Use and Misuse of Drugs in Scotland inquiry – Response from The Hepatitis C Trust

April 2019

Introduction

What is hepatitis C?

Hepatitis C is a blood-borne virus (BBV), primarily affecting the liver. An estimated 34,500 people are infected with hepatitis C in Scotland, with around half undiagnosed. Of these, around 90% will have the virus as a result of sharing equipment for injecting drugs.

People can live with hepatitis C for decades without symptoms, but untreated cases can cause fatal cirrhosis and liver cancer. Hepatitis C can also have a much broader impact and has been linked to cardiovascular disease, mental health issues, kidney problems, and musculoskeletal pain.

These significant health harms demonstrate the importance of supporting hepatitis C prevention efforts for people who use drugs, as outlined below.

Hepatitis C and drugs use

Hepatitis C is the most common blood-borne infection for people who inject drugs, with around half of this group having been infected with the virus at some point, and a quarter currently infected.[1]

Transmission occurs mostly through the sharing of injecting equipment, as well as of straws or bank notes for snorting drugs. The Scottish Drug Misuse Database found that 9% of drug users shared injecting equipment in 2017, a significant reduction from 20% ten years ago due in part to the provision in Scotland of low dead space syringes (LDSS) in needle exchange and alcohol services.[2]

The LDSS provision and other pioneering policies, such as the *Hepatitis C Action Plan (2006-2011)* and the current *Sexual Health and Blood Borne Virus Framework (2015-2020)*, have led to a significant increase in the numbers of people diagnosed and treated in Scotland over the past decade. However, not enough progress has been made in recent years. During the inquiry preceding The Hepatitis C Trust's January 2018 report, *Eliminating Hepatitis C in Scotland: A Call to Action*, there was agreement from experts that the World Health Organisation's target of elimination by 2030 will not be achieved based on current treatment numbers.

Until 2014, hepatitis C treatment was primarily injection-based, lasted between 24 and 48 weeks, resulted in significant unpleasant side effects leading to many people not completing the treatment, and had an overall cure rate of less than 50%. New direct-acting antiviral (DAA) treatments first became widely available in 2015. These treatments are tablet-based, last between 8 and 12 weeks, have few side effects, and result in cure rates upwards of 95%. This combination of high success rate and short treatment period provides a great opportunity to finally eliminate hepatitis C, particularly if people who inject drugs are targeted. This is currently being tested by researchers at the University of Bristol at a site in Dundee. The project, EPIToPe, will treat around 500 people who inject drugs over two years across multiple sites including the community, prisons, pharmacies and addiction services. It is estimated that this will reduce chronic HCV in people who inject drugs in Dundee from nearly 30% to less than 10%.[3]

People who inject drugs have been identified as the main driver of the hepatitis C epidemic, so it is essential that they are provided with harm reduction advice, offered testing, and supported to complete treatment.[4]

In this response we have decided to answer only the questions most relevant to hepatitis C policy.

To what extent does UK-wide drugs legislation affect the Scottish Government's ability to address the specific drivers of drugs abuse in Scotland?

While there are other ways to ensure drug users are injecting as safely as possible with minimal risk of BBV infection, drug consumption rooms (DCRs) are those most affected by UK-wide drug legislation.

What are DCRs?

DCRs are legally sanctioned facilities where people can use illicit drugs obtained themselves, under the medical supervision of trained staff. A 2017 report from think-tank Volteface, commissioned by Westminster's Drugs, Alcohol and Justice Cross-Party Parliamentary Group supported the introduction of DCRs, citing evidence that proves such rooms offer numerous benefits to the community and to drug users.[5] Safer consumption facilities are already in operation in some European cities, such as in Germany where there are 24 DCRs, and there is thirty years of evidence demonstrating their benefit.[6] Along with recent shocking figures showing the largest number of drug-related deaths in Scotland since records began, for the past three years Glasgow has been experiencing a worsening HIV outbreak, leading to a large amount of interest in introducing a pilot DCR in the city.[7]

Substance misuse policy in the UK is currently highly focused on a criminal justice-led approach. The Hepatitis C Trust advocates a rebalancing towards a health-based approach, with drugs being a devolved issue in the same way that health is. Supervised DCRs are an example of a bold, health-based prevention measure that should be implemented by the Government. Therefore, The Hepatitis C Trust supports the introduction of a pilot DCR as a means of reducing the transmission of BBVs such as HIV and hepatitis C. DCRs are also well-placed to provide testing and a pathway to treatment for people who inject drugs, offering a unique opportunity to raise awareness of hepatitis C with people who are often the hardest to engage.

The challenge of UK-wide legislation

Despite all key stakeholders being in favour of the introduction of a DCR in Glasgow, such as Glasgow City Council, Scottish Parliament, NHS Greater Glasgow and Clyde, and voluntary sector organisations, the UK Government refuses to consider a pilot as a viable way of reducing drug-related harm.

The Home Office has long argued that under current legislation DCRs are illegal and their introduction would require a change to the Misuse of Dugs Act 1971. Yet there have been various exemptions in recent years which demonstrate that ways around the Act are possible. The Loop has been working at festivals around the UK since 2016, testing people's drugs and sharing the contents and potency information with them, as well as giving individualised, confidential advice to reduce drug-related harm. More recently, the Home Office granted a licence for the first time allowing a pilot drug-checking service in North Somerset to be run.[8] This will provide a similar service to the festival testing, with clients able to discover the results of the testing in 10 minutes, during which time they have a conversation with a substance misuse practitioner as part of the harm reduction package. Given this scheme has gained exemption to the Act from the Home Office, it should be possible for a similar arrangement to be made regarding DCRs.

In 2018, Theresa May responded to Glasgow Central MP Alison Thewliss's challenge at Prime Minister's Questions saying that there is no legal framework for the provision of DCRs in the UK and there are no plans to introduce them.[9] However, many groups are still pushing for DCRs, with new evidence regularly emerging in their favour.[10] Alison Thewliss tabled a Private Members' Bill which had its second reading on 22nd March 2019.[11] Last week the Labour Party also came out in support

of DCRs as a means of reducing drug-related deaths in the UK.[12] Additionally, Westminster's Health and Social Care Committee launched its Inquiry on Drugs Policy on the 4th February 2019, which will hopefully consider the introduction of a pilot DCR in Glasgow.[13]

Other ways to reduce BBVs among people who inject drugs

DCRs are by no means the only way to reduce hepatitis C in people who inject drugs.

Since 2017, Scotland has provided LDSS in needle exchange and drug and alcohol services to all users, which reduces the risk of onwards transmission. LDSS achieve this by reducing the amount of 'dead space' left in a needle or syringe once the plunger has been depressed, thereby limiting the residual fluid which may harbour BBVs. Services offering needle and syringe programmes (NSP) like this, as with DCRs, also have an important role to play in passing on information and advice about hepatitis C to those accessing the service. They are in an optimal location for offering testing and treatment for hepatitis C, with many of those attending not engaged with substance misuse services or other healthcare services. It is therefore essential that services providing NSP receive adequate funding if hepatitis C is to be eliminated in Scotland.

A needle exchange was set up in a Boots branch in Glasgow Central Station in 2016 following a spike in HIV infections in the city. It was one of the busiest needle exchanges in Scotland, providing 1,000 transactions a month and issuing over 40,000 clean needle kits.[14] However, 14 months later, against the wishes of the police, Scottish Government, and the NHS, it was closed by Network Rail, who own the building. Network Rail made the decision after drug-taking equipment was found in public areas and a drug user died from an overdose in the station.

Many groups working with drug users condemned the closure, with the Scottish Drugs Forum claiming there had been only 10 minor incidents and one major incident over the past year, with drug users likely to be in the area regardless. The Scottish Government was concerned at the time about the impact this would have, and the Minister for Transport and the Islands spoke to the managing director of the ScotRail Alliance to try to change the decision, though was unsuccessful.[15] Additionally, most customers using the transport service were not aware of the needle exchange, with one survey of passenger concerns about policing on the Scottish rail network placing drug use only tenth in the list.[16]

The closure led to a drop of people using NSPs by 20%[17] and a sharp decline in the number of clean needles issued to drug users in the months following.[18] To counter this and to continue to tackle the HIV outbreak, NHS Greater Glasgow and Clyde bought a mobile needle exchange a few months later which visits known city centre hotspots for drug consumption. It also offers BBV testing, such as for HIV and hepatitis C, and staff are trained to signpost people to services.[19] It is crucial that NSPs continue to provide drug users with clean equipment to prevent the transmission of hepatitis C and other BBVs, and act as a link to testing, information and other services.

Opioid substitution therapy (OST) can also reduce hepatitis C transmission, as well as being a highly effective alternative to injecting drug use. However, expert witnesses questioned during the All-Party Parliamentary Group on Liver Health's inquiry into eliminating hepatitis C in England (supported by The Hepatitis C Trust as the group's secretariat) reported that funding pressures in substance misuse services were preventing them from encouraging and supporting patients into OST, with pressure on workers to get people through treatment quickly and an emphasis on abstinence-based recovery, rather than OST.[20] For many clients, OST can be a more effective means of transitioning away from injecting drug use, therefore eliminating the risk of hepatitis C infection. It is The Hepatitis C Trust's position that OST should be made available to all who need it.

What is the relationship between poverty and deprivation and problem drug use?

Hepatitis C disproportionately affects disadvantaged and marginalised communities, most of whom are people who inject drugs. In Scotland, half of all hepatitis C cases are concentrated in the most deprived fifth of the population.[21]

The introduction of a DCR in Glasgow could potentially reach 400 to 500 people who currently inject drugs publicly, according to HIV Scotland, Hepatitis Scotland, Waverley Care, and Glasgow City Council in their response to the Health and Social Care Committee's current inquiry into drugs policy.[22] A DCR would create a link to a particularly vulnerable population who face severe and multiple disadvantages. This population are disproportionately affected by health inequalities, in part because they are expected to be proactive in reaching out for and identifying information about hepatitis C. People with hepatitis C may not be in a position to be proactive, either because they are unaware of their infection status, as is the case for 50% of people who inject drugs, or due to a combination of socioeconomic or psychological factors.[23] The stigma associated with hepatitis C often compounds the existing stigma and exclusion experienced by individuals as a result of poverty and addiction issues, which acts as a further barrier to engaging with healthcare services. This results in inequality of access to care and treatment, a situation which would be ameliorated by the link between service-user and services which a DCR would provide.

How effectively do the UK and Scottish Governments work together to tackle drugs misuse in Scotland? Do the UK and Scottish Governments share best practice, information and policy outcomes to help address drugs misuse in Scotland?

With regards to the introduction of DCRs, it is our view that the UK and Scottish Governments have not been able to work effectively. As already described, this is due to the uncompromising stance of the UK Government to ignore the extensive evidence in favour of DCRs and to refuse either to relax the Misuse of Drugs Act 1971, or to devolve sufficient powers to the Scottish Government.
This decision is counter to the views of major stakeholders in the Glasgow area who support the use of DCRs, such as NHS Greater Glasgow and Clyde, and the Glasgow City Alcohol and Drugs Partnership, an official body which itself includes Police Scotland, Glasgow City Council, Community Safety Glasgow and many others.

In August last year a letter to the Home Secretary Sajid Javid was sent by Chairs of the Drugs, Alcohol and Justice Parliamentary Group, the APPG on Drug Policy Reform, the APPG on HIV/AIDS, the APPG on Liver Health, and the APPG on Sexual and Reproductive Health regarding the need for a DCR in Glasgow. The reply from Victoria Atkins, Minister for Crime, Safeguarding and Vulnerability, set out that the Home Office had no plans to introduce a DCR because they allegedly went against the existing framework and were not 'aligned to the spirit of the Government's 2017 Drug Strategy'. Additionally, Ms Atkins mentioned legal and ethical concerns, especially those around appearing to condone the illicit drugs trade. As well as ignoring extensive evidence in support of DCRs, her response demonstrated the inconsistencies in the UK Government's approach to drugs, given they are prepared to allow interventions such as heroine-assisted treatment and festival drug testing. It was also frustrating that Ms Atkins declined to meet with representatives from the APPGs to discuss the matter further. The Drugs, Alcohol and Justice Parliamentary Group have since sent another letter at the end of February 2019 requesting to meet as a matter of urgency, though no response has been received.

We believe that the Home Office should work closely with the Scottish Government and engage with other relevant stakeholders to change course on supporting DCRs.

Would further devolution of powers enable the Scottish Government more effectively address drugs misuse in Scotland and tailor their approach to Scotland's needs?

The UK Government has continued to oppose DCRs on the grounds that they are unlawful under the Misuse of Drugs Act 1971. Following approval of a DCR by Glasgow's Integrated Joint Board last year, Scotland's senior law officer, the Lord Advocate, stated that no exemption from the Act could be made, meaning both the DCR's users and its professionals could be arrested. Drug law is reserved to Westminster, so it is up to the UK Government alone whether they would approve the proposal to relax the law, or devolve the Act to Edinburgh. An alternative is in the works in the form of Alison Thewliss's Private Members' Bill 'Supervised Drug Consumption Facilities Bill 2017-19', currently before parliament, however this is likely to be a lengthy process with no certainty of success.

Should the Home Office continue to refuse to allow a licence for DCRs, as it already has for a drug testing service, devolution may be another option. As outlined above, The Hepatitis C Trust advocates a health-based approach to substance misuse policy. Health matters have been devolved, and therefore so should those relating to drug policy. If drug law was devolved, DCRs could be implemented with the speed desperately needed to tackle this outbreak of BBVs, such as HIV and hepatitis C, and drug-related harm.

What could Scotland learn from the approach taken to tackle drug misuse in other countries?

DCRs have been operating in Europe for over three decades, with a total of 88 official facilities across Switzerland, Germany, the Netherlands, Spain, Norway, Belgium, Denmark and France. Outside of Europe there are DCRs in Australia and Canada. Not a single overdose-related death has ever been recorded at any DCR.[24]

There is over 30 years of evidence demonstrating that medically-monitored drugs consumption rooms contribute towards the elimination of overdose-related deaths,[25] a reduction in public injecting,[26] improvements in hygiene restricting the transmission of BBVs,[27] and engaging highly marginalised populations with services. [28] Often the first concern about implementing a DCR is that it leads to an increase in drug use and drug-related crime in the area. However, there is no evidence that the availability of DCRs is associated with an increase in drug use.[29] Similarly, evidence from the supervised injecting facility in Sydney showed no increase in drug-related crime, with the study noting a decrease in public injecting and the number of syringes found in the area. [30] Given that there has been a 68% increase in call-outs to Glasgow City Council to remove needles and other drug-related equipment between 2016 and 2017, reducing this potentially harmful litter should be a priority.[31]

Dutch DCRs, such as the Princehof facility in Amsterdam, should be considered examples of best practice. Drug users are not only medically supervised to safely inject drugs, but are also provided with access to social workers, referrals to mental and physical healthcare, and housing and employment advice. This is supplemented by warm meals, tea and coffee, showers and recreational activities, and low-threshold work opportunities such as cooking, cleaning and bicycle repair. Such an integrated service not only reduces the direct health harms of drug use but strengthens the DCR's function as a starting point for engagement between people who use drugs and other health and social services. Where possible, any DCR established in Scotland should aim to replicate this model.

About The Hepatitis C Trust

The Hepatitis C Trust is the national charity for people with hepatitis C. It is a patient-led and patient-run organisation; most of its board, staff and volunteers have had hepatitis C themselves. We are committed to eliminating hepatitis C in the UK by 2030 at the latest. We are committed to ensuring that all our actions are for the benefit of patients. Our strategy is based around pillars of better prevention, more diagnosis and treatment for all.

We have established strong partnership models of working with substance misuse and homeless service providers across the UK. In substance misuse services, we deliver staff training, peer-led education about the importance of testing and availability of new treatments, and personal one-to-one support from initial diagnosis through to treatment.

We run a range of support services, including a confidential national helpline run by staff and trained volunteers who have all had personal experience of living with hepatitis C. Helpline staff also provide patient-centred responses via email, and run a designated prison freephone helpline service for prisoners across the UK.

Our policy and parliamentary team works across the UK Parliament and the devolved nations to ensure hepatitis C stays firmly on the political agenda. We also publish a range of reports and resources on aspects of the hepatitis C care pathway.

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