

Scottish Affairs Committee

Oral evidence: [Problem drug use in Scotland](#), HC 1997

Tuesday 2 July 2019

Ordered by the House of Commons to be published on 2 July 2019.

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Members present: Pete Wishart (Chair); Deidre Brock; David Duguid; Hugh Gaffney; Christine Jardine; Ged Killen; John Lamont; Paul Masterton; Danielle Rowley; Tommy Sheppard; Ross Thomson.

Questions 239 - 338

Witnesses

I: Dave Liddell, CEO, Scottish Drugs Forum; Martin Powell, Transform Drug Policy Foundation; and Jim Duffy, Law Enforcement Action Partnership UK].

II: 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; and Superintendent Kevin Weir, Durham Police.

Written evidence from witnesses:

- [Law Enforcement Action Partnership UK](#)
- [Scottish Drugs Forum](#)

Examination of witnesses

Witnesses: Dave Liddell, Martin Powell, and Jim Duffy.

Q239 **Chair:** We welcome you to the Scottish Affairs Committee to help us in our inquiry into problem drug use in Scotland. For the record, please say who you are, who you represent and anything by way of a short introductory statement. We will start with you, Mr Powell.

Martin Powell: Thank you. My name is Martin Powell. I work for the Transform Drug Policy Foundation. Transform is an international think-tank that does three forms of work. One is the international stuff. We have advised the Canadian Government, for example, on legal regulation of cannabis markets. My personal role is looking at drug consumption rooms, heroin-assisted treatment, working with police, police and crime commissioners and so on, but perhaps our most important work is with our Anyone's Child project, which is working with bereaved families across the UK, including in Scotland.

About a week ago we were outside here on College Green with bereaved families, planting 1,500 of these Forget-Me-Not flowers, each one representing someone who has already lost their life to drugs this year in the UK. Five hundred of these were sent down from Scotland, including this one, which has the name Eamon written on it, this one, which says Lizzie, and this one, which just has Mum on it. Why I am here today is in the hope that this Committee and the work that you do can help make sure that there are fewer Lizzies and Eamons and Mums to put in the ground next year.

Q240 **Chair:** Thank you very much for that. Mr Liddell.

Dave Liddell: I am David Liddell. I am the Chief Executive of the Scottish Drugs Forum. We are an NGO in Scotland, funded through a range of sources, including the Scottish Government, with an aim of reducing drug-related harm in Scotland. We undertake a range of work. Some of you visited our offices a couple of weeks ago to see some of that work in our addiction worker training programme and peer research, but fundamentally we are about representing the sector in aiming to improve responses and use resources in the most effective way.

One of our key concerns, alongside what Martin has said, is the fatal overdose deaths and the continued rise in those, which is a major concern of ours. We are particularly concerned about aspects of treatment and care and how that can be improved, particularly issues around suboptimal prescribing of methadone, for example, and poor retention rates in services and so on that can impact on that. We have been pushing for many years about drug consumption and heroin-assisted treatment as well, so that is really it. We are about reducing drug-related harm and working with a range of agencies across Scotland to try to deliver that.



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Q241 **Chair:** Thank you. We are incredibly grateful to you, Mr Liddell, for facilitating us the other week in visiting your centre and speaking to some of the centre users. It was a very helpful experience for us, so thank you for that. Mr Duffy.

Jim Duffy: Good morning. My name is Jim Duffy. I am a retired police officer. I was with Strathclyde Police for 32 years, between 1975 and 2007. In 2005 I put forward what is called a discussion motion at the Scottish Police Federation Conference that it should have a debate about the legalisation of drugs. Following on from the furore that caused, I was approached by a group of people in America called LEAP, which is Law Enforcement Against Prohibition. It is a group of serving and retired police officers, undercover agents, sheriffs, legislators, senators and judges who understand that the war on drugs as it currently stands is completely lost and completely unwinnable.

We currently have a market across the world that is entirely controlled by criminals who care not a jot for the age of the person who buys the drugs, the state of them, what the content is, what it is adulterated with. All they are interested in is the money. We understand that prohibition does not work, so our stance is that now across over 115 countries around the world we have representatives, much like myself, people who were involved in the justice system who try to convince people that the way forward is not to follow the current Misuse of Drugs Act, which has been in place now for 48 years and has been an out and out failure.

There is not a drug-free town, street, village or city anywhere, certainly not in this country, because if there was there would be a queue of people standing around it to say, "Look what we have done". That is the shortest queue in the world. We are of the view that what is currently in place is not working. We need a radical rethink; we need a change; we need to take it away from criminals; we need to take it away from the organised crime groups. We need to legalise and legislate and control.

Q242 **Chair:** Thank you all for being so concise and brief. What we are trying to explore today is the criminal justice interventions, how effective they are and what type of criminal justice interventions are currently being pursued by a range of different authorities. To start things off, could you give us some sort of idea of just how many problem drug users come into contact with criminal justice interventions? Do you have any idea what these numbers are and what percentage of the problem drug-using community would be involved? Mr Liddell, we will start with you.

Dave Liddell: The prison survey in 2017 suggested that 36% of people had a drug problem on the outside before entering prison. If you do the rough mathematics around the number of admissions, that suggests probably about 12,000 people with a drug problem go in and out of prison in a year, but that is very rough. If you wanted to give it a scale, that is roughly it.



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In addition to that, you have things like the drug treatment and testing orders, which are for high-tariff offenders. That is people who would otherwise get a custodial sentence but are given drug treatment and testing orders. There were 525 of those in 2017-18. I think of the overall number of orders, 500 were completed and 168 were breached.

You also have community payback orders with a condition of treatment, then you have all of the possession offences, which I think amount to 27,000, and also possession with intent to supply, that figure being 3,877. Interestingly, also you heard from our addiction worker trainees. We have done a rough look at their criminal histories over the years and what we find is that for most of those individuals the offences are mostly shoplifting, housebreaking and then Misuse of Drugs Act offences, roughly half and half. Over the years we have had 200-odd people through that programme and that seems to be the breakdown.

The engagement with the criminal justice system is significant, probably more so for the street users in the big cities, for example, where there is much more engagement directly with the police. Then beyond that you have arrest, custody and so on as part of that. That is roughly it. I don't know whether Martin wants to add to that, because he looked at similar figures.

Martin Powell: I did. Overall, according to the Scottish Government, there were about 131,000 people taken into police custody in 2017-18 and between 11% and 35% of those were dependent on some kind of substance. That is taken from the Scottish Government's stats from the drugs strategy.

You are also looking at 27,000 drug possession offences, 4,000 supply offences, with 12,000 proceeded against in court. In terms of prison itself, as you will be aware, Scotland has the highest rate of imprisonment in western Europe—150 people per 100,000 of population. On 21 July I had a look at the stats and there were 8,175 people in custody. Of the numbers affected by drugs, 15% of prisoners said they committed their offences to get money for drugs and 38% were under the influence of drugs at the time of their offence, which again gives you an indication that this is a major issue in terms of impacts of the drug using population.

Q243 **Chair:** Do any of you know whether this is the first contact that these individuals have had with the criminal justice system? What I am trying to suggest is: is it the problem drug use that leads to that contact or is there anything that precedes it, any sort of arrest or stopping by the police at all? Is it the problem drug use that leads to the criminal justice system?

Dave Liddell: Obviously you have looked at routes into problematic drug use. What is clear with the young offender population is that a significant proportion have been in care. It may be that other issues relating to other offences have preceded the problematic drug use, but I am not



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sure of the exact data on any of that. It is more anecdotally that people may be involved in particular groupings prior to their problematic drug use, when I suppose their drug use may still be more recreational than problematic.

Q244 **Chair:** I am interested to hear from you, Mr Duffy. Do you think that problem drug use is made worse by this criminalisation?

Jim Duffy: To try to put a proportionality on to it, the last World Health Organization survey I looked at said that we have about 430,000 casual cannabis users in Scotland and we have somewhere between 50,000 and 55,000 heroin addicts. Those figures combined take you to an area of around 500,000 people in a population of just over 5 million. That is quite a lot of people. Not all of those people come into contact with the criminal justice system. There are many people who use drugs recreationally who will never come into contact with the police system because they have stable backgrounds, they are in employment, they are in stable relationships and they have the money to go and purchase the drugs.

The people who come into contact with the criminal justice system are the people without hope, without jobs, who have suffered trauma in their lives, who turn to drugs as a means of escape. Nobody wakes up as a 15 or 16 year-old with the ambition in life to be a drug addict or a heroin addict or become addicted to something. It is something that happens through circumstances and maybe poor choices. For those who do come into contact with the criminal justice system, at the moment that can have a devastating effect on the rest of their lives.

If you are stopped as an 18 year-old and you have a joint on you, you get arrested and get a conviction in court for a narcotics offence, 10 years later you are a happily married man with two children and you take the kids to Disney and you get to American immigration and you do not get across because they see you have a narcotics conviction. Try explaining to a four or five-year-old that, "Ten years ago Daddy had a joint and because of that, you can't get to Disney". That is a slightly comedic effect but it is a reality. It has a huge impact on people's lives.

Q245 **Chair:** What you are saying to this Committee is that there is a particular profile of those who consume drugs, maybe take them recreationally, and those who have a problem drug use and will come into contact with the criminal justice system. Is that what you are saying to us today?

Jim Duffy: Yes.

Q246 **Chair:** Just from the other two, what sort of impact does that have on the individuals who are convicted of these drugs offences?

Martin Powell: I will run through these. A lot of bodies have looked at this: the Royal Society for Public Health, the World Health Organization, BMA, the EMCDDA and so on. These kinds of contacts lead to greater exposure to drugs in prison, they sever family and other support networks, sometimes leaving children in care, and provide barriers to



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education and employment, which we talked about. The stigma and fear of arrest discourages people from coming forward to get help and kills people, to be blunt.

One of the families that was out on College Green with us last week was Rose and Jeremy Humphries who lost two of their sons to heroin overdoses. One of them died, they think, because his friends were too slow to call an ambulance because they were afraid of arrest because they would be criminalised for it. Their other son died later, after he had been abstinent for some years and he relapsed. He did not seek help because of the fear of stigma and the impact on his career and was found alone, having lost his life. These are very real impacts.

You also get displacement to other drugs from enforcement. You get criminalisation creating practical obstacles to healthcare professionals delivering, including drug consumption rooms. Finally, if you are trying to educate young people about the dangers of drugs, trying to arrest and punish them at the same time drives them away from that. There is a lot of research and I can provide evidence of this as well. There are myriad different negative impacts from criminalisation.

Q247 Chair: There must be some examples where coming into contact with criminal justice will have a positive impact and benefit for some problem drug users. There must be some evidence that suggests that. I think we saw something on the BBC last week, the cops and cons project, for example, where it seemed to suggest that this was a means and a way forward for dealing with some of this.

Dave Liddell: I mentioned the drug treatment and testing orders that have been running since 2000 or thereabouts. They have proved successful, but they are particularly successful for a small group who tend to be the older population, 35 and over. Those are very intensive programmes, probably costing around £12,000 per individual. It is the wraparound support that is the key. That is the sort of support we should be mirroring across a range of organisations for treatment and care services. Those work well. As I said, the numbers of breaches are relatively small. That is for a group who have committed significant amounts of crime and would otherwise go to prison.

Obviously there are other things like arrest referral programmes that you will hear more about.

Chair: We are going to come on to that.

Dave Liddell: There have been diversion from prosecution programmes as well, for example, that have worked well, but they are not consistent. Drug treatment testing orders are available and of course you have prison-based treatment services and so on as well, and "through care" programmes that try to connect people on release from prison, because obviously that is a crucial point, particularly for fatal overdose death. We



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have done a lot of work in prisons in supplying people with naloxone so they have that on release to reduce the risk of fatal overdose.

Q248 **Chair:** Did you want to come in, Mr Duffy?

Jim Duffy: I think there is a very small number of people who, when they are caught by the police doing something illegal, will learn from it and not do it again. I think by far the majority of people who are caught doing something illegal by the police learn how they were caught and learn not to make that mistake again.

Q249 **David Duguid:** In answer to Mr Wishart's earlier question about the numbers, there are some quite startling numbers there, but because this Committee and this inquiry is focused on why in Scotland we seem to have a problem more so than elsewhere, what can be done or indeed what has been done within the current devolution settlement to make the Scottish criminal justice system more constructive in helping problem drug users?

Dave Liddell: The drug treatment and testing orders are a distinctive Scottish response, as were the drug courts in Glasgow and in Fife. Those have now closed, but the drug courts and the drug treatment testing orders were based on the notion that it was far better to keep those long-term, problematic drug users out of prison at all costs. Even at the cost of £12,000, that is far cheaper than the cost of putting somebody in prison. Those are the more distinctive things.

There have been arrest referral programmes that were developed. In terms of the intensive support, those have largely disappeared now. For example, in Aberdeen in the past there was a particular programme for diverting people from prosecution where a social worker went through all of the prosecution papers and picked out individuals to divert away from the court proceedings. I guess those would be some of the more distinctive things that I can think of.

Q250 **David Duguid:** Can I skip ahead? I think that brings me on to the question I was going to ask a little bit later but it probably makes sense to ask it now. What measure of success have those diversion activities shown in Scotland, or is it a bit too soon to tell? Is there evidence that shows that the various tactics you have just described have had a measure of success?

Dave Liddell: The problem in a sense is that we are talking about 56,000 or more people with a drug problem. The drug treatment testing orders are for about 500 or 600 a year, so they are very specific towards a particular target group. But the last data show 500 orders were completed and the number breached was 168. To my mind, that is very successful with this population who have been using problematically for potentially 20 years or more. The arguments are around replicating that across the whole range of services rather than necessarily investing a lot more in those particular programmes, but they have worked for this particular group.



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Q251 **David Duguid:** That is the diversion initiatives in particular?

Dave Liddell: That is the alternatives to custody and there is also the community payback orders, with a condition of treatment. Those are sometimes used as well.

Q252 **David Duguid:** If you do not have the numbers to hand, could we maybe get that provided to the Committee, just the measure of success that those have had over time?

Dave Liddell: The measure of success, yes.

Q253 **Deidre Brock:** I want to pick up on what you said, Mr Liddell, about the social worker in the Aberdeen area diverting folk away from prosecution. What criteria would that social worker have used in order to decide one person over another?

Dave Liddell: It was working with the procurators fiscal, so it was done in conjunction with them. I suppose in a similar way to the drug treatment testing orders, it would look at the fact that a more suitable disposal for an individual was to work with them in a treatment system as opposed to sending them to prison and that there was strong evidence that those outcomes would be better overall. I do not have the actual detail. It was many years ago, but I am still in contact with the person who ran that programme so I could find out more detail. But this is one of the problems that we have with programmes that work well and are successful but then are not replicated and just disappear because of lack of funding or other reasons.

Deidre Brock: That would be interesting to hear. Thank you.

Q254 **John Lamont:** I want to ask about how the criminal justice system interacts with the health service and whether there are interventions from the health system into the criminal justice system and whether you think they are being used effectively.

Dave Liddell: Is that to me again? I guess it probably is. Yes, I suppose I hesitate to go back to the drug treatment testing orders, but that is the one example where basically there is a significant health component to it. For example, most people on the drug treatment testing orders would go on opioid replacement therapy, so they would be on methadone. The condition is that you comply with the order, not that you stop using drugs, so that is a key feature of those programmes. They operate in a harm reduction fashion. One of the issues has been that people at the end of those orders have to then move into mainstream treatment and there has sometimes been problems of that continuity of care at the end point, which is an issue around the health service.

There is health involvement in custody suites, for example, GPs and nursing care in that environment as well. Then in the prison setting we now have devolved responsibility for health. In the prison setting it is now health board led, so there is significant involvement, particularly with things like opioid replacement therapy in the prison setting. There are a



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lot of those connections, but maybe the point you are making is that there could be an awful lot more. If we are focusing on a public health approach, I would argue that there should be. We may come on later to how those could be progressed.

Q255 John Lamont: We have heard evidence to this effect, that drugs are readily available in prison in Scotland—I see nodding heads—and I understand why, because it is easier to manage a prison population rather than having lots of prisoners going through cold turkey and coming off drugs. But do you not think we should be doing more when we have people in custody in prison and they have a drug problem, rather than just accepting drugs in prison because it is easier to manage the people in that condition? Should we not be doing more to try to address the underlying drug addiction that invariably may have resulted in them being in prison in the first place?

Dave Liddell: I will let Martin come in, but I think it is a question of where you place the resources. Another issue, particularly around fatal overdose deaths, is the lack of continuity of care going into prison and then in prison and then on release. That is a big issue. Often that is do with opioid replacement therapy, which people are taken off potentially when they come into prison. They have a period of abstinence in prison but immediately relapse on release.

The solutions are not simple in that environment. Some people may choose to come off and then attempt to stay off following release, but the problem we have is the significant number of fatal overdoses. That has reduced in recent times because of better through care, issues around naloxone supply and so on, but those issues are challenging.

There is a new opioid replacement therapy that is long-acting, using long-acting buprenorphine, where you can have a two-weekly or a monthly injection. That may help with some of the logistics in prison of daily supervised dispensing, which tends to take up a lot of prison healthcare time that otherwise they might be able to spend on dealing with other issues of prisoners. Martin, you wanted to add to that.

Martin Powell: For us, yes, if someone is in prison, of course you should do the best you can for them with treatment and so on. But I was at a meeting with the governor of Her Majesty's Prison Featherstone, who told us that if you want to end the prison drug problem, stop sending people with drug problems to prison. He said, "You send me your people out of society, more of them will come out with a drug problem than go in". Her Majesty's Chief Inspector of Prisons in England and Wales said 13% of people with a drug problem coming out of prison developed it while in prison.

Q256 John Lamont: But surely the answer to that is to tackle the drug problem in prison. From the public's perception, if somebody has committed a crime and the justice system has determined that they should be in prison and your argument is, "Don't send them to prison



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because they are going to get a greater drug problem as a consequence of that", surely the answer is to sort out the problem of drugs in Scotland's prisons rather than just stopping people going to prison?

Martin Powell: It is twofold. First of all, they did a programme of 10 pilot recovery wings in England and Wales in prisons and they found that nine of those 10 still had drug problems, even though they were meant to be drug free, so it is an issue of practicality. But it is also that what you see by the time you get people to this point is there has been a ratcheting up of the criminal offences that has led to them ending up in prison. What we would be much keener on is looking at systems like the diversion models, which I know some of our policing colleagues will be talking about later, that look at ways to get people to engage with treatment earlier so they never reach that point in the first place.

That is one of the powerful things about drug consumption rooms. Yes, they save lives. The latest evidence out from British Columbia this month, which you will not have seen yet, is 230 lives saved in a 20-month period in British Columbia with a similar population to Scotland, just from their drug consumption rooms. But the main thing is that they are engaging people in treatment in a population that is difficult to engage. Even if those drug consumption rooms were engaging one in four people, that is brilliant, frankly.

Jim Duffy: The question absolutely focuses on why the drugs war has failed. Prisons are secure places. My understanding of most of them is it is four walls, one door, one way in and one way out. 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. The people who run the drugs markets are criminals and they are clever, adaptive and innovative people. They do their research into supply and distribution and costs and all the rest of it and they have many ways of getting drugs into prison. The easiest way is to corrupt a member of staff. If you have someone in the prison service who, for example, is on £20,000 a year and you give them a brown envelope with £15,000 in it, they are yours for the rest of their service. They will do exactly what you tell them to do because you have control over them; you can blackmail them, you can do whatever you want.

If you cannot keep drugs out of four walls and a single door in a prison, how do you expect to keep them out of the general population when there are no walls and no doors as there are in a prison? What we are currently doing by prohibiting it does not work, so we need to change what we are doing and we need to take it away from the criminals and bring it back under control.

Chair: You have irked a lot of attention around the Committee. I think we have four people who want to come in with what they have heard before we move on to Mr Sheppard.



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Q257 **Paul Masterton:** Back to the start of the question, the specialist drug court in Glasgow has been fairly successful. Do you think there are grounds for seeing more of those types of approaches around not just Scotland, but within the different justice systems in the United Kingdom?

Dave Liddell: Say that again? Has it been more successful?

Paul Masterton: Yes. Do you think that the success of the Glasgow Drug Court merits looking at rolling out similar models more widely?

Dave Liddell: I am not familiar with the detailed costings, but my sense would be the specialist drug court is more expensive than running the drug treatment testing orders. It is probably when you have the volume of cases that it would merit that. I think it is probably better to look at the drug treatment testing orders rather than the drug courts. They have almost become a thing in being highlighted as such wonderful practice, particularly from the US. I would be more in favour of concentrating on the drug treatment testing orders than necessarily the specialist courts.

On the comparison to other jurisdictions, they are successful in their own terms. I would have to go and look at the comparative data compared to other countries, but there is a risk, as my colleagues would probably allude to, of concentrating too heavily on those interventions as opposed to trying to do more to keep people out.

Q258 **Chair:** I remember when the drug court was announced—this was about 15 years ago now—it was a big initiative that was going to make a significant difference. Has that been the case?

Martin Powell: I am not familiar specifically with Scotland, I am afraid, but there is some research just out looking at drug courts more widely around the world. Ireland has had them for 10 years, one in Dublin for a decade. There the gold standard of people remaining abstinent is 37 people over 10 years. The conclusion was that most of those were people whose lives were fairly stable, relatively—they had the social support networks anyway to assist them—who could probably have been helped in other ways. If you are looking at a model to help those with the most chaotic lifestyles, that evidence suggests drug courts are not the way to go.

Dave Liddell: If I can add to that though, the Scottish Drug Court is not focused on abstinence and nor are the drug treatment testing orders. They are focused on compliance with the court order.

Q259 **Paul Masterton:** Are there stats for breaches of treatment orders?

Dave Liddell: Yes.

Q260 **Paul Masterton:** You talked a lot about the continuity of support. Are you guys all satisfied that when someone is put on these treatment orders, the funding and the resources are there for continuing to support someone to comply with that order?



Dave Liddell: When the DTTOs started, the funding was ring-fenced and very closely monitored by the Scottish Executive, the Scottish Government. That is less so now. I think there may be some difference in how they operate in different parts of Scotland, particularly because of the local authority element of funding part of those. I do not think they are as coherent as they once were with a similar model operating in every jurisdiction of Scotland.

Q261 **Paul Masterton:** The success of those orders is not intrinsic to the orders themselves. It is dependent on the resource being followed up to continue to support that person, and what you are saying is that is patchy around Scotland?

Dave Liddell: Yes. For example, there are significant numbers of orders in Edinburgh, far greater than anywhere else in Scotland, so it is being used disproportionately in Edinburgh compared to elsewhere.

Q262 **Paul Masterton:** Is there a concern that the reason they are being used so disproportionately is to keep people out of prison—to manage that issue—but without having the resources in place to properly support that individual on the journey they need to make, as a result of which they end up back in the criminal justice system anyway?

Dave Liddell: No, I do not think so. I think probably other areas might be underusing those orders, so more people are going into prison who could otherwise be placed on those high interventions.

Chair: We have a number of interventions yet.

Q263 **Ged Killen:** I think Mr Duffy anticipated my question. I was going to follow on from what Mr Lamont was saying about the idea that we have to deal with this issue as it is and not as we would like it to be. Is there any example of a prison anywhere in the world where they have managed to effectively control the flow of drugs into prison and what have they done differently than what we are doing here?

Jim Duffy: The only prison area where I understand that it has been slightly reduced is in the Philippines. It is another prime example of the war on drugs not working. As you will probably be aware, in the Philippines the guy in charge has a single view about drugs and drug users and drug dealers and that is a 9 millimetre bullet in the back of the head. Over 5,000 people have been killed there in the past two years and the prisons are absolutely full. As they are full, the people inside are not getting access to the same amount of drugs, but the drug use outside of prisons, despite the deaths, despite the very rigid enforcement, has not changed and they have said it has not changed. No, there is not a prison that I am aware of anywhere where you cannot go in and get drugs.

Q264 **David Duguid:** Mr Powell, you said something earlier about drug consumption rooms in Canada and you said that they had been shown to save 250 lives. Given that a lot of the evidence we have received shows a wide range of complex factors that contribute to why people get into



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drugs in the first place, why people develop problem drug use, can you say a bit more about how you can measure the effect of drug consumption rooms in particular having saved those 250 lives? What is the direct causation—not correlation but causation?

Martin Powell: The research they have done there is looking at the combination of OST, methadone and so on, the use of naloxone and the use of drug consumption rooms and how the three interact with each other and how they change. British Columbia declared a public health emergency, something that we feel Scotland should do.

David Duguid: It declared what, sorry?

Martin Powell: A public health emergency in 2016.

David Duguid: Right, another emergency.

Martin Powell: Then it introduced a range of these measures and stepped them up. That is something we would like the Westminster Government to do—declare a health emergency and lay special powers to allow Scotland to do some of these things. But this specific research is looking at the interaction of those three. The numbers of lives saved by the drug consumption rooms, when taken in combination with those others, is higher. That is isolating the drug consumption room element from that. It is a range: 160 to 320, with 230 around the mid-point.

Q265 **David Duguid:** It has taken a sort of mid-range. Given that several different interventions have been made, how do you know that drug consumption rooms on their own have had any effect?

Martin Powell: An incredibly complicated statistical analysis has been done, which frankly is above my pay grade in terms of the academic mathematics involved with it, but they are very confident. It has been peer reviewed, published, looked at by other scientists and mathematicians who understand these measures better than I.

Q266 **David Duguid:** Speaking as a recovering scientist myself, could we get that presented to the Committee so we can have a look at that? Genuinely we are interested in how you come to that conclusion. I would like to be able to review that.

Dave Liddell: The point with British Columbia is that it has drug consumption rooms across the state of British Columbia, not in one location. We will come on to that, but obviously one drug consumption room is not going to have an impact like that.

Q267 **David Duguid:** Just to give you the background to my question, as a former chemist, when you carry out an experiment, you can only do one change at a time to qualify that result. If you make multiple changes, you cannot tell which change you have made achieves the result, regardless of how positive that result is.

Martin Powell: I am happy to tell you that Dave and I had this conversation. We are both chemists as well.



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Chair: On that, we also had the evidence from Dr Priyadarshi at our last meeting, who was saying something similar about some of the impacts of statistics, so maybe we could get concise evidence on that. Anything you could do to help us with that is good, because we have been having a debate within the Committee about some of the analysis and evidence.

Q268 **Christine Jardine:** Mr Duffy, you have possibly anticipated my question, but you were talking about the reality of the situation in prisons with drugs and the easiest way to get them in is to corrupt a member of staff, give them a brown envelope with cash in it. If we were to decriminalise drugs, would it be fair to say that that would remove the incentive of paying or corrupting prison staff if it was not a crime and we controlled it better and it was regulated and we regulated it in prisons, for example? You then take the criminal element out of it. It is the same argument, if you like, in prisons as out. You begin to take control of the situation and correct it and change it from being a problem that is completely out of control to one that you are managing and you are taking out the criminal element.

Jim Duffy: Perhaps the best example of taking the criminality out is, as you may be aware, in 2014 the state of Colorado in the United States of America decriminalised cannabis for personal and recreational use. There were many people at that time who said, "The sky will fall in, this will become the drug capital of America" and that did not happen. Last year, the state of Colorado sold \$1 billion worth of recreational and medicinal cannabis. From that \$1 billion of sales, \$200 million went in tax to the local authorities. That is \$200 million that was used for schools, hospitals and education. In fact, I spoke to two people from Colorado last week who said their roads have never been so well maintained and their streets have never been so clean. People hear that argument and think that is a good thing and I cannot deny that.

But what I try to get people to do is look beyond the \$200 million to the other \$800 million, that \$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. That is not a bad thing if that is not going to them.

To take it back to the prisons, yes, if you legalise it, you have to regulate it and you have to control it. You have to put in place systems and regulations, as they do in Canada, that allow people to grow in their own homes under licence, people to sell it under licence so that you know what you are getting, that it does exactly what it says on the tin, so you know the purity, the strength, the effect and your responsibilities. If you are going to do that in the general public you could extend it to people in prison. They have stopped them smoking in prison. We could do other things as well.

Q269 **Ross Thomson:** I wanted to ask a question about taking the criminality out of it, as you have mentioned. I have always said in the Committee that as long as there is a demand there is a supply, because people want



to make profit off addiction. Take it away from the criminals and hand to corporations or companies or whatever to do so. But we already find that, for example, the prevalence of illicit alcohol, particularly across central Latin America and Africa, outstrips the legal trade. The WHO said that illegally and informally produced alcohol made up on average about 25% of alcohol consumed worldwide. Then in tobacco, over 450 billion cigarettes are sold illegally across the global tobacco market.

If you hand the profits to corporations, you will still have a black market, because no doubt they would want make a profit, and there would be those that do not want to pay it. Even in relation to prisons, you will have those operating in the criminal world. I cannot see how you take the criminality out of it even if you legalise it. Do you agree that there would still be an illicit black market in drugs even if we were to legalise?

Jim Duffy: At the moment you have a drugs market that is completely and utterly unregulated. It is controlled by criminals, by gangs of people who use violence, extortion and all sorts of things to get their way and make their money, money that they pay no tax—nothing—on. If you were to bring in a legalised, regulated control system, you would get a degree of control over it, so if you were to say to me, “We will put in a legal system that will give you 75% control over a system over which you currently have no control at all” I would bite your hand off. There is no silver bullet to take this whole thing away and make it disappear and go into the past. There is always going to be a market in illegal tobacco and illegal alcohol and there will always be a market in illegal drugs. But if you can take that market down from what is currently 100% of that market down to 25% or 15% or 10%, that has to be an improvement.

Q270 Tommy Sheppard: Good morning. I want to come back and widen the focus on this whole relationship between what people are trying to do about the problem and the legal framework for the supply, distribution and use of drugs and the fact that we have public agencies at all levels in Scotland trying to cope with what is a major problem, but the legal framework is, in its entirety, reserved to this place. Could you tell us how the current legal framework impacts upon the ability of criminal justice and health and social care agencies to do something about the problem?

My second question is this. We have had some tentative suggestions that even within the existing framework, without changing the law, there is more that could be done and ought to be done. Could you talk about that as well?

Finally, this is the opportunity where I invite you to comment on whether and how you would like to see the legal framework changed.

Martin Powell: First of all, in terms of what more could be done at the moment, the police use recorded police warnings for cannabis and there were about 6,000 of them issued in the last year I looked at. We would like to see those expanded to include all other drugs. I understand from police contacts that the concern was that it is easy to identify cannabis, less easy to identify other drugs, but if you expand it to all other drugs it



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does not matter so much what that white powder is that you found. Then you can link that to a diversion scheme, such as I know you are going to hear about from Thames Valley Police, about referring people for an assessment for treatment or other things as well. That is one of the things that we would very much like to see done north of the border.

Q271 Tommy Sheppard: Can that be done within the existing law? There is no legal problem with that?

Martin Powell: Yes.

Dave Liddell: It can. Just to add to that though, I think it does need clarity around amounts that people can have for possession. We do not have that with cannabis recorded warnings at the moment. There is no clarity around how much you can possess and it would only result in a warning.

Martin Powell: I know that colleagues behind us will tell you about how they managed that issue within their diversion schemes.

Other things that we would like to see changing in terms of the Misuse of Drugs Act would be very specifically in the short term to allow drug consumption rooms to be piloted, so a law change around that. It would be to allow de jure decriminalisation like Portugal, because there are many benefits that are missing with diversion schemes that you can deliver with full decriminalisation, and ultimately to allow Scotland—we would ideally like this in the rest of the UK as well—to explore some of these other models of legal regulation to see whether they might be beneficial in a cautious piloted way, where you can roll it back if it is not working and so on. No big bangs, no sudden shocks to the system; a very careful, cautious, evidence-based approach.

Q272 Tommy Sheppard: Just to press you, do you accept the argument that a drug consumption room in Glasgow cannot happen unless the law is changed here?

Martin Powell: I think in practical terms it cannot. From talking to some of the people who would implement it, for them to put their staff in a potential position of legal jeopardy is very challenging, even if they think that it is only a slightly grey area. If you are the NHS and you are being asked to put in money to fund something like this, it is very challenging. There is probably more to be done in moving the debate onwards, but just in practical terms.

Dave Liddell: If I could add to that, we certainly do have a frustration that the Misuse of Drugs Act is used as a means for delaying responses. 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. I know the Lord Advocate and the Minister will be speaking to you next week. A frustration that we have is that there are delays in that. I would



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encourage the Scottish Government to be braver in that regard and progress that.

Similarly with things like drug checking, which has taken place in other parts of the UK—for example, at festivals there is drug checking undertaken by the Loop and also there is the WEDINOS programme in Wales that does drug checking and feeds the analysis back to users—that is an area that Scotland has not progressed and could do within the existing legislation. Similarly, as Martin says, with extending the police recorded warnings, we could do all of that in Scotland within the existing framework. That is basically moving towards a model of decriminalisation and we should be brave enough to do that, because it would help.

I know you are going to visit Portugal later on. I think it should be in line with the Portuguese model, which is one of social inclusion fundamentally. It is not just about decriminalisation. It is about all of those other issues of better access to treatment, better quality of treatment, looking at housing, employability, welfare benefits and so on. It is quite a profound shift and that is what we would be looking for in decriminalisation, including drug consumption rooms and heroin-assisted treatment as part of that.

Martin Powell: You divert the money you save to fund these things, so you end up with more money going in. Decriminalisation is a critical enabler of change.

Q273 **Tommy Sheppard:** One of the things we have talked about hardly at all in this inquiry so far is cannabis, to be honest. Everyone just sort of seems to accept that that is a different category, yet of course it is just as illegal to use cannabis as it is illegal to use heroin. I detect there is probably not an appetite in this place for a radical change in the 1971 legislation to the extent that I guess you guys would like to see, but it may be possible to get some movement on the recreational use of cannabis over the next few years, bringing it into line with the development in the States, Canada and elsewhere. Given that, I am not aware that any of these fatal overdoses, for example, any of the drug deaths are related to cannabis. How would decriminalisation or legalisation of cannabis in this country have any impact at all on the deaths that come from opiate-based drugs?

Jim Duffy: I think you are absolutely right. There has never been, as far as I am aware, a death certificate in relation to a drug death that says cannabis was the cause of death. We have a tremendous number of cannabis users socially, medically and recreationally. If you go across and look at Colorado, where it has legalised medicinal and recreational cannabis, I have already alluded to the income that it receives from that in tax and what it can do with that in the way of education and treatment.

There is also a fairly substantial body of evidence now in Colorado and in the other 11 states in America where they have legalised the possession



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and use of cannabis that people who were previously addicted to opioids are using cannabis to come off that addiction, so there is a benefit there, inasmuch as they can wean themselves off the opioid with the cannabis. Some people would say it is the lesser of two evils. I think if it is something that helps them to be better people and to live better lives, it should be supported.

What we are looking at here and the thing to get our heads around is that this is about saving people's lives and about people who have addictions and problems who are dying now in Scotland in their thousands. We sit here and we talk about it and we go around the edges. We need to do something positive to start saving lives. Lives are being saved all over the world, in Canada and America. Where they have legalised it in certain states, there are not the same number of fatalities. When you see what they have done in Portugal and Switzerland, there are not the same number of people dying. But then you come to Scotland and the United Kingdom and in Scotland we are dying in our thousands and we are not doing anything about it.

Martin Powell: Very specifically on cannabis, the reason that was a major driver for the Netherlands introducing their cannabis cafés was to separate out the cannabis market from the other drugs. You would not get offered any other drug when you went in there to purchase, so when young people went in to buy they were not offered opiates or anything else. That would be one potential way where if you manage a cannabis market here in the UK to separate it out, you could in the longer term help with those kind of issues.

Q274 **Tommy Sheppard:** Are you suggesting that because cannabis is illegal, if the 500,000 users in Scotland want to use it, they have to come into contact with illegal supply and that then puts them into a place where they are more likely to use other drugs? Is that the argument?

Martin Powell: They are more likely to be offered other drugs.

Jim Duffy: They might well be offered other drugs, but it does not necessarily mean that people who smoke cannabis will go on to use other drugs. That is like saying people who drink beer are eventually going to drink vodka because it is much more powerful and gives you a hit much quicker. It is about choice.

Q275 **Tommy Sheppard:** No, I get that. I am just wondering whether, if there was a change in the law in relation to cannabis, it would help this problem of people dying from overdoses of heroin or other drugs.

Dave Liddell: I think from the recorded warnings we have already seen a movement in that direction, but our argument would be that we should decriminalise possession of all drugs rather than just focus on cannabis, particularly because the argument around the Portuguese model is one of social inclusion, bringing people back in, sending a message that people are part of society and the problem should be normalised. I remember



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the US talked about denormalisation and the Dutch talked about normalisation. Normalisation and social inclusion is the key to what we should be trying to achieve.

Q276 Ross Thomson: I know Colorado has been mentioned a couple of times. I did have the opportunity to visit Colorado and speak to politicians in Denver. What I noticed was a lot of people with mental health problems on the streets who were using cannabis. A study just put out, that was conducted back in 2016, said there had been a threefold increase in hospital emergency rooms receiving people who had been consuming cannabis and those who were consuming cannabis were 33 times more likely to end up in A&E than before it had been legalised. Do you not see that potentially you take the criminality out of the issue, but it can lead to other issues around mental health?

Martin Powell: Specifically on that, one of the confounding factors there is that because it was illegal people were not going into A&E because they did not want to admit that they had been taking drugs, so you have to be very cautious with those kinds of statistics. We need to look more at the longer term trends, rather than anything that happens in the first couple of years, when people get used to the laws. If you are concerned about the problems of using, for example, high-strength cannabis, you can only manage that within a regulated market. As I say, we advised the Uruguayan Government on their model. What they have done down there is you have an anonymised registration process before you can access cannabis; you get it from government licensed pharmacies and they cap the strength at 10% THC that you can get through them. Those are the kind of measures that are only possible in a regulated market.

Q277 Ross Thomson: I understand that. I was part of a campaign to ban the sale of legal highs in Aberdeen. That was where you could walk into a shop and buy it and some of them were cannabinoid-style substances. As part of that campaign and speaking to those in Foresterhill in Aberdeen, they were saying that they had people coming in through their doors who had worse injuries, having taken legal highs, than they would have if they had been in a car accident. They said it was horrendous. That was strong cannabinoid-style substances that were freely available but have now been banned. I am still very concerned about the wider health impact, because we have had something that is legal and we have just made it illegal and now we are looking at taking a reverse step.

Martin Powell: The Netherlands, for example, has no problem with synthetic cannabinoids at all to speak of. It never arose, because people were able to access cannabis. What we have done through criminalising cannabis here is drive people to use these legal highs. Well, they are no longer legal highs. But for us, the criminalisation of them en masse, while it has reduced the very visible access in head shops and so on, has compounded the problem in places like prisons, as we know.

I met the deputy secretary general of the Prison Officers' Association, who is aghast at the state of this issue. They are keen to look at



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alternatives that mean fewer people end up in prison. That means starting way back down the chain in providing the treatment and support so that people never reach that point and when they do encounter police there are steps where—

Chair: I am just conscious of the time. We only have a few minutes left and I want to make sure everybody gets in.

Q278 **Danielle Rowley:** We have talked a lot about international examples. Are there any good evidence-based examples of countries where they went for the decriminalisation approach and there is evidence to show it has had a positive impact on reducing problem drug use and drug deaths, ultimately?

Dave Liddell: The Portuguese example is clear in both drug-related deaths and HIV. We have not mentioned, although I am sure it has been mentioned earlier in your evidence, that Glasgow has a current outbreak of HIV among street injectors. The alarming thing about that is that Athens had a similar outbreak at the time of severe austerity and it managed to get its outbreak under control more quickly than Glasgow has. We have those issues of real concern. I am not saying it can all be dealt with by decriminalisation, but it is the wider package of measures that I am particularly keen to link to decriminalisation rather than seeing decriminalisation as the panacea on its own.

Norway recently has developed a whole strategy around fatal overdose deaths and that is also linked to a process of decriminalisation. Many countries have linked those two issues together to make wider progress, but for me it is about the social inclusion aspect of that and the message that sends to people who are highly stigmatised and marginalised, that we care about them and we want to give them the appropriate level of support they need.

Martin Powell: A concrete example is the Czech Republic. The Czech Republic only criminalised drug use in 2000 to try to clamp down on drugs. After 10 years it did a cost benefit analysis and it found that criminalisation had made things worse, had increased social costs and harm and had not reduced use. It decriminalised again at that point in order to do these things and divert some of the money into treatment.

Q279 **Chair:** We are looking for examples of nations that have perhaps decriminalised or taken a more liberal approach to drug use. Denmark came up as an example, and I think it was suggested that we look at Norway, wasn't it, Dave? Is there a clear example of evidence that nations that have gone down a path of more liberalisation, perhaps decriminalisation, have decided it does not work and then tried to reverse that and made it much more difficult or have criminalised them again?

Dave Liddell: I suppose the Czech Republic was an example that went one way, went the other and then went back again.

Q280 **Chair:** But in Denmark, we have evidence that there are areas of



Copenhagen, for example, where there are issues for some of the local population. Is there anything that you have observed that should concern us?

Martin Powell: I think you have to do it well. That is the core issue on this. There is a lot of detail around the implementation where you can get it wrong, things like thresholds, how much you set that people are allowed to take, whether you put the money in to do other things. We can send you links to a lot of different countries with comparators about this, but the core issue here is that the fundamentals work. It only goes a bit wrong when you do not get the detail right in looking at it holistically, but there are no terrible examples where you point at it and say, "That means decriminalisation does not work". You might say, "That did not work because you did not do this".

Q281 **David Duguid:** On the particular example of the Netherlands and its famous brown cafés, I remember visiting Amsterdam once when there were still people coming up to you in the street, literally opening up their coats and showing a range of various drugs.

Tommy Sheppard: You get that in Glasgow.

David Duguid: But not so much in Amsterdam these days, I have noticed. I visit Amsterdam a lot; there are excellent art galleries and other attractions. My question is: why did the authorities in the Netherlands pull back from their liberalised policy in the first place and did that succeed or did that have the desired effect?

Martin Powell: We have written a briefing on this. There was concern about people coming in from France in particular into some of the smaller towns at the edge and you get lots of tourists and people who are uncomfortable with that. They tried to introduce a residents-only permit for sales to exclude that. Some of the big cities like Amsterdam objected because tourism is a big industry and there, and cannabis is part of it, just the same as your distilleries in Scotland and so on. In the end, what they went with was to give the municipalities the power to do that if they wanted, so some have no cannabis cafés and some have residents-only cafés still. Most did not, and the places that did introduce them reintroduced the street markets again. It was being sold on the streets again, so some of those were reversed as well. But this is only possible if you have a regulated market, the same as Uruguay has a residents-only law for its cannabis as well. It is an argument for regulation, as far as we are concerned.

Q282 **Tommy Sheppard:** This leads me on to a more general question. If we were minded to argue for a change in the law, could you comment on what the potential risks and benefits are of decriminalisation versus a legalisation approach, perhaps drawing on international examples of where things have worked best? What do you think would work for the UK and for Scotland?



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Jim Duffy: I think what would work for the UK and Scotland is if we were big enough and brave enough to realise that what we are currently doing is not working. The biggest danger to us is that we continue to sit and wring our hands and say, "This is terrible, we must do something about it" and not do anything. We need to realise that what we are doing is not working, so we need to change it. The change that we advocate is that you legalise, regulate and control it and you take it away from the criminals. The danger there—and this has already been alluded to—is that we do not do it properly, that we do it in bits and pieces and we allow big pharma to take over huge swathes of it and we do not allow the cottage industry, as they call it, when people do their own production and use. That is the big danger there.

People have to get the understanding of the difference between decriminalisation and legalisation. Decriminalisation is when we make it no longer a crime. Legalisation comes with the other two words, regulation and control. It is not a free-for-all. You have to put in place systems that allow it. For instance, Johann Hari has a very good book out called "Chasing the Scream" and he gives a beautiful example in relation to the alcohol industry. The head of Tennent's doesn't go around and beat up the head of Carlsberg in order to get a bigger share of the market and they do not do that because they have licences to lose, they have markets to lose and they are regulated and controlled. We do that with alcohol, tobacco, gambling and vehicles, all things that people can get addicted to and cause lots of deaths in the country.

Why do you think that continuing to prohibit drugs is going to be a different game-changer? We need to realise that the prohibition does not work. The only place where they tried prohibition on any great scale—as I am sure everybody remembers—is the United States of America. The only thing that people remember from that nowadays is Al Capone. How did Al Capone go to jail? Not for drug offences. Al Capone went to jail because he did not pay his taxes.

That is the huge amount of money that could be brought into the Government and into the country. The cannabis industry in the UK alone is £6 billion a year. What could you do with the tax take on that, along with the savings from police time, court time, hospital time and the rest of it? It calls on us to be brave and forward looking and we need to do that.

Martin Powell: I would agree entirely with what Jim has said. There is a process about this as well though. We could decriminalise drugs. Given the power, very rapidly we could do that. Then it is about sequencing, so do what we know works already, look at cannabis regulation where it is in place and is working. By the time this was done, we would have two or three more years of evidence on that. Look at expanding heroin-assisted treatment significantly in the cohort who that is relevant for. About 10% use around half of all the heroin, so you take half the heroin market away immediately from that. Then you do piloting of other measures in a



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careful, cautious way, learning from the lessons from alcohol and tobacco, pharmaceuticals and so on, and opt for more strict than you think you need at first. It is much easier to ease back on those controls, so complete bans on advertising, all those kind of measures. We have a whole book on this if anyone wants to read it.

Chair: Anything you have please send on.

- Q283 **Hugh Gaffney:** You may have answered this, Jim. My interest is the gangs. Once a gang master takes control and once you have done your job, you have wiped him out, somebody else steps up to the mark, so we have no control over it. The thing you have just described here was a good way of putting it: the police and all the time wasted. We have kids now down in the street getting murdered, stabbed, because they are running with drugs. That is the way I see it, so we have to look at this wholeheartedly. I think your assumption just two minutes ago summed it up and we do need to look at this properly. Maybe we have to put a licence on it and take away the power through the gang masters.

Jim Duffy: That is like stealing the thunder from the people who will follow me on to this table. There are 164 organised crime groups in Scotland and two-thirds of them are involved in drug trafficking. Quite often when I go around the country and talk to people they will say, "If they were not doing drugs, they would be doing something else", to which I say, "Good, let's make them work for their money, because at the moment they do not have to". At the moment everything is set up and focused around drugs and the constant flow of money that comes in. Nothing would be better than to cut that off from them and make them do something else.

- Q284 **David Duguid:** Do you have any evidence—yourself in particular, Mr Duffy—of what other crimes previous drug dealers get into when we take that opportunity away from them? It is maybe a question for the next panel.

Jim Duffy: I don't. We have not had the situation yet where we have taken that away from them—

David Duguid: But elsewhere in the world?

Jim Duffy: —but knowing that they are resourceful and educated and clever people, they will have something else to do, unfortunately.

Martin Powell: For us that is not an argument. In the same way that the police generally tell us to lock our windows to stop burglars coming in, they would not say, "Leave your windows open because the burglars might go and do something else".

- Q285 **Christine Jardine:** Mr Duffy, you have said quite clearly that decriminalisation has to go hand in hand with tighter regulation. You have touched on some of this already, but are there specific regulatory changes you think we would need to make right away for it to be



effective?

Jim Duffy: To do something right away and to become effective is extremely difficult because we are governed not by the rules that are set in this place, but by the United Nations and its attitude towards drugs. That attitude is heavily influenced by the United States of America. There is a huge lobby group within the United States of America not to have any change. There are a huge number of lobbyists who work for the private prisons who are actively campaigning for stronger drug laws, longer prison sentences and more prisons because they are run privately and they make almost as much money out of the prisoners as the drug lords are making out of the dope. There is a fundamental change that needs to happen there, which is a very difficult thing to influence. However, I struggle to see why we should accept the level of deaths in this country from the drugs market and say we cannot do anything about it because of what they have said. Let's do it.

Q286 **Christine Jardine:** Going back to the crime element of it again, would it be unrealistic to say that a lot of crimes are the consequence of drug use and that the rates of those crimes might fall if we decriminalised or legalised drugs in a way that it was regulated because the consequential effect of taking the gangs out of it is that the people who want the drugs would not be involved in crime? There is a wider picture. We think all the time about drugs and crime, but if you throw the pebble into the stream of deregulating it, there is a whole lot of ripples that go out and affect other crimes and would give the criminal justice system an easier burden to deal with by reducing the overall level of crime.

Jim Duffy: If you take, for example, Switzerland, which made the very brave decision a number of years ago to do the heroin treatment centres and gave the heroin addicts heroin, the crime rate at that time was horrendous. There were parts of the city that people could not go into. It put the scheme in place and crime fell by 80%. Switzerland went back to the people 10 years later and said, "Do you want to continue with this?" and the people of Switzerland said, "Yes, you are absolutely right we want to continue with this because it works". As far as I am aware, so far there has not been a drug death from a heroin overdose among any of the people that are on the heroin treatment programme.

Q287 **Christine Jardine:** To simplify it and summarise it, if we tackle drug problems properly and look at a solution, we could be also looking at a solution in a lot of other areas as a consequence of dealing properly with drugs rather than just going for a straight-out prohibition, which does not work?

Jim Duffy: It does not work.

Q288 **Chair:** There is no chance of any of this happening, is there? We heard the last statement from the current Home Secretary, that because of his childhood experience in his neighbourhood he was not of the view to do anything about our drugs laws. I am just looking at the statement from



the Home Office. The Home Office refused to come and give us evidence. We find it absolutely appalling that it is not prepared to come here and defend its position when it comes to this, so we are still trying to encourage it to come. The only statement that we received from the Home Office is that, "Legalising cannabis would send the wrong message to the vast majority of people who do not take drugs". This seems to be Government policy. This seems to be their approach to these loads of drug deaths, all the issues about criminality, drugs gangs and everything else. We have no chance of this ever happening, have we, with this as the current view of the Home Office?

Dave Liddell: But as we have said, within the existing framework we can deliver decriminalisation in Scotland through recorded warnings. We can do that. We also developed heroin-assisted treatment. That could be rolled out more widely. Maybe to add to that point, in Switzerland it is not just heroin-assisted treatment, it is a range of other treatments and options for people as well. Switzerland has a very high proportion of people with drug problems in treatment, which we do not have. We have potentially—I think you have heard that figure—only 40% in treatment.

The other issue is that we have very poor retention rates in many parts of Scotland for people in treatment. All of the issues of people going into prison, dropping out of services and so on—

Q289 **Chair:** That is all well and good—yes, of course there are those things—but you are up against a Government whose approach is "sending wrong messages" and so on.

Dave Liddell: Yes, but my argument is that we have a crisis in Scotland and we need to do those things now. We should not wait for the Home Secretary and Westminster; we should do them now. We need to do them now.

Q290 **Chair:** Why won't they accept some of the evidence that is coming from international examples?

Martin Powell: Interestingly, they do accept it, even in their own research. The Home Office has produced reports that accept the evidence that criminalising people does not reduce use. They accept the evidence that drug consumption rooms work. It is not that they do not accept the evidence, it is that they stick with some of these old ideological ideas about sending messages, when the criminal justice system is historically an appalling way to try to send health messages particularly to young people. It does not work. If you want to send messages to young people, you need to be engaging with them and talking to them.

But I am much more optimistic. We have seen this Government shift quietly in ways that I would not have expected. They are not trying to stop diversion schemes. They licensed a drug safety testing clinic in Weston-super-Mare. They are supportive of heroin-assisted treatment, even though they will not fund it, which they should do. Also we have



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seen with many issues, “No, no, no, no” and then all of a sudden it changes, “Yes”. We just need to keep pushing.

Chair: That is hopeful.

Q291 **Christine Jardine:** On that point, you are here giving us evidence on specific questions, but in the hope that you can influence us or that we can see the evidence that you present so that perhaps later on this Government—or maybe even a different Government, because we do not always have the same Government—might see the evidence and you might find that a different Government have a different attitude. If we listen to the evidence here and we record it, that is the effective way to make change.

Dave Liddell: If we look back to the 1980s, we have seen incremental change all the way along. You imagine somebody now getting six years in prison for 1 gram of heroin, so things have shifted a long way. The challenge is always that it tends to be incremental change as opposed to more fundamental change.

Chair: We are going to leave it there, gentlemen, but thank you ever so much. That was a fascinating session and we very much enjoyed the contributions today. I think there are a couple of things that we have asked you for, which hopefully you will be able to provide to the Committee. If there is anything else that you could usefully contribute, please get in touch with us once again.

Examination of witnesses

Witnesses: Professor Alex Stevens, Chief Inspector Jason Kew, Assistant Chief Constable Steve Johnson, and Superintendent Kevin Weir.

Q292 **Chair:** Thank you very much for joining us today in our inquiry into problem drug use in Scotland. For our record, please say who you are, who you represent and anything by way of an opening statement, which will have to be a very short statement, given we have four of you here today.

Chief Inspector Kew: Jason Kew, Thames Valley Police. I am a Detective Chief Inspector and I implemented the Thames Valley Police diversion scheme, which is a pre-arrest scheme designed to—*[Interruption.]* Do I need to be worried about that bell?

Chair: No, it is just telling us that we have started.

Chief Inspector Kew: We do not have to run outside. Thank you. It is a pre-arrest diversion scheme, which enables everyone found in possession of a controlled drug, regardless of their age and regardless of the type of drug, to receive an initial assessment at the drug service and an education programme, which is non-judgmental and provides better outcomes for that individual.

Q293 **Chair:** Thank you. I will just call you Mr Johnson, if that is okay.



Assistant Chief Constable Johnson: That is absolutely fine.

Chair: I am not even too sure what ACC is, but you could tell us.
[Interruption.] Assistant Chief Constable.

Assistant Chief Constable Johnson: I am glad you got that. I am Steve Johnson, Assistant Chief Constable. I was the lead for specialist crime and intelligence for Police Scotland for the past three years and holding the drugs strategy portfolio, responsible in the main for targeting organised crime and dealing with counter-terrorism in Scotland.

Superintendent Weir: Good morning. My name is Kevin Weir. I am a Detective Superintendent in Durham Police and I am the strategic lead for the Checkpoint programme, which offers a four-month diversion from prosecution if you comply with the issues that you have and does not result in any prosecution if you successfully comply.

Professor Stevens: My name is Alex Stevens. I am a professor in criminal justice at the University of Kent. I recently stepped down as President of the International Society for the Study of Drug Policy. I am a member of the Advisory Council on the Misuse Drugs for the UK. I was the lead author of its report in 2016 on "Reducing Opioid-Related Deaths in the UK" and also its very recent report on reducing drug-related harms in transitions between custody and community.

I should mention that I cannot speak on behalf of the council, because only the chair can speak on behalf of the council, but I can speak about the council as an independent academic. I should declare I am also a special adviser to the Health and Social Care Select Committee on its similar inquiry that it is running at the moment and it will be meeting this afternoon.

Q294 **Chair:** We have three very distinguished police officers with us today, with vast experience in this particular field. How do criminal justice interventions help us deal with some of the issues that we have heard about today and how does it help us address some of the appalling drug deaths that we have had in Scotland? Do criminal justice interventions work? We will start with you, ACC Johnson.

Assistant Chief Constable Johnson: It is a balance. I can give you some statistics. I have been in Police Scotland for the past three years and we are now shy of 3,000 drug-related deaths in Scotland. The official statistics are: 2015, 539; 2016, 788; 2017, 903; 2018—and this is an unofficial statistic, I keep a tally of the drug-related deaths every day—we are going to hit around about 1,067, maybe just break the 1,100 mark once we get past the suspected drug deaths.

Since 2015 the figures have doubled in Scotland. For me, those are not just statistics. I get reported every day the names, the ages and the locations across Scotland. Of the 13 divisions, there is not a division in Scotland that has not seen an increase, certainly from 2017 to 2018, very nearly a 20% increase in drug-related deaths. One thing I would want to



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get across to the Committee is probably the sense that is felt by the root and branch officers, of what I think they would call the hamster wheel. That is our custody staff and our operational staff who see people. It is just a matter of time: they come through the custody door, they get processed through the criminal justice process, they go in through the Sheriff Court, they go into prison. Of those people that come out of prison, 11% of them will die within the first month of having been released, according to the statistics.

But the police officers get used to this carousel, this sense of hopelessness and helplessness. The first duty of every police officer is to preserve life and when people do not come back through the doors with that alarming frequency, it is probably because the person is dead. It is not because there has been a successful intervention through the criminal justice process. That is a sense of foreboding within law enforcement.

But there is an awful lot of good that we do with partners around diversionary streams, trying to divert people away from criminal justice, the work that we do with young offenders in Polmont, trying to divert them away from organised crime. But overwhelmingly the sense for me, dealing with the serious and organised crime group, is that we have had some successes. There was a question earlier on: from 163 serious and organised crime groups in Scotland, we are down to about 96 now.

I think what is missing in the criminal justice process is it is seen as supply, importation, almost a white collar sense to the criminality, and the criminality of these organised crime groups I do not believe is linked to the harm that is caused to the citizens in Scotland. It is death and it is death on a large scale. It is an epidemic scale.

Q295 Chair: We all appreciate the work that the police service does in trying to keep people safe. We have seen great examples of that and some of that has been presented to this Committee, but what we are finding difficult to understand is that we can understand disrupting supply and going after the big criminals who are the leaders of organised crime, but does criminalising drug users seriously assist them in dealing with their problems? That is what we need to hear from you and maybe you could help us with that.

Superintendent Weir: From our point of view, we obviously look after victims as best we possibly can, but most of the offenders we meet are vulnerable in some way because they have some issue that attracts them to commit the crime. What we try to do is work with them to do that. If we are talking about specifically drugs, we will offer Checkpoint schemes, which is our diversion scheme, to people who are low-level suppliers—meaning they supply to their friends in the streets. We make a distinction between sad versus bad and we have a scale that we use to be able to do that, but we try to change the underlying causes of why they commit crime and improve their life chances so they can stop committing crime but take a better part in society.



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We have developed a scheme that is a four-month deferred prosecution. They have to admit the offence or at least we have enough evidence—

Q296 **Chair:** I want to come specifically to some of the things that you guys are doing, because we are impressed by some of the things that are being offered by the Police Service, but I am just interested in this ideological question. You are police officers, you are the front line and the interface between the criminal justice system. You are not health professionals; you are not experts in addiction disorders. Maybe you could help us with this, Mr Kew. Why is it that you guys are dealing with this issue and not health professionals and what do you actively contribute to making this better?

Chief Inspector Kew: I can speak from a personal point of view. I do not want to bring my organisation into any form of disrepute from own views. Speaking as an individual, I would say that criminalisation does not work for simple possession of drugs. I say that because there is a significant amount of stigma attached to policing. Taking best evidence from the Checkpoint and West Midlands Turning Point schemes and Bristol's Drugs Education Programme, all have seen evidence that the role of the police and the role of capture and punishment has little effect on drugs possession. I am only talking about drugs possession in isolation here.

What is the role of police in drugs possession? The police aren't punishers. We collect evidence. As ACC Johnson just mentioned, the primary role of police officers is to prevent harm. With such significant numbers of drug-related deaths, our role—my role—has turned towards a health-based approach to enable education, no stigma. The most teachable moment—and there is strong evidence to suggest this—in any interaction with police is that moment on the street, so what can we do to maximise that opportunity when someone comes into contact with police officers there and then on the street?

Q297 **Chair:** Professor Stevens, I know you cannot speak on behalf of the Advisory Council on the Misuse of Drugs, but you can speak about it. This Committee is having a difficulty about what your formal role is when it comes to Government policy. You advise Government on the evidence about drugs issues; would that be correct?

Professor Stevens: Yes. The council has a statutory duty under the Misuse of Drugs Act to advise Ministers on the reduction of drug-related harms.

Q298 **Chair:** What usually happens to that advice?

Professor Stevens: If that advice is to tighten control on drugs, it is generally accepted. If that advice is to loosen control on drugs, it is generally refused.

Q299 **Chair:** It is next to useless then, given the evidence that we have heard about the fact that drug consumption rooms work internationally, the



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decriminalisation seems to make a strong impact, so you would be—

Professor Stevens: I would strongly dispute that the council is next to useless.

Q300 **Chair:** The Government know this evidence though.

Professor Stevens: The Government do not always know the evidence. We are distillers of the evidence.

Q301 **Chair:** Isn't that your job, to give it to them?

Professor Stevens: We do give it to them, yes. It is the Government's prerogative to refuse or accept it. Sometimes they accept it. For example, when we recommended that naloxone should be made more available in 2013, it was made more available, and that has probably saved people's lives. In 1988, when we advised the Government that it was more important to keep people alive than it was to punish them for using drugs, the Government accepted that advice and we created a harm reduction system that was the envy of the world and saved loads of people's lives.

Q302 **Chair:** You advise Government based on the evidence that you see and have acquired, probably some that you even commission, looking at international examples, and you present that to Government. If it is something that suggests a hardening approach to drugs, they tend to accept it, but with anything that leads to a more liberal approach they would say, "No, we do not like that. It does not fit with our general policy of sending a message", which seems to be Government policy when it comes to drugs?

Professor Stevens: Yes, which I think is fascinating, because 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 just does not fit with their professional expertise.

Q303 **Chair:** Do we not need a better arrangement than this then? You spend all this time, present them with the evidence, which is rejected and conditions and situations possibly get worse. We have these drug deaths here in Scotland. Do we not need to make sure the Government accept the evidence?

Professor Stevens: I would much prefer that Government not only accepted the evidence but put it into practice. For example, in the 2016 report "Reducing Opioid-Related Deaths in the UK" that the ACMD published, we had several recommendations and the Government formally accepted all of them, except the one on drug consumption rooms. They formally accepted our recommendation, the most important one, that investment in opioid substitution treatment therapy of optimal dosage and duration should be maintained. They formally accepted that



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recommendation. They have since cut the public health budget in England by 25%.

We recommended that there be central funding provided for heroin-assisted treatment. They formally accepted that recommendation on the basis that there should be heroin-assisted treatment, but they said it was up to local authorities to provide that heroin-assisted treatment, not acknowledging the fact they had massively cut the amount of money that local authorities have available to provide heroin-assisted treatment. While they sometimes accept our recommendations in the letter, in the actual practice we don't see that.

But that is not for the council. The council has no powers to implement policy; all we can do is recommend policies to the Government. It is the Government's democratic duty and right to decide whether to implement our advice or not.

Q304 **Chair:** Yes, because the Home Secretary famously said that he would not accept drug consumption rooms because of what he experienced as a child in his locality and neighbourhood. What do you do when you are confronted with that—you are presenting the evidence and the Home Secretary turns around and says something like that?

Professor Stevens: I am an academic, not a campaigner, but people on the previous panel, for example, are campaigners who will try to get that evidence accepted and more power to them.

Q305 **Chair:** Lastly from me on the Misuse of Drugs Act 1971, are the categorisations effective? Are the current categorisations of drugs working?

Professor Stevens: I will refer you to the report of the Science and Technology Select Committee in 2006, which was titled "Drug classification: making a hash of it?" which was about drug classification. It made the point very strongly that there is not a rational justification for the current classifications of particular substances. I would also refer you to recommendations of the ACMD that cannabis is in the wrong class. The ACMD has recommended that cannabis should be in class C; it is currently in class B. The ACMD has recommended that ecstasy, MDMA, is in the wrong class. The council has recommended it should 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 was controlled under the Misuse of Drugs Act.

Q306 **Chair:** This is just so depressing, listening to this. You are charged with advising Government and it is all absolutely, totally rejected. What is the point in you?

Professor Stevens: This is public information. We are here in public telling you, as representatives of the public, what the best evidence available is on what should be done about drugs. That is a valuable public role to play, whether the Government accept it or not.



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Q307 **David Duguid:** Moving on from the rhetorical questions, can I ask Professor Stevens in particular a question you can possibly answer on your behalf, if not that of the council? Can you explain the role of the Advisory Council on the Misuse of Drugs and what the drugs policy ratchet is?

Professor Stevens: Yes. The drugs policy ratchet is a term that I used in a paper that I wrote with Professor Fiona Measham in 2014 to describe this very process, by which if the Government are advised to tighten control, they tighten control, but if they are advised to loosen control, it does not go the other way. It is a one-way system.

David Duguid: Yes, it ratchets up.

Professor Stevens: It just ratchets up. This is partly based on rhetorical commitments to toughness, so this idea that 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 tough approach. For example, when we recommended that pregabalin and gabapentin should be more tightly controlled on the basis there is quite a lot of evidence of harm from those substances, especially in prisons, that was accepted because it was consistent with this message of toughness.

Q308 **David Duguid:** It sounds like that is consistent with the evidence we have seen from a lot of people based on other legal substances, such as alcohol and nicotine. They are already legal, so if you were to add extra control to those, it would be much more difficult to take it away. Likewise, if you have illegal substances, it is far more difficult to remove the control than it is to apply control. Is that the same idea?

Professor Stevens: In theory, in the parliamentary process it is as easy to remove control as it is to tighten control.

Q309 **David Duguid:** But in terms of public opinion and the other things that we, as politicians, all need to—

Professor Stevens: It is a political question.

David Duguid: Yes, okay. Thank you.

Q310 **Tommy Sheppard:** Good morning. The Advisory Council has previously recommended a number of things, including, for example, its support for drug consumption rooms, as I understand it. The Chair has already suggested some of the political and ideological statements that the Home Secretary of the day may make on this, but the Home Office as an institution seems to have set its face against change, which, given the changes that are happening internationally in this debate, does seem quite remarkable. I presume that the police officers have contact with the Home Office as well. I would welcome your reflections. Why do you think this resistance to change is so engrained, or is it? Are we just seeing what they want us to see? Is there stuff happening beneath the surface in terms of this debate opening up that perhaps we are not aware of?



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Professor Stevens: Historically, if you go back to the beginning of the British drug control system in the 1910s and 1920s, it is always the Home Office that has taken the lead in pushing a social control type of policy on to British drug policy. It has always been this balance between medical experts and the Home Office, sometimes with the police in support but increasingly not so, deciding whether health or criminal justice responses should be in the lead.

The Home Office has an institutional commitment, as you said, to the idea of social control and repression of certain activities being the way forward. I think that is crumbling now because the evidence is so strong on the other side. For example, 20 years ago you would not have had senior police officers publicly disputing the Home Office line on how drug policy should be. I think that there is an opportunity now to make some change.

Assistant Chief Constable Johnson: I think that we have an ideal opportunity in Scotland. The move from justice to health as an issue in relation to the drug strategy is a huge bonus that we have there. The performance regime in the past—how many different arrests for different classes and different types, how many custodial, how many sentences—are very much a numerical, valueless type of performance statistics. That is against the backdrop of increasing deaths and, as Jason and Kevin have said, many of the people that we see are vulnerable without taking the drugs. They have other complex issues happening in their lives. The drugs potentially are part of the management of that or symptomatic of that and it feels very punitive.

I cannot answer for the Home Office; I think that it is for the Home Office to answer for itself. For me, there is a sense of proportionality and pragmatism now in the application of the law. 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 will unfortunately for most of them mean at some point they are going to die.

Statistically as well, an awful lot is said, particularly in Scotland, about this "Trainspotting" generation, my generation, 45 to 55. Depressingly, the names and the dates of birth that I am starting to see come through on a daily basis are people in their mid to late 20s. It is not even "Trainspotting 2"; this is people who were not around then. It is growing and it is growing in numbers. Of the 61,500 problematic users in Scotland, for the vast majority, with the stigma, the end for them is at the moment death. The criminal justice process is probably deleterious in that. It is pushing people into a place where there is more harm. While it might be statistically an outcome that is a criminal justice outcome, it



does not seem to me to present good social justice in rehabilitation, putting people back out into society who can be contributors to it.

With initiatives that Kevin and Jason are doing south of the border, there is a real opportunity for us in Scotland with the devolved nature of policing—but not this particular aspect of law—and the move to health to start to make great strides in that, which can take real confidence and real courage. What I do not think we can have is what you have probably seen in Canada, police chiefs turning a blind eye to the law. I think that is the thin end of the wedge. We are there to uphold the law, not pick and choose which ones and when we want to do it.

Chief Inspector Kew: Following directly on from that—and in saying this I would not want to undermine anyone's position, say the Lord Advocate's position on the prosecution of the management of a DCR or overdose prevention centre, or that of the Home Office—I would say of the Lord Advocate's position on prosecuting the management of an overdose prevention centre if one should pop up in the current health emergency: is there a public interest to prosecute? That is a comment that I do not mean loosely either. That is a very serious element for policing to take forward. 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.

There is another thing about language. As ACC Johnson has just mentioned, this is an emergency. People's lives are being destroyed by drugs and we have a significant issue with drug-related deaths. Language is key to fuelling stigma. DCRs give an interpretation of a loose nature where someone can go in and shooting galleries pop up in the newspapers. 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, a very small section of the community, who are injecting, poly-using crack and heroin, injecting into their necks and groins five, six, seven times a day. An overdose prevention centre—

Chair: We are going to come on specifically to drug consumption rooms, so we will leave that. I know that Tommy was wanting to come back in.

Q311 **Tommy Sheppard:** I will let Superintendent Weir come in first.

Superintendent Weir: From my point of view, my organisation treats people as vulnerable. What we are trying to do is work within the legislation that currently exists to be able to do different things. We are trying to look at heroin-assisted treatment centres with partners because we can do that with a licence from the Home Office. We are looking at what we do with low-level people who function in their lives around drugs, because within the legislation we can divert them from prosecution. We can give them an out-of-court disposal, which prevents them going to court.



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We do speak with the Home Office. The Home Office has been several times to visit the force, but the organisation of Durham Police wants to treat everybody at a lower level with current legislative guidance that is already there. That is what we do. We do not break the law. We don't not arrest people for drug-related offences. We just dispose of them differently.

Q312 Tommy Sheppard: Can I explore this a little bit more? It seems to me that we have this situation in public policy now throughout the UK, more acute in Scotland, where you have the body of Home Office legislation and practice that I think is no longer fit for purpose but no one wants to particularly change it and they will not admit that. There is an element probably of embarrassment within the Home Office that will choose to turn a blind eye or will allow some leniency if people want to push something and give dispensation for it.

On the other hand, you have this drive towards people trying to have alternative approaches to criminal justice and to the problem. You are saying health intervention and harm reduction techniques and all the rest of it, which you as practitioners on the ground seem to see merit in and are being dragged into that as well. We have this lack of clarity about what people should be doing and what is official policy, which gives you some discretion.

That brings us to what Chief Inspector Kew has said. In your operational policies, you presumably have to make a judgment as to what the priorities should be given you cannot do everything all the time and you have to decide which is better in the public interest. For example, with half a million people using cannabis in Scotland every week, technically you could arrest every single one of them and give them a criminal record. That is the law, but you do not do that because it would be ridiculous. You do not bust every student with a joint or every kid at a club with a pill or whatever.

My question is: if someone were to set up a drug consumption centre in Glasgow or elsewhere and says this is an intervention that the crisis now demands that we do, would it be in the public interest for Police Scotland to close that down and to arrest people?

Assistant Chief Constable Johnson: Given our duty around preservation of life, I do not think it would be in the broader public interest. 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 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 and take those drugs, where they have access to naloxone, medical support and medical intervention, 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



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been in a custody facility, put in front of the sheriff, from the sheriff to the court— we know the story. That is a harsh reality faced.

We see police officers making life and death decisions—albeit at the time they do not feel like life and death decisions—based on pragmatism and preservation of life and potentially working with a facility like that, yet the litigious nature of society is such that it would probably be seen as a death after police contact—meaning a referral to the PIRC and an officer's life in turmoil for making what they thought was the pragmatic, right decision seeking the right sort of outcome but which did not actually work out that way.

Within the system there is not that much clarity. There is a fear because we should be—1971. If 1,000 people died on the roads in Scotland, we would have seen changes in the Road Traffic Act. We would have seen enforcement being different in that. We would have also seen a systemic and whole system approach to that, which we have seen in terms of road traffic, vehicle designs and preventative activity. We are not seeing consistency in approach around the nature of harm. When 1,000-odd people die, it seems a little bit odd that 48 years after an Act, given the increase in technology and the proliferation of the use of technology in the commission of the supply, which means this can be delivered to people's houses who are very vulnerable, very young, with easy access, completely invisible to an awful lot of law enforcement or the medical profession, we are not seeing the legislation keep step with society and the advances in society, let alone protecting officers who are trying to uphold the law for all the best intentions around preservation of life.

Professor Stevens: 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". The problem is that it then leaves the police services and individual officers in invidious positions such as have just been described.

We were asked earlier about the difference between diversion and decriminalisation. One of the advantages of decriminalising it and doing in the law is 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.

Q313 **Chair:** It strikes me that there is almost a dishonesty going on here where the Government have one approach that they have decided is going to be their policy towards drugs, and that is what they present to the public: they are tough on drugs, they are not going to change the



law, they are sending out a message because of legality. Then we have senior police officers and police officers on the street who are doing something entirely different. Wouldn't it be much better to have a consistency of policy and approach?

Professor Stevens: There are two simple things that could be done to create some of that consistency. For example, the Misuse of Drugs Regulations could be amended so that it was no longer an offence for a person who was employed by a drug consumption room to be in possession of a substance. That would help the police be clear about whether they do or do not arrest those people. We could amend section 8 of the Misuse of Drugs Act to make it clearer that people who are running a drug consumption room are not going to be subject to prosecution for running a premises that is being used for production of drugs. These are quite simple changes that could be made.

Q314 **Tommy Sheppard:** How could they be amended? Could that be done by secondary legislation?

Professor Stevens: The Misuse of Drugs Act is secondary legislation, so that would be easier than changing the Misuse of Drugs—

Q315 **Tommy Sheppard:** A statutory instrument could give effect to that?

Professor Stevens: Sorry, I meant the Misuse of Drugs Regulations 2001. Those already include exemptions—people who are exempt from the offence of possession. You could expand that list of exemptions to include people who are working in a drug consumption room. That would be very easy. There is a statutory instrument going through right now correcting an error that was made around the banning of third generation synthetic cannabinoids.

Q316 **Chair:** When do you think that statutory instrument will be presented to Parliament?

Professor Stevens: It is a statutory instrument. It could be done pretty quickly.

Q317 **David Duguid:** Some of the questions I was going to ask have been answered. We have heard a lot about what can be done in Durham, for example, within the existing framework to do things differently locally. Specifically to ACC Johnson: is there anything more that we can be doing, or are doing, within the current devolution settlement or is there anything we can learn from places like Durham that we should be taking note of in this Committee to recommend to the Government? Without necessarily changing the Misuse of Drugs Act 1971, apart from maybe taking on board your suggestion for an amendment for consumption room staff, is there anything more that we could be doing on the ground as Police Scotland to do things differently in the interests of improving public health?

Assistant Chief Constable Johnson: As I said, Kevin's and Jason's work is something that we will look closely at to see how we might be



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able to implement something similar in Scotland. There are three categories. You have your individuals who are substance users who in many respects—and I don't mean this in the way that it might come across—are particularly hopeless and helpless individuals who are victims, and they need society's support in moving away from their substance addiction by whatever means they can. That is a clear health issue.

At the other end of the spectrum, you have the serious and organised criminals who are responsible for supply and importation. As I have already said, the approach taken to them does not link their activities with the harm that they are causing and the deaths they are causing. I think that we should look at either legislation or an approach that targets them, and that is certainly what we have been doing in Police Scotland. We are targeting the principals, many of whom do not even live in the United Kingdom, let alone Scotland anymore, with significant wealth causing significant harm in Scotland.

Then there is a middle band, and I think that Kevin referred to it. It is the vulnerable people who are somehow involved in the trade and supply, whether they have been cuckooed or whether they are part of county lines. These are vulnerable people who potentially have either mental health, addiction or other vulnerabilities, who are used in the supply of drugs. That is a grey area for law enforcement where we would seek clarity.

More recently in Dundee—and only in the past week we have just finished operations in Edinburgh—we approached the Lord Advocate. The only way to deal with many of the people we observe through some of our policing activity who are involved in buying drugs was for them to enter the criminal justice process. We had to arrest people to make the referrals, and what we were seeking to do was just make the referrals.

The recent Operation Fundamental in Dundee saw 30-odd individuals arrested for being concerned in the supply of substances but about 100 adults and about 30 young people referred to partners to try to get that support. Unfortunately, again, that referral had to come on the back of a criminal justice approach rather than referring as victims. Some of the blockers are things like GDPR. Can we just share the information with partners that ultimately is about trying to keep someone alive? If it is a functioning individual who takes heroin, we cannot share that information.

Q318 David Duguid: You mentioned cuckooing and county lines there. Is there an opportunity to improve co-operation between Police Scotland and other police organisations across the rest of the United Kingdom?

Assistant Chief Constable Johnson: We definitely do there. In the Police Scotland database—which was probably one of the formations for the National Crime Agency when it did the database that mapped the whole of the United Kingdom in the co-ordination and how the lines



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impact—we have fairly good handles on the county lines, where they originate and where their final destinations are. For us, it is predominantly the north-east of the country. We have really good lines on that and we have seen some good successes in targeting those.

Where we need to do it—and we heard this from the previous panel—is to go at both ends of the spectrum. We really need to nail the suppliers, the importers and those who are causing the harm. We need to absolutely screw them into the ground and deal with them as robustly as we possibly can and, at the same time, try to take the market away. As I think a previous person has said, the laws of supply and demand are absolutely there. Even if you do legalise, they will all try to undercut the market.

Chair: Thank you for that. I am conscious that we have a big panel, so could we maybe keep answers a little bit more concise? Being senior police officers, I am pretty sure you are used to that.

Q319 **Hugh Gaffney:** I am interested in your hamster wheel thing. In Scotland just now the suicide rate is younger and younger. Is that the same with the hamster wheel? Are the kids coming in younger and younger? I wanted to go out with my local police station and they said, “You can’t come out in the car because we have no cars”. When we are dealing with the local police, they deal with the local vulnerable people and they are saying if they arrest them, they will go to court, they are going to be fined, and they are going to come back and do the same crime again. Now I am hearing that the judges are starting to say, “What is the point?” Do you think that politicians’ power should be to make the judges send them back to a rehab or go for some of the stuff you are talking about? There are two questions: is the hamster wheel getting younger and can we as politicians ask the judges to do something different?

Assistant Chief Constable Johnson: The age thing is interesting. I think that statistically you will see this behaviour from all young people. Whether that is with alcohol, drugs or other risky activity, we will always see it. The activities being taken by these two gents in their jurisdictions are absolutely valid and a way of addressing that.

I have a slightly different view from the previous panel insofar as far too much is voluntary. Many of these people we are asking to make decisions at a point in their life when my view is—and I am a cop: are they really in a position to make those life-changing decisions and stick to them at that point in their life? With short-term sentences, we have heard that 11% unfortunately will pass away within that month.

Perhaps there is something in trying to drive down the level of drugs activity that exists within prison, a place where I believe society thinks it should not take place. Whether that is keeping the inmates passive, I don’t hold with that. I think that it should be free of drugs. If it is, we do need to make sure that if people go into prison, by the time they come



out they have had a full rehabilitation, not just a criminal justice rehabilitation but their health and life prospects.

Chief Inspector Kew: I would like to add that it is end to end. One in 11 adults consume a controlled drug. That is a significant market in supply and demand. Early and consistent education in primary schools and preparing school children for that transition period into secondary education are absolutely vital. They are the next market and some sectors that I have seen are sitting ducks. They are vulnerable to exploitation. The evidence that we are seeing from the Thames Valley scheme is that it shows significant success in diverting young people away from the criminal justice system through education, but it creates another opportunity for the education sector to take on diversion in order to reduce the number of school exclusions and the number of exploitable children and young people.

Q320 **Danielle Rowley:** The Committee was in Canada recently and we visited a safe consumption site and heard about the relationship that it has and that the health services have with the police. You said earlier, ACC Johnson, that you do not really think the model of almost turning a blind eye is a good model. If we were to overcome the legal barriers and have a safe consumption room in Scotland, what approach would Police Scotland take to ensure that it was safe?

Assistant Chief Constable Johnson: I think that Kevin has hit the nail on the head. These are vulnerable people who the police are sworn to protect. We have a sworn duty to protect these individuals within our society. We will do, as we do for all other vulnerable people. We will work with partners. If it is a legitimate facility, we will work with colleagues from the Scottish Drugs Forum, the health service, whichever agency they come from, to try to get the best outcomes for broader society.

Many of these people commit secondary crime. The possession and the drugs taking is one aspect of that. I can speak from experience and I am sure the gents either side of me can. When you are sitting in custody and somebody comes off these drugs, nine times out of 10 it is disbelief at what they have done. That is cold comfort if they have assaulted someone or they have stolen something. There is another victim out there. On behalf of society, we cannot keep pushing people through the hamster wheel. We have to start to shorten that learning cycle. It feels to me that we have reached that point where we are the fly that is flying into the light bulb so many times and getting burnt.

We have to be the generation that starts to say, "No, we can learn. It is working somewhere else". If that means building a relationship with partners and that person enters those facilities, starts to access mainstream services, starts to address their underlying issues, that has to be good for us because we are not putting them through expensive criminal justice processes. It is proportionate with the legitimacy that we seek as law enforcement of keeping the whole of our community safe.



Q321 Danielle Rowley: You said that there is not an area in Scotland that is not having a rise in drug deaths, but there must be different types of drugs in different areas and different types of drug use. Is this something where local authorities need to have a bigger role in how work is designed on the ground? It might be different in Durham from how it would be somewhere else.

Assistant Chief Constable Johnson: All partners are engaged in that. Our recent report on the profile had 45 different drug types. These are the drug types that are found in the post-mortem toxicology of drug deaths in Scotland: 45 different contributory drugs across the whole spectrum. In there you would expect that you would find alcohol as well. About 17% of people have alcohol in their system. There is a huge range of drugs right across the whole of the country and that is about availability, supply, the criminal patchwork and where they are getting their supply from, some of it medicinal and misuse of medicinal supply.

In terms of local authorities—this follows on from Jason’s point about early years, prevention, education, health provision, safe social spaces, the night-time economy and the day-time economy—there has to be a whole holistic approach. In Scotland we have an ideal opportunity. The leadership moved from criminal justice to health. What it now needs is that leadership and strategic approach that is outcome focused rather than performance focused. It sounds betwixt two places but if the outcome is preservation of life—and I don’t know how you put a measure on that in this instance—everything underneath then starts to see an improving picture. The police will find its role in that, which will clearly be about enforcement of the law, whatever that is, but it should be about preventing vulnerable people from falling victim to criminality and targeting those who cause the most harm.

Professor Stevens: Can I come in on this question of internationally how police services deal with the presence of a drug consumption room? In the UK it is not that much different from the legal challenges presented by a needle exchange being in a community, as many communities have. There are examples internationally where people have gone further. For example, 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. The research that is coming out of that is showing that has improved the relationship between the people who use drugs and the police in that area.

Two things should be mentioned. One is that that is good for people who are very highly victimised. People who have problems with drugs suffer rates of victimisation, including violent victimisation, that are far above the rest of the community.

The second is that that is a useful source of information for the police to do their work. For example, in Portugal when decriminalisation was being



decided upon, the police were initially quite reluctant because traditionally a very good source of information about the operation of the drug markets is people who are arrested for low-level drug offences. The police were afraid they would lose that intelligence. What they found was that by improving their relationship with people on the streets because they were not threatening them with arrest, they were still getting good intelligence that they could use to look at higher ranks in the market.

Decriminalisation provides a framework where the police can be clear about improving the relationship with these vulnerable communities that they are working with.

Q322 **Ross Thomson:** I know that you have touched on the county lines issue. My question is directed to ACC Johnson and it is about what Police Scotland is currently doing to reduce the supply of drugs in Scotland. You might be able to touch on some of the drug trafficking, whether that is opium production coming in from Afghanistan, cocaine production coming in from Columbia, which we know is at record levels, and what you are doing at ports and airports, and where vehicles are coming in, to try to reduce that.

Assistant Chief Constable Johnson: It is a broad spectrum and it is an ever-growing spectrum. We work very closely with colleagues south of the border on the county lines and where they originate and then come into Scotland. On an international level, the organised criminality in Scotland has a landscape that covers five continents. We work with the National Crime Agency and its network of liaison officers. We have good relationships with the FBI and the Drugs Enforcement Agency and our counterparts right around the globe in trying to target that.

Interestingly, one area that it would be remiss of me not to mention is that it is not unlawful to buy a pill press and the constituent parts for many of the drugs actually come in various levels of control. One of the things that we are seeing in Scotland is a real desire to provide pill presses. The benzodiazepine market—and I think a colleague may have touched upon it—seems to be trying to fill that void around some of the minimum unit alcohol pricing. We are seeing organised crime groups trying to buy pill presses, and it seems remarkable to me that an organised crime group can go out and buy a pill press. It is completely unregulated. Why would anybody want to provide a pill press that produces 40,000 tablets in 12 hours and then floods the market with illegal drugs?

Everything from the chemical precursors to the machinery to make the drugs in a usable format, right the way through to the importation and the exploitation that goes on in terms of that, including coercion of officials, is something that we are engaged in. We have some good examples. I think that you will have recently seen the Operation Engagement and Operation Escalade trials in Scotland. They are still very much ongoing operations targeted at the higher echelons. There is a lot more to do there.



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An approach that frees up some of our criminal justice activity—the officers on the ground—to support vulnerable people, still very much community based, but which then reemphasises and targets those causing the most significant harm, is going to challenge us. As I say, most of that effort is abroad. It is people who don't even reside in Scotland. Their money, their wealth, is amassed outside of Scotland but the harm is felt there. We have to do that alongside the National Crime Agency and other international partners.

Q323 Ross Thomson: The wider drugs trafficking industry would also involve money laundering, arms and modern day slavery. Could you touch on what Police Scotland is doing in those areas as well to help address the issue?

Assistant Chief Constable Johnson: Absolutely. One of the things that we do have in Scotland, as you will be aware, is the Scottish Crime Campus. There are 21 agencies represented there. We do an awful lot of work. One of the most recent partners that has joined us is the Department for Work and Pensions, where we saw vulnerable people being housed in locations and then basically being taxed for their benefits and their rent. That was alongside potentially the use of those people in the sex trade and also in the supply of drugs and being treated as a commodity themselves.

We have an approach in Scotland, because of the Scottish Crime Campus, where we have multi-agency tasking. You have already heard about Al Capone. I do not care which one of the 21 agencies in that room uses one of the pieces of the legislation that they have to bring an organised crime group to its knees as long as we do it. Whether it is the tax people—it is normally the tax people—who can get people or whether it is DWP or whether it is environment protection, whichever piece of legislation we can best use to bring that organised crime group down and then support the vulnerable people, the switch has been making sure that we are joined up with the local authorities and the health providers. That is where some of the challenges come around information sharing. It is difficult sometimes to share information other than anonymised, which is useless when you are talking about victims. It has to be personal.

Q324 Tommy Sheppard: I want to come back to this question of whether the current legal framework is a help or a hindrance to you dealing with the problem on the ground. The experiences from Portugal and elsewhere seem to suggest that if you do create a sector within drug use that is not criminal, or not criminalised, that allows law enforcement authorities more ability to focus on the elements of criminality in terms of supply routes and all the rest of it. Even the person who would advocate the most level of reforms, for example, would insist that the purpose of a legal regulated framework is to take action against people who operate outside it. If there were people who were trying to put stuff that was cut with poison on the streets, if they were trying to push to kids at school or whatever, you could focus energy on that. To what extent would a



change in the law assist you to prioritise your activity on the real criminal aspects of drug supply?

Chief Inspector Kew: For me, we need to look closely at the evidence of Portugal. It had 16 drug-related deaths last year, so clearly decriminalisation in that legal context is working. Emulating best practice from the Portuguese dissuasion committee model into our diversion scheme principles hopefully is working to reduce drug-related harm. For legislation, diversion does create better outcomes for the person, better outcomes for the police, freeing up resources, less demand, but also harm reduction and better outcomes for the individual concerned in the first place.

On regulated markets, my view is an open mind, really. We need to look closely at the evidence of Canada and how that pricing framework is going to impact and lessen the availability of harmful high-THC cannabis to younger people, for instance. That market will not go away in any regulated market, so it is how that model reduces harm to those risk groups. I am not a professional or expert when it comes to regulated models, I am afraid.

Superintendent Weir: The demand on the police from a lower level point of view around low-level crime and particularly drug-related offences is vast. There is the dichotomy between targeting the people, as the ACC said, who operate at the top level, who are not necessarily drug users but use it as a medium to make money, versus the massive demand that we have every day around all the other externalities that you get around mental health, alcohol and drug-related criminality. Thirty-two per cent. of our demand in Durham is crime related; the rest of it isn't. Lots of those people who are drug abusers and drug addicts are operating across the whole gamut, not just the criminal aspect. If we did some sort of decriminalisation, would we arguably reduce the demand at a lower level for the beat officers and our response cops? Yes, I think that we probably would.

Professor Stevens: I would like to add to that. As somebody who has written quite a lot about Portugal and its decriminalisation model, one of the most important things to remember about Portugal is that 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 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. The demand that you are talking about is from a group in society who have been excluded across the board and their criminality and their contact with the police is just one aspect of the way that they have been excluded. These are people who have been in care, suffered brain injuries, been excluded from school, are homeless. There is a whole range of issues and we have to deal with those people in their complex wholeness rather than just



saying we can solve this problem by stopping criminalising them. Yes, we should stop criminalising them but there are other things we need to do to support those people to live full and healthy lives.

Assistant Chief Constable Johnson: There is a public narrative as well that we would need to address. I think that you have heard evidence about the stigma, and 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. Most of the communities will know these people themselves. They see them as helpless, hopeless individuals within the community who should warrant the full support of all the social systems that can try to help these people overcome their health issues. While it remains the responsibility of the police and had remained the responsibility of the police, the only approach to dealing with that was through criminal justice. Any legislation that sees vulnerable people treated as a health issue—as people who need social support and health support—would be welcome.

Then there is the delineation to those who cause the harm, as I think the point was made. As for those who bring in the drugs, who do the cuckooing, the county lines, the mistreatment, the exploitation of vulnerable people in our society, any resources that we free up in one hand we should refocus on making sure that those people are brought to book and that the punishments reflect the harm they cause. At the moment, it does feel very white collar and has very little correlation. No drug dealer who has imported multi kilos of heroin ever gets a mention of the number of heroin-related deaths in their charges, but we should be talking about that. I believe that there is a direct correlation to the drugs that these people bring in unlawfully and the deaths that occur on our streets.

Q325 **Tommy Sheppard:** It sounds as if as senior police officers you would welcome a change of the law to allow you to reprioritise your actions.

Professor Stevens: I think so, yes.

Q326 **Chair:** I think that we are all really impressed with what is happening in both Durham and Thames Valley. Looking at some of your statistics and what we have heard from you, Chief Inspector Kew, what has been achieved is impressive and we congratulate you for what you are doing. I am wondering—for both of you—how what you are currently doing in operation and practice would differ from actual decriminalisation. It almost sounds like de facto decriminalisation. What would be different about how you would approach these operations if drugs, or cannabis particularly, were decriminalised?

Chief Inspector Kew: At the moment, the Thames Valley scheme still records the crime, hence we are not decriminalising. There is still a record of that intervention or interaction with the person involved. What the community resolution does is it affords an opportunity for that case



not to appear on a DBS check. When someone later applies for a job, it does not show up and destroy their future opportunities. Community resolution is within the current legal framework, as you know. I cannot imagine—this is hypothetical—that decriminalisation is much different from the dissuasion committee model that Portugal operates. It is a robust, proven and evidenced process.

Superintendent Weir: From my point of view, what we find with people who we arrest for drugs offences is that they have other issues. We take the view that we have to sort out all of those issues as well as the drugs. Our aspiration would be that we do not arrest people, we stop them on the street and divert them into the treatment that they need across the whole gamut of offences. We work with 300 partners to try to divert people. The cops have the ability to log on to see what diversions are available. Taking out the drug market would just mean that we would be able to deal with the people in a different way. Drugs would not be the factor that decriminalises them; it would be the other issues they have that we try to help.

Q327 **Chair:** In Scotland, of course, recorded police warnings is the model that has been adopted there. It does differ in a number of ways from what we are hearing from both of your colleagues. Would Police Scotland consider one of these schemes that have been outlined, Checkpoint or the—

Assistant Chief Constable Johnson: I think we have to. We have to look at the evidence base. One of the things that we do is this evidence-based policing. We have to look at what works elsewhere. Clearly, we have to liaise with the Lord Advocate and the Crown Office around what we can do because much of the practice is set through the devolved nature in Scotland. I think that Police Scotland can provide a track record of trying to be innovative, making approaches to the Lord Advocate to try to change our approach, which is to address and try to implement similar work that the gentlemen have introduced here. As I have said a number of times, because of the devolved nature in Scotland we have a better chance than anywhere else. We do not have the patchwork quilt—two forces out of 43. For us it is one force and one country.

Chair: That is what strikes me as immediately apparent. You have much more scope, I suppose, to manoeuvre and do these types of things differently with the devolved responsibilities in Scotland. We are speaking to the Scottish Government Minister and the Lord Advocate next week so we may be able to put that to them directly.

Q328 **Danielle Rowley:** One of the things that disappointed me when we visited the consumption site in Canada is that they had different bodies within the centre to help but they did not have anything targeted at women. I have seen through my own work in my own community women who are trapped in abusive relationships because they are addicts and that is where their supply is. We know from speaking to families that have been affected that there are a lot of different issues for women when you look at drug misuse. Are there any examples of good practice



that are going on where women are being helped or any recommendations or research that you might have done?

Chief Inspector Kew: I am aware of good practice within drug services that operate women-only spaces and women-only session times as well. That is a holistic approach to identify any domestic abuse elements of that, controlling an addiction, to promote health. Yes, there is good practice out there.

Superintendent Weir: From a Checkpoint point of view, we take domestic abuse offenders and victims as part of the scheme. It has been really successful, particularly with women who are offenders and victims. We have lots of evidence that we are busy writing up at the moment about why women commit offences for different reasons than men do. There is now a body of evidence around why they do that and it is some of the things you have suggested. Lots of stuff that women offend for is because they have no self-esteem because of relationships. Men do not seem to have that. The people who work for us to divert these people are trained in those skills to deal with women-specific offending.

Q329 **Danielle Rowley:** There is sometimes an extra barrier as well for women. We heard from a former drug user that she would never have reached out for help because of the fear of having her children taken off her. I think that creates an extra barrier for the police to connect sometimes with families as well.

Superintendent Weir: We work closely with social services when forming our contracts to understand that. In a lot of ways it works because it is a sword of Damocles: work with us, improve your life and you will not have your children taken off you. It seems to work. It has been one of the big successes of Checkpoint.

Q330 **Chair:** All these projects that you have seem to be operating within what I would not describe as a grey area but as an interpretation of the current legislation as defined by the Misuse of Drugs Act. Would that be a right characterisation, that you are able to do these things because you have looked at the legislation and you have decided that with your operational independence you are able to put forward these schemes?

Superintendent Weir: No, I think some years ago the Government changed, certainly in England, the ability for police to give out-of-court disposals, so it was a police decision to prosecute. That covers some serious offences as well as others and not just how we dispose of people.

Q331 **Chair:** What I am wondering is if they could give you this—and obviously you have a degree of operational independence—they could easily just take it away again, couldn't they? They could say, "Public opinion is such that we have to be tougher on drugs, we have to respond to a *Daily Mail* campaign" or something like that. All this could be taken away if they decided to do that.



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Professor Stevens: It already is being taken away for a particular group. The Home Office, for example, has made it clear that it will tolerate local police services working with drug-checking agencies at festivals, which largely deal with white, middle-class, young people, but it has said that it will not tolerate police services working with the drug consumption room in Glasgow, which is going to save the lives of mostly middle-aged, working-class people. I think that there is a real discrimination there.

Q332 **Chair:** I am wondering about the views of the police officers. Isn't legislation required? It is fantastic that you are able to do all these things within the interpretation of the law and some of your operational independence, but I am wondering where it rubs up against what the Government have as their objectives, approaches and policies.

Superintendent Weir: I think that there is a need for legislative change and that would help us dramatically.

Chief Inspector Kew: I was thinking about it from a different perspective. I think that the current climate gives an opportunity for innovation and any decision to implement a scheme within a local police force is a local operating one for that chief officer to make. What we do have to acknowledge and be very careful about, of course, is the postcode lottery effect of the current patchwork of schemes, such as our difference with Checkpoint.

Q333 **Hugh Gaffney:** With Checkpoint and the schemes you are all doing, has the Advisory Council given those to the Government to say, "Why are we not rolling this out?" Checkpoint has been going for three years now. It sounds like a good success story, so why is the Advisory Council not telling the Government and have the Government reacted to it?

Professor Stevens: The Advisory Council works on a mixture of being commissioned by the Government to look at things and also by choosing things it can on its own behalf take to the Government. There are some things we have taken the initiative to take to the Government. We tend to choose those on the basis of how much social harm we think is being created and how much evidence there is to use to provide an evidence base for the Government.

At the moment, the main priority that I can see is reducing drug-related deaths. We have taken evidence on that and produced reports on that and there is strong evidence on how you do that around opiate substitution treatment, heroin-assisted treatment and drug consumption rooms. At the moment, there has not been peer-reviewed evidence coming out of these schemes and there is not yet very strong evidence that these schemes on their own will save people's lives. That might occur, but at the moment we are seeing good indications of effect in reducing crime and being more effective than other forms of punishment. We are not yet seeing strong evidence, gentlemen, of saving lives, so it is a question of both the prioritisation of the issues that are being



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addressed and the amount of evidence that is available to use in advising the Government that has probably prevented us from doing a specific report on these types of schemes.

I have recently written a report for the Irish Government, which is looking at decriminalisation, and we have included some of the evidence that is coming out of the schemes. I am happy to share that report with you when it is freed up by the Irish Ministers.

Chair: We would be very interested, yes.

Q334 **Hugh Gaffney:** Just on that point, has Checkpoint improved over the three years? According to the figures, only 42% of the people who entered it have been saved. Is that percentage going up? Is that a time factor thing?

Superintendent Weir: Yes. Part of it has now been peer reviewed and it will continue to be. We ran a randomised control trial, which we are waiting for next year, that will have two years post-trial. I think that that will be evidence that is accepted. Indications are that there is a reduction in reoffending rates, but there is also a reduction, as self-scored by the people who go on to the scheme, so we improve their life chances and that seems to continue. The reoffending rate for the control group is going up while the treatment one is stabilising. I think that in the next year or so there will be some peer-reviewed evidence that would say that Checkpoint does work and it certainly works for drug offences.

Q335 **Tommy Sheppard:** I am intrigued by this question. We have representatives of two English forces in front of us and we have invited you here because you are doing interesting and innovative stuff. In each case, the PCC has given the political backing to this. What I am now curious about is whether or not you guys are on your own in the general view of operational police managers in this country or whether you think that among your colleagues in the other forces, who may not have the same particular schemes that you have in operation, the general feeling is that the 1971 Act now needs to be changed, repealed, overhauled or whatever. Would you say that? Of course, we see an awful lot of former police officers who, no longer constrained by office, are joining in the campaign for legislative change. Do you think it is now the settled view of the police service throughout England that the law needs to be changed? Steve Johnson, you presumably talk with colleagues in other forces. Do you think that this is something that should be reflected in Scotland if indeed it is a significant overall change?

Assistant Chief Constable Johnson: I was just thinking then for the Act to have come into force in 1971 means most of the work was probably done in the late 1960s. If you think back to the late 1960s—I am just about able to remember that—and the technological advances, the science advantages, the distribution networks, in many respects this one aspect of policing, and even the title “Misuse of Drugs” or the supply of drugs and the use of drugs within our society, if there is one area that



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is ripe for a refresh of the legislation and a refresh of the evidence base, I would suggest it is the Misuse of Drugs Act 1971.

Q336 **Tommy Sheppard:** Are your two forces the exception that proves the rule or are you out on a limb?

Superintendent Weir: No, from our point of view weren't alone. It is supported by the chief constable and it is supported by the PCVC in Durham. There are trial areas. The Ministry of Justice looked for four trial areas, which they have in West Yorkshire and other forces. There are also four other forces in the country that are currently running whatever their force's Checkpoint scheme is.

Not just in relation to drugs but across the whole critical pathways agenda and the diversion within the law, lots and lots of other forces are coming round to the issue that we have to do something different. If other people cannot do it, the police will have to do it in consultation with partners. Does that mean they all agree that there should be changes to the Misuse of Drugs Act? I guess lots of them do think there should. I don't know anybody who would say that, but it stands to reason that if you are trying to work with people to reduce the harms they are caused because they are vulnerable people themselves, lots of British policemen would think that you should reform it.

Q337 **Chair:** You obviously cannot speak on behalf of all the police forces across the whole of the United Kingdom, but does the Police Federation, for example, take a view on this? What is its current approach to the Misuse of Drugs Act? How would we get a view of the police force, if you want to call it such, across the UK on this issue?

Chief Inspector Kew: The federation has come out, I believe, for a public consultation on drug policy towards the health-based approach. That was at the last conference. Correct me if I am wrong on that.

Chair: We will see if we can locate that then.

Chief Inspector Kew: There is a national working group within the National Police Chiefs' Council for out-of-court disposals, which is what our scheme fits within and that of Checkpoint. There is an appetite nationally for change for a number of offences, not just drugs, and we are moving in that direction. If you collectively asked the opinion of most police officers, dare I say this but I think that there is a general appetite for a health-based approach to simple possession.

Assistant Chief Constable Johnson: I think that there is a national position with the National Police Chiefs' Council and the National Police Chiefs' Council lead could obviously provide that view on behalf of the police service as a whole.

What is interesting is that for the police service I think we are very good and where we are responsible and accountable we take the lead and we take the lead with pride and we get stuck in. We find ourselves in the



difficult position where we have been in the lead. All the informed wisdom is that this is a health issue, and one of the interesting things would be whether health is happy now to take the lead. We can talk about changes in the legislation from an enforcement perspective, but the health service will need a change in the legislation as a key enabler for it to do its work. Seeking the views of senior police officers and the National Police Chiefs' Council is one thing, but if this is going to be seen as a health issue rather than just the police saying it is, the health service is going to need an enabling framework.

Professor Stevens: That would imply a change in lead responsibility at UK level from the Home Office chairing the UK Drug Strategy Board to the Department of Health and Social Care chairing the Drug Strategy Board so that health is clearly in the lead.

Going back to an earlier question about evidence, I also think that if the Department of Health and Social Care was in charge of drug policy and co-ordinating drug policy across Departments, then the Department of Health has a more institutional commitment to the use of evidence and spending money wisely on the basis of evidence than does the Home Office. That would also have the effect of introducing a more evidence-based approach to drug policy if the Department of Health and Social Care was in charge of it rather than the Home Office.

Q338 **Chair:** We all remember the example of Professor Nutt when he was presenting his particular proposals to Government and the way that a press campaign was almost organised and orchestrated against what he was saying. Do you think we are still in that territory when it comes to the Home Office responding?

Professor Stevens: I hope not, but there has been a backward step recently in that regard.

Chair: Gentlemen, thank you ever so much. This has been another fascinating session. I think that we have asked for a couple of other bits of evidence that I am sure you will be able to supply us with. If there is anything that you feel you could usefully contribute to this ongoing inquiry, please get in touch with the Committee.