**Written evidence submitted by** [**Volteface**](http://volteface.me/)

*Executive Summary*

* There has been a sharp increase in HIV diagnoses among people who inject drugs in Glasgow. The outbreak remains uncontained and cocaine injecting, homelessness and incarceration have been identified as infection risk factors.
* Scotland has the highest rate mortality rate caused by drug use disorders. The key driver of DRD in Scotland is that there is an ageing cohort of people with a drug problem who have multiple complex health and social care needs.
* Scotland, and other countries in the UK, are witnessing the emergence of a new phenomenon where social media platforms are being used to facilitate the supply of illicit drugs.
* The Glasgow City Health and Social Care Partnership announced, after conducting a local needs assessment and feasibility study, that introducing a Drug Consumption Room in Glasgow city centre would address the burden of health and social harms caused by public injecting. However, attempts to implement such facilities have been blocked by the Home Office.
* Further devolution of powers to the Scottish Government would remove the obstacles that are preventing Glasgow Greater and Clyde from implementing Drug Consumption Rooms.
* Scotland could learn from the approach taken in Portugal where illicit drugs for personal use have been decriminalised, in Canada where the federal Government has legalised and regulated cannabis for adult use; and in Iceland where a holistic and resilience-based approach has been taken to prevent substance use among young people.

1.0 Volteface is a cross-party organisation that informs the public debate around drugs through excellence in policy, research and advocacy. We cultivate fresh thinking and new ideas through our policy reports, online magazine and an ongoing programme of private and public events. We work with an array of partners across civil society, business, media and government to foster public engagement and formulate new evidence-based policy ideas. We are UK-based and focused, whilst engaging with ideas and practice from across the world.

1.1 Volteface is contributing to this Inquiry as an organisation that has undertaken extensive work on drug-related deaths and Drug Consumption Rooms,[[1]](#footnote-0) a service that Greater Glasgow and Clyde are seeking to implement.

* What are the unique drivers of drug abuse in Scotland? How is drug misuse in Scotland different from the rest of the UK?

1.2 Since 2015, there has been a significant decline in new HIV infections among people who inject drugs in the UK.[[2]](#footnote-1) However, in Glasgow, there has been a sharp increase in HIV diagnoses, with more than 120 people testing positive since 2015. The outbreak remains uncontained[[3]](#footnote-2) and almost all patients have co-infection with Hepatitis C.[[4]](#footnote-3) A recent study published in the *Lancet* identified the rise of cocaine injecting as the driver of new infections. As cocaine is a stimulant, users inject more frequently than they would inject heroin, which compromises their ability to access clear and sterile equipment. At the same time as the prevalence of cocaine injecting in Glasgow City Centre increased from 37% to 77%, HIV prevalence rose from 1.1% to 10.8%. Homelessness and incarceration were also identified as risk factors.[[5]](#footnote-4)

1.3 Scotland has the highest mortality rate caused by drug use disorders (See Table A).

**Table A[[6]](#footnote-5)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Scotland | Wales | Northern Ireland | England |
| Drug use disorders | 19.9 | 14.4 | 15.7 | 11.8 |

Age-standardised mortality rates are expressed per 100,000 population and standardised to the 2013 European Standard Population. Age-standardised mortality rates are used to allow comparison between populations which may contain different proportions of people of different ages.

1.4 The National Drug Related Deaths Database (Scotland) Report has reported that a key driver of drug-related deaths in Scotland is that there is an ageing cohort of people with a drug problem who have multiple complex health and social care needs. Similar characteristics of the people who have died was that they are male, aged over 35, socially deprived, lived alone and had a history of injecting opioid use and non-fatal overdose. Though female drug-related deaths are in the minority, they have increased at a higher rate relative to male drug-related deaths.[[7]](#footnote-6)

1.5 Emerging use of Etizolam, diclazepam, Gabapentin and pregabalin, which are consumed alongside opioids to enhance their effects, may substantially increase the risk of overdose. The report also raised concerns that, although coverage of Take Home Naloxone has increased, provision has not prevented substantial increases in opioid-related deaths. The report also identified that the number of people in specialist drug treatment at the time of death continued to increase.[[8]](#footnote-7)

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

1.6 The Glasgow City Health and Social Care Partnership announced, after conducting a local needs assessment and feasibility study, that introducing a Drug Consumption Room (DCR) in Glasgow city centre would address the burden of health and social harms caused by public injecting.[[9]](#footnote-8)

1.7 DCRs operate in 60 cities worldwide[[10]](#footnote-9) and act as professionally supervised healthcare facilities where people can use drugs in safe conditions. Inside a DCR, medically trained staff reverse overdoses, provide injecting equipment and refer people into key services such as drug treatment, counselling and housing services.[[11]](#footnote-10)

1.8 Recent reviews of the evidence base conclude that DCRs can be efficacious in:

* Reducing drug-related deaths at a city level where coverage is adequate.
* Reducing self-reported injection risk behaviors, such as syringe sharing.
* Promoting safer injecting conditions.
* Reaching and staying in contact with highly marginalised target populations.
* Increasing uptake of detoxification and drug dependence treatment, including opioid substitution.
* Enhancing access to primary healthcare.
* Decreasing public injecting.
* Reducing the number of syringes discarded in the vicinity.

1.9 The evidence does not suggest that a DCR:

* Increases drug use or frequency of injecting in the surrounding environment.
* Increases drug dealing, drug trafficking or drug-related crime in the surrounding environment.[[12]](#footnote-11)

2.0 The Glasgow City Health and Social Care Partnership made an application to the Lord Advocate, the chief legal officer for the Crown Office and Procurator Fiscal Service, requesting discretionary guidance that would have allowed the implementation of a drug consumption room. This application for discretionary guidance was rejected by the Lord Advocate, who advised that implementation of a DCR in Glasgow would require the UK Government to amend the Misuse of Drugs Act.[[13]](#footnote-12) In a letter to Glasgow City Council, Home Office officials recognised the evidence base, but concluded that they could not support the creation of DCRs due to concerns over law enforcement, ethical quandaries for medical professionals and the risk that users would travel long distances to use the room.[[14]](#footnote-13)

2.1 The Home Office’s position has blocked any further progress to be made in implementing a DCR in Glasgow city centre.

* How is the drugs market in Scotland changing? How well do current regulations meet the challenges of new trends in drug disruption, such as the “dark web”? Are any changes needed to the current regulatory landscape?

2.2 A report commissioned by the Scottish Government identified that social media platforms are being used to facilitate the supply of illicit drugs. This report warned that this new phenomenon creates “particular challenges for local statutory partners, who may not have ready access to the central resources and capabilities required to deal with highly mobile and/or technology-enabled criminality”.[[15]](#footnote-14)

2.3 There are anecdotal reports of social media platforms being used in this way across the UK, however, no study has yet identified prevalence.

2.4 Volteface’s upcoming paper aims to fill this gap by examining the extent to which social media platforms are being used to facilitate illicit drug supply, how they are being used and what impact this is having on the illicit market, enforcement and young people’s wellbeing. The research has involved commissioning a national poll, manually trawling social media platforms and interviewing, and holding focus groups with, young people and frontline professionals.

2.5 The paper will critique the Government’s recently released Online Harms White Paper, which sets out a package of measures to keep UK users safe online, including increased regulation of social media platforms.[[16]](#footnote-15)

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

2.6 Further devolution of powers to the Scottish Government would remove the obstacles that are preventing Glasgow Greater and Clyde from implementing a DCR.

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

*Portugal:[[17]](#footnote-16) Decriminalisation of All Illicit Drugs for Personal Use*

2.7 By 1999, Portugal had the highest rate of drug-related AIDS in the EU and the second highest prevalence of HIV amongst injecting drug users. There were concerns that the criminalisation of drug use was increasing drug health harms by socially excluding and marginalising drug users. Within this context, the Government accepted a proposal from an expert commission to decriminalise all illicit drugs for personal use in 2001.

2.8 A 2010 review of the policy found that the following changes occurred after Portugal decriminalised:

2.9 Drug use

* Small increases in reported illicit drug use amongst adults.
* Decline in use among young people.

3.0 Health

* Reduced illicit drug use among problematic drug users and adolescents.
* Increased uptake of drug treatment.
* Reduction in opiate-related deaths and infectious diseases.
* Increases in the amounts of drugs seized by the authorities.
* Reductions in the retail prices of drugs.[[18]](#footnote-17)

3.1 Crime

* It is not yet clear what impact decimalisation has had on crime, apart from reducing the burden on the criminal justice system.
* Between 2001-2006, homicide rates increased by 40%,[[19]](#footnote-18) though these homicides were not drug-related. Between 1995/96 and 2000/04, opportunistic crimes linked to drugs – most notably street robberies, theft from motor vehicles and theft of motor vehicles – increased by 66%, 30% and 15%, respectively. It is possible that this increase in opportunistic offence rates may have been because police were able to use the time they saved by no longer arresting drug users to tackle (and record) other low-level crimes.

*Iceland: Drugs Education***[[20]](#footnote-19)**

3.2 In the 1990s, Icelandic youth experienced high levels of drug use and, as problematic use rose, a new approach to drug prevention was implemented by the Icelandic Government. The concept was to teach young people aged 14 and over new skills and give them positive experiences which would produce a natural ‘high’. Alongside new skills, young people were given quality life education, which taught them how to manage their thoughts, feelings and interactions with people.[[21]](#footnote-20)

3.3 To encourage young people to engage with their families and reduce the amount of time they spent outside of the home (which was perceived as times of risk with regards to drug and alcohol use), Iceland introduced a curfew for all young people aged 13 to 16.

3.4 The Government also raised the legal age of buying cigarettes to 18 and alcohol to 20, and banned all advertising for cigarettes and alcohol, although this has been relaxed in recent years.

3.5 An additional law was brought into effect which involved every school in Iceland having to establish parental organisations and a school council with parental representation. To provide parents with additional guidance and support, the Government created an organisation called ‘Home and School’ which had four key areas of focus:

1. To raise the importance of spending quality time with children in the home.
2. To talk to children about their lives and experiences.
3. To learn who the children’s associates were.
4. To ensure children stuck to the curfew and were in their homes at night.

3.6 Parents in Iceland were given $500 to spend on after-school activities to keep children occupied, with the Government investing heavily in sports facilities. Participation in after-school activities was not only encouraged, but made easily available as leagues were established for children of all abilities.[[22]](#footnote-21)

3.7 The decline in drug use and increase in family engagement took place at the same time as the ‘Youth in Iceland’ project was implemented.[[23]](#footnote-22)

*Canada: Legalisation of Recreational Cannabis*

3.8 On the 31st October 2018, Canada became the first G7 country to legalise the sale and possession of cannabis. The case for legalisation was explicitly made on the grounds of protecting young people.

3.9 The reform seeks to: restrict youth access to cannabis; protect young people from promotion or enticements to use cannabis; deter and reduce criminal activity by imposing serious criminal penalties for those breaking the law, especially those who import, export or provide cannabis to youth; protect public health through strict product safety and quality requirements; reduce the burden on the criminal justice system; provide the legal production of cannabis to reduce illegal activities; allow adults to possess and access regulated, quality-controlled legal cannabis; and enhance public awareness of the health risks associated with cannabis.

4.0 The Cannabis Act states that no person can sell or provide cannabis to any person under the age of 18 (in some provinces the age is 19). It created two new criminal offences, with maximum penalties of 14 years in prison, for giving or selling cannabis to youth, and using a youth to commit a cannabis-related offence.

4.1 The Act also prohibits: products that are appealing to youth; packaging or labelling cannabis in a way that makes it appealing to youth; selling cannabis through self-service displays or vending machines; and promoting cannabis, except in narrow circumstances where the promotion could not be seen by a youth. Penalties for violating these laws include a fine of up to $5million or three years in prison.[[24]](#footnote-23)

4.2 The Canadian Government has committed to spending close to $46million over the next five years on public education and awareness activities to inform Canadians, especially young people, of the health and safety risks of using cannabis.[[25]](#footnote-24) Young people have been placed at the centre of the Canadian Government’s proposed policies and assessing their outcomes would be a worthwhile exercise.

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14. https://www.bbc.co.uk/news/uk-scotland-glasgow-west-44357774 [↑](#footnote-ref-13)
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17. As Portugal’s decriminalisation was a conscious policy choice, which only decriminalised one offence and was subjected to repeated monitoring and evaluation from the very start, the evidence base is more robust than what has been produced in the Netherlands. It is difficult to isolate the effects in the Netherlands as both possession and sale (coffee shops) were de-facto decriminalised at the same time and there has been limited evaluation of the policy change. [↑](#footnote-ref-16)
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