norma Howarth:** I am Norma Howarth. I am operations manager for Signpost Recovery, which is a third-sector organisation delivering services to drug and alcohol users across Forth Valley. My background is that I have been working in the addiction sector for more than 20 years in Scotland and England.

**Patricia Tracey:** I am Patricia Tracey. I work for Turning Point Scotland as practice and development lead. We have services across Scotland for drug and alcohol issues, homelessness and criminal justice.

**Iain Clunie:** I am Iain Clunie. I am the community co-ordinator for Scotland for UK SMART Recovery, which delivers mutual-aid training programme for individuals suffering from any form of addictive behaviour.

Q172 **Chair:** We are grateful; that was very short and concise. We thank you for that. Perhaps going again from left to right, would you outline the services that your organisations offer and the approach and ethos that lie beneath them?

**Dr Budd:** I work in a GP practice. We offer the range of GP services that all your GPs will offer you, but we have additional services specifically for people who have homeless issues—those who are experiencing homelessness and those who are particularly at risk of homelessness. They often have significant difficulties accessing services.

When we audited our records, 70% of our patients had what is called the tri-morbidity of long-term substance use issues, chronic mental health problems and chronic physical health problems. When we consider that the average age of our patients is 39, we are really looking at a morbidity picture that you would expect to see more in people in their mid to late-80s. It is a very unhealthy population.

Q173 **Chair:** Have you any explanation of why people of that age experience that type of morbidity?

**Dr Budd:** The majority experience of poverty from early life. The vast majority have very significant adversity in childhood, with significant levels



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of trauma. People have high rates of exposure to violence throughout their lives. Many people along with that then have difficulties in establishing and making use of relationships throughout their lives. Probably 70% of patients would fit the diagnostic criteria for having personality disorder issues, which makes it very difficult for them to access and make use of services. Homelessness is an expression of those underlying difficulties. I think about 74% of our patients have substance use problems, and that again is very much an expression of those underlying difficulties.

**Norma Howarth:** Signpost Recovery provides a broad range of services. We describe ourselves as an open-access service, in so far as anyone can walk through our door—they can self-refer or a family member can refer. At that moment, we engage them with to do a preliminary triage assessment to ascertain what their situation is. From that, we have services that we deliver ourselves in key working for core drug and alcohol use that is non-opiate—anything from cannabis through to stimulant use, through to use of alcohol and forms of over-the-counter medication.

We also provide key work alongside the NHS for opiate substitution therapy, and across the whole of Forth Valley we have the harm reduction service, which is an assertive outreach approach, working with people who are actively engaged in substance misuse. We provide them with injecting equipment and harm reduction advice and information. We are also a gateway referral system into our mental health colleagues, if we have people who have those particular needs.

In addition to that, we offer two specialist projects, funded by the integrated joint boards in Forth Valley, called the social inclusion project. They work with the most excluded and vulnerable adults who have issues of comorbidity, significant antisocial behaviour, housing and involvement with criminality. That is in collaboration with Police Scotland and our housing.

We provide key work posts within the three prisons in Forth Valley, which are all national prisons: Cornton Vale, Polmont and Glenochil. We also support children who are affected by parental substance misuse—a Big Lottery-funded project called “Time for Us”. We look at the other side of a child’s experience of a family member who uses drugs or alcohol.

At any one point, we work with between 600 and 1,000 people—

Q174 **Chair:** Did you say 600 to 1,000 people?

**Norma Howarth:** Yes, because we have the harm reduction component. We have that contact with people who have come in for a particular part of the service, and then move on.

Q175 **Chair:** Are people triaged when they come to your service? Do you make an assessment?

**Norma Howarth:** Yes, they are triaged. Last year, 2,148 people were referred to our service, and we triaged 1,680; of those, 85% went on to engage in treatment. We have quite a high volume that comes through



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and, from the latest data, between 45% and 52% people presenting are brand new to the service—they are not people who have relapsed and then re-presented. A broad range of the population comes through to us, but we work in collaboration with every possible partner because we want to treat everybody as an individual and be as effective as we can in getting them on the path to recovery.

**Patricia Tracey:** At Turning Point Scotland, we believe that people matter, so we have a range of services throughout the country. Our drug and alcohol services include the crisis service in Glasgow, which offers 24-hour support, including a 24-hour needle exchange and a mobile needle exchange. We also offer short stays for people experiencing a crisis in their drug use.

We also have residential rehabilitation services in Glasgow, and a range of integrated services throughout the country. In Edinburgh, we work in partnership with the NHS prescribing service, and in Glasgow we employ our own medical nurses to work along with the social care staff. We have also been involved in the pilot for Housing First, which is a service that has now been rolled out across Scotland. We learned a lot from that evaluation about how we work with individuals, giving them a house and then working with their other issues after that. We work in a number of prisons throughout Scotland as well.

We work with the individual, at their pace, and look at their needs, whether that involves drugs, alcohol or any other issues in their life. We take a harm reduction approach and promote recovery.

**Iain Clunie:** SMART Recovery is an international product. We are present throughout the world, in 14 countries, and are massively used. In the UK, we are covering just shy of 400 meetings a week, and in Scotland 104 meetings a week, touching up to a maximum of maybe 3,500 individuals within Scotland who access the programmes.

SMART Recovery is not just one programme—it is not just recovery. We have SMART Recovery, and we have our friends and family programme, which deals with the loved ones of people who are affected by drugs and alcohol or addictive behaviours. We also have a teen SMART programme, military SMART, and InsideOut, which is prison-based. It works on a modular basis; the individual can take their book to their cell with them at night and contemplate what they are having explained to them, and what they are told and taught about.

SMART believes in using scientific methods of recovery, such as CBT and REBT—cognitive behavioural therapy rational emotive behaviour therapy. It is about giving somebody a toolbox, so that they can use those tools to build and maintain their motivation, cope with their urges, manage their thoughts, feelings and behaviours, and help them to live a balanced life. It is a progressionary model.

We are a licensed product in the UK. Our funding normally comes directly from ADPs or substance misuse teams within the local area, normally on a



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whole-area agreement under which we can have as many meetings as possible. Unfortunately, not every ADP within Scotland buys into that, so we have separate issues with regard to licensing for specific service providers and so on.

All in all, the client group that we deal with is not just drug addicts, and it is not alcoholics. We don't believe in using those two words. The programme we offer is specifically non-stigmatic. We deal with people with addictive behaviours, which follow a majority of people through their life. It may be a case of having an issue with chocolate biscuits—it can be anything. It is just about a change of behaviour and understanding that you can change that behaviour in a positive manner. It is about how we interact with that individual.

**Q176 Chair:** What we have been looking at in this Committee is why certain people develop particular issues and problems with drug use. We are learning a lot—it is a process for us, too—about things like addiction disorders, adverse childhood experiences, stigma, deprivation and mental health. You see all these people who come through your services. Are there any key factors that you have identified that explain why people might develop these problems? I am interested in what role personal choice has when people who are suffering from a range of addictions come to your services. How does that influence the progression through the treatment services that are available and on to recovery? Maybe we can start with you, Mr Clunie.

**Iain Clunie:** We meet people daily, and to answer your first question about whether there is anything atypical for a person who attends a meeting, there is not. There is no particular social background. We have businesspeople, we have the homeless, we have individuals who are working and maintain their addiction through that. It is very much a case that addiction is non-particular. There is no defining factor—"You are going to have this. You have an addictive personality." I hate the analogy of an addictive personality. There are so many other factors that may show themselves. For me, it is about the relationship between the addictive substance and the behaviour. Everyone will talk about how much they enjoyed it at the start. It is about that transference.

**Q177 Chair:** We have been hearing a lot about that, too. Yesterday, we had a fantastic session at the Scottish Drugs Forum and saw some of their programmes. We have had a number of people in with lived experience. There seems to be some sort of theme that develops through that. Is that what you are finding in your service, Ms Howarth?

**Norma Howarth:** I would agree. I have watched the other Committees, and it is absolutely fantastic for you to hear about the lived experiences. Not one person I have ever met in 20-odd years has told me that from their very first initiation into substance misuse, they intended to become chemically dependent. It is not something that is there from the outset. Drug use starts opportunistically through a situation, but mostly just because there is a driver at that point to use that substance, and then it continues. We have different strands. We have that initiation into



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substance use, we have reasons for people to maintain their substance use, and then we have people with reasons to cease their substance use, so we have different strata.

Like Iain says, for most people the first point is an enjoyable point. There is some reason for people using, and they get something from that. Then there is a tipping point when it becomes non-pleasurable. It is a requirement; it is something that the person has to do to survive, rather than getting the pleasure and the purposeful result from it. That is when a lot of people come through our doors to seek some support. That is very individual. It is very much their choice and when they are ready. Often, it is a bit stop-start. We are open doors, and we don't care how many times somebody comes through and decided it is not the right moment, drops out, and then comes back. We are open no matter how many times that person goes through the cycle, because it can take a few starts for the person to really get on.

Q178 **Chair:** Surely then, Dr Budd, you should be looking at abstinence-based approaches, like ensuring that there is no supply of illegal drugs, because people may find themselves having these addiction problems later on.

**Dr Budd:** I might first step a bit further back and then come on to that. All our services work with individuals, yet the evidence is overwhelming that health is socially determined. The No. 1 risk factor for people becoming homeless is that they were impoverished as children, so childhood poverty is a major driver of long-term health outcomes. None of us chooses our parents, what area we were born into, our country or anything like that. For the patients I see, I would say that personal choice has no place in terms of the fact that they end up sitting in my consulting room telling me about their lives—whether it is substance use, rough-sleeping for 10 years or whatever it may be. Very few people would make those life choices if there were alternatives.

We know that poverty drives people, and childhood adversity is very much concentrated in poorer communities and poorer social circumstances. We know from a biological point of view—we can now do clever PET scans looking at children's brains—that for those children who are exposed to early adversity you can physically see the difference in their neurodevelopment, which limits their ability to choose and pursue things that we would see as healthy choices. Choice plays very little role in that sense.

Having said that, we do try to build relationships with patients, to enable them, bit by bit, to start trusting us, because trust is a huge issue for many of our patients. We do that bit by bit, to show them that they can make use of healthy, caring relationships. That is really important.

We operate under a harm reduction ethos—enabling people to reduce the harms to which they are exposing themselves. In that enabling way, we try to introduce an element of people starting to make choices about the life ahead that they want to pursue. We are under no illusion that that is a simple free choice. It is one step forward and often then a pace



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backwards. It is a slow, developmental process. Just looking for abstinence is not going to be very helpful for many of my patients, because we are trying to offer people a much slower, longer term service.

Q179 **Chair:** I'll come to you in a minute, Ms Tracey, because we are interested in your views. Mr Clunie, you advocate a sort of abstinence-based service, from what we have seen and what you have presented.

**Iain Clunie:** SMART is not an abstinence-based product, but it does point towards abstinence. It is about harm reduction. For some people that might mean changing the delivery method of their drug. That is harm reduction. It may be changing from a bottle of vodka to a bottle of wine. That is harm reduction—stepping in the right direction.

When they are sitting in a meeting surrounded by a lot of individuals who have abstinence, it creates positive encouragement. It is about building that positive relationship, as my colleague said. It is about building that up, to take them to the next level and challenge them at the next level. For me, it is about giving them achievable challenges and goals. It's about that self-reward thing—rebuilding their self-confidence and self-belief. Unfortunately, a lot of the people we see, as has been said, may have experienced childhood trauma or post-traumatic stress disorder. Those sorts of things challenge their self-belief and self-worth. By starting to rebuild that, you are giving them the best opportunity to gain abstinence.

**Chair:** Thanks for that.

**Patricia Tracey:** People who have experienced a lot of trauma are often using medication to make themselves feel better. We need to work with that individual to rebuild positive things in their life—rebuilding their life. It is about giving them the choice to make better decisions, but also helping and supporting them with the things that cause them to use substances in the first place.

Q180 **Christine Jardine:** I was going to ask Mr Clunie about something, but something Ms Tracey just said struck a chord with me. I knew someone a couple of decades ago who, as the result of a trauma in their family, the loss of someone they were very close to, became involved with drugs and became addicted. That led them down a really bad path for a few years.

Should we be thinking—I don't know how we would do this, but I wonder if you have any suggestions—about counselling and trying to identify people who might be at risk, when they go through a trauma, and whether there is some way that social services can be involved in doing that sort of thing? I do realise that social services are not always involved when it happens. I wondered if that was an area you are already working on.

**Patricia Tracey:** I think that if we work to reduce stigma across the country, people would be more open to asking for help. Services are available, but people often find it difficult to come forward, and the services are on the periphery rather than the mainstream. We need to



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address the stigma. People experience difficult times and sometimes they abuse substances. We can work with them.

**Q181 Christine Jardine:** That strikes a chord, because, for example, the families of teenage children often have a huge sense of familial pride and social regard, and they don't want to admit that their child has a problem. Is that something that you come across a lot?

**Patricia Tracey:** Yes. There is a real stigma and shame in the way that we look at substance use, in a lot of things we see in the press and even just the way we term things. A lot of stigmatising language is used, even within the system. We don't yet have a consistent language, which is something we should work towards.

**Q182 Christine Jardine:** Also, Mr Clunie spoke about how if someone has an addictive personality it could just as easily be chocolate biscuits, cigarettes or alcohol.

**Iain Clunie:** Yes, 100%. For me it's very much a case of there being no rhyme nor reason for it. There is no magic button. This issue can affect anybody at any time, and it is about that relationship change from something being a thing people take for enjoyment, to becoming something they need. When that switch goes over, that is the start of the addiction and this is about how people then tackle it. It might mean tackling the trauma that led to it, or dealing with something else away from that to allow someone to deal with their addiction. A good analogy was that we speak of a dual diagnosis, and about the fact that sometimes a person with an addiction also has an associated mental health issue, but they cannot get mental health help until they have been clean for six months.

**Chair:** I am conscious that we are still on question one, and we have a big panel in front of us. I know you all have important things to tell us, so let us see whether we can get through this a little more efficiently. We have a supplementary question before we move on.

**Q183 Paul Masterton:** Just quickly, Iain, you say that there is no rhyme or reason why people may choose to take drugs, above and beyond other substances. Are we at a point where we just accept that drugs are there and will be easily available? Will we ask questions about why it is so easy for people to get their hands on drugs, or are we now at the stage where we just accept that drugs are a part of society, and that people in these circumstances will be able to get them? Are we dealing with the consequences, rather than considering measures to remove some of the supply and impact the supply chain?

**Iain Clunie:** Personally speaking—this comes from somebody with lived experience—you could always get drugs in the '60s, '70s and '80s. Drugs were always about. They are still about. The only way to remove them from the market is to radically change the policy behind them. That is the only way you will ever remove them. But even if you remove them, people will find something else. It is a behavioural thing. People always look for something else, and that is the bit you need to look at. How do we



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make this safer? Once we have made it safer, how do we remove drugs from the marketplace safely? That is a different challenge to that of dealing with problematic drug use as a whole.

**Norma Howarth:** I would agree. I think we are constantly playing catch-up. New substances and variations of tablets are coming through all the time. Service users come to our service to say, "Can you take this to a chemist? Can you take this to Police Scotland and get it tested, because I am not sure what it is?" We do not know what it is because the supplies come through all sorts of different routes. Traditionally, 20 years ago it was kind of easy to manage what we were doing, and I know Police Scotland are doing a fantastic job to try to curtail the amount of drugs available.

**Chair:** We were in Canada recently and we heard about the availability of Fentanyl and Carfentanil, which is being sent in envelopes from China and is then easily cut up. For us—well, certainly for me—this is about how we could stop that type of access.

Q184 **Ged Killen:** Just a quick follow-up to that question—something Paul Masterton said piqued my interest. His question assumes that we are talking only about illegal or illicit drugs, but how many people have you come across on a daily basis who have an addiction to prescribed medication? Is that an issue you see as well?

**Norma Howarth:** Yes, a lot.

**Dr Budd:** It is an issue. As has been said, people have always used substances—we all do in our lives—but this is about when that becomes a problem. That is where a focus on harm reduction is helpful. People will always use substances, but we must look at the underlying reasons for why substances use becomes problematic for some people. I have to disagree—I don't think it is just a random thing. If you look at hospital admissions for drug use problems, they are predominantly folk from poorer backgrounds and deprived communities. If you look at drug or alcohol related deaths, those are very focused on people coming from deprived backgrounds. The harms related are not just a random selection. It is very much a health inequality issue.

Q185 **John Lamont:** Dr Budd, you have touched on this already, but to what extent have you tried to integrate the addiction and healthcare services that you provide with other services such as housing, legal, welfare and other types of support for your patients?

**Dr Budd:** We try to do that. That is very much the ethos under which we operate—the idea of a one-stop shop. As I was saying, our patients obviously struggle to access all sorts of services, so we co-locate with our housing colleagues from the local authority and our homelessness social work colleagues. We have third-sector partners who come in: we offer legal advice, we have a Shelter colleague who comes in offering housing advice, and we have specialist colleagues. We have treated over 100 people for hepatitis C. We now run a pet clinic, because we know that for many homeless folk, the most important relationship that they have is



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with their dog, and if we can offer them support with their dog, we might be able to encourage them to engage with us so we can support them too.

We very much try and bring all sorts—a range of services—under one roof, and increasingly we are trying to work closely with people with lived experience as well. We are moving into new premises; we are getting patients involved in the design of those new premises, and hopefully we will be linking them in on an outreach basis as well.

**Q186 John Lamont:** Is that because you think one of your objectives is trying to understand the reason why the person is using drugs, and trying to provide a solution to that so that the drug addiction is no longer there? Do you see that as part of the service you are providing—trying to get to the nub of the problem?

**Dr Budd:** To be honest, one of the ways that we work is that we have 250 people on opiate substitute treatment, mainly methadone. We have about 900 patients on our books at any one time. In a way, I see the drug or alcohol substance-related problems as an expression of the underlying difficulties, so we can use opiate substitute treatment to draw people into services and then we can actually start working with them on other issues, whether it is about their dog, their mental health or their respiratory condition. As I say, the vast majority of our patients have long-term chronic physical health conditions at a very young age. The average age of death for our patients is 47, so we are talking about Victorian levels of life expectancy.

In some ways, opiate substitute treatment just enables people to have a degree of stability in their life. If we can then get them into some accommodation, that further enables them to start looking at some of the other underlying issues.

**Q187 John Lamont:** So you will actively signpost people to the providers of other services who might provide solutions to this.

**Dr Budd:** We are partner agents with housing, so our housing colleagues will get folk. There is a real shortage of emergency and temporary accommodation in Edinburgh, but we can access it through our housing colleagues.

**Q188 Ross Thomson:** Already as part of the discussion, we have touched on the issue of stigma, so I would be interested to find out what your views are about what the UK Government could do to tackle the issues of stigma around drugs and also treatment.

**Dr Budd:** One of the things that we got prepped about before coming was the Equality Act, and whether substance dependence was a disability or not. In Scotland, with housing, we are taking a rights-based approach. With our new drugs strategy and alcohol strategy, there is to be an emphasis on rights, and for rights to have any meaning, they have to be established in law. Having substance dependence recognised as a long-term disability would be a big step forward in terms of addressing stigma and discrimination.



Q189 **Ross Thomson:** Out of interest, would the rest of the panel agree that extending the Equality Act would help de-stigmatise problem drug use?

**Iain Clunie:** Yes.

**Patricia Tracey:** If you look at the social part of disability, then yes, so that people can get better access to different services. Having had a history of drug use and alcohol use, and maybe having had a gap from employment, people need support to get back into employment, or if they have never worked before. Being able to use that to help people access services would be really positive.

**Norma Howarth:** I think so, and I think it would actually contribute to our service users ceasing to self-stigmatise, because that is what they do as well. A lot of our service users are very late presenting for basic health and social support because of what they think somebody will perceive of them. We have got late presentations with people in advanced ill health, with diseases, COPD, emphysema or even early stage cancers. In maternity services, people are presenting late because they are fearful of the response they will get because of how they are presented in our society. I totally agree; it is about an opportunity for people to gain access to the services they need without fear.

**Dr Budd:** I think it is about the language as well. In Edinburgh and Lothian, our drug and alcohol services are called the substance misuse directorate. That in itself is stigmatising because, as colleagues have said, people use drugs and alcohol often as a means of coping, as a means of self-medicating for their mental health issues, so for many that is actually a logical thing to do. It's not misuse; it's use. Unfortunately, there are also a lot of harms that go along with that, but how we name our services and how we use language is a big part.

Q190 **Chair:** Is there a consensus on that? There is a consensus among this panel about the change to the Equality Act, but among all service providers, is there a general consensus that the Equality Act needs to be amended on this, or is there any resistance that you have identified?

**Dr Budd:** I've never come across folk in service provision who have been resistant to that idea. We all see our patients as hugely marginalised and excluded and often those who experience the sharpest inequalities of anyone in our society.

**Chair:** Thank you for that.

Q191 **Hugh Gaffney:** What changes should be made in current UK employment law to better support recovering problem drug users? How can we improve it?

**Iain Clunie:** To be honest, we're actually quite lucky in some areas in Scotland. Speaking specifically of East Lothian, there is an agency there called Access to Industry, which removes the possibility of a sanction for a year while an individual takes training. It is a perfect example of what could be used, because people within the drugs culture have transferable skills. They can be used within industry, numerous types of industry,



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especially business management, because they've managed to work the business very well. It's about promoting and encouraging self-belief and self-worth to allow them to access training courses that will then access them in with the removal of the sanction, especially within universal credit in Scotland. It is working great in that area. I would think that would be beneficial Scotland-wide. It would be a massive improvement to give somebody the opportunity to develop themselves back into a more workable individual.

**Q192 Hugh Gaffney:** Does that also help with welfare and housing? The three seem to be tied in together. How do we derisk it?

**Iain Clunie:** There is an agency out there already.

**Hugh Gaffney:** Is this a trial thing that has happened?

**Iain Clunie:** I am not 100% sure. I know it works on that basis, but again, it's to give the opportunity to an individual who is in recovery to realise what training they wanted to do, whether it was hairdressing—six months later they might change their mind and want to do something else, and that's okay. It removed the major issue for them, which was the sanctioning, to promote them to train, to develop and move on. Doing that helps to tackle housing issues and social security issues. It tackles all that and allows people to get a better transition back into employment, especially coming from an addictions background.

**Q193 Hugh Gaffney:** Reading the report, it looks like the employees are asking the Government to change it for them—to take all these sanctions away and stop this vicious circle. Maybe it is something worth looking at. Have we got a nod there? Okay, all approved.

**Dr Budd:** In terms of sanctions—again on prepping, one of the questions was about a punitive approach—all the evidence from a psychological point of view is that a punitive approach does not promote positive behaviour change. Sanctions just drive people further away from support and entrench them in a position of dependence and disability. Sanctions are a very negative and retrogressive approach to people who really need support now.

**Hugh Gaffney:** It seems a shame that you have a chance to change your life and the employer sees the one thing—drugs—and says, “No, thanks.” We heard a gentleman yesterday who just felt he was always getting knocked back.

**Chair:** We will have a couple of supplementaries and then we will move on. I know that Christine has to go soon, so we will take you first, and then Ged.

**Q194 Christine Jardine:** We have heard in previous sessions that a punitive and sanctions-based approach to welfare can be a barrier to recovery for problem drug users. Does that match with what you are hearing from your clients?

**Iain Clunie:** Yes, 100%.



**Patricia Tracey:** Even when people try to access benefits in the first place, a lot of systems are going electronic and people don't have access to digital. They have to apply online. Okay, you can go to a local library, but for many of the people I work with, the local library is not accessible. Even being able to access somewhere they can apply for benefits or even having the skills and confidence to be able to apply are barriers. Before getting to the stage of sanctions, you are getting periods of time when you can't even get access.

**Norma Howarth:** I think the changes to the welfare system have put an incredible expectation of autonomous responsibility and ability on our service users that they cannot manage. To be able to access a system, to maintain appointments and to have the ability to engage in a system is quite complicated for our service users who skirt around quite a large, chaotic lifestyle. It is an expectation that is to their disadvantage.

Having the payment of universal credit in arrears is quite difficult. Again, because it is a monthly payment, there is an expectation that our service users can budget, where that is not something that they have learned, particularly if their substance misuse is a generational social norm within that home. We have quite a challenge on our hands.

On a separate note, talking about employability, we have a particular issue where people are discriminated against because they have previous offences and those offences might be quite historic, but they need to be declared. That has been used as a selection criteria, and people have not looked beyond that to the skills and abilities and future recovery capital of the person who is now ready and who wants to take that next step in their life. I think it is about considering how we use that.

The PVG scheme is there for a particular reason, to protect vulnerable groups—we get that—but we are hearing from our service users that they feel that employers are using that as a vetting system. When you apply for your PVG, it declares what we know, but that then discounts that person from progressing into the next stage of employability. That is a barrier that I think we have to be conscious of.

Q195 **Christine Jardine:** Apart from accessibility, which obviously is a big thing, are there any other changes that you think the UK Government should make to the delivery of social services to help tackle problem drug use? Is there anything they could do differently?

**Norma Howarth:** I think it is going to come down to resources, to be honest, in so far as we need to invest in the services that we need to help that person to blossom. Like Iain said, it takes time to have a programme that gives a person a year to find their feet, get some skills and training, without fear of a sanction or some sort of punishment. That is a fantastic opportunity that we do not have for everybody.

We have had schemes in the past. We had the Progress to Work scheme that ran from 2002 to 2009. That was fantastically successful across the whole of the UK. That had enhanced job coaching that was substance



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specific. Addiction workers working with Jobcentre Plus are looking at how we can support a person to move beyond their substance-using years and into gaining skills, qualifications and employability. That funding needs to be deployed at that point.

We have had successful schemes in the past that we can reflect on and say: "What can we bring back in our current context, because it worked?" We have feedback from individuals who have that lived experience that can tell us about that enhanced input into those programmes. I think we probably have the solutions in our own history that we can dust off and reframe for what we are looking at right now.

**Ged Killen:** I think Ms Howarth has covered it, but I wanted to ask about barriers to employment if people are coming forward and may have a criminal record or have to disclose that they have used drugs in the past. I have seen this in my surgery. What changes do we have to see to employment law to stop that happening? I think you pretty much covered it there, but has anyone else anything to add?

Q196 **Chair:** No? Okay.

We were at the Scottish Drugs Forum yesterday and speaking to people who have current problem drug use. One of the things that came out quite powerfully was their experience with universal credit. Issues were raised about transport, about navigating oneself across Glasgow. For example, I think there was a requirement to pick up a prescription in one centre and have it delivered in another part of Glasgow. There were proposals such as a free transport pass for people with problem drug use—I am looking at Mr Gaffney who is shaking his head—which we found to be a sensible suggestion. There were other things to do with universal credit, such as short periods in prison that have the impact of losing accommodation, which then has an impact again when there is no address for universal credit. The nature of the payments being on a monthly basis was also picked up.

This isn't working for problem drug users at all, is it? Other than the transport suggestion, which is one thing we took away, is there anything that could be specifically done to design universal credit provision to help problem drug users?

**Norma Howarth:** From my perspective, it is just about individuality. There are monthly payments, but special cases can be made for people to get that changed so that they can get weekly or fortnightly payments, if we know we have the ability to do it. Job coaches are doing a remarkably great job, but they are short on resources, so they don't have the time to spend. I think it is just about taking the time and having that resource to be able to respond to our service user group.

The principle of universal credit is great, in bringing all the benefits into one. The whole principle is there, but our service users tend to forget that their housing benefit comes within that payment and, therefore, they may forget to take that bit out. Is there an opportunity for us to look at more direct payment from housing to the landlord, so that it is taken out and we



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are not risking accommodation, not accruing huge arrears, and not looking at evictions and people losing their tenancies because they don't have their rent paid? Basically, it is about reviewing the system and tweaking, and listening to individuals who are feeding back to say what they are finding difficult.

**Q197 Chair:** I am conscious that we are a Westminster Committee. Most of the features of universal credit are reserved to Westminster. I am interested in whether there is anything we could suggest or recommend.

**Dr Budd:** One thing that has been very difficult since welfare change started a few years ago is the fact that it has felt like an adversarial system. Increasingly, we are trying to work in partnership across different agencies, between health, social work, the voluntary sector and the police, yet the Department for Work and Pensions isn't at the table. There needs to be a change in ethos, with the Department for Work and Pensions coming out as a partner agency, actually linking in and discussing with us about our patients and clients—

**Chair:** And you don't get that just now at all. Is there no communication?

**Dr Budd:** Hardly. From my perspective, as a GP, there is very, very limited communication from the Department for Work and Pensions, and it would make a huge difference. With the Scottish social security system, there is talk of decentralising, to take the social security service out to where people are, perhaps in GP clusters or whatever it might be. It would be a huge step forward for the Department for Work and Pensions to be working as a partner agency, because it is a welfare agency and that aspect seems to have been lost.

**Chair:** That is interesting. We have also just initiated an inquiry into social security in Scotland, so that is why we are interested in this feature of problem drug use.

**Q198 Ged Killen:** Just to go back to homelessness, which we have touched on a couple of times, we heard in previous sessions that experience of homelessness is common among problem drug users. I think the Scottish Government had evidence from Crisis that 91% of older drug users across Scotland had been homeless at some point. Would tackling homelessness reduce problem drug use?

**Dr Budd:** Yes. Homelessness is a huge issue and, sadly, an increasing issue. We are seeing people stuck in homelessness a lot longer. I was chatting to a patient yesterday who was telling me he had had 18 months in a bed and breakfast, which is enough to drive anyone to unhealthy activities. Homelessness can be a consequence of substance-related problems and it can be the other way around. In homeless services, there can often be a culture of substance use and people can fall into it when they are particularly distressed and homeless. Getting folk into long-term, safe, secure accommodation would be a huge step forward for many, in terms of helping them to reduce the harms related to substance abuse.



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**Norma Howarth:** I would agree with that. I think there is also the other stratum about supporting people to be able to maintain tenancies. In the Forth Valley we don't have the challenges you have in Edinburgh about access to accommodation, because the three local authorities work very hard to provide accommodation, but it can be very difficult for our service users to maintain it. They don't know how to manage a tenancy; they don't know how to budget; and it is quite difficult for them to safeguard and protect their door, and therefore to protect themselves from the other individuals coming into their home and using it for whatever purposes. We have a turnover, so people then lose their tenancies or give them up because they cannot cope.

Earlier, Patricia mentioned the Housing First model, which Falkirk Council is looking at. It is an enhanced support plan around individuals who really need that additional help—multi-agency—to get them able to maintain and sustain their tenancy appropriately so that it gives that longer-term stability in their life.

It is not just about four walls; it is what that person then does within those four walls and how they can live healthily and safely.

**Patricia Tracey:** I think that giving a tenancy alleviates homelessness, but it is about making sure we have the right support at different times for different people, because people's journeys are not always the same; their needs to go up and down, and it is about tailoring that support to them.

I think there is also an issue about preventing homelessness. There are also people who are using substances before they are homeless. It is about getting in there early and making sure that they get that right support, in terms of what Norma was saying about making sure that people are safe. When you are using substances and become homeless, you add in another level of trauma on multiple traumas, which again can keep people in the cycle.

Q199 **Chair:** We have heard a lot about Housing First; it came up yesterday in our session with the Scottish Drugs Forum. I think it was you, Ms Howarth, who said that Falkirk is looking at it and pioneering it. Is it a solution that you think might actually work, and has any evaluation been done of it thus far? Should we be considering rolling out this model a bit further? Dr Budd is shaking his head, so he obviously thinks there is an issue. However, I am interested in hearing your views, because it seems to be a reasonable solution: if housing is at the heart of problem drug use and some of the issues of stigma and morbidity, we should be looking at these types of innovative solutions.

**Norma Howarth:** I would say so. In Falkirk specifically, Signpost Recovery has a social inclusion project, which works with drug and alcohol users who are the most vulnerable and chaotic. It is a collaboration with Police Scotland, housing and adult social care. It looks at addressing the source and the reasons for antisocial behaviour. It also tackles health inequalities, so it is people who will ring 999 for emergency services



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because they are not registered with a GP, because they don't present to primary care.

Under that model, Falkirk housing has looked at putting in a funding bid to the Scottish Government for the Housing First model, and it has learned from the Glasgow experience, to say, "Actually, that kind of intensive care management approach does work", but it would not specifically be only for drugs and alcohol; there would be a broader population who have those housing needs.

It is a collaboration that looks at a high-level care management plan for an individual, including one-to-one support, getting the right services in place and giving sustained input to allow that person to manage their problems, get engaged with drug and alcohol services, cease antisocial behaviour, and get the support they require.

We know from the perspective of the social inclusion project that that works, because there is a huge reduction in the drain on the public purse to do with emergency services, so we know that if we take it into housing further, we will get positive benefits there, too.

**Chair:** Thank you. It was interesting, given that it emerged in a couple of the sessions we have had. We will move on because we are conscious of the time.

**Q200 Paul Masterton:** I have a quick question. In common with a lot of MPs, I get a lot of people coming along to surgeries with complaints and issues around antisocial behaviour. When you drill down, you see that a lot of that is about neighbours with problematic drug use, people who are recovering, and so on. It seems to me that one of the difficulties is that for a lot of local authorities there is a real dearth of accommodation to put people in, and certainly of appropriate supported accommodation. If somebody presents as homeless with drug issues, they are just parked into whatever flat might be available and there is not really any proper follow-up support. That individual is perhaps still living a chaotic lifestyle, which is impacting on an 85-year-old lady in the flat above who has been there for 10 years and is now miserable.

This pilot seems to me to be a constructive attempt to manage and avoid that situation, so that people with problematic drug use are actually being housed appropriately and given the support they need so that those sorts of antisocial behaviour issues do not affect other people in the flats or on the stairs.

**Norma Howarth:** Yes, it is about addressing the issues. If a person has a chaotic lifestyle and cannot safeguard their own threshold such that every other person is trying to get into their home to use their drugs or alcohol because they are not strong enough to be able to manage that, they need support to be able to deal with that. A lot of the antisocial behaviour that we see in our areas is not by the person who has the tenancy, but by the people who come into that tenancy. There therefore needs to be a wider focus on how we support and protect people so that they can maintain their own threshold without being victims of somebody else coming in to



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exploit that. We have a lot of vulnerabilities in our service user group. Their behaviours might be outwith social norms and they can be exceptionally vulnerable to exploitation by others. If a tenancy comes up and people are in a homeless cohort, a little cluster comes into that home and situations escalate. The Housing First model—the social inclusion project model—really looks at working collaboratively to put the right supports in place so that the cause of those antisocial behaviours are being addressed.

**Q201 Paul Masterton:** We have seen quite large cuts to the alcohol and drug partnership funding in budgets. How much is that limiting your ability not only to continue projects that you have already been doing, but to try some of these more innovative models that you would like to do and that could be helpful? Are you finding that, because of these budget cuts—I think it was 17%, 18% or 22% that was cut from this budget—you are not able to try some of these things, as the money is not there?

**Norma Howarth:** It is incredibly difficult. From our perspective, we look for alternative sources of funding. We are working with integrated joint boards, because their priorities for communities match our priorities. We apply for funding from the Robertson Trust, but it is a big lottery. As part of the third sector, we are looking for alternative sources, but obviously there is a limit to how much funding you can draw in. As Dr Budd says, we really need to look at this as a health issue and we need to look at health inequalities, so there is a responsibility to invest in statutory as well as the third sector to address this, rather than looking at project funding that lasts for 18 months and then has to be renewed. It is a huge challenge.

**Chair:** Do you want to come in briefly, Dr Budd? It will have to be brief.

**Dr Budd:** There are certainly huge delays in getting people into life-saving opiate substitute treatment in Edinburgh and elsewhere in Scotland. A large part of that is due to funding limits. It can take three months to get someone on to an opiate substitute treatment, and we know there is huge morbidity and mortality associated with that kind of delay. It is a major issue.

**Chair:** I am going to extend the session to half-past 11, just to ensure we get the full range of questions that we want to ask.

**Q202 Tommy Sheppard:** Good morning. I would like to look at the interface with the criminal justice system in this area. I think all of you are engaged in helping individuals from what I would call a health-centred perspective, but you are dealing with people who have a problem with substances—the possession, use, sale and distribution of which is a serious criminal offence. How does that legal framework, and the fact that these substances are prohibited by law, affect the users you are dealing with? How does it affect your ability to assist them?

**Iain Clunie:** Personally speaking, the people who appear at our meetings have come from illicit drug use, prescription drug use, alcohol use or whatever else. We also have a massive impact in prisons. We run prison meetings with, I think, eight or nine different prisons at the moment. We



see it on that side as well. You see both sides of the coin, including from inside the judicial system when somebody is in there. At the moment, there are as many drugs inside the prison as there are outside. Drug-wise, it is never going to change unless we actively change it. The criminality aspect of it is not a deterrent.

**Q203 Tommy Sheppard:** Let me add a supplementary question and perhaps you could take this up in your responses. What I am trying to get at is whether you have any view on whether it would be helpful to change the legal framework within which this problem is being addressed. I would like to know what it is like on the ground because of this framework, and I would also like to know whether you have any views on how it could be changed.

**Iain Clunie:** Do you mind I go first? For me personally, seeing what we have at the moment—looking at an example such as Portugal, where there is complete decriminalisation, it has shown so many good benefits of going down that route. It would be silly not to look at that as a possible model. I am not saying it will be the perfect model, but it is a possible model.

For me, a lot of the drug deaths are due to poly-drug use. It is down to the quality of the drugs and what they are actually buying, not what they are actually taking, that causes a lot of the drug deaths. If you decriminalise or legalise, you are opening up the option to basically standardise and quality control what is in the marketplace. The bottom line for that is that you will then reduce drug deaths.

I know there is an argument that, if it becomes legal and it can be sold, there will be an increase in users, but it would be an increase of safe users. In that case, you are tackling the drug death problem. To me, that is a route that is definitely one to look at. Again, however, be mindful of the fact that even if you make legal every drug in the world, people will still find new drugs or new substances to use, because that is the nature of the beast—they are always looking for something else. For a lot of people, it is the excitement of doing something illegal that is the big thrill.

**Chair:** Anybody else?

**Tommy Sheppard:** I hope everybody has a view on this.

**Patricia Tracey:** If we change the legal framework, we take away some of the stigma. It is an illegal activity, so people are more secretive about it and are less likely to come forward, especially to statutory services. There are particular concerns about access to social work services. If it was within a legal framework, we could look at getting the right support to people and take away some of the barriers.

**Norma Howarth:** It comes back to the point you made earlier about whether we accept that drugs are part of our society—that they are there and people will use them. That is the point. If that is where we are at, we have to look at doing something differently, and amending the legal framework would give us that opportunity, as you say, to engage with people safely.



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We have had discussions here before about supervised consumption rooms, which are an opportunity to engage with people and help them to use more safely, so there is less risk of disease, less risk of injury and less risk of death. If we are accepting the fact that drugs are a key part of our society—and they are—how do we do something differently, rather than having somebody somewhere unsafe, using badly and paying the most negative consequence of losing their life?

We are at this point—an impasse—of making decisions. As Patricia said earlier, there are countries that have made that decision and are giving us an opportunity to see how we can shape that for Scotland or the whole of the UK, if we are looking from a Westminster perspective.

**Dr Budd:** In terms of the first part of your question, on how I see it impacting on patients I work with, it is a frequent thing that people cycle in and out of prison. I had a chap who was doing really well, who was stable, in his accommodation, on stabilised methadone treatment, not using illicitly and starting to look at volunteering, and the next minute he was back in prison from a drug-related charge six months or a year ago—back in that situation where he is destabilised, loses his housing and is at risk of further harms.

We know that short sentences of less than 12 months are detrimental to someone's wellbeing. They have no positive benefit for anybody. It seems crazy that we are putting people in prison for drug-related issues for such short periods of time that do no long-term good.

On the flip side, last week I had a man who was also on methadone treatment, who was stable and had just gone into a new tenancy. He had a long-term mental health difficulty that meant that at times he became very paranoid. He was very paranoid, to the extent that he could not return to his tenancy, so he was pacing the streets at night and spent five nights rough sleeping down at the sewage works in Edinburgh.

I was trying to get this man into a psychiatric hospital for his mental health and wellbeing. I was informed that there were no psychiatric beds in Scotland—the whole of Scotland. The only way to admit him to psychiatric hospital for his safety and wellbeing would have been for me to section him under the Mental Health Act. That is a shocking but not unusual state of affairs—the lack of mental health capacity in services. The criminal justice system does a mopping-up service for folk who have significant mental health difficulties yet cannot access mental health support. Sadly, that is a positive role that they offer.

In terms of decriminalisation, I think that would be a really positive thing, and with any savings made through people not going to prison we should look at developing capacity and services to deal with the huge morbidity associated around drugs and alcohol and mental health.

**Chair:** That is one of the features of the Portuguese system. Some of us will be going to Portugal in the next few weeks to examine this further. Am I right in saying that they are reinvesting part of the decriminalisation



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programme in services? I am seeing everybody shaking their heads, but we will find that out for ourselves.

**Q204 Ged Killen:** Mr Clunie, you said a moment ago that there are as many, if not more, drugs in prison than there are outside prison. The flip side of this argument that we sometimes hear is, "Well, we should just be even tougher, then. We should just stop these drugs getting into the prison. If we are sending people to prison they shouldn't get access to drugs." What would you say to that argument?

**Iain Clunie:** My honest opinion, having spent time in jail myself, is that you can never do that. People will always find a way. People still brew their own alcohol in prisons. That is prisoners. They know what they are looking for. They know what they are doing. They do it. As a perfect example, the use of prescription drugs in a non-traditional manner—they get highs off them, so they have actually gone and researched some of these things, and that is what they do to get their high, because they are not happy where they are. It is not positive for them; it is a negative experience and that is what they do for the escapism.

I don't think there is any way. Even when you look at America and Australia, some of the larger penal communities there have all still got drug problems. Their security is so much higher than ours, but there are still drugs going in. We removed cigarettes from prisons. Everyone gets a vape now. Again, it is a good measure for public health, especially for the health of the staff there, but will it ever remove tobacco? No, it won't. There will still be tobacco there, because they will always find a way of getting it in. It is as simple as that. You can't police something when sometimes the methods of coming in are by individuals who are going to, no matter what, bring stuff in with them in whatever way they can.

**Patricia Tracey:** Maybe it is about understanding the issues, though, and helping people get the right support while they are in prison. Then they wouldn't feel the need to be using the substances. Maybe it is not just about trying to stop the substances getting in, but actually trying to understand the problems and help the people.

**Iain Clunie:** The rehabilitation of the individual, rather than just locking them up for the sake of locking them up.

**Q205 John Lamont:** You have all argued for the legalisation of drug use. This inquiry is about drugs, but Scotland has also got a very unhealthy relationship with alcohol, which is entirely legal. Do you not look at that and think, "Actually, we are not going to solve the problem by legalising drug use. We are just going to take it away from being criminal, rather than actually getting to the nub of the problem"?

**Norma Howarth:** I think it is about the emphasis, though, isn't it? We have been talking from a health and equalities perspective today, but we have just touched on criminal justice. We have got a hugely unhealthy relationship with alcohol in Scotland, but people don't end up in prison for purchase of alcohol. They can be imprisoned or they can be in the criminal justice system because of the consequences of intoxication from alcohol.



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We have got significant health risks there, but I guess the illegality of substance use, and what people are doing to acquire and use it, brings them into contention with our legal system. Therefore, when they have these convictions it offsets their ability to be able to find employment, go on training courses and progress further. Where alcohol use is damaging, it is certainly a significant concern, but alcohol users don't face the same stigma or the same social consequences as drug users. I think that is why we have got two parallel populations.

Certainly, from Signpost's perspective, we work a lot with alcohol users. They are a more rapid turnover of population, because we are looking at more psychological, therapeutic approaches to cessation, but there is also quite a relapse in presentation. Our illicit substance users take longer to work with because of the nature of their entrenched use, and their drivers for that use. I guess it is that thing of we need to be looking at different ways of engaging our population and reducing the barriers, and I think that decriminalising is one of those.

**Dr Budd:** On the alcohol issue again, alcohol isn't something that affects us all across society equally. It is very much the case that the harms related to alcohol are weighted towards those who are coming from deprived backgrounds and histories of poverty and trauma.

Q206 **Chair:** I think we are all done. We are very grateful for your conversation and evidence today. I always ask distinguished panels like yourselves this question: what is the one thing that you would suggest that this Committee should recommend—primarily to the UK Government, whom we hold accountable and to whom we will report—that would, in your experience, make things better for the people you work with?

**Iain Clunie:** For me, it is about having the confidence to actually devolve some of the powers to the Scottish Government, especially regarding drugs policy. On the Westminster base of things, it is about potentially radically looking at the drug and criminal justice policies in place, to remove the stigma and give somebody the best opportunity to get a sustained recovery.

**Patricia Tracey:** For me, it is about looking at the evidence. We have evidence for lots of different treatments, like supervised consumption facilities, heroin-assisted treatment and lots of other things that we know work, but we can't make them happen. It is about looking at the evidence and educating people, and making sure that we can use these evidence-based practices. We work with these people every day and they are dying every day. We know things that can work, but the law stops us from doing that.

**Norma Howarth:** I would echo that. I would also say an investment in resources, because if we are going to look at the evidence and do things differently, we need to have people and the services in place. We spoke earlier about budget cuts; we need to have the budgets back, if we are going to look at supporting a population that is not getting any smaller. The numbers are not going down. Therefore, we need an infrastructure

that supports the population and to meet them at the door when they need us.

**Dr Budd:** I would say eradicate childhood poverty. Then we would be dealing with so many issues; alcohol, drugs, mental health.

**Chair:** Is that all?

**Dr Budd:** That is well within the capacity of our Government and us as a society, if we chose to do that.

**Chair:** We are grateful, as always. Thank you for your evidence today. If there is anything you feel you could usefully contribute in further evidence, please get in touch with the Committee.

## Examination of witnesses

Witnesses: Elinor Dickie and Dr Saket Priyadarshi.

Q207 **Chair:** Thank you very much for joining us today for our inquiry into problem drug use in Scotland. For the record, please tell us who you are, who you represent and anything by way of a short introductory statement.

**Elinor Dickie:** My name is Elinor Dickie. I am public health intelligence adviser for NHS Health Scotland, which is the national agency focusing on tackling health inequalities in order to improve population health. I work in the evidence for action team and have a remit for problem drug use. I have worked in this field for about 15 years, having previously specialised in hepatitis C prevention and HIV services and strategic planning.

**Dr Priyadarshi:** I am Saket Priyadarshi. I am the associate medical director for alcohol and drug recovery services in Glasgow and Greater Glasgow and Clyde health board. I am a GP by background, but have worked in specialist services with alcohol and drug problems there for 16 years. I have been part of the national advisory structure in Scotland and am vice chair of the National Forum on Drug-Related Deaths. More recently, I have been closely involved with the Glasgow alcohol and drug partnerships proposals around heroin-assisted treatment implementation and a safer drug consumption drug facility for the city.

Q208 **Chair:** Fantastic. Thank you for that. One of the things that sparked this inquiry was the number of drug deaths experienced in Scotland. We believe it is probably about the highest rate in western Europe and we all anticipate that there will be more than 1,100. I don't know what your view about all that is. Why do you think we have a particular issue with drug deaths, particularly with multi-morbidity, which seems to come out as a feature in the evidence you submitted to us? Could you talk us through why we have such difficulty in Scotland, what factors are behind it and whether there is anything we should be looking at in particular that might be able to address some of the issues we have? Just a couple of



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small questions for you to get started—we will start with you, Dr Priyadarshi.

**Dr Priyadarshi:** We have very high rates of drug-related deaths and drug-related harms in Scotland, but in many ways that is not really surprising, given the high numbers of at-risk individuals that we have. By that, I mean problem drug users in Scotland; the latest estimates are about 60,000 problem drug users, a national prevalence of 1.6%, which is double that of England. Therefore, it is not surprising that we have double the rates of drug-related deaths and other problems in Scotland.

Unfortunately, though, we have greater than double the rates and some of that is to do with the patterns of drug use that happen in Scotland. Scottish drug users, particularly problem drug users, use quite significantly depressant drugs—we are talking about heroin, benzodiazepines and alcohol—which predispose people to respiratory depression and then overdoses and, unfortunately, fatal overdoses.

As well as that, there is the issue of the ageing population. We are talking about older drug users, who have been heroin users for 20 or 30 years or more. As they age, biologically they are ageing much faster than their real age, and they develop multiple morbidities, particularly respiratory diseases, liver diseases and blood-borne viruses. That adds a further vulnerability with regard to overdose deaths. Those are some of the drivers of the serious situation we have in Scotland at the moment—you are right that, while the official figures will come out in July, all our intelligence seems to be that there will be a very significant rise even from last year's figures, which were the highest ever recorded.

Q209 **Chair:** Ms Dickie, why do we have such difficulties in Scotland? Why is it so high? Even for the United Kingdom, we have figures that are way beyond those for England and the rest of the UK.

**Elinor Dickie:** Saket has described the complexities of these people's experience, having had long-term histories of problematic use, and the social circumstances in which they are living. We see extreme health inequalities experienced by this group: the burden of disease in our poorest communities is 17 times higher than in our most affluent communities, so the impact of poverty in Scotland is really contributing to the problem.

If I could add to what Saket said about this population and their needs, we have done quite a lot of work in Scotland to try to understand this group that we class as older people with drug problems, and from the evidence we know that we need to tailor our services to them. They now make up 60% of our problematic population, and services need to adapt, think about their design and think about being age-appropriate. That includes having age-appropriate staff, having a breadth of training across the workforce and thinking about the care pathways that these individuals need, based on the different health issues they have experienced beyond solely their drug dependence.

Q210 **Chair:** A lot of people refer to this older group as the "Trainspotting"



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generation. Is that a lazy characterisation of this particular group? Again, why does Scotland seem to have a problem with older drug users that does not seem to be experienced in the rest of the UK or—I don't know—possibly elsewhere in the rest of Europe?

**Elinor Dickie:** There has been research and, as you say, it is maybe an easy characterisation. I think people can understand the “Trainspotting” generation. Research has demonstrated the impact of the social and economic policies of the 1980s—when this generation, particularly of young men, were coming of age and looking for employment—and that the opportunities and resources available to them were very limited. That is where we see problematic drug use as a symptom of not having opportunities available for education or employment. If you did a calculation from the '80s to now, that is where we are seeing this ageing population of people aged 35, 40 and 45.

**Q211 Chair:** We are speaking to senior clinicians and we are in a basic learning curve about things like addiction disorders, adverse childhood experiences, social deprivation and mental health-related issues. Is there something particular with that range of issues that you could help us better understand, Dr Priyadarshi?

**Dr Priyadarshi:** It is echoing much of what Elinor has said. When we look at the incidence of heroin use in Glasgow—for example, we have done some academic work around that—we see a very clear bell-shaped graph that rises from the '80s and peaks in the mid to late-'90s. The good news is it then reduces.

The covert effect is that it is a group of people who initiated on to heroin use in the '80s and into the '90s—perhaps the early 2000s—but that is a discrete population. There hasn't, as yet, been a growth of that in the younger population. They are very much associated with the most deprived communities in Scotland. They have very difficult personal and family histories. We are often talking about generational unemployment and generational history of substance misuse, trauma and adversity.

I am talking now particularly about the population that presents to us in clinical services. Invariably, we find our service users have not only come from deprived areas but have clear childhood adversity, often complex trauma and other social determinants, very much echoing what you heard earlier from Dr John Budd. I can't emphasise the importance of that enough. With the multiple health problems we are seeing, these lead to a whole range of other problems that I would describe as complex needs. Many of the people we are seeing in our services have complex needs around their physical and mental health; there is substance misuse, homelessness and interaction with the criminal justice system. The complexity is quite a challenge for services and systems to respond to.

**Q212 Paul Masterton:** I have a quick follow-up question about the cohort you mentioned and the social and economic changes. Is there no matching evidence in the north-east, the midlands and other areas where there were the same economic changes taking place as there were in Scotland?



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If not, why is Scotland still showing differently? I was interested by what you said about Scottish drug users tending to take different drugs. Is it the case that that is the primary driver? Even though Scotland was not unique in terms of the social and economic changes that it saw at that time, it is still presenting differently to other areas, such as the midlands and the north-east that saw those same changes. Even if that is the premise for why the rise exists, I was interested to understand why it still doesn't seem to explain why it is more prevalent in Scotland than in other areas that saw the exact same changes.

**Dr Priyadarshi:** On the ageing cohort, all across Europe and parts of the western world, it is an ageing population that is experiencing the worst harms. There are few countries that have younger populations experiencing these harms. That cohort is linked to the socioeconomic policies and developments that happened.

**Paul Masterton:** Post-industrialisation?

**Dr Priyadarshi:** Yes, post-industrialisation. It wouldn't be accurate to say that the cities in England didn't experience similar issues; I am fairly confident they did. If you think of where the prevalence of problem drug use is highest in England, for example, it tends to be in the north, in the north-east.

Why is the extent of problems in Scotland much higher than elsewhere? Certainly, in Glasgow, our prevalence of problem drug use is more than 3% of the adult population, which is five or six times higher than that of the English population. That might be because there was more reliance on, and more involvement, in the industries pre-change in the 1980s. There was everything from shipbuilding, coalmining, steel industries and so on, which gave people not only employment but also meaning.

Those changes, and the pace of change, may have impacted a population that was more dependent than others on those economies and industries. That is very much my interpretation of the data and some of the theories of addiction. A key theory of addiction that you might want to refer to is that of Bruce Alexander, the sociology professor from British Columbia, who describes this as a theory of dislocation.

Q213 **Paul Masterton:** I still do not quite get this point. I understand why all that data makes the prevalence in Scotland high, but I still do not understand why it makes it higher than the equivalent places at the other ends of the United Kingdom where there were still huge dependencies on coalmining, shipyards or steelworks. I get slightly confused; it almost seems that this is just an immediate thing to go to as the justification for it. However, it still does not explain clearly to me why it is higher in Scotland—particularly the west coast—than in very equivalent communities in other parts of the United Kingdom, where the demographics and the reliance on those same industries were identical. You described Scottish drug users as using different things, and I wondered if it was because people in those other parts of the UK tended to go towards different drugs that were less likely to result in drug deaths



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or anything like that?

**Dr Priyadarshi:** The patterns of substance misuse are different across different parts of the UK, absolutely. There are even different patterns between the east and west coasts in Scotland. In the west coast it is much more depressant drugs, such as heroin, benzodiazepines and alcohol, which, as I described earlier, are individually and cumulatively very harmful. In the east coast and in other places, for example in London, cocaine and crack cocaine and other stimulants have traditionally been used.

Q214 **Paul Masterton:** Is there any reason for that? Is there any particular reason why the patterns are different?

**Elinor Dickie:** I could not answer why the patterns are particularly different. It is historical that we see excessive poly-drug use, as we describe it—multiple drugs being used at the same time. As Saket has described, in Scotland the multiple drugs used are all respiratory depressants; benzodiazepines and opiates have similar effects on the body, which compounds the impact.

On your question on dislocation, it appears that the policies in the '70s and '80s had a greater impact on communities in Scotland, in terms of displacement and dislocation. If we look at the social determinants of health—housing and employment—as Saket described, those changing socioeconomic circumstances and the displacement of communities, disentangling their resilience, appears to have had a greater impact in Scotland. The research is ongoing to understand that, but there is an excess mortality in Scotland, as you describe, which we are trying to understand. There is a body of work that the Committee might be aware of. If not, I can share some resources.

**Chair:** That would be very helpful to us, because it is a big issue for us to try to understand better why there are distinct issues that we have in Scotland. Thank you.

Q215 **John Lamont:** My question is to Elinor and about the Equality Act. Do you think alcohol and drugs should be included within the definition of disability?

**Elinor Dickie:** I do, yes. As you heard from the panel this morning, in terms of their experiences within their services, we see that that is a barrier in terms of self-stigma, and in the community and social understanding of the impacts of drug dependence. In terms of recovery, which is the focus, something that has come up in conversations with colleagues and partners is transport. Concessionary access to transport is impacted by the understanding of disability within our statutory legislation and guidance. The way that is implemented and the support that is offered to people is variable and can have an impact. As John Budd eloquently described in terms of taking a rights-based approach, having that documented in legislation is a key aspect for consistent practice.

Q216 **John Lamont:** Would there be any cost impact to that change in terms of



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Government funding for different services?

**Elinor Dickie:** I would not be able to comment on that. I am not in a commissioning role.

**Q217 Chair:** You heard the previous panel—an impressive array of contributors to our sessions—and about the range of services offered. I am presuming that you support those initiatives, which would involve a range of different services being made available alongside treatment. Given that you are both within the NHS, what is offered by the NHS in terms of wrap-around services, signposting to treatment, and some of the triaging that is going on for people who present? Can you say a little about what happens specifically in your various departments in the NHS?

**Elinor Dickie:** This is probably harder for me to answer as I am not in a service delivery role, but we know that co-hosting services in terms of the multiple needs of this group can facilitate access to broader needs. We know that social circumstances affect the ability to change. We see treatments as more than just prescribing; they are about providing that range of support services.

**Dr Priyadarshi:** I will speak about the services I am aware of in Greater Glasgow and Clyde, and in Glasgow city. Services are delivered through health and social care partnerships, and integration is a key priority in that. Our services are delivered as a partnership between the health board and Glasgow City Council. Our service users can expect an integrated care manager who looks after their health and wider social care needs. They will work in partnership with a range of other health and social care partners, including housing or criminal justice officers, and specialists such as blood-borne virus teams who now deliver services on site, rather than expecting service users to attend multiple appointments elsewhere, which often many of them find difficult. We have a range of tiered services from tier 1 to tier 4, with tier 4 being the most specialist. We have two in-patient units for detoxification and stabilisation, and we commission everything from street teams to residential rehab units. We work closely in partnership with our recovery communities. We have employed recovery co-ordinators, and we see a continuum from harm reduction treatment and care to recovery. We are trying to manage a system of care that will allow individuals to work their way through that continuum, and ensure that we meet their needs at each stage.

**Q218 Chair:** How well do the NHS and the Scottish Government work with the UK Government to support integrated services across reserved and devolved policy areas?

**Elinor Dickie:** I can only really answer about the function that I play, which is knowledge based. There is a lot of partnership in terms of information exchange and understanding the data and trends we see within the health harms experienced and changing drug markets. I am not sure I can really answer. We know that it is a social policy question. It is harder to judge whether the underlying effects are being changed by that.

**Q219 Hugh Gaffney:** Are harm reduction measures in themselves an end point



for problem drug treatment? Or should they be viewed as a means to minimise harm to get to the root of the substance misuse and to get the patient to stop using drugs? When we start to do the harm reduction, we start to change the misuse of drugs. Is that the end point?

**Elinor Dickie:** What we see from harm reduction services is immediate public health benefits in terms of both the individual and the broader community social impacts. We view harm reduction services as a range of services. That is the first point of engagement. It initially minimises the harms that people are currently experiencing in order to build a relationship with that person through service engagements. In terms of the integrated care that Saket described, the trust and therapeutic relationship that services can offer to individuals is really important. Through that process, in terms of physically coming over the threshold or physically meeting service providers and building that relationship, we can then open up broader discussions about broader needs and really think about signposting people both into wider primary and secondary care services, but also on to their recovery journey.

Medically assisted treatment is one of the most significant harm reduction services, so methadone, buprenorphine and heroin-assisted approaches are offered to reduce the risk of fatal overdose and drug-related deaths. We have seen in the research that those in treatment have a mortality rate of less than a third, so it is quite significant to the importance of having people in treatment and keeping them in treatment. That is where the integrated model of care is really essential to be able to provide that broader support.

Harm reduction services in terms of injecting equipment and take-home naloxone have twofold benefits in terms of that engagement and also in reducing the immediate harms: blood-borne virus transmission, testing and treatments, and reducing the prevalence more broadly in the population. Take-home naloxone is an intervention that we can offer people at the point of overdose to reduce the risk of death.

**Q220 Hugh Gaffney:** The people we spoke to, and people we have met in the past—others are saying this as well; they have been on methadone and all that for a long time—are asking whether we should have a time limit on harm reduction.

**Elinor Dickie:** There has been a particular body of research around understanding what the needs are for medically assisted treatment. Time-limited treatment is not effective; it is contrary to recovery goals and outcomes, and it would be an arbitrary limit to set at a particular time. It is a very personal experience. We know from the research that there might be a number of reasons why people are on long-term prescriptions. It could be that they have for the first time achieved stability in their lives and had a positive relationship with services, so they might have a positive relationship with their prescriber, which they do not want to see finish. Or they might also have had repeat, failed and difficult occurrences in trying to become abstinent, which essentially makes them feel that they are too ill or too afraid to take that on board. They might have



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experienced further episodes of adversity around bereavement or different social circumstances that really would leave them with little resilience to try and take on such a big change. That is where, as I said, in terms of the therapeutic alliance with services, if we deal with that sensitively we can move people through their recovery goals.

**Q221 Chair:** I know that Dr Priyadarshi wants to come in. I will just throw this in too. One of the places where the political debate meets the services that you provide is on methadone and the idea that people are “parked” on methadone. The political language that is used when it comes to this refers to how something must be done to get people off methadone, and that this should be built into any strategies that are developed around opioid substitutes. What are your views on that, and should it be built in for people to secure a prescription?

**Dr Priyadarshi:** I find this area very difficult. I am sure it is not your intention, but even using the term “parked” on methadone is stigmatising.

**Chair:** That is the word used in the political debate.

**Dr Priyadarshi:** Absolutely. Let’s think about who is “parked” on methadone: it is somebody who has had a difficult relationship with drugs, is dependent on drugs, may have been a high-risk drug user, would have been involved in acquisitive crime, may have gone in and out of prison, may have been at a high risk of blood-borne viruses, overdose and death, may not have been able to look after their children or maintain a tenancy and may have caused a lot of public disorder.

That individual has made a decision to come to treatment and they are getting some benefit from that treatment. Now, we are saying to them, “We don’t value that. We want you to stop your treatment and take a risk.” We know that recovery is possible, but it is very individualised and it is difficult to direct an individual to a certain route of recovery. Therefore, if we think about individualising person-centred care plans and non-stigmatising care plans, if somebody considers their drug addiction as a long-term condition and they need long-term treatment for that, that might be a useful thing, especially if you consider the risks that we are discussing for that individual.

In response to the first question about whether harm reduction is an end in itself, as I described, I consider harm reduction, treatment, care and recovery as a continuum. The evidence suggests that injecting equipment provision and drug consumption rooms are gateway services to treatment and care, and treatment and care are a way to help people to enter recovery.

**Q222 Paul Masterton:** When we were at the drugs forum yesterday, we met a chap who is battling addiction. He said that he was put on 30 mg of methadone but he was still using, so he went back the next week and said that he was still using and was put up to 40 mg. The next week he was up to 50 mg, and then 60 mg—10 mg at a time until he was up to 100 mg. He also pointed out that there is a whole range of services that



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are closed off to him because he is on 100 mg and that he cannot access until he comes back down to 30 mg, but there did not seem to be any clear pathway of support to reduce that. He presented a picture of going in, being asked one or two questions, the revised prescriptions being handed over and being shown the way out.

While I accept everything you say, it appeared from the evidence we took yesterday that there are not huge amounts of personalised, individual meaningful support given to help people once they are on those replacement substances, who need to keep increasing their amount to get them off heroin, to start reducing that. When people get to the stage of being able to manage a constant level of the replacement, how are they able to get that back down—even if it is not to come off altogether—slowly over a long period of time? The evidence from yesterday showed that the support structure is not in place to get people to bring that level down, even if it takes years.

**Elinor Dickie:** I will comment on the dose issue, although I am unable to comment on service structures in that sense, not being a service provider and not knowing the experience of that individual. We know that dose is very important. The evidence demonstrates that having an optimal dose to stabilise someone and, as you described, offer that personalised care is very important. While I recognise the issue you outline—personalised care is very important—we must not lose sight of the fact that the dose of medically assisted treatment is equally important. We need that dual intervention in services. The evidence is very clear that, in terms of retaining people in treatment, the dose is very important.

Q223 **Paul Masterton:** The goal, presumably, must be to get that dose dropping, even if it takes 10, 15 or 20 years. Presumably it is not a good situation to say, “We’ve found the dose that replaces, and takes you off, the illicit substance—that’s you for the rest of your life on that.”

**Elinor Dickie:** It would come back to the personalised care that you described, and working with the individual on what their recovery goals are, thinking about the other circumstances in their life and what further changes they can or cannot make.

Q224 **Paul Masterton:** Dr Priyadarshi, you mentioned at the start that you work closely with the local alcohol and drugs partnerships. Obviously we have seen funding cuts on the whole to those, but there has been regional variation. I think in some parts of the country the funding has gone up. In Greater Glasgow and Clyde I think it dropped by about 11%. Does that place challenges on the ground for being able to give that more individualised care, or are you able to work within a lower budget just by restructuring the way in which you do things and work with those partnerships?

**Chair:** We will come on to the methadone-related issue, but I know that you were keen to come in, Dr Priyadarshi.

**Paul Masterton:** You could answer the question that I asked first.



**Dr Priyadarshi:** Managing caseloads and the capacity to do that is a significant challenge for all services across Scotland, and Glasgow and Greater Glasgow and Clyde are no different. In order to spend as much time with individuals as we would want, we would need to develop our capacity further, especially to give the personalised care plans as much priority as we want.

However, we are managing at a time of difficult public finances. We are looking at priorities as well, and some of our priorities are around the complex needs and very high-risk population, for example in Glasgow city centre. We are looking at how we can use current resources to try to engage them in treatment, harm reduction and safer patterns of drug use. It is a challenging environment for everybody involved in this field at the moment.

In relation to your questions about dosage, I will not repeat what Elinor said but, apart from dosage, there are two other key elements that make for an evidence-based methadone or buprenorphine programme: retaining people in treatment for a considerable length of time—we are not talking weeks or months; we are probably talking over a year to start getting the benefits of that—and having a good therapeutic relationship with at least one individual in the service who will support you and support your steps into recovery.

The low dose reduction that you described is clinically something that we are very wary of, because addiction is a relapsing condition. You can slowly and in good faith reduce doses, but if somebody relapses with those lower doses, they do not then have the background level of tolerance that they require to manage that relapse with as minimal risk as possible. Those are the sorts of clinical decisions that a doctor and their patient and the key worker are having every day. Those discussions are difficult, because they undoubtedly raise an issue with whether patients and service users are requesting lower doses.

Again, I would point to stigma about that. Methadone is one of the most evidence-based medical treatments that exist, but it is probably the most stigmatised treatment. We are talking about a group of patients and service users who often want to dissociate themselves from using a very stigmatised treatment. Some of the ways that we deliver that—for example, supervision in pharmacies and so on—add to the barriers.

**Q225 Chair:** I think you are absolutely right. We all laugh at Methadone Mick on “Still Game”, for example, but the stigmatising impact of that must be quite profound if you are a problem drug user and you are witnessing these types of things.

I am really interested in the dosage issue, because I think that this is really quite important. I hope that there is something that you may be able to present to the Committee. Maybe we could have a proper look at and study of this. Another feature that we heard yesterday was that even a drop of 1 mg, in terms of prescription, could start to have some of the physical impacts of drug dependency and people have actually



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experienced that with just a small dosage. If we could better understand some of those things, it would be really quite helpful. I know that one or both of you possibly have something that could help us with that and that you could give to the Committee.

**Dr Priyadarshi:** I am happy to send you some information about the dosage and the evidence base.

**Chair:** Excellent. Thank you.

Q226 **Ged Killen:** Dr Priyadarshi, in discussions that I have had about the inquiry, one of the criticisms that I have heard is that the guidelines for heroin-assisted treatment are too narrow. Is that something you experience?

**Dr Priyadarshi:** As you know, we have not yet had experience of delivering heroin-assisted treatment. We have plans to implement it in the autumn of this year. The evidence base from across the world—it is a pretty good evidence base with good-quality randomised controlled trials—is focused mostly on drug users who have tried other modes of treatment, so methadone and buprenorphine, but have not had the benefits of those treatments. Therefore, heroin-assisted treatment is a second or even third-line treatment. What your question is therefore implying is that we need to have patients work their way through the conventional treatments before we can offer them heroin-assisted treatment.

Our plans in Glasgow are to use it as a second or third-line treatment for people who have not benefited from methadone or buprenorphine initially. It is the most expensive form of replacement therapy, it is very labour intensive, and it is probably the highest-risk form of treatment in terms of the delivery of the service. Therefore, it is appropriate that we use it where we think the impact will be felt most and where it will be greatest, and that is on patients who are refractory to other treatments.

Q227 **Tommy Sheppard:** We want to move on to a series of questions about drug consumption rooms. I cannot remember whether this is session five or six, but we are a good way through our inquiry now and a lot of witnesses have made particular reference to the Glasgow drug consumption room proposal. You two are closer to the argument than anybody we have had before, so this is the point in our inquiry where we ask you, in summary, to make the case for the drug consumption room, to put it in some sort of context for us and to say how you think it would assist in dealing with the problem as you see it—as concisely but comprehensively as possible.

**Elinor Dickie:** We will both gladly make the case for this service. Internationally, we have 30 years of cumulative evidence of the practice of these facilities being available, and at least 20 years of formal evaluation, which really consistently and universally demonstrate that the services attract the most vulnerable people—those experiencing homelessness and those with a history of incarceration. They also consistently demonstrate that the services provide, as well as the safer injecting process and



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education around how to reduce the risks from current practices with injectors, an opportunity for engagement across other services.

Users of the services report that, although safer injecting is really important to them, and having that safe space, it is about working with competent, non-judgmental healthcare practitioners across a variety of care. We know that it is an opportunity to enhance access to primary care and, importantly, engagement with other treatment modalities, so thinking about treatment but also cessation of injecting and detoxification programmes. The work that we have seen from these facilities is really meeting a broad range of needs for this group of people who are currently not engaging with services, from what we know, in terms of their injecting-related needs.

**Dr Priyadarshi:** In terms of the application of that evidence base across Scotland, in Glasgow city, for example, we know that there is a population who could really benefit from a drug consumption room. We have that evidence from a health needs assessment that we carried out in Glasgow following the first cases of HIV that came to light in 2015. That health needs assessment told us that there is a concentrated population of people involved in high-risk drug injecting in Glasgow city centre, including injecting in public places. Those individuals have severe and complex needs relating to addictions, homelessness, criminal justice and other issues. They are not engaged fully in many services, but they are involved in very high-risk activity.

When we looked at the evidence base internationally for responding to the needs of that population, one of the clear developments in other countries with similar populations has been safer injecting facilities or drug consumption rooms. Drug consumption rooms can refer to rooms that allow for the smoking and inhalation of drugs as well as injecting those drugs. Our view is that the evidence base matched the need of the population that we identified. We have worked with stakeholders who work with the population I am talking about, but also people with lived experience of drug use and people with living experience of chaotic or high-risk drug use. They are very supportive of matching that population to the evidence base that exists around drug consumption rooms.

We feel strongly that piloting such a facility in Glasgow would not only meet the needs of that population, but help us to explore how this can be delivered and where its place lies in the broader Scottish and UK scene on drug services. We think a robust evaluation of this would help to inform the UK evidence base and help to inform alcohol and drug partnerships and Governments across the UK about the role of such a facility for populations identified.

**Q228 Paul Masterton:** You touched on this briefly, but there seemed to be a bit of confusion in the press over the weekend between the heroin addiction treatment that is going to be trialled from the autumn and safe consumption rooms. It would be helpful if you could explain the difference between the two in a couple of sentences, because over the weekend some of the newspapers seemed to confuse the two and think



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that what you were going to be trialling in August was the safe consumption rooms. For the record, can you just explain what the difference is?

**Dr Priyadarshi:** Heroin-assisted treatment is a highly structured treatment where patients are assessed clinically and provided with prescriptions of diamorphine to replace their street drug use. It is only for individuals who are accepted into that treatment, and it is going to be relatively low numbers to begin with in relation to the at-risk population. Drug consumption facilities are safe, hygienic environments where people bring their own drugs and use them on that site, under the supervision of clinical staff, to ensure that they use them as safely as possible. It usually has a much higher capacity, because you are trying to reach a much larger number of the at-risk population.

**Chair:** Thank you, because we all noted that piece in *The Daily Telegraph*.

Q229 **Ross Thomson:** On the drug consumption rooms, we all accept that it must be a priority to prevent drug use and to get people into recovery. What I struggle with, and what I would like to hear your views on, is those who are supporting in these centres. Given that drugs are inherently harmful, does that not raise ethical issues for medics and those who are working there? What about the practical difficulties for the police? The Misuse of Drugs Act 1971 is very clear, so how do you get around that? The law must be enforced.

**Elinor Dickie:** The ethical imperative to act is stronger, because we know—this is my judgment, anyway—there is evidence that these facilities are effective in reducing the risks associated with drug use, which, as you say, can be quite harmful. There have been no recorded fatalities in these services. That is the crux of the issue. The entire sector in Scotland is unified on reducing drug-related deaths, and this is a means to do that.

On the police implications and the illegal activity related to this, it would be important to work with the police, as we have seen elsewhere. Colleagues in Canada report that the police's response, in the context of rising drug-related deaths—that is where these facilities are brought in—has been that this sounds like an appropriate health intervention. Building a partnership with the police and, more broadly, establishing a legislative exemption for these services would be appropriate mechanisms to reduce the harms that these members of our community are already experiencing. That is worth considering.

**Dr Priyadarshi:** From a medical profession point of view, clinicians work with active drug users all the time. In terms of this population in this service and the balance of risks, when we look at the environment in which people are currently publicly injecting and the harms they are experiencing—skin infections, blood-borne virus infections, overdoses and death—on balance, ethically, I have not heard those concerns being raised by many. But of course we are looking for a legal framework that would allow the legitimate staffing of these services, and protection for staff who worked in the services as well as for service users. There are protocols



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between police and these services around the world, and we have looked at those. In due course, again with the correct legal framework, we would want to work in partnership with the police and develop the appropriate protocol with Police Scotland.

**Chair:** That is what we found when we visited a drug consumption room in Ottawa. There was an arrangement with the police whereby people were able to access the service without fear of being apprehended or arrested.

Q230 **Deidre Brock:** We have heard from a number of witnesses what they consider to be the root causes of poverty. You have mentioned some today, but they include the impact of austerity policies through the welfare and benefits system, child poverty, traumatic incidents, mental health issues, lack of opportunities and, as you mentioned, displacement and disaffection after the '80s. It has been suggested by some folk that safe consumption facilities do not address those root causes sufficiently. I wonder how you would respond to that criticism.

**Elinor Dickie:** It is important to consider the individuals accessing those services. The services would work with those individuals first on their drug-related issues and then, more broadly, on understanding the underlying issues behind them. In terms of tackling the health inequalities this group experiences, we know that the burden of disease is 17 times higher in our most deprived communities. We know that providing intensive support to those most at risk is a means to reduce health inequalities. That is where these facilities really respond to that need. It is not a societal-based intervention, as you have described. It is about the individuals: thinking about the circumstances they are already experiencing and about how we can reduce further harm, mitigate those circumstances and support them to access other health and social care services.

**Dr Priyadarshi:** The wider social determinants are beyond the scope of a single drug consumption room, but I absolutely think that there needs to be a societal view on those social determinants and, as John Budd stated at the end of his evidence, a real commitment to tackling them. From a more pragmatic point of view, what can drug consumption rooms do to meet the wider complex needs of the population there? They give us an opportunity over time to engage with individuals with complex needs. We work, as I said, in an integrated health and social care partnership and we can therefore utilise the benefits of that to deliver health needs such as wound dressings, blood-borne virus needs, take-home naloxone and social care needs.

In Glasgow, we have really scaled up our Housing First options, so we would want to prioritise getting people into housing first. We can work with mental health and criminal justice partners to look at wider needs and welfare rights officers to maximise welfare payments and so on. In the longer run, I hope that many of those individuals will enter formal treatment and then, from treatment, will enter recovery and have employability opportunities as well. I think that they are the beginning of meaningful conversations with people at high risk and with complex needs.



**Q231 Deidre Brock:** That is certainly the impression that I think many of us gained from the visit to the Canadian facilities. It is also about gaining the trust of individuals who have experience of very traumatic incidents at times, and that takes time.

**Dr Priyadarshi:** Yes. Our case for a safer drug consumption facility in Glasgow is based on public health, on societal benefits in terms of cost-benefit analysis and reduced drug-related litter, and on the impact on residents and businesses, but it is also based on recovery. Having said that, we have to be realistic, because we are talking about people who have quite deeply entrenched and complex problems, so the time that it takes from engaging with them in a drug consumption room to helping them to progress through the continuum of care that I described will not be immediate. It will take the building of trust and therapeutic relationships before we can expect that level of outcomes.

**Q232 Tommy Sheppard:** Can we turn to how you would respond to some of the criticisms of the project? Before I get to that, from our experience in Canada and from what we have learned elsewhere, one of the benefits of having supervised drug-taking facilities is that there is the ability to intervene in the case of immediate respiratory failure, for example, so that you can prevent people dying there and then. There is also, through the provision of clean needles and so on, the ability to remove problems to do with contamination or blood-borne infection. Has anybody made a case—or even a guess—about what the difference would be in terms of the number of drug-related deaths in Glasgow between proceeding as we are or bringing in a supervised drug consumption facility? That is my first question.

Obviously, there is a big debate about this. Some people have a contrary view. Just this weekend, the Home Secretary has reiterated his views, which are quite resistant to any form of change. The general Home Office response is that this would “send the wrong signal”, by which I presume they mean it would be seen as condoning or even encouraging problematic drug use. Some people have talked about it being the thin end of a wedge. I am not sure what is at the thick end of the wedge in that analogy. How do you respond to the criticism that by providing that medical facility, we are somehow giving the wrong signal and would be encouraging the problem rather than diminishing it?

**Dr Priyadarshi:** On the impact on drug-related deaths, there are two useful studies: one from Vancouver and one from Sydney. The Vancouver study, which is probably the most robust in measuring outcomes on drug-related deaths, showed that in the vicinity of a drug consumption room—in Vancouver, it is sited very much around where public injecting was highly localised—there was a very significant reduction in the number of drug-related deaths. From a city-wide perspective, that is a very small population compared with the whole city’s population, so there was less impact on the city’s number of drug-related deaths. The city’s drug-related deaths reduced, but not to the same extent as in the immediate vicinity of the drug consumption room in Vancouver.



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The Sydney study showed that there were very significant reductions in ambulance call-outs for overdoses around the site of the medically supervised injecting centre in Sydney.

Translating that evidence to Glasgow would suggest that because we have the highest risk population in the city centre involved in injecting drug use, there is likely to be the benefit of reducing their mortality rates, if they utilise a drug consumption room. Its impact would be on that cohort. The wider city's impact is determined by so many other factors that it is difficult to predict. That would be one of the questions in an evaluation. If you ran a service for two or three years, what is the impact on the mortality rate in the locality? What is the impact on drug-related deaths in the city? We would have to see the outcomes, but I would expect to see some positive outcomes from that.

**Q233 Tommy Sheppard:** What ambition would the policy have? What would be the hope for the number of deaths you might avoid?

**Dr Priyadarshi:** I really cannot comment on that. The evidence base does not allow us to model a number. All I would say is that drug-related deaths in Glasgow are rising at unprecedented levels, so we need to think about all the tools we can find to address the crisis that has developed there.

**Elinor Dickie:** On the numbers issue, the first thing we need to do is stop the rise. As Saket says, we have seen this rise for the last four years. Each year, we have seen the highest number ever recorded. We really need to stop that in the first instance. We cannot model particular numbers. Any death is obviously very tragic for families and communities.

On the critique that this would condone and encourage drug use, that is not shown by the data from all these facilities around the world. I will come back to the point on the wrap-around care that we have described, in terms of engagement with both treatment and detox programmes. Actually, the evidence is that people stop injecting as a result of their engagement with this service, having not engaged with other services. We also see in the research that these facilities have not contributed to any increase in the number of people who inject drugs, or in the number of drug deals in the area. Such facilities are frequently placed in areas where there are high levels of problems—they are located there to capture those individuals. We do not see any change in the number of drug deals, or an increase in the number of people who inject. It is really about meeting the needs of the existing population.

**Q234 Chair:** Is there any evidence that drug consumption rooms do not work, and that they have adverse impacts and cause societal harm?

**Dr Priyadarshi:** No.

**Elinor Dickie:** Not that I have come across in the research and reading that I have done.

**Chair:** Is there nothing that you could point to that shows they have any

sort of negative features?

**Elinor Dickie:** I think one key factor is working with the local community so that residents and businesses build a relationship there. We see in the data that residents favour them because they are located in areas of difficulty. We perhaps need to continue to work on some of the broader perceptions, but in terms of health data and hard facts of harms—

Q235 **Chair:** How do we get this evidence across to the UK Government? We saw the Home Secretary's response: because of what he experienced as a child, he was prepared to dispense with all evidence—with all the things that you tell us are having a positive impact and could save lives. It was all to do with what he saw. How do we start to impress upon those who are the gatekeepers that this is important stuff?

**Dr Priyadarshi:** We have noted, in the response from the Home Office to our proposals and to communication with police and drug commissioners that has been made public, that the Home Office has acknowledged the evidence base around drug consumption rooms.

The Advisory Council on the Misuse of Drugs, the Government's own advisory committee, has made a recommendation to pilot it. The Government's own reports have shown the potential benefit of this. The Government has also acknowledged the EMCDDA evidence. So, it is not a question of a need to convince around the evidence base. There are perhaps other arguments to be made there.

We can only reiterate the evidence base and maybe allay some of the fears. For example, some of the fears are, as Elinor alluded to, around condoning or perpetuating drug use. Elinor has responded to that. Another fear is around the so-called "honeypot effect"—that people will travel for miles and miles to come to this. All the evidence from all the drug consumption rooms that have been studied suggests that that is not the case.

The Home Office has highlighted the situation on the Jutland peninsula, between Denmark and Sweden, but that is a unique situation where Swedish drug users often come into Denmark to try to access harm-reduction services that perhaps don't exist in Sweden.

The Government have also highlighted the risk of drug dealing developing. Again, the evidence suggests that if you have good police accords and service management, that does not really arise. We have made those arguments.

**Elinor Dickie:** Quickly on the issue of the Home Secretary, as you asked very specifically, I obviously don't know the circumstances of his experiences as a child but they are clearly completely valid, I am sure. What we have to think about is the situation now. I wonder whether visiting the sites in Glasgow, where we see public injecting and the drug litter in the middle of the city centre, and where we see from the research evidence that these facilities respond to those needs, may be one further mechanism.



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As Saket has described, we know that the Home Office has acknowledged the evidence of effectiveness. It is really about we in Scotland, within our local context, wanting to pilot this service. There is good reason for that. Perhaps witnessing the realities of that could be a further means of trying to convince the Home Secretary.

**Q236 Chair:** Leaving aside consumption rooms, which is one area that is within the gift of the UK Government, is there anything in the suite of reserved powers and responsibilities that might be usefully devolved to the Scottish Government to improve the appalling rate of drug deaths in Scotland?

**Elinor Dickie:** That is a very complex question and we are not constitutional experts. My judgment, based on the evidence, is that there is an incongruence, because the health response, which we have discussed today, along with the harms that people experience that are health-related, is a devolved policy in Scotland, but it comes within a criminal framework that is reserved, including the Misuse of Drugs Act.

I believe that in Scotland we should be looking at a new mechanism, or at least considering whether it is fit for purpose after 50 years. It is quite an old piece of legislation and the circumstances when it was written, probably in the late 1960s, compared with today, would be very different. That would enable the Scottish Government to look at an amendment or exemption, particularly around personal possession, where it would really not be deemed in the public interest to prosecute those small discrepancies or offences. It serves as a huge barrier to harm-reduction services and as a psychosocial barrier for individuals, as you heard this morning, that it is classed as an illegal activity, with the shame and stigma associated with that.

There are other factors within the social security system, as you also heard from colleagues, around conditionality and sanctions. The public sector is trying to understand the continuity of care that we have to offer these individuals and is really thinking about the need for drug treatments and claimants' commitments within jobcentres, and trying to harmonise that relationship. At the least, I believe that the evidence from research in Scotland on the health impact of welfare reform recommends that sanctions for this group, particularly for missed appointments, are removed.

**Dr Priyadarshi:** I agree with everything that Elinor said, but I just want to focus specifically on an element of the Misuse of Drugs Act, which I think is a recurring theme through the Committee's hearings. The Act is quite a complex piece of legislation and covers many areas. The Committee should consider whether certain elements of it should be prioritised, in terms of devolution. In terms of being able to deliver, for example, a drug consumption room and being able to respond to the public health framework that is being used by the Scottish Government around drug policy, perhaps sections of the Act are barriers at the moment to our delivering certain interventions and services. Those should have the highest priority.



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**Q237 Chair:** We will be having both somebody from the Home Office—I am not sure who yet—and a Scottish Government Minister, and we will put these questions to them. With the range of devolved responsibilities and powers that the Scottish Government have at their disposal, is there more that they could be doing, particularly looking at the health sphere and responsibilities for treatment and recovery?

**Dr Priyadarshi:** We really appreciate the support of the Scottish Government for the proposals around a safer drug consumption facility in Glasgow. Beyond that, there are two issues for me. In Scotland, we see reducing numbers of problem drug users engaged in treatment, and treatment care services struggling to manage the complex needs and person-centred care plans that we want to have for everybody in treatment. Two things that would be particularly helpful in that regard would be, of course, increased resources for services, and secondly, promoting the role of treatment in care and harm reduction in the continuum towards recovery—anti-stigma work around supporting services.

**Q238 Ged Killen:** I appreciate that you are not constitutional or legal experts, but if we get to a situation in which the Home Office will not change its mind on drug consumption rooms, is there anything more that we could do in Scotland to really test the boundary of that? Is there more room to manoeuvre than we are currently taking advantage of to trial these rooms in Glasgow, for example?

**Elinor Dickie:** As you said, we are not legal experts, so I am not sure on the exact mechanisms. However, Police Scotland introduced recorded police warnings for possession of small amounts of cannabis—cannabis only; no other drugs—which was largely a resource issue and a public interest issue, because it was not really worth pursuing those offences.

On drug consumption rooms and the possession of drugs on the premises, exploring whether those recorded police warnings for cannabis could be applied to other drugs may be one means to get around that issue of possession—so not pursuing those offences. We already see that around injecting equipment provision services. Police surveillance around those services has been deemed not in the public interest in England and in Scotland. The Crown Prosecution Service and the Lord Advocate have said that it is not within the public interest to pursue people going in and out of these services if they are accessing new equipment, and that really it is an opportunity for engagement. We should perhaps look at that in more detail, in terms of how the police implement these regulations.

**Chair:** We are very grateful to both of you. Thank you for a fascinating session. I think there are a couple of things that we have asked you for, which hopefully you will be able to provide the Committee with. If you observe anything as we continue to conduct the inquiry that you feel you could usefully contribute, please get in touch with us. For now, thank you for coming down today.