OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 30 January 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 30 January 2018

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HEALTH AND SPORT COMMITTEE
4th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Adam Brodie (Royal College of Psychiatrists in Scotland)
Emma Crawshaw (Crew 2000)
Lorna Holmes (Cyrenians)
Andrew Horne (Addaction Scotland)
Dr Carole Hunter (NHS Greater Glasgow and Clyde)
Dharmacarini Kuladharini (Scottish Recovery Consortium)
David Liddell (Scottish Drugs Forum)
John McKenzie (Police Scotland)
Teresa Medhurst (Scottish Prison Service)
Fiona Moss (Glasgow City Health and Social Care Partnership)
Dr Craig Sayers (Royal College of General Practitioners)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 30 January 2018

[The Convener opened the meeting at 10:05]

Subordinate Legislation

National Health Service Superannuation Scheme (Scotland) (Miscellaneous Amendments) (No 2) Regulations 2017 (SSI 2017/434)

The Convener (Lewis Macdonald): Good morning, and welcome to the fourth meeting in 2018 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones are off or on silent, and I remind people that although it is acceptable to use mobile devices for social media, there should be no photography or recording, as we have people in the Parliament to do that for us and all of that is readily available.

We have received apologies from Miles Briggs.

Agenda item 1 is subordinate legislation. We have one instrument that is subject to negative procedure to consider today. We considered the instrument last week and agreed to seek clarification from the Scottish Government because of points that were raised by the Delegated Powers and Law Reform Committee regarding the drafting of the regulations. A response has been received, in which the Scottish Government has advised that there is no detrimental effect on any members of the superannuation scheme and that the error will be corrected as soon as possible. It is a drafting error rather than one that has a substantive effect. On that basis, do members agree to make no recommendations on the instrument?

Members *indicated agreement.*

Preventative Agenda

10:07

The Convener: Agenda item 2 is on the preventative agenda. There is an opportunity now for members of the committee who have visited local drug support services over recent weeks briefly to put their comments on the record before we open the wider round-table discussion.

Ash Denham (Edinburgh Eastern) (SNP): I visited Turning Point Scotland in Edinburgh and met a group of people who use the service. We had a conversation for over an hour in which a number of issues came through strongly, which I will outline.

The people said that they feel that heroin users are being parked on methadone, and that everyone should be on a reduction plan to get off it, but that is not the norm. They feel that general practitioners are not always able to signpost people effectively to available services and support. They feel that new psychoactive substances should be added to the strategy, because they are more addictive than heroin and users are very unpredictable. They think that NPS is a growing problem that should be looked at and that there is a strong link between mental health issues and the likelihood that someone will start using drugs, and that intervention at that early stage could be very preventative.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I visited the alcohol and drug partnership in Kirkcaldy yesterday and met service users for about an hour. Of the main issues that were highlighted to me, the first concerns homelessness. The rurality of Fife means that people who become homeless and apply for rehousing are often moved around. That causes great stress, because people can be moved to locations far away from where their family and doctor are. As a result, there are issues about getting their medication, and there is an issue to do with people's prescriptions not following them. For example, if someone is hospitalised as a result of taking an overdose, their script might not follow them to hospital and there is a lengthy wait for their treatment to kick in again.

People highlighted waiting times for referral. They talked about how long it takes to get a doctor appointment and how long it takes when the doctor refers a person to the alcohol and drug partnership and they are then referred to a more local service in Fife. I am led to believe from yesterday's evidence that it can take months.

As in Ash Denham's experience, people talked about the stigma that is associated with drug use and the shame and embarrassment that can be

felt in a community where people know one another.

Emma Harper (South Scotland) (SNP): I visited the alcohol and drug prevention facility at Lochfield Road in Dumfries and met service users.

A big issue for people in our area is stigma and rurality, because everybody knows your business. Rurality is also an issue in the context of travel. It was suggested that giving bus passes to people who are in treatment would facilitate engagement and attendance at appointments.

People said that shared care between general practices is a problem, because some practices do not engage.

There is support for decriminalisation, following the Portuguese and Canadian models, which is interesting.

I spoke later to staff who talked about having a central electronic database for digital prescribing. They said that a system that uses no paper and that has traceability would make it easier to follow things up and improve governance.

Staff said that people at the end of their prison sentence do not have a GP and cannot register with one because they are seen as homeless. There are challenges there. They also talked about the challenges of opiate dependence and gabapentin use, and said that over the next five to 10 years we will need to think about the services that we will have to provide to deal with the knock-on effect on their workload.

Alison Johnstone (Lothian) (Green): Miles Briggs and I visited the Spittal Street centre in Edinburgh and met a group of young people in recovery who are trying very, very hard.

What came across was that the young people feel that the support that they get is invaluable. They said that being able to attend every day and to meet peers—some of whom have gone on to attain degrees—gives them inspiration and makes them feel that recovery is possible. Peer support and positive role models are extremely important to them.

The young people were absolutely clear that attending the centre is much more helpful than visiting a GP and getting a prescription. Having to get up and go somewhere every day makes a huge difference and introduces an element of structure to their lives. Attendance might decrease gradually; the person might be expected to attend every day at first, then a couple of times a week and then weekly, as they improve.

People talked about the difficulty of finding the service and said that pathways need to be made much clearer: the service needs to be more easily accessible.

The service also works with people who are on the streets in Edinburgh. Staff find and work with homeless people, bringing them towards the services that the centre provides. That is an important part of the centre's work.

The people to whom we spoke were adamant that we need more such services.

Ivan McKee (Glasgow Provan) (SNP): I visited the north-east Glasgow recovery hub. The issues that came up were very similar to those about which we have heard. There is certainly concern about people being parked on methadone for a long time.

There is concern about change in how services are delivered, from what people called community day services to a new model. There was a lot of comment made about how programmes used to last six to eight months, but now they are much shorter and last only a few weeks. People said that there is a lack of peer support and that they have to go to different places to get services. They also said that the previous service had been abstinence based, whereas the new service is not, which they think is a significant issue.

People also talked about going into prison clean and coming out as an addict, which is concerning.

There was a comment about people on the recovery journey who go into college courses. Some people experience low self-esteem and find it difficult to settle into a mainstream college course, so people asked whether something could be done to support them.

10:15

Brian Whittle (South Scotland) (Con): I visited Addaction in Kilmarnock, where many of the themes that have been mentioned, such as people being parked on methadone, were highlighted. For example, a lady had been on methadone for 20 years before she realised that people could get off it. She did not know that that was even a possibility, and found out only through a chance meeting with a peer—Alison Johnstone talked about the impact of peers—who had come off methadone.

An issue that came across strongly was the effect of living a life on methadone—there is no dignity, and there is a feeling of life slipping away and every day being a groundhog day. Methadone is seen as part of a solution; it is not in and of itself the solution.

We heard that there is no rehab or detox available in East Ayrshire. There is a lack of resources and GPs do not know where or how to refer people. As has been said, it was mentioned that mental health teams should be part of the solution.

Pertinent to our discussion is that there is no map of the services or the opportunities that are available to people who are living chaotic lives and are perhaps not best placed to access services themselves.

Sandra White (Glasgow Kelvin) (SNP): I thank the people whom I met at the north-west Glasgow community addiction team and the local alcohol and drugs partnership. They were very honest. Some of them are users, and some have been users but now work for the teams.

I had four questions to ask. The first one was about new psychoactive substances, which are not included in the Government's strategy. There was one young boy who, through using illegal highs—some people call them legal highs—had become addicted and had been in and out of prison. The group believe strongly that those substances should have greater recognition and be part of the strategy.

My next question was to ask what evaluations have been done. The group responded that it is possible to overevaluate and there are no outcomes. It was suggested that there should be evaluation after six months, after which there would be a follow-up. At the moment, they do not get enough information; people consider that they are evaluated too much but do not know what the intended outcome is.

I also asked about the methadone programme. The responses that I received were the same as those that other members got. For example, people are being parked on methadone for 25 years. The people said that, for other drugs, including heroin, there is a six-week or six-month detox, and that people are not left in the same situation for 20-odd years. Such services must be put in place because people are on methadone for far too long.

I asked whether the current strategy is effective. It is seen to be effective for some individuals, but it does not cover older drug users—people who are 45 and older. That age group needs to be included in the strategy. They also want a more holistic policy to be put into place that covers education, employment and training. In addition, staff such as people in jobcentres should be trained in addiction.

One area came out very strongly: one lady said that women are treated differently from men, and that there are not enough services for women drug users. I note that point was made in some of the policy documents that I have read, too. Women are less likely to get into rehab and that there are no women and children's rehab centres. The group wants that issue to be looked at, too.

The Portugal model was raised a couple of times.

The Convener: Thank you, colleagues—that has been very helpful in setting the scene for our wider discussion. I note that my predecessor as committee convener, Neil Findlay, visited West Lothian drug and alcohol service in Livingston, and will provide us with a written report. We will publish that on our website in order to provide a complete picture of the visits that were made.

The Convener: Item 3 is a round-table discussion of the issue. For those who have not have taken part in a round-table discussion before, the format is more informal than a panel discussion, but it will be helpful if questions and responses come through me, as convener. I will, of course, try to call everyone who wants to speak.

To get us under way, I will ask everyone to introduce themselves very briefly. For those whom I have not met, I am Lewis Macdonald, convener of the committee and an MSP for the North East Scotland region.

Ash Denham: Good morning. I am the MSP for Edinburgh Eastern and the deputy convener of the committee.

Lorna Holmes (Cyrenians): I am head of services for the Cyrenians.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning everyone. I am the MSP for Edinburgh Western and the Liberal Democrats' health spokesperson.

John McKenzie (Police Scotland): Good morning. I am a police superintendent in Police Scotland with responsibility for the safer communities department.

Jenny Gilruth: Good morning. I am the MSP for Mid Fife and Glenrothes.

Dharmacarini Kuladharini (Scottish Recovery Consortium): Good morning. I am the chief executive of the Scottish Recovery Consortium.

Emma Harper: I am an MSP for the South Scotland region.

Alison Johnstone: I am an MSP for Lothian.

Fiona Moss (Glasgow City Health and Social Care Partnership): Hello and good morning. I am the head of health improvement and equalities for the Glasgow city health and social care partnership, and I chair the prevention education component of the Glasgow alcohol and drug partnership.

Ivan McKee: Good morning. I am the MSP for Glasgow Provan.

Dr Craig Sayers (Royal College of General Practitioners): Good morning. I am the clinical lead for prison health care in NHS Forth Valley

and the Scotland representative on the secure environment group of the Royal College of General Practitioners.

Brian Whittle: Good morning. I am an MSP for South Scotland.

Sandra White: Good morning. I am the MSP for Glasgow Kelvin.

Dr Carole Hunter (NHS Greater Glasgow and Clyde): I am the lead pharmacist in addiction services in NHS Greater Glasgow and Clyde and I manage the needle exchange programme in the health board.

David Stewart (Highlands and Islands) (Lab): Good morning. I am an MSP for the Highlands and Islands region.

The Convener: Thank you. You will all know that the purpose of our inquiry is to highlight the preventative agenda across health services. With regard to substance misuse, we want to consider whether the strategy and approach need to be revised, reviewed or reformed in any way, and to gain as much evidence from as many different angles as we can in order to understand that better. I ask Brian Whittle to begin our discussion.

Brian Whittle: Thank you, convener, and good morning to the panel. I will start with a general question. Some of the evidence that we have heard today was about the belief that people are being parked on methadone and that methadone should be part of the solution but is not the solution itself. One piece of evidence that I heard was that not enough reviews of control of methadone are put in place. What are the panel's views on how the system should work? Does the evidence that I have referred to reflect the way in which drug misuse rehabilitation should be carried out?

Kuladharini: I am very happy to begin. I used to run several treatment services in the Glasgow area and in the Forth Valley area, and I currently head the Scottish Recovery Consortium. On methadone, first I ask whether you would ask such questions about any other medication that is offered for a serious illness. We have to think about what kind of stigma we might attach to drug use that we do not bring to other areas of public health.

On the main point of your question regarding whether people are being parked on methadone, the opioid replacement therapies review looked at that question and said that there is a need for wraparound services and for methadone therapy to be a part of that. The Scottish Recovery Consortium looked at that review and asked what we in the recovery community could contribute in terms of good practice. It is good practice to ask people when they go on a programme when they would like to come off it. The obvious question to ask is, "Where do you see this fitting into your recovery journey?"

Nobody disagrees that methadone is a helpful tool in recovery: it takes people from extreme states of mind and behaviour around having to score drugs to being able to find a landing space in which to consider their next steps and to move more cautiously towards a problem-free, drug-free lifestyle, if that is what they choose.

That is the first step. The second step is to invite people to take part in mutual-aid support outside treatment. Members might not know that Scotland is unique in having created the opiate replacement therapy recovery network, which is a new mutual aid to help people to come off methadone. A total of 14 meetings have been set up across Scotland by volunteers who are in recovery from methadone in order that other people can hear their stories about how to come off methadone, and get inspiration and help from their peers to come off it.

Members have heard how peer support is helpful. In the first instance, people are put on methadone with a programme for when they think they would like to come off it, and that is reviewed regularly.

Secondly, there are medications that some people are on for their whole life—for example, antidepressants. Not everyone who experiences mental ill health or mental distress is on antidepressants, but they may need to go on them for periods in their lives. I would not want to impose on someone's personal medical care journey from the beginning and from the outside by saying that they can be on a drug only for six weeks because we are uncomfortable with their being on it for any longer.

We need to maintain the "Orange Book" guidelines on methadone—I am sure that Carole Hunter knows a lot more about that than I do—for making good patient-centred care plans that include the best available treatment and a vision of how the patient will come off methadone.

Dr Hunter: I agree with most of what Kuladharini said. There is a role for pharmacists in this—there is a lot of untapped potential in the profession. It is interesting that the three visits by MSPs were all about methadone and that there was no mention of alternatives such as buprenorphine or of heroin-assisted treatment.

The pharmacy profession has the greatest amount of contact with this group of patients—greater than that of any other healthcare professionals. There is a role for pharmacists to be more formally involved in, for example, relaxing supervision or identifying patients who are chaotic

or destabilising. That is something for consideration.

Brian Whittle: Thank you for those responses. I recognise the system that you describe that should be in place, but do you accept that, from our evidence, that is not necessarily happening at all times and in all areas? Does there need to be a refresh of good practice? How can we share that to ensure that good practice is in evidence across all areas?

Kuladharini: I agree that that practice is not in evidence. However, we have had a policy in place for 10 years and we have not yet shown that the systems to which you refer that have parked people on methadone are resilient when it comes to policy change. You have to look at how we encourage major institutions of the national health service to take on the policies that already exist. That has been the challenge for recovery. How do we see those policies being enacted on the ground? Some areas are doing brilliantly, but in other areas the requirements for them to be implemented have no teeth.

Sandra White: People I spoke to told me that they use other drugs as well as methadone. I think that that is quite common, given the circumstances. People might spend 23 years on a particular drug, such as methadone, but Carole Hunter mentioned that there are alternatives. Are people advised about that? The folk I spoke to said that they were told, "You're on methadone and that's it." What help do they get to suggest an alternative?

Kuladharini: You need to consider the fact that all the conversations that you had were with current patients. I remember that you also talked to people in longer-term recovery. We have just written a book, "Methadone Memoirs", which is available on the Scottish Recovery Consortium website. That was a major piece of work to gather people's stories about and perspectives on their experience on methadone. What you have described is a common experience. When you go back into that dialogue, you see that a person's perspective is skewed by the drug that they are on. We see that their experience is that they have not heard that they have been offered alternatives.

I saw a front page of the *Daily Record* a couple of years ago, with the face of a person on methadone. You will have seen it—it was shocking. The person said: "I've been on the methadone programme for X years and no one has ever offered me help." None of the treatment services could get on the phone and say, "Actually, that person was offered three types of help." He may not have been offered help but, just from looking at where he lived, I know that there are three community rehabs in that area and at least 12 mutual-aid meetings, all of which are types of help.

You are hearing about people's internal experience at that moment, which I do not doubt. However, to get perspective on that experience, you need to go for the whole range of the recovery journey.

I have been involved in many people's recovery journeys from methadone and I have supported the new mutual-aid ORT recovery. The perspective shifts when people start to own responsibility for their part in recovery. The treatment service could have been better and people could have been better, but we are not looking for evil or for bad guys. The situation is complex and involves people's internal experience and objective reality. In any given area, you can count how many places are available for treatment and know what is objectively true. In the case that I saw in the *Daily Record* it was not objectively true that there were no spaces in community rehab.

10:30

The Convener: Alison Johnstone has a brief question on that issue.

Alison Johnstone: We do not want to stigmatise anyone who is on a methadone programme, any more than we would want to stigmatise someone who has been on antidepressants for a long time. However, we want to make sure that best practice is employed in all situations; the committee has heard in other inquiries that we could use the pharmacy model far more than we do.

We want to make sure that no one is parked on any drug unnecessarily, but our briefing says:

> "Scottish outcome research has shown that while methadone maintenance leads to improved outcomes in a range of domains, it is associated with low rates of sustained abstinence."

At the centre that I visited, the people were keen to get on to a 12-week residential programme. They wanted to move on, but is there the opportunity, to the degree that we want, to move beyond methadone to alternatives?

Kuladharini: I do not know the answer. I am not going to say that I definitely know about our follow-on services in Dumfries and Galloway. We can always improve. I do not say that the situation is fantastic, but you need to find a new tool to encourage policy change into the practice of the treatment services.

We need community support to be extended. In Glasgow, I was involved in community rehabs that were extremely good. I am no longer involved in treatment provision. I campaign about recovery

issues. I know that small piece of research to which you referred, which suggests that continued use of methadone is not associated with abstinence and that long-term employment is not associated with methadone use. Methadone does not prevent people from working, but there is the practicality of going to pick up medication each day. However, my point is that people need to be asked when they want to come off methadone and be supported when they are ready.

The Convener: Alison Johnstone has questions on substance misuse and prisons.

Alison Johnstone: Dr Sayers highlighted in his evidence areas of concern about drug use in prisons. In particular, you highlighted that people are more susceptible to overdose harm on liberation. The committee has had a short inquiry on that issue and heard directly from prisoners. You also mentioned the abuse of prescription medications obtained through prison GPs and said that there was no evidence of illicit production, so the drugs must have been prescribed properly. Could you expand on those points? What does the misuse service look like?

Dr Sayers: A high volume of patients use illicit and prescribed medications for purposes of intoxication on admission, and that continues within prison to a degree—it is one of our greatest challenges. All prisoners are seen by addiction services within one day of admission and harm reduction is issued. We offer substitute treatments if patients are with us for long enough, mainly with methadone but also with buprenorphine. Take-home naloxone is offered for liberation.

The reason for drug-related deaths on release is the loss of tolerance to the medications and substances that patients used on arrival. In the female estate, where I worked for a long time, it was not uncommon for people to have taken daily illicit substances with a value of in excess of £100 or £200, to which tolerance disappears quickly. On release, a patient's body cannot handle that amount of drugs.

The numbers that I quote on the increased risk of mortality are from a recent England and Wales study of all prison admissions and liberations over a period of a couple of years. It is striking that all-cause mortality is 50 times greater than in the general population in the first two weeks after release, for equivalent age and sex patients, and 11 times greater in the first four weeks. Drug-related deaths are eight times greater in the first four weeks if patients are not released on a substitute treatment.

There is definitely a need to prevent immediate post-release death, so there is a driver for—and we are keen on—having the most vulnerable people liberated on substitute treatments. However, I fully agree with the comments about not parking people on methadone for 20 or 30 years. We see patients coming in who have no motivation. They collect their methadone every four weeks, but no objective work is going on to try to address the situation and move it forward. We need to revisit the group of patients who feel that they have been parked.

Used well, methadone can be extremely beneficial to patients, but the increasing addition of prescription medications, notably gabapentinoids, is a concern. I highlight those because they represent the biggest difficulty in prisons in relation to routine consultations. The main reason for prisoners accessing gabapentinoids is for neuropathic pain, or nerve pain. With most patients, however, if there is a thorough examination and a full history is taken, there is no cause of neuropathic pain. In those circumstances, GPs need to have the confidence to say no.

You will be aware of the lack of GPs in all services outside and, unfortunately, that is mirrored inside, where we are also very short of medical resources. We often operate with locums or less experienced GPs who do not have the confidence to say no to patients who can be intimidating and threatening. Use of such medication is not initiated in prisons all that often. That does occur, but it is more about the continuation on admission of prescriptions that were given outside, and reluctance to challenge those prescriptions. It is far easier just to carry them on.

My concern is that, as recent figures show, gabapentinoids were present in 29 drug-related deaths in Scotland in 2012, but that increased to 225 in 2016.

Alison Johnstone: Recent testing suggests that more people are positive for illegal drugs on liberation than was the case several years ago. Why is that the case?

Dr Sayers: I could not speak to that. I have seen that prevalence testing results show that 30 per cent of patients have illicit substances present on liberation. I struggle to say why there would be that increase. Services and resources in prisons to address drug misuse have certainly increased dramatically.

I am surprised by the increase in illicit substances given that we have reduced the use of short-term sentences. One of the greatest risks is patients who are remanded for a matter of weeks, or six-month sentences where patients would serve half or get a tag and be out six or seven weeks later. That is an insufficient time to address things in any meaningful way. Thankfully, over the

past four or five years, the number of people serving such sentences has reduced significantly.

It is disappointing that the number of people using illicit substances is so high. I cannot give you a reason for that. We now have patients for longer periods and we would hope that the interventions that are offered would reduce the amount of illicit use in prisons, but that does not appear to be the case.

Alison Johnstone: It is clear that prisoners need more support when they are liberated, in order to prevent overdose situations. Homelessness has a part to play in that, too. Has the NHS taking responsibility for healthcare in prisons made any difference?

Dr Sayers: Until the transition, prisons sat in isolation when it came to healthcare. There are pros and cons to the transition. Before the provision of healthcare in Scottish prisons transferred to the NHS, it was all delivered via the Scottish Prison Service, so we had uniform prison policy. Our prisoners still move between prisons, but the transition has meant that that joined-up prison network has been lost. We tend to work for our health boards, and it is difficult to get agreed policy among all the different health boards, because we do not have the forum to get people together any more.

The benefit is that, overall, healthcare was poorer before the transition to the NHS and we now have more support from our primary and secondary care colleagues. However, the link on liberation is extremely difficult, for a couple of reasons. Given the computer service in the prisons, there is no electronic prescribing. When patients come into prison, I can access electronically which medications they are receiving from their GPs outside, but the reverse does not happen. We have to provide a handwritten letter, which the prisoner may or may not give to their GP. They will not have a GP if they have been in for a sentence of more than six months, so they will have to reregister, which can be difficult. It is very difficult, if not impossible, to arrange that in advance because, even more often, there will not be an address that the patient is going to. Throughcare out is difficult and would be addressed, or certainly improved, by provision of accommodation prior to release, so that a GP could be set up in advance. I appreciate that that is difficult, but it is a big barrier to smooth throughcare.

Alison Johnstone: Thank you very much.

Ivan McKee: Thanks, everybody, for coming along to talk to us this morning. We very much value your input.

To touch on the prisons issue, I have visited HMP Barlinnie in my constituency a number of times. From the evidence that Alison Johnstone mentioned, we have seen a significant increase in the number of patients testing positive for illicit drugs on release, so clearly something is not working there.

I would like to explore in a bit more detail the issues on release and how we might join those up. It looks as though we all agree that there is a significant problem there, and others around the table will probably have input on that as it will affect the services that pick up the pieces on the outside. It also sounds as though there are simple, practical things that we could do, with joined-up thinking and procedures. Perhaps Dr Sayers might like to talk through that, and I am sure that others will want to come in as well.

Dr Sayers: From a personal point of view, the key improvement would be for prisoners to be able to register with a GP prior to release and for us to have access to that GP, so that we could transfer information about not only medication but all healthcare interventions that have been received in prison.

The big difficulty with the larger jails is transition. Barlinnie will have prisoners who are mainly from Glasgow, but some will be from a greater distance away. Over the past few years, the distribution of where Cornton Vale's female population is from has changed. Previously, Cornton Vale housed all women prisoners on a national basis. It is incredibly difficult to arrange throughcare for prisoners from Aberdeen, Dumfries or other places a long distance away. I appreciate that community-facing units are being introduced. I am hopeful that having those, with prisoners working with people with whom they will continue to work on release, will smooth the transition back out and increase engagement on release, as opposed to having prisoners just meeting a named person whom they have never met before. I hope that that model will mean some improvement in uptake in throughcare for all services, including housing, employment, colleges, healthcare and addiction services. Perhaps in the future there will be potential to expand that to the male estate as well.

Dr Hunter: I want to quickly pick up on a point that Craig Sayers made. He described the pathway when a prisoner came into prison and talked about how he had access to the prisoner's GP records. Those records would tell him when methadone or buprenorphine, for example, was last prescribed, but they would not tell him when it was last consumed, which is a very important point. The only place in which such information is held is the pharmacy, so there is a strong argument for linking pharmacies to patient records as well, and to do the same when someone is being discharged.

Dr Sayers: In most cases, methadone is prescribed by a secondary care CAT team, which does not appear on the electronic record. Unless that medication has been prescribed by a GP, we phone the service to let it know where the patient is. On top of that, I also phone the pharmacy to confirm the last collection date and whether it was supervised.

Dr Hunter: But it would be really good if we were all linked up.

Dr Sayers: It would be far better.

The Convener: That is a good message to draw.

Kuladharini: I did not expect to be talking about this, because I usually talk about recovery, but I ran a prison throughcare system from Cornton Vale. I worked there and set up the 218 service for women who commit crime in order to fund their drug use, and I have probably about 10 years' experience in the area.

People use drugs in prison because they are in pain. People die on the way out of prison because they are a population in movement—and we have difficulty in dealing with those. Jenny Gilruth mentioned that she saw that homelessness is a big issue when it comes to being able to get consistent service. If we consider that everyone who is in prison is now homeless, we can see that they are a population in movement. They are in pain in the same way that people who are on the streets are in pain. With any immediate cause of dislocation—whether it is because their family has been busted up or they have been pulled out of prison—they are more likely to use drugs to soothe their discomfort and pain. Most people who die from that do so because they are in pain.

10:45

I have been party to all those conversations. I have set up throughcare and I did liberation-day lifts from Cornton Vale. I took women directly from Cornton Vale to their homes, bypassing all the opportunities to use drugs in the city centre, and tried to connect them to a service.

We tried to create a service. I am not saying that we should not do that. We should continue with the efforts to do it, but there is a bigger question that we fail to consider when we try to get a technical fix between computers. The fact is that we have a population in movement and we are not good at dealing with populations in distress and in movement.

It is very hard to link the preventative agenda with the treatment agenda because you are asking the wrong question. You are asking how a policy can ensure that women in Cornton Vale do not die on the way and you are seeing those women in isolation. Some of the messages that you have from mental health services indicate that you are not seeing their mental health at the same time. Most of the women in Cornton Vale had extreme mental health problems as well as drugs problems. They are the tip of the iceberg.

It is about prevention. If you stop treating drug and alcohol behaviour in the community as if you can isolate it and, instead, put it together with the range of ways that we as a human population express our distress, you will notice an increase across all the indices. Suicide, depression and obesity are on the increase.

The overall point that I do not want to leave without making is that you must not go too small. If you do, you will stick with a technical fix when we need a paradigm shift. We need a sea change in how we consider the matter. All the problems are real and it would be great it you did all that you have said, but we need bigger thinking.

The Convener: In truth, we need a bit of both.

Alex Cole-Hamilton: We do. Good morning, everyone. My question stems neatly from that. We have heard from the prison services that are represented at the table that the focus is on physiological stabilisation and recovery treatment. However, to pick up on the previous point, most drug use is, as we have heard, an antidote to pain that people experience. Often it is a human response to unresolved trauma, is cyclical and is self-sustaining. To that end, what additional services are bolted into the prison offer specifically to address trauma recovery and mental health recovery and to stem the original catalyst for drug misuse?

Dr Sayers: All prisons have an extensive team of mental health nurses supported by psychology services and visiting forensic psychiatrists. We acknowledge that, particularly in the female group but also in the male group, the drugs are a symptom of a coping strategy that happens outside, and if prisoners are able to use drugs within prison as a coping strategy, we fully understand that.

On moving that forward, the patient focus when they come in is usually physical health—the physical withdrawal. We need a week or two to remove the illicit substances from the person and get them not concentrating on physical health. There is then, often, the opportunity to engage with mental health services, which go hand in hand with the addiction services. Often, the addiction nurses are the mental health nurses at the same time.

It is welcome that there are fewer short sentences because, for us to intervene effectively and deliver cognitive behavioural therapy or counselling, the individual needs to be with the

same person for a significant period. It would be wrong to open a can of worms, such as the child sexual abuse that some of our females have experienced, for two or three weeks. That would make their emotions worse and then, if they were to walk out of the door with their heads struggling, they would go back to what they know.

The key is to have people for a sufficient period, to tell them what we offer and—to go back to the initial comments—instead of parking them on a treatment and leaving them, to plan the journey with them. That involves asking them what their issues are, asking them what they feel ready to tackle at that time and working through one issue at a time. It might be their mental health issues or it may be that they are more focused on hepatitis C treatment. If we are going to use substitute treatments, it is about using them to help the patient to work through their mental and physical pain or whatever issues they have, with a view to reducing and stopping their addiction outside prison or within prison in a long sentence. There needs to be a full journey.

There are extensive mental health services in all prisons. Mental health and addictions go hand in hand. I agree that they are not separate issues.

Alex Cole-Hamilton: You have talked quite a lot about the impact of short-term sentencing on your ability—or lack thereof—to make a meaningful difference in stabilising and treating prisoners and helping them to recover. Without wanting to draw you into endorsing Liberal Democrat policies on legalisation and decriminalisation, I ask you whether you believe that our Scottish courts should consider addiction and substance misuse when they hand down sentences. They know that we have an opportunity to address some of those issues meaningfully. There is a presumption against short-term sentences, but we all know that sentencing of less than six months still happens and people are liberated within three months. Should we radically reform our sentencing agenda for drug-related crime so that we can do something meaningful with those people or treat them in the community rather than taking them into incarceration?

Dr Sayers: I would certainly welcome that. Many of our prisoners who come in have already been on a drug treatment and testing order. Lots of the faces that I have dealt with over the past 15 to 20 years have used a DTTO well and have not come back to us, so there are certainly successes. Ultimately, if people have been down that route or do not wish to engage with a DTTO, or the court feels that a prison sentence is required, my perspective is that the sentence needs to be of a sufficient duration for us to do anything meaningful. Shorter sentences introduce the risk of decreased tolerance overdose on release and do not really afford us an opportunity to do meaningful work.

Lorna Holmes: As Kuladharini pointed out, we are talking about people who are in pain. We ask them to invest in the services that we offer them, and in order for that to happen, people need to have trusted relationships that follow them. Instead, we are putting them into systems that work with them for only short periods of time. We are looking at health boards that cannot work across boundaries, and prisons that are geographically serviced.

There are solutions. The third sector is in an ideal position to deliver some of them because we can work with people across those boundaries. It is incredibly important at this stage that we do not overlook the importance of those trusted relationships for people who have been let down at every point in their lives. If we engage with them for only very short periods of time, why would they work with us and engage with what we say we are going to offer and the help that we are going to give them?

Emma Harper: Craig Sayers's point on national digital prescribing, which would link prisons, GPs and pharmacies, was raised with me by staff members in the Friday session last week. They said that many complaints in prisons come from the fact that prisoners do not get the drugs that they want when other non-prescribing interventions can be delivered. What are your thoughts on national prescribing?

The other issue that I want to mention is the addressing of adverse childhood experiences. That came up with the staff members, but the service users did not use that language at all about any trauma that they had experienced in childhood. One service user, who was going home to Dumfries from elsewhere, blamed the place as the cause of him taking heroin again after being clean for 14 years. It was interesting that there was no issue around his personal history.

Dr Sayers: From the point of view of big prisoner numbers, people have past traumas, not just from childhood but from young and late adulthood. By the time that I see people, they are certainly not using drugs for fun; they are using drugs to blank the trauma out.

On electronic prescribing, the complaints about people not receiving medication were probably due to a doctor being capable of saying no. In my experience, any complaints about people not getting medication are not due to an oversight or to our not chasing it up properly. The majority of complaints tend to occur when patients come in on commodity medications, which are traded in prison, such as gabapentinoids, sleeping tablets,

benzodiazepines and opiate analgesia, and the clinician stops that medication, which is maybe not felt to be clinically justified. To me, that is good clinical practice, so I do not think that the situation would be improved by electronic prescribing.

Electronic prescribing would help us more if it could join up with GP services when patients leave prison.

Emma Harper: That is what I mean—electronic prescribing for the whole system. The feedback that I got on the complaints process was that positive prescribing is not just about giving people what they want, but about giving people what they need.

Dr Sayers: Do you mean that patients complained that, on release, they did not get medication?

Emma Harper: Yes.

Dr Sayers: There are several reasons for that. We cannot directly communicate with GPs electronically and there is just a handwritten paper liberation note on supply of medication. I am well aware that many of our prisoners who I know have received that note will present to a GP to register, and if what they are seeking is not on the note, they will suggest that they are on other medication, and often they receive it. Electronic prescribing would be a safety net for the GP outside as well. If they are not sure, they have the option, in the same way that I have, to ring the prison and say, "What was this patient on on release?", but we do not get many calls that way.

The Convener: That is a very important area, but I am keen to move on and hear from some of our other witnesses. I believe that Jenny Gilruth has a question on the handling of substance misuse issues from the police point of view.

Jenny Gilruth: Thank you, convener. My question links to some of what Alex Cole-Hamilton said about trauma. The Police Scotland submission says:

"more could be done to identify the drivers to problem drug use and tackle these under-lying factors collectively".

Social inequalities and ACEs are also mentioned in that part of the submission.

The Glasgow city ADP submission talks about

"A stronger recognition of adverse childhood experiences ... and trauma as a predictive risk for drug use and misuse."

However, only just under 4 per cent of the Glasgow city ADP's spend is on preventative measures, so there is a disconnect between the rhetoric in the submission and what is happening on the ground.

What needs to be done to join up services in order to identify childhood trauma when it happens and to identify the risk factors? The committee is hearing week in, week out about the disconnect between the health system and the education system. The education system, which is tasked with closing a poverty-related attainment gap, is dealing with a lot of the problems that we are identifying today. What work do you do with local schools? Is that where the disconnect is happening or is it a bigger problem than just health and education not talking to each other?

John McKenzie: I am not convinced that the view that the police and education are not speaking to each other is an accurate reflection. On what is spent on prevention, the police perspective is that our role involves addressing a number of areas related to prevention, but we will always pursue the enforcement and intelligence-gathering aspects of our role in relation to the wider drugs issue.

On prevention, a lot of good work on drug use is being done among partners in health, education, the police and the third sector. We highlight in our submission our on-going work in schools and education, which is clearly a primary way of addressing some of the longer-term impacts of drug misuse in our communities.

The term "ACEs", which has come up recently, is interesting. I think that, since 2004, ACEs have been dealt with under the getting it right for every child agenda, through which we work collectively on a number of key factors of ACEs. The work that is done between agencies under getting it right for every child can be transposed into the area of ACEs. Obviously, there are other aspects to do with poverty and incarceration.

There are areas where we work collectively. I think that the challenge here is evaluation. It is about understanding how the work that we do prevents on a longer-term basis and how that can be evaluated. I would suggest that it is inaccurate to say that agencies are not working hard or collectively.

Jenny Gilruth: I do not think that agencies are not working hard enough; I think that there is a disconnect. We have taken evidence from Harry Burns, who spoke about GIRFEC. He was very complimentary about the system, but he said that it is not going far enough and that, on the ground, we are not joining up that knowledge, sharing it with professionals and highlighting where risks exist so that there can be intervention at an earlier stage.

For example, when children go to school for primary 1 and they do not have enough speech and language skills for their age—age 5—that information should be communicated at an earlier stage. It might be a wider indication of trauma or other things that have happened earlier in the

child's life. It is about the systems talking to each other. It has certainly come through in a lot of the evidence that we have taken that there is a disconnect. It is not that systems are not working hard enough; it is just that they do not seem to talk to each other.

11:00

John McKenzie: I think that the named person process was an attempt to allow agencies to identify issues in education at an early stage. That process has a number of positive aspects. Agencies have made attempts to progress that matter and understand how to identify trauma issues at an early stage. Education and health services have a key role. It was hoped that the named person process would assist with that, and I hope that it will. The issue is the mechanism to allow agencies to speak and share data in a legal framework. That challenge has to be overcome, and that issue has existed for the past couple of years with regard to the named person service.

Fiona Moss: Jenny Gilruth has covered a lot of issues. I am sitting here thinking quite defensively that we are absolutely working well together, but we always do that when we are challenged.

In Glasgow, we are building together the work that we are doing around prevention for community justice, the work that we are doing around child poverty, and addiction prevention. We have a prevention forum. However, the challenge is that we could always do more. There are pockets in which things work extremely well together because people get it—they have the same language and they work well together—but that does not happen in other pockets. I do not think that any of us in this room would say that, fundamentally, we have it all tied together.

The opening question was about whether drugs prevention is where it needs to be in the strategy "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem". I would say that it is not. We have done an awful lot with education, but that work is only one of the many areas of prevention work that we need to do. In NHS Greater Glasgow and Clyde, we have a model with 12 component parts, of which education is one. We need to ensure that the other 11 parts are very strong as well.

Nationally, we need to do more to work with people who are more vulnerable to addictions, whether because of childhood trauma or other reasons. We do not have a range of engagement with or support for a whole range of people to make prevention really come alive. We have done work on constructive connections, which involves working with families—particularly the children in those families—who are affected by the justice system and addiction. The stigma that is associated with that and how young people try to keep themselves distant from that stigma have become evident to us from that work.

How do we engage with young people to be able to support them with what they are experiencing? There is a lot that we are yet to discover about needs and vulnerabilities and how we work around issues. We have also done trauma needs assessment work for staff who work in prisons and addiction services. To what extent are staff who support people with addictions trauma aware? What are their learning and education needs? All of that comes into prevention. However, unless we have a broader scope of prevention, we will not see an issue, investigate it and address it.

David Stewart: Fiona Moss helpfully linked into the issue that I am interested in, which is understanding more about the effect of stigma in relation to treatment. Is stigma a real issue when it comes to treatment in Scotland?

Dr Sayers: Yes.

Fiona Moss: Absolutely. The young people whom we have worked with would not necessarily know whether one of their parents was in prison and had addiction issues. If they did know, they might not tell anybody at all. If that is not stigma that could prevent a person from getting their emotional issues dealt with, which might have longer-term impacts on them, I do not know what is.

David Stewart: Is there a hierarchy of stigma? Are there multiple layers of exclusion, such as homelessness, mental illness and drug injecting?

Fiona Moss: Yes—absolutely. I agree that there is a hierarchy. There are cultural patterns to stigma as well. Something could be quite stigmatising now, but in a couple of years' time it might be more acceptable and something else will come along. It is as not as if we have stigma that just stays as it is, although it is absolutely embedded. It changes with our culture.

David Stewart: I am happy for other people to come in on that as well, but I will throw in another question. I was interested in the Scottish Government's 2016 social attitudes survey. The panel will know that its results were very contradictory. They said that people were basically very tolerant of people who inject drugs, but the key point was that they would not want those people living next door to them. Do people understand that contradiction? I will be grateful if the panel can cast some light on that survey.

Kuladharini: I can cast light on that survey, because we sponsored it and the first issue is that it was a rubbish survey.

David Stewart: Is that the technical term?

Kuladharini: The classic "When did you stop beating your wife?" question that managed to get through was "Would you live next door to a drug user?" Is anybody going to answer yes to that? If you were asked, "Would you live next door to a woman who is struggling a bit?" you might say, "Yes, I do." If you were asked, "Would you live next door to somebody who has had a bit of trouble this week?" the answer might be, "Yes, I already do." The answer to, "Do you already live next door to someone who is using alcohol, popping pills or on antidepressants?" might be, "Yes, I do," but I do not know anybody who would put up their hand and say yes if they were asked, "Do you want to live next door to a drug user?"—and I have worked in the field for 20 years and am in personal recovery. What I am saying is that it was like the question, "When did you stop beating your wife?" There is no way to answer that question and come out of it well.

In September, we held an event in the Tramway for 350 representatives of Scotland's recovery community, and we carried out a new piece of research around the theme of stigma. I have the draft report and it will be available within the next month. We discovered that 96 per cent of the participants experience stigma in their lives in a way that prevents them from accessing services. The stigma around addiction that we are all part of creating—the feeling that, "It's not me, it's them"—is preventing people from seeking help.

I did not seek help because I was not one of them. I thought, "I'm an educated woman who runs a business, not one of them." Then, when I discovered that I am one of them, I had to get over myself in order to get help. Stigma prevents people from getting help, but the visible face of recovery—which I am showing right now, accidentally—allows people to see that it is possible to get better, and they are then more liable to seek help. That is what we do with our recovery work.

Stigma exists and, in our most recent research, people said that their most damaging experiences of it were in public services—it was not businesses, in the street or name calling, but when people rock up to a service and ask for help. People are still experiencing stigma and the most damaging places are not where we expected—they are in the services.

David Stewart: Would you suggest that the 2016 survey should be rerun with more balanced questions? That might give a fairer representation of what people actually feel.

Kuladharini: I do not think so. We should do something else altogether.

John McKenzie: Kuladharini made an interesting point about stigma, and she referred to the fantastic Tramway event. Even the fact that we have come here today demonstrates the difficulty of the subject. The perception given by some media outlets is that the police should not be involved in the conversation about stigma, and that in itself raises concerns about how society stigmatises the issue of drugs.

I want to make a point on that aspect of stigma and open it up slightly from a police perspective. If the police were not involved in the wider conversation about stigma and the public health aspect of drug misuse in our society, the public should ask why. Last week we received plaudits from across the world about the 70 per cent reduction in knife crime. We have taken a public-health approach to knife crime: I do not see why it should be any different with regard to drug misuse.

In addition, we had a situation a few weeks ago whereby the bravery of officers and members of the public resulted in members of an organised crime group being given 87 years of incarceration time. However, still when we come to have a discussion about this public health issue, we find ourselves being criticised because we are using terms such as "the stigma linked to drug misuse in society". It is an interesting dynamic across some media outlets, which do not have a balanced approach to the subject.

The Convener: That is very helpful.

Brian Whittle: One aspect of the police involvement and intervention that I am interested in is that the police have to work to the directives that they are given. In general terms, for my benefit, what kind of directives are you given regarding interactions? Your officers will come across drug misuse and drug users all the time. What objectives are you given to work with?

John McKenzie: Our directives are quite clear. We work to a legislative framework under the Misuse of Drugs Act 1971. The Lord Advocate's position is clear. However, that does not mean that we do not recognise that individuals who are substance users or abusers may have wider issues such as mental health issues or other challenges in their lives. We undertake all possible action in terms of referring individuals to agencies.

Mr Whittle highlighted in his opening comments the difficulty of getting agencies to which to refer people. That is certainly a challenge. However, in terms of the directives, officers are clear—we work to legislation, but we also have the challenge of ensuring that we protect people who are at risk of harm in our communities. That means that we are a referring agency to partner agencies to try to support individuals who are drug users or abusers. That is the position that we will continue to hold.

The issue of drugs is multifaceted. We recognise that we cannot impact on the issue of demand as a single agency. There is a collective approach. However, we will continue to work to the legislative framework that we have. It is interesting that in the 2008 strategy, "The Road to Recovery", there is a chapter about enforcement. We would be keen to continue to have at least reference to enforcement in any new strategy. In the chapter about enforcement, we have clear aims regarding tackling serious and organised crime and ensuring that the legislation is adhered to, but we will refer onwards individuals who have wider challenges in life.

Brian Whittle: Do you have latitude within the law to do that kind of referral and to look at the greater health issue rather than just the judicial issue? Do you have that ability to work with other agencies?

John McKenzie: We have latitude in as much as there are two possible approaches to take. There is the legislative approach in terms of reporting the set of circumstances, if a criminal act has taken place, but that does not prevent us from considering the wider health issues or the wider partnership opportunities for referring individuals on. We will always ensure that the Crown Office is clear about the wider circumstances so that a judgment can be made about whether the criminal justice process is the appropriate process to adopt, although the decision is ultimately for the Crown Office. We have the opportunity to refer on to other agencies.

Ivan McKee: I want to take a wee step back—maybe we should have had this question earlier, to set the scene. The data in the evidence is quite confusing. It says that drug use is down but that drug-related deaths are up. The age profile is changing, so maybe that is part of the driver for deaths; I do not know. The prevalence looks flat, but drug-related hospital admissions are up. We have talked about prisons as well.

Does anyone have any general comments on whether we have made progress over the past number of years and what data there is to evidence that? Maybe the Scottish Parliament information centre can look into this: I would be interested to know, out of the drug-related deaths, how many of those individuals had been through the prison system. That would be an interesting data point.

Dr Sayers: I do not know the data for the number of drug-related deaths. We know that about 90 per cent of all patients seen by community addiction teams have been through the prison system within a five-year period, so there is a huge correlation—it is essentially the same population. I cannot give the exact number of deaths, particularly early deaths, but it is the same group transitioning between services.

Dr Hunter: The data that we have from the needle exchanges reflects much of what has just been said. The most common age group that we see is 35 to 39 and we predominantly see heroin injectors—opiate injectors. However, the second-biggest group—who have not been mentioned today and do not appear in any strategy—is people who use image and performance-enhancing drugs. It is interesting that that is a much younger age group. Some of the risks for that group are the same and some are different, but there are definitely health risks and health harms for them.

11:15

Kuladharini: We have to put together the drug death increase, the alcohol increase, the suicide increase and the increase in obesity and ask ourselves the bigger question, which is, "How can we look at all that distress in our culture in a much more proactive way?" We talked about ACEs. ACEs are not restricted to people with alcohol or drug problems or depression; 60 per cent of the population will score highly on ACEs. I score 10, but you can only work so well.

The big question is, "Can we put all that together?" As Phil Hanlon said in "Making the case for a 'fifth wave' in public health", those are the diseases of modernity. Each one is a symptom of a greater malaise. Until we attack those deep-seated difficulties in our culture, we will just be moving things from one place to another—we will be putting the alcohol problem to one side while we look at the drug problem and so on. We need to sit back and see that the data is telling us something quite extreme about Scotland, which is that we are still suffering in a way that we did not expect.

Fiona Moss: The drugs issue is complex. If you go to any single data source you will get a skewed picture. You have to look at the issue in the round. We are seeing some positive moves in reporting by young people on drug use and a range of other things, which are good indicators, but at the same time we are seeing some really concerning issues.

In Glasgow ADP we had a meeting that was dedicated to looking at our drug deaths, our alcohol deaths and our suicide deaths to try to see what was going on for us in the city across the piece and what we could do about it. We have to piece together some of the policy and some of the changes. We have to put together what is going on in community planning, local regeneration, our mental health strategy, alcohol and drug work and children's work. "The Road to Recovery" perhaps does not link those strategic elements enough and

it perhaps does not enable us to work across agendas on that.

Ash Denham: I read in the briefing that only about 30 per cent of problem drug users are women, but they might have specific circumstances and experiences that are different from those of their male counterparts. Will someone shed light on the differing patterns of behaviour and risks for women problem drug users?

Fiona Moss: We need to take an equalities-sensitive approach to all the work that we do. There will always be gender issues and other issues, too. That relates not just to people's drug-taking patterns but to all the other aspects of their life. In our addiction services in Glasgow, women have asked us to do something different because they need it. It is absolutely critical that we can bring an equalities-sensitive approach to prevention, treatment and recovery work.

Kuladharini: You asked what makes things different for women. Women are at the bottom of the pile. I cite my experience. I set up and ran the 218 service and ran the Turning Point service in prison, so I have 10 years' experience of working directly with women who commit crime in order to fund their drug use. They are at the bottom of every pile; they are the lowest of every denominator. A man who uses drugs might often have a woman in the background or another family member in the background who helps him to keep his life together. When a woman goes down, the kids go down—the whole ship goes down and she has nowhere else to go.

When a woman is working the streets to fund her drug use, there is nowhere lower for her to go, in terms of society's stigmatising of her and lack of belief in her as a human being with potential. Women will be raped, kidnapped and starved, and they will be the victims of attempted murder and violent abuse, because of their drug use. When they go down, they go down further, faster and harder, and it is harder to come back up.

I set up woman-sensitive, trauma-sensitive services and I established women's spaces, where a woman can reconnect with being a woman as part of her journey to being more well—because women often lose that.

Ash Denham: You talked about services that are targeted at benefiting women. Are those isolated examples? Across the system, are there enough services that target vulnerable groups such as women?

Kuladharini: I am open to what my more up-to-date colleagues have to say. As I said, I have been out of the field.

Gender-specific groups—and I am talking about groups for men as well as women—are a helpful part of any recovery programme, because people are generally safer in such groups. Women in early recovery can be vulnerable to predation and to seeking approval through sexual behaviour, because they are used to trading in that. For such women, there are no safe people, so it is about trying to create a safe environment.

We did some experiments with men who were coming out of prison. The male suicide rate in prison is just as high as the female suicide rate. We found that gender-specific groups helped men in their long-term recovery journeys. Gendered approaches are helpful additions.

Sandra White: The women whom I spoke to felt that they suffered more stigma, because they were regarded as bad mothers and so on. They would steal money not just to feed their drug habit but to feed their kids—you are spot on, there, Kuladharini. The women felt that they were at the bottom of the pile.

The women were asking for more rehab centres for women. They want centres where their children could go along, with help and back-up, of course. Do you agree that there are not enough rehab centres for women and that there is not enough support for women who are trying to get off drugs?

Kuladharini: I would not want to comment on the existing service, but the issue is worth exploring. There used to be two women's rehabs in Glasgow, but they were closed down. I do not know why; they might not have been meeting the outcomes that they needed to meet.

When the recovery agenda changed the landscape and we created recovery programmes, we found that community rehabs, or day rehabs, were helpful for everyone across the board—women and men—because people were allowed to keep their houses. When someone goes into a residential rehab, they become part of the homeless population again; they lose their house.

Support for women and children is helpful, but it is a complex issue, which needs more consideration. I ran services for women for 10 years, and I can tell you that I needed a nursery twice.

The Convener: Thank you.

Finally, I ask Lorna Holmes to talk from the Cyrenians perspective about the wider issue of prevention and the role of general practice. Is there anything that you want us to note in that regard?

Lorna Holmes: We run dedicated recovery services in West Lothian, but recovery is an issue in all the work that Cyrenians does, given our work with homeless people and rough sleepers. We

think that GPs have a much larger role to play in signposting people to recovery services. It is about understanding that there is more to someone's recovery than prescribing substitute medications.

I came here today to talk about recovery. There are three separate elements to prevention, which we must think about and be aware of. First, there is the prevention work that takes place in schools, to ensure that people do not go down the substance misuse pathway in the first instance. Secondly, there is the prevention of harm when people are using substances. Thirdly, there is the prevention of relapse when people are on their recovery journeys. The three elements are equally important in addressing substance misuse.

I get a sense that there is an appetite for systems change in relation to the work that we do. At Cyrenians, we are incredibly hopeful that the right conversations are taking place to enable us to better support people who are on the recovery journey.

The Convener: That is a positive note on which to conclude our round-table discussion, and I think that it reflects the evidence that we have heard this morning. I thank all the witnesses for coming in and sharing their experience and knowledge.

11:24

Meeting suspended.

11:31

On resuming—

The Convener: I welcome to the committee David Liddell, the chief executive of the Scottish Drugs Forum; Andrew Horne, the director of Addaction Scotland; Emma Crawshaw, chief executive officer of Crew 2000 Scotland; Teresa Medhurst, the director of strategy and innovation in the Scottish Prison Service; and Dr Adam Brodie of the faculty of addictions psychiatry, from the Royal College of Psychiatrists in Scotland.

We will go straight to questions. As we have had so many expert witnesses in our two evidence sessions this morning, we are tight for time. However, the first question will give the witnesses the opportunity to touch on wider issues, if they wish, while answering the question.

David Stewart: Good morning to the witnesses and thank you for coming along and providing us with your expertise. As you will have heard in the previous evidence session, I am very interested in the issue of stigma. Quite a lot of academic work has been done from the 1970s around stigma—from memory, there was Erving Goffman's famous book, for example. Do you see stigma as a big barrier to treatment in Scotland today?

David Liddell (Scottish Drugs Forum): Stigma is a huge issue that we face. As you highlighted, there is a hierarchy of stigma, and the real challenge is knowing how to deal with that. There are different stigmas for people in long-term recovery compared with those for people who currently use drugs. That touches on the earlier discussion that we heard around methadone, because that is also stigmatised now. Because of the stigma associated with the drug, people are probably more reluctant than they were before to go on methadone. There are a range of issues and problems.

As part of our work, we do stigma training with both the specialist and the generic workforce. You might not be surprised to know that a lot of the stigma from wider society is also apparent in the workforce. We are working hard to deal with those attitudes around stigma in the workforce. In particular, there is the notion that drug use is a lifestyle choice. However, as we have heard today, the fact is that people are presenting with serious problems and their drug use is a symptom of the underlying problems that they experience.

If we can get beyond using terms such as "addict", "abuser" or "misuser" and start talking about people with problems, we will start to deal with some of the stigma. We have had discussions with the media about that, and their classic refrain is that the word "addict" is shorthand and everybody knows what it means. However, its use reinforces the fact that the person is defined by their drug use rather than by the wider aspects of their lives and who they are.

David Stewart: In the 1980s, the old Scottish Health Education Council did an excellent poster that I had in my office when I was a young social worker. It said, "Six months after Alice had her nervous breakdown, her friends are still recovering". That was an interesting way of looking at stigma. Can you relate to that in your occupation?

David Liddell: Absolutely. There is a wider stigma on the family. As we heard earlier, there are particular issues around stigma for the children who are growing up in those households—how they deal with it and how they are dealt with. That can add to the possibility of those children developing substance problems.

The issue is massive and the challenge is to see it holistically rather than simplistically in a hierarchy of stigmas. If we look at reducing the stigma on those who are recovering from drug problems, we might inadvertently increase the stigma on those who are still in the midst of a serious problem.

David Stewart: May I ask another question, convener?

The Convener: There are other witnesses who would like to respond to your opening question, so we will take those first and come back to you.

Andrew Horne (Addaction Scotland): It is a really interesting question. Stigma is endemic; it sits at all levels. If you spend time with people who are in recovery, they will talk about being "clean" but if somebody is clean, somebody else is dirty. Stigma is deep in the thinking, even in the thinking around recovery.

About six months ago, we set up a live chat on our website. We did not know what we were going to get. It was United Kingdom-wide although it was run from Glasgow. In six months, we have had 4,000 interventions. These are people who are never going to put their head above the parapet. They are never going to go to the service. If we are thinking about a strategy for the future and a refresh in 10 years, we will have to think much more creatively about how people will engage with the service, given stigma. Will they be much more anonymous or engaged with recovery communities online?

We need to think of solutions to stigma, because we will not get rid of it. I will tell you how endemic stigma is. I was listening to "Call Kaye"—I do not know why I was listening to it; I must have been having a bad day—and I cannot remember what the topic was, but a woman caller was allowed to get away with saying, "Well, at least I'm not a junkie." Kaye Adams allowed that to happen in the phone-in and I immediately tweeted her to ask why she did not challenge that. People who have drug misuse problems are not just a group; they are all of us.

The perception is that people who have drug misuse problems might be homeless and so on, but they are a minority group and we have to ask ourselves whether we would allow any other minority group to be treated in the same way. Would we allow a minority group to be refused basic primary care because they belong to a specialist organisation and that is somebody else's problem? We just would not tolerate that for any other group and that is how deep it goes. It makes my blood boil.

Emma Crawshaw (Crew 2000): David Liddell and Andrew Horne have put it really well. However, I hope that we are not going to make the same mistake with our refresh of "The Road to Recovery" as has perhaps been made in England. Such a clear focus on abstinent recovery is a limited view of recovery and tackling drug problems. That strategy has inadvertently resulted in a lack of focus on prevention and harm reduction, which in itself replicates that stigma. The suggestion is that only those who are willing to "get clean" deserve support. We have to learn from the mistakes that have been made down south.

Teresa Medhurst (Scottish Prison Service): Witnesses on the previous panel referred to the stigma that is attached to people who have addictions, but those people who have addictions are often the same people who have been in custody and experienced homelessness. That stigma is attached to them in a number of different guises and they get different results because of the services that they need to link in with. If they are not seen in one service as an addict, they will be seen in another, either as a prisoner or an ex-offender or as a homeless individual. The stigma is attached to the individual in several different guises and results in different impacts.

Dr Adam Brodie (Royal College of Psychiatrists in Scotland): It is hard to add to what has been said already. The issue is perhaps equally important, if not more so, in relation to older drug users, because access to universal services is critical to helping people with longer-lasting or emergent physical or mental health problems. There is still a considerable amount of stigma around mental health problems, which are incredibly prevalent among people who use substances.

David Stewart: Some of the witnesses might have already covered this, but is it clear that there are multiple layers of stigma, such as homelessness, drug use and drug injecting? Is there a hierarchy of stigma?

Dr Brodie: I do not know what the other witnesses think. There is probably less stigma than there used to be. There used to be clear separations between how people viewed themselves; the term "junkie" was considered to be one of the worst. I suspect that there is now more crossover. If someone has multiple issues all playing a part, it becomes harder.

I agree that the internal attribution is an issue: people believe that they are bad for doing certain things. It is not a moral choice—you are not intrinsically bad because of the path that life has taken you down. We need to address that. In respect of mental health, guilt is a huge issue and leads to relapse and all sorts of problems.

Andrew Horne: Stigma can be substance specific. The word "junkie" has been mentioned, and there has been a lot of conversation around methadone and heroin. However, cocaine is not particularly stigmatic, although it has a stigma when it becomes a problem. Our media centres, clubs and bars—everywhere—are full of cocaine. Cocaine is the number 1 drug that we see online and that is becoming a problem. MDMA use among young people does not have a particular stigma, nor does the use of new psychoactive

substances—that is normal behaviour in our universities, and they are seen as very much the norm.

Drunkenness might be stigmatic and seen as less acceptable, particularly in this highly engaged social media era. If you are aged 20 and are getting drunk at university, you will really want to think about your Facebook and Instagram pages. Young people are very savvy in what they use and how they use it. My point is that stigma is often tied to a drug rather than to drug use in general.

David Stewart: Are you saying that the reverse is true, so that for high-income groups using cocaine is a status symbol rather than a stigma?

Andrew Horne: Yes—and the new £5 notes are brilliant.

David Liddell: The complexity of the hierarchy is that people have multiple stigmas, for example the drug injectors in Glasgow who also have HIV, are homeless and have mental health problems. For most people, the primary label is as a problem drug user, whereas in fact they have multiple problems and can be stigmatised across the whole range.

It is a pretty big task, as we have observed from the training that we have done with professionals—unfortunately, their views tend to represent the views of the wider public.

David Stewart: That is helpful.

Emma Crawshaw: One of the big changes since 2008 when "The Road to Recovery" came out is that the drugs market is now far more responsive to stigma and will exploit that. Medications, such as Xanax, are presented to look like medicines, although they are illegal in the UK and are not prescribed here. People do not know what they are getting, but because they are packaged beautifully and look like medicines, they may think that they are buying something that is medicinal. As Kuladharini put it so beautifully earlier, people often use such drugs because they are in pain and it makes sense to them. However, they do not necessarily see themselves in the same terms as people who are buying heroin.

The Convener: That is a fair point. Let us now have a slight change of tone.

11:45

Alex Cole-Hamilton: Good morning, panel. Thank you for coming to see us today. I would like to ask about the funding environment, particularly for recovery services in the community. In 2015, the Scottish Government made a cut in its budget of 23 per cent for alcohol and drug partnerships around the country. Some health boards weathered that better than others; some found money elsewhere to plug the gap and to continue service provision, but others did not. In the city of Edinburgh alone, for example, the cut represented a £1.3 million reduction each year for the two years of the cut. Happily, at the end of last year, there was an announcement of £20 million to plug much of that gap.

Is there a correlation or a line of sight between the budget cut and delivery on the ground? Is that why we are now the worst-performing country in Europe in terms of drug deaths? What has been the impact of the cut on the ground?

Andrew Horne: That is a really interesting question. Addaction is one of the largest providers of drug and alcohol services in the country. About 85 per cent of our money is spent on people—the rest is rent and overheads—so, if you cut 20 per cent of the budget, you are cutting people. If you cut people, you cut hours and, if you cut hours, you create waiting lists or you cut quality. The money that was cut—the 20 per cent—has been reintroduced, but we should be looking at a 100 per cent increase if we are going to take this seriously.

We heard some barbed criticism earlier about treatment, which is both fair and unfair with regard to the attitudinal stuff, but, more generally, it is unfair. If you are carrying a case load of 60 people, how much quality recovery work can you do? There has been a lot of conversation about methadone and substitute prescribing. If you have a case load of 60 people, you are a machine; you are not doing recovery work with people, because you are perhaps seeing people for 15 minutes once a month. I am a smoker and I do not think that I would recover with 15 minutes' recovery work a month, so I would have to wait a long time to get myself sorted.

We also talked about whether people were parked. Sandra White was very eloquent when she talked about people being on a particular drug for 23 years without anybody questioning that. If you have a case load of 55 people, you are not going to ask the question. I sometimes give the example of when I single-handedly ran a needle exchange in Earl's Court in London. There were 1,000 people registered to that needle exchange and I was the single worker so I never asked anybody how they were. It was a pointless exercise for me. It was glorified shopkeeping; it was fast and self-service.

You talked about the cuts and money. We need to reinvest to save. We all know about our hospital crisis and bed blocking, and people in the drug and alcohol services user group block beds when they go into hospital. They go into hospital because they are not engaged in primary care or involved in treatment—I said what that treatment is. There are many opportunities in the recovery

movement, but people can only get to those opportunities if they are helped. If they are stuck in a system—living in a flat, isolated in their community and stigmatised—how are they going to do it? We just have to reinvest. I will repeat myself: we have to reinvest to save.

Emma Crawshaw: Andrew Horne is absolutely right. If we do not pay now, we will pay much more later. The cuts so far to service provision have reinforced the stigma. I cannot imagine another public service being cut by 20 per cent and there not being a public outcry about it. The King's Fund has demonstrated quite well how discriminatory and disproportionate the cuts to drug services are. There is an understanding among the public, which perhaps takes a different view of drug services than of other public services.

Andrew Horne also made a good point about us losing good people and years of experience from the field because of the cuts. We cannot embed good prevention practice if the front line is at threat, and the front line will always take precedence over prevention investment, which we have seen in schools. What Fiona Moss said earlier about the broader concept of prevention cannot happen without joined-up working and a significant reinvestment of time.

Andrew Horne: To manage the 20 per cent cut, many ADPs—logically—put a lot of their services out to contract and used the contracting process as a way of cutting. Such examples are everywhere; I will not go into those of individual ADPs. If they had a budget of £400,000 currently in service and the service was coming up to contract, they put it out to contract because they could get a new one for £300,000. That is just laying off people.

David Liddell: On the commissioning front, there is good evidence from England—I guess that it is the same in Scotland—that providers are changing every three years, which is a rapid rate, and that the focus is on cost reduction.

My point about funding, which is the same point that Emma Crawshaw made, goes back to the issue of stigma. It is seen as acceptable to take out that £15 million of funding for ADPs. It is regrettable that the key argument on reinvestment is about unplanned hospital admissions, but that is how policy works. We have worked with the Information Services Division on modelling those costs, which is mentioned in our evidence. In the past year, there have been 867 fatal overdose deaths. The figure has doubled in the past 10 years, but it not as great a concern as it should be.

Looking at the wider prevention agenda, we know what the drivers are—we have talked about the underlying trauma, but there are also links with poverty, inequality and deprivation. Those links are clearer in the Scottish context than they are in lots of other countries. The fact that we have probably the highest rate of drug problems in Europe per head of population is driven largely by those factors; therefore, we need investment in a range of support services to help people out of their problems. We might come to that issue later. It is a key area in which we need extra investment.

The Government is talking about a strategy that gets more people into services and keeps them there for as long as they need to be there—we may come back to the issue of methadone in that regard—but the key element is then dealing with all the wider issues of housing, employability, welfare support and so on. Those are the parts that we largely forget about. We first need to keep people alive long enough that they can recover, but we then need things for those people when they recover, and that is the big issue that we are missing. We need substantial investment in that area so that we do not end up blaming methadone for the failure of the strategy. That would clearly be nonsense, because it is only one part of the overall solution.

There is a risk in talking about people being "parked" on methadone, because we do not have the data on that. There are 24,000 people on methadone, and our research on those who are aged 35 and over shows that the big issue is that people are not on methadone long enough for it to have an impact. There is a huge cost to the system because people are on methadone for too short a time. The other issue is the need to widen the range of support medication on offer.

Other countries that are far more successful than us across the system have a higher number of people in the services over the longer term. Also—this picks up Emma Crawshaw's point—the goal tends to be improving people's quality of life rather than narrowly judging success by whether people are still using.

Dr Brodie: There are wider societal issues, as substance misuse problems impact across large parts of the public domain irrespective of whether we are talking about health, social care or anything else.

On drug and alcohol partnerships, there is big value in funding being disbursed by a multi-agency grouping that includes everybody from statutory and third sector providers to the voluntary sector and the people who represent the carers and the families as well as the service users themselves. That approach is really helpful. The fact that the funding is ring fenced in what might be called straitened financial times is deeply helpful, too, because there is higher visibility—or more acceptable targets, if you like—for that money.

On the way to the meeting, I was wondering about an issue. From the point of view of health and social care, treatment services—and shoring them up—are, as was alluded to in the question, seen as core business. That makes me wonder, because preventative work is a lot more important down the line, although it is hard to provide evidence of its impact in the short term. I wondered whether ring fencing the funding for preventative work might protect the value of our spending for the future and avoid our having to constantly react to the current situation. I echo the point that it may take resources to balance the seek, keep and treat initiative with a HEAT—health improvement, efficiency and governance, access and treatment—target of three weeks from referral to treatment.

The Convener: Brian Whittle has a brief supplementary question.

Brian Whittle: I will provide an illustration of the use of throughcare in the preventative agenda. In Ayrshire, the catalyst project, which works with people while they are in prison and on release, uses art, music and drama as its hook. I took two things away from my visit to the project, the first of which relates to David Liddell's point. There is a chap on the project who is an incredible artist, and he now has somewhere to go, which enables him to feel attached to something of importance. I asked him why it was only when he went to prison that he found out that he could be an artist. His answer, of course, was that he had never had access to that opportunity.

There are two aspects to the preventative agenda. The first is that people need to have access to such opportunities early enough. The second is that the figures from the catalyst project show a huge decline in readmission.

When we discuss financing the prevention agenda, we need to look at education at a young age and at the provision of a through service. How are those being connected up? How well are we managing that process?

Teresa Medhurst: I think I know the service that you are talking about. You are right in saying that it is very good.

In the earlier evidence session, mention was made of the fact that support is not available for people who leave custody, and that is the case for prisoners on short sentences. We know and understand that the members of that group, who can be quite chaotic individuals, are often in a revolving-door scenario. Following the pilots that were undertaken in Low Moss and Greenock prisons in 2015, we established throughcare support officers, who are prison officers who work with people on short-term sentences in the six weeks up to their release and for the first three months of their time back in the community. The first day will be spent attending appointments for housing, registering with a GP and signing up for addiction support services.

Last year, we had an independent evaluation of that service done, and we found that it had benefits and an impact in supporting connectivity between services and in sustaining the individual. As was mentioned earlier, when people first come out of prison, they face risks when passing an off-licence or known dealers. The existence of the throughcare service means that there is support for them that can be sustained.

The point that was made earlier about trust and trusting relationships resonates with us at the moment. We have experience of that and know how difficult it can be for people when they come out of prison. For example, they might have to wait in a housing office for two hours just to be seen. We have started to use that knowledge to inform other work that we are doing. In December, we worked with the Association of Local Authority Chief Housing Officers, the Society of Local Authority Chief Executives and Senior Managers and the Convention of Scottish Local Authorities to establish a set of housing standards for people who go into custody or are released from custody to ensure that, where possible, their tenancies can be sustained. That is particularly important for people on remand and those on short-term sentences. In that way, we can alleviate some of the difficulties that people have been experiencing.

12:00

Andrew Horne: I will take a Kuladharini approach and go global. My simple question is this: why is that group of people imprisoned in the first place?

I am a member of the PADS group—the partnership for action on drugs in Scotland—and I advise the Scottish Government. That conversation takes place a lot, and the answer is that the matter is reserved. However, policing and policy on the matter are not reserved; they belong in this building. We can make a decision here, as a group and as a country, about how we want to police and make policy about people who have drug and alcohol problems.

We heard Dharmacarini Kuladharini and others speak eloquently about pain, hurt, mental health problems, social care, background, privilege and the lack of chances, but what do we do? We put people in prison. The answer to David Stewart's question about stigma is that we put those people in prison.

We have heard three or four times about the Portuguese model, but it goes only halfway in that it talks only about the decriminalisation of drugs. I

would go further and talk about the decriminalisation of people. Very few people go to prison for the possession of drugs; they go to prison because of acquisitive crimes such as shoplifting, soliciting and minor fraud and for affray. We have just discussed why we put people in prison for under six months. The prison service asks up front what it is supposed to do: should it stick a plaster on and tell people to go back out? I often feel for the police, because they are the front line of social care. Police officers think, "Oh God. I have to arrest this person, but I don't want to. I am just putting them back into a system." I will get off my hobby-horse.

David Liddell: I will follow up the issue of drug law reform. It is not widely understood that, at the same time as introducing decriminalisation, Portugal increased resources significantly for drug treatment, employability programmes and welfare reform—all the wider things that are necessary to make recovery possible. That is the interesting bit, because you cannot separate decriminalisation from those wider issues. The point is well made that we send far too many people into the prison system.

The more specific issue on alternatives to problematic drug use is access to employability and employment, on which Scotland does really badly. The Scottish Drugs Forum runs a small programme that trains about 20 former drug and alcohol users a year as addiction workers. It is hugely successful, with about 80 per cent of those people going on to long-term employment. However, we have identified that such training and employment opportunities are very limited. We could do far more across a range of training programmes in, for example, horticulture, catering and the building trade. It is important that we learn lessons from revisiting examples from the past such as the new futures fund, which put employability into the front-line services.

In our work with older drug users who are 35 and over, we surveyed 123 individuals and identified that 79 per cent of them—with an average age of 41—lived alone. For people who are still using, isolation is a hugely important issue. We have dealt with isolation among people in recovery, to some extent, because there are recovery communities and groups, but those groups are primarily for people who have stopped using. The issue is how we fit current drug users into local community groups, such as art groups, to encourage them to see a life beyond their drug problem and have hope about what they can achieve. Those things are missing for too many people. In our survey, a person who lived in Glasgow said that he hoped that the study would be useful for others but that it was too late for him—he was aged 41.

Sandra White: The witnesses have given us some ideas for the strategy. When I visited Glasgow's north-west community addiction team, people who were in training were mentioned, and a paper has been submitted on what the strategy should be. A holistic approach would definitely include employment. We have talked about budgets; surely we should look at all the Parliament's budgets and bring the issue into areas such as employment, not just health, for the specific group that we have discussed.

To pick up on Andrew Horne's point, maybe we should re-educate ourselves about the language that we use. When I spoke to drug users, they said that they had no hope—or no aspirational hope—when they were using drugs although they did have an aspiration to come off drugs, get better, get a job and then be independent.

I know that we are talking about the strategy that we have, but should we be looking at each budget strand that parliamentary committees consider rather than tinkering around the edges with the strategy as it currently is?

David Liddell: The challenge around drug policy is the assumption that it can fix everything. Clearly, it cannot do that, because drug use is a wider social problem that needs to be addressed in all the ways that have been referred to. That would be the ideal.

The problem goes back to the first question that was asked, which was about stigma. The reason why employability programmes do not target people with drug problems is that they are not seen as worthy. That attitude appears across a series of policy agendas. You are right in saying that we should approach drug policy across different agendas, but the question is how we would deliver that policy in practice. We have been struggling to pull in resources from other areas for the small programme that I talked about, for example. We have funded it for the past 18 years, but it is expensive at £20,000 per person. In terms of the outcomes and people being in long-term employment and paying taxes, it makes perfect sense; the question, though, is how we fund such programmes.

The Convener: Thank you. I am sure that the other witnesses will have an opportunity to comment on that in responding to other questions.

Ash Denham: I want to pick up on something that was raised in earlier evidence. I believe that most, if not all, of the witnesses were in the gallery for it. The strategy has been going for 10 years and has been characterised as maybe having uneven service provision through that time and across Scotland. An observation was made that the strategy is "resilient" with regard to policy

change. Is that a fair comment? Do you have anything else to say about that?

Teresa Medhurst: I am not sure whether that is a fair comment. The public sector landscape has changed so much in the years since the policy was introduced. We now have Police Scotland and the integration joint boards in place, for example. There have been a number of changes—from the SPS perspective, there has been the transfer of medical services to the NHS. Much of the work that is reflected in the strategy is probably outdated, and patterns of drug use are changing, which we have heard a lot about today. It is fair to say that, because of some changes in how the public sector works and how that situation has manifested itself and is developing, it is the right time to refresh the strategy in order that services can be appropriately brigaded.

Dr Brodie: Unfortunately, I missed the earlier evidence session, but I am sure that it has already been said that there are a lot of positive things in "The Road to Recovery" document. Probably among the most important things for me at the time when I read it, which I still remember, were the messages about hope, positivity and recovery potential. If there is to be a new strategy, the attitudes and values that it displays will be as important as anything. Perhaps I am being a bit overoptimistic, but we need that general feeling that people can recover. If I was seeing the 41-year-old gentleman who was referred to earlier, terrible as the situation is I would challenge his belief, because I refuse to accept that people lose the ability ever to recover. Some things in the strategy are timeless. Attitudinal aspects are important.

Andrew Horne: Unfortunately, I was around 10 years ago and was possibly party to "The Road to Recovery". I still think that it is a fantastic document and that its aspiration is still alive today. I think that people around the world look at "The Road to Recovery" and see that aspiration and hope are attached to it.

I work for a UK-wide organisation and have just seen the English drugs strategy. I do not want to give it a mark out of 10, but I will say that it leaves a lot to be desired. It still has an outcomes approach that uses a payment-by-results idea, which is not helpful.

I would say that there are resistors of change. We are 10 years on. The Scottish schools adolescent lifestyle and substance use survey—SALSUS—report says that we need to look to the future. As David Liddell said eloquently, there is a cohort that we see every day in our service that is made up of older people—although I do not like using the word "older" to describe them, because they can be around 35, so they are not even middle aged—who have been using drugs since the 1980s or 1990s. You can see them in Edinburgh and Glasgow. There will be casualties in that group. We cannot stop that, although we can work really hard with them. We are right to focus on the phrase "seek, keep and treat", but I would like to see the phrase being, "seek, keep, properly treat and recover". I would like all those words to be included.

We need to think about what is coming around the corner. I know that Emma Crawshaw will follow up on that. What are we going to do about cocaine and MDMA users, who are not like opiate users, but have some problems? Are our current treatment services fit for purpose? No, they are not. What happens in Scotland if we repeat what is happening in America? Are we ready for another opiate epidemic? I do not like the word "epidemic", but that question needs to be asked. Will we use the same tools that we used last time? We made a lot of mistakes. The refresh is absolutely timely, and must include a number of elements.

I want to finish on a point about "The Road to Recovery". A lot has been said this morning about prevention. At this moment in time—possibly disgracefully—although drug use has diminished and shifted among young people, there are few services available in the places where drug use is a problem. Whether a person gets a service at all is a postcode lottery. Further, the services might be based in adult services, which means that people between 14 and 16 years old, who could cost us a fortune in the future—not only financially, but in terms of the cost to their family, themselves and the community—are receiving very little intervention. That is the age group that we really want to catch. Those people are coming to the attention of accident and emergency departments, police and school pastoral care, including truancy services and so on. We have to put the money in.

Emma Crawshaw: Andrew Horne is wise to highlight cocaine. As you will have seen in my submission, there were four cocaine deaths in 2000 and 123 in 2016. People can now buy drugs much more easily. A person does not need to go to a dealer if they have a debit card and access to a computer. "The Road to Recovery" highlights the need to investigate further what we need to do about deaths from stimulant drugs if the problem continues to increase, which we can see fairly conclusively has been the case.

If the new strategy is to have teeth, we need to realise that the complex technology that exists around communication and the movement of drugs around the world can be exploited to enable us to reach out to people better and more effectively. We can use that to ensure that we get help to people through things such as the live chat that is run by Addaction and Crew 2000's "My crew" online service.

The last thing I want to say is that although SALSUS gives us a picture of declining drug use among young people, Public Health England has said that heroin use is decreasing while cocaine, MDMA and cannabis use are increasing. The global drugs survey says the same thing for Scotland. We have to remember that to complete SALSUS, which is the basis for our drug policy and work, schools must choose to do the survey in the first place. However, the young people who cannot sit still for 45 minutes under exam conditions because they are suffering at home and are experiencing trauma are not being heard in SALSUS. We need to reach out to those young people and ensure that they have a voice in the refresh.

David Liddell: On the question around being resilient when it comes to change, "The Road to Recovery" was clear about moving towards person-centred care. The challenge is how to do that when you are dealing with 3,000 or 4,000 people, which is the case in some of the big NHS addiction services. We need to look at that issue in particular.

12:15

The refrain that we hear from a lot of our surveys of people with drug problems is that they have to fit the service rather than the service responding specifically to their needs. As part of that, we should consider extending prescribing beyond methadone to other choices such as buprenorphine. Other countries use slow-release morphine and heroin-assisted treatment. Some countries have recognised that for a certain group who have failed on other treatments, heroin-assisted treatment is likely to be the only thing that will keep them in the service.

Andrew Horne spoke about casualties that we cannot stop—I disagree with that, in relation to fatal overdoses. The evidence from other countries is that if enough people are held long term in treatment, overdose rates go down to very small numbers and deaths are due to other factors—for example, underlying health conditions such as liver disease. There is strong evidence from other countries that if we keep more people in the service for long enough, we can make an impact.

I agree entirely that we have taken our eye off the ball when it comes to vulnerable young people, because there continues to be a population of vulnerable young people whose life experience is very similar to that of the people with drug problems. As has been described, they are a group who are in pain, with a wide range of problems including mental health issues, childhood trauma and so on. We need to focus on that group to ensure that we are not just storing another generation of problems for the future.

The Convener: Dave Stewart has a very brief supplementary.

David Stewart: I am conscious of the time, so I will make a brief comment in relation to Andrew Horne's point about opiates in America. I was over there last year and was really struck by the explosion in opiate deaths. CNN was showing middle-class couples being found dead in their 4x4s. There were no stigma issues and no deprivation, which was a bit like the cocaine users that have been described. Is there anything that we can learn from America's experience? What is happening in America is very serious in terms of the number of deaths.

Andrew Horne: We have to understand that America's relationship with medicine is very odd. If you ever spend any time in America, just watch the ads. I watched an Ireland game at 10 o'clock in the morning during which there were 22 ads for drugs. The transaction between the patient and the doctor is a financial transaction. If a person wants gabapentin, they will get it. That is the culture.

In America, the situation is very interesting. People always have fantastic teeth, but then you meet people and you think, "They've got a drug problem." It is mad. If you go into the middle of the country, you find huge areas of deprivation—the no-hope, sinking towns. However, there is something else that we need to understand not just about America's pain medicine, but about its insurance medicine. Someone in this country who has severe back pain will probably be referred for physiotherapy. It is so much cheaper to give someone a drug, which is why you see so much middle-class drug use in America. They are in and out in six weeks rather than the doctor saying, "That will take four months of treatment."

David Liddell: On stigma, it is interesting that a lot of the media coverage of the problems in America refers to "victims". You never hear that in the Scottish context.

Emma Harper: I have a quick question. Does "The Road to Recovery" strategy need a radical rewrite? For example, perhaps there is a need to target the print media. Do they have a job to do in terms of not using the words "junkie", "alkie", or "druggie"?

Emma Crawshaw: Yes.

Emma Harper: Also, as far as I am aware, in the 15 years of the radical approach that has been taken in Portugal, there has been a 50 per cent reduction in heroin injectors. That was mentioned in the "TED Talk" by Johann Hari. What are the key asks for a radical change in our policy?

Emma Crawshaw: As Sandra White said, we need a genuinely cross-cutting broad approach that looks at every single area of policy. David Liddell mentioned in his evidence the idea of having an impact assessment when developing a policy and an impact assessment when reviewing a policy in order to establish what impact we have had on this vulnerable group. They do not have legal equalities protection, but maybe we should think about that because they are clearly a highly disadvantaged group in our society who experience death at a differential rate, so we need to do something about that.

Why not bring in the media on that, as Emma Harper suggested, and give them some responsibility? I could not believe it when *The Guardian* started using the term "junkie" again, after years and years of knowing that it could not get away with doing that. We cannot let others take their eye off the ball.

Andrew Horne: There is not one person in this room who is not personally affected by drug and alcohol use—not one. It might be in your family. I am one of 10, and just being brought up as one of 10 is traumatic enough, but there are lots of problems. As Kuladharini said, it is not about someone else—it is not "them", it is "us".

When we think about our families and workplaces, when we think about our brothers and sisters and our colleagues and friends, and when we think about the clubs and other places that we go to, we all know someone about whom we say, "Ah, well, that's Jean. She likes a drink", or whose brother used to have a cocaine or heroin problem, or whatever.

That is how we hook in the media—one of the groups of people in which there are problems with drink and other drugs. What I think I am saying is that we have to stop blaming people. It has to stop being about them and start being about us.

Ivan McKee: I thank everyone for coming along. It is a fascinating discussion and I hope to get people's insights on the area that I want to explore.

In the earlier part of the meeting I talked about contradictions in the data. Sometimes the figures are up, sometimes they are down and sometimes they are flat. I would like to hear the panel's reflections on that.

I would also like to hear your opinions on what we should be measuring, given that some of you have said that a person's quality of life is as important as, or more important than, their coming off substances completely.

Will you also talk about funding and costs? We have talked about there not being enough funding for recovery and treatment, and we have talked about whether people should be in the justice system, in which the cost of keeping people locked up is frightening. Imagine what we could do with that money if it were used for recovery and treatment.

We have talked about vulnerable young people, which is an issue that Harry Burns rightly pushes, because the costs over an individual's whole life can amount to millions.

David Liddell: The data on young people is whole-population drug use data, and we have to recognise that a lot of vulnerable young people will not appear in the data, because they might not be in school. We do not have good data on vulnerable young people. From the training that we do around services for young people, we have a lot of anecdotal evidence that the issue is significant. All the issues to do with risky behaviours among vulnerable young people are evident in care homes, for example, and it is clear that we need to do far more than we are doing. That touches on all the issues.

On outcomes and drug treatment services, England previously had the National Treatment Agency for Substance Misuse and has what might appear to be much better data—the caveat is that I question the accuracy of some of it. The data suggest that there have been 20,000 drug-free successful exits from treatment a year over the past 10 years, but that figure does not match the prevalence figures. We have to be quite careful not just about the data that we collect but about recognising that some of the data is potentially—how shall I put it?—not as accurate as we would hope.

The Government is developing an integrated drug and alcohol database, which I think is due to come on stream from 1 April. The aim is to collect a range of data. Linked to that is the recovery outcomes tool, which is trying to measure recovery across a series of domains. Some of that work is useful, but I argue that we need to talk directly and regularly to service users about the services that they receive.

Going back to the work that we did around older drug users, we got a much more nuanced view of the issue in our study, in which we used peer researchers. It was frightening that when we asked people about treatment that they were receiving, they said a lot more when the tape recorder was switched off, because they were fearful of a punitive response by the service. We have not mentioned that today, but it is linked to issues around stigma and the notion of drug use being seen as lifestyle choice. Across a range of services, people are continually being punished for the problems that they have, rather than being helped appropriately.

There is an issue about understanding the reality of how services operate, and about not just looking at the headline figures of the data but digging beneath them. For example, we have recently done a needle exchange study in a part of Scotland, which has been quite illuminating in respect of services' responses on how people are treated.

Andrew Horne: Ivan McKee's question is a brilliant one. In my submission, I was quite scathing because, at the moment, we measure process. For example, we ask whether we hit a waiting time, or how many people are in the system. Instead, we might ask what recovery means to an individual. For some people, it means being drug and alcohol free, or making non-problematic use of drugs and alcohol. We do not have a measurement for that, although we are trying to achieve it. However, to take David Liddell's point, recovery is also about quality. We might ask what a person's quality of life is because they were involved in a treatment system. If I were going to a surgeon because I had broken my leg or had a dodgy knee, I would want to know my chances of being better. In this business, we are not very good at asking such questions. Such an approach was once described as being like inviting people round to your house for a party but locking the door behind them.

There is a sense of there not being a future aspiration. I ask my services to have written on every wall statements such as, "Sixty per cent of people who come to Addaction feel better and do better." They are there in front of people because we have to sell hope and the idea that there is a tomorrow. Kuladharini has come around a few times and we have spoken about visible recovery. Ash Denham asked whether "The Road to Recovery" is still applicable. It is all about the idea of the word "recovery". The idea that all these recovery movements have happened—and are happening every day—organically is fascinating. We can measure some of that. As a service provider, I have had to create targets for my services, because there are none in Scotland. I have had to say, "If we deal with 100 people, how many will leave in a planned, co-ordinated, happy way?", and the target that we have set is 40 per cent. I would like it to be 70 per cent, but we have said, "Let us go for 40 per cent and set a benchmark," because we could not get one from anybody else. As far as I know, the English benchmark on treatment services is 7.5 per cent, which is their expected throughput. However, I want to reiterate that, as David Liddell has said, recovery has many guises. It does not have to mean being drug free; it may just mean being happier and healthier.

Emma Crawshaw: As far as data is concerned, we also have groups of vulnerable adults who are very difficult to engage with—not through their own fault but because we have not set things up in the right way to make them feel safe enough to do so. For example, we have people who are homeless and who use SCRAs—synthetic cannabinoid receptor agonists, or synthetic cannabis as it is called, even though it is not actually cannabis—and it is very difficult to get data on those. If people are using SCRAs, their behaviour tends not to be conducive to getting through the door of a drugs service in the first place.

It is a commendable effort that we have DAIsy coming in as an integrated drug database to track outcomes. However, the vast majority of people who come to Crew seeking help are aged 35-plus, are using cocaine and are on the point of losing their jobs, their houses and their families. They are not going to give their information to the DAIsy database; they want to be recorded anonymously, as we currently record them on the clinical outcomes for routine evaluation database and on the Scottish drug misuse database. However, that is not being offered to them, so we are going to lose all that data because we are not listening to what people who need help actually require.

Alison Johnstone: I thank all the panel members for their evidence, which has been compelling. We have spoken about the context in which people find themselves requiring your services, and the fact that it is not about choice. If we are talking about outcomes—I think that Addaction has said, "Please, Government, ask us to produce outcomes,"—and if the outcome of all our other policies is that people need to use your services, that is not great, is it? How frustrated do you feel about that? "The Road to Recovery" will have to deal with a heck of a broad range of other policies in order to prevent people from having to access your services. Alex Cole-Hamilton pointed out that we are the worst-performing country in Europe on drug deaths and that problem drug use is higher here than in many other western countries. Does that suggest that all our other policies are failing, too? Why are we doing so badly?

12:30

Andrew Horne: I may have sounded it, but I am not that pessimistic. I have lived in the west coast of Scotland for a long time, but I have managed to keep some optimism going. My optimism is based on the change in drug use and the fact that we have a different dynamic. I spoke a little about what young people think about drug use and how they use drugs. I have four children who are now young adults and every now and then I catch their Facebook pages, which is interesting. I have seen people talking about "the Monday morning fear". That is interesting. What are they talking about? You and I might know what they are talking about,

but I am not all that worried or concerned about that. However, I am concerned about the young people who have had trauma and who live in traumatic conditions. There is still a cohort who will need our help, and the earlier we can get them that help, the better.

I do not have to say it in this room, but Scotland is a great country, and we have made huge strides. I came to Scotland in 1994. Anybody who lives in or around Glasgow will remember what Castlemilk, Easterhouse and Drumchapel were like then. They are now completely different places. Previously, 12 or 13 per cent of young people in those areas were using drugs problematically, to escape from their environment. There has been a huge shift across the country in the whole dynamic and in confidence.

I go back to the point that "The Road to Recovery" is a fantastic document. There are good things happening, but we need to do more. We should not forget that we have a changing dynamic. We need to think smarter and think about a digital world and a digital offer, given Emma Crawshaw's point about anonymity. However, things are not terrible.

David Liddell: One example of Alison Johnstone's point is welfare reform, which is resulting in higher rates of sanctioning of individuals, with the impact that has on people's lives. That goes back to the point that we have been making that wider social policy can have a huge impact. It is like the discussion on methadone. It is easy to blame methadone as the cause of the problem, but clearly it is not—methadone is one part of the solution. All those wider social issues come to bear. As I said at the beginning, they are the drivers of the problem in the first place and the reason why Scotland has the largest drug problem and the highest fatal overdose rate. Those drivers are also the things that should be the solutions, but that takes us back to the issues of stigma and the fact that we just do not put in the appropriate level of resource because the population that we are talking about are not seen as worthy or deserving—they are seen as people who are engaged in a self-inflicted pastime.

Those in the 35 and over age group are doubly stigmatised, because of their age. Interestingly, through our employment programme, people who have never worked in 20 years have got work. Actually, it is the older people who tend to be the ones who recover. The key challenge is to ensure that we can keep folk alive and reduce the harm until such time as they feel capable of recovering. We have talked about needing those opportunities for people. Sadly, there are few routes into those opportunities. We have the route into the care sector, and that is what most people are referring to when they talk about potential employment opportunities, but we should be facilitating and investing appropriately in a range of other opportunities.

Alison Johnstone: My question is for Teresa Medhurst. Who is responsible for prisoners' welfare on release? We heard from the earlier panel about the possible risks of liberation and the need to ensure that prisoners are properly supported before they leave prison. Is anyone in particular responsible for the released prisoner?

Teresa Medhurst: For those who are serving sentences of more than four years and are released under statutory conditions, criminal justice social work is responsible for their supervision back into the community and the links into case management. How that individual's journey is progressed through their sentence is clearly mapped out, so there are fairly robust and rigorous processes in that regard. That includes anyone who falls under the multi-agency public protection arrangements.

For long-termers, there are fairly clear, well-planned-out supports in place for when they are released. We have not touched today on individuals who are on remand. Those who are remanded in custody can experience the same difficulties as those who experience short-term sentences, including the loss of their accommodation, disruption from services and supports, a lack of confidence and family breakdowns. There is no service or support.

Part of the difficulty with those on remand is that it is sometimes very difficult to know when they will attend court. Therefore, even setting up support around the court service might be fairly problematic, because it is difficult to identify when they will be released from custody.

For those on short-term sentences, there are a number of Government-funded schemes provided by the third sector for dealing in particular with young people under the age of 26 and women. As I have said, our throughcare support officers operate in 11 prisons providing support to those people on short-term sentences who agree to be supported on release. If people ask for it, social work support is available but, invariably, those who come into custody do not seek out such support on release.

The Convener: I thank all our witnesses this morning. It has been another excellent session, which has been very informative. I have no doubt that it will stimulate further discussion among committee members.

12:38

Meeting continued in private until 13:02.

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