Citizen Participation and Public Petitions Committee

17th Meeting, 2022 (Session 6), Wednesday 7 December 2022

PE1900: Access to prescribed medication for detainees in police custody

Lodged on	14 September 2021
Petitioner	Kevin John Lawson
Petition summary	Calling on the Scottish Parliament to urge the Scottish Government to ensure that all detainees in police custody can access their prescribed medication, including methadone, in line with existing relevant operational procedures and guidance.
Webpage	https://petitions.parliament.scot/petitions/PE1900

Introduction

1. The Committee last considered this petition at its meeting on 23 November 2022. The Committee took evidence from David Strang, former Chair of the Scottish Drug Deaths Taskforce and Dr Carole Hunter, former member of the Scottish Drug Deaths Taskforce.

2. At its meeting, the Committee will take evidence from the Minister for Drugs Policy.

3. The petition summary is included in **Annexe A** and the Official Report of the Committee's last consideration of this petition is at **Annexe B**.

4. The Committee has received a written submission from the petitioner which can be found at **Annexe C**.

5. Written submissions received prior to the Committee's last consideration can be found on the petition's webpage.

6. Further background information about this petition can be found in the SPICe briefing for this petition.

7. The Scottish Government's initial position on this petition can be found on the petition's webpage.

Action

The Committee is invited to consider what action it wishes to take.

Clerk to the Committee

Annexe A

PE1900: Access to prescribed medication for detainees in police custody

Petitioner
Kevin John Lawson

Date Lodged
14/09/21

Petition summary
Calling on the Scottish Parliament to urge the Scottish Government to ensure that all detainees in police custody can access their prescribed medication, including methadone, in line with existing relevant operational procedures and guidance.

Previous action
I have written to Jamie Halco Johnston MSP who spoke to Humza Yousaf, who confirmed that detainees in police custody should have access to their prescribed methadone. I have also written to the Chief Executive of the local NHS Board who said it was not their policy to treat detainees in accordance with Official Guidance, and contrary to the Mandela Rules 24-25. I also wrote to the Chief Constable of Police Scotland who stated it wasn't his problem.

Background information
Police Scotland standing operating procedures says that, as long as it is safe and appropriate to do so, detainees should have prescribed medication continued whilst in police custody including the consideration of opiate substitution therapy such as methadone. The NHS delivers that care.

Humza Yousaf said that this is what should be happening, however, the Chief Executive of the local NHS Board confirmed that it was not their policy to treat detainees.

I am angry that detainees are not being treated in accordance with Official Guidance nor **The Mandela Rules**, Rules 24 and 25. I believe that this actually breaks **Article 3 of the Human Rights Act**.

I therefore want the Scottish Government to make sure that detainees are being given their prescribed methadone, as they would in the community, or is prison, in accordance with the Official Guidance.

Annexe B

Extract from Official Report of last consideration of PE1900 23rd November 2022

The Convener: Good morning, and welcome to the 16th meeting in 2022 of the Citizen Participation and Public Petitions Committee. I apologise for our slightly late start this morning.
Agenda item 1 is consideration of continued petitions. The first petition that we will consider is PE1900. The petition, which is a very important one that we have previously heard evidence on and considered, is on access to prescribed medication for detainees in police custody. It was lodged by Kevin John Lawson, and it calls on the Scottish Parliament to urge the Scottish Government to ensure that all detainees in police custody can access their prescribed medication, including methadone, in line with existing relevant operational procedures and guidance.

We are joined by David Strang, who is the former chair of the Scottish Drug Deaths Taskforce, and Carole Hunter, who is a former member of the task force. Carole is joining us remotely. I warmly welcome both of you. Obviously, we are aware that the task force is no longer operational, so we are grateful for your taking the time to discuss the petition with us, even though you have been decommissioned, so to speak.

Members would like to explore a number of questions. I recognise that you have produced a report and have moved on from the task force. We are very keen to understand where you think that that report can assist us.

Do you have a preference as to who will answer? David Strang can indicate to me whether he will lead or invite Carole Hunter to take the flak on each question. We will see how it proceeds.

David Strang: If Carole is happy with that, I am happy with it.

The Convener: During your time on the task force, what were the key concerns that were raised regarding the experience of people who use drugs and their current interactions with the justice system?

David Strang: I will begin. Thank you for inviting me to appear before the committee. You are right. I chaired the Scottish Drug Deaths Taskforce for the first six months of this year, from January until July. I am now chair of the national drugs mission oversight group, which is overseeing the implementation of the recommendations.

Once I have kicked off, I will invite Carole to comment.

The main thrust of our report was to say that substance dependency should be treated as a health issue and not as a justice or crime issue. Fundamentally, we received evidence that people who use drugs often got second-class treatment from some health and care services. In particular, when they were in the justice system,

they tended to be treated as lesser citizens—people who were not deserving of top-quality healthcare. In our report, we said that everyone in the justice system—all those who pass through police stations, prisons and courts—is a citizen and has a right to good healthcare.

We know that lots of people who are engaged with the criminal justice system have poor mental health and addiction and substance issues, and that, often, they are not well treated when they are in the justice system. We recommended that every point at which someone has contact with the justice system—whether that is the police, the courts or prison—should be an opportunity for them to engage with health services and for support to be provided for people who have substance dependency issues and who need care or treatment.

That was the main thrust of our recommendations on treatment in custody, whether in a police cell or in a prison context.

Dr Carole Hunter: I thank the committee for the opportunity to speak to it today.

We were always very keen that the work of the task force should be evidence based. I would like to make reference to the United Kingdom guidelines on drug dependence and how it should be treated in the UK. The highlighting of health inequalities is not unique to Scotland. The national guidelines on drug misuse and dependence and how that should be clinically managed, which were published by the Department of Health in England, were endorsed by all four devolved nations.

The task force thought that, although the evidence is there, in practice that was not what people were experiencing. There is a whole chapter on criminal justice settings in the guidelines. The transitions to, from and between different criminal justice settings were highlighted as potential transition points. There is evidence that, if maintenance treatment on methadone or buprenorphine is not maintained at those transition points, there is a risk of relapse and overdose.

The Convener: Thank you.

Fergus Ewing (Inverness and Nairn) (SNP): Good morning to both witnesses. I would like to ask both of you two questions. First, how important do you feel it is to embed the medication-assisted treatment—or MAT— standards in practice, especially for ensuring that individuals receive appropriate medication while in police custody? That is a point that David Strang made clearly in his opening remarks.

David Strang: The answer to your question is that that is very important. A cornerstone of the work of the task force that predated my time as chair was the production of the medication-assisted treatment standards, which set out what standards people should expect if they are seeking assistance and service for drug dependency. One of the key MAT standards involves people getting access to support when they need it. They should have some say in what treatment they should receive, in the same way that anyone might for other cases.

The risk is that people do not get continued replacement therapy when they are in police custody. That has a detrimental effect on their health and general wellbeing,

and on their likelihood of reducing offending. Therefore, I think that it is absolutely important that the MAT standards are met.

Dr Hunter: I would go as far as to say that that is essential.

Fergus Ewing: Thank you. I thought that that would be the answer; obviously, it is the answer that one expected.

I have one more question, which has two parts to it. First, are the witnesses aware of any data on the availability of healthcare staff to administer methadone in police custody? I ask that general question because questions have been raised by the petitioner and others about there perhaps not being sufficient, appropriately qualified medical staff to do the job of ensuring proper treatment in police custody.

Secondly, the petitioner has asserted that, in NHS Grampian, there is inappropriate prescription—as he considers it—of a drug. From memory, I think that it is dihydrocodeine. Is either of the witnesses able to comment on whether that is inappropriate, in their view? Do they have any information with regard to that?

In saying that, we will perhaps make direct inquiries to NHS Grampian to be fair to it, and put that point to it, as is right and proper.

David Strang: I am not a clinician, and I cannot comment on the second point. In the task force's report, we laid out the standard that we expect. That will vary across different police areas and national health service board areas. I am not aware of data about the available healthcare staff in police stations.

Dr Hunter: I cannot give members any information on staffing either.

Dihydrocodeine is sometimes prescribed in custodial settings. There is guidance on exceptional circumstances within the UK guidance that I mentioned. Its prescription should not be routine as a replacement, but there are some exceptional circumstances—including when it is not possible to get access to existing prescribed medication safely—in which it would be used by an experienced clinician.

Fergus Ewing: I am most grateful to Dr Hunter for that very useful clarification. We can pursue that further.

I go back to the first question, about the availability of healthcare staff. As neither of you is able to give us information about that, can you suggest from whom we may be able to obtain information? If the answer is that there is nobody from whom we can obtain such information because records are not properly kept, does that not point to a lacuna in the system of oversight of the application of correct treatment and sufficient medical personnel available to deliver it for those people in police custody who require it?

David Strang: To be helpful, I could make inquiries and let the committee know the extent to which that data is available. I have said that I am not aware of its being available, but that does not mean that it is not available. It may well be locally or

nationally collated, but I am simply not aware of the availability of data on healthcare staff in police stations. We could advise you on that.

Fergus Ewing: So it is a known unknown.

David Strang: It is definitely a known unknown from my point of view.

Dr Hunter: Each health board should be able to give you information on the NHS staff that it has in certain settings. You would also need to explore prescribing staff, who might be different from those who can supervise once the medication has been prescribed.

The Convener: Quite a bit of the evidence that we have heard was not so much about the ambition around the delivery of various principles. Alexander Stewart will ask a couple of questions in relation to that.

I go back to the medication-assisted treatment standards and the importance that you attach to their being embedded—I refer back to that word. To what extent did the work that you did suggest how far adrift we were from the delivery of that principle?

David Strang: We fell considerably far short. Those standards were published in the spring of 2021. When the task force originally published them, the Scottish Government gave a commitment to implementing them within a year. In fact, that was overambitious—our report said that we would expect the standards to be implemented by 2024.

There was an audit and a report by Public Health Scotland. I think that it audited the first five MAT standards, and a report was published in the spring of this year—that was a year on from the publication of the standards—that showed where the shortfalls were. They were substantial across Scotland. That is an important piece of work on which local health boards and alcohol and drug partnerships still need to deliver.

The Convener: Before I come to Carole Hunter, I refer to your first answer. Do you have an ambition to include in the oversight role that you referred to in your opening response seeking to ensure that those procedures will be effectively embedded? Is that part of the oversight function?

David Strang: Yes. The oversight group's function is to hold the Scottish Government to account on the delivery of the national mission and, specifically, the recommendations in the "Changing Lives" report, and to give advice to the Scottish Government. The group has a twin role. We will absolutely consider the implementation of the MAT standards, and there will be regular reports. There is a MAT standards implementation team in the Scottish Government. It will report to the oversight group.

The Convener: Does Carole Hunter have anything to add before I bring in Alexander Stewart, who will pursue that point?

Dr Hunter: Just that the medication assisted treatment implementation support team—MIST— is in place and is working with the alcohol and drug partnerships on the implementation of the MAT standards.

Alexander Stewart (Mid Scotland and Fife) (Con): You have already alluded to the fact that potential gaps still exist around the MAT standards. Is anything still needed to ensure that the standards are fully implemented and working as intended?

David Strang: Each area has been required to produce an action plan to say how they are implementing the standards and what resource they need. The minister has directed them to identify a lead person because, as our report comments on, clear accountability for leadership can often get diluted when there is collaborative working, with people saying, “Oh, I thought they were doing it.” One person has therefore been identified as responsible for leading that work, which is helpful.

Some of the issues relate to training personnel, which might take some time and be about resourcing. By focusing on the 10 standards, we are saying, “This is what needs to happen,” which should ensure consistency across Scotland.

One of the criticisms of drug support services across Scotland is that they are patchy and different according to area. I accept the challenges of Scotland’s geography and that cities will have a different footprint from rural areas. However, if you are drug dependent and need support, you should be able to access the treatment that you need timeously, wherever you are in Scotland.

Alexander Stewart: You have identified that there is a postcode lottery for some services, depending on location and geographical situations and circumstances. That is important because, if services are not fully implemented and working collectively across the whole estate and the whole country, there will be massive gaps for individuals, who are at risk if they are in that situation.

David Strang: I know that you are using the term “postcode lottery” in a pejorative sense, but people might argue for local flexibility, because there are different needs in the Scottish Borders and Edinburgh, for example. However, I agree that everyone who needs treatment should be able to get it. Things such as residential rehabilitation might not be available in every local authority, but, wherever you live, you should be able to get access to whatever treatment you need, whether that be opiate substitution therapy or residential rehab.

Dr Hunter: Workforce recruitment is a challenge in every area of Scotland, no matter the geography, although there might be different challenges in each area. From speaking to my colleagues across Scotland, I know that they all experience challenges with recruitment, which will affect implementation.

Alexander Stewart: Did the Scottish Government consult with the Scottish Drug Deaths Taskforce on the evidence gap that was identified regarding prescription medication being made available to individuals who are in custody? If so, what progress has been made on that?

David Strang: I am not able to say. We published our "Changing Lives" report on 21 July. I have not seen the latest update on the implementation, so I do not have up-to-date information on that. With the report's focus on that issue and the Government's commitment to respond to its recommendations, we would hope to see an improvement—as your question implies—but I have not yet seen the data.

Alexander Stewart: Is it correct to say that the gap was identified during the process?

David Strang: Yes. Recognising that there are inconsistencies across Scotland and that we should have standards to address them led to the introduction of the MAT standards. The gap that you have referred to will vary across the geography of Scotland and will depend on resourcing.

Dr Hunter: I have recently retired as the lead pharmacist for alcohol and drugs services in NHS Greater Glasgow and Clyde; however, I am still working two days a week. In our area, there has always been good communication between police custody and collection services. Twenty years ago, we developed a form for the collection of drugs from pharmacies. I do not think it is fair to say that there is a complete gap, because there are patches of good practice.

The Convener: That was one of the most striking parts of the earlier evidence that we heard in the consideration of the petition. From the committee's point of view, it took some time before we were able to get the Government to accept that there seemed to be a breakdown in how it could be demonstrated that a prescribed drug had reached the individual for whom it was intended. It was not that the intention was not there or that the process was not happening, but it was impossible to demonstrate that it had actually happened because of the lack of a national standard. As a committee, we felt that that was a significant deficiency. The petitioner's experience, which was tragic and sad in its ultimate conclusion, made that clear. That is the reason that we continue to pursue the points that the petition raises.

Paul Sweeney (Glasgow) (Lab): I thank our guests for their insights so far. I note the points that have been raised by the task force, particularly those that relate to Friday releases from custody. Page 10 of the "Changing Lives" report says: "Prison releases on a Friday or the day before a public holiday should be banned to give people a better chance to access support."

Has the Scottish Prison Service or Police Scotland given you any indication that it would be willing to adopt that policy?

David Strang: Action 96 on page 73 of the report recommends that "The Scottish Government should change the legislation to implement a blanket policy of no liberations on a Friday or the day before a public holiday", so you are absolutely right that that was a key recommendation.

There is legislation on the books at the moment that allows someone to be liberated a day early if it is considered essential for them to get the support and treatment that they need as they leave prison. However, it is used very rarely, and the day of the

week when most people are released from prison is still the one that is worst for their health: Friday.

The reason why Friday is the day with the highest number of releases is that the length of a person's sentence is calculated on the day of sentencing—they will know what day they should be released at that point—but, if that day falls on a Saturday or Sunday, the person cannot lawfully be held until they are released on the following Monday, so they have to be released on a Friday. That means that we end up with three sevenths of releases taking place on a Friday and one seventh each taking place on a Monday, Tuesday, Wednesday or Thursday.

The reason why Friday is the worst day is that, on the day of release, if someone does not have accommodation—which is very often the case, as they could have lost their tenancy while in prison— they have to go to the local authority housing office. They also have to register with a general practitioner if they need medication and, if they have no money, they need to register with the Department for Work and Pensions for benefits. Those services are often closed on a Friday afternoon and on a Saturday and Sunday, so that is the reason that it is the worst day for people's health.

The day of release and the following two or three days are a very vulnerable time for drug overdoses and potential drug deaths. People's tolerance will have changed while they have been in prison and they are at risk of succumbing to an overdose, so that is why we say that, rather than it being discretionary, it should be mandatory that people are not released on a Friday. There is no flexibility in the law at the moment. It is unlawful to detain a person until the Monday following the end of their sentence, but, if they were released early, they would be unlawfully liberated. There needs to be a change in legislation to allow that.

The principle is that people leaving prison should be well supported; ideally, they should have accommodation, the healthcare that they need and access to funds. If we do not put those things in place, we should not be surprised that the level of offending is so high, because, if someone is released with no money, nowhere to live and no lawful medication, we can see what will happen.

Paul Sweeney: I take your point entirely, and I think that it is really important. Anecdotally, from my experience in representing Barlinnie, the largest prison in Scotland, and having visited it on several occasions, prison officers have described to me quite candidly that they have repeat customers who they liberate on a Friday, who then go into the city centre to shoplift, purchase and take drugs—usually in an unsafe way—and who will likely then be arrested and back in prison on the following Monday. Those people are, in effect, serving life sentences in short bursts.

When I participated in the unofficial overdose prevention pilot in Glasgow, we frequently had people turning up to the ambulance who had just come straight from Barlinnie prison or Low Moss prison and were seeking a safe place to inject.

You made a very important recommendation, but I want to know whether there has been any indication from the Government that it considers that recommendation to

be an urgent action that it is willing to expedite. Are there any indications of the timescales for adjustments?

David Strang: As an aside, I spent five years as Her Majesty's chief inspector of prisons, so I am very familiar with the picture that you have described.

Our recommendation in the report was that the Scottish Government should produce an action plan, and we gave it six months. It has not yet had those six months. We have seen a general response from the Minister for Drugs Policy, Angela Constance. As members would expect, she welcomed the report, and she said that the Government will look at it in detail and provide a report. The national drugs mission oversight group, which I mentioned, will receive the Scottish Government's detailed response to each of the 20 recommendations and the 139 action points in the report. We are awaiting that. The answer to your question is therefore no, I have not seen the response to that.

Paul Sweeney: That is certainly helpful for when we come to future evidence sessions. Would Dr Hunter like to make any points in relation to my questions?

Dr Hunter: I would. I was on the Scottish Drug Deaths Taskforce as a representative of the Royal Pharmaceutical Society. There is a wider role for pharmacy. The UK guidelines on clinical management that I mentioned earlier said that prescribing arrangements should be in place before someone is liberated, and that is a responsibility for healthcare professionals. I think that there is a lot more that community pharmacy could do there.

In my health board area, roughly 10 per cent of the pharmacies are open seven days a week, and some of them, although not many, are open until late in day—until 10 o'clock at night. We do not utilise that service enough, and we do not use the prescribing capacity enough in community pharmacy. Communication is the key to that, and we need to be a key partner.

Paul Sweeney: Thank you very much for that. I really appreciate it.

Another important point that I noted that the task force raised was that people who use drugs should be provided with naloxone on liberation. That seems to be a relatively straightforward recommendation to implement. Is there any indication at this stage that the Government is adopting that policy and that it will instruct Police Scotland and the Scottish Prison Service to do that? I know that you mentioned that you are awaiting a detailed report.

David Strang: I mentioned that I was previously chief inspector of prisons. It was Scottish Prison Service policy that naloxone was offered. One of the task force's successes has been the national roll-out of naloxone. Police Scotland has committed to all its front-line officers carrying it. In my time, which was pre-2018, the families of people who were drug users and leaving prison were offered naloxone kits. I know that that has happened, but the approach was probably patchy, depending on local arrangements.

We want national consistency to ensure that naloxone is available. It is clear that people who are leaving prison are at high risk of being in the company of someone who overdoses or of overdosing themselves. We are very strong on recommending that naloxone should be available as widely as possible.

Paul Sweeney: That is great. Does Dr Hunter have any points to make on that?

Dr Hunter: Yes. As a former chair of the national naloxone advisory group—that was when Mr Ewing was the Minister for Community Safety—I think that everyone should carry naloxone. It is not just about supply from prisons; it is about whole community coverage. That is really important, because we know that there is a high risk of overdose at the post-liberation point.

Paul Sweeney: Mr Strang raised a really important point about availability of support in the community, particularly on Fridays, in the critical risk period following liberation, and Dr Hunter raised a point about community pharmacy availability and utilising that network more readily to support people. We have mentioned naloxone. It is clear that there is an effort from the Scottish Government and the health and social care partnership in Glasgow, in particular, to launch an official overdose prevention pilot in Glasgow. Do you have a view about how such a facility might assist people who have been liberated from prison and do not necessarily have a safe place to go? It could be a key interface for people who are in the justice system and being liberated. Could that add value?

David Strang: Are you referring to a supervised drug consumption facility?

Paul Sweeney: Yes.

David Strang: We make a key recommendation that that should be explored. As you know, there are legislative problems with that, because policy, under the Misuse of Drugs Act 1971, is still reserved to Westminster. NHS Greater Glasgow and Clyde has been pursuing the establishment of a supervised drug consumption facility, with some assurance from the Lord Advocate that it will be allowed to do that. The legislation is 50 years old and contains some things that are unhelpful nowadays, for example in relation to drugs paraphernalia and allowing premises to be used for injecting.

The answer to your question is yes. If supervised drug consumption facilities were available, they would reduce the harms of drug taking and increase access to healthcare and support.

Paul Sweeney: Dr Hunter, do you have any comments?

Dr Hunter: Absolutely. I would fully support the implementation of a facility in Glasgow—I am part of the working group locally that is looking at that. It is hugely important to provide a safe space, where people can be supervised and where there is someone who can intervene if there is an overdose. All the evidence around the world shows that such spaces can encourage people into treatment and support them until they are ready to get into treatment. Supervised facilities are not just about

preventing overdoses; they are about preventing blood-borne viruses and infections and generally promoting health and wellbeing. There are a huge number of benefits.

Paul Sweeney: Thank you. Your points are really important and help to colour the overall context of this policy area.

The Convener: Mr Strang, you referred to dozens of recommendations in the report. I am sorry that we are not here to do full justice to the report today. The work of the committee has been very much focused on the issues raised in the petition, despite Mr Sweeney's heroic endeavours to draw out slightly wider evidence, which I am sure is also very useful to the committee. Is there anything that we have not touched on that either you or Carol Hunter would like to add?

David Strang: Not in relation to the petition. We are just grateful for the committee's interest. The more people who read the report and take an interest in it, the better.

The Convener: Carol Hunter?

Dr Hunter: There is nothing else from me.

The Convener: In which case, I thank you both very much. Your evidence has been very helpful to our consideration of this distressing petition. Thank you for being present remotely and in person today.

I will suspend the meeting shortly, once members have agreed that we are content to consider the evidence at a subsequent meeting.

Members *indicated agreement.*

Annexe C

Petitioner submission of 23 November 2022

PE1900/K – Access to prescribed medication for detainees in police custody

Thank you, I watch you today vindicate my view that Dihydrcodeine was an unlicensed unlabelled drug, which should not be given en masse to detainees by medically unqualified police custody staff. That means by simple extrapolation, since 2014 when NHS Grampian took over Healthcare thousands of detainees have been unlawfully medicated without consent.

In Elgin custody suite, 2100 detainees per annum average, of these 45% will be addicts, my source is: https://www.policecare.scot.nhs.uk/wp-content/uploads/2015/01/SM_Literature_Review-Final.pdf

Total over 8 years =
18000 Kittybrewster
7560 Fraserburgh
7560 Elgin
Total = 33120 Detainee

So committee, since 2014 in Elgin alone approximately 7560 detainees have been inappropriately medicated by medically unqualified police custody staff, frightening isn't it.

That is an enormous abuse of human rights, yet Police Scotland refuse to investigate discrimination in their establishments by NHS Grampian. This crime is verging on a hate crime.

Committee, in a sea of apathy, you and Richard Lochhead MSP are a beacon of truth and honesty.