MRC/CSO Social and Public Health Sciences Unit


MRC/CSO Social and Public Health Sciences Unit Consultation Response

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| **Title of consultation** |
| Use and Misuse of Drugs in Scotland inquiry |
| **Name of the consulting body** |
| Scottish Affairs Committee |
| **Link to consultation** |
| https://[www.parliament.uk/business/committees/committees-a-z/commons-select/scottish-affairs-](http://www.parliament.uk/business/committees/committees-a-z/commons-select/scottish-affairs-) committee/inquiries/parliament-2017/misuse-drugs-scotland-17-19/ |
| **Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?** |
| It provided an opportunity to feed our research evidence and other relevant evidence into the Scottish Affairs Committee enquiry on the use and misuse of drugs in Scotland. |
| **Our consultation response** |
| * Contributors: Joe Tay, Martin Anderson, Mark McCann, Emily Tweed, Kathryn Skivington, Marcia Gibson * What are the unique drivers of drugs abuse in Scotland? How is drugs misuse in Scotland different from the rest of the UK?   + This may be the wrong question. It may be that the drivers for drug use are the same here in Scotland as in the rest of the UK, however the drivers of drug related death and other harms may be different. The distinction is important, as focussing on the latter more directly addresses the stark reality that there has been a 3 fold increase in drug-related deaths (DRD) from 267 in 1996 to 934 in 2017 in Scotland (McPhee et al., 2018).   + There is also strong evidence that Scotland’s high and climbing DRD rate is closely linked with structural inequality, with numbers in the most deprived area 23 times that of the least deprived area (McPhee et al., 2018).   + Relative inequalities (the difference between the most and least well-off regions) widened between 1981 and 2011 for all-cause mortality and for several causes of death in Scotland (Brown et al, 2019). A significant cause for this is deaths due to drug- and alcohol-related harms and male suicide have increased and at a faster rate in more deprived areas (Brown et al 2019, Parkinson et al., 2018).   + Scotland has experienced a number of social, economic and political changes in the 1980s which may have created a delayed negative health impact affecting a   cohort born between 1960 and 1980 (Parkinson Et al., 2018). |

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| * A key determinant of the extent of both drug harms and drug related deaths is responsiveness to public health crises as they arise. The HIV epidemic related to injecting drug use and homelessness started in 2015 in the context of drug treatment services being cut across Scotland by almost a quarter over the past few years (Burki, 2018). * To what extent does UK-wide drugs legislation affect the Scottish Government’s ability to address the specific drivers of drugs abuse in Scotland?   + It is important to recognise that the legal status of drugs - affecting their availability and sanctions for their use - is only one factor in the complex system that determines people’s likelihood of drug use, problem use, and drug-related harms. This is described well by Rhodes’ et al’s (2002) model of the risk environment, which recognises the multiplicity of factors from micro to macro in influencing the risks of drug-related harms. The risk environment model suggests it is important to attend to policy forces as drivers of drug-related harm, but these are much broader than just legislation relating to the control and classification of drugs, encompassing other policy areas – both reserved and devolved - such as education, the economy and labour market, social security, and urban planning.   + The fact that the UK Government has declined to review the Misuse of Drugs Act to permit the introduction of a safer drug consumption facility in Glasgow has   constrained that area’s ability to implement the full package of treatment and harm reduction interventions supported by the evidence base (Tweed et al, 2018), though this is more relevant to reducing harms rather than preventing drug use in the first instance.   * What is the relationship between poverty and deprivation and problem drug use?   + Evidence from survey and administrative data indicates a close relationship between poverty, deprivation, and problem drug use in Scotland. For instance, the Scottish Crime and Justice Survey (2014/15) found that people in routine/manual occupations or living in more deprived areas were more likely to have used or been offered drugs in the last year than their more advantaged peers, and among those who had used drugs in the last month, people from more socioeconomically disadvantaged groups were more likely to self-report dependency (Scottish Government, 2016). With regard to drug-related harms, people living in the most deprived areas of Scotland experience much higher rates of drug-related hospitalisation and drug-related death (Scottish Public Health Observatory, 2019).   + One (but by no means the only) mechanism linking poverty and deprivation and problem drug use (in particular, the excess mortality from said drug use) is complex trauma and adverse childhood experiences. Smith et al., (2016) present data which may support the hypothesis of childhood adversity affecting attachment processes and through this, adult personality, behaviour and resilience to stress correlating also with adult morbidity and mortality.   + Besides the adverse experiences of childhood poverty and socio-economic   deprivation themselves; adverse childhood experiences such as parental |

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| problematic substance use, suicide, mood disorders and other health conditions act as risk factors for children’s wellbeing. This, in turn, affects life course outcomes, such as health and social development, educational attainment, employment prospects.   * Some forms of childhood adversity are more prevalent in Scotland than the rest of the UK, including parental substance use, incarceration, suicide rates and numbers of children being taken into care. * Problem drug use has been linked to the fragmentation of traditional sources of social cohesion and support, with drug-using subcultures providing a form of substitutory psychosocial integration for those who have experienced the most severe social dislocation under global capitalism (Alexander, 2008). As such, problem use is most prevalent in marginalised communities (McPhee, 2018). Poverty and social exclusion are drivers of problem use and barriers to recovery; relapse may be a consequence of difficulty in securing a position in mainstream community life (Buchanan, 2004). A lack of resources at the community level restricts the likelihood of overcoming these barriers, as a significant component of ‘recovery capital’ involves community resources (Best and Laudet, 2010) which are scarcer in deprived areas. * The relationship between poverty and DRDs are elements of a broader complex system and risk environment. A complex systems model conceptualises health inequalities as outcomes of a multitude of interdependent elements, which cannot be solved with individual-level interventions. Interventions should aim to reshape whole systems in ways which produce favourable outcomes (Rutter et al., 2017). Problem AOD use takes place within a ‘risk environment’, including the relationships within drug-use social networks, the physical environments of the drug scene, and the political and legal context. A risk environment approach seeks not to change individuals but the social situations and structures individuals inhabit, creating ‘enabling environments’ through community-level interventions (Rhodes, 2002). Social network interventions, such as peer-led interventions, have been developed to improve network conditions influencing sexual health (Forsyth et al., 2018). Similar network interventions could be used to increase participation in overdose-prevention training (Wagner et al., 2013; Latkin et al., 2004). Network interventions may also promote recovery by helping people to develop recovery support networks (Litt et al., 2007; Mericle, 2014; Kee et al., 2017) * What role could reserved social security policy play in addressing problem drug use?   + The use of conditionality and sanctions in the social security system is reserved to Westminster. While government guidelines state that vulnerabilities such as drug addiction should be taken into account when developing a client’s Claimant Commitment, evidence from a large survey of homeless people suggests that these guidelines frequently are not implemented correctly (Reeve 2017). Indeed, a report commissioned by the DWP indicates that the most vulnerable clients are more likely to receive a sanction (Oakley 2014). Reports of street homeless drug users with no computer access being required to apply for 15-20 jobs per week   suggest that, in practice, understanding of the challenges faced is limited (Reeve |

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| 2017). Benefit sanctions applied for failure to comply with such requirements can hinder progress towards recovery and trigger relapse among this population (Johnsen et al 2018). It is unrealistic to expect individuals with deep-seated addiction issues to find and sustain employment before these issues are addressed (Bauld et al 2012). If activities associated with rehabilitation and recovery were treated as work-related activity for the purposes of the individual’s Claimant Commitment, it may be possible for the social security system to support problematic drug users in their journey towards recovery.   * Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland’s needs?   + Significant harm can be caused by social and drug policy, regardless of whether it is formulated in Westminster or Edinburgh. Monaghan (2012) identifies a moralisation of UK social and drug policy over a number of decades. In this, Scotland has not been immune.   + Duke et al., (2013) critically appraise the political context of the development of Scotland’s recovery-oriented treatment system in 2008 with the publication of its new drug strategy, The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem. The moralistic “anti-methadone” abstinence focussed stance that evolved from this policy was in keeping with public attitudes both in Scotland and the UK against spending taxpayers money on what was perceived as an undeserving group. There is however substantial evidence of the effectiveness of opiate replacement therapy such as Methadone programmes (MMT) in preventing the transmission of HCV and reducing associated morbidity and mortality (Platt et al., 2018), a significant decrease in injecting drug use, sharing of injecting equipment and HIV transmission (Karki et. al, 2016) .   + With DRD essentially climbing with every passing year since 2008, this drug policy was incongruent with the situation in Scotland. Yet it has only now been revised 11 years later.   + While further devolution of powers may indeed provide more flexibility in what can be done to address public health crises related to drug use as and when they occur (see below), it may not be as important as an evidence based, well-funded, non-judgemental application of existing harm reduction interventions.   + The harmonised administrative data linkage infrastructure across the UK provides large scale datasets that allow researchers to conduct natural experimental evaluations of health policies (Craig et al, 2017). The variation in policies between England and Scotland have facilitated the use of natural experimental methods to for the evaluation of Minimum Unit Pricing: [https://www.journalslibrary.nihr.ac.uk/programmes/phr/11300540/#/documentation](https://www.journalslibrary.nihr.ac.uk/programmes/phr/11300540/%23/documentation). Devolved variation in policy implementation - or phased roll-outs across jurisdictions of UK wide policies - provides the ability to conduct studies that gives evidence that provides learning for all jurisdictions. There is no equivalent to MUP, that is, there are no devolved policy levers for drugs other than alcohol. This suggests that UK-wide drugs legislation limits the opportunity of all UK jurisdictions   to evaluate the effectiveness of preventive measures to tackle drug use and |

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| harms. Further devolution would serve to improve tailored approaches for Scotland, and also the other jurisdictions.   * What could Scotland learn from the approach taken to tackle drug misuse in other countries?   + Overdose prevention sites (OPSs) are spaces for people to inject their previously- obtained illegal substances with sterile equipment in a setting where staff (often peers) can observe and intervene to prevent overdoses. These are also known as safer drug consumption facilities. In British Columbia, these sites were implemented as an emergency temporary measure to save lives without breaching existing federal illegal drug legislation pending approval of supervised consumption services. Rapid implementation of OPSs sites meant that within a few days to a few months approximately 20 sites were implemented across the province. The rapid implementation of OPSs is an international example of a responsive, novel service design combining the benefits of state-sanctioned injection services with community-driven implementation Wallace (2019).   + Safer drug consumption facilities have been recommended in Glasgow on the basis of evidence of effectiveness from other countries and evidence of local need. Their implementation has been stymied by existing legislation for the control of drugs, which is reserved to the UK Government. However, it is important to acknowledge that safer consumption facilities/overdose prevention sites are not a panacea and are only one element in what should be a comprehensive and holistic approach to the treatment of problem drug use and prevention of related harms.   + A grassroots movement for ‘visible recovery’ has developed in Scotland over the past decade, extolling the power of community in supporting long-term recovery. Recovery community building has been central to this movement, creating new forms of social organisation through which a marginalised group may redefine and assert themselves, such as recovery cafes and recovery walks (White, 2009; Best and Lubman, 2012). It is important that an emphasis on recovery is not co-opted into an attack on specialist treatment and harm-reduction, a significant risk given that the movement developed alongside the global financial crisis and subsequent austerity measures (Best, Alwis & Burdett, 2017). However, it creates an environment in which there is support for transferring and adapting novel forms of recovery intervention from international settings to the Scottish context, a key example being the IFDAS River Garden project, transferred from San Patrignano in Italy (Devlin and Wight, 2018).   + Swiss drug policy is devolved to each of the Cantons (states); the variation between cantons is considered a strength, as this approach to governance contributes to “the efficiency of public action” (Zobel, 2017). Combined with the UK’s health data infrastructure, devolved health policy making provides opportunities for efficient policy making, complemented by rigorous evaluation methods. |
| **When was the response submitted?** |
| Date here |

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| **Find out more about our research in this area** |
| Find out more |
| **Who to contact about this response** |
| Contact Details |

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