Record of Discussion - SDPC 12: Drug Related deaths
13th September, The Academy of Government

Record compiled by Anna Ross

Chair/facilitators: Anna Ross and Mike McCarron

Speakers: Roy Robertson

Participants:

- Aileen O'Gorman – The University of the West of Scotland
- Elinor Dickie – NHS Health Scotland
- Emma Crawshaw – Crew 2000
- Kenny Simpson – Police Scotland
- Leon Wiley – Hepatitis Scotland
- Mary Munro – Scottish Justice Matters
- Neil McKeganey – The Centre for Substance Use Research
- Rosalind Roux – Edinburgh University Students for Sensible Drugs Policy
- Roy Robertson – Partnership for Alcohol and Drugs, G.P.
- Suzanne Sharkey – Recovering Justice and LEAP
- Vicki Craik – Crew 2000

Main Outcomes

There was broad agreement on the following outcomes:

1. **PUBLIC ENQUIRY -** Call for a public enquiry, commission or citizens assembly into drug policy in Scotland involving all stakeholders and requiring mandatory participation from identified stakeholders. This reflects Recommendation 66 of the Commission for Parliamentary Reform report (2017, p.69) which advocates the use of deliberative processes. SDPC will work towards this in the coming months. It was also felt that in order to input into the current refresh SDPC should work with the Scottish Government to collect submissions from stakeholders currently not engaging in the process.

2. **UNIVERSAL INCOME –** there was across the board support for the implementation of the Universal Income. It is envisaged that the impact of the Universal Income would help reduce the financial instability experienced by many problematic drug consumers that results from benefit sanctions for missed appointments, inability to access the right benefit advise, etc. Furthermore, the Universal Income would help reduce the stigma and stress associated with being in receipt of benefits, allowing individuals to access employment and voluntary opportunities not currently available. Finally, it shifts the focus away from economic need to social need.

3. **HARM REDUCTION -** Implementation of effective harm reduction, including **harm reduction champions** similar to recovery champions. It is felt that currently Scottish harm reduction initiatives are not adequate. While there are embedded practices such as needle exchange and naloxone provision, harm reduction as a policy is not implemented across the board. Sub-optimal prescribing, the barriers currently being experienced in regards drug consumption rooms, low uptake of heroin assisted treatment, resistance to drug testing and decriminalisation of drug possession are all examples of inadequate harm reduction measures.

4. **LANGUAGE –** the language should move away from the language of recovery to the language of well-being, for example 'The Road to Well-Being'. This can incorporate recovery and abstinence but reflects the fact that not all drug consumers wish to become drug free, and moves the conversation towards more holistic approaches to the complex issues surrounding problematic drug use.

5. **FRUSTRATION –** there is deep frustration across all disciplines at the lack of political leadership in regards the implementation of non-controversial initiatives shown to reduce drug related harm. The reserved nature of some aspects of drug policy should not be a barrier to championing these initiatives.

6. **CURRENT POLICY IMPACT ASSESSMENT –** a impact assessment of the current policy, reserved and devolved, would be helpful in understanding what works, and what exacerbates problematic drug use.

7. **DRUG AMNESTY –** encouraging drug consumers to discuss their drug using habits with G.P.'s and support services by creating an amnesty of disclosure of drug use. This would help reduce the stigma associated with disclosure, and help doctors understand their patients drug using habits better, in order to prescribed and design individual treatment options.

8. **DRUG PROBLEMS ARE SOCIAL PROBLEMS –** more emphasis needs to be put on the role poverty and current austerity measures (such as the reduction in funding for drug services) are having on drug using patterns.

Introduction

Mike McCarron welcomed everyone and outlined the programme of conversation for the evening. The main focus of the evening was to reflect on what has been explored in recent meeting and committees of the numerous organisations impacted by the drug death statistics. Furthermore we aimed to explore options which are not currently being explored, or need to be looked at in more depth, with a view to informing the Scottish Governments 'overhaul' of the Road to Recovery.

Anna Ross then updated the group on her role with the Medicinal Cannabis Reform Scotland (MCRS) campaign and the questions it raises in regards the role of SDPC and its members. MCRS is a recently formed medicinal cannabis stakeholder group formed as a result of growing frustration at the lack of engagement with medicinal cannabis users despite it being SNP policy, and the fear that implementation of medicinal cannabis will result in pharmaceutical domination of the market, to the detriment of small business and patients. Anna's role in the campaign has been to advise and attempt to create dialogue between the different stakeholders.

The question this involvement raised was 'who is SDPC', is it the conveners (Anna, Mike and Aileen) or is it the wider membership base? If it is the wider membership base what role to the members play? It is possible that the role they play is one of encouraging collaboration, respectful dialogue and engagement from all parties pertinent to the issue being looked at, in this instance medicinal cannabis reform. It was agreed that this will be an ongoing discussion and highlights the independent and flexible nature of the Conversations.

The feedback generated some discussion on the current situation regarding drugs policy in Scotland. In particular there was frustration expressed by many at the lack of political leadership on issues such as medicinal cannabis, drug consumption rooms and heroin assisted treatment. Many stakeholders such as G.P's, pharmacists, treatment providers and support services have been heavily impacted by the recent reduction in funding, and while the announcement of 20 million in the drug field is welcomed, there is a lack of clarity on what this money will be spent on. Will it replace the funding gap that many organisations including ADP's experienced over the last few years?

Furthermore the Road to Recovery refresh, or overhaul, lacks focus and clarity at the moment, and clarity on the process would be welcomed.

Roy Robertson – presentation on the 2015/16 drug related deaths figures

- Numbers have gone up by 23% and that is a bit of a shocker – it has stimulated things and brought attention from the top of the leadership.
    - The deaths reported are actually lower than reality, partly to do with the coding and how it is recorded. There are other deaths where drugs are present but not the cause of deaths.
    - BBV's are not included. However, with alcohol they do a fractional calculation of all other deaths and include this in alcohol deaths and this would be a welcome move in relation to drug deaths.
    - The trend is upwards, and there has been a sharp increase over the last 3 years – but over the last 20 years it has been steadily going upwards.
- The aging cohort argument is convenient but the fact is there are still a lot of young people dying, and this cannot be attributed to the 'Thatcher effect'.
- Benzodiazepam figures are interesting, and even amongst physicians there was no agreement on what is a good policy in regards Benzodiazepam – plus no agreement on what is a non-toxic amount. Benzo's appear in a lot of deaths and new kinds which are synthetic and not available on prescription or licenced, therefore illegally imported or made locally.
- 4 main drugs implicated in drug deaths, but mainly opiates and poly drug use.
- Certain hot spots where the deaths are largely evident and reflect areas of deprivation.
- Prescription drug deaths have increased and despite being asked by the ACMD to control them, as a result of lobbying by Pfizer they are not.
- Methadone – how much is it implicated in drug deaths? Very few methadone related deaths, and those that were implicated it looks like the methadone was diverted, as opposed to prescribed.
- Scotland has the highest rate of deaths than any other country in Europe. European Drug Monitoring Centre's take is that more people take drugs in Scotland and therefore a higher mortality rate. Why do we have a bigger group? A legacy of Thatcher and poverty – plus new poverty.
- 300 deaths where NPS were implicated but often as part of other drugs.
- Future developments – What usually happens is a flurry of press and then it goes away. However, a build-up of tension and the refreshment of the RTR may open up the opportunity to create more collaboration and involvement from stakeholders such as G.P's.
- Consumption room authorisation has slowed down, and the Lord Advocate won't say anything about them.

After Roy's presentation there was a group discussion on the current situation regarding drug deaths the participants experience and opinion, and ideas on how to move forward. This is summarised below. **Points are not indicative of all opinion and reflect the broad range of experience and organisational knoweldge.**

- Figures are gathered and published every year and they make for sad reading. Organisations and departments could collect and publish quarterly results which would give a closer picture of what is going on and how to respond. However, there is a fear of publishing incomplete data resulting from institutional inability to build flexibility and shift into reporting outcomes.

- There is a lack of organisational understanding in many disciplines. This results in many cases where drug use and prevalence is underestimated, and frustration is building among different parties at the lack of coherence and inability to build a broad picture of the drug using landscape.

- The use of multiple definitions amongst organisations can prevent coherence. There needs to be an understanding/mechanism by which everyone can comprehend what the data means, and how to react.

- There is a feeling that, unlike previously, the issue of drug deaths will not go away. This is in part because drug deaths will continue to rise despite the best efforts of services, but also that the current systems is clearly not working and there needs to be a structured and coherent approach engaging all stakeholders and the broader public.

- There is support for the Ministerial Announcement and that the Government were prepared for the DRD's release and therefore pre-empted criticism by announcing a refresh.

- There is a frustration at the toxic determinism of some in regards drug harm. The focus on drug harm masks the context in which they are being taken: social inequality, austerity, lack of funding, lack of support services and broader social contexts such as the neo-liberal obsession with personal responsibility and control over one's own environment.

- The biggest challenge is the social contexts that encourages drug use. There should be a focus away from drugs as the issue, and a strong focus on the social contexts.

- in Scotland we are trying to address and respond to a cultural problem of **'dis-connection'** with a predominantly medical /pharmacological response - we need to adopt a wider more aspiration view and understanding of health for those at risk of 'drug related harm' …… Toxicology figures and statistics do not capture malnourishment , the effect of prolonged stress on health, stigma, and dis-connection from day to day life to enable health

- Interventions should include meaningful access to stable housing, employment, financial stability and psycho-social support. Although this is outlined in the Road to Recovery there are still barriers, such as funding, which prevent these interventions from being carried out properly.

- Financial incentives have been shown to work in some studies – although this was countered with the concern that it ties into benefit sanctions for failed drug tests, the result being an increase in drug related harm (from financial instability) as opposed to a decrease drug use – see further reports on Australian initiative.

- The persistent rise in drug related deaths may demonstrate a failure of harm reduction because despite harm reduction being implemented over the last few years it has failed to stem the increase. Importantly those who have sustained problematic drug consumption over decades do not respond to harm reduction initiatives. It must be noted that this opinion was not shared by all participants and rebuttals included:
    - Current harm reduction initiative have not been implemented properly or across the board resulting in poor outcomes for some areas and consumers.
    - Barriers to implementing effective harm reduction measures such as person centred (optimal) prescription and long term maintenance because of a moral reluctance to condone drug use, and/or provide drug consumers with their optimal dose. This is also compounded by the complexity in understanding what an optimal dose is: individual needs vary and there needs to be more honest and open dialogue with patients about the levels of drugs they need. Providing optimal dosing would decrease reliance on black market drugs. There is a feeling that many consumers 'top up' and have higher tolerance levels than us currently recognised, and that some deaths may be attributed to recovered clients relapsing and having lower tolerances.
    - There is conflict over the evidence of what works, and disagreement on what a successful outcome should look like. Abstinence or maintenance.
    - Journey should start with harm reduction, onto recovery and then abstinence, if that is what the consumer wants. Reducing the harm of drugs and encouraging the promotion of individual well-being should underlay all interventions.

- The focus on criminality is putting pressure on police resources when many drug related incidents should be a mental health/NHS intervention.

- Many, but not all, felt decriminalisation of all drug use should be implemented in order to reduce the stigma of drug use and to reduce pressure on the Police and the courts.

NEXT STEPS

After a short break and informal chats the group reconvened and separated into small groups to discuss outcomes based on the previous discussions. These are outlined in the main outcomes at the top of this document.

Crucially all participants supported a call for greater engagement and deliberative processes in regards drug policy, and this is supportive of Recommendation 66 of the Commission on Parliamentary Reform Report (2017, p.69) that deliberative processes and meaningful public and stakeholder engagement is incorporated into the parliamentary process.

The next SDPC will take place once we are clearer on the parameters of the refresh but no later than January 2018.