In Scotland, we define problem drug use as the use of opiates (heroin) and benzodiazepines (valium-type drugs). Latest estimates are that there are 61,500 people with a drug problem in Scotland (1). The UK has the highest estimated prevalence of high-risk opioid use, per head of population, in Europe. In the context of the UK, the prevalence of problem drug use in Scotland is far higher than the other UK nations. (2)

Prevention must be based on an understanding of the root cause and drivers of problem drug use. A focus on personal health behaviours and so-called lifestyle choices offers limited insight and misses the most obvious causes and drivers of much of the problem drug use in Scotland – poverty and inequality (3); the experience of trauma, abuse, neglect and other adverse experiences in childhood and early adulthood are also significant; and a lack of opportunity to access education, training and employment both drive the development of, and prevent people from moving on from, problem use.

In terms of primary prevention of problem drug use, the issues are –

- How the total assets and resources in Scotland are distributed across Scottish society.
- How inequalities in education and opportunities for housing, education and employment, as well as access to services, for example mental health services, are reduced.

These are wider policy perspectives than lie within the remit of the Committee, the drugs strategy itself or the expertise of Scottish Drugs Forum but they are crucial to prevention. In terms of a cost benefit analysis, a reduction in problem drug use should be included in consideration of policies that reduce inequalities and relative poverty.

We might also look at how children and young people are protected from trauma – a common factor in many people with drug problems is a history that includes some or all of the following – bereavement, abuse, neglect, being in care, poor experience of education, police contact, offending, imprisonment, homelessness, unemployment.

We could define problem drug use as drug use that causes harms. In this light, eliminating or reducing harms can be viewed as prevention – secondary prevention.

It is hard to separate the human and financial costs, but in terms of total years lost due to premature death and years lived with disability – drug use is 8th in the league table of causes. By comparison, dementias are ranked 7th; alcohol dependence is 12th and diabetes is 14th(5)
In Scotland we had an early start and success in terms of harm reduction with the response to the outbreak and rapid spread of HIV in Edinburgh and, on a smaller scale, Dundee, in the 1980s. This involved the introduction of services providing sterile injecting equipment and methadone to people injecting heroin. This contained the HIV outbreak. The success of this work is internationally recognised.

There is a huge body of evidence regarding the impact of Opioid Replacement Therapy (ORT) (4) and needle exchanges in reducing harm. But these must be delivered according to agreed good practice standards.(6)

Injecting equipment provision and substitution treatment are both available across Scotland now. But we are failing in preventing considerable drug-related harms – so, for example, we had 867 overdose deaths in 2016 (7); we have an ongoing uncontained outbreak of HIV in Glasgow involving 115 new cases… why?

There is both a failure to invest adequately and to deliver models of care which are person centred and able to adapt to individual need, rather than requiring the person with the problem to fit the available service. With regard to ORT in particular, it is estimated that 24,000 people of the 61,500 are on ORT at any one time. However, what is clear from our research among those aged 35 and over with a drug problem is that many of the most vulnerable are not in ORT for a long enough period of time for the provision to impact positively on their lives. (8)

Countries with lower fatal overdose death figures are those who have higher numbers of people on ORT and where people remain long enough in the service for it to make an impact.

Large scale specialist treatment services led by the NHS have frontline staff who have large caseloads. As a result, staff are focussed narrowly on prescribing and monitoring and dealing with health and other crises rather than addressing the wider health and social issues facing their service users. Medication is often prescribed in sub-optimal doses and there is little opportunity to develop a therapeutic relationship between staff members and service users.

Yet there are significant opportunities to save money by spending money more wisely. Investment in the treatment services that prevent further health and other harms could be funded from savings available if, for example, we could prevent these same NHS patients presenting at A&E and being admitted to hospitals. This group is hugely over-represented in statistics for both. Why? Because their health problems reach crisis point and because they have little other option as they are not engaged by primary care services.

Statistical modeling work undertaking by the Information Services Division produced estimates for the number of hospital bed stays for people with a drug problem over the next ten years, showing that there would be nearly 200,000 hospital bed days annually by 2028, if current responses remained broadly the same. (9)
It is estimated that the following hospital usage figures were associated with People with a Drug Problem (PDPs) in 2012/13:

168,200 hospital bed days (estimated to cost £88.8 million)
26,800 hospital stays; of which,
20,700 were emergency hospital stays (9)

The following hospital usage figures associated with PDPs are projected in 2027/28:
192,600 hospital bed days (estimated cost: £101.8 million (based on 2012/13)
30,100 hospital stays; of which,
21,800 were emergency hospital stays (9)

Influenced strongly by the increase in the vulnerability of those aged 35 and over who have had drug problems for many years, the Government is proposing a treatment strategy around the concept of Seek, Keep and Treat. This is our understanding of what the different elements will contain:

**Seek**

The aim is to decrease the number of people who have a drug problem but are not in specialist addiction treatment.

Means to do this include:
• Arrest referral
• Assertive outreach
• Prison and hospital throughcare
• Ending additional barriers to accessing treatment
• Having easy and rapid access to treatment

The need to invest in these elements will be reduced the more attractive and effective treatment is. The quality of treatment is key.

Keep

Ensure that people remain in medical treatment so long as they can benefit from it. This can be achieved through the provision of high quality medical treatment services which:

• are acceptable to this group of patients
• deliver to national standards and guidelines of good practice
• offer a person-specific approach
• can prescribe a full range of medications
• allow informed patient choice

Treat

The model rightly makes clear that medical treatment is a narrow focus and that people with a drug problem have a wider set of issues and needs. In this respect, many of their needs will be similar to other members of their community; however, they often lack access to services around advocacy, housing, housing support, education, training, volunteering and employment.

This model and approach, if successfully implemented, does have potential in delivering real savings to non-drug services in secondary and tertiary care and to police and prison services.

Notes

3) Shaw, A et al *Drugs and Poverty A Literature Review* (Scottish Drugs Forum and SAADAT, 2007)