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Scottish Affairs Committee

Problem drug use in Scotland

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relating to the report*

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The Scottish Affairs Committee

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Summary

The rise in drug deaths in Scotland has been relentless, reaching an all-time high of 1,187 deaths last year. This tragic increase over the last two decades shows that a new approach is needed to tackle problem drug use. The UK Government must declare a public health emergency and be open to taking radical steps to implement innovative evidence-based solutions if we are to stand a chance of halting Scotland's spiralling drug crisis.

The UK Government currently treats drugs as a criminal justice matter. However, the evidence we have heard overwhelmingly shows that the current approach is counter-productive. We therefore recommend that the UK Government adopts a public health approach to drugs, and transfers lead responsibility for drugs policy from the Home Office to the Department for Health and Social Care. We also recommend, in line with this approach, that there should be full protection for people with problem drug use in key equality legislation.

There have been calls to introduce safe drug consumption facilities as part of the immediate solution to Scotland's drug crisis. Our evidence suggests that these facilities, where people can take drugs in safe and supervised conditions, are proven to reduce overdoses, drug deaths, blood-borne virus infection rates, and public injecting, and witnesses told us that the case for such a facility in Glasgow is amongst the most compelling in Europe. We are therefore disappointed that the Home Office has blocked the proposal despite the overwhelming evidence that they work and has not made the legal changes necessary to allow such a facility to be opened. We therefore recommend that the UK Government brings forward the legislation necessary to allow for the lawful establishment of a pilot safe drug consumption facility in Scotland. If the UK Government is unwilling to do this, we argue that it should devolve the necessary powers to allow the Scottish Parliament to do so.

However, safe consumption facilities and the adoption of a public health approach will not address all the problems caused by the criminalisation of drugs. Going further would require decriminalising drugs. Drawing on international case studies and examples of localised decriminalisation schemes in the UK, we outline clear evidence that decriminalisation is a pragmatic response to problem drug use, and an effective way of reducing stigma and encouraging people into treatment. As such, we recommend that the UK Government commits to decriminalising the possession of small amounts of drugs for personal use.

Throughout our inquiry we heard that the UK Government routinely ignores the evidence on what would be the most effective approach to reducing problem drug use. We call on the UK Government to take an evidence-based approach to drugs policy and accept expert advice.

Finally, Scotland's drug crisis is not just the responsibility of the UK Government. The Scottish Government is responsible for health delivery, and there is undoubtedly more it could do within its existing powers to address problem drug use. We believe the Scottish Government should improve its response to problem drug use in areas that are already devolved, and that funding for drug-related health services in Scotland must be protected.

1 Introduction

1. Scotland is in the midst of a drugs crisis. The rise in drug-related deaths in Scotland has been relentless, with the number of deaths increasing almost every year since the 1990s earning Scotland the title of “drug death capital of the world”.¹ Some 1,187 people died from drug-related causes in 2018—an all-time-high for Scotland, higher than any other European country, and nearly three times that of the UK as a whole.²

2. Drugs policy is an issue on which the UK and Scottish Governments take divergent approaches. The UK Government treats problem drug use primarily as a criminal justice matter, whereas the Scottish Government believes it should be addressed as a health issue.³ This difference in approach has caused disagreements between the two governments, most notably with the Home Office blocking an application for a safe consumption facility in Glasgow, as criminal justice sanctions for drugs is a policy area currently reserved to Westminster. This led to calls from some for drugs laws to be devolved to Holyrood, to enable the Scottish Government to take all measures it deems necessary to address Scotland’s drug crisis. Others argued that, as health and justice are devolved matters, the Scottish Government already has the main powers necessary to address problem drug use.

Our inquiry

3. As the number of drug deaths in Scotland reaches record levels, and given the public disputes over powers and approaches, we decided to investigate why Scotland has such a severe drug problem, and whether changes are needed at a UK-level to halt the spiralling number of drug-related deaths.

4. The division between reserved and devolved competence has been a key consideration for how we have structured our inquiry. Although we have discussed devolved policy areas—such as prisons and the delivery of drug-related health services—it has not been the focus of our inquiry, and we do not make recommendations on policies exclusively within the Scottish Government’s competence. However, we have discussed and commented on areas of devolved competence and will be writing to colleagues in the Scottish Parliament to raise these issues with them. We have focused on reserved policy, which necessarily means many of the recommendations in this report would apply UK-wide. Whilst our focus has been problem drug use in Scotland, drug-related deaths are also at a record high in England and Wales too, and UK-level reforms to address the situation in Scotland could also benefit the rest of the UK.⁴

5. We held eight oral evidence sessions, hearing from; academics, individuals and families with lived experience of problem drug use, third sector and charity groups, service delivery organisations, UK and Scottish police forces, as well as the responsible Scottish

1 Daily Record - [Cheap street pills help turn Scotland into drug death capital of world, 17 July 2019](#)

2 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

3 Scottish Government, [Rights, respect and recovery: alcohol and drug treatment strategy](#), November 2018

4 Office for National Statistics, [Deaths related to drug poisoning in England and Wales: 2018 registrations](#), 15 August 2019

Government minister. It is regrettable that it took the Home Office nearly 6 months to appear before us to give evidence, despite repeated invitations.⁵ We are also disappointed that the Home Office has not provided the Committee with written evidence.

6. We held several public engagement events in Edinburgh and Glasgow, where we heard from sector groups and individuals with lived experience of problem drug use in a more informal setting. We also visited Ottawa, Frankfurt and Lisbon, to see what the UK could learn from how problem drug use is addressed in other countries.⁶ We are grateful to all those who contributed to our inquiry. We are particularly grateful to the individuals who shared their personal stories with us both in person and in writing; these were often extremely moving and impactful, and we appreciate that they were sometimes difficult to share. We are also grateful to our two specialist advisers Anna Ross, and Professor Catriona Matheson, University of Stirling, who have provided invaluable assistance throughout our inquiry.⁷

7. We begin this report by exploring the key drivers and patterns of problem drug use in Scotland in chapter 2. We then examine and evaluate the criminal justice and public health approaches to problem drug use in chapter 3. In chapters 4 and 5 we turn our focus to the debate over safe consumption facilities and decriminalisation, before discussing the role of stigma as a barrier to recovery in chapter 6.

5 [Letter from the Chair of the Scottish Affairs Committee, to the Parliamentary Under-Secretary of State, Home Office, regarding appearance before the Scottish Affairs Committee, 21 June 2019](#)

6 [Summary of Scottish Affairs Committee's visit to Canada, 27–30 May 2019, Summary of Scottish Affairs Committee and Health and Social Care Committee's visit to Portugal and Germany \(15th-18th July 2019\)](#)

7 [Anna Ross was appointed on 23rd April 2019, Professor Matheson was appointed on 12th June 2019](#)

2 Problem drug use in Scotland

What is problem drug use?

8. Problem drug use can be defined in a number of ways.⁸ Official definitions tend to focus on the prolonged use of particular drugs. For example, NHS Health Scotland defines problem drug use as the “use of opioids [...] and/or the illicit use of benzodiazepines, and implies routine and prolonged use as opposed to recreational and occasional drug use”.⁹ Under this definition, there is estimated to be between 55,800 and 58,900 people with problematic drug use in Scotland.¹⁰ This represents an estimated prevalence rate of approximately 1.62% of the population.¹¹ However, problem drug use can also be defined more broadly as use of any drug which is causing medical, social, psychological, physical, financial or legal problems.¹² We heard that there could be “thousands” of individuals covered by this broader definition which are not accounted for in official statistics.¹³

9. Regardless of what definition is used, not all drug use is categorised as problem drug use. According to Aberdeenshire Alcohol and Drug Partnership, recreational drug use is fairly common, but only a minority of people, approximately 10%, develop problems.¹⁴

Drug-related deaths

10. A drug-related death is one in which poisoning from the toxic effects of a drug was implicated in, or potentially contributed to, the cause of death.¹⁵ The number of drug-related deaths in Scotland has risen almost year-on-year since records began in the mid-1990s, from 224 in 1997, to 1,187 deaths in 2018.¹⁶ The largest number of drug-related deaths were recorded in Greater Glasgow and Clyde (33% of the total), followed by Lothian (13%), Lanarkshire (11%) and Tayside (9%).¹⁷

8 [Q117](#)

9 NHS Scotland, Information Services Division, [Prevalence of Problem Drug Use in Scotland: 2015/16 Estimates](#), March 2019

10 [Q5](#); NHS Scotland, Information Services Division, [Prevalence of Problem Drug Use in Scotland: 2015/16 Estimates](#), March 2019

11 [Q5](#); NHS Scotland, Information Services Division, [Prevalence of Problem Drug Use in Scotland: 2015/16 Estimates](#), March 2019

12 [Q2](#); [Q184](#); Scottish Government, Road to Recovery, 2008

13 [Q109](#)

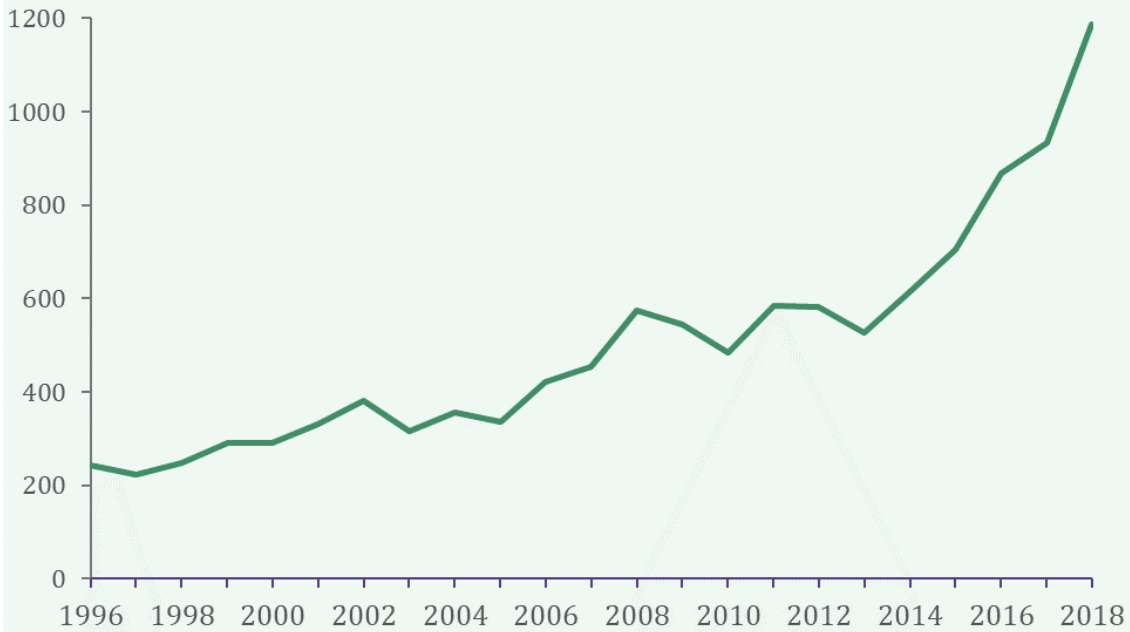
14 Aberdeenshire Alcohol and Drug Partnership ([UMD0006](#))

15 Crew2000, [Drugs at Crew Trend Report 2017–19](#), August 2019; National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

16 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

17 Information Service Division (2019) [Prevalence of Problem Drug Use in Scotland: 2015/16 Estimates](#)

DRUG-RELATED DEATHS IN SCOTLAND (1996-2018)



Source: National Records of Scotland, Drug-related deaths in Scotland in 2018, July 2019

Of the 1,187 drug-related deaths in 2018, opioids (such as heroin) were implicated in 86% of deaths.¹⁸ Benzodiazepines in 67% of deaths,¹⁹ methadone in 47% of deaths,²⁰ and cocaine in 23% of deaths.²¹

Why are drug deaths increasing?

11. We explored why we have seen such a relentless increase in drug-related deaths in Scotland. Several key factors were identified, including:

- a) **An increase in poly-drug use** (the consumption of two or more drugs at the same time).²² Dr Andrew McAuley, Glasgow Caledonian University, told us that benzodiazepines are being consumed “on top of their normal level of heroin, alcohol, methadone [...] putting people much more at risk of overdose”.²³ Of the 1,187 drug-related deaths in 2018, only 68 were cases in which only one drug was implicated in the death.²⁴
- b) **Increased strength and toxicity.** Dr McAuley explained that the benzodiazepines consumed in Scotland are now “much more toxic” and are often “ten times as strong as the diazepam that people used to be taking”.²⁵
- c) **An ageing cohort.** The average age of people who use drugs has been rising. Scotland now has an ageing cohort of middle-aged people who use drugs who

18 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

19 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

20 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

21 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

22 Scottish Drugs Forum ([UMD0024](#))

23 [Q15](#)

24 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

25 [Q15](#)

began their drug use in the late 1980s.²⁶ This particular cohort of people who use drugs is “ageing prematurely” due to “multiple comorbidity”.²⁷ In other words, these individuals often experience additional health problems—such as respiratory, circulatory or cardiovascular disease—and are often therefore “physically and mentally more vulnerable”.²⁸ Age is also a “proxy” for other relevant life circumstances which act as catalysts for health decline, such as “increasing social isolation, [and] bereavements in social networks”.²⁹

- d) **Rise in blood-borne viruses.** An outbreak of HIV in Glasgow since 2015—the first HIV outbreak in over 30 years—has contributed to the increase in drug-related deaths in Scotland.³⁰ This outbreak has been driven by high-risk methods of drug consumption such as sharing of injecting equipment. According to Turning Point Scotland, there were 228 newly diagnosed cases of HIV reported in Scotland in 2017.³¹ As many as 159 deaths in Scotland from HIV and Hepatitis C since 2015 could have been attributed to drug misuse.³² This is particularly concerning as it marks a reversal of earlier progress to reduce the rate of new infections, which addressed the HIV epidemics experienced by both Dundee and Edinburgh in the 1980s.³³

12. Scotland is in the midst of a drug death crisis. The relentless increase in drug deaths in Scotland is a tragedy that cannot be allowed to continue. We call on the UK Government to declare a public health emergency, and to work with the Scottish Government to take urgent and radical steps to halt Scotland’s spiralling drug crisis. Both Governments must be open to implementing innovative evidence-based solutions with the scale and urgency required by Scotland’s drug crisis.

Drivers of problem drug use

13. As noted earlier, not all drug use is problematic. We therefore sought to explore why some peoples’ usage becomes problematic, while others’ does not. We heard there are a number of risk factors which make it more likely that an individual “will progress from initial use to repeated use, and then problematic use”, and that these factors can also act as a barrier preventing people from recovering from problem drug use.³⁴ The main risk factors and structural drivers we explored are outlined below.

Poverty, inequality and deprivation

14. The single biggest structural driver of problem drug use is poverty and deprivation.³⁵ Problem drug use is more prevalent “among people from more deprived areas [... and] from less advantaged backgrounds”.³⁶ NHS Health Scotland told us that drug use

26 [Q3](#)

27 [Q3](#)

28 [Q3](#); [Q13](#)

29 [Q14](#)

30 BBC News, [Cocaine injecting and homelessness ‘behind Glasgow HIV rise’](#), 10 April 2019; [Q32](#)

31 Turning Point Scotland ([UMD0017](#))

32 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

33 BBC News, [Cocaine injecting and homelessness ‘behind Glasgow HIV rise’](#), 10 April 2019

34 [Q109](#)

35 [Q16](#); [Q113](#)

36 [Q12](#)

disorders are 17 times more prevalent in Scotland’s most deprived areas, compared with the least deprived.³⁷ It is not necessarily the case that poverty in itself is a direct driver of problematic drug use; however, those in poverty are more likely to be exposed to additional risk factors, such as unstable home life, unemployment, and adverse childhood experiences which increase the likelihood of a person being predisposed towards problematic substance use.³⁸ Deprivation also make it less likely that a person will overcome their drug problems because “they have less access to factors that support recovery such as meaningful employment and suitable housing”,³⁹ and having access to secure employment and housing are key protective factors against problem drug use.

15. Addaction told us that, in many cases, people experiencing social exclusion and disadvantage turn to drug use in early adulthood as a form of “escape”, to help them deal with the fact that they do not have access to the opportunities or resources available to the rest of society.⁴⁰ Aberdeenshire Alcohol and Drug Partnership made a similar point, saying that drug-related deaths are often referred to as ‘deaths of despair’, because most relate to “people who have little hope for the future due [to] their experience of poverty [and] inequality of opportunity”.⁴¹ As such, “those experiencing hopelessness and despair are most at risk”, and these individuals tend to be amongst the poorest and most deprived in society.⁴²

16. We heard many examples of this from individuals with lived experience of problem drug use, including Colin Hepburn, who explained how his experience of poverty and deprivation whilst growing up caused him to turn to substance use:

The area that I was living in was being pulled down. It was an area of urban deprivation. There was high unemployment and crime. It seemed that nobody was working. Bear in mind that I grew up during the miners’ strike, you know. It was probably a sense of hopelessness throughout the area. There was no investment in the area. There was no community centre as such. For me looking back, it was a sense of no hope and no sense of purpose [...] Just that: feeling heartbreak, feeling “what’s the point?” and I coped with that by using substances.⁴³

17. During public engagement events we heard numerous cases of individuals with lived experience whose problematic substance use developed as a result of self-medicating to treat chronic underlying health conditions.⁴⁴ Those experiencing poverty and deprivation are more likely to develop long-term health issues and therefore, by extension, to self-medicate.⁴⁵ We also heard that individuals from poorer backgrounds are more likely to be exposed to drugs in childhood in the first place (for example, in the home), and are therefore more likely to consume drugs later in life, and to experience problems and dependence.⁴⁶ Vicki Craik, Crew 2000, explained:

37 NHS Health Scotland/NHS National Services Scotland ([UMD0021](#))

38 Addaction ([UMD0020](#))

39 Addaction ([UMD0020](#))

40 Addaction ([UMD0020](#))

41 Aberdeenshire Alcohol and Drug Partnership ([UMD0006](#))

42 Aberdeenshire Alcohol and Drug Partnership ([UMD0006](#))

43 [Q57](#)

44 [Summary of Scottish Affairs Committee’s Problem Drug Use in Scotland public engagement event, June 2019](#); [Summary of Scottish Affairs Committee’s Problem Drug Use in Scotland public engagement event, May 2019](#)

45 [Q113](#); [Q178](#)

46 [Q113](#)

When people are brought up in poverty it leads to the snowball effect of drugs. If the people around you are taking drugs in a problematic way, you are also likely to take them in a problematic way.⁴⁷

18. Dr McAuley also explained that the link between poverty and problem drug use was the reason why problem drug use is less prevalent in the middle classes; “whether it is income, employment, stable housing [...] the middle classes are much less exposed to those factors and these are the factors that are more likely to drive people in the more deprived communities into problematic use”.⁴⁸ This does not mean that *recreational* drug use (as opposed to problem drug use) is any higher in more deprived communities, compared to other groups.

19. The evidence we have heard suggests that reducing poverty and deprivation would alleviate the primary structural driver of problem drug use. Dr McAuley said:

It takes much larger forces to impact on income, wealth, housing, employment, but these are the structural forces that created the problem drug use cohort in the first place, and these are fundamentally the things that will address it in the future.⁴⁹

Dr Tweed, University of Glasgow, similarly recommended that the UK Government’s “absolute priority” should be reducing poverty and inequality, which would, in turn, help reduce problem drug use.⁵⁰ Dr Budd, Edinburgh Access Partnership, Dr McAuley, and the Scottish Drugs Forum, amongst many others, all shared this view.⁵¹

Mental health, trauma, and Adverse Childhood Experiences

20. Poor mental health—often caused by traumatic experiences—is also a key risk factor amongst people who use drugs.⁵² Indeed, Turning Point Scotland told us that mental health is the most common issue present in people who access their support services.⁵³ Adverse Childhood Experiences (ACEs)—stressful and/or traumatic events which occur in childhood—can be a factor which may predispose individuals towards developing problematic drug use later in life.⁵⁴ Examples of ACEs include neglect, physical, sexual or emotional abuse, having a parent in prison, and having a parent with mental health problems within the home.⁵⁵ Turning Point Scotland told us that “adults who experienced four or more adversities in their childhood, were [...] eleven times more likely to have used crack cocaine or heroin”.⁵⁶

21. In adulthood, traumatic personal experiences of adversity might include witnessing or being a victim of violence, bereavement, military service in a combat zone, imprisonment, and homelessness.⁵⁷ Homelessness, in particular, was a recurring theme throughout our

47 [Q113](#)

48 [Q18](#)

49 [Q16](#)

50 [Q56](#); Dr Emily Tweed ([UMD0038](#))

51 [Q206](#); Scottish Drugs Forum ([UMD0024](#))

52 [Q4](#); [Q12](#); [Q109](#); [Q172](#)

53 Turning Point Scotland ([UMD0017](#))

54 [Q109](#)

55 [Q4](#)

56 Turning Point Scotland ([UMD0017](#))

57 Scottish Drugs Forum ([UMD0024](#))

inquiry. Dr Budd told us that rates of homelessness are increasing, and that it is both a consequence and driver of problem drug use.⁵⁸ According to analysis by Turning Point Scotland, experiences of homelessness and difficulties with housing/accommodation were present in nearly 30% of individuals accessing their support services.⁵⁹ Dr Budd explained that getting homeless people who use drugs into secure accommodation is the first part of the solution, as it then “enables them to start looking at some of the other underlying issues”.⁶⁰

22. People who have experienced traumatic experiences may turn to drugs as a way of coping with “overwhelming emotional and somatic sensations” caused by their experiences.⁶¹ For example, Addaction told us that “people misuse substances to address the traumatic stress they experience—including self-medicating to escape invasive memories, or make traumatic relationships more tolerable”.⁶²

Criminal justice interventions

23. We heard repeatedly that involvement with the criminal justice system is a risk factor for problem drug use. Dr Tessa Parkes, University of Stirling, explained that:

It is more challenging for people who experience problem drug use if they are criminalised in the criminal justice system to manage to pull out the recovery capital or the social resources to try to mitigate some of the harms.⁶³

There are many reasons for this, which will be explored in more detail in the next chapter. In short though, criminal justice interventions can lead to exposure to drugs in prison, loss of housing and employment, sever family and social support networks, and create barriers to future education and employment. The experience of incarceration can also be—in its own right—a traumatising experience, which individuals can attempt to treat through self-medication.⁶⁴

Social and familial networks

24. Social exclusion and weak family structure can also be a risk factor for problem drug use. Vicki Craik, Crew 2000, explained that social and familial support networks are a “protective factor”, which might support individuals who are potentially at risk of using substances problematically.⁶⁵ Sharon Brand, a person with lived experience of problem drug use, explained how the sudden loss of family networks caused her to turn to drugs:

In the space of three weeks, I lost my grandparents. My grandmother and my dad emigrated and my support system left. Everything fell apart around us and I was associated with people who were using heroin. I succumbed to that after about a year.⁶⁶

58 [Q198](#)

59 [Turning Point Scotland \(UMD0017\)](#)

60 [Q186](#)

61 [Q12](#)

62 [Addaction \(UMD0020\)](#)

63 [Q12](#)

64 [Q12](#)

65 [Q113](#)

66 [Q57](#)

25. The absence of social or familial structures often leads to social marginalisation, which can result in “people who feel that they have very little to benefit from or investment in the wider society, who feel rather left behind”.⁶⁷ Dr Parkes explained that, as a result, these individuals often “go under the radar, and are harder for us as health service providers, social service providers, and friends and family members to bring back”.⁶⁸

Stigma

26. Stigma is also a key structural driver, because it instils a fear in people from “coming forward” and seeking treatment for their substance use, due to fear of social judgement and shaming.⁶⁹ As Dr Iain McPhee said, “the stigma associated with being a drug user, the way in which they are treated, and the way that they see themselves being treated in services, all exacerbate the drugs issue”.⁷⁰ Some accounts suggested stigma towards problem drug use could be particularly prevalent in Scotland compared to other places. The Scottish Drug Forum told us that Scotland “often seems to have a comparatively judgemental, moralistic and stigmatising cultural attitude”.⁷¹ Evidence suggests that addressing stigma would help address problem drug use by encouraging individuals to “be more open to asking for help”.⁷² We explore this further in chapter 6.

27. People’s drug use often becomes problematic because of things beyond their control, rather than because of a proactive ‘decision’ to become dependent on substances. People who use drugs are a vulnerable group who require help and support, not prejudice and judgement. Both Governments must ensure that their approaches to problem drug use acknowledge and address the underlying causes, such as poverty and inequality, social marginalisation, trauma and the lack of strong family structures and support networks.

Is problem drug use different in Scotland?

28. The drug-related death rate (per head of population) in Scotland is roughly three times that of the UK as a whole.⁷³ A key question throughout our inquiry has been “why?”, and whether the drivers are different on either side of the border. The evidence we heard suggests that the structural drivers themselves are no different in Scotland, but that they are more severe, and their effects are therefore felt more keenly in Scotland, compared to the rest of the UK.⁷⁴ The Scottish Drugs Forum explained:

Although none of these [factors] are unique to people in Scotland, it may be that Scotland has a higher rate of some or all of these issues than elsewhere.⁷⁵

Dr Priyadarshi said “it wouldn’t be accurate” to say that England has not experienced the same issues as Scotland. Indeed, drug-related deaths are also at an all-time high in

67 [Q113](#)

68 [Q12](#)

69 [Q180](#); [Q181](#)

70 [Q113](#)

71 Scottish Drugs Forum ([UMD0024](#))

72 [Q180](#)

73 National Records of Scotland, [Drug-related deaths in Scotland in 2018](#), July 2019

74 Turning Point Scotland ([UMD0017](#))

75 Scottish Drugs Forum ([UMD0024](#))

England and Wales too.⁷⁶ However, the structural changes which drive problem drug use have been felt more acutely in Scotland compared to the rest of the UK, and the prevalence of problem drug use is therefore disproportionately higher north of the border.⁷⁷

29. We heard accounts which suggested that there is a particular link between problem drug use and poverty and inequality caused by the UK's socio-economic policies of the 1970s and 80s—notably de-industrialisation.⁷⁸ Dr Saket Priyadarshi, NHS Greater Glasgow and Clyde, explained that the closure of Scotland's industries—“everything from ship building, coal mining, steel industries and so on”—resulted in a loss of employment, and a loss of “meaning” in many Scottish communities.⁷⁹ Dr McAuley added that these closures “may have impacted a population that was more dependent than others on those economies and industries”.⁸⁰ Elinor Dickie, NHS Health Scotland, explained:

It appears that the policies in the '70s and '80s [...] those changing socio-economic circumstances and the displacement of communities, disentangling their resilience, appears to have had a greater impact in Scotland.⁸¹

Similarly, the Scottish Drugs Forum noted that economic changes between the 1960s and 1990s resulted in “dispossession and social displacement”, the legacy of which continues to manifest itself as “The Glasgow Effect” today.⁸²

30. Another example of the drivers of problem drug use being more pronounced in Scotland is traumatising and adverse childhood experience, with the Scottish Drugs Forum noting that “Scotland has a far higher rate of children being removed from parental care by the state and being brought up in care than England”.⁸³

Integrated policy responses

31. As we have seen, problem drug use has its roots in a complex mix of poverty and deprivation, stigma, mental health issues, and criminal justice interventions. Addressing this issue cuts across both governments' responsibilities—the Scottish Government controls health and social care policy, while powers over the economy and welfare delivery are often shared or entirely within the UK Government's control.

32. Dr Tweed, a clinical lecturer at the University of Glasgow argued there is a particular role for the UK Government in addressing economic inequalities and poverty as drivers of problematic drug use.⁸⁴ The same point was made by the Scottish Drugs Forum, who told us that although the Scottish Government has control over the health service and social

76 Office for National Statistics, [Deaths related to drug poisoning in England and Wales: 2018 registrations](#), 15 August 2019

77 [Q212](#)

78 [Q212](#)

79 [Q212](#)

80 [Q212](#)

81 [Q214](#)

82 Scottish Drugs Forum ([UMD0024](#))

83 Scottish Drugs Forum ([UMD0024](#))

84 [Q30](#)

care, it has “more limited control” over Scotland’s economy and the distribution of wealth, which is key to addressing the longer-term effects of socio-economic change.⁸⁵ Dr Parkes, University of Stirling, supported this point, adding that:

In terms of the most substantial levers that we have talked about, including socio-economic, they do not have all the levers to do so. They do not necessarily have the taxation [powers] to do that [via] welfare [systems].⁸⁶

33. We heard that the most effective approaches to addressing problem drug use have tended to be those which ‘join-up’ and integrate relevant policy areas. This is particularly difficult given the type of radical, whole-system change that could be required to address the root causes of Scotland’s drug epidemic. The importance and effectiveness of radical, whole-system change is evident in the case of Portugal, which was the most oft-cited example of the successful implementation of a public health approach. Numerous witnesses explained that decriminalisation in Portugal (which we explore further in chapter 5) went hand-in-hand with a number of equally important changes in other areas—including welfare, employment, education, as well as economic reform.⁸⁷ These reforms were designed to tackle poverty and unemployment, thereby reducing structural health inequalities, social disempowerment, and marginalisation, which led to problem drug use. Dr Parkes explained:

They brought in not only expanded harm reduction and treatment but also an administrative response and minimum wage. They basically reformed the system around humanity, pragmatism and participation [...] What we can see is that enhancing social and economic supports can go some way towards alleviating [...] problem drug use because people are no longer excluded from society.⁸⁸

34. We heard of other successful interventions which are based on similar principles. For example, we heard that the Edinburgh Access [GP] Practice has taken an integrated approach to substance use treatment. Dr Budd explained that the Practice tries to bring all relevant services “under one roof”.⁸⁹ For example, in addition to the usual GP and nurse services, the Practice also offers mental health and psychology services, hepatitis treatment clinics, housing advice surgeries, welfare rights advice drop ins, and legal advice clinics.⁹⁰ The availability of these different services seeks to address each of the individual risk factors people who use drugs may be experiencing, and thereby address the underlying drivers and barriers to recovery.

35. However, our evidence suggests that the UK Government’s approach to problem drug use is not as integrated as it could be. Many witnesses argued that key Government departments are not proactively engaged with the health services, and that departments do not adequately consider the impact their policies have on people who use drugs. This can threaten the continuity of care which is essential to ensuring a stable path to recovery for people who use drugs.⁹¹ The Department for Work and Pensions (DWP) was

85 Scottish Drugs Forum ([UMD0024](#))

86 [Q42](#)

87 [Q152](#)

88 [Q16](#)

89 [Q185](#)

90 [Q185](#); Edinburgh Access Practice, [Clinics & Services](#)

91 [Q236](#)

a frequently cited example. For example, when asked whether there is any communication or involvement between the DWP and health services in relation to problem drug use, Dr Budd, replied “hardly”.⁹² He explained:

From my perspective, as a GP, there is very, very limited communication from the Department for Work and Pensions, and it would make a huge difference [...] It would be a huge step forward for the Department for Work and Pensions to be working as a partner agency.⁹³

36. The DWP told us that in Scotland the Department is engaged with a number of key stakeholders, such as local authorities, the NHS, and other partners, in order to “maximise access to services which would benefit customers with addictions”, and that the Department has a network of “ever growing partnerships with specialist agencies” to support vulnerable people by addressing their complex barriers to employment.⁹⁴

37. The Home Office told us that it recognises the link between poverty and problem drug use; however, the minister did not expand on how this understanding has informed its drugs policy.⁹⁵ The minister told us that he hopes to convene a comprehensive drug-death summit in Glasgow before Christmas, to bring together key stakeholders and governments at a local, national and regional level to create a fully integrated response to problem drug use. He said this summit would be informed by this Committee’s report, the work done by the Health and Social Care Committee and the Carol Black review, as well as advice from the Advisory Council on the Misuse of Drugs.⁹⁶

38. Addressing the root causes of problem drug use requires radical, whole-system change, rather than piecemeal reform. We welcome the planned cross-government summit in Glasgow and encourage the UK and Scottish Governments to be bold, imaginative and evidence-based. Both Governments must work together to implement an integrated, cross-departmental, and cross-government approach to drugs, which fully utilises the potential impact of joined-up policing, justice, employment, welfare, housing, physical and mental health policies and services. The UK Government must also ensure that all departments are proactively engaging with each other, the health services and third-sector organisations, in order to help address problem drug use in Scotland.

Social security

39. A key policy which the UK Government can influence which would address a key driver of problem drug use is the delivery of social security in Scotland—which is currently a shared responsibility. As discussed, poverty and inequality are the single biggest drivers of problem drug use, and social security policy plays a key role in this. As Dr Tweed said, “welfare reform has particular impacts on people who use drugs because they use public services, they often have precarious circumstances, needing support from benefits”.⁹⁷ Some witnesses were particularly critical of the sanctions-based approach used by the DWP. A sanction is the reduction of welfare payments for a set period, in response to a

92 [Q197](#)

93 [Q197](#)

94 Department for Work and Pensions, UK Government ([UMD0046](#))

95 [Q454](#)

96 [Q442](#)

97 [Q54](#)

failure to meet certain commitments (called ‘conditionality requirements’)—for example, for failing to attend a Job Centre meeting.⁹⁸ Dr Budd was critical of this “adversarial system”, arguing that:

Sanctions just drive people further away from support and entrench them in a position of dependence and disability. Sanctions are a very negative and retrogressive approach to people who really need support now.⁹⁹

40. Elinor Dickie, NHS Health Scotland, Iain Clunie, SMART Recovery UK, Patricia Tracey, Turning Point Scotland, and Norma Howarth, Signpost Recovery, amongst others, agreed that sanctions-based approaches to welfare are a barrier to recovery.¹⁰⁰ Norma Howarth argued that sanctions place “an incredible expectation” of autonomous responsibility and ability on service users which cannot always be managed by people with problem drug use:

To be able to access a system, to maintain appointments and to have the ability to engage in a system is quite complicated for our service users who skirt around quite a large, chaotic lifestyle. It is an expectation that is to their disadvantage.¹⁰¹

Elinor Dickie used the example of sanctions for missed appointments to highlight the counterproductive effects of sanctions.¹⁰² We saw the impact of this ourselves during a visit to the Scottish Drugs Forum in June. We spoke to a person with current problematic drug use, who explained that sanctions for missing DWP appointments—often due to poor public transport infrastructure, or lack of concessionary access to travel—have left him unable to support himself financially, which caused him to relapse from recovery.¹⁰³ This was also the view of the Scottish Government minister, Joe Fitzpatrick MSP, who argued sanctions often “create a whole new cycle”, which “pulls people away from treatment”.¹⁰⁴

41. The Department for Work and Pensions told us that sanctions are only applied when conditionality requirements are missed “without good reason”, that claimants are “given every opportunity to explain why they failed” to meet the agreed requirements, and that consideration is given for health conditions and disabilities.¹⁰⁵ The Department added that in May 2019, 2.42% of Universal Credit claimants had a deduction from their welfare payment as a result of a sanction, and that claimants can appeal sanction decisions in an independent tribunal.¹⁰⁶ We also note that since 2010 the UK’s unemployment rate has decreased significantly to levels last seen in the mid-1970s, reducing joblessness which our evidence suggests is a driver of problem drug use, and a barrier to recovery.

42. The welfare policies of the Department for Work and Pensions have a detrimental impact on people who use drugs, and often become a barrier for many people trying to enter recovery. The Scottish Government should also make full use of its existing powers to support people recovering from problem drug use. *The UK Government*

98 Department for Work and Pensions, [Sanctions](#)

99 [Q193](#); [Q197](#)

100 [Q194](#)

101 [Q194](#)

102 [Q236](#)

103 [Summary of Scottish Affairs Committee’s Problem Drug Use in Scotland public engagement event, June 2019](#)

104 [Q393](#)

105 Department for Work and Pensions, UK Government ([UMD0046](#))

106 Department for Work and Pensions, UK Government ([UMD0046](#))

must review the impact welfare sanctions have on people who use drugs, and outline steps it will take to make the welfare system less adversarial for people who use drugs who are trying to enter recovery.

3 Approaches to problem drug use

43. There are two broad approaches to problem drug use—criminal justice, and public health. The former perceives problem drug use as a moral failure and criminal behaviour, which should be dealt with primarily through punitive sanctions delivered by the criminal justice system. It focuses on policing and law enforcement as the primary means of addressing and reducing drug use.¹⁰⁷ The UK Government’s current policy on drugs has been characterised as a criminal justice approach—because lead responsibility for drugs policy currently lies with the Home Office. Dr Parkes, University of Stirling, told us that the UK Government’s 2017 Drugs strategy takes “very much [...] a criminal justice approach”:

There is little or no mention of harm reduction for drugs within that strategy. It equates recovery quite narrowly with abstinence and it talks about having a vision of a drug-free society.¹⁰⁸

The Home Office disputed this characterisation and argued that the current strategy is a “balanced” one which reduces drug demand and supply, whilst also promoting recovery.¹⁰⁹ The minister highlighted investment in specialist information for schools, early interventions, and compulsory health education from 2020.¹¹⁰

44. A public health approach recognises substance use as a complex health disorder characterised by a chronic and relapsing nature, which is preventable and treatable, and is not the result of moral failure.¹¹¹ It views criminal sanctions as ineffective, and instead emphasises health interventions to prevent, treat, and support the recovery of people who use drugs.¹¹² Dr Tweed told us:

A public health approach would move away from criminalising that individual with the stigma, the criminal record, the potential impacts of prison on that person, and would very much focus on how we can help that individual with treatment and harm reduction.¹¹³

Dr McAuley explained the public health approach is also concerned with the community impact of drugs, and proposes solutions designed to benefit “not just the individuals using drugs but perhaps the businesses or the residents in areas where public drug consumption is very visible”.¹¹⁴

45. The public health approach also holds that drug use is—and has been throughout history—a reality of human society, which should be faced up to and dealt with pragmatically. This approach accepts that some drug use is inevitable and looks for ways to reduce the harm it causes. Norma Howarth, Signpost Recovery, explained that:

107 [Q24](#)

108 [Q27](#)

109 [Q427](#)

110 [Q427](#)

111 Nora D. Volkow, Valdimir Poznyak, Shekhar Saxena, Gilberto Gerra, and UNODC-WHO Informal International Scientific Network, [Drug use disorders: impact of a public health rather than a criminal justice approach](#), World Psychiatry, 2017 June, 16(2), pp. 213–214

112 Nora D. Volkow, Valdimir Poznyak, Shekhar Saxena, Gilberto Gerra, and UNODC-WHO Informal International Scientific Network, [Drug use disorders: impact of a public health rather than a criminal justice approach](#), World Psychiatry, 2017 June, 16(2), pp. 213–214

113 [Q25](#)

114 [Q28](#)

If we are accepting the fact that drugs are a key part of our society—and they are—how do we do something differently, rather than having somebody somewhere unsafe, using badly and paying the most negative consequence of losing their life?¹¹⁵

The Scottish Government has treated drug use as a public health issue rather than a criminal justice issue since 2016, and responsibility for drugs policy lies with the Minister for Public Health, Sport and Wellbeing (rather than the minister responsible for criminal justice).¹¹⁶

Criminal justice approach

Structural effects of criminalisation

46. The vast majority of witnesses we heard from were critical of the criminal justice approach, arguing that it is ineffective in reducing problem drug use, and could even perpetuate the main structural drivers of it. Dr McAuley told us that there is a growing consensus that “the war on drugs or the criminalisation approach [...] has largely failed” in the UK as demonstrated by the consistent rise in drug-related deaths, despite taking a criminal justice approach for decades.¹¹⁷

47. One main criticism of the criminalisation of drug use is that it reinforces social stigma, and marginalises substance users, making it harder to identify and less likely that people will come forward to seek help. One witness with experience of problem drug use explained that:

As long as taking drugs is illegal there will always be a stigma attached to drug use or addiction, and those in society who are not immersed in that lifestyle will always have that stance towards people—that lack of understanding and education about where it comes from and why it exists.¹¹⁸

Dr Iain McPhee said, “by criminalising the drug-taking, we automatically make it a problem. In doing so, we increase stigma and discrimination and we also demonise users”.¹¹⁹ We heard first-hand accounts from people with problematic drug use who had not come forward for treatment due to a fear of being judged, discriminated against, or arrested for criminal offences.¹²⁰

48. Another criticism was that criminalisation “automatically makes drugs more dangerous and harmful” by pushing drug markets “underground”, where there is no way to monitor or regulate the quality and safety of drugs.¹²¹ It was also argued that criminalisation can incentivise individuals to consume drugs in the street immediately after purchase, in “closes, alleyways, car parks and so forth”, due to a fear of being arrested

115 [Q203](#)

116 [The Salvation Army \(UMD0033\)](#)

117 [Q26](#)

118 [Q71](#)

119 [Q116](#)

120 [Summary of Scottish Affairs Committee’s Problem Drug Use in Scotland public engagement event, June 2019;](#)
[Summary of Scottish Affairs Committee’s Problem Drug Use in Scotland public engagement event, May 2019](#)

121 [Summary of Scottish Affairs Committee’s visit to Canada, 27–30 May 2019](#)

for possession of drugs.¹²² Dr Tweed explained that this rushed use is more likely to result in negative (and often fatal) health implications, such as overdose and blood-borne virus infections.¹²³

Impact of prison sentences

49. We also heard that prison sentences for people who use drugs often make an individual's situation worse and make it less likely a person will recover. This is because prison sentences can mean individuals lose their job, their home and family and social networks, which makes recovery much more difficult. Dr Budd, Edinburgh Access Partnership, recounted a specific example from his surgery:

I had a chap who was doing really well, who was stable, in his accommodation, on stabilised methadone treatment, not using illicitly and starting to look at volunteering, and the next minute he was back in prison from a drug-related charge six months or a year ago—back in that situation where he is destabilised, loses his housing and is at risk of further harms.¹²⁴

We heard a similar story from two parents, whose son is currently recovering from problem drug use. The parents explained the devastating impact their son's imprisonment for a drug-related offence had:

It caused so much trauma that he emerged six months later jobless, crushed and a heroin addict. He became highly dependent on substances to mask the devastation of his life, and it only added to the trauma, taking him further and further out of the reach of recovery.¹²⁵

50. Criminal records for a drug-related offence can also make it more difficult for people who use drugs, and those who have recovered, to find a job. Norma Howarth, Signpost Recovery, argued that potential employers are often unable to look “beyond [criminal records] to the skills and abilities and future recovery capital of the person who is now ready and wants to take that next step in their life”.¹²⁶ As discussed earlier, employment security is a key protective factor; the absence of it therefore risks trapping people trying to recover from problem drug use in a cycle of hopelessness and economic insecurity, which makes them more likely to turn towards illicit drugs and harmful behaviour.¹²⁷

51. Custodial sentences for drug-related crimes can also be particularly counterproductive due to the prevalence of drugs in prisons. Many experts, as well as those with lived experience, told us that people who use drugs often emerge from prison with a worse drug problem than when they entered.¹²⁸ It is estimated that 13% of people with problem drug use coming out of prison developed their problematic use whilst in prison.¹²⁹ Assistant Chief Constable Johnson, Police Scotland, told us that a custodial sentence:

122 [Q17](#)

123 [Q17](#)

124 [Q203](#)

125 [Q79](#)

126 [Q194](#)

127 [Qq16–18](#)

128 [Summary of Scottish Affairs Committee's Problem Drug Use in Scotland public engagement event, June 2019;](#)

[Summary of Scottish Affairs Committee's Problem Drug Use in Scotland public engagement event, May 2019](#)

129 [Q255](#)

Potentially exposes them to more drugs or different sorts of drugs within the prison system, which then puts them back out into society where the inequalities or health issues that have probably led them [to take] the drugs will unfortunately for most of them mean at some point they are going to die.¹³⁰

In many cases, the exacerbation of individuals' existing drug problems (or introduction to drugs) within the prison system, combined with a "lack of continuity of care going into prison and then [...] on release" means that 11% of all people with problematic drug use die within the first month of having been released from prison.¹³¹

52. Some witnesses argued that the solution to this is to remove drugs from prisons, to improve the effectiveness of criminal justice sanctions. For example, Dr Neil McKeganey—a long-time proponent of the criminal justice approach—argued that:

[If an individual] acquires a drug problem because of the preponderance of drug use in prison, that is a set of circumstances that we should be rightly seriously concerned about [...] However, that does not lead me to offer the view that criminal justice sanction is the cause of the problem here. I think the problem there is our failure to stop drugs from getting into prisons.¹³²

However, the vast majority of witnesses argued that drugs in prisons are—unfortunately—simply a reality that has to be faced. Iain Clunie, SMART Recovery UK, argued that "people will always find a way" to get drugs into prisons, irrespective of the level of security.¹³³ Jim Duffy, Law Enforcement Action Partnership UK, made the same point:

Every prison in the world is a place where you can get drugs, everyone knows that, and if you hold to the belief that if you put people away in a secure room it is not going to happen, that is just not reality.¹³⁴

Martin Powell, Transform, summarised this view, arguing that "if you want to end the prison drug problem, stop sending people with drug problems to prison".¹³⁵

53. However, Dr McKeganey argued that there is a legitimate role to be played by criminal justice sanctions:

I do think that at a societal level it is really important to have a criminal justice sanction against those activities that one is trying to discourage, to signal very clearly that engagement in those activities could have serious adverse consequences for the individuals involved.¹³⁶

The Home Office has previously argued that criminal sanctions for drug use are important for sending a message that drug use is not acceptable:

130 [Q310](#)

131 [Q294](#)

132 [Q129](#)

133 [Q204](#)

134 [Q256](#)

135 [Q255](#)

136 [Q129](#)

It is important that the Government continues to send a clear message that drugs controlled under the Misuse of Drugs Act 1971, and their supply, present such harms that possessing them under any circumstances must be subject to a commensurately strict regime.¹³⁷

No other witnesses we heard from supported this perspective.¹³⁸ When we heard from the Home Office minister responsible for drugs policy, Kit Malthouse MP, he did not argue that criminalisation is needed “to send a clear message”, and he distanced himself from arguments based on “the so-called war on drugs”.¹³⁹

54. Dr McKeganey also argued that the potential effectiveness of the criminal justice approach has not had the opportunity to be proven, because there has not been any systematic, well-coordinated, and long-term anti-drug campaigns or programmes within Scottish schools; “We have not had a national campaign focused on reducing the incidence and prevalence of drug usage. We have not had it in the media. I think that our school programmes are ad hoc”.¹⁴⁰ However, Dr McPhee challenged this, and argued that anti-drug campaigning which tries to “instil fear in young people to act as an inoculation against” drug consumption, is prevalent in the mainstream print and online media.¹⁴¹ Dr McPhee argued that such “insidious and consistent” messaging is “sensationalist” in how it “demonise[s]” people who use drugs, and that it is “ineffective” in addressing problem drug use.¹⁴² This point was echoed by Vicki Craik, Crew 2000, who highlighted that a Scottish Government evaluation of the “Just Say No Approach” found it to be counterproductive in reducing drug use and drug harm within young people.¹⁴³

Public health approach

55. Throughout our inquiry we heard that problem drug use is a complex health disorder. This case was made powerfully by individuals with lived experience; as one woman, whose daughter was recovering from problem drug use, told us:

My daughter did not say at five, “I’m going to be a heroin addict when I grow up”—she wanted to be a school teacher, not a heroin addict. She is ill. She is really, really ill. It is evidence-based that it is an illness. It is a disease of the brain, addiction. How are you a criminal, if you are ill? If you had cancer, you would not get sent to jail for having cancer, but you will get sent to jail because you are an addict—because you are very ill and you need treatment.¹⁴⁴

Most witnesses echoed this and argued that Government should therefore treat problem drug use as a health issue. For example, Scottish Families Affected by Alcohol and Drugs argued that “drug use is a public health issue, and our response should reflect this”.¹⁴⁵ This view is shared, not just by third-sector organisations, but also by public bodies at the forefront of health service delivery. For example, the Alcohol and Drug Partnerships for

137 Letter from the Home Office to Glasgow City Council, obtained by Committee team

138 [Q290](#); [Q302](#)

139 [Q421](#)

140 [Q142](#)

141 [Q143](#)

142 [Q143](#)

143 [Q143](#)

144 [Q97](#)

145 Scottish Families Affected by Alcohol and Drugs ([UMD0029](#))

Dundee, Glasgow City, Angus, and Perth & Kinross all called for problem drug use to be treated as a public health priority, rather than a criminal justice one.¹⁴⁶ This was also the view of NHS Health Scotland, who argued that the public health approach results in “the best possible health outcomes”.¹⁴⁷

56. The evidence we heard was overwhelmingly supportive of the public health approach. Witnesses argued that because the public health approach is based on the systematic collection of data to inform policy and practice, rather than ideology, the result is “better outcomes”.¹⁴⁸ Our evidence suggests that the public health approach is proven to reduce harm to the most vulnerable people (by reducing stigma and marginalisation) and thereby also delivers benefits to the wider community.¹⁴⁹ For example, NHS Shetland told us that “a more health-based focus reduce[s] stigma and promote[s] inclusiveness of this vulnerable sector of society”.¹⁵⁰

57. This view was shared by other police representatives, including Chief Inspector Jason Kew, Thames Valley Police, who claimed that amongst the UK’s police officers, “there is a general appetite for a health-based approach to simple possession”.¹⁵¹ It was for similar reasons that Assistant Chief Constable Johnson, Police Scotland, argued that the Scottish Government’s move in 2016 away from criminal justice, towards public health is therefore “a huge bonus”.¹⁵² Some witnesses argued that the UK Government should follow suit, and should transfer responsibility for drugs policy from the Home Office to the Department for Health and Social Care. Campaign group Transform argued that doing so would “help ensure the UK has a joined up, health-led approach”.¹⁵³ Professor Alex Stevens, University of Kent, also supported this proposal, and argued that the Department for Health and Social Care has a greater “institutional commitment to the use of evidence and spending money wisely on the basis of evidence than does the Home Office”, which would result in “a more evidence-based approach to drug policy”.¹⁵⁴

58. Transferring primary responsibility to the Department of Health and Social Care was also recommended by the Health and Social Care Committee, in its recent report on drugs policy.¹⁵⁵ The Committee argued that transferring responsibility “would not only benefit those who are using drugs, but reduce harm to and the costs for their wider communities”.¹⁵⁶ In oral evidence to us, the Home Office appeared open to this suggestion. Kit Malthouse MP, Minister for Crime, Police and Fire, told us that the Home Office is responsible for drugs for “historical” reasons, and agreed that “health [definitely] needs to be as much in the lead as enforcement on drugs”.¹⁵⁷ The minister highlighted that departmental responsibility is a matter for the Prime Minister, but that he would “digest” the suggestion.¹⁵⁸

146 Dundee ADP ([UMD0011](#)); Glasgow City Alcohol and Drug Partnership ([UMD0016](#)); Angus Alcohol & Drug Partnership AND Perth & Kinross Alcohol & Drug Partnership ([UMD0010](#))

147 NHS Health Scotland/NHS National Services Scotland ([UMD0021](#))

148 Release ([UMD0026](#))

149 The Salvation Army ([UMD0033](#))

150 NHS Shetland ([UMD0018](#))

151 [Q337](#)

152 [Q310](#)

153 Transform ([UMD0043](#))

154 [Q337](#)

155 Health and Social Care Committee, [Drugs Policy: First Report of Session 2019–20](#), HC 143

156 Health and Social Care Committee, [Drugs Policy: First Report of Session 2019–20](#), HC 143

157 [Q424](#)

158 [Q424](#)

59. Some witnesses argued that criminal justice and public health approaches are not necessarily mutually exclusive, and that there are ways they could be combined, such as using the criminal justice system to mandate specific health interventions.¹⁵⁹ Drug Treatment and Testing Orders (DTTOs), drug courts, and recorded police warnings were raised as examples of criminal justice interventions which can be used as an opportunity to identify substance use, and provide rapid access to monitored treatment programmes designed to reduce the risk of further offending and harm. Dave Liddell, Scottish Drugs Forum, argued that DTTOs had “proved successful” at getting offenders into treatment and care services.¹⁶⁰

60. The Home Office told us that the criminal justice and health related responses to problem drug use are not “binary” options, and that “health, crime and drugs are inextricably intertwined”.¹⁶¹ The minister argued that their current policy of criminalisation seeks to address “all three of those strands at the same time”.¹⁶² Mr Malthouse added that the “threat of a criminal justice sanction hanging over them [people who use drugs]” is necessary to try and “push them towards treatment and diversion”.¹⁶³ The minister used de facto decriminalisation diversion schemes, such as the one in operation in Durham, as an example of this (explored further in chapter 5). He also pointed to the current HOPE (Hawaii’s Opportunity Probation with Enforcement) programme in Hawaii, which operates on a similar basis. However, this argument does not provide a defence of criminalisation of drugs in areas of the UK where diversion schemes are not in place.

61. The criminal justice approach to people with problem drug use has failed. Problem drug use is a health issue, and it should be treated as such by the UK Government. The Government must revise its strategy for addressing problem drug use in line with a public health approach. We support the call from the Health and Social Care Committee for the UK Government to transfer lead responsibility for drugs policy from the Home Office to the Department for Health and Social Care. This would demonstrate its commitment to a health-focused approach to drugs.

Evidence-based policy

62. Some witnesses emphasised that the Home Office has accepted the evidence that its current criminal justice approach does not work. For example, a 2014 report from the Home Office acknowledges that there is “no obvious relationship between the toughness of a country’s enforcement against drug possession, and levels of drug use in that country”.¹⁶⁴ The Advisory Council on the Misuse of Drugs—the statutory body responsible for advising the UK Government on drugs policy—has repeatedly recommended, policy changes in line with a public health approach.¹⁶⁵ Martin Powell, Transform, argued the issue is “not that they do not accept the evidence, it is that they stick with some of these old ideological ideas about sending messages”.¹⁶⁶ This dynamic has been evident in recent months in the comments of the previous Home Secretary. Sajid Javid MP said that his exposure to illicit

159 [Q26](#)

160 [Q247](#)

161 [Q468](#)

162 [Q468](#)

163 [Qq420–421](#)

164 Home Office, [Drugs: International Comparators](#), October 2014

165 ACMD (2016) Reducing Opioid-Related Deaths in the UK, London: Home Office

166 [Q290](#)

substances during his childhood has “put [him] off drugs” and that because of this he was very hesitant” to look at policies he felt would “increase drug usage”, despite clear evidence that other approaches might be effective.¹⁶⁷

63. Professor Alex Stevens, a former member of the Advisory Council (giving evidence in an academic capacity, rather than on behalf of the Council) argued that, even though the Home Office accepts the evidence against criminalisation, it is disregarded in favour of “rhetorical commitments to toughness”.¹⁶⁸ Professor Stevens said that whenever the Advisory Council on the Misuse of Drugs recommends that drugs laws are tightened, the Home Office accepts this recommendation while, whenever the Council recommends that drug laws are liberalised, the recommendation is rejected.¹⁶⁹ The Home Office disputed this characterisation, and argued that there are a number of examples of the Government accepting the ACMD’s recommendations (for example, on heat-proof foil and psychoactive substances).¹⁷⁰ Mr Malthouse MP also highlighted that the ACMD’s ultimate role is to advise the Committee, and that the final decision always lies with the minister.¹⁷¹

64. The adoption of a public health approach must reflect the UK Government taking an evidence-based approach to drugs policy. *The Home Office must commit to implementing an evidence-based approach to drugs policy. This includes the Government giving full weight to all reports and recommendations from the ACMD. Where the UK Government chooses to go against expert advice from the ACMD, the Government must publicly outline its reasons for doing so and set out its evidence base.*

The Misuse of Drugs Act 1971

65. The Misuse of Drugs Act 1971 is the main piece of legislation which regulates the production, supply and possession of controlled drugs in the UK, and underpins successive UK Governments’ criminal justice approach to drugs.¹⁷² Controlled drugs are categorised into three classes—A, B and C—with correspondingly severe criminal penalties for possession offences. Throughout our inquiry, many witnesses argued that the Act is incompatible with a public health approach, and that it is “long overdue for review and renewal”.¹⁷³ For example, Dr McAuley told us the Act’s system of classification “is not based on any evidence related to harms”.¹⁷⁴ In other words, the criminal penalties associated with each class of drugs do not necessarily match with the harm caused by their consumption. We heard that some changes in classification recommended by the ACMD, to make the classifications reflect the harm caused, have been ignored by the UK Government. For example, Professor Stevens noted that:

The ACMD has recommended that cannabis should be in class C; it is currently in class B. The ACMD has recommended that ecstasy [...] should

167 The Scotsman, [Sajid Javid opposes drug consumption rooms because of childhood experience](#), 17 June 2019

168 [Q307](#)

169 [Q298](#)

170 [Q464](#)

171 [Q463](#)

172 House of Commons Library, [Drugs policy](#), October 2018

173 [Q31](#)

174 [Q31](#)

be in class B. It is currently in class A. I also raise the recommendation of the ACMD that khat should not have been controlled under the Misuse of Drugs Act, but it [is].¹⁷⁵

66. We also heard that the Act is constraining the Scottish Government’s ability to take a public health approach to drugs. Glasgow City Alcohol and Drug Partnership told us that due to the Act:

Key required levers to enable the full implementation of a public health-based drug strategy are not available to Scottish and local government. This has inevitably hampered the development of an appropriate local response to identified public health needs in Scotland and in Glasgow.¹⁷⁶

Other witnesses told us that there are specific public health interventions which the Scottish Government has not been able to implement—most notable is the introduction of a safe consumption facility in Glasgow, which we discuss in more detail in the following chapter. The Scottish Government minister for Public Health, Sport and Wellbeing, Joe Fitzpatrick MSP, argued that, in this respect, “I am fighting with one hand tied behind my back”.¹⁷⁷

67. For these reasons, Professor Matheson, Dr McPhee, Dr McAuley, Dr Tweed, amongst many others, supported a review of the Misuse of Drugs Act 1971, to bring it in line with a public health approach.¹⁷⁸ Other organisations—including Transform, Release, and NHS Health Scotland—argued that if the UK Government is unwilling to implement a public health approach across the whole of the UK, then drugs laws should be devolved to Scotland to enable the Scottish Government to implement the specific public health interventions it wants. Dr Tweed said that devolution—and its potential to “respond to local needs”—could be a way to address the specific patterns of problem drug use in Scotland.¹⁷⁹ This was also the view of the Scottish Government, who told us that devolving drugs laws to the Scottish Parliament would be the best way of ensuring “a more joined-up approach in the interface between the health and social care systems and the justice systems, which are already devolved”.¹⁸⁰

68. We have heard that the Misuse of Drugs Act 1971 is outdated, its classification system is arbitrary, and that it is fundamentally incompatible with a public health approach. If the UK Government is to implement a public health approach as we have called for then the Misuse of Drugs Act must be substantially reformed.

Drug-related health services in Scotland

69. Although reserved drug legislation does put some limitations on the Scottish Government, health is a devolved matter, and the Scottish Government has full responsibility for the provision of drug treatment and health services in Scotland. Witnesses raised concerns about the levels of funding for drug-related services in Scotland. We heard that drug treatment services in Scotland have been cut by almost a

175 [Q305](#)

176 Glasgow City Alcohol and Drug Partnership ([UMD0016](#))

177 [Q389](#)

178 [Q31](#); [Q49](#); [Q121](#)

179 [Q30](#)

180 [Q374](#)

quarter over the past few years, during a time when HIV and homeless prevalence has increased.¹⁸¹ In 2016–2017 the Scottish Government reduced the budget for Alcohol and Drug Partnerships across Scotland by £15.3 million.¹⁸² Dr Emily Tweed highlighted that such funding cuts result in the withdrawal of services, reduced provision, under-staffing or under-skilled staffing, and lack of continuity in relationships for clients.¹⁸³ Norma Howarth, Signpost Recovery, told us that it has therefore become “incredibly difficult” to continue providing their drug-related services in the face of such budget cuts.¹⁸⁴ Dr Budd similarly argued that budget cuts have caused “huge delays in getting people into life-saving opiate substitute treatment [OST]” in Scotland.¹⁸⁵ In some cases, it can take up to three months to get someone onto OST, which is resulting in “huge morbidity and mortality”.¹⁸⁶ The Scottish Government have since reinstated the reduced funding (and has guaranteed it until 2021), and has announced an additional £20m over the next two years.¹⁸⁷

70. We also heard multiple proposals for how the Scottish Government could do more within its existing powers to improve the provision of drug-related health services. Campaign group Transform told us that there is more the Scottish Government could do to expedite the scaling up of the availability of Heroin Assisted Treatment in Scotland.¹⁸⁸ Dave Liddell, Scottish Drugs Forum, echoed these calls, and added that more could also be done in relation to the availability of drug-checking services, and recorded police warnings (addressed more fully in chapter 5).¹⁸⁹ He also suggested that the methadone dosages currently used may be sub-optimal in some parts of Scotland, and that this could be addressed without any further change in powers.¹⁹⁰ Mr Liddell also argued that more could be done to improve the “very poor retention rates” amongst people in treatment who are recovering from drug use.¹⁹¹ We also heard calls from people with lived experience of problem drug use for better funded addiction treatment services in Scotland, more support and funding for recovery communities and family support provisions.¹⁹² For example, one person with lived experience told us that “family support services and counselling [should be more] easily available and visible”.¹⁹³ This point was also made by the Home Office minister responsible for drugs—Kit Malthouse MP—who argued that the Scottish Government “should, and could, invest more” in recovery and treatment.¹⁹⁴ The minister added that the UK Government “might [...] think about” other interventions such as safe consumption facilities, only “if and when Scotland [...] can honestly say that [it is] investing all [it] can in treatment”.¹⁹⁵

181 MRC/CSO Social and Public Health Sciences Unit ([UMD0022](#))

182 Scottish Drugs Forum, [ADP Funding Timeline](#)

183 Dr Emily Tweed ([UMD0038](#))

184 [Q201](#)

185 [Q201](#)

186 [Q201](#)

187 Scottish Government, [Protecting Scotland’s Future: the Government’s Programme for Scotland 2019–2020](#)

188 Strang J., Teodora Groshkova T., Uchtenhagen A., Wim van den Brink W. (2105) Heroin on trial: Systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction. *British Journal of Psychiatry*; 207(1):5–14; Transform ([UMD0043](#))

189 [Q272](#); [Q288](#)

190 [Q240](#)

191 [Q288](#)

192 [Q62](#); [Q71](#)

193 [Q80](#)

194 [Q431](#)

195 [Q448](#)

71. Throughout this inquiry we heard that there is more the Scottish Government could, and should, be doing to address problem drug use with the powers it already has, in areas such as mental health, housing, education, community regeneration, policing and justice. We were particularly concerned to hear of the impact that funding cuts, including previous cuts to alcohol and drug partnerships in the 2016/17 Scottish Government budget, have had on health services for people who use drugs. While it is not for us to make recommendations to the Scottish Government, we believe that if it wants to call for greater powers to tackle the drugs crisis it must demonstrate that it is doing everything it can within its existing responsibilities, including properly funding health services.

4 Safe consumption facilities

72. In 2016 a proposal was put forward to open a safe consumption facility (SCF) in Glasgow City Centre as part of efforts to address the city's high number of drug-related deaths and high HIV infection rate amongst people who use drugs. A SCF is a facility where people who use drugs can bring drugs to consume in a safe environment, with access to sterile equipment and medically-trained staff who are at hand to deal with complications. However, the Home Office has blocked the proposal arguing that such facilities pose ethical quandaries for medical staff and could lead to people who use drugs travelling large distances to access the facility. This has led to a protracted public debate between the UK and Scottish Governments, the NHS, third sector organisations, and the wider public. The proposal was raised by numerous witnesses and has been a key focus of our inquiry.

Harm reduction and SCFs

73. Harm reduction is a key tenet of the public health approach. Harm reduction holds that since some substance use is inevitable, the response to drug use should therefore primarily be focused on reducing the overall level of harm caused by use, rather than trying to prevent people taking drugs in the first place.¹⁹⁶ Injecting equipment provisions are a prime example of harm reduction by reducing the risk of people who inject drugs contracting diseases or infections by sharing or reusing injecting equipment.

74. Safe consumption facilities are also a harm reduction tool which aims to; limit the acute risk of disease transmission through equipment sharing, prevent drug-related overdoses and connect people who are considered at high-risk of harm with health treatment and other related services. They also seek to reduce drug consumption in public places, thereby reducing harm to the wider community.¹⁹⁷ Inside these facilities, medically trained staff typically provide people who inject drugs with sterile injecting equipment, supervision and education on safe injection methods, emergency care in the event of overdose, as well as referrals to appropriate social services, healthcare and drug treatment services.¹⁹⁸ Medically-trained staff within this facility are not allowed to administer any substance on behalf of the service users. There are now around 100 safe consumption facilities in operation worldwide, including in France, Germany, Denmark, Canada and Australia.¹⁹⁹

75. The general medical and academic consensus has been that these facilities are effective in reducing the level of harm caused by consumption of drugs. For example, the European Monitoring Centre for Drugs and Drug Addiction has shown that safe consumption facilities provide benefits such as improvements in safe, hygienic drug use, increased access to health and social services and reduced public drug use and associated nuisance.²⁰⁰ The Advisory Council on the Misuse of Drugs (ACMD) has also shown that

196 Harm Reduction International. 2016. [What is harm reduction?](#)

197 Scottish Parliament Information Centre, [Drug Misuse](#), March 2017

198 EMCDDA (2016c). [Drug consumption rooms: an overview of provision and evidence](#); European Monitoring Centre for Drugs and Drug Addiction. 2018. [Perspectives on Drugs—Drug consumption rooms: an overview of provision](#)

199 [Q32](#)

200 EMCDDA (2016c). [Drug consumption rooms: an overview of provision and evidence](#)

they reduce high-risk injecting behaviours and overdose fatalities, based on studies of the effectiveness of facilities in Vancouver and Sydney.²⁰¹ The ACMD's report states that:

In addition to preventing overdose deaths, they can provide other benefits, such as reductions in blood-borne viruses, improved access to primary care and more intensive forms of drug treatment. No deaths from overdose have ever occurred in such facilities.²⁰²

Academic and medical evidence also suggests there is no evidence that these facilities “increase injecting, drug use or local crime rates”.²⁰³

76. We heard that SCFs reduce the sharing of injecting equipment and dangerous injecting practices, which is the biggest risk factor for blood-borne viruses such as HIV.²⁰⁴ Others argued that SCFs have also been proven to reduce the prevalence of drug-related litter, which has substantial health and social benefits for surrounding communities.²⁰⁵ Many witnesses were also clear that where these facilities have been introduced internationally, there has been “no apparent increase in crime or antisocial behaviour in the vicinity”.²⁰⁶ Other witnesses were clear that there is “no evidence that people prolong or progress their drug use as a result of safe consumption facilities”.²⁰⁷ When asked whether there is *any* evidence to suggest that SCFs are ineffective, have adverse impacts, or cause societal harm, Dr Priyadarshi and Elinor Dickie—expert representatives for NHS Scotland and Glasgow Alcohol and Drug Recovery Services—responded “no”.²⁰⁸ The Health and Social Care Committee have recently expressed their support for safe consumption facilities, and recommend that they should be piloted in areas of high need.²⁰⁹

77. In May 2019 we visited a safe consumption facility in Ottawa (Canada), and saw for ourselves how SCFs operate. Officials at the facility explained that the most effective safe consumption facilities are those which integrate health and addiction treatment with other relevant drug-related services, such as psychiatrists, psychologists, councillors, and welfare and housing advisors.²¹⁰ Dr Angus Bancroft made the same point, highlighting that harm reduction—including safe consumption facilities—“is not an end in itself, but it is to make other things happen around it”.²¹¹ As it is often difficult to engage people who use drugs with treatment services, SCFs can act as a “gateway” to get people who use drugs to engage with housing, welfare and legal support services which can address the underlying drivers of their substance use.²¹² During our visit to Ottawa, we heard that approximately 85% of all clients of the safe consumption facility were referred to another service, and that there is no evidence to suggest the facility has increased or prolonged

201 Advisory Council on the Misuse of Drugs, [Reducing Opioid- Related Deaths in the UK](#), December 2016; Transform (UMD0043)

202 Advisory Council on the Misuse of Drugs, [Reducing Opioid- Related Deaths in the UK](#), December 2016

203 Potier, C. et al. 2014. Supervised injection services: what has been demonstrated? A systematic literature review. *Drug Alcohol Depend.* 1(145). Pg. 48–68; European Monitoring Centre for Drugs and Drug Addiction. 2018. Perspectives on Drugs—Drug consumption rooms: an overview of provision; Advisory Council on the Misuse of Drugs, [Reducing Opioid- Related Deaths in the UK](#), December 2016

204 [Q32](#)

205 [Q32](#)

206 [Q32](#); [Summary of Scottish Affairs Committee's visit to Canada, 27–30 May 2019](#)

207 [Summary of Scottish Affairs Committee's visit to Canada, 27–30 May 2019](#)

208 [Q234](#)

209 Health and Social Care Committee, [Drugs Policy: First Report of Session 2019–20](#), HC 143

210 [Summary of Scottish Affairs Committee's visit to Canada, 27–30 May 2019](#)

211 [Q138](#)

212 [Q32](#); [Q32](#); [Q227](#)

drug use.²¹³ Members who visited Frankfurt saw a range of different approaches to SCFs, and felt the ones which offered wrap-around services, including employability training and accommodation were more effective than those which only offer a supervised space for individuals to consume drugs.²¹⁴

Opposition to SCFs

78. Although the vast majority of evidence we have gathered unequivocally supports the effectiveness of SCFs, we have heard dissenting opinions. Dr McKeganey made an argument of principle against such facilities, saying that “I do not think it is the responsibility of services to facilitate drug consumption”.²¹⁵ He added that SCFs establish a false choice between “just leaving them [people who use drugs] in the streets, or providing a drug consumption room”.²¹⁶

79. In written evidence, Dr Ian Oliver argued that much of the evidence supporting the effectiveness of SCFs is “false”, and objected to the facilities because they “send out entirely the wrong message to people, particularly the young, that drug use is acceptable”.²¹⁷ Dr Oliver contradicts a prominent study on the effectiveness of SCFs in British Columbia, and argues that official statistics show that SCFs result in an increase, not a decrease in drug-related deaths.²¹⁸ However, the study Dr Oliver criticises has been through an extensive independent review process, and clearly shows that there has been a 35% reduction in fatal overdoses after a SCF was introduced in Vancouver.²¹⁹ Dr Oliver also argued that the SCF in Vancouver has caused an increase in public disorder, which has turned the surrounding area into a “war zone”.²²⁰ One facility in Frankfurt, which some members of the Committee visited, did have high levels of drug use immediately outside it, which staff at that centre attributed to budget cuts which had reduced its opening hours on the day that we visited.²²¹

80. The UK Government has also expressed opposition to SCFs. The Home Office has recognised the evidence base supporting the effectiveness of SCFs in addressing the problem of public nuisance associated with public drug use, and in reducing health risks for people who use drugs. However, they concluded that they could not support the implementation of them due to concerns over law enforcement, ethical quandaries for medical professionals and the risk that users would travel long distances to use them.²²²

213 Public Health Ottawa, Report to Ottawa Board of Health: Harm Reduction and overdose prevention - Follow-up report, February 2018

214 [Summary of Scottish Affairs Committee and Health and Social Care Committee’s visit to Portugal and Germany \(15th-18th July 2019\)](#)

215 [Q149](#)

216 [Q148](#)

217 Ian Oliver ([UMD0047](#))

218 Ian Oliver ([UMD0047](#))

219 Marshall BD, Milloy MJ, Wood E, Montaner JS, Kerr T, [Reduction in overdose mortality after the opening of North America’s first medically supervised safer injecting facility: a retrospective population-based study](#), *The Lancet*, April 2011, pp. 1429–37.

220 Ian Oliver ([UMD0047](#))

221 [Summary of Scottish Affairs Committee and Health and Social Care Committee’s visit to Portugal and Germany \(15th-18th July 2019\)](#)

222 Letter from the Home Office to Glasgow City Council, obtained by Committee team

81. The Home Office has also highlighted evidence that SCFs create a ‘honeypot effect’, whereby people who use drugs travel long distances to access the service.²²³ The particular example highlighted is the case of the Jutland Peninsula (between Denmark and Sweden), in which “Swedish drug users often come into Denmark to try to access harm-reduction services that perhaps don’t exist in Sweden”.²²⁴ Dr Priyadarshi argued that this is a particularly “unique situation”.²²⁵ Dr McAuley added that “there is no evidence of that happening in any equivalent services worldwide”.²²⁶ The Members of the Committee who visited Frankfurt also heard from professionals there who felt there had been some displacement of people who use drugs from Bavaria to Hessen because of the contrast between the criminal justice approach taken in Bavaria, and the public health approach taken in Hessen, including the availability of SCFs.²²⁷

82. In oral evidence to us, the Home Office minister told us that there is a “philosophical issue about [...] condoning the commission of [...] crimes”:

Fundamentally, those drugs are dealt illicitly and illegally, acquired illegally and consumed illegally. Paraphernalia is provided illegally. The premises would be provided illegally, unless obviously the law changes.²²⁸

83. Many witnesses took issue with the Home Office’s claim that SCFs raise “ethical quandaries for medical professionals”.²²⁹ Elinor Dickie, NHS Health Scotland, argued that “the ethical imperative to act is stronger”.²³⁰ Dr McAuley similarly told us:

I do not see what the ethical quandary would be there. They would be providing an evidence-based intervention. They would also be ethically addressing people at their point of need, reducing people’s likelihood to come to harm, so I cannot see that being a barrier.²³¹

Dr Saket Priyadarshi—himself a practicing Associate Medical Director for the NHS—also questioned the validity of the Home Office’s argument, saying “on balance, ethically, I have not heard those concerns being raised by many [health professionals]”.²³²

84. The Home Office minister emphasised that SCFs are often seen as “a so-called silver bullet”, but that this is not the case, and that investment in treatment would instead be a more effective way to address problem drug use.²³³ However, most witnesses we heard from were keen to highlight that harm reduction, treatment, care and recovery are “a continuum” and that, as discussed earlier, they are a “gateway service” which is best utilised in conjunction with the provision of treatment services.²³⁴ Some witnesses also challenged the Home Office’s claim that SCFs can increase drug use in the area surrounding the facility. Elinor Dickie argued that “we see in the research that these facilities [around the

223 Home Office, [Drugs: International Comparators](#), October 2014

224 [Q235](#)

225 [Q235](#)

226 [Q35](#)

227 [Summary of Scottish Affairs Committee and Health and Social Care Committee’s visit to Portugal and Germany \(15th-18th July 2019\)](#)

228 [Q442](#)

229 Letter from the Home Office to Glasgow City Council, obtained by Committee team

230 [Q229](#)

231 [Q36](#)

232 [Q229](#)

233 [Q448](#)

234 [Q221](#)

world] have not contributed to any increase in the number of people who inject drugs, or in the number of drug dealers in the area”.²³⁵ Dr Priyadarshi supported this point, and added that the negative risks associated with SCFs—such as increased visibility of drug dealing—can be mitigated through appropriate coordination with the police, the local community, and service management, as well as appropriate levels of funding.²³⁶

85. Safe consumption facilities are proven to reduce the immediate health risks associated with problem drug use. These facilities do not come without their challenges. However, when effectively managed with appropriate levels of funding and cooperation from the police and other stakeholders, these risks can be mitigated. However safe consumption facilities should not be seen as a ‘silver bullet’, but as a way to get people with problem drug use to engage in other services which can address the underlying causes of their substance use.

Case for a safe consumption facility in Glasgow

86. As mentioned earlier, a safe consumption facility has been proposed for Glasgow by the Glasgow City Health and Social Care Partnership. After conducting a local needs assessment and feasibility study, the Partnership concluded that a safe consumption facility in Glasgow city centre would help address the health and social harms caused by public injecting.²³⁷ The proposal was supported by the Scottish Government, as well as groups including the Scottish Drugs Forum, National AIDS Trust, the Hepatitis C Trust, Waverley Care and Turning Point Scotland.²³⁸ The proposals have also been supported by the Scottish Parliament.²³⁹ We also heard that 79% of people using injecting equipment provision services in the centre of Glasgow said they would use the proposed safe consumption facility.²⁴⁰

87. Almost all of the witnesses we heard from were supportive of the proposal for a pilot facility. Dr McAuley told us that Glasgow’s case for a SCF “is arguably the most compelling case [...] Europe has seen, not just the UK”.²⁴¹ He added:

If you look at the most recent one that was opened in Paris, the case that that was built on was nowhere near as compelling as Glasgow, if you think about the HIV outbreak, the drug death epidemic, largest botulism outbreak Europe has ever seen. There is a whole host of reasons why Glasgow is a perfect case for the UK’s first consumption room.²⁴²

Whilst saying it would be impossible to predict exactly how many drug-related deaths a SCF would prevent, Dr Priyadarshi argued that a similar facility in Vancouver saw “a very significant reduction in the number of drug-related deaths” after its introduction.²⁴³ The Home Office minister took issue with this, and argued that “even in the best performing”

235 [Q233](#)

236 [Q235](#)

237 Tweed, E. Rodgers, M. 2015. “Taking away the chaos” The health needs of people who inject drugs in public places in Glasgow city centre. Glasgow. NHS Greater Glasgow and Clyde

238 Scottish Government, Letters publicly provided under the Freedom of Information (Scotland) Act 2002; [Q33](#)

239 Scottish Government, Letters publicly provided under the Freedom of Information (Scotland) Act 2002

240 [Q33](#)

241 [Q34](#)

242 [Q34](#)

243 [Q232](#)

safe consumption facilities, “you are looking at two to twelve” deaths being avoided.²⁴⁴ However, our evidence suggests that the number of lives saved could be much larger. Referring to a study on the same facility in Vancouver, Martin Powell, Transform, said “230 lives [were] saved in a 20-month period in British Columbia with a similar population to Scotland, just from their drug consumption rooms”.²⁴⁵

88. The UK Government also raised questions about the cost-effectiveness of SCFs. The Home Office minister highlighted that the operating cost of a SCF in Vancouver is \$1.5 million, and implied that such costs—relative to drug-related health treatment and recovery—do not represent the best value for money.²⁴⁶ However, the estimated average lifetime cost of treating someone with HIV is £360,000 per person.²⁴⁷ This equates to more than £28m for the 78 new HIV cases developed amongst people who inject drugs in Glasgow for 2015/16 alone (or £500,000 per year). This suggests that a SCF in Glasgow would be a highly cost-effective measure. This was also reflected in the written evidence we have received. For example, NHS Health Scotland told us that, factoring in the savings made by reducing the transmission of blood-borne viruses such as HIV, safer drug consumption facilities are highly cost-effective and contribute to savings in health systems.²⁴⁸ Dr Tweed made a similar point:

We see in Canada and Australia these facilities were cost-saving, so although they require quite a substantial initial investment of money, they saved the health service money because of the averted blood-borne virus infections and overdoses. Those were quite conservative assumptions they used in looking at costs.²⁴⁹

The Advisory Council on the Misuse of Drugs has also made this point, highlighting that SCFs “save more money than they cost, due to the reductions in deaths and HIV infections that they produce”.²⁵⁰

89. However, the Home Office has rejected an application for a full statutory exemption for the reasons outlined in the previous section—namely, law enforcement concerns, ethical quandaries for medical professionals and the risk that users would travel long distances to use the facility.²⁵¹ The Home Office said “there is no legal framework for the provision of drug consumption rooms in the UK, and we have no plans to introduce them”.²⁵² The Government also reiterated that the Home Office has “no plans” to devolve responsibility for the control of drugs to the Scottish Parliament.²⁵³

90. The Scottish Government minister, Joe Fitzpatrick MSP, argued that if the UK Government does not want to grant a legal exemption for the facility, then the relevant drug laws should be devolved to the Scottish Parliament. He told us that there has been

244 [Q442](#)

245 [Q256](#)

246 [Q446](#)

247 NHS Health Scotland/NHS National Services Scotland ([UMD0021](#))

248 NHS Health Scotland/NHS National Services Scotland ([UMD0021](#))

249 [Q32](#)

250 Advisory Council on the Misuse of Drugs, [Reducing Opioid- Related Deaths in the UK](#), December 2016

251 Letter from the Home Office to Glasgow City Council, obtained by Committee team

252 Scottish Government, Letters publicly provided under the Freedom of Information (Scotland) Act 2002

253 Scottish Government, Letters publicly provided under the Freedom of Information (Scotland) Act 2002

“absolutely” no attempt from the Home Office to continue discussions to find a mutually beneficial outcome in relation to SCFs, and that the Government has refused to engage with the Scottish Government on this issue for some considerable time.²⁵⁴

91. In oral evidence to us, the Home Office minister put less emphasis on his opposition to SCFs being based on his department’s previously made arguments around “ethical quandaries” or moral arguments. Instead, he said he has an “open mind” about potential solutions to problem drug use, and that he would be happy to have discussions about these.²⁵⁵ The minister’s principal concern appeared to be based, firstly, on the legal difficulties of practically implementing SCFs. Referencing the Lord Advocate’s evidence, the minister explained that under current legislation there are “some significant legal hurdles”, including civil liability issues.²⁵⁶ We address this later in this chapter.

92. The minister’s other primary reason for opposing SCFs, is that there are “lots of things that can be done immediately” and that we should not be fixated or distracted by one solution.²⁵⁷ He pointed to investment in heroin-assisted treatment, naloxone and methadone as examples of treatment services which are more “efficient and effective”, and result in better outcomes for people who use drugs.²⁵⁸ He added that financial resources are finite, and that funding a SCF may not be the best use of the Scottish Government’s resources.²⁵⁹

93. We believe there is a strong evidence base for a safe consumption facility in Glasgow, which would be a practical step to reducing the number of drug-related deaths in Scotland. Health is a devolved matter, and it is therefore deeply regrettable that the UK Government has chosen to block the proposed facility. We are not convinced by the UK Government’s argument that it will not give permission for such facilities because it believes that there are more cost-effective health care interventions. Under the devolution settlement, spending on health delivery is a matter for the Scottish Government. We recommend that the UK Government supports the proposed pilot safe consumption facility in Glasgow.

In the following section we will explore in more detail how the proposed facility could be lawfully implemented.

Legal options for Glasgow SCF

94. Under the Misuse of Drugs Act 1971, the proposed safe consumption facility in Glasgow would be illegal, and some form of special legal dispensation from the Act is therefore required for the facility to be lawful.²⁶⁰ The proposal would also result in a number of common law offences and issues of civil liability, which would need to be addressed. The Home Office has said “there is no legal framework for the provision of drug consumption rooms in the UK, and we have no plans to introduce them”.²⁶¹ However

254 [Q398](#)

255 [Q449](#)

256 [Q442](#)

257 [Q452](#)

258 [Q451](#); [Q447](#)

259 [Q450](#)

260 [Q357](#)

261 Scottish Government, Letters publicly provided under the Freedom of Information (Scotland) Act 2002

throughout our inquiry it was suggested that, despite the Home Office’s rejection, it may be possible to open a facility under the existing legal framework. We explore these options in the following sections.

Letter of comfort

95. The first proposal was for the Lord Advocate—Scotland’s chief public prosecutor—to issue a ‘letter of comfort’. This document would contain a guarantee that the facility’s operation would not be legally challenged or the subject of prosecution, despite the technically illegal activity that would be conducted inside. Glasgow City Health and Social Care Partnership wrote to the Lord Advocate seeking such a letter. In November 2017 the Lord Advocate declined to offer the requested guarantee on the basis that “while the Lord Advocate can make decisions as to whether or not a criminal offence will be prosecuted, he cannot alter the basic quality of the activity as criminal in law”.²⁶² In other words, the Lord Advocate argued that the legal guarantee sought by the Partnership was beyond the scope of the dispensation he was able to offer.

96. The Scottish Drugs Forum was critical of the Lord Advocate’s decision, and argued that the proposed guarantee would be within the scope of the Lord Advocate’s powers, noting that a similar exemption from prosecution has previously been granted for similar harm reduction measures—notably, injecting equipment provision services—and that it is therefore possible to do the same for safe consumption facilities.²⁶³ Dave Liddell, CEO, Scottish Drugs Forum, told us that:

Our view—and obviously that was the view of Glasgow as well when it put it forward—was that the Lord Advocate could issue a letter of comfort, as he has done in other related areas like naloxone, for example.²⁶⁴

However, the Lord Advocate told us that a SCF requires a legal solution which provides “an appropriate system for licensing and oversight, addresses the scope of exemptions from the criminal law, and deals with issues of civil liability”.²⁶⁵ He explained that a legal solution of that complexity is beyond “what it is appropriate for me to do as the person charged with the enforcement of the criminal law”, and that “I simply cannot create that kind of regime through a letter of comfort”.²⁶⁶

Police agreement

97. Instead of formal dispensation from the Lord Advocate, some witnesses argued that an agreement between the facility and local police not to pursue drug-related offences within the facility might be sufficient. During our visit to a SCF in Ottawa, we heard that a working agreement with local law enforcement is crucial to the effective operation of the facility.²⁶⁷ Professor Alex Stevens explained such an arrangement is also used for a comparable facility in Copenhagen:

262 Lord Advocate ([UMD0049](#))

263 Scottish Drugs Forum ([UMD0024](#))

264 [Q272](#)

265 [Q357](#)

266 [Q357](#); [Q358](#)

267 [Summary of Scottish Affairs Committee’s visit to Canada, 27–30 May 2019](#)

The drug consumption room in Vesterbro in Copenhagen has a police-declared non-enforcement zone for possession offences around it. Within that zone, people who use drugs will know that they are not going to be arrested and punished for possession of substances.²⁶⁸

Elinor Dickie, NHS Health Scotland, suggested a similar agreement might be an avenue worth exploring in Glasgow.²⁶⁹ Detective Chief Inspector Kew, Thames Valley Police, also expressed support for this approach, and questioned whether the ‘public interest’ test would be met for taking legal action against the proposed SCF in Glasgow. DCI Kew argued that “if there is no public interest to meet that threshold for a prosecution, the positioning of the legislation standpoint is undermined by that health emergency”.²⁷⁰ This view was also supported by Assistant Chief Constable Johnson, Police Scotland, who argued that “given our [police forces’] duty around preservation of life, I do not think it would be in the broader public interest”.²⁷¹ ACC Johnson added that if the proposed facility was “legitimate”, Police Scotland would work with the NHS and other stakeholders to support it.²⁷²

98. However, we heard concerns that any solution short of a full legal exemption—including the proposed agreement between local law enforcement and the facility—could place staff who work in the facility in legal jeopardy. This was the view of Professor Stevens, who argued that the absence of a full legal exemption puts police services and individual officers “in invidious positions”.²⁷³ This concern was shared by police force representatives. Assistant Chief Constable Steve Johnson, Police Scotland, explained the difficult position legal ambiguity presents for on-duty police officers:

From an officer perspective, if you are an officer and you are walking the streets of Glasgow where that facility is and you stop someone who is on their way [there] in possession of those drugs, there is a hefty dose of the “woulda, coulda, shoulda” squad. If the person does not then go to the safe facility [...] but takes themselves down by the side of the Clyde and injects and falls in the river and dies, the “woulda, coulda, shoulda” would be “what are the police doing? You had a power; you did not exercise it”. That person should have been in a custody facility, put in front of the sheriff, from the sheriff to the court [...] That is a harsh reality faced.²⁷⁴

The Lord Advocate did not comment at length on the legality of an agreement between a facility and police authorities, but stated that “in my view that would not be an appropriate approach”.²⁷⁵

Exemption from the Misuse of Drugs Act

99. Given the problems with both approaches, we returned to the question of what legal changes would be needed to allow a SCF to be opened in Glasgow. Our evidence suggests

268 [Q321](#)

269 [Q238](#)

270 [Q310](#)

271 [Q312](#)

272 [Q320](#)

273 [Q313](#)

274 [Q312](#)

275 [Q363](#)

that the implementation of a legal framework would not require a substantial or lengthy legal change,²⁷⁶ and could be implemented using existing powers under section 22 of the Misuse of Drugs Act 1971. This was the preferred position of NHS Health Scotland, who have recommended that the UK Government make the necessary changes to reserved legislation to allow a facility to open or, failing that, to “devolve the powers in this area”.²⁷⁷ Waverley Care similarly advocated for the removal of legislative barriers, or the devolution of drugs laws to the Scottish Parliament. The Lord Advocate argued that, if it is decided that the proposal should go ahead, it is “absolutely” the responsibility of Westminster to legislate, rather than it being up to him to create a legal work-around. He added that, since SCFs are a controversial solution, legislation is the most appropriate way to “resolve the policy issues in a democratically accountable way”.²⁷⁸

100. The Home Office minister argued that “it would take some time to sort out the legislation” necessary, and that “there are other things that could be done much more quickly”.²⁷⁹ However, the necessary legislative changes could be made with simple and expedient regulations under existing powers in the Misuse of Drugs Act.²⁸⁰ The minister also argued that even if the criminal aspects of SCFs could be dealt with through legislation, there is still the risk of civil liability which, he argued, cannot be dealt with by legislation.²⁸¹ However, our legal advice (see footnote) suggests that civil liability issues could be dealt with through primary legislation.²⁸² It was also not clear whether the civil liability risks the minister identified were any different to those associated with any other lawful medical intervention.

101. We do not believe that it would be acceptable to try to open a safe consumption facility in Glasgow under the current legal framework. Doing so would risk putting clients, NHS staff, and governance bodies in legal jeopardy. We recommend that the UK Government brings forward the legislation necessary to allow for the lawful establishment of a pilot safe consumption facility in Scotland. If the UK Government is unwilling to do so, it must instead devolve competence for drugs legislation to the Scottish Parliament, so that it can implement the health approach it deems to be in Scotland’s best interest.

276 [Qq315–316](#); see footnote 283

277 NHS Health Scotland/NHS National Services Scotland ([UMD0021](#))

278 [Q357](#)

279 [Q442](#)

280 See footnote 281

281 [Q442](#)

282 The criminal consequences of operating a SCF, under the Misuse of Drugs Act 1971, could be avoided by simple, expedient regulations made by the Secretary of State under section 22 of that Act. These would be made by statutory instrument and subject to Parliamentary scrutiny under the negative resolution procedure, whereby either House of Parliament could cancel (annul) the regulations: see section 31 of the Act. The offence of being the occupier or manager of premises and knowingly allowing the supply of a controlled drug, contrary to section 8, could be avoided, as could offences of, for example, supplying syringes contrary to section 9A. The possibility would remain, though, of those operating SCFs being sued (e.g. for damages) in civil proceedings by, for example, anyone injured as a result of things done in the SCF. If operators could not insure against the risk of civil liability, primary legislation might be needed.

5 Decriminalisation

102. As we saw in chapter 3, the clear majority of our witnesses were critical of the criminal justice approach to problem drug use, arguing that it perpetuates stigma, marginalises people with problem drug use, and increases the harm caused by substance use. As a result, many witnesses advocated decriminalisation. Decriminalisation means that the possession of small amounts of drugs for personal use is no longer a criminal offence. Criminal penalties can be replaced by civic or administrative penalties such as fines or community service.²⁸³ Sometimes those found in possession of drugs are required to attend some form of treatment or education.²⁸⁴ However, the sale or supply of drugs remains a criminal offence under decriminalisation.²⁸⁵

The case for decriminalisation

103. We heard from a number of proponents of decriminalisation, who argued that criminal justice sanctions are ineffective, costly, and increase the harms associated with substance use. Criminalisation increases the stigma associated with drug use, making it less likely that people will seek support. Custodial sentences can also exacerbate problem drug use and decrease the chances of successful recovery. Advocates for decriminalisation argue that the best way to prevent this harm is to remove the criminal sanction for the possession of small amounts of drugs, telling us that “the evidence is clear that it works”.²⁸⁶ This was also the view of law enforcement professionals, as well as academics and healthcare professionals. Assistant Chief Constable Johnson, Police Scotland, argued that the Home Office’s criminal justice policies are “deleterious [... in] pushing people into a place where there is more harm”.²⁸⁷ He went on to say that:

If our first duty is to save life, then there is a clear tension, isn’t there, between upholding the law that says mere possession of a tiny amount of a substance should lead to either a police warning or an arrest that puts somebody into custody, which potentially exposes them to more drugs or different sorts of drugs within the prison system, which then puts them back out into society where the inequalities or health issues that have probably led to them taking the drugs [... This] will unfortunately for most of them mean at some point they are going to die.²⁸⁸

104. Throughout our inquiry we heard from many people who are recovering from problem drug use whose first-hand experience supported this assessment. Hannah Snow served a number of custodial sentences for drug-related offences, and explained that in her experience criminal sanctions are “not a deterrent”, and they do not address the root causes of substance use:

What benefits are you getting from sending a known drug user into prison to do a drug sentence, who will get released to do the same thing? Enforce an order that has to put them through a recovery-based programme, instead

283 [Q39](#)

284 [Q27](#)

285 Scottish Parliament Information Centre, [Drug Misuse](#), March 2017

286 [Q40](#)

287 [Q310](#)

288 [Q310](#)

of putting them into a criminal procedure programme where the cycle just starts again. If you go up in court for drug use, and you are then forced to go to a recovery programme, you have a better chance of changing your life in that than you do of changing your life in prison.²⁸⁹

105. Portugal was frequently cited as the main example of a country which has successfully introduced decriminalisation. In 2001 Portugal decriminalised the possession of all drugs for personal use in response to their own drugs crisis, with over 1% of the population addicted to heroin, and the highest rate of drug-related AIDS in the European Union. Decriminalisation in Portugal was part of a wider harm reduction approach which saw drug prevention and treatment services scaled up, improvements in public health education, and an increase in enforcement action against the supply of drugs.²⁹⁰ As a result of these reforms, the number of drug-related deaths in Portugal fell from 80 in 2001, to 30 in 2016. This equates to 4 deaths per million in 2017, which is lower than the most recent European average of 22 deaths per million.²⁹¹ There has also been an 80% reduction in the country's HIV infection rate.²⁹² Some Members of this Committee visited Portugal, on a joint visit with the Health and Social Care Committee, as part of our inquiry. Our delegation was impressed by Portugal's comprehensive approach to the health and social issues surrounding substance use, the country's focus on early intervention, and the role of the Dissuasion Committee in ensuring those found in possession of drugs can be given access to education and treatment.²⁹³

106. Decriminalisation can also allow for better targeting of resources to tackle the root causes of problem drug use, by moving spending away from enforcement of possession offences to health interventions.²⁹⁴ The campaign group Release said that decriminalisation in Portugal allowed resources to be “diverted from the criminal justice system into health and other services for people who use drugs”.²⁹⁵ Others similarly argued that decriminalisation in Portugal “was the ‘critical enabler’ that released additional funding for treatment and allowed a more integrated health-based approach”.²⁹⁶ Professor Matheson highlighted that Portugal, even after redirecting resources to health, education and other law enforcement efforts, had seen “an 18% reduction in costs overall to society as a result of their approach”.²⁹⁷

107. However, witnesses were clear that decriminalisation alone is not the answer to problem drug use, and it must be implemented alongside a wider package of reforms, including health, social and economic measures.²⁹⁸ Professor Stevens explained that decriminalisation worked in Portugal because it did not just decriminalise drugs:

It expanded the treatment system substantially, mostly through getting more people into drug substitution treatment at a low threshold. They also

289 [Q67](#)

290 EMCDDA, [2013 National Report \(2012 data\) to the EMCDDA by the Reitox National Focal Point: “Portugal” New Developments, Trends and in-depth information on selected issues](#)

291 European Monitoring Centre for Drugs and Drug Addiction, [Portugal: Country Drug Report 2019](#)

292 [Q41](#)

293 [Summary of Scottish Affairs Committee and Health and Social Care Committee’s visit to Portugal and Germany \(15th-18th July 2019\)](#)

294 [Q29](#)

295 Release ([UMD0026](#))

296 Transform ([UMD0043](#))

297 [Q27](#)

298 [Q37](#)

improved their welfare system. They introduced a guaranteed minimum income, and the whole point of the whole package of measures, which included decriminalisation, was to reintegrate or, indeed, integrate people into society.²⁹⁹

This point was reiterated by most of the witnesses we heard from who supported decriminalisation.³⁰⁰ The Health and Social Care Committee also pointed to the example of Portugal in their recent report, and recommended that the Government should consult on the decriminalisation of drugs for personal use.³⁰¹ The Committee, mirroring arguments made by many of our witnesses, said that that decriminalisation must go alongside improving treatment services and increasing the provisions of education, prevention measures and social support.³⁰²

108. The Scottish Drugs Forum told us that, considering the evidence of the effectiveness of decriminalisation, the UK Government's current approach "is hard to justify".³⁰³ We also heard support for decriminalisation from police representatives from across the UK. Assistant Chief Constable Steve Johnson, Police Scotland, Detective Chief Inspector Jason Kew, Thames Valley Police, and Detective Superintendent Kevin Weir, Durham Police, all indicated their support for decriminalisation.³⁰⁴ ACC Johnson, for example, said:

Any suggestion of decriminalisation and legalisation is always met with, "It's the police going soft on drugs". It is far from that. It is actually the police being very pragmatic about the nature of the harms that are experienced within the communities.³⁰⁵

Professor Alex Stevens, University of Kent, argued that the police representatives' views were particularly poignant:

We have just heard from senior police officers with a wealth of experience that they can no longer toe the Government line, which is that we need to criminalise people to send a message to reduce harm. We have heard from these senior police officers that that just does not fit with their professional expertise.³⁰⁶

109. Although the vast majority of the evidence we heard supported decriminalisation, we heard dissenting views. The UK Government has previously said it opposes decriminalisation for the same reason it objects to safe consumption facilities; that it wants to "send a clear message" that controlled drugs can be harmful, and that they must therefore be subject to a "commensurately strict regime".³⁰⁷ In response to a public petition to hold a referendum for the liberalisation of cannabis laws, the Home Office justified this position on the basis that liberalisation:

299 [Q324](#)

300 [Q16](#); [Q26](#); [Q37](#)

301 Health and Social Care Committee, [Drugs Policy: First Report of Session 2019–20](#), HC 143

302 Health and Social Care Committee, [Drugs Policy: First Report of Session 2019–20](#), HC 143

303 Scottish Drugs Forum ([UMD0024](#))

304 [Qq322–326](#)

305 [Q324](#)

306 [Q302](#)

307 Letter from the Home Office to Glasgow City Council, obtained by Committee team

Would send the wrong message to the vast majority of people who do not take drugs, especially young and vulnerable people, with the potential grave risk of increased misuse of drugs.³⁰⁸

Professor Alex Stevens argued that the Home Office’s position is contrary to its own evidence base.³⁰⁹ He claimed that, even though the Government accepts that criminalisation does not work, the Home Office “wants to put forward that it has a tough approach to drugs, and that any loosening of control would be in conflict with that”.³¹⁰

110. In oral evidence to us the Home Office minister reiterated that he is “not supportive of the decriminalisation push”.³¹¹ The minister argued that criminal justice sanctions “have to be a tool that is available, particularly for persistent drug users and for those who commit other offences”.³¹² Mr Malthouse MP also took issue with the oft-cited example of Portugal as a country which has successfully implemented decriminalisation. The minister argued that the success of Portugal’s approach is attributable to the “enormous amounts of money” invested in treatment, recovery and education.³¹³ The minister is correct to say that there was a significant increase in funding for drug-related health intervention in Portugal following decriminalisation. However, we heard during our visit—and from other witnesses—that this increase was only possible because of the savings made through decriminalising drugs.³¹⁴ We also heard that decriminalisation had other positive effects, such as reducing stigma and encouraging people who use drugs into treatment.³¹⁵ During our visit to Portugal it was also made clear to us that decriminalisation itself was the “prime” change which fuelled progress.³¹⁶

111. The Scottish Government told us that if the UK Government will not decriminalise drugs across the whole of the UK, then drugs laws should be devolved to allow the Scottish Parliament to take this approach.³¹⁷ When this proposal was put to the UK Government, the Home Office minister told us that having two different regimes on drugs would present “significant challenges”, including issues around policing a single UK border.³¹⁸ He also said different regimes would create “an open market for gangs to run drugs into a less-regulated market in Scotland”, and that existing problems with ‘county lines’ would be exacerbated.³¹⁹

112. Dr McKeganey also opposed decriminalisation arguing that it was likely to increase the use of drugs and therefore increase harm.³²⁰ Dr McKeganey raised particular concerns about potential increases in the availability and use of heroin in Scotland, which should encourage policy makers to be “very cautious” about initiating policy which could result

308 UK Government and Parliament, [Hold a referendum for the legalisation of cannabis](#)

309 [Q307](#)

310 [Q307](#)

311 [Q424](#)

312 [Q425](#)

313 [Q424](#)

314 [Summary of Scottish Affairs Committee and Health and Social Care Committee’s visit to Portugal and Germany \(15th-18th July 2019\); Q324; Q152](#)

315 [Summary of Scottish Affairs Committee and Health and Social Care Committee’s visit to Portugal and Germany \(15th-18th July 2019\) ; Q324; Q152](#)

316 [Q425; Summary of Scottish Affairs Committee and Health and Social Care Committee’s visit to Portugal and Germany \(15th-18th July 2019\)](#)

317 [Q374](#)

318 [Q435](#)

319 [Q435](#)

320 [Q119](#)

in the availability of drugs increasing.³²¹ However, Dr Bancroft took issue with this, and argued that a distinction should be drawn between a potential for increased recreational drug use, and increased *problematic* drug use.³²²

113. We also heard that there is some evidence from international case studies suggesting that decriminalisation can have negative consequences. The Czech Republic and the Netherlands were raised as examples of countries where drug liberalisation reforms led to increased visibility of drug markets, an increase in public order offences, and community disruption due to tourism. In both cases, some aspects of the liberalisation reforms were subsequently reversed. On the other hand, Dr McAuley argued that evidence from Portugal shows decriminalisation:

Has certainly not increased the size of that market [... Instead] there are fewer people using drugs problematically and a massive reduction in levels of harm among those that are. The evidence is clear that it works.³²³

114. Decriminalisation of the possession of drugs for personal use is an evidence-based solution to problem drug use. There is a strong case for doing this across the UK, as decriminalisation is proven to address the root causes of problem drug use. Decriminalisation would also allow the Government to focus efforts and resources on tackling the drug supply chain and providing services to support people who use drugs into recovery.

De facto decriminalisation

115. Despite the current legal context there are some areas of the UK where de facto decriminalisation is currently taking place. De facto decriminalisation means that drug possession is effectively decriminalised.³²⁴ The laws making drug possession an offence remain in place, but a decision is taken not to take legal action, and divert offenders towards treatment or civil penalties instead of criminal sanctions. We looked at two such systems, operated by Durham Police and Thames Valley Police, to further evaluate the effectiveness of decriminalisation and see whether its benefits could be delivered under the current legal regime.

Durham and Thames Valley police diversion schemes

116. Thames Valley Police have run a pilot scheme whereby eligible individuals found in possession of drugs are offered a community resolution outcome, such as referral to a drug treatment provider, instead of being prosecuted. If the person declines this, they are dealt with via traditional criminal justice routes. If they accept, their details are passed to the drug service provider who arranges for an appropriate intervention. The police then liaise with the drug service provider to ascertain whether the individual has engaged with them or not. If the conditions of the referral are broken, then the individual would subsequently be charged with a possession of drug offence.³²⁵

321 [Q131](#)

322 [Q119](#)

323 [Q40](#)

324 Reform, [Glossary: Decriminalisation](#)

325 Policing Strategy Unit ([UMD0042](#))

117. Initial assessments of the pilot’s effectiveness show that 53% of all drug cases were diverted to treatment, and nearly half of the individuals diverted completed the full treatment programme. Most referrals (76%) are for possession of cannabis. Thames Valley Police say that without a diversion scheme, 84% of those who were sent for treatment would have received a sanction that would likely not have addressed the reasons for their drug use. The scheme has also delivered sizable cost savings, with Thames Valley Police estimating that 944 Sergeant and Constable hours would be saved over the course of a year, equating to £26,976 of savings for the small local police area where the pilot was conducted.³²⁶ Detective Chief Inspector Jason Kew, Thames Valley Police, told us that the effectiveness of the scheme is “robust, proven and evidenced”, and that it “create[s] better outcomes for the person, better outcomes for the police, [by] freeing up resources”, which can then be put into harm reduction and education.³²⁷

118. Durham Police have been running a similar voluntary adult offender diversion scheme—‘Checkpoint’. Under the scheme, eligible drug-related offences are classed as a ‘deferred prosecution’, which can be invoked at any point for four months after the offence is committed, should the offender breach the conditions of the deferral. The programme has been running since April 2015. Initial evaluations of effectiveness suggest that the deferred prosecution model reduces the level of re-arrests, reoffending, harm, and cost to police, compared with traditional criminal justice processes.³²⁸ Superintendent Weir, Durham Police, told us that the scheme is improving the life chances of those who come into contact with the criminal justice system for drug-related crimes.³²⁹

119. Professor Stevens noted the significance of the approaches taken by the two police forces. He said:

I think this is fascinating, because what we are hearing is the police creating ways to reduce the harm that is being done by the Misuse of Drugs Act, with police at local level saying, ‘If we fully implemented this law of criminalising everyone who we find in possession of these substances, we would be creating harm, so in the interests of serving our communities we are not going to create those harms, we are going to find ways of not doing that’.³³⁰

120. Kit Malthouse MP, the responsible Home Office minister, was supportive of these schemes, calling Durham’s Checkpoint scheme “a wholly laudable project”, adding that “if it results in an overall reduction in crime and offending, it seems sensible to me”.³³¹ The minister also appeared relaxed about the prospect of de facto decriminalisation schemes being implemented more fully in Scotland.³³² However, this apparent support for de facto decriminalisation did not extend to statutory decriminalisation. The minister said he is “not supportive of the decriminalisation push”.³³³

326 Policing Strategy Unit ([UMD0042](#))

327 [Q326](#); [Q324](#)

328 Kevin Weir, Gillian Routledge, Stephanie Kilili, [Checkpoint: An Innovative Programme to Navigate People Away from the Cycle of Reoffending: Implementation Phase Evaluation](#), *Policing: A Journal of Policy and Practice*

329 [Q334](#)

330 [Q312](#)

331 [Q429](#)

332 [Qq429–439](#)

333 [Q424](#)

De facto decriminalisation in Scotland

121. Police Scotland have offered Recorded Police Warnings (RPW), as an alternative to prosecuting some drugs offences for a number of years. RPWs can be issued to anyone over the age of 16 for a range of low-level offences.³³⁴ RPWs are often provided on the condition that individuals voluntarily present themselves to addiction treatment services. In 2017–2018, 17,291 RPWs were issued, and 77% of these were for a category of offence which includes drug possession.³³⁵ Police Scotland have argued that the RPW system offers “a consistent, swifter, more effective and proportionate way of dealing with low-level offences”, which reduces the strain on the criminal justice system.³³⁶ Unfortunately there is no detailed evaluation of RPW in Scotland. However, evidence is available from Australia where all eight states now have forms of diversion scheme, education and/or treatment. A review of reoffending in prior offenders, found a decrease in re-offending ranging between 52.8% in Tasmania and 66.3% in Victoria.³³⁷

122. We heard calls for the current RPW system in Scotland—which is currently limited to cannabis—to be extended to all other drugs. It was argued that this would deliver many of the benefits of decriminalisation, but without requiring legislation change at UK-level.³³⁸ Martin Powell, Transform, told us:

In terms of what more could be done at the moment, the police use recorded police warnings for cannabis [...] we would like to see those expanded to include all other drugs.³³⁹

Dave Liddell, Scottish Drugs Forum, supported this proposal, arguing that “within the existing framework we can deliver decriminalisation in Scotland through record warnings”.³⁴⁰ In written evidence, Release similarly argued that the approach taken in Portugal is possible in Scotland, “if there is multi-agency agreement to divert people away from the criminal justice system”.³⁴¹ The Lord Advocate confirmed he had the discretion to decide whether the RPW system is expanded to include additional drugs, and an expansion would not require any legislative changes.³⁴² ACC Johnson, Police Scotland, also expressed support for considering implementation of a wider diversion scheme similar to those used by Thames Valley and Durham police forces.³⁴³

123. However, we also heard that the de facto approach presents difficulties. Professor Stevens argued that the advantage of fully decriminalising drugs through the law is that:

You are reducing this ambiguity and helping the police, giving them some clarity both at the individual officer level and at the service level, as to what the Government and the public want us to do about drugs that does reduce harm rather than increasing the harms of this vulnerable population.³⁴⁴

334 Ask the Police, [What is the Recorded Police Warning Scheme?](#)

335 Scottish Government, [Criminal proceedings in Scotland, 2017–2018](#), January 2019

336 BBC News, [Some drug users may receive a warning instead of prosecution](#), 10 December 2015

337 Payne, J., Kwiatkowski, M., & Wundersitz, J., [Police Drug Diversion: A Study of Criminal Offending Outcomes](#), AIC Reports: Research and Public Policy Series 97, Canberra: Australian Institute of Criminology, 2008, p63–70

338 [Q270](#)

339 [Q270](#)

340 [Q288](#)

341 Release ([UMD0026](#))

342 [Qq344–349](#)

343 [Q327](#)

344 [Q312](#)

These are the same kind of difficulties we discussed when looking at whether safe consumption facilities could be delivered under the current legal framework. Anything short of full legal decriminalisation presents a legally ambiguous context in which police officers can be put in the “invidious position” of deciding whether to apply the available decriminalisation disposals, and does not provide certainty about how these issues will be treated in future, as policing and prosecuting policy can change more quickly than legislation.³⁴⁵

124. The Lord Advocate also argued that such radical changes—whether it’s decriminalisation of drugs or the introduction of safe consumption facilities—should be introduced only after a “democratically accountable consideration of the policy issues”.³⁴⁶ The Lord Advocate added that it is “absolutely” the responsibility of Westminster or Holyrood to change the legal frameworks, rather than it being his responsibility to create legal “loopholes” to work around the existing law.³⁴⁷

125. We support the innovative approaches to decriminalisation taken by police forces across the UK, but believe that statutory decriminalisation is a preferable solution which removes the legal ambiguities inherent in non-statutory approaches.

126. We also believe that decriminalisation should be implemented by elected and accountable politicians. Whilst we are encouraged to hear the Home Office minister tacitly supports de facto decriminalisation schemes in the UK, it is unclear to us why the Government has not implemented diversion as a UK-wide policy, and has chosen instead to leave this difficult issue to local police officials. It is also not clear why the UK Government is supportive of de facto decriminalisation, but will not support statutory decriminalisation. The UK Government must be clear on its policy and be accountable for its decisions.

127. We recommend that the UK Government decriminalises the possession of small amounts of drugs for personal use across the whole of the UK and should consult on how this could be rolled out in practice. As a transitional approach, the Home Office should encourage all police forces across the UK to introduce diversion schemes. If the UK Government does not decriminalise drugs, this will only strengthen the case for the devolution of drugs laws.

Decriminalisation and the supply chain

128. We heard that decriminalising the possession of drugs for personal use would not legalise the supply of drugs and could allow resources to be freed up to target drug supply operations. For example, ACC Johnson, Police Scotland, argued that decriminalisation means law enforcement efforts can be focused on “the suppliers, the importers and those who are causing the harm”.³⁴⁸ Dr Tweed pointed to Portugal’s experience of using savings from decriminalisation to more aggressively tackle the supply chain, and claimed this shows that decriminalisation and law enforcement are not mutually exclusive.³⁴⁹

345 [Q312](#)

346 [Q339](#)

347 [Q372](#)

348 [Q318](#)

349 [Q29](#)

129. The level of co-operation between UK and Scottish police forces in addressing the supply of drugs was raised several times by the Committee throughout our inquiry. In their written evidence, the National Crime Agency (NCA) told us that they have an “effective and successful relationship with our Scottish law enforcement partners” through its Organised Crime Partnership (OCP).³⁵⁰

130. The NCA described the OCP, created in September 2018, as a “step change in our joint mission to identify and investigate those involved in serious and organised crime in Scotland”, and said that in the 11 months to March 2019, OCP investigations led to the arrest of 28 individuals, the recovery of 47kg of Class A drugs and 55 firearms, as well as the seizure of £138,990 cash.³⁵¹ The NCA also highlighted the role of the OCP in disrupting the sale of drugs through social media sites, and its work to combat the smuggling of drugs into the UK through Scotland.³⁵²

131. The Home Office minister also highlighted the importance of a strong relationship and intelligence sharing between Police Scotland, the NCA and Border Force. He said that while policing is a devolved matter, the link between Police Scotland and these national bodies were “good and strong” and that “if Police Scotland wanted to do more on supply [...] we would be very supportive of that”.³⁵³ He also raised concerns that decriminalisation in one part of the United Kingdom and not in the other, would make tackling drug import and supply more difficult.³⁵⁴

132. We welcome the high level of co-operation between the UK and Scottish law enforcement agencies to address the supply of drugs, as well as the Organised Crime Partnership which has strengthened joint efforts to combat drug supply. However, we are not convinced by the minister’s argument that decriminalisation, in Scotland or the whole of the UK, would undermine these efforts, as the decriminalisation of possession for personal use would not alter the illegality of organised crime groups supplying illicit drugs, which this joint work seeks to address. Decriminalising drugs could free-up resources which could be put into efforts to combat supply and import of drugs.

Legalisation

133. Some witnesses advocated going further than decriminalising drugs, by legalising them. This would make it legal to buy, sell and tax drugs. Canada and the Netherlands have taken this approach and have developed regulatory frameworks for the sale and taxation of cannabis. Dr Iain McPhee argued that legalisation allows for the regulation and control of drugs (which decriminalisation does not). He said:

If we are truly committed to reducing harm through a public health framework and challenging the criminalised elements, which stigmatise and discriminate against users, then we should be regulating and controlling and not leaving it to the hands of people who care very little about the consumers to whom they are the main vendors.³⁵⁵

350 National Crime Agency ([UMD0048](#))

351 National Crime Agency ([UMD0048](#))

352 National Crime Agency ([UMD0048](#))

353 [Q339](#)

354 [Q339](#)

355 [Q137](#)

134. Dr McPhee argued that a substantial number of drug-related deaths are a result of the consumption of drugs which have been “cut” with unsafe substances, and that only legalisation fully allows for “standardisation and quality control”, which would reduce drug-related deaths.³⁵⁶ Law Enforcement Action Partnership UK (LEAP UK), supported this point, and called for legislation to be accompanied by “a range of regulatory models for all drugs that focus on quality control, child protection, and taxation to fund education and treatment services”.³⁵⁷ Such regulatory models would be designed to ensure the safety and quality of drugs which, under the current prohibition model, are often lacking “health and safety information, and are of unknown (and variable) strength and purity, increasing risk of overdose, infection and poisoning”.³⁵⁸ Transform told us that there are numerous examples of successful drug production and supply regulation models around the world, which the UK could learn from.³⁵⁹

135. We heard that one of the benefits of legalisation over decriminalisation, is that legalisation takes drugs out of the hands of criminals.³⁶⁰ Jim Duffy argued that although decriminalisation removes the criminal penalties for drug possession, it does not remove the incentive for serious organised crime groups to traffic and trade illegal substances. However, if regulated drugs are available legally, it was argued that significant financial pressure would be put on criminal gangs, as revenue from drugs is diverted to state-funded services:

Last year, the state of Colorado sold \$1 billion worth of recreational and medicinal cannabis [...] that [is] \$1 billion in total that did not go to criminals, that did not go to the black economy, that did not fund people trafficking, child prostitution, counterfeiting, all those other things that organised crime does.³⁶¹

We heard that the cannabis industry alone in the UK alone is worth £6 billion a year which, under a legalisation regime, could be diverted to treatment or drug trafficking enforcement services.³⁶²

136. Finally, Dr Angus Bancroft argued that legalisation also has an advantage over decriminalisation in how it separates problematic drug markets, and “cuts out the tendency to move on to other drugs”:

One issue in the way in which people move from, say, Ecstasy to cocaine to an opioid will sometimes be that the person selling it also has that other drug for sale, so they are in the same place and they are available or they have other kinds of connections through that. One possibility for legalisation might be to separate that.³⁶³

137. During evidence sessions some Members explored with witnesses concerns that legalisation would increase exposure to drugs, not address the root causes of problem

356 [Q203](#)

357 Law Enforcement Action Partnership UK (LEAP UK) ([UMD0023](#))

358 Transform ([UMD0043](#))

359 Transform ([UMD0043](#))

360 [Q241](#)

361 [Q268](#)

362 [Q282](#)

363 [Q119](#)

drug use, and create a “gateway” effect to harder drugs.³⁶⁴ We also explored the possibility that legalisation might cause an increase in drug-related harm and fatalities, due to the perception that “because it’s legal, it’s therefore safe to take”.³⁶⁵ Dr McKeganey expressed such concerns, and opposed legalisation for the same reason that he opposed decriminalisation—namely, that it would “inevitably” result in increased drug use:

I say “inevitably” because those who were inclined to use those substances when they were illegal will clearly continue to use them when they become legal and those who were disinclined to use them when they were illegal will be more inclined to use them if they become legal.³⁶⁶

Dr McKeganey added that he felt the “sheer increase” in the prevalence of drugs caused by legalisation would also generate “an increased range of problems”,³⁶⁷ including a “a very substantial” increase in the use of heroin.³⁶⁸ Dr McPhee recognised that legalisation may result in a short term “spike” in people trying drugs, but added that this spike may level-off in due course.³⁶⁹ Dr McKeganey also argued that the legalisation of drugs would create the “very real risk” of a commercial industry developing comparable to the UK’s alcohol and tobacco industries.³⁷⁰ However, Dr McAuley countered this point, arguing that legalisation does not increase the size of drugs markets.³⁷¹ Drawing on international examples, Dr McAuley said:

It has certainly not increased the size of that market, which is a lot of what people perhaps thought the unintended consequence of [...] legalisation would cause, that there would be much more people using drugs and much more people experiencing levels of harm. The evidence [...] is the exact opposite.³⁷²

138. Dr Ian Oliver shared many of Dr McKeganey’s concerns, and told us that the belief that legalisation would limit the potency of drugs and take them out of the hands of criminals is “naïve”, and demonstrates “no realisation that criminals will continue to operate, target young people in particular, and offer more potent drugs to all willing customers”.³⁷³ However, Dr Bancroft argued that legalisation has the opposite effect, by removing individuals’ contact with drug dealers, and thereby removing an opportunity for dealers to introduce people to harder drugs.³⁷⁴ Indeed, both Dr Iain McPhee, University of the West of Scotland, and Vicki Craik, Crew 2000, agreed with Dr Bancroft that legalising drugs would reduce harm.³⁷⁵ Witnesses also agreed that there are workable, evidence-based proposals, which draw on successful international examples of legalisation, for how a properly regulated drug market could operate in the UK.³⁷⁶

364 [Q119](#); [Q205](#)

365 [Q99](#)

366 [Q119](#)

367 [Q119](#)

368 [Q131](#)

369 [Q166](#)

370 [Q131](#)

371 [Q40](#)

372 [Q40](#)

373 Ian Oliver ([UMD0047](#))

374 [Q119](#)

375 [Q123](#)

376 [Q137](#)

139. Whilst we heard that the legalisation of drugs would deliver more benefits than decriminalisation, decriminalisation alone would be a radical departure from the Government's current approach to drug policy. We therefore believe that the Government should focus on delivering decriminalisation.

6 Stigma

140. Throughout our inquiry we repeatedly heard about the role stigma plays in perpetuating problem drug use, preventing people seeking treatment, and causing those who do enter treatment to drop out.³⁷⁷ Martin Powell, Transform, told us that “stigma and fear of arrest discourages people from coming forward to get help and kills people”.³⁷⁸ As well as preventing people seeking help for their drug use, stigma can also prevent people accessing treatment for health conditions that their drug use may be exacerbating. Norma Howarth, Signpost Recovery, explained:

A lot of our service users are very late presenting for basic health and social support because of what they think somebody will perceive of them. We have got late presentations with people in advanced ill health, with diseases, [like] COPD [Chronic Obstructive Pulmonary Disease], emphysema or even early stage cancers.³⁷⁹

141. Criminalisation, which is addressed in the previous chapter, is one of the main causes of stigma.³⁸⁰ If the UK Government adopts a policy of decriminalisation, that would go a long way to addressing the stigma associated with drug use. However, there are additional steps which can be taken to help address stigma, which we discuss below.

Stigmatising language

142. Language is an important driver of stigma. Patricia Tracey, Turning Point Scotland, added that “a lot of stigmatising language is used, even within the system. We don’t yet have a consistent language, which is something we should work towards”.³⁸¹ Dr Budd provided one such example:

In Edinburgh and Lothian, our drug and alcohol services are called the substance misuse directorate. That, in itself, is stigmatising because, as colleagues have said, people use drugs and alcohol often as a means of coping, as a means of self-medicating for their mental health issues, so for many that is actually a logical thing to do. It’s not misuse; it’s use.³⁸²

143. Many witnesses called for the media, politicians, and other public commentators to be more robustly challenged when they use stigmatising language and rhetoric.³⁸³ As Colin Hepburn, a person recovering from problem drug use, put it, “the stigma is always going to be present, but we can challenge it”.³⁸⁴ This point was also made repeatedly during the public engagement events we held in Scotland. For example, during a visit to the Scottish Drugs Forum in June 2019, we heard that the quality of public debate on drugs policy is hampered by stigma, which has historically prevented the implementation of evidence-based policies which would be more effective in addressing problem drug use.³⁸⁵

377 [Q377](#)

378 [Q246](#)

379 [Q189](#)

380 [Q275](#); [Q375](#)

381 [Q181](#)

382 [Q189](#)

383 Dr Emily Tweed ([UMD0038](#))

384 [Q76](#)

385 [Summary of Scottish Affairs Committee’s Problem Drug Use in Scotland public engagement event, June 2019](#)

144. Sharon Brand, an individual with lived experience of problem drug use who is now in recovery, told us that:

The media have a huge part to play, with the language they use and how they portray people who use drugs. [...] The language and the images the media sometimes use are horrendous. They dehumanise people. They do not treat people as human beings; they treat them as less than that. That has been the case for a long time—since the war on drugs, I think.³⁸⁶

145. We have unfortunately seen stigmatising language for ourselves in the coverage of this inquiry. For example, safe consumption facilities have often been referred to by the media as ‘fix rooms’ and ‘shooting galleries’. Detective Chief Inspector Kew argued these terms misrepresent the nature of these facilities by giving an impression of a “loose” arrangement, that did not reflect the reality of how these medically-supervised facilities operate:

They are not like that. They are nothing like that at all. An overdose prevention centre is a medical facility to look after those most in need.³⁸⁷

Dr Tweed argued that stigmatising language is driven by, and reinforces the view, that “problem drug use is a moral failing”, rather than a complex health issue.³⁸⁸

146. The Home Office minister told us that “I do not think we are necessarily doing anything to reduce the stigma as such”, although Mr Malthouse MP did highlight investment in school education, and upcoming changes in the curriculum to educate young people on the health implications of drug use.³⁸⁹ We also noted that the minister inadvertently used stigmatising language during his evidence session with us, for example, referring to the objective of drug treatment programmes being to make people “clean” (which implies that people who use drugs are inherently ‘unclean’).³⁹⁰

147. We heard that changing how we talk about drugs could reduce stigma and help people who use drugs “gain access to the services they need without fear”.³⁹¹ For example, we heard from parents of a person recovering from problem drug use that, “the biggest obstacle to families attending the [support] groups and family support is actually shame and stigma”.³⁹² Turning Point Scotland called for public debate to find a way to talk about drugs that:

captures the social dimension of the issue rather than reinforcing ideas of individual weakness, failings or ‘otherness’. Talking about drug abuse or misuse plays on the ‘fault’ of the individual; if we talk instead about problematic drug use, we are focussing on the problem that can be fixed rather than on the person who has failed.³⁹³

386 [Q76](#)

387 [Q310](#)

388 Dr Emily Tweed ([UMD0038](#))

389 [Q457](#)

390 [Q428](#)

391 [Q189](#)

392 [Q80](#)

393 Turning Point Scotland ([UMD0017](#))

148. **The UK Government should be doing everything it can to reduce the stigma surrounding problem drug use. The UK Government must lead by example by ensuring it promotes appropriate and non-stigmatising language when discussing drugs. The Government should also be proactively challenging stigmatising language and misrepresentation, in order to improve the quality of public and political understanding of drug-related issues.**

Equality legislation

149. Some witnesses argued that problem drug use should be recognised as a disability in the UK. Dr Budd, Edinburgh Access Partnership, told us that “having substance dependence recognised as a long-term disability would be a big step forward in terms of addressing stigma and discrimination”.³⁹⁴ Iain Clunie, SMART Recovery UK, Patricia Tracey, Turning Point Scotland, and Norma Howarth, Signpost Recovery, amongst many others, agreed with this point.³⁹⁵

150. The International Classification of Diseases, which is issued by the World Health Organisation, is used by the NHS when diagnosing mental health disorders. It classifies drug and/or alcohol dependence as a mental health disorder. The Diagnostic and Statistical Manual of Mental Disorders, the equivalent classification system in the USA, also defines substance misuse as a mental disorder. Despite this recognition, individuals with alcohol and drug addiction issues are currently explicitly excluded from protection under the Equality Act 2010. The Equality Act 2010 is a law which identifies certain ‘protected characteristics’ (such as age, disability, race, sex, and sexual orientation), and makes it unlawful for individuals to be discriminated against (directly, or indirectly) on the basis of these characteristics.³⁹⁶ The Equality Act (Disability) Regulations 2010 explicitly excludes an individual’s drug or alcohol dependence from creating an impairment qualifying for protection under the 2010 Act, unless that addiction “was originally the result of administration of medically prescribed drugs or other medical treatment”.³⁹⁷ Without this explicit exemption, drug or alcohol dependence could most likely be protected under the Equality Act 2010. There are very few explicit exemptions to the Equality Act—others include, tendencies “to set fires”, “to steal”, and to physically and sexually abuse people.³⁹⁸

151. We heard calls from some witnesses for this exclusion to be removed from equality legislation. This would have the effect of expanding the Public Sector Equality Duty (PSED) to those experiencing drug or alcohol dependence which would, in turn, ensure public authorities properly consider the impact policy can have on people with problematic drug use. Extending the PSED to cover drug or alcohol dependence could potentially also result in increased protection of funding for addiction services, and greater consideration to the suitability of public sector housing for people with problematic drug use. NHS Health Scotland argued that the removal of the exemption would “enhance access to recovery support and tackle a significant example of institutional stigma getting in the way of

394 [Q188](#)

395 [Q189](#)

396 Equality Act 2010

397 Reg 3(2) Equality Act 2010 (Disability) Regulations 2010

398 Part 2, Equality Act 2010 (Disability) Regulations 2010

recovery”.³⁹⁹ This point was also made by the Aberdeen Alcohol and Drug Partnership, who argued that the exclusion exemplifies the “institutional stigma” which needs to be tackled.⁴⁰⁰

152. Elinor Dickie, NHS Health Scotland, outlined some of the real-life impacts the exemption from the Equality Act 2010 has for many people who use drugs. Concessionary access to transport was raised as a key example of something which is “impacted by the understanding of disability within our statutory legislation and guidance”.⁴⁰¹ The Aberdeenshire Alcohol and Drug Partnership also noted the importance of concessionary travel.⁴⁰² We saw the importance of this during our visit to the Scottish Drugs Forum (SDF) in June 2019. When we asked one current SDF service user what policy change would best aid his recovery, he said a free bus pass. The individual explained that this would allow him to travel to the designated pharmacy to pick up his methadone prescription. This is something he cannot consistently afford, thereby causing him to drop out of treatment.⁴⁰³

153. In oral evidence, the Home Office minister said the UK Government would not consider removing the exemption.⁴⁰⁴ He argued that removing the exemption:

Would possibly interfere with the generally accepted definition of disability, which is that it requires some impairment. [...] We are generally, necessarily, indifferent to the cause of that impairment, but there are people who are drug addicts who operate at a very high level and who do not exhibit any impairment of any sort. I do not think that anybody would maintain that they were disabled in some way just because of their addiction.⁴⁰⁵

While the Minister is right that the general definition of disability “is indifferent to what causes the impairment”, this is not the case with impairments caused by drug use, as the Equality Act explicitly prevents an impairment being caused by drug use being considered a disability—this is why there have been calls for the Government to change the law.⁴⁰⁶ The response from the government therefore does not appear to demonstrate a complete understanding of the current law or criticisms of it.

154. It is unacceptable that drug dependence is excluded from the Equality Act 2010, despite it being fully recognised (in the UK and internationally) as a health condition. This can have damaging real-life consequences for many people who use drugs—often by preventing them fully accessing recovery services. The UK Government must immediately review the exemption of substance dependence from equality legislation and assess the impact it has on people who use drugs.

399 NHS Health Scotland/NHS National Services Scotland ([UMD0021](#))

400 Aberdeenshire Alcohol and Drug Partnership ([UMD0006](#))

401 [Q215](#)

402 Aberdeenshire Alcohol and Drug Partnership ([UMD0006](#))

403 [Summary of Scottish Affairs Committee’s Problem Drug Use in Scotland public engagement event, June 2019](#)

404 [Qq461–462](#)

405 [Q461](#)

406 [Q461](#)

Conclusions and recommendations

Problem drug use in Scotland

1. Scotland is in the midst of a drug death crisis. The relentless increase in drug deaths in Scotland is a tragedy that cannot be allowed to continue. *We call on the UK Government to declare a public health emergency, and to work with the Scottish Government to take urgent and radical steps to halt Scotland's spiralling drug crisis. Both Governments must be open to implementing innovative evidence-based solutions with the scale and urgency required by Scotland's drug crisis.* (Paragraph 12)
2. People's drug use often becomes problematic because of things beyond their control, rather than because of a proactive 'decision' to become dependent on substances. People who use drugs are a vulnerable group who require help and support, not prejudice and judgement. Both Governments must ensure that their approaches to problem drug use acknowledge and address the underlying causes, such as poverty and inequality, social marginalisation, trauma and the lack of strong family structures and support networks. (Paragraph 27)
3. Addressing the root causes of problem drug use requires radical, whole-system change, rather than piecemeal reform. *We welcome the planned cross-government summit in Glasgow and encourage the UK and Scottish Governments to be bold, imaginative and evidence-based. Both Governments must work together to implement an integrated, cross-departmental, and cross-government approach to drugs, which fully utilises the potential impact of joined-up policing, justice, employment, welfare, housing, physical and mental health policies and services. The UK Government must also ensure that all departments are proactively engaging with each other, the health services and third-sector organisations, in order to help address problem drug use in Scotland.* (Paragraph 38)
4. The welfare policies of the Department for Work and Pensions have a detrimental impact on people who use drugs, and often become a barrier for many people trying to enter recovery. The Scottish Government should also make full use of its existing powers to support people recovering from problem drug use. *The UK Government must review the impact welfare sanctions have on people who use drugs, and outline steps it will take to make the welfare system less adversarial for people who use drugs who are trying to enter recovery.* (Paragraph 42)

Approaches to problem drug use

5. The criminal justice approach to people with problem drug use has failed. Problem drug use is a health issue, and it should be treated as such by the UK Government. *The Government must revise its strategy for addressing problem drug use in line with a public health approach. We support the call from the Health and Social Care Committee for the UK Government to transfer lead responsibility for drugs policy from the Home Office to the Department for Health and Social Care. This would demonstrate its commitment to a health-focused approach to drugs.* (Paragraph 61)

6. The adoption of a public health approach must reflect the UK Government taking an evidence-based approach to drugs policy. *The Home Office must commit to implementing an evidence-based approach to drugs policy. This includes the Government giving full weight to all reports and recommendations from the ACMD. Where the UK Government chooses to go against expert advice from the ACMD, the Government must publicly outline its reasons for doing so and set out its evidence base.* (Paragraph 64)
7. We have heard that the Misuse of Drugs Act 1971 is outdated, its classification system is arbitrary, and that it is fundamentally incompatible with a public health approach. If the UK Government is to implement a public health approach as we have called for then the Misuse of Drugs Act must be substantially reformed. (Paragraph 68)
8. Throughout this inquiry we heard that there is more the Scottish Government could, and should, be doing to address problem drug use with the powers it already has, in areas such as mental health, housing, education, community regeneration, policing and justice. We were particularly concerned to hear of the impact that funding cuts, including previous cuts to alcohol and drug partnerships in the 2016/17 Scottish Government budget, have had on health services for people who use drugs. While it is not for us to make recommendations to the Scottish Government, we believe that if it wants to call for greater powers to tackle the drugs crisis it must demonstrate that it is doing everything it can within its existing responsibilities, including properly funding health services. (Paragraph 71)

Safe consumption facilities

9. Safe consumption facilities are proven to reduce the immediate health risks associated with problem drug use. These facilities do not come without their challenges. However, when effectively managed with appropriate levels of funding and cooperation from the police and other stakeholders, these risks can be mitigated. However safe consumption facilities should not be seen as a 'silver bullet', but as a way to get people with problem drug use to engage in other services which can address the underlying causes of their substance use. (Paragraph 85)
10. We believe there is a strong evidence base for a safe consumption facility in Glasgow, which would be a practical step to reducing the number of drug-related deaths in Scotland. Health is a devolved matter, and it is therefore deeply regrettable that the UK Government has chosen to block the proposed facility. We are not convinced by the UK Government's argument that it will not give permission for such facilities because it believes that there are more cost-effective health care interventions. Under the devolution settlement, spending on health delivery is a matter for the Scottish Government. *We recommend that the UK Government supports the proposed pilot safe consumption facility in Glasgow.* (Paragraph 93)
11. We do not believe that it would be acceptable to try to open a safe consumption facility in Glasgow under the current legal framework. Doing so would risk putting clients, NHS staff, and governance bodies in legal jeopardy. *We recommend that the UK Government brings forward the legislation necessary to allow for the lawful establishment of a pilot safe consumption facility in Scotland. If the UK Government*

is unwilling to do so, it must instead devolve competence for drugs legislation to the Scottish Parliament, so that it can implement the health approach it deems to be in Scotland's best interest. (Paragraph 101)

Decriminalisation

12. Decriminalisation of the possession of drugs for personal use is an evidence-based solution to problem drug use. There is a strong case for doing this across the UK, as decriminalisation is proven to address the root causes of problem drug use. Decriminalisation would also allow the Government to focus efforts and resources on tackling the drug supply chain and providing services to support people who use drugs into recovery. (Paragraph 114)
13. We support the innovative approaches to decriminalisation taken by police forces across the UK, but believe that statutory decriminalisation is a preferable solution which removes the legal ambiguities inherent in non-statutory approaches. (Paragraph 125)
14. We also believe that decriminalisation should be implemented by elected and accountable politicians. Whilst we are encouraged to hear the Home Office minister tacitly supports de facto decriminalisation schemes in the UK, it is unclear to us why the Government has not implemented diversion as a UK-wide policy, and has chosen instead to leave this difficult issue to local police officials. It is also not clear why the UK Government is supportive of de facto decriminalisation, but will not support statutory decriminalisation. The UK Government must be clear on its policy and be accountable for its decisions. (Paragraph 126)
15. *We recommend that the UK Government decriminalises the possession of small amounts of drugs for personal use across the whole of the UK and should consult on how this could be rolled out in practice. As a transitional approach, the Home Office should encourage all police forces across the UK to introduce diversion schemes.* If the UK Government does not decriminalise drugs, this will only strengthen the case for the devolution of drugs laws. (Paragraph 127)
16. We welcome the high level of co-operation between the UK and Scottish law enforcement agencies to address the supply of drugs, as well as the Organised Crime Partnership which has strengthened joint efforts to combat drug supply. However, we are not convinced by the minister's argument that decriminalisation, in Scotland or the whole of the UK, would undermine these efforts, as the decriminalisation of possession for personal use would not alter the illegality of organised crime groups supplying illicit drugs, which this joint work seeks to address. Decriminalising drugs could free-up resources which could be put into efforts to combat supply and import of drugs. (Paragraph 132)
17. Whilst we heard that the legalisation of drugs would deliver more benefits than decriminalisation, decriminalisation alone would be a radical departure from the Government's current approach to drug policy. We therefore believe that the Government should focus on delivering decriminalisation. (Paragraph 139)

Stigma

18. The UK Government should be doing everything it can to reduce the stigma surrounding problem drug use. *The UK Government must lead by example by ensuring it promotes appropriate and non-stigmatising language when discussing drugs. The Government should also be proactively challenging stigmatising language and misrepresentation, in order to improve the quality of public and political understanding of drug-related issues.* (Paragraph 148)
19. It is unacceptable that drug dependence is excluded from the Equality Act 2010, despite it being fully recognised (in the UK and internationally) as a health condition. This can have damaging real-life consequences for many people who use drugs—often by preventing them fully accessing recovery services. *The UK Government must immediately review the exemption of substance dependence from equality legislation and assess the impact it has on people who use drugs.* (Paragraph 154)

Formal minutes

Tuesday 29 October 2019

Members present:

Pete Wishart, in the Chair

Deidre Brock	Paul Masterton
David Duguid	Danielle Rowley
Hugh Gaffney	Tommy Sheppard
Ged Killen	Jamie Stone
John Lamont	Ross Thomson

Draft Report, (*Problem Drug Use in Scotland*) proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 67 read and agreed to.

Paragraph 68 read.

Amendment proposed, after “approach.” to insert

“However, we also heard that the Misuse of Drugs Act acts as an important sanction to send a clear message against acts that, on a societal level, should be discouraged as they often lead to problem drug use.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, to delete “substantially reformed” and insert “reviewed” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3
David Duguid
John Lamont
Ross Thomson

Noes, 7
Deidre Brock
Hugh Gaffney
Ged Killen
Paul Masterton
Danielle Rowley
Tommy Sheppard
Jamie Stone

Question negatived.

Paragraph 68 agreed to.

Paragraphs 69 to 85 read and agreed to.

Paragraph 85 read.

Amendment proposed, to leave out “Safe consumption facilities are proven to” and insert
“Our evidence indicates that safe consumption facilities can help” – (David Duguid)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3
David Duguid
John Lamont
Ross Thomson

Noes, 7
Deidre Brock
Hugh Gaffney
Ged Killen
Paul Masterton
Danielle Rowley
Tommy Sheppard
Jamie Stone

Question negatived.

Paragraph 85 agreed to.

Paragraphs 86 to 92 read and agreed to.

Paragraph 93 read.

Amendment proposed, to leave out paragraph 93 and insert

“We heard mixed evidence on the potential costs and benefits of a safe consumption facility in Glasgow. While some witnesses argued that it could be a practical step to

reducing the number of drug-related deaths in Glasgow, we also heard that the operation of such facilities could only serve to facilitate addiction and undermine efforts to deter drug use. We recommend that the UK Government does not support a proposed pilot safe consumption facility in Glasgow at this stage.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3

David Duguid

John Lamont

Ross Thomson

Noes, 7

Deidre Brock

Hugh Gaffney

Ged Killen

Paul Masterton

Danielle Rowley

Tommy Sheppard

Jamie Stone

Question negatived.

Paragraph 93 agreed to.

Paragraphs 94 to 100 read and agreed to.

Paragraph 101 read.

Amendment proposed, to leave out

“We recommend that the UK Government brings forward the legislation necessary to allow for the lawful establishment of a pilot safe consumption facility in Scotland. If the UK Government is unwilling to do so, it must instead devolve competence for drugs legislation to the Scottish Parliament, so that it can implement the health approach it deems to be in Scotland’s best interest.”

And insert

“We recommend that, while the current legal framework persists, the Scottish Government focusses its efforts on revising its broader drugs strategy; and only revisits the option of a safe consumption facility after options within its current range of powers have been exhausted.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3	Noes, 7
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Ross Thomson	Ged Killen
	Paul Masterton
	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, to leave out

“If the UK Government is unwilling to do so, it must instead devolve competence for drugs legislation to the Scottish Parliament, so that it can implement the health approach it deems to be in Scotland’s best interest.” – (Paul Masterton)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Amendment negatived.

Paragraph 101 agreed to.

Paragraphs 102 to 113 read and agreed to.

Paragraph 114 read.

Amendment proposed, to leave out “Decriminalisation of the possession of drugs for personal use is an evidence-based solution to problem drug use.”

And insert

“The evidence on the effectiveness of decriminalisation of the possession of drugs for personal use is mixed; and in the most positive example of its implementation—Portugal—it formed part of a well-funded, joined-up approach that included tougher measures to restrict the supply of drugs.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, to leave out “There is a strong case for doing this across the UK, as decriminalisation is proven to addresses the root causes of problem drug use.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, to leave out “would also” insert “could” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, after “supply chain” to insert

“, although this may prove difficult if a further round of devolution were to allow for two or more separate regimes on drugs within the United Kingdom,” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, at end of paragraph to insert “However, there is not necessarily a conflict between not decriminalising personal drug possession and focussing on tackling supply and assisting people in recovery.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Paragraph 114 agreed to.

Paragraphs 115 to 124 read and agreed to.

Paragraph 125 read.

Amendment proposed, to leave out “but believe that statutory decriminalisation is a preferable solution which removes the legal ambiguities inherent in non-statutory approaches”

And insert

“and would recommend that, if it so wishes, the Scottish Government should implement these approaches more fully in Scotland before either requesting more powers or calling for statutory decriminalisation.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Paragraph 125 agreed to.

Paragraph 126 read.

Amendment proposed, to leave out “We also believe that decriminalisation should be implemented by elected and accountable politicians. Whilst”

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed to leave out paragraph 126 – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Paragraph 126 agreed to.

Paragraph 127 read.

Amendment proposed, to delete paragraph 127, and insert

“We recommend that the UK Government review current criminal procedures relating to the possession of small amounts of drugs for personal use across the whole of the UK, while taking into account the possibility that decriminalisation could fuel an open market for organised crime, and also lead to increased drug use and, by extension, increased problem drug use. In the meantime, the Home Office should remind all police forces across the UK of the option to introduce diversion schemes.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Paragraph 127 agreed to.

Paragraph 128 to 131 read and agreed to.

Paragraph 132 read.

Amendment proposed, to delete “However, we are not convinced by the minister’s argument that decriminalisation, in Scotland or the whole of the UK, would undermine

these efforts, as the decriminalisation of possession for personal use would not alter the illegality of organised crime groups supplying illicit drugs, which this joint work seeks to address.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, After “seeks to address” insert “While” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, at end insert “, this should not be seen as a zero-sum choice. Both Governments should commit to redoubling their efforts to combat the corruption that facilitates the supply of drugs, in particular in ports, airports, and prisons.” - (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Paragraph 132 agreed to.

Paragraphs 133 to 138 read and agreed to.

Paragraph 139 read.

Amendment proposed, at delete paragraph 139 and insert

“While some witnesses advocated the legalisation of drugs, we also heard that legalisation would carry with it the real risk of creating a commercial drug industry like that which exists for alcohol and tobacco. Moreover, as the example of Canada demonstrates, legalisation does not necessary eliminate the illicit drug trade wholesale. We are furthermore concerned that decriminalisation may prove a slippery slope towards legalisation.” - (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Paragraph 139 agreed to.

Paragraph 139 to 154 read and agreed to.

Summary read.

Amendment proposed, in paragraph 3 of the summary to leave out “are proven to” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3	Noes, 7
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Ross Thomson	Ged Killen
	Paul Masterton
	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, in paragraph 3 of the summary to leave out

“We are therefore disappointed that the Home Office has blocked the proposal despite the overwhelming evidence that they work, and are not made the legal changes necessary to allow such a facility to be opened. We therefore recommend that the UK Government brings forward the legislation necessary to allow for the lawful establishment of a pilot safe drug consumption facility in Scotland. If the UK Government is unwilling to do this, we argue that it should devolve the necessary powers to allow the Scottish Parliament to do so.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3	Noes, 7
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Ross Thomson	Ged Killen
	Paul Masterton
	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, in paragraph 3 of the summary to leave out

“If the UK Government is unwilling to do this, we argue that it should devolve the necessary powers to allow the Scottish Parliament to do so.” – (Paul Masterton.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, in paragraph 4 of the summary to leave out “caused by the criminalisation of drugs” and insert “associated with problem drug use”. – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, in paragraph 4 of the summary delete “We recommend that the UK Government commits to decriminalisation ” and insert “We recommend that the UK Government considers decriminalisation” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, in paragraph 4 of the summary at end of paragraph insert “; and call on the Scottish Government to first consider using its existing powers to emulate in Scotland the localised de facto decriminalisation schemes in place in other parts of the United Kingdom” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Amendment proposed, in paragraph 6 of the summary at end of paragraph insert “Given that the rate of drug deaths is considerably higher in Scotland than in England and Wales, we believe that the Scottish Government should first seek to use its existing powers to implement our recommendations insofar as possible, before considering requesting any additional devolution of powers.” – (Ross Thomson.)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 4	Noes, 6
David Duguid	Deidre Brock
John Lamont	Hugh Gaffney
Paul Masterton	Ged Killen
Ross Thomson	Danielle Rowley
	Tommy Sheppard
	Jamie Stone

Question negatived.

Summary agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

[Adjourned till at time and place to be determined the Chair .

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 7 May 2019

Professor Catriona Matheson, University of Stirling, **Dr Emily Tweed**, University of Glasgow, **Dr Andrew McAuley**, Glasgow Caledonian University, **Dr Tessa Parkes**, University of Stirling [Q1–56](#)

Tuesday 21 May 2019

Colin Hepburn, **Sharon Brand**, **Scott Ferguson**, **Hannah Snow** [Q57–79](#)

Tuesday 4 June 2019

Vicki Craik, Crewe 2000, **Dr Iain McPhee**, University of the West of Scotland, **Dr Neil McKeganey**, Director, Centre for Substance Use Research, **Dr Angus Bancroft**, University of Edinburgh [Q108–170](#)

Tuesday 18 June 2019

John Budd, Edinburgh Access Practice, **Norma Howarth**, Signpost Recovery, **Patricia Tracey**, Service Manager, Turning Point Scotland, **Iain Clunie**, SMART Recovery [Q171–206](#)

Elinor Dickie, Public Health Intelligence Adviser, NHS Health Scotland, **Dr Saket Priyadarshi**, Medical Director for Addictions, NHS Greater Glasgow and Clyde [Q207–238](#)

Tuesday 21 May 2019

Justina Murray, CEO, Scottish Families Affected by Alcohol and Drug, **Grand-daughter Family A**, **Grandmother Family A**, **Grandfather Family A**, **Family B** [Q80–107](#)

Tuesday 2 July 2019

Dave Liddell, CEO, Scottish Drugs Forum, **Martin Powell**, Transform Drug Policy Foundation, **Jim Duffy**, Law Enforcement Action Partnership UK [Q239–291](#)

Professor Alex Stevens, University of Kent, Advisory Council on Misuse of Drugs, **Chief Inspector Jason Kew**, Drugs policy lead, Thames Valley, **Assistant Chief Constable Steve Johnson**, Police Scotland, **Detective Superintendent Kevin Weir**, Durham Police [Q292–338](#)

Tuesday 9 July 2019

James Wolffe QC, Lord Advocate, **Iain Logan**, Principal Procurator Fiscal Depute, Policy Unit, Crown Office and Procurator Fiscal Service

[Q339–373](#)

Joe FitzPatrick MSP, Minister for Public Health, Sport, **Beverley Francis**, Drug Law and Health Harm Lead, Scottish Government

[Q374–416](#)

Wednesday 23 October 2019

Kit Malthouse MP, Minister of State for Crime, Policing and the Fire Service, **Dan Greaves**, Director, Crime, Policing and Fire Group

[Q417–468](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

UMD numbers are generated by the evidence processing system and so may not be complete.

- 1 Aberdeenshire Alcohol and Drug Partnership ([UMD0006](#))
- 2 Addaction ([UMD0020](#))
- 3 Advocate, Lord ([UMD0049](#))
- 4 Alcohol & Drugs Action ([UMD0007](#))
- 5 Alternatives-West Dunbartonshire Community Drug Service - Supplementary Evidence ([UMD0045](#))
- 6 Alternatives-West Dunbartonshire Community Drug Services ([UMD0004](#))
- 7 Angus Alcohol & Drug Partnership AND Perth & Kinross Alcohol & Drug Partnership ([UMD0010](#))
- 8 Anyone's Child ([UMD0036](#))
- 9 Bauld, Barbara ([UMD0005](#))
- 10 Beani, Consultant Psychiatrist, Fellow of Royal College of Psychiatry, Honorary Senior Lecturer Leeds Medical School, Dr Amal Y ([UMD0050](#))
- 11 BIRD, Honorary Professor at Edinburgh University's College of Medicine and Veterinary Medicine Sheila M. ([UMD0014](#))
- 12 Corra Foundation ([UMD0013](#))
- 13 Crew 2000 ([UMD0009](#))
- 14 Crew 2000 ([UMD0041](#))
- 15 Department for Work and Pensions, UK Government ([UMD0046](#))
- 16 Dundee ADP ([UMD0011](#))
- 17 European Federation of Therapeutic Communities ([UMD0040](#))
- 18 Glasgow City Alcohol and Drug Partnership ([UMD0016](#))
- 19 The Hepatitis C Trust ([UMD0008](#))
- 20 Hutcheon, Rosie ([UMD0039](#))
- 21 Law Enforcement Action Partnership UK (LEAP UK) ([UMD0023](#))
- 22 The Law Society of Scotland ([UMD0019](#))
- 23 Lothian deprivation interest group ([UMD0035](#))
- 24 MacArthur, Kenneth ([UMD0001](#))
- 25 McAndrews BSc (Hons), Michael ([UMD0037](#))
- 26 Member of the public UMD0003 ([UMD0003](#))
- 27 MRC/CSO Social and Public Health Sciences Unit ([UMD0022](#))
- 28 NAT (National AIDS Trust) ([UMD0012](#))
- 29 National Crime Agency ([UMD0048](#))
- 30 National Pharmacy Association Ltd ([UMD0027](#))
- 31 NHS Health Scotland/NHS National Services Scotland ([UMD0021](#))

- 32 NHS Shetland ([UMD0018](#))
- 33 O’Gorman, Dr Aileen ([UMD0031](#))
- 34 Oliver, Ian ([UMD0047](#))
- 35 Policing Strategy Unit ([UMD0042](#))
- 36 PRAXXIS Women ([UMD0030](#))
- 37 Recovering Justice ([UMD0034](#))
- 38 Release ([UMD0026](#))
- 39 Release ([UMD0044](#))
- 40 Robertson, Professor Roy ([UMD0002](#))
- 41 Royal College of Psychiatrists in Scotland ([UMD0025](#))
- 42 The Salvation Army ([UMD0033](#))
- 43 Scottish Drugs Forum ([UMD0024](#))
- 44 Scottish Families Affected by Alcohol and Drugs ([UMD0029](#))
- 45 Transform ([UMD0043](#))
- 46 Turning Point Scotland ([UMD0017](#))
- 47 Tweed, Dr Emily ([UMD0038](#))
- 48 University of the West of Scotland ([UMD0015](#))
- 49 Volteface ([UMD0028](#))
- 50 Waverley Care ([UMD0032](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	European Union (Withdrawal) Bill: Implications for devolution	HC 375
Second Report	The future of working practices in Scotland	HC 449 (HC 1067)
Third Report	Royal Bank of Scotland branch closures	HC 682 (HC 1529)
Fourth Report	Immigration and Scotland	HC 488
Fifth Report	Digital Connectivity in Scotland	HC 654 (HC 1612)
Sixth Report	The future of the oil and gas industry	HC 996 (HC 2177)
Seventh Report	Scotland, Trade and Brexit	HC 903 (HC 2480)
Eighth Report	The relationship between the UK and Scottish Governments	HC 1586 (HC 2532)
Ninth Report	The future of Scottish agriculture post-Brexit	HC 1637
Tenth Report	Access to cash in Scotland	HC 1996
First Special Report	Jobcentre Plus closures in Scotland: Government Response to the Committee's Third Report of Session 2016–17	HC 432
Second Special Report	The future of working practices in Scotland: Government Response to the Committee's Second Report	HC 1067
Third Special Report	Royal Bank of Scotland branch closures: Government Response to the Committee's Third Report	HC 1529
Fourth Special Report	Digital Connectivity in Scotland: Government Response to the Committee's Fifth Report	HC 1612
Fifth Special Report	The future of the oil and gas industry: Government response to the Committee's Sixth Report	HC 2177
Sixth Special Report	Scotland, Trade and Brexit: Government Response to the Committee's Seventh Report	HC 2480
Seventh Special Report	The relationship between the UK and Scottish Governments: Government to the Committee's Eighth Report	HC 2532

Session 2019

First Special Report	The future of Scottish agriculture post-Brexit: Government Response to the Committee's Ninth Report of the Session 2017–19	HC 47
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