This briefing explores the issue of drug misuse in Scotland. It begins with an overview of the Scottish Government’s National Drugs Strategy before providing a summary of the prevalence and trends in drug misuse from the latest available data. It then covers approaches to the treatment of people with a drug problem and drugs services in Scotland. Current policy issues are discussed in the final section.

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EXECUTIVE SUMMARY

• In 2008, the Scottish Government published its National Drugs Strategy, *The Road to Recovery*. The strategy focuses on the concept of recovery and developing person-centred approaches to treatment (page 5).

• Drugs legislation is reserved to the UK Parliament. The Misuse of Drugs Act 1971 lists prohibited drugs and the penalties associated with their possession and supply (page 7).

• Surveys of the general population in Scotland show a reduction in the prevalence of drugs use among adults (aged 16-59) between 2008 and 2015. Illicit drug use is more prevalent among males and young adults aged 16-24 (page 10).

• Trends in drug use among children (13 and 15 year olds) also show a decline in the prevalence of drug use with a higher rate of drugs use among 15 year old boys (page 12).

• Cannabis is the most commonly used drug in Scotland and the UK in general. In 2015, 5% of adults in Scotland self-reported using cannabis in the last year and 10% of 15 year olds reported using cannabis in the last month (page 10–12).

• In Scotland, problem drug use is disproportionately high compared to England and other European countries. Problem drug use associated with the prolonged use of opioids and benzodiazepines, particularly among injecting users, are associated with the most severe health harms. Opioids were implicated in 89% of all drug-related deaths in 2015 (page 17).

• Problem drug use has strong links to poverty and deprivation. Individuals from deprived communities are more likely to have experienced psychological trauma and mental health issues. This can lead to the use of high-risk drugs to escape psychological stress and trauma (page 14).

• In the latest available data for 2015, there were 706 drug-related deaths registered in Scotland. This was the highest number ever recorded. 90% of these deaths involved the use of more than one drug (polydrug use) (page 19).

• There is a growing population of older people with a drug problem aged 35 or over. Many of these people have a prolonged history of drug use and suffer severe health problems such as viral infections as a result of needle sharing and mental health problems. 73% of drug-related deaths in 2015 were of individuals aged 35 or over (page 23).
Drug treatment services offer a range of treatments to reduce the physical harms of drugs, provide counselling and aid recovery. These include harm reduction strategies such as providing sterile needles to reduce blood-borne viruses and infection and replacement therapies to provide a stable withdrawal from drugs (page 25).

Plans for a facility that provides supervised injecting of drugs in Glasgow have been presented to the Glasgow City Integration Joint Board. A draft business plan was submitted in February 2017 with the request for approval to continue a formal evaluation of the proposal (page 38).

There are over 200 community and residential rehabilitation centres across Scotland. These centres provide detoxification support as well as treatment services and counselling (page 33).

Drugs designed to replicate the effects of illegal substances known as New Psychoactive substances (NPS) or “legal highs” have increased in popularity over the last decade. The importation and exportation of NPS and possession in a custodial institution is now illegal under the Psychoactive Substances Act 2016 (page 36).

In recent years, attitudes towards drugs legislation have changed both internationally and within the UK. In the USA, cannabis remains illegal under federal law but is now legal under state law in eight States. There have also been calls for reform of drugs legislation in the UK (page 39).

Internationally, there is no clear relationship between different approaches to drugs legislation and the prevalence of drugs use. However, approaches to decriminalisation in Portugal incorporating a shift towards health-based strategies has resulted in an increase in the number of people in treatment and a reduction in problem drug use and associated health effects (page 39).

**Definition of key terms**

Illicit drug use: The terms “illicit” and “illegal” are used interchangeably in this briefing. However, it is recognised that neither term is technically accurate under law. Consumption of drugs controlled under the Misuse of Drugs Act 1971 is not unlawful and neither is possession of substances under the Psychoactive Substances Act 2016.

Drug Misuse: This briefing adopts the World Health Organisation definition of drug misuse as “the use of a substance not consistent with legal or medical guidelines.” (WHO, 2006). However, this definition also does not take into account legal exemptions for consumption and possession outlined above.
INTRODUCTION

The use of illicit drugs can cause serious harm to individuals and communities. The majority of these harms are associated with people who develop a long-term addiction to high-risk drugs.

In Scotland, there are longstanding and serious problems associated with drug use which present significant challenges for law enforcement and the delivery of healthcare along with substantial costs to the Scottish economy. Furthermore, these problems are concentrated in the most deprived communities, where health inequalities and social exclusion make it harder for people to access specialist treatment.

This briefing begins by outlining the Scottish Government’s national drugs strategy. It then provides a summary of the prevalence and trends of drug use in Scotland, before discussing approaches to drug treatment and services available in Scotland. The final section highlights emerging trends and current policy issues.

THE SCOTTISH GOVERNMENT NATIONAL DRUGS STRATEGY

In 2008 the Scottish Government launched a new national drugs strategy, *The Road to Recovery*. The strategy was developed in acknowledgement of Scotland’s long-standing drug problem, and the perceived need for a fresh approach to addressing drug misuse. A brief summary of this strategy is provided below.

PERSON-CENTRED RECOVERY

Central to the strategy was an approach to tackling problem drug use based on the concept of recovery. This focussed on the need for a person-centred process, recognising that “recovery is most effective when service users’ needs and aspirations are placed at the centre of their care and treatment” (Scottish Government, 2008, p.23).

To implement this strategy the Scottish Government prioritised providing a range of treatment and support services at local level, allowing different routes to recovery. This included an emphasis on improving integration of health and social care services to address the physical, mental health and other needs of people with problem drug use.

PREVENTION

The strategy also recognised the importance of preventing drug misuse. This takes into account the need to tackle the wider factors affecting drug misuse such as health inequality, deprivation, homelessness and mental health. A key priority was information and education, with an emphasis on promoting health education in schools. This included continued funding for drugs information campaigns and implementing substance misuse education within the Scottish Government’s *Curriculum for Excellence* programme.

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1 The World Health Organisation (WHO) defines health inequalities as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes.
LAW ENFORCEMENT

The law enforcement strategy focussed on continuing efforts to reduce the supply of drugs. This included supporting the Scottish Crime and Drug Enforcement Agency (SCDEA) to gain a better understanding of the supply, availability and price of illegal drugs. The strategy also sought to strengthen legislation under the Proceeds of Crime Act 2002 to track down and recover profits from illegal drugs trafficking to be recycled into local communities.

Addressing drugs use in prisons was another priority. The strategy committed to continued efforts to reduce the supply of drugs into prisons through improved security measures but also emphasised the need to improve access to drug treatment services in prisons. The key aim was to provide an integrated package of care tailored to individual prisoners with continuity of care after discharge. Transfer of primary healthcare from the Scottish Prison Service to the NHS was also being reviewed as part of this strategy.

PROTECTING CHILDREN IN SUBSTANCE MISUSING FAMILIES

Lastly, the strategy focussed on addressing the risk of neglect and abuse of children in substance misusing families. It identified 3 main aims to improve the life chances of vulnerable children:

1. Improving identification, assessment, recording and planning and information sharing.
2. Building the capacity, availability and quality of support services.
3. Strengthening the consistency and effectiveness of the management of immediate risk.

The strategy also recognised the importance of dealing with needs of children affected by parental alcohol misuse.

ILlicit DRUGS AND THEIR EFFECTS

Drugs are chemical substances that affect the central nervous system altering the user’s feelings or perceptions. The appeal of drugs lies in the expectation that they will produce desirable affects. The Advisory Council on the Misuse of Drugs (ACMD, 2006) lists the following effects:

- generating or enhancing feelings of pleasure or relaxation
- diminishing pain, depression, sadness or fatigue
- increasing energy or concentration
- facilitating socialisation.

People take drugs for a variety of reasons: for pleasure, to treat physical or emotional pain, for stress or anxiety. Almost all substance use has a social element and users often report that one of their drivers for use is because their friends take drugs. The majority of people who experiment with illicit drug use will not go on to develop a long-term drug problem (SDF, 2007). The Scottish Government National Drugs Strategy identifies three broad categories drug users:

---

2 The SCDEA was subsumed under Police Scotland on 1 April 2013.
3 The responsibility for provision of healthcare to prisoners in Scotland was transferred from the Scottish Prison Service (SPS) to the National Health Service (NHS) on 1st November 2011.
The use of illicit drugs is associated with significant health risks. These risks are outlined in the health consequences section of this report.

**CATEGORIES OF CONTROLLED DRUGS AND THEIR EFFECTS**

When categorised according to their physical and psychological effects, there are seven main categories of drugs (Figure 1).

**UK LAW**

Drugs legislation is currently reserved to the UK Parliament. Drugs such as those listed in the outer wheel of Figure 1 are subject to the Misuse of Drugs Act, 1971 (MoDA 1971). This legislation was introduced to prevent the non-medical use of certain drugs. Drugs subject to the Act are known as “controlled” drugs. Controlled drugs are divided into three classes. Possession and supply of controlled drugs can lead to imprisonment and/or fines (Table 1). However, the consumption of controlled drugs is not an offence.

1. **Experimenters**: People who try legal and illegal drugs, including alcohol, tobacco, cannabis and psychostimulants. They are unlikely to be in touch with drug services, except for those providing information. These users will come from a mixed social and demographic background.

2. **Regular users**: Individuals typically using legal and illegal drugs regularly. These users are also from a mixed social and demographic background. They may have had some contact with drugs information services but are unlikely to have used any other drug service.

3. **Problem users**: People experiencing or causing social, psychological, physical, medical or legal problems because of their drug use. They are likely to be in touch with drug treatment services, although many will not.
Figure 1: The Drugs Wheel. Categories and effects of illegal drugs. Outer Ring: Substances controlled under the Misuse of Drugs Act 1971. Inner Ring: Substances controlled under the Psychoactive Substances Act 2016.

Source: The Drugs Wheel by Mark Adley based on a work at www.thedrugswheel.com (correct as of January 2017).
<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Possession</th>
<th>Supply &amp; Production</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class A</strong>: Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth).</td>
<td>7 years + unlimited fine or both</td>
<td>Life + unlimited fine or both</td>
</tr>
<tr>
<td><strong>Class B</strong>: Amphetamines, barbiturates, cannabis, codeine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (e.g. mephedrone, methoxetamine), ketamine.</td>
<td>5 years + unlimited fine or both</td>
<td>14 years + unlimited fine or both</td>
</tr>
<tr>
<td><strong>Class C</strong>: Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat.</td>
<td>2 years + unlimited fine or both (except anabolic steroids)</td>
<td>14 years + unlimited fine or both</td>
</tr>
<tr>
<td><strong>Temporary class drugs</strong>&lt;sup&gt;4&lt;/sup&gt;: Some methylphenidate substances (ethylphenidate, 3,4-dichloromethylphenidate (3,4-DCMP), methylamphetadine (HDMP-28), isopropylphenidate (IPP or IPPD), 4-methylmethylphenidate, ethylamphetamine, propylphenidate) and their simple derivatives</td>
<td>None, but police can take away a suspected temporary class drug</td>
<td>14 years + unlimited fine or both</td>
</tr>
</tbody>
</table>

Most drug offenders are convicted for unlawful possession. Although maximum penalties are severe, only around one in five people convicted of possession receive a custodial sentence (drugwise.org.uk).

**THE PSYCHOACTIVE SUBSTANCES ACT 1971**

The Psychoactive Substances Act (PSA) came into effect in May 2016. This legislation was introduced to outlaw the supply of drugs which were developed to be chemically different but have similar effects than those banned under the MoDA 1971. These substances are often (although misleadingly) referred to as “legal highs”.

The PSA makes it an offence to produce, supply, offer to supply, possess with intent to supply, import or export a psychoactive substance for human consumption. This includes purchasing substances online (import) and supplying to friends (social supply). There are a number of substances exempt from the legislation including, controlled drugs, medicinal products, alcohol, nicotine and tobacco products, caffeine and food. It is an offence to possess a psychoactive substance within a custodial institution. This includes staff and visitors.

The PSA differs from the MoDA in that the legislation is based on the psychoactive effect of substances, rather than their harms and that possession offences outside of custodial institutions are not outlawed. Offences and penalties are summarised in Table 2.

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<sup>4</sup> The government can ban new drugs for 1 year under a ‘temporary banning order’ while they decide how the drugs should be classified.
Table 2: Offences and penalties under the Psychoactive Substances Act (2016).

<table>
<thead>
<tr>
<th>Offence</th>
<th>Summary (Magistrates Court)</th>
<th>Indictment (Crown Court)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possession</td>
<td>Up to 12 months and/or a fine*</td>
<td>Up to 2 years and/or a fine</td>
</tr>
<tr>
<td>Possession in a custodial institution</td>
<td>Up to 12 months and/or a fine*</td>
<td>Up to 7 years and/or a fine</td>
</tr>
<tr>
<td>Possession with intent to supply</td>
<td>Up to 12 months and/or a fine*</td>
<td>Up to 7 years and/or a fine</td>
</tr>
<tr>
<td>Supply/offer to supply etc.</td>
<td>Up to 12 months and/or a fine*</td>
<td>Up to 7 years and/or a fine</td>
</tr>
<tr>
<td>Production</td>
<td>Up to 12 months and/or a fine*</td>
<td>Up to 7 years and/or a fine</td>
</tr>
<tr>
<td>Importation/exportation</td>
<td>Up to 12 months and/or a fine*</td>
<td>Up to 7 years and/or a fine</td>
</tr>
<tr>
<td>Failure to comply with a Prohibition or Premises notice</td>
<td>Up to 12 months and/or a fine*</td>
<td>Up to 2 years and/or a fine</td>
</tr>
</tbody>
</table>

Source: DrugWatch (2016).
*Summary convictions in Northern Ireland are up to 6 months and/or a fine

PREVALENCE AND TRENDS OF DRUG MISUSE IN SCOTLAND

Understanding the prevalence of illicit drugs use is difficult because much of the activity of the drug using population is hidden. Surveys of the general population can provide estimates of the prevalence of drug use, however it is important to recognise that bias may be introduced by under-reporting or non-response. Furthermore, general population surveys only include households and therefore do not capture individuals without a permanent address.

Results from the 2014/15 Scottish Crime and Justice Survey (SCJS) (Scottish Government, 2016) show that illicit drug use in Scotland is falling (Figure 2). In 2014/15 6.0% of adults reported using one or more illicit drugs in the last year. This rate has declined steadily from 7.6% in 2008/09.

Cannabis is the most commonly used drug with 5.0% of adults reporting use in the last year down from 6.2% in 2008/09. Among the 6% of adults who had reported using drugs in the last year, 80.7% said that they had used cannabis, 29.3% said they had used cocaine and 21.7% said they had used ecstasy.

Reported use of drugs ‘in the last year’ is higher among men (8.9%) than women (3.4%). Those aged 16-24 were more likely to report using drugs ‘in the last year’ (18.8%) compared to 8.3% of those aged 25-44, 2.7% aged 45-59 and 0.2% aged 60 or older.
Figure 2. Prevalence and trends of drugs misuse in Scotland

Drug Misuse Trends in Scotland

Percentage of adults who had used any drug in the last year

- 2008/09: 7.6%
- 2009/10: 6.8%
- 2010/11: 6.5%
- 2012/13: 6.0%
- 2014/15: 6%

Drug use is falling

Rates of adults who reported using drugs in the last year

Drug class
- CLASS A: 2.6%
- CLASS B: 5.2%
- CLASS C: 0.5%

Gender
- Men: 8.9%
- Women: 3.4%

Since 2008/09
- Men: 2.2% pts.
- Women: 1.0% pts.

Age
- 16-24: 18.8%
- 25-34: 8.3%
- 35-44: 2.7%
- 45-59: 0.1%
- 60+: 0.2%

Since 2008/09
- 16-24: 4.7% pts.
- 25-34: 1.8% pts.
- 35-44: 0.1% pts.
- 45-59: 0.3% pts.

Drug choice
- Cannabis: 5.0%
- Cocaine: 1.8%
- Ecstasy: 1.3%

Since 2008/09
- Cannabis: 1.2% pts.
- Cocaine: 0.9% pts.
- Ecstasy: 0.5% pts.

Polydrug use
- Of adults who had taken drugs in the last year
- 65% had consumed alcohol at the same time
- 51% had taken more than one drug at the same time

Source: Scottish Crime and Justice Survey (2014/15)

Icons made by Freepik from www.flaticon.com
DRUG USE AMONG CHILDREN AND YOUNG PEOPLE

Trends in this section are taken from the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) (Scottish Government, 2016b). This survey provides estimates for the prevalence of drug use among S2 (13 year olds) and S4 (15 year olds) pupils from schools across Scotland.

Results from this survey show that the majority of pupils have never used drugs (95% for 13 year olds and 81% for 15 year olds). There has been a general decrease in the proportion of children reporting drug use since 2002 (Figure 3). However, more recently there has been a small increase in the proportion of boys who took drugs (from 11% in 2013 to 13% in 2015). 15 year old boys were more likely to have taken drugs than 15 year old girls (13% for boys and 9% for girls).

Figure 3: Proportion of pupils who have used drugs in the last month, by age and gender (1998-2015).

Cannabis is the most widely used drug; 10% of 15 year olds had used cannabis in the last month and 17% had used it ever. Among 15 year olds, there has been an increase in the number of pupils who say they have ever taken ecstasy (5% in 2015, compared with 2% in 2013) or cocaine (4% in 2015, compared with 2% in 2013). 27% of 13 year olds and 40% of 15 year olds had been drinking alcohol and 16% of pupils had used more than one drug (including alcohol) (polydrug use) the last time they used drugs.

The proportion of pupils who had ever been offered drugs declined between 1998 and 2013. However, since 2013 there has been a 5% increase in the proportion of both 13 and 15 year olds who have ever been offered drugs.

HEALTH CONSEQUENCES

The nature and severity of health effects associated with drugs misuse depends on the type and prevalence of drug use. Data from ISD Scotland show that in 2015/16, opioids were associated with two-thirds (62%) of drug-related general acute hospital stays. Sedatives and hypnotics
accounted for 98% of emergency admissions and psychiatric stays were most commonly associated with multiple/other\(^5\) drugs (54%) (ISD, 2016a).

An overview of common acute adverse health effects associated with illicit drugs is shown in (Figure 4). More detailed information on health effects can be found in the 2011 Department of Health report *A summary of the health harms of drugs* (Jones et al., 2011).

**Figure 4: Examples of adverse acute and psychiatric health effects associated with drug misuse.**

![Health Effects of Illicit Drugs](image)

*Source: Jones et al., (2011)*

\(^5\) The ‘multiple/other’ drugs category includes hallucinogens, volatile solvents, multiple drug use and use of other psychoactive substances (e.g. ecstasy).

**Drug use and mental health**

Dual diagnosis of substance misuse and mental health problems is common. The prevalence of psychiatric comorbidity among drug users in Europe varies depending on the study but is considered to be around 50%. The most frequent psychiatric comorbidities among people who use drugs are major depression, anxiety and personality disorders (EMCDDA, 2015a).

Although co-occurrence of drug misuse and mental health problems is common, establishing which came first and why can be difficult. The National Institute on Drugs Abuse *report on comorbidity* (NIDA, 2008) list the following key considerations:
The EMCDDA review on comorbidity of substance use and mental disorders in Europe provides a more detailed overview on co-occurrence of drug misuse and mental health problems.

It is recognised that individuals with dual diagnoses require integrated psychiatric and addiction treatment. The Department of Health guidelines Drug misuse and dependence: UK guidelines on clinical management and Dual diagnosis good practice guide provide further guidance for treatment.

In 2006, The Scottish Executive published research into existing service provision for people with co-existing mental health and substance misuse problems in Scotland. It found that, with notable exceptions, the care that services provided was unsatisfactory and inadequate. It recommended that specialist staff should be based within mainstream mental health and/or substance misuse services and not necessarily reside in stand-alone specialist co-morbidity teams (Hodges et al., 2006).

POVERTY AND PROBLEM DRUG USE

The onset of problem drug use in Scotland can be traced back to the early 1980s when illegal drug taking became endemic in large cities and urban areas. The rise in heroin use coincided with the opening of a new supply route in Iran and Pakistan in the late 1970s and a rise in unemployment associated with deindustrialisation. During this time, problem drug use spread to young, unemployed users in socially deprived communities (Pearson, 1987; Yates, 2002; Buchanan and Young, 2000; Buchanan, 2006).

Today, Scotland still has concentrated areas of intense deprivation where inequalities in health, employment, education and access to services persist. Evidence indicates that individuals from deprived communities are more likely to suffer health problems from drug use. For example, in the most deprived quintile\(^6\) drug-related hospital admissions in 2015/16 were 14 times higher than in the least deprived quintile (Figure 5).

There are strong links between poverty, deprivation, inequalities and problem drug use (SDF, 2007). However deprivation does not directly cause addiction and the links between poverty and drug misuse are complex (ACMD, 1998). The main mechanisms that are described as credible links between deprivation and problem drug use are:

\(^6\) Quintile refers to the Scottish Index of Multiple Deprivation (SIMD) which assesses 38 indicators of deprivation. Rates are reported by ‘quintiles’. Quintiles divide the population into five equal proportions so that 20% of the population falls into each quintile.
- Weak family and social bonds
- Psychological discomfort/personal distress
- Low employment opportunities
- Few community resources

Deprivation may lead to psychological and emotional harm through increasing levels of stress brought on by financial worries, unemployment and housing. These factors can result in a lack of choices and control on life that can explain the need to consume psychoactive substances for their psychological effects to reduce stress and anxiety (SDF, 2007).

**Figure 5: Number of drug-related general acute hospital stays in Scotland in 2015/16 by deprivation quintile.**

![Graph showing number of drug-related general acute hospital stays in Scotland in 2015/16 by deprivation quintile.]

Source: Information and Statistics Division (ISD) Scotland

In the most recent data, around half of patients with either a general acute or psychiatric stay in relation to drug misuse lived in the 20% most deprived areas in Scotland (National Statistics, 2016a).

**ECONOMIC COST**

A Scottish Government report *Assessing the Scale and Impact of Illicit Drug Markets in Scotland* (Scottish Government, 2009a) estimated the total economic and social cost attributable to illicit drug use in Scotland was around £3.5bn in 2006 (Figure 6). Problem drug use accounts for the largest proportion (96%) of total estimated costs to the economy from illicit drug use.

The largest share of economic costs is associated with wider costs to society. These costs include the cost of premature death and the cost to victims of crime perpetrated by people with a drug problem.

Costs to the economy also include absences from work, lost productivity due to unemployment and lost output due to premature death which accounts for the largest estimated cost (£33 million). Absences from work are the only case where recreational use accounts for a higher proportion of costs (£15 million).

The healthcare costs of visits to accident and emergency by problem drug users each year is estimated at £10 million and drug treatment is estimated at £23 million.
Fraud and forgery committed by problem drug users accounts for the highest criminal justice costs (£190 million) and the cost of arrests for breach of the peace are estimated to cost £7 million.

There are no recent estimates on the economic costs associated with drug misuse. Therefore the overall cost to the economy is likely to have increased over the last decade, in part due to better recording.

Figure 6: Estimated economic cost to the Scottish Economy as a result of problem and recreational drug use.

Source: Scottish Government (2009)
PROBLEM DRUG USERS

People who use drugs can be broadly categorised into recreational and problem drug users. Recreational drug use is uniform across the spectrum of social advantage and disadvantage.

Problem drug use in Scotland is associated with the use of opioids (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines, and implies routine and prolonged use. These drugs are associated with the most severe health consequences of all illicit drugs and have the largest share of drug-related deaths and hospital admissions. Problem drug use of other substances, notably cocaine and alcohol, are not included in statistics on problem drug use.

Of the 706 drug related deaths registered in 2015, opioids were implicated or potentially contributed to death, in 606 cases. Around two thirds (62%) of drug misuse general acute hospital stays in 2015/16 were associated with opioids (ISD, 2016a). Figure 7 shows the latest available estimates of the prevalence of problem drug use across Scotland for each council area. Estimates are reported every 3 years in Scotland. The 2015/16 study is underway and is expected to be published in 2018.

For individuals, the pathways to problem drug use can be complex, involving a combination of psychological, biological and environmental factors (ACMD, 2006). However, evidence indicates some common links associated with problem drug use such as those described in the sections on poverty and problem drug use and drug use and mental health.
Figure 7. Estimated prevalence of problem drug use in Scotland.

Estimated Prevalence of Problem Drug Use by Council Area in 2012/13

5 Highest Prevalence Rates

Source: Data from ISD Scotland (2014).
**DRUG-RELATED DEATHS**

In this section, trends in drug-related deaths are based on data from National Records of Scotland (NRS). The latest available data provides information on DrDs in 2015. A summary of these findings is provided in the Drug-related deaths in Scotland in 2015 report (NRS, 2016). Data for 2016 are due to be published in August 2017.

In 2015 there were 706 drug-related deaths\(^7\) registered in Scotland (Figure 8). This was the largest number ever recorded and more than double the number in 2005 (336 deaths).

Males accounted for 69% of drug-related deaths in 2015. Heroin and/or morphine were implicated in, or potentially contributed to, the cause of 345 deaths (49% of the total). Opioids (including heroin/morphine and methadone) were implicated in, or potentially contributed to, 606 deaths (86%)\(^8\).

The increase in the number of drug-related deaths can largely be attributed to the growing population of older problem drug users aged 35 and over. Figure 9 shows 5-year averages for drug related deaths registered in Scotland for individuals aged 15-34 and 35 years and over. In the younger age group, deaths have remained at a relatively constant rate of between 190-250 deaths and show a decreasing trend since 2011. Among older people aged 35 and over, drug-related deaths have increased year-on-year from 69 deaths in 2000 to 397 in 2015.

\(^7\) Based on the UK Drugs Strategy definition where the underlying cause of death is due to 'mental and behavioural disorders due to psychoactive substance use' or where a drug listed under the Misuse of Drugs Act (1971) was known to be present in the body at the time of death. Full details of the definition are provided in NRS (2016) report.

\(^8\) The percentages add up to more than 100 because more than one drug was implicated in, or contributed to, many of the deaths.
Figure 8: Trends in drug-related deaths in Scotland.
VULNERABLE GROUPS

In a 2010 report by the Scottish Drugs Forum a number of vulnerable groups are identified (SDF, 2010). They state that injecting drug users are 15 times more likely to overdose than non-injectors. Risk of overdose is especially high when tolerance is reduced due to periods of reduced use or abstinence. People who have recently been discharged from hospital or released from prison are particularly vulnerable. Older drug users who have been using drugs for a long period of time are more likely to overdose due to health problems (SDF, 2010). Other vulnerable groups include:

- polydrug users (including people who drink alcohol with other drugs)
- people who have suffered recent trauma or psychological problems
- people who have recently begun Opioid Replacement Therapy.
- people who have recently been discharged from treatment services.

SCOTLAND COMPARED WITH THE REST OF THE UK AND EUROPE

The Crime Survey for England and Wales (CSEW) provides information on the prevalence and trends of illicit drugs use for the rest of the UK excluding Northern Ireland. This provides comparable data to the Scottish Crime and Justice Survey. Results from the 2014/15 surveys show little difference in the proportion of adults aged 16-59 reporting using drugs of any kind in the last year in Scotland (8.5%) and England and Wales (8.6%).

The UK Focal Point on Drugs provides an annual review of the UK drug situation. The latest edition published in 2015 provides estimates for the number of problem drug users (referred to as “high risk drug users”\footnote{Estimates of high risk drug use in the UK are derived using two indirect measurement techniques: the capture-recapture method; and the multiple-indicator method. The drugs, data and time periods and definitions used in these estimates differ across the administrations. For further details of these differences, see pages 54-55 of the UK Focal Point on Drugs report.}) in England, Scotland and Wales. A comparison of these figures is
shown in Table 3 below and shows that the rate of high risk drug users in Scotland is double the rate for England but similar to the rate for Wales.

Table 3: The estimated number of high risk drug users: number and rate per 1,000 population aged 15 to 64, in the UK.

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimate</th>
<th>95% Confidence Interval</th>
<th>Rate (per 1,000 population)</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>293,879</td>
<td>291,029 - 302,146</td>
<td>8.4</td>
<td>8.3 - 8.6</td>
</tr>
<tr>
<td>Scotland</td>
<td>59,500</td>
<td>57,500 - 61,600</td>
<td>16.8</td>
<td>16.3 - 17.4</td>
</tr>
<tr>
<td>Wales</td>
<td>30,443</td>
<td>23,172 - 38,809</td>
<td>15.7</td>
<td>12.0 - 20.0</td>
</tr>
</tbody>
</table>


In 2013, Scotland had a drug-related death rate of 147 cases per million population among adults aged between 15-64\(^\text{10}\). This was one of the highest rates in Europe when compared to the most recent trends for 2013 ([Figure 10](#)). However, it is important to note that calculating rates based on the whole population, the majority of whom do not use drugs, does not provide a reliable indication of the risk of death by drug overdose ([NRS 2016; p.21](https://www.gov.uk/government/publications/national-record-of-statistics-2016)). The rate of drug-related deaths is more comparable to other European countries when considering the size of the drug using population. Comparisons between European countries is also challenging due to differences in reporting and coverage ([EMCDDA, 2016a](https://www.emcdda.europa.eu/)).

**Figure 10:** Rates of drug related deaths per million population among adults aged (15-64) in 10 countries reporting the highest values in 2013.

Source: [EMCDDA](https://www.emcdda.europa.eu/)

\(^{10}\) Based on 518 deaths among adults aged 15-64 ([National Records Scotland](https://www.nrscotland.gov.uk/)) and a mid-year population of 3,526,673 for the same age group and year ([National Records Scotland](https://www.nrscotland.gov.uk/)).
OLDER PEOPLE WITH A DRUG PROBLEM

A high proportion of problem drug users are aged 35 years and older. In Europe, available data show that the total number and the proportion of older chronic, problematic drug users have increased significantly over the last decades (EMCDDA, 2010a). In Scotland, the latest available estimates show that the proportion of all male problem drug users aged 35 to 64, increased from 43% in 2009/10 to 51% in 2012/13 (ISD, 2014).\(^\text{11}\) In this age group, drug users are more likely to have prolonged history of drug use and exhibit health problems generally associated with people in the general population who are fifteen years older (Vogt, 2009). The most recent data from ISD in 2014/15 shows that:

- The proportion of people aged 35 years and older being admitted to hospital for drug-related general acute stays was twelve times higher than in 1996 (Figure 11).
- This age group now accounts for the largest proportion (60%) of all drug-related hospital admissions.
- 73% (513) of drug related deaths registered in 2015 were for individuals 35 years and older.
- In 2014/15, almost half (48%) of individuals assessed for specialist drug treatment were aged 35 and over, compared with one-third (30%) in 2006/07.

There is an ageing group of older problem drug users that will grow in size in the coming years. It is estimated there are over 30,000 problem drug users over the age of 35 in Scotland (SDF, 2016).

**Figure 11: EASR\(^{12}\) rate of general acute hospital stays per 100,000 (EASR with diagnosis of drugs misuse 1996-2016 by age group).**

Source: Data extracted from the Drug-Related Hospital Statistics Database (ISD Scotland).

\(^{11}\) The proportion can only be given for males as the number of females was too small to provide accurate age breakdowns.

\(^{12}\) European Age and sex Standardised Rates (EASR) are standardised to the European Standard Population 2013. EASR allows comparisons across geographical areas by controlling for differences in the age structure of local populations.
**DRUG USE IN PRISONS**

In 2011, responsibility for health care in prisons was transferred from the Scottish Prison Service (SPS) to NHS Scotland. The transfer was driven by the need to reduce health inequalities for people in prison, improve equity of access to health care, improve continuity of care for people when they enter or leave prison, and to have a more sustainable health service (Royal College of Nursing, 2016).

A health care needs assessment carried out in 2007, which was used to inform the decisions to transfer health care to the NHS, showed that the health of prisoners was worse than the general population. The prevalence of addiction and mental health issues were particularly high (Table 4).

**Table 4: Comparison of health needs of people in prison compared to the community.**

<table>
<thead>
<tr>
<th></th>
<th>Prevalence on admission to prison</th>
<th>Prevalence in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol problems</td>
<td>41% male / 36% female</td>
<td>13% male / 7% female</td>
</tr>
<tr>
<td>Illegal Drug Use</td>
<td>67%</td>
<td>8%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>9% male / 36% female</td>
<td>0.5%</td>
</tr>
<tr>
<td>Depression</td>
<td>25%</td>
<td>5%</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>66% approx</td>
<td>5% approx</td>
</tr>
</tbody>
</table>

Source: Prison Healthcare Advisory Board. Data from Graham (2007). Table adapted from Royal College of Nursing (2016).

An online survey of 108 members of the Royal College of Nursing (RCN) who work in criminal justice nursing was conducted in 2016 to review the transfer of healthcare to the NHS. Of the 43 respondents who were employed by the SPS prior to the transfer of healthcare to the NHS, 41% thought that addictions services had improved since the transfer while 19% thought things had worsened (RCN, 2016).

The national standard for drug and alcohol treatment waiting times require 90% of people to receive specialist drug and alcohol treatment services within 3 weeks of referral. The most recent ISD report was published in December 2016 and shows a high proportion of people receiving early access for their first drug or alcohol treatment in the quarterly trend over the past two years. For the 4,282 people seeking drug treatment between July and September 2016, 93.7% waited three weeks or less. In prisons this figure was 97.7% for the 1,116 people who began drug treatment over the same period. All NHS Boards, except NHS Borders, NHS Highland, NHS Lothian and NHS Shetland met the Scottish Government’s Local Delivery Plan Standard (ISD, 2016b).

However, in the 2011 SPS prisoner survey (Carnie and Broderick, 2011), 41% of prisoners reported that they were given the chance to receive treatment for drug use and 36% said they received treatment during their sentence. In 2015, this had decreased to 28% reporting they were offered treatment and 24% reporting they received treatment (Carnie and Broderick, 2015).
Addiction Prevalence Testing (APT) is conducted across all Scottish prisons annually. During one month of the year, prisoners arriving in custody are tested for the presence of illegal drugs. Similarly, those leaving custody during the month are tested to assess progress towards the 'reduced or stabilised' offender outcome. These tests also provide a useful indicator of the prevalence of drug misuse in the community.

Trends over the last five years show an increase in the proportion of prisoners testing positive for illegal drugs between 2011/12 and 2013/14 from 70% to 77%. During the same period, the proportion of prisoners testing positive on leaving custody also increased from 20% to 25%. This continued to rise to 29% in 2014/15 despite a 7% fall in the proportion of prisoners testing positive on entering custody (Figure 12).

Figure 12: Percentage of prisoners testing positive for illegal drugs when entering and leaving custody by year.

Source: SPS Addiction Prevalence Testing statistics. Available at ScotPHO.

TREATMENT AND RECOVERY

HARM REDUCTION

Harm reduction is a term that defines policies, programmes, services and actions that work to reduce the health, social and economic harms to individuals, communities and society associated with drug misuse (Newcombe, 1992). A harm reduction approach recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug use. This is by a range of measures such as reducing the sharing of injecting equipment, providing support for stopping injecting, and providing substitution opioid drugs for people who use heroin with support for abstinence from illegal drugs. (NHS, 2010). These approaches neither exclude nor presume a treatment goal of abstinence (EMCDDA, 2010b).

Opioid Replacement Therapies

Opioid Replacement Therapies (ORT) substitute the use of illegal opiates such as heroin with synthetic alternatives. They are prescribed to treat opioid dependency with the aim of providing
a withdrawal regime, or to achieve stability to reduce drug use and crime and improve health (British National Formulary, 2017). Medications used in ORT provide a milder, less euphoric and less sedating effect than those associated with heroin. They also last longer allowing someone who has perhaps been using heroin several times a day to take their medication only once a day.

The international evidence base shows that ORT is effective at improving health, reducing crime and improved retention in treatment – a protective factor against drug-related deaths. Evidence is particularly strong for improvements in physical health and reducing the risk of HIV and other blood-borne viruses (Lind and Roberts, 2013).

A long-term study of 794 patients receiving ORT treatment in Edinburgh from 1987-2007 found that morbidity and mortality improved – especially in those in treatment for more than five years. However, the study also found that although ORT patients were less likely to die, they were also less likely to become abstinent (Kimber et al., 2011).

Although the evidence is clear that ORT improves health and stability of drugs users, its effectiveness is dependent on the delivery of services. Attendance, treatment dose and the quality of therapeutic relationships are particularly key to the success of treatment. However, there is a lack of high-quality research in the UK to assess how international evidence relates to UK practice (Lind and Roberts, 2013).

**Methadone and Buprenorphine**

Methadone and buprenorphine are both approved for the treatment and prevention of withdrawals from opioids. The Department for Health and the devolved administrations provide [UK clinical guidelines](#) for ORT treatment. They state that:

“It is generally agreed that there is less risk of opioid overdose associated with the use of buprenorphine than with oral methadone, although the former has greater potential for misuse by injection and intranasally.” (p.46).

On effectiveness they also state:

“Evidence suggests that methadone is more likely to retain patients in treatment but the evidence for the relative effectiveness of methadone and buprenorphine at preventing illicit opioid misuse is mixed.” (p.48).

These guidelines also highlight that due to the different risks, properties and potency associated with either drug, the following factors that should be considered when deciding an appropriate medication:

- Level of opioid use.
- Safety, for example likelihood of diversion and overdose risk.
- Patient experience with both illicit and prescribed medications, treatment history and response.
- Patient preference.
- Retention and treatment compliance.
- The prescriber’s experience with different medications.

Widespread use of methadone in Scotland began in 1988 as a public health response to high HIV rates among heroin injectors in Edinburgh and Dundee. At present, methadone is the most commonly prescribed drug used in ORT in Scotland (ISD 2016a).
Although methadone is considered to be effective in ORT, it is not free from risk and can lead to overdose death, particularly when obtained illegally, where dosage cannot be monitored or when used in combination with other drugs. This has led to criticism of the methadone programme from the Scottish media and concerns over the use of methadone were raised in a debate in the Parliament on the National Drugs Strategy. An independent review of ORT in Scotland was commissioned in 2012 as a result of these concerns (Lind and Roberts, 2013). This review stated:

“International expert opinion recognises that some in ORT treatment may continue to use illicit drugs sporadically and it is possible that for maximum long term benefit some may require to receive ORT indefinitely. This review is of the view that, for those in these circumstances, this outcome – long-term ORT – should not be considered a failure. Indeed, any intervention which helps to stabilise such a complex picture can help shift people to a position where they can begin to accumulate positive recovery capital to help them move towards their recovery goals – a view supported by the majority of those experts in the area of recovery from around the world.” (p.106).

Heroin Assisted Treatment

In addition to ORT, it is possible for licensed practitioners to offer Heroin Assisted Treatment (HAT), i.e. the prescription of pharmaceutical grade heroin as opposed to synthetic opioids. Randomised Injectable Opiate Treatment Trials (RIOTT) conducted supervised heroin treatment in three NHS clinics in London, Darlington and Brighton between 2010 and 2012. Researchers reported reductions in street heroin use and substantially reduced criminal activity along with savings in legal, prison and healthcare costs that more than cover the cost of treatment (Metrebian et al., 2014; Strang et al., 2015). These studies conclude that HAT has a place, in addition to ORT, for a small proportion of chronic heroin addicts in the UK. This has more recently been supported by the ACMD. There are currently proposals to introduce HAT in Durham and Glasgow.

Needle exchange services

Needle sharing among drug users is a common route of viral and bacterial infections (e.g. Hepatitis B, C, HIV, Anthrax etc.). The purpose of needle exchange service is to promote safe injecting practice and reduce the risk of infections. These services are offered free of charge in Injecting Equipment Provision (IEP) outlets across Scotland. A total of 4,376,456 needles were distributed in Scotland in 2014/15 (71 needles per problem drug user), compared to 4,437,672 (80 per problem drug user) in 2007/08 (ISD Scotland 2016). HIV infection is uncommon among people who inject drugs in the UK, with HIV prevalence among people who inject drugs in the UK low compared with many other European countries (EMCDDA, 2013a). A report by Public Health England shows that in Scotland, sharing of needles and syringes in the previous month fell from 22% during 2006-07 to 15% in 2014-15 among individuals attending drug treatment services, while in England, Wales and Northern Ireland sharing of needles and syringes fell from 28% of those surveyed in 2005 to 16% in 2015 (Figure 13). Among those attending needle and syringe programmes in Scotland during 2015-16, 1.9% were HIV antibody positive. The noticeable increase in the number of HIV diagnoses in 2015 was due to a recognised outbreak, primarily within the Greater Glasgow & Clyde NHS Board area. This outbreak occurred despite a steady rate in the estimated number of needles distributed per problem drug user in Glasgow and Clyde between 2008-15 (ISD Scotland, 2016c).

13 Per problem user figures are based on the number of problem drug users estimated in 2012/13 (ISD 2014).
Figure 13: Prevalence and trends of needle sharing risks and behaviours in Scotland.

Needle & syringe sharing and bacterial infection

- **6%** Reported sharing needles or syringes in the last month in 2014/15*
- **4% pts.** Since 2008/09
- **20%** Of people who had injected drugs in the last year reported symptoms of bacterial infection in 2015**
- **8% pts.** Since 2013/14

Trends in viral infections

- Percentage hepatitis C antibody positive**:
  - 2008/09: 23%
  - 2010: 24%
  - 2011/12: 20%
  - 2013/14: 22%
  - 2015: 30%

- Reported number of new HIV infections**:
  - 2008: 18
  - 2009: 17
  - 2010: 18
  - 2011: 18
  - 2012: 14
  - 2013: 22
  - 2014: 23
  - 2015: 50

National Naloxone Programme

Naloxone is a drug which rapidly reverses the effects of a potentially fatal opioid overdose. Scotland was the first country in the world to announce a National Take Home Naloxone Programme (NNP), which ran from April 2011 to March 2016. Individuals at risk of opioid overdose can be supplied with naloxone. Training is delivered by a range of staff: nurses, pharmacists, voluntary-sector workers and peer trainers, and takes place typically in community substance misuse services, pharmacies and prisons (Bird et al., 2016). Information on Naloxone...
Training is available on the [Scottish Drugs Forum website](#) and the [official website of the Scottish National Naloxone Programme](#).

The NNP targets [vulnerable groups of drugs users](#), particularly individuals being released from prison or discharged from hospital. Over the duration of the five year NNP, ISD Scotland produced annual monitoring reports. Figures from the [2015/16 NNP Monitoring Report](#) (ISD, 2016c) show that a total of 29,309 THN kits were issued over the five years from 2011/12 to 2015/16 through prisons and the community. During this period there has been a significant reduction in opioid-related deaths within 4 weeks of prison release, from a baseline of 9.8% in 2006-10 to 4.7% in 2015\(^{14}\) (Figure 14).

**Figure 14: Trends in opioid-related deaths after prison release or hospital discharge compared with number of THN kits issued between 2011 and 2015.\(^{15}\)**

Source: [ISD Scotland (2016d)](#)

\(^{14}\) These figures should be treated with caution due to the relatively small numbers (for example, 18 deaths in 2013 and 14 deaths in 2014). Figures are relative to an overall increase of opioid-related deaths.

\(^{15}\) NB: individuals released from prison may also have obtained naloxone from community services.
The number of opioid-related deaths within four weeks of hospital discharge has fluctuated around the baseline level since introduction of the NNP. There has been no statistically significant reduction since 2011 (ISD, 2016c). The reasons for the comparative lack of reductions in opioid-related deaths on hospital release are unclear. One suggestion is that it is a lack of awareness of the high risk of drug-related death on hospital discharge compared to release from prison (Bird et al., 2016).

RESIDENTIAL DETOXIFICATION AND REHABILITATION

The primary aim of residential detoxification is to provide the means for safe withdrawal from a drug of dependence. Residential rehabilitation programmes aim to support individuals to attain a drug-free lifestyle and be re-integrated into society. Typically, they provide intensive psychosocial support and a structured programme of daily activities which residents are required to attend over a fixed period of time (Scottish Government, 2004).

Detoxification programmes range between a few days to a few weeks and rehabilitation from 2-3 months to a year. Completion rates for residential detoxification programmes are high (around 75-80%). However, relapse following treatment is common. A Scottish Government review of residential detoxification and rehabilitation services for drug users (Scottish Government, 2004) identifies four main factors that influence the effectiveness of residential treatment:

1. **Time in Treatment**: Residential rehabilitation programmes of at least three months duration are more effective than shorter programmes.

2. **Retention**: Those who complete residential rehabilitation programmes have significantly better long-term outcomes than those who leave prematurely. Unfortunately, residential rehabilitation programmes have high drop-out rates. Studies have shown that one-quarter of clients leave within two weeks of entry and 40% leave within three months.

3. **Client Characteristics**: Clients with less severe problems are more likely to be retained in treatment. However, even clients with very severe problems, including co-morbid psychiatric problems, can achieve similar outcomes to those with fewer difficulties if more intensive individualised services are made available to them.

4. **Provision of aftercare**: Following completion of a residential rehabilitation programme, community aftercare is necessary to sustain the good outcomes.

An overview of these services is provided in the Scottish Government review of Residential detoxification and rehabilitation services for drug users. (Scottish Government, 2004)

BARRIERS TO RECOVERY

Whether or not a person is able to recover from problem drug use depends on individual circumstances. Common factors affecting recovery are listed in Table 5.
Table 5: Common barriers to recovery from problem drug use.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental and physical health</td>
<td>People with a drug problem suffer physical and mental health problems. This may affect other aspects of recovery such as achieving and maintaining employment.</td>
</tr>
<tr>
<td>Access to housing</td>
<td>The availability of stable and supportive accommodation is a critical factor in the rehabilitation process. A lack of social housing or stigmatisation by landlords often leads to homelessness.</td>
</tr>
<tr>
<td>Access to welfare and employment</td>
<td>People with a drug problem can have difficulties meeting the requirements of the welfare system. Attending regular appointments can be difficult due to a lack of accommodation, health issues or the requirements of substitute medication programmes such as Methadone. Many lack education, skills and training to meet job requirements. Sanctions for missed appointments can lead to relapse for recovering drugs users.</td>
</tr>
<tr>
<td>Access to treatment services</td>
<td>Access to treatment services may be limited due to geographic location, or due to long waiting times for referral to treatment services.</td>
</tr>
<tr>
<td>Involvement in crime</td>
<td>People with a drug problem may resort to crime in order to fund their drug use or may be prosecuted for possession of illegal drugs. Involvement in the criminal justice system may prevent access to ongoing treatment or reduce opportunities for employment.</td>
</tr>
<tr>
<td>Family and personal relationships</td>
<td>Establishing positive and supportive social networks is important for recovery. Living in adverse social environments, such as living with other drugs users or having abusive family relationships can impair recovery.</td>
</tr>
<tr>
<td>Stigma</td>
<td>Public perceptions of problem drug users lead to social exclusion. This makes access to welfare, housing and employment particularly challenging. Research from a number of studies(^\text{16}) show that drug users often encounter discrimination from employers, support professionals, landlords, health services, criminal justice and even drug treatment services workers.</td>
</tr>
</tbody>
</table>


**Stigma**

In 2016 the Scottish Government commissioned a public opinion survey on public attitudes towards people with drug dependence and people in recovery (Scottish Government, 2016c).

The survey showed that one fifth of the sample had ever used recreational drugs, and 3% have ever been dependent on drugs. A further 50% of respondents reported they know someone who has used recreational drugs, and 37% know someone who has ever experienced drug dependence. This indicates that the majority of the Scottish adult population (69%) has had direct or indirect experience of recreational drug use, whilst four in ten (40%) have had direct or indirect experience of drug dependence.

The majority of respondents were found to agree with sympathetic statements and understanding towards people with drug related issues and agreed that people recovering from drug dependence should be part of the community and have the same rights to a job as anyone else.

However, a significant minority of people agreed that one of the main causes of drug dependence is a lack of self-discipline and willpower (42% agreed) and that if they wanted to stop using they could do so (38% agreed).

Many respondents also expressed concern when asked to consider how they would feel personally about welcoming people with a history of drug dependence into their community. The more experience people have had with drugs, either recreational use or drug dependence, the more sympathetic their views and opinions were.

**DRUGS SERVICES IN SCOTLAND**

Responsibility for treatment, support and other service provision is devolved to Scotland's 30 **Alcohol and Drug Partnerships (ADPs)** (formerly Alcohol and Drug Action Teams) to commission evidence-based, person-centred and recovery-focused treatment services to ensure that their local recovery pathway addresses the needs of people with drug problems in their area. **Figure 15** shows an example of a recovery pathway. The **Framework for Local Partnerships on Alcohol and Drugs** (Scottish Government, 2009b) provides further details of how decisions are made with regards to provision of services. It is important that a range of services is available as it is unlikely that a single service or type of treatment will suit everyone (Audit Scotland, 2009).
Community rehabilitation centres

There are 186 community based rehabilitation centres in Scotland (Figure 16). They provide a range of specialist substance misuse interventions. This includes detoxification support, substitute medication services, blood-borne virus testing, needle exchange services and counselling. In 2007/08, 82% of NHS board and council spend went to community based treatment with the remainder to residential treatment (Audit Scotland, 2009).

Residential detoxification and rehabilitation centres

There are 21 residential detoxification and rehabilitation facilities in Scotland with 352 beds available for drug treatment. In some areas of Scotland, people with drug and alcohol problems can be referred to residential treatment, while in other areas this service is rarely offered. Almost universally, clients access a residential intervention only after the failure of all community based options (Scottish Government, 2007).

17 Access to treatment, timescales and pathways through treatment services will vary depending on the provision of services in the community and the needs of the client.
Figure 16: Location of drugs services in Scotland. White lines are local authority boundaries.

On average, the cost of residential rehabilitation programme ranges between £310 and £425 per week, although some facilities cost considerably more than this. In 2007/08, £19.4 million was spent on residential treatment by NHS boards and local authorities. In 2006 in Aberdeen City, it was estimated that the average package of care for residential rehabilitation per person cost £20,000 per year compared to £3,000 for community rehabilitation (Audit Scotland, 2009).

Source: ISD Scotland (2016c), scottishdrugservices.com
Most non-NHS residential treatment facilities receive self-referrals, and in such cases the client is usually also self-funded. However, many referrals to residential programmes are also made by statutory services.

**Injecting Equipment Provision (IEP) Outlets**

The latest figures for 2014/15 show there are 288 IEP Outlets in Scotland. The majority (74%) are located in pharmacies and the remaining 74 (26%) were as part of other services, known as agencies (ISD, 2016d). The remainder are based in specialist outreach services, police custody suites and hospital emergency care units.

In 2014/15, 328,329 attendances were reported by IEP outlets, an increase from 226,056 in 2013/14. While this national increase can partly be attributed to the provision of pharmacy data by NHS Lothian, all boards with the exception of NHS Dumfries & Galloway reported increased attendances in 2014/15 (ISD, 2016d).

**Funding for Alcohol and Drug Partnerships**

The Scottish Government draft budget, published in December 2015, included a reduction in direct funding for drug and alcohol treatment and support services. In 2016-17 an allocation of £53.8 million was made to NHS Boards, for delegation to Alcohol and Drugs Partnerships (ADPs), down from £69.2 million in 2015-16. The Cabinet Secretary for Health, Shona Robinson wrote to ADPs, informing them that NHS boards would be expected to maintain spending at 2015-16 levels, pursuant to a budget increase in board baselines. Funding allocations for ADPs are shown in **Table 6**.

**Table 6: ADP Funding Allocations for Alcohol and Drug prevention, treatment and recovery support services in 2015-16 and 2017-17**

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>2015-16 (£)</th>
<th>2016-17 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>4,527,872</td>
<td>3,538,392</td>
</tr>
<tr>
<td>Borders</td>
<td>1,352,190</td>
<td>1,049,582</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>1,983,834</td>
<td>1,531,826</td>
</tr>
<tr>
<td>Fife</td>
<td>4,258,881</td>
<td>3,297,789</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>3,389,704</td>
<td>2,653,555</td>
</tr>
<tr>
<td>Grampian</td>
<td>5,788,922</td>
<td>4,511,429</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>18,629,576</td>
<td>14,479,283</td>
</tr>
<tr>
<td>Highland</td>
<td>3,655,485</td>
<td>2,847,456</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>6,937,386</td>
<td>5,424,984</td>
</tr>
<tr>
<td>Lothian</td>
<td>11,469,680</td>
<td>8,887,133</td>
</tr>
<tr>
<td>Tayside</td>
<td>5,363,523</td>
<td>4,158,654</td>
</tr>
<tr>
<td>Orkney</td>
<td>558,443</td>
<td>427,044</td>
</tr>
<tr>
<td>Shetland</td>
<td>600,591</td>
<td>462,202</td>
</tr>
<tr>
<td>Western Isles</td>
<td>692,982</td>
<td>530,672</td>
</tr>
<tr>
<td><strong>Total Scotland</strong></td>
<td><strong>69,209,071</strong></td>
<td><strong>53,800,001</strong></td>
</tr>
</tbody>
</table>

“The draft Scottish Government budget for 2017-18 provides for the allocation of £53.8 million to support Alcohol and Drug services. The agreed funding allocation will be directed through NHS territorial boards for delegation to Integration Authorities. Supporting the delivery of Alcohol and Drug Partnerships' work is a priority for Integrated Authorities in 2017-18. As in previous years, the funds provided directly from the Scottish Government budget sit alongside funds provided from other NHS sources, statutory partners and the third sector, which collectively makes up the resources package for this important work.”

CURRENT POLICY ISSUES

NEW PSYCHOACTIVE SUBSTANCES

New Psychoactive Substances (NPS) are drugs that are designed to replicate the effects of other illegal substances. These substances are commonly (although misleadingly) referred to as "legal highs". The speed and scale at which NPS are emerging has increased since 2005. Many NPS are untested or have had limited testing on humans, therefore the risks of taking them, alone or in combination with other substances are not well known (Home Office, 2014a, 2015). New substances are monitored by the European Early Warning System. In 2015 there were 98 new substances reported and between 2005-2013 there was a seven-fold increase in the number of seizures reported across Europe (EMCDDA, 2015b, 2016a) (Figure 17).

Results from the Global Drugs Survey 2016 show that the UK has the highest rate of NPS purchase of any country surveyed (11.6% of UK sample). In Scotland, 1.6% of adults reported that they had ever taken NPS or "legal highs". Those in younger age groups were more likely to report having ever used NPS (4.1% of 16-24 year-olds, 2.7% of 25-44 year-olds in comparison to 0.5% of 45-59 year-olds) (Scottish Government, 2016a). Among children, 5% of 15 year olds reported having ever used NPS and 2% reported using NPS in the last month (Scottish Government 2016b).

In custodial settings, over a quarter (27%) of Scottish prisoners reported using “legal highs” before going into prison and one in ten (11%) reported use while in custody in 2015 (Carnie and Broderick, 2015).
Because the PSA was only recently introduced it is not yet possible to assess the impact of the PSA on the prevalence of NPS use. The Home Office have committed to undertaking a 30 month review of the act. Results from a Scottish Government report (MacLeod, 2016) based on survey results of NPS users before introduction of the PSA legislation show that less than one in eight (11%) respondents said they had used NPS because it was legal. However, nearly all of those surveyed (99%) also reported using traditional drugs. Therefore this group are less likely to be concerned with legality. The most frequently reported reasons for trying NPS were:

- ease of access
- curiosity
- socially embedded reasons (e.g. because friends were using it)
- price

In response to the rise in NPS, the Scottish Government commissioned an expert review group to review the current legal framework available to Scottish public authorities to govern the sale and supply of NPS in Scotland who reported in February 2015 (ScotPHO). The review group made a number of recommendations including establishing a national centre of excellence in forensic analysis to lead the detection and identification of NPS in Scotland. In response to this recommendation the Scottish Government sent a questionnaire to stakeholders from 30 organisations to inform proposals for this centre. Work is currently being undertaken to identify the membership, terms of reference and functions of the forensic centre for excellence.

Source: Figure adapted from EMCDDA (2016a).
SUPERVISED CONSUMPTION FACILITIES

Supervised consumption facilities aim to reduce the acute risks of disease transmission through unhygienic injecting, prevent drug-related overdose deaths and connect high-risk drug users with treatment and drugs services. They also seek to contribute to a reduction in drug use in public places. Typically these facilities provide drug users with:

- Sterile injecting equipment.
- Emergency care in the event of overdose.
- Primary medical care and referral to appropriate social healthcare and addiction treatment services (EMCDDA, 2016c).

As of May 2016 there were a total of 74 drug consumption facilities in operation in European countries. There are also two facilities in Sydney, Australia and one facility in Vancouver, Canada. Research into the effectiveness of existing facilities have shown they provide benefits such as improvements in safe, hygienic drug use, increased access to health and social services and reduced public drug use and associated nuisance (EMCDDA, 2016c).

Proposals for a pilot safer consumption facility in Glasgow have been made in response to significant outbreaks of HIV in 2015 and several serious outbreaks of infectious disease among people who inject drugs in the city. There have been recent developments in these proposals. In October 2016 the Glasgow City Integration Joint Board approved the development of a business case for the facility.

A draft business case was submitted to the Integration Joint Board on 15 February 2017 with the request for approval to continue a formal evaluation. A further progress report is expected in June 2017 outlining a proposed location for the service, operational parameters and principles, the evaluation framework, update on actions to resolve legal issues, and details of the proposed financial framework. The progression of a proposed facility is dependent on Lord Advocate guidance allowing an exemption from the 1971 Misuse of Drugs Act or amendment to the Act.

MEDICINAL USE OF CANNABIS

Cannabis extract can be used to provide relief of chronic muscle spasm or spasticity associated with multiple sclerosis (Zajicek et al., 2012). The licensing of medicines is reserved to the UK Parliament overseen by the Medicines & Healthcare products Regulatory Agency (MHRA). In December 2016 the MHRA recognised products containing cannabidiol (CBD) used for medical purposes as medicines.

The approval for routine use of medicines within NHS Scotland is decided by the Scottish Medicines Consortium (SMC) on the basis of clinical and cost effectiveness. To gain approval by the SMC, a formal submission has to be made by the holder of the marketing authorisation of the medicine.

The cannabis extract medicine, Sativex® is a licensed therapy approved by the MHRA. Clinicians in Scotland can prescribe Savitex on a case by case basis but they take full responsibility (as they do in prescribing any medication) for doing so. This could be a GP or a consultant. They could do this via an Individual Patient Treatment Request (IPTR). No submission has been made by the marketing authority of Savitex to the SMC – therefore it is currently not available for use within the NHS.

In 2016 the legislation was passed in Ireland to legalise cannabis for medicinal use.
DECRIMINALISATION AND LEGALISATION

There is an important difference between decriminalisation and legalisation. Each has different implications for drugs legislation:

- **Decriminalisation** removes penalties for possession of small amounts of drugs. However, consumption, sale or storage remains a criminal offence.

- **Legalisation** makes it legal to acquire, possess and use drugs. Legalisation also allows governments to regulate the sale and taxation of drugs.

Examples of decriminalisation and legalisation

The use, possession, sale, cultivation and transportation of cannabis is illegal under federal law in the United States. However, individual states can pass laws to decriminalise or legalise drugs at state level. In 1996, California became the first US state to legalise the medicinal use of Cannabis. As of November 2016, the use of recreational and medicinal cannabis is now legal in eight states.

In 2000, the Portuguese Government approved the decriminalisation of the possession and consumption of all illicit drugs. This decision was part of a National Strategy for the Fight Against Drugs (NSFAD), approved by the Government in 1999. As well as removing the punitive approach to drug consumption and possession, the strategy aimed to extend healthcare services and needle exchange programmes and to increase investment in scientific research and specialist training (Gonçalves et al., 2015).

Effectiveness of decriminalisation and legalisation

Support for the decriminalisation of drugs has increased in recent years. Organisations such as the World Health Organisation and the Global Commission on Drug Policy have advocated the removal of punitive approaches to drugs misuse and a shift to strategies aimed at improving public health and reducing overcrowding in the criminal justice system.

Since decriminalisation was introduced in Portugal, there have been improvements in trends of drug misuse. The number of drug users in treatment has increased, new cases of HIV among drug users has decreased and rates of problematic drug use and injecting drug use has declined (Hughes and Stevens, 2010; EMCDDA, 2013b). However, these improvements cannot be attributed to drugs legislation alone. Decriminalisation was introduced alongside a wider, health-based strategy, expanding harm reduction services and welfare reform.

A 2014 report by the UK Home Office compared different approaches to drugs misuse internationally. On approaches to drugs legislation they state:

> Looking across different countries, there is no apparent correlation between the ‘toughness’ of a country’s approach and the prevalence of adult drug use. (Home Office, 2014b: p.51).

Recent developments in the UK and Scotland

Drugs legislation is currently reserved to the UK Parliament. The Cannabis (Legalisation and Regulation) Bill 2015-16 was presented to the House of Commons on 23 March 2016 under the Ten Minute Rule by Liberal Democrat MP Norman Lamb. The bill made no further progress due to the closing of the parliamentary year.
In Scotland the SNP supported a motion in favour of decriminalising cannabis for medicinal use at their 2016 National conference\textsuperscript{18}. The UK Home Office currently have no plans to allow the medicinal use of cannabis.

The Scottish Liberal Democrats have also advocated decriminalising drugs and reforming drugs policy to treat drug misuse as a health issue rather than a criminal issue\textsuperscript{19}.

In January 2016, Police Scotland introduced a change in policy towards cannabis. People caught in possession of small quantities are now issued Recorded Police Warnings rather than facing prosecution\textsuperscript{20}.

Durham’s Police and Crime Commissioner Ron Hogg has also promoted a relaxed approach to personal use of cannabis and has requested local public health departments to suggest options for introducing Heroin Assisted Treatment in Durham.

\textsuperscript{18}The Independent (online).
\textsuperscript{19}http://www.scotlibdems.org
\textsuperscript{20}Scottish Drugs Forum (online).
ANNEX 1: DEFINITION OF KEY TERMS

**Benzodiazepine:** sometimes called "benzos", are a class of psychoactive drugs whose core chemical structure is the fusion of benzene ring and a diazepine ring. Benzodiazepines enhance the effect of the neurotransmitter gamma-aminobutyric acid (GABA) at the GABA_A receptor, resulting in sedative, hypnotic(sleep-inducing), anxiolytic (anti-anxiety), anticonvulsant, and muscle relaxant properties.

**Buprenorphine:** a semisynthetic opioid derivative of thebaine (opiate alkaloid, chemically similar to morphine and codeine). It is a mixed partial agonist opioid receptor modulator that is used to treat opioid addiction in higher dosages, to control moderate acute pain in non-opioid-tolerant individuals in lower dosages and to control moderate chronic pain in even smaller doses.

**Cannabinoid:** any of a group of closely related compounds which include cannabinoi and the active constituents of cannabis.

**Comorbidity:** Two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both.

**Opioid:** Opioids include opiates (drugs derived from opium, including morphine and heroin (diamorphine)) and semi-synthetic and synthetic drugs similar to heroin and morphine.

**Psychoactive substance:** Psychoactive substances are substances that, when taken in or administered into one's system, affect mental processes, e.g. cognition or affect. This term and its equivalent, psychotropic drug, are the most neutral and descriptive term for the whole class of substances, licit and illicit, of interest to drug policy. ‘Psychoactive’ does not necessarily imply dependence-producing, and in common parlance, the term is often left unstated, as in ‘drug use’ or ‘substance abuse’.

**Scottish Index of Multiple Deprivation (SIMD):** used to calculate deprivation rates. SIMD has 38 indicators in 7 domains (income, employment, housing, health, education, skills and training, geographical access and crime) at data zone level, which have been combined into an overall index. Rates are reported by quintiles. Quintiles divide the population into five equal proportions so that 20% of the population falls into each quintile.

**Spasticity:** is a condition in which certain muscles are continuously contracted. This contraction causes stiffness or tightness of the muscles and can interfere with normal movement, speech, and gait.
SOURCES


Scottish Drugs Forum (2013) *Trauma and recovery amongst people who have injected drugs within the past five years*. Available at: [http://www.sdf.org.uk/resources/reports-and-research/](http://www.sdf.org.uk/resources/reports-and-research/) [Accessed 27 March 2017].


RELATED BRIEFDINGS

SB 16-70 Integration of Health and Social Care (2,050KB pdf)

SB 14-36 Mental Health in Scotland (1,933KB pdf)

SB 12-51 The licensing of new medicines in the UK and approving their use in NHS Scotland (537KB pdf)

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