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(DRU0040)

**Written evidence submitted by Dr. Carlton Brick (DRU0040)**Introduction & Summary

1. This submission adopts a critical approach to current Scottish Government policy on drugs and drug deaths specifically. It pinpoints the increasing tendency of harm reduction strategies to undermine approaches to drug recovery that advocate abstinence as a realistic goal. The submission suggests that harm reduction undermines the capacity of both medical treatment and the individual drug user to address and overcome the problem of addiction. Following McKeganey (2011: 169) - who argues that 'Retaining moral judgements about drug use and accepting the stigma directed towards drug use if not drug users may be an important part of an effective approach aimed at tackling the use of illegal drugs in society' – this submission suggests that Scotland's drug death crisis is underpinned by a wider moral abdication of responsibility by government, policy makers and the wider political community, towards both the individual addict and wider society. As such this submission argues that the drugs issue is no longer simply a question of policy but has become a fundamental moral question that pertains to how the UK and devolved administrations understand addiction in relation to the interests, common norms and values of civil society and the wider national community.

Drug Deaths & Opioid abuse in Scotland

2. Scotland has the worst drug related deaths per head of population in Europe and is over 3 and a half times that of the UK as a whole. In 2020, there were 1,339 drug-related deaths registered in Scotland. This was 5% more than in 2019 and the largest number since records began in 1996. Moreover, deaths have increased substantially over the last 20 years with almost 5 times as many deaths in 2020 compared with 2000 (National Records of Scotland, 2021a)

3. To put both the scale and nature of Scotland's current drug deaths crisis in a global context, Scotland's drug deaths per 100,000 of its population stands at around 33.6. The United States rate is 20.6. 89% of drug deaths in Scotland involve opioid abuse. This includes drugs like codeine, morphine, tramadol, heroin and of course methadone. America's 'supposed' opioid crisis pales compared to the extent of the opioid crisis in Scotland, which in 2018 was more than double the rate in the United States. Methadone accounts for almost 50% of all of Scotland's drug related deaths (van Amsterdam, 2021). Deaths from methadone have almost tripled since 2015. Methadone is also the drug administered directly by the Scottish government to wean addicts off heroin as part of a maintenance and harm reduction strategy

4. Whilst recognising that there are specific variables (for example gender, age and economic) that shape the pattern of drug deaths in Scotland – the National Records of Scotland (2021b) suggest that the majority of drug-related deaths occur within a cohort of males aged between 35 and 54 (the average age increasing from 32 to 43 over the last 20 years). Those living in the most deprived areas are 18 times more likely to die from a drug-related death than those in the least deprived – these variables do not in and of themselves explain the high rates of drug related fatalities as a percentage of the population.

5. Indeed, recent academic research has identified the rapid increase in opioid related deaths in Scotland as 'remarkable' and 'worrisome'. When comparing opioid related death rates across the UK as a whole research suggests that there are '... no clear regional differences...' and as such their role as drivers of the Scottish opioid crisis is probably limited' (van Amsterdam, 2021).

6. The key driver in Scotland's drug-death crisis is government policy. This submission notes that there are apparent differences in how the UK and Scottish Governments view and treat the issue of drugs. The UK government is characterised as favouring a criminal justice centred approach, whilst the Scottish administration seemingly favour a public health centred approach.

7. However, as will be explored below the apparent divergence between the UK and Scottish Government's on this issue is perhaps not as clear cut as first presented. Both governments approach emphasises a policy of harm reduction. In the case of the Scottish example, advocates of harm reduction strategies have been successful in arguing that the idea of abstinence and prohibition, as meaningful outcomes of drug treatment are no longer tenable. This has potentially worrying impacts for the shape of drug policy in the UK more widely. This submission will now look at some of these trends within the context of Scottish drug policy and will then go on to explore the problems associated with the adoption of harm reduction policies more broadly.

## Scottish Drug Policy and the Retreat from Abstinence

8. The Scottish Government's approach to developing a response to the perennial drug deaths crisis has effectively jettisoned abstinence as a meaningful or desired outcome when treating addiction. This is a view also shared by academics and experts. This tendency underpins recent Scottish government initiatives such as the national anti-addiction stigma campaign. Launched in December 2020 as part of the Drug Deaths Taskforce set up by the Scottish Government in 2019, the campaign suggests that '...many who could benefit from treatment can be discouraged from doing so by language, attitudes and behaviours that appear judgmental...' and that '...tackling stigma could make a significant contribution to reducing drug-related deaths in Scotland.' As such the campaign suggests that 'anyone, including media, writing or commenting on issues relating to substance abuse, including drug related deaths, to do so without using the stigmatising language or imagery that perpetuates harm to those at risk.'

9. The campaign which includes a series of posters and TV adverts suggests that terms such as 'user', 'addict', 'drug abuse' or 'drug user' should no longer be used to describe individuals with substance abuse issues. Moreover, the campaign ads continue:

*Substance use has been seen as a lifestyle choice or the result of poor decisions. It's also been described or viewed as a mistake or the result of moral weakness. This is stigmatising and unhelpful. It shows a connection between drug or alcohol use and personal failures. This allows substance used to be linked to character or morals. Viewing this as just a personal issue adds to stigma. A drug or alcohol problem is a health condition. People should receive help and support, not judgment. Let's end the stigma of addiction.*

(<https://www.scotsman.com/health/stop-saying-junkie-adverts-aim-to-end-stigma-over-alcohol-and-drug-problems-3483132> )

10. However, the Scottish governments campaign has little to do with actually helping drug addicts. Far from promoting tolerance and respect, the campaign appears to stigmatise the established belief held by many ordinary people that generally speaking, individuals are responsible for what they do and if it is harmful to themselves or others, they have a responsibility to desist from such behaviour.

11. The Scottish government and its drug experts have all but jettisoned the idea of recovery and have become enthralled to the idea of harm reduction. The dominant view is that stigma and discrimination of Scottish drug addicts, rather than their actual addiction itself, is the leading contributory factor to the annual increase in drug deaths.

12. In April of last year Scottish First Minister Nicola Sturgeon suggested that public discussion of drug rehabilitation was a distraction, and that too much time had been wasted in Scotland debating the issue (<https://www.scotsman.com/news/politics/the-scotsman-2021-election-hustings-decriminalisation-is-key-to-ending-nicola-sturgeons-drugs-death-disaster-says-campaigner-peter-krykant-3199831>).

13. In July 2020 under the then stewardship of Professor Catriona Matheson, Professor of Substance Use at the University of Stirling, the Task Force published its stigma and drug abuse strategy. Subtitled 'We all have a part to play' the strategy argues that the commonly held belief that addicts should be encouraged to abstain from taking drugs is no longer an acceptable view to hold. Matheson argues that abstinence is discriminatory and should no-longer be the aim of official drug policy because it stigmatises those drug addicts who fail to quit. Government policy on addiction, the Task Force argues, is undermined '... by the common perception among service staff and others that abstinence is the purpose of treatment... a notion based in stigma... and is a key driver of drug-related deaths' (Drugs Death Task Force, 2020).

14. A 'hierarchy of stigma' exists in Scotland which informs a deeply ingrained prejudice against drug users. 'Public discourse, political discourse, criminal justice discourse, public health discourse, media coverage' contributed to a climate whereby 'Stigma is absorbed and internalised by people who have been subjected to persistent stigma. People with a drug problem often have a perception of themselves that simply reflects the prejudices of others that are based in their stigmatisation.' In other words, as long as public opinion on addiction is shaped by attitudes that are fundamentally opposed to substance abuse, discrimination against drug addicts will continue.

15. According to Scottish government experts the stigma faced by addicts, is systemic in Scottish society and is a far bigger problem than their actual addiction. Moreover, it is a form of discrimination on a par with racism and sexism, and as such local communities and Scottish public opinion need to be re-educated in

relation to the way in which their stigmatised options are discriminatory and perpetuate social inequality (Drugs Death Task Force, 2020).

### Harm reduction & Moral Ambivalence

16. Current Scottish policy is often justified on the grounds that it is a far more compassionate and socially just approach to treating substance abuse in Scotland and is often contrasted favourably with approaches south of the border. However, harm minimalization has characterised both medical and government approaches to drug addiction in the UK since the 1980s - the adoption of methadone as a 'therapeutic' substitute for heroin (Fitzpatrick 2001; McKeganey, 2011).

17. Introduced by the Conservative UK Government in an effort to initially control the spread of HIV infection, harm reduction strategies, such as needle exchange, and outreach education on safer injecting techniques have now become common practice in dealing with UK drug problem. In 2002 the Home Office (2002:3) issued guidance stating that 'All problematic drug users must have access to treatment and harm minimization services not within the community and through the criminal justice system'. This now also included the introduction of 'methadone maintenance' as a principal strategy in treating addiction. As outlined in the Government White Paper 'Tackling Drugs to Build a Better Britain' (President of the Council, 1998) and the guidelines on clinical management provided by the Department of Health in 1999 (Department of Health, 1999) the UK approach was now predominantly public health centred. Drug addiction was something to be managed rather than something to be cured.

18. Indeed, as Fitzpatrick (2001) argues this new 'public health' approach was characterised by its sidelining of abstinence as a meaningful policy goal in favour of a more instrumentalised outcomes such as harm reduction. The objective was no-longer to encourage users to become drug free, but to replace a dependence upon one illicit substance with long-term dependence (or 'maintenance') on methadone. This has had disastrous consequences for the drug addict as evidenced above the high levels of Scottish opioid deaths. However, it would be wrong to single out the use of methadone as a cause of Scotland's drug death rates – used as a strategy within a correct context that centres recovery as its primary goal, methadone has a valuable role to play. As Fitzpatrick (2001: 99) notes that 'Since its introduction into the treatment of heroin addiction in the USA in the 1940s it [methadone] has been prescribed to patients in steadily reducing doses, with a view to achieving abstinence.'

19. The key distinction between the initial use of methadone to treat addicts and the contemporary context is the differing conceptualisation of abstinence as a meaningful and desired outcome. As already noted, the turn towards harm reduction that occurred in the 1980s and 90s has all but negated the ideal of abstinence as a worthwhile endeavour, favouring instead a much more instrumentalised, detached notion of addiction management.

20. There is evidence that clearly suggests that harm reduction strategies do indeed reduce the addict's exposure to harm – as defined as interventions that encourage 'safe' consumption and drug use. However, as McKeganey (2011) notes harm reduction is far less successful in successfully treating the more pressing harm of addiction. As the case in Scotland clearly evidences, a policy predicated solely upon 'safely' maintaining a patient's addiction without addressing the principal problem of addiction itself means very little if the end result is premature death. Indeed, McKeganey (2001) goes as far to characterise the contemporary harm reduction movement as morally ambivalent. I find it hard to disagree with his assessment, only to suggest that in the case of current Scottish drug policy it represents a complete abdication of both moral and social responsibility on the part of government, policy makers and the wider political community in Scotland.

21. The addict doesn't only swap one addiction to a dangerous and deadly substance with another, they also become increasingly more dependent upon the state. This fetishization of harm reduction strategies both pacifies the addict as a wilful subject and institutionalises the notion that addiction is something to be managed rather than overcome. Harm reduction policy negates the possibility of the drug user being able to rehabilitate themselves and overcome their addiction. It subordinates the actual interests of the addict and drug abuser – to get better – to the instrumentalised managerial logics of the spreadsheet. It views the addict as statistic, a piece of data, and the role of the state to try and make sure the statistic does not die. The management of addiction has become an end in itself rather than a means to an end, albeit, as Scotland's drug death figures testify, it is a profoundly dysfunctional one.

## Concluding Remarks

22. The focus upon harm reduction at the expense of recovery and rehabilitation endorses an idea that addiction is socially acceptable and should be respected by wider society. It provides a technocratic managerial solution to what is in fact a fundamentally moral question about the individuals responsibility to wider society and their ability to contribute purposively to that society– in this case the addict’s willingness to exercise personal responsibility for their condition and give up. The retreat from the view that substance abuse is an aberrant and socially unacceptable form of behaviour negates the moral responsibility that the individual addict has to wider society to take responsibility for and through the exercise of personal restraint and abstinence overcome their drug problem, and thereby reintegrate themselves with the wider social community. Scotland's approach to substance abuse does little for actual addicts, except condemn them to death. It reflects an increasingly technocratic and pessimistic view of the capacity of the individual to take control of their life.

**March 2022**

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