Health and Sport Committee
Preventative Agenda – Substance Misuse
Additional Written Submission

The Road to Recovery – 2017
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5th February 2018

Rational
Thank you for the opportunity to submit evidence and attend the Committee Meeting on Tuesday 30th January 2018. I am the director of Addaction Scotland the largest charity provider of drug and alcohol services in Scotland. I have been working in the field of drugs and alcohol for over 30 years. I have been an advisor on the Essential Care working group, The Opiate Replacement Therapy working group, the Drug Strategy Delivery Commission and the Partnership Action on Drugs.

I have requested to submit supplementary evidence after reflecting on the range of documents presented and the verbal content of the committee meeting. It is my opinion, there was a disconnect between the questions asked for written evidence and the subsequent questions at the committee meeting. The former concentrated on prevention while the latter was focussed on the refresh of the Road to Recovery. Some of this will be repetition of the evidence presented but hopefully with more clarity.

Prevention Young People
Addaction is of the view that drug and alcohol prevention with young people is in the main best suited within the remit of the curriculum for excellence. We believe that teachers are best placed to address these issues as part of the whole curriculum and not make this a “special” or expert subject. There may be a need for teacher training on the basics but it is our contention introducing “experts” further mystifies the subject. In addition there is no evidence base as to the efficacy of this approach. The same applies to any scatter gun approach. In the written submissions there was reference to “whole class” evidence based prevention. We can not find any objective validation of this approach.

Prevention Young People at Risk
Our experience is that there is a case for prevention/intervention for young people at risk. In particular those who are coming to the attention of the authorities due to lack of school attendance, challenging behaviour, criminal activity, hospital admissions and/or social work involvement as a result of child protection issues. Structured, evidence based one to one, group work and meaningful activity can produce significant behavioural change and positive tangible outcomes. There is currently a dearth of young peoples services across the country.
Harm Reduction, Treatment and Recovery – Three episodes on the same journey.

In the submitted and verbal evidence the writer was struck by concentration and imbalance given to 2 recurring themes.

1. Drug Use: the new strategy is to be a drug and alcohol strategy yet during the deliberations, there was little mention of alcohol and its negative effects on individuals, families and communities. Indeed the day after the committee meeting the alcohol related death report was published for 2015 stating that 3700 of our citizens died as a result of alcohol related conditions. In addition there were 41000 admissions to hospital due to alcohol use. Compare this to drug use where there were 8500 admissions to hospital and 800+ deaths during 16/17.

During the 1990’s and into the 2000’s 70% of people in our services had a primary drug problem and 30% a primary alcohol issue. In 2017 that balance has completely switched to 70% alcohol and 30% drugs.

It would seem to me that the balance is not right and this is, in my opinion, reflected in treatment services, which leads me to my second observation.

2. There was a concentration on methadone (ORT) prescribing which was disproportionate but nonetheless reflects public perceptions and resource allocation. In deed when we refer to “treatment” we commonly understand this to be medical/prescribing, ORT or alcohol detox treatment.

It was stressed at committee, that both these treatments are useful interventions for dependent drug and alcohol users. However, they are not appropriate for the vast majority of people with drug/alcohol problems. For instance, harmful/hazardous alcohol drinking, stimulant/cocaine use, ecstasy, new psychoactive substances, cannabinoids and families/friends require something completely different. Alarmingly the recovery services designed to meet the needs of these people often receive a fraction of running costs of treatment services. In deed these services are also required to work with those leaving treatment.

During the meeting there was much discussion regarding people being “parked” on methadone. Addaction agrees that people should be able to stay in treatment as long as they need to. Importantly, they also need to be given other options for their own recovery plans. The truth is that the majority of treatment services are so over stretched delivering prescribing treatment that they do not have the capacity (nor sometimes) the expertise to engage in quality psychosocial interventions to assist people get more from their recovery journey. One can understand the frustration from both the service user and staff perspective.

A further discussion needs to begin to ascertain what type of services are best suited to deliver holistic, person centred, whole population services. In taking forward this discussion we need to address the need for clear leadership and vision across toss the country.
Seek, Treat, Keep

- There has been much talk in recent months regarding Seek, Keep and Treat as the cornerstone of the new “drug” strategy. This has been met with a very mixed reaction from both professionals and people with a lived history. From Addaction’s perspective the sentiment is largely correct. Seek – search and rediscover – is essential to re-engage with people. We have proposed to ADP’s to set up search and rediscover teams with our statutory partners to find those people who have fallen out of treatment. Treat – see comments above regarding treatment. Unless there is considerable investment the quality of said treatment may be suspect. Keep – this might be another way of saying parked. It may also be interpreted as a warning to services not to discharge without a full risk assessment which would be both ethical and worthy. We need to be mindful that Methadone was attributed to 55% of people who died last year. Consequently it can be presumed that the majority of these people were in treatment.

The objections are that such a strategy lacks aspiration. That they are contrary to quality principles and we are aware of cases already where people are being refused reductions in prescribing on “clinical” grounds despite the persons expressed wishes. This is the truth for many in the treatment system. Seek, Treat and Keep is not enabling and sounds more like an action done to people rather than choice.

- More worryingly for Addaction is the frequent and increasing use of gatekeeping to stop people with complex needs (multiple and chaotic drug use) accessing treatment. These people are often the highest risk from overdose and death yet are refused treatment across large parts of the country. This is in complete contravention to agreed NHS Scotland/UK guidelines.

- We agree that there needs to be special attention and care given to both older people who drink and/or take drugs. Our work with Drink Wise Age Well and the substantive research that we have done into older people who drink and SDF into older people who take drugs is that their needs can be fundamentally different to a younger cohort. In particular, stigma is compounded with age. There is an attitude of “they are too old to change”. Care of this aging population tends to treat the symptoms rather than the whole person. Our research also indicates that older people are much more likely to have a successful outcome when they get appropriate treatment. We recommend that there needs to be a distinct section in any refresh regarding the needs and aspirations of older people*.

The Road to Recovery – Fit for Purpose and 10 year forward

Big Picture

- The Road to Recovery was and is an aspiring strategy. It recaptured/reinvented recovery. It was clear in its intent that there is no difference between harm reduction, treatment and recovery. It allowed for the growth and blossoming of the recovery movement in all its
different guises. It struck a cord for hope and balance. Our wish is that any refresh further captures these elements.

- There is a mood across the country that the legal status quo is no longer fit for purpose. This mood is expressed in our parliament across all parties, police, judiciary, media, people in the field and the public. The criminalisation of people with problems does not make sense and more often causes more problems than it solves. Any new strategy needs to be bold in approach. Drugs law may be a reserved matter but drug policy and policing are devolved. We urge the Scottish government to be brave, to challenge stigma and change the approach. We call for the decriminalisation of personal drug and with in reason associated crime and manage this as a health and social care matter. To use an old phrase people with drug/alcohol problems are usually more sinned upon than sinning.

- Drug and Alcohol use has changed considerably in the last ten years. It is rare for services to see people under the age of 30 present with heroin/opiate related problems. Ten years ago the average age of people in service was 27, now it is more likely to be 40. That is not to say that young people don’t take drugs – anecdotally drug use is even more prevalent across all ages groups, races and class now than in 2007. It is just very different. It tends to be alcohol and stimulant based.

- Our experience (through our digital offer) is that a significant percentage of people develop problems but will seek out very different treatment options. Increasingly they will use on line and virtual services. Any new strategy needs to explore a comprehensive and flexible digital offer.

- Our drug and alcohol deaths are a shame on the country. We need to resource person centred treatment and recovery services so that people have the resilience to lead healthy and happy lives. We need to further enforce that there is no one recovery journey and no one successful outcome. In keeping with the quality and care inspectorate standards, you are the owner of your own plan.

* The Drink Wise, Age Well programme would like to see specific reference to older adults in any revision of the strategy. We would want the reference to include;
  - Ensuring that services do not discriminate against the needs of older drinkers via cut off ages or accessibility
  - service commissioning takes into account the needs of older adults within service design
  - data collected by Scottish Government allows for analysis of need by age with particular reference to older adults
  - health promotion messaging considers the needs of older adults
  - workforce development and training for alcohol factors in the specific needs for older adults