The Scottish Parliament
Pàrlamaid na h-Alba

Scotland's
Futures Forum
Fòram Alba air Thoiseach

Drugs in Scotland

Friday 4 May 2018, the Adelphi Centre, Glasgow

Introduction

As directors of Scotland's Futures Forum, **Adam Tomkins MSP** and **Clare Haughey MSP** chaired this event on drugs in Scotland, which was being held in response to a request by a cross-party group of MSPs.

With the Scottish Government undertaking a refresh of its policy strategy, this was an appropriate time to take a step back and consider the landscape of drug use in Scotland.

The role of the Futures Forum as the Scottish Parliament's think-tank is to bring MSPs and others together away from the spotlight of party politics to consider issues beyond the usual electoral cycles.

With that in mind, Adam welcomed participants by sharing his expectation that this event would enable participants to discuss freely the opportunities and challenges around drug policy.

Elinor Dickie, Public Health Adviser, NHS Health Scotland

In the 10 minutes available to her, Elinor chose to highlight some key messages from what we know about those in need and what we know of what works. She focused on problematic drug use, older people with drug problems and medication-assisted treatment, before giving her thoughts on what should come next.

Problematic drug use

Elinor opened by stating that we are facing a public health crisis from problematic use of drugs and rising drug related deaths.

The good news is that drug use in the general population is falling and remains low amongst young people: in 2016, 95% of 13 year olds and 81% of 15 year olds had never used drugs.

However, although the level of problem drug use has not changed significantly in recent years, the age profile has changed. Of the estimated 61,500 problematic drug users, over half are now estimated to be aged over 35.

We are also witnessing a rising trend in drug-related deaths. In 2016, 867 drug-related deaths were registered in Scotland, the largest number ever recorded for the third year in a row. The number was 23% (161) more than in 2015 and more than double (106%) the figure for 2006 (421). The increase is largely accounted for by increased deaths among over 35s: at the same time, there has been a fall in the number of deaths of people aged under 25.

Most drug related deaths were of people who took more than one drug, but opiates and opioids were implicated or contributed to nearly 90% of deaths. Some 68% (592) were men, although the percentage increase over time has been greater for women (169% compared with 60%) from 2002 to 2006 and 2012 to 2016.

In 2014, we know over half of those who died a drug-related death (53%) lived in the most deprived quintile, a clear inequalities issue.

As a public health issue, the Scottish Burden of Disease Study sets these deaths in context. It shows that drug use disorder is the sixth leading cause of early death in Scotland. Out of 132 illnesses assessed by the study, it is behind only heart disease, lung cancer, chronic obstructive pulmonary disease (COPD), stroke, and dementias.

> Over half of those who died a drug-related death lived in the most deprived quintile, a clear inequalities issue.

Older people with drug problems

Elinor turned to the situation for older people with drug problems (classed as those aged 35 years and older due to advanced physiological health damage experienced from prolonged drug use). This group reports psychological and social barriers preventing them from seeking support and accessing services, despite having multiple and complex health needs. Therefore, specific tailored support is required, both in the actual treatment and in the way in which it is delivered.

Elinor emphasised this point as important, as the literature reports that equivalent improvements in health and social outcomes are achievable for this group, provided the right support is in place. It is important to recognise that we can intervene: these deaths are preventable. They are not inevitable in this older group or otherwise.

Medication-assisted treatment

Turning to the evidence on medication assisted treatment, Elinor noted that the prescription of opioid substitution does work. There is evidence of improvements for the individuals in a range of health and social outcomes: substance use, physical and physicological health, offending and social functioning.

A minimum of three months consistent retention in treatment at optimal dose is needed to achieve these outcomes, and a range of medication options is required to meet individual needs and enable these treatment gains. However, Elinor emphasised the point that time spent in treatment is protective for those with opioid dependence: the evidence demonstrates a reduced mortality rate of less than a third compared to those out of treatment, with the greatest difference in the number of deaths from overdose.

Elinor asked participants, if they take away just one message from her today, to remember that being in treatment saves lives. It is literally the most fundamental harm reduction measure. People can only recover if they are alive, and treatment keeps them alive.

Is our system effective?

Some older people with drug problems reported five or more treatment episodes and Elinor noted the evidence of an elevated risk of death when individuals move in and out of treatment.

Elinor also pointed out that the drug waiting times target is that 90% of those waiting for a drug treatment should wait three weeks or less. The figure for 2016–17 was 94%, but it was unclear what they were waiting for. Waiting times data from ISD shows for the majority (nearly nine out of 10) the treatment type is for the category "structured interventions". We therefore do not know how long people are waiting for the most effective interventions, such as medication-assisted treatment.

> Treatment is literally the most fundamental harm reduction. People can only recover if they are alive, and treatment keeps them alive.

Elinor finally noted that in 2015–16 of the discharge records, over a third (38%) had a 'non positive' discharge (disciplinary or unplanned). This merits investigation through assertive outreach, to understand individual needs and enable services to support individuals to stay in treatment due to the protective nature of being in treatment.

What should we do?

Asked to suggest what we should do, Elinor suggested that we need to keep doing what we know works: ensuring a range of treatment options; workforce development in inequalities sensitive practice, trauma informed approaches and age appropriate staffing for the older group; and adequate resources.

Elinor suggested that we need to deliver some things differently, providing intensive tailored support and ensuring continuity of care including assertive outreach, and housing first models. One size does not fit all in treatment and services.

We need to ensure evaluation of implementation as well as impact.

On changing what we do, Elinor challenged Scotland to be brave and bold. We've seen we can do it, she said, with the smoking ban and minimum unit pricing – Scottish and global firsts. She suggested we have to find a proportionate public health response for Scotland: a regulatory model that puts health first and tackles the inequalities experienced by this group of problematic drug users.

Elinor finished by pointing out that what we do matters for today and for five to 10 to 15 years time. Research shows that there is a cohort effect for those born between 1960 and 1980, particularly young men from deprived areas, who have been negatively affected by social and political policies of the time.

We need to learn from the past; otherwise, in 10 or 20 years, we will find ourselves back to this same future, with another cohort undergoing the same challenges as we face now.

Acknowledgements

- Lesley Graham and Lee Barnsdale – NHS ISD
- National Records of Scotland
- Scottish Burden of Disease Team – ScotPHO
- Scottish Government Health Analytical Team
- Older People's Expert Group
- PADS Harms Subgroup

Dave Liddell, Chief Executive, Scottish Drugs Forum

Dave opened by reflecting on all that been developed in Scotland over recent years. The range of services included outreach, needle exchanges/injecting equipment provision, opioid replacement therapy, social care support mostly through the voluntary sector, naloxone, criminal justice interventions such as drug treatment and testing orders, recovery groups/cafes, employability services, family support, housing including housing first, and welfare rights support.

Injecting equipment provision

The approach to injecting equipment provision remained relatively unchanged, although there had been some reductions through cuts and other issues, such as at Glasgow Central Station. The provision is mostly through pharmacies, with some examples of very stigmatising practice in those settings. There was, however, significant evidence of harm reduction in, for example, HIV and bacterial infection rates.

On injecting equipment provision, Dave suggested that certain developments are required: increase the number of outlets that include outreach, improve the delivery of pharmacy provision and enable drug consumption rooms, whenever possible.

Opioid Replacement Therapy (ORT)

Of the 61,500 problem drug users, approximately 27,000 of them are on opioid replacement therapy at any one time. This is mostly with methadone, but small proportion is using Suboxone. The wait for ORT is often much greater than three weeks (as Elinor noted, the waiting times target is met through providing "structured support"). Dave pointed out that the retention rate for the most vulnerable people is poor and that punitive practice remains in parts of Scotland. Furthermore, the models of deliver vary greatly across Scotland, with differing levels of GP involvement for example, and there is poor wider support for many people on ORT.

Dave suggested that we need to improve the quality of ORT, making it person centred, and to increase the prescribing options to include heroin-assisted treatment and slow release morphine. We also need to increase the proportion of the 61,500 problem drug users on ORT and increase their retention within the treatment. That will involve looking at new delivery models that integrate health and social care, with greater GP involvement particularly for those aged 35 and older. We should also extend nurse and pharmacy prescribing and provide an environment for those being treated that is psychologically and trauma informed.

Social Care

Dave suggested that there is good coverage of social care across most of Scotland, but that there is a wide variety of approaches and that short-term funding remains an issue. Better joint work, including co-location, with opioid replacement therapy provision would assist, as would longer-term funding.

Naloxone

Again, there is good coverage for Naloxone across most of Scotland, with 40,000 kits distributed and some 3,000 kits used in an overdose reversal. However, Dave suggested that we need to develop a wider distribution, particularly to include peer distribution.

Employability and employment

There is little in the way of employability and employment opportunities for people with problematic drug use. At most, there are 50 supported employment places, nearly all in social care, although some other opportunities are being developed such as through Elevate in Glasgow.

> **I'd just like to be living like the same mundane existence that eight tenths of the population are living.**
>
> A PROBLEMATIC DRUG USER

However, Dave noted that we need to identify the aspirations of people with drug problems and develop wider range of options for training and employment in other sectors such as horticulture, catering and construction, rather than just in social care.

Housing and welfare rights

Dave pointed out that the housing first model has a good evidence base and needs to be rolled out. The placing of welfare rights workers in drug services has a good evidence of increasing income, but again we need to identify the aspirations of people with drug problems and develop a wider range of options for training and employment to support them further.

Enforcement and wider criminal justice

On drug possession, Dave noted that there are no prosecutions for small amounts of cannabis and only approximately 3,000 prosecutions for cannabis per year. In terms of prison and alternatives to custody, Dave pointed out that the prison population, including the proportion of drug users, is static, and the numbers of drug treatment and testing orders is also static.

Dave suggested that we have to develop models to divert from prosecution for all drugs possessions. He pointed to models from Bristol and Durham, in particular. We also need to improve the throughcare and continuity of care, along with a wider range of alternatives to custody through court disposals, such as DTTO Lite in Edinburgh.

Aspiration

Dave finished by showing a quotation from a problematic drug user that he said encapsulated the issue: ***"I would just like to get a job and all that and just be like a normal person, but certain months of the year take a break, take a holiday and ... (I'd) just like to be living like the same mundane existence that eight tenths of the population are living."*** The aspiration outlined above may not seem high but it is a big job. Dave pointed out that we will pay for these people in one way or another, and that paying to build pathways to recovery is more than worth it.

Rosie Hutcheon, Step Together

Rosie Hutcheon was invited to speak as someone who has had contact with drug services.

I am here primarily as a mother. I appreciate the opportunity to share some of my experiences and observations as the mother of a seemingly happy child who became consumed by addiction, a process which started in his early teens. He is now 36 and in early recovery, but I know that that may change tomorrow. I am still connected to my son and we continue to support him, but from a distance which allows us all to live our own lives.

As all of us here are aware, addiction is an illness which affects the whole family system. For every person suffering from addiction of any kind there are many friends and family members suffering alongside them. In our family, we have six people close to our son whose lives have been significantly shaped by his addiction: parents, partners, a sibling and a daughter. However, the effects are far reaching, and our relationships with friends and extended family have also been impacted.

The evidence is clear that those living alongside active addiction become ill in a way which mirrors the devastation of their loved ones' lives. Family members gradually adapt to cope with the shame, pain and chaos and, without understanding addiction, they adapt in ways which perpetuate the illness and its impact. They enable their loved ones' addiction and become enmeshed in their lives to the exclusion of their own needs.

We suffer from chronic anxiety, depression, isolation, fractured relationships, rifts within close family; we develop physical health problems and financial problems; we lose the capacity to maintain employment. My experience over two decades now has encompassed all of of these difficulties.

Around five years ago my son went into residential rehab. Part of their service is a weekly family programme, which we were offered. My husband was reluctant, but he knew I needed help and went initially for my sake. We were both immediately struck by the comfort of being with people who understood how we felt and what we had endured. At last I was in company where I didn't feel different. The time for me to enter family recovery had arrived. I was ready to accept what we were dealing with.

> **For every person suffering from addiction of any kind there are many friends and family members suffering alongside them.**

We found ourselves in a setting which provided us with the tools we needed to rebuild our lives and regain a sense of ourselves and to provide more effective support for our son as much of what we need to do in our situation is counter intuitive as parents. My closest friends now are women I met in the first few weeks at Leap.

After some time, we decided we would repay our gratitude and train as facilitators ourselves. We trained to deliver the evidence-based solution-focused SMART Family and Friends Recovery Programme.

Two and a half years ago we set up a new group in Linlithgow. It has been very successful and in November last year we became a constituted group, Step Together Family Support, with a committee of six. Our group members also wanted to pass on their experience, and so in February this year we opened our second group in Bathgate in which two of our Linlithgow group take the lead.

> Just as addiction is a family illness, so the antidote – support to families – has a ripple effect

Our two groups dovetail and complement the work of West Lothian Drug and Alcohol Service, with whom we have had a long personal association. Sadly, commissioned services have recently had to cut back. Until the true benefits and cost effectiveness of fully supporting families are recognised, commissioned services will be financially constrained and limited in what they can provide to families.

Based on our experience we are now passionate family recovery activists, keen to take up opportunities to promote the benefits not only to individuals or the wider recovery community, but as a cost effective means of reducing the harms relating to addiction and improving cost effective outcomes for all concerned. Adfam commissioned research which concluded that for every £1 spent on family support there is saving to the taxpayer of £4.50.

Many people believe the savings to be much greater. Just as addiction is a family illness, so the antidote – support to families – has a ripple effect and benefits many people beyond those directly receiving that support.

One example of cost effectiveness that I can evidence is that with the right support I was able to give up my reliance/dependence on temazepam, Prozac, dihydrocodeine, amitriptyline, citalopram and various other efforts made at different times by well-meaning medical professionals to address my despair and deteriorating health. I can now see the sheer irony of creating addiction to prescribed medications in family members, but back then I just needed to get through the days. I now have different ways of managing. I would like to see family support prescribed as a viable, and possibly the best, medication for families coping with these challenges.

Families constitute a huge army of carers. We were described in a 2012 report from the UK Drug Policy Commission as the "Forgotten Carers". We care for our loved ones, and evidence demonstrates that families in family recovery are much more likely to get their loved ones to accept help and sustain their own recovery. We certainly help to keep them alive. We effectively reduce the likelihood of drug deaths.

In significant numbers we also care for the children – our grandchildren – and help to mitigate the adverse effects of their difficult start in life.

My son is stable at the moment, but we have accepted that he suffers from a relapsing condition and when he has his struggles now, we handle it very differently. It still hurts, but we accept what we can't change.

With education about addiction we can turn anger and resentment into compassion and understanding. With solution-focused groups, we can learn new and more effective ways of responding and communicating. With social support of peers who walk our walk, we gain the strength to make difficult choices, but also to challenge stigma where and when we meet it.

Rosie Hutcheon, Step Together *(continued)*

So, what points in relation to family recovery would I like those with influence to consider?

- Recognition of the support needs of family members in their own right.
- Recognition of the key role of families supporting recovery and the fact that family members receiving the right support in tandem with their loved ones are better equipped in that role.
- Recognition of family as advocates. I believe those suffering from addiction have mental health problems and are often lacking in the self-esteem and confidence to make demands when services are not responding or where they encounter institutional stigma which informs some aspects of policy, provision and sadly even practice.
- Recognition of family as advocates for change. My personal vision is of working towards a family recovery movement. We recently hosted a local event attended by 57 people across the wider recovery community and with representatives from six family support groups across the Lothians. We are invested in seeking fairer treatment of our loved ones based on current evidence and scientific data.
- Recognition of the shameful lack of provision across Scotland. West Lothian may be on the way to being Family Recovery Central, but there is no accessible support in many parts of Scotland, particularly in rural areas. I have the details of all services across Scotland with me as researched by Scottish Families Affected by Alcohol and Drugs.
- We ask for recognition, funding and support for our national body, Scottish Families Affected by Alcohol and Drugs, who provide a wide range of services and try to support rural communities through TELEHEALTH and their helpline. They were also a great source of support and encouragement to us when we started out, and we have had ongoing support to our members such as bereavement counselling which has sadly been required by two of our members, who have lost daughters.

> **My personal vision is of working towards a family recovery movement.**

- Recognition of the needs of children, not only those who come to the attention of services involved with their parents, but those whose loved ones are not in services. There are many children suffering the impact under the radar. This requires commitment, funding and creative approaches to reach these children.

I have limited time to speak this morning, but I also have views directly informed by my son's and our family's painful experience on welfare benefits, housing (the one strike out recovery hostels versus housing first models), decriminalisation, safe injecting sites, family inclusive practice and the wasted opportunity inherent in three-month waiting times for treatment. Our sons and daughters and partners die on waiting lists, and it is well evidenced that motivation is at its peak in crisis when they ask for help.

A final word about Step Together Family Support: we are a peer-led support group and we are very proud of our achievements. We try to be more than a weekly support meeting offering a range of activities and opportunities. With a recent injection of funding, we are hoping to develop further. I believe in the transformative impact of peer support, but I would prefer to be working collaboratively with commissioned services utilising our commitment and enthusiasm, but providing our group, its volunteers and participants with the professional expertise, funding, training, supervision and back-up which would give us sustainability and longevity.

Families deserve more equitable treatment, and support to families needs to be provided in all communities where families like ours struggle to live alongside addiction in any of its guises.

Discussion

Adam Tomkins thanked the speakers for their contributions, and opened the floor for discussion.

The first question was whether addiction was seen in isolation. It was suggested that, although health and social care is improving the situation, people were still pushed between mental health and addiction services. Primary care was seen as particularly important given the range in health conditions affecting problematic drug users over 35 years of age. It was also suggested that NHS addiction services have not changed in 25 years, and that other models are more effective, particularly when integrated with others, such as social care and housing first.

It was noted that imprisonment for drugs offences can be counterproductive. One example was given of a young man who was sent to Polmont for dealing ecstasy. Six months after going in as a recreational user of cannabis and ecstasy they came out a heroin addict who had suffered several assaults. Such trauma can lay firm foundations for addiction.

The stigma attached to families was also mentioned. Feelings of shame and guilt can lead family members to becoming isolated from their friends and communities.

Finally, there was a discussion about retention in treatment and disciplinary discharges, which were described as unhelpful: people present to services as an addict and then are punished for being an addict.

It was stated that services should be more person-centred, particularly for those struggling with abstinence. It was pointed out that Norway stopped disciplinary discharges from support services and has seen a benefit from that. Bringing people into treatment, and keeping them there, works, and so services should go and conduct assertive outreach.

Workshop groups

Clare Haughey MSP introduced the workshop groups, which looked at four key questions:

- **What is Scotland doing well?**
- **What could Scotland to better?**
- **Where should we learn from?**
- **Where do we want to be in five years?**

This report brings the feedback together.

> All in all, there was a sentiment that Scotland is starting to take the right approach

What is Scotland doing well?

Some participants admitted that it can be a struggle to point out what is right, partly because cultural habits mean that we are more used to pointing out what is wrong.

That said, the fact that drug use is reducing was welcomed, although the level of harm from drug use was seen as a more important indicator.

There was general support for the Scottish Government decision 10 years ago to move drugs policy from justice to health. The framing of the issue as a public health one is positive, and it has helped develop greater understanding and support at local and national level for those addicted to drugs and, more successfully, their families.

This has had a positive impact on services. The development of alcohol and drug partnerships, the increasing involvement of families and the building of a recovery community in Scotland were all seen as progressive developments. There is enthusiasm and commitment among the key service providers within Scotland.

In particular, it was noted that Scotland has had success around blood-borne viruses, with a strong strategy and world-leading research. Equally, the decision to distribute Naloxone has also had important preventive effect and demonstrated that we can make bold decisions.

The 2008 Scottish Government strategy "Road to Recovery" was seen by many as a good document that has prompted a useful journey in supporting harm reduction. However, questions remain about implementation and the role of abstinence in the recovery approach.

All in all, there was a sentiment that Scotland is starting to take the right approach, using our evidence base correctly to take the right decisions based on the right knowledge.

Finally, the fact that Scotland is having these discussions about the future of drug policy was seen as a positive. We bring the right people to the table, but there was some frustration that there is not enough output. There is an ambition to improve. As was noted, "We could be leaders. People are dying, and we need to change."

What could Scotland do better?

Services

Not enough people are in treatment: more people in treatment will make a positive difference to the number of deaths and the harm experienced in Scotland.

The services are not resourced to cope with the full demand – the waiting times for treatment are already too long, and it was suggested that a punishment attitude in the disciplinary discharges may be linked to caseload demands.

Services need to be better integrated, both within the public sector and between the public and voluntary sectors. They also need to reflect the individual needs of the people being treated, partly by building different menus of recovery programmes and learning from people in recovery who have lived experience. They should also involve fewer points of contact for the various services involved.

> **People present to services as an addict and are then punished for being an addict.**

Diversion projects already exist but should be used more widely. The number of drug treatment and testing orders, for example, remains static.

The needs of those affected by problematic drug use, including families and local communities, must also be better met. We should work better towards recovery in the community.

Stigma

There is a stigma attached to those who use drugs, their families and their communities.

This feeds through into the approach of service providers: as noted earlier, people present to services as an addict and then are punished for being an addict. There is therefore a lack of belief that people can have honest discussions about their drug use in their interactions with services.

The use of language such as "junkies" and "users" rather than people leads to an othering that makes helping those in need harder. It also affects their family and friends – those who are often best placed to support them in treatment. This all reduces the number of people accessing treatment.

There is a recovery movement but it needs to be more visible. People know about recovering alcoholics but less about recovering drug addicts. There needs to be more public awareness.

There is support from elected politicians and some media, but not around elections and not always for addicts themselves – more for families affected by the addiction.

The question was asked: how can stigma be challenged while drugs are criminalised?

Public policy framework

The move from the justice to the health portfolio is a positive step, but there is still work to do. There should be more transparency about policy, strategy and who is responsible for delivery.

Too much money is spent on drugs related issues in the criminal justice system. The current Police Scotland attitude to drugs could be improved. Targets that play a role in the focus of police activity should be better crafted to avoid a negative effect.

There is too great a focus on one cohort of drug users, which does not take into account the issues related to recreational drug use. The focus is too negative on death rather than what there is to live for – helping people build lives with good housing and work.

The overall framework for our approach to drugs hasn't changed since the Misuse of Drugs Act 1971 – nearly 50 years ago. This leads to a constant negative portrayal of drug users as criminals. A focus on wellbeing and quality of life will help establish a more positive approach.

The Scottish Government's "Road to Recovery" is based on abstinence as the target. It should take more notice of evidence from the Advisory Council on the Misuse of Drugs about the dangers of too narrow a focus on abstinence. Managed drug use can be an acceptable outcome for some people, but that is not captured in "Road to Recovery". Indeed, people struggling with problematic drug use do not need another sense of failure when they don't achieve full abstinence.

Where should we learn from?

There were many suggestions of services, places and countries that we could learn from. The housing first approach to homelessness, the River Garden in Auchencruive and the Haven in Kilmacolm were all given as examples from Scotland.

In Durham, a new approach has been trialled with police involvement to bring in diversion from prosecution. There are also examples of drug testing for safety in conjunction with music festivals and those involved in the night time economy.

In Europe, the examples of Ireland, Norway, Switzerland, the Netherlands and Portugal were all brought up. Norway has seen a reduced number of drug deaths, partly perhaps from reducing disciplinary discharges from treatment, while safe injecting rooms are running successfully in Switzerland and being introduced in Ireland.

Most notably, the example of Portugal was shared. It was noted that the headline approach of decriminalising drugs was also accompanied by a campaign to tackle stigma and provision to increase access to services. A change in the law should not be seen in isolation.

Further afield, the Queensland approach to drug testing in Australia and the decriminalisation of cannabis in Uruguay and US states such as Colorado were also noted.

Participants all pointed to the importance of remembering and reflecting on cultural trends and differences in different countries, and being wary of taking simplistic lessons from elsewhere.

> **The countries that have succeeding in reducing harm from drug use are those that have implemented policies based on the evidence.**

It was pointed out that one way to approach the question is to ask which countries have had success and what they did to achieve that success. Generally, it was suggested, the countries that have succeeding in reducing harm from drug use are those that have implemented policies based on the evidence.

In Scotland, therefore, we have to follow the evidence base and implement policies coherently across portfolios that reflect what we know about drug use and harm in Scotland.

Where do we want to be in five years?

There will be a massive decrease in drugs deaths

As part of that, we will have controlled the HIV outbreak in Glasgow, had a real impact on rough sleeping and enabled people who have problems with substances to connect and reconnect with their communities. Overall, we will not just manage the problems better, but reduce them.

Services will be better run and better delivered

Services, and their budgets, will be more joined-up. They will bring together public and third sector organisations to meet the individual needs of drug users and their families. **Person-centred care, with supported employment and family involvement as standard** throughout the country, will be the norm. The Haven and River Garden models may have spread throughout the country, too.

Services should be more accessible. **Proactive outreach services will enable a single point of contact** for the user and their support network and **a focus on recovery through peer and community support**. As an example, there will be an addictions nurse in every health centre in Scotland, and they will be available to be seen with little notice. More people will be in treatment, and fewer will suffer harm or die.

Treatment options will be broader

Opioid replacement therapy, heroin assisted treatment and safe injection facilities may take place throughout the country, along with the requirement for all GPs to take part to enable all people to benefit from treatment.

There will be a shared **understanding of new psychoactive substances** and the ways to tackle the harm brought about by their use.

Stigma will be reduced

The stigma attached to those who take drugs and their families will reduce, with a rehumanising effect on the services provided and communities affected. **Public opinion and the language used in the media will change**, with greater support both for and from communities and acceptance that drugs use is a health issue.

Where do we want to be in five years? *continued*

There will be a less punitive use of resources

Although abstinence will remain an aim for many, **there will be an acceptance of the continuum from harm reduction to abstinence**. A lack of abstinence will not be a barrier to treatment or understanding, and services and support will be designed, delivered and explained to individuals who take drugs and those around them on that basis.

Public policy will cover the range of issues

Blood borne viruses will not fall off the agenda, and successes will be built upon in other fields of research and service delivery.

Scotland will have had a serious conversation about decriminalisation

The legal framework in relation to drug taking will be considered carefully, with an understanding of people's hopes and fears. Issues such as the approach to possession of drugs for personal use and the prescription of cannabis for medical use will feature. **Decisions will have been taken based on all the evidence available.**

Scotland will have a clear vision of success

Scotland will feel able to take brave decisions and a leading role in drug policy approaches. Everyone involved will have a clear understanding of the indicators for the steps required to achieve the vision, and **politicians will sign up on the understanding that they may not see results within one election cycle.**

Thanks and next steps

Clare Haughey MSP and Adam Tomkins MSP both thanked participants for their involvement and contributions. The results from this discussion would be fed back into the work of both the Futures Forum and the Scottish Parliament. On the back of feedback, the Futures Forum would decide what more it can bring to the conversation currently taking place on drug use in Scotland.

Attendees

Mark Clark	The Haven
Emma Crawshaw	Crew 2000
Emilia Crighton	Glasgow City Alcohol and Drug Partnership
Roz Currie	Office of Tommy Shepherd MP
Ian Davidson	West Lothian NHS Addictions Service
Elinor Dickie	NHS Health Scotland
Allan Elderbrant	Police Scotland
John Finnie	MSP
Fiona Gilbertson	Recovering Justice
Deborah Gillespie	Inverclyde Health and Social Care Partnership
Clare Haughey	MSP
Carole Hunter	Glasgow City Alcohol and Drug Partnership
Colin Hutcheon	Step Together Family Support
Rosie Hutcheon	Step Together Family Support
Neil Kerr	East Ayrshire Alcohol and Drug Partnership
Johann Lamont	MSP
Dave Liddell	Scottish Drugs Forum
Gary Lister	The Haven
Mike McCarron	Transform
Steve McGeady	Glasgow City Alcohol and Drug Partnership
Iain McPhee	University of the West of Scotland
Alison Munro	Drugs Research Network Scotland
Justina Murray	Scottish Families Affected by Alcohol and Drugs
Aileen O'Gorman	University of the West of Scotland
Tessa Parkes	University of Stirling
Saket Priyadarshi	Glasgow City Alcohol and Drug Partnership
Anna Ross	Scottish Drugs Policy Conversation
Joe Schofield	Drugs Research Network Scotland
Suzanne Sharkey	Recovering Justice
Barry Sheridan	Renfrewshire Council
Adam Tomkins	MSP
Heather Watson	West Lothian Drug & Alcohol Service
Anne Whittaker	University of Stirling

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