Written evidence submitted by Release (SDC0008)

Submission to the Scottish Affairs Committee - House of Commons

In response to the call for evidence entitled:

'Problem drug use in Scotland follow-up: Glasgow's Safer Drug Consumption Facility'

Submitting Organisations and Contacts:

Release - Release is the national centre of expertise on drugs and drugs law in the UK. The organisation, founded in 1967, is an independent and registered charity. Release provides free non-judgmental, specialist advice and information to the public and professionals on issues related to drug use and to drug laws. The organisation campaigns directly on issues that impact on its clients – it is their experiences that drives the policy work that Release does and why Release advocates for evidence-based drug policies that are founded on principles of public health rather than a criminal justice approach. Release is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations. Contact: niamh@release.org.uk

The Benzo Research Project is a young people-led non-profit which seeks to understand and improve the lives of young people who use benzodiazepines non-medically across the UK through research, policy advocacy, and advancing harm reduction education and support provision. Contact: hello@brp.org.uk

RATS - 'radical acts to survive', is a drug user union resisting the violence and neglect of the 'war on drugs' and organising for harm reduction and collective liberation. Contact: londonharmreduxrats@gmail.com

All three organisations are members of the **London Harm Reduction Collective**, a coalition of experts and groups committed to reducing drug-related harm in our communities.

Introduction

1. The submitting organisations are grateful to provide this report to inform the inquiry by the Scottish Affairs Committee, assessing the legal and policy challenges faced in establishing the pilot Safer Drugs Consumption Facility (SDCF) in Glasgow this year.

2. This submission concerns both the evidence for SDCFs and the legal framework for managing these facilities.

Questions

1. Why is a pilot Safer Drugs Consumption Facility (SDCF) being opened in Glasgow, and how is it intended to reduce harm from problem drug use in the area?

1a. What were the key legal, policy and political barriers to opening the pilot facility?

3. As the Committee is fully aware the drug-related death crisis in Scotland is acute, with an estimated fatality rate of 277 per million of the population [1] which is equivalent to the rates seen in the United States and Canada. That being said, drug-related deaths are increasing across all countries of the UK, in England & Wales there has been a 113% increase in fatalities in the last decade, and the North East of England has a drug-related death rate of 108.5 per million of the population.[2] This is a crisis for the whole of the UK, and SDCFs are a key part of a whole-systems approach to addressing this crisis. At the heart of this emergency are those whose lives have been lost, and the loved ones they have left behind.

4. That is why is so disheartening and distressing that UK governments, both present and past, allow for the barriers discussed below to continue; it is ultimately a political choice to prevent the establishment of SDCFs across the country, and it is the political that has been, and continues to be, the barrier to opening and scaling up these lifesaving facilities.

Below we outline the legal, policy and political barriers that were relevant to the opening of the pilot facility in Glasgow:

Legal - The facility's current legal position

5. There is no law specifically directed at prohibiting the existence of SDCFs and thus no definitive answer in any single legislative provision on the legal position of this or other SDCFs. As outlined at below, the legal position of the facility is ultimately a question determined by the collection of offences that may or may not arise in the course of using or running a SDCF, most obvious of which is simple possession. In the absence of the repeal of these offences, then, the position of the facility is, at law, no different from this general legal position. That is not to say the position is unchanged.

6. The key legal concerns articulated in the context of most discussions in respect of a potential safe consumption facility in the UK, centre on breaches of the Misuse of Drugs Act 1971 (MDA 1971).

[1] National Records of Scotland, 'Drug-Related Deaths in Scotland in 2023' (2024) https://www.nrscotland.gov.uk/publications/drug-related-deaths-in-scotland-in-2023
[2] Office for National Statistics, 'Deaths Related to Drug Poisoning in England and Wales: 2023 Registrations' (2024), https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2023registrations

7. Although Scotland maintains its own criminal legal system, with Scottish police and the Crown Office and Procurator Fiscal responsible for law enforcement, drug laws are set by Westminster. This creates a dynamic whereby any change in Scottish drug law (less reform at Westminster) has to be pursued through how the law is enforced, rather than through legislative reform or repeal.

8. In September 2023, the Scottish Lord Advocate Dorothy Bain KC, Scotland's most senior prosecutor, issued a statement on prosecution policy that indicated she would be prepared to publish a prosecution policy that it 'would not be in the public interest to prosecute drug users for simple possession offences committed within a pilot safer drugs consumption facility'[3].

9. The Lord Advocate clarified that '[T]he requested statement will not extend to any criminal offences other than possession of controlled substances, contrary to section 5(2) of the Misuse of Drugs Act 1971'[4]. The UK government later confirmed it would not intervene in any pilot pursued by the Scottish government.

10. Although the Lord Advocate's statement unlocked a key legal obstacle to a safer consumption facility, it should be noted that the provision of the MDA 1971 cited, and the prosecution policy not to prosecute those in contravention of it on the basis of public interest, is already employed across the UK in respect of extant drug services. For example, the Crown Prosecution Service of England and Wales has a similar policy in place to protect the users of needle and syringe programmes (NSPs), the policy also extends to staff of NSPs. The CPS policy states:

    "These schemes [NSPs] need police and CPS co-operation because those who run and use them will necessarily commit offences under the Act. It is therefore not normally in the public interest to prosecute:

    - *a drug user retaining used needles;*
    - *a drug user possessing sterile needles;*
    - *bona fide operators of schemes.*

[3] Lord Advocate Dorothy Bain KC's Statement on pilot safer drug consumption facility to the Crown Office & Procurator Fiscal Service, 11 September 2023, available at: https://www.copfs.gov.uk/about-copfs/news/lord-advocate-s-statement-on-pilot-safer-drug-consumption-facility/#:~:text=Lord%2520Advocate%2520Dorothy%2520Bain%2520KC,pilot%2520safer%2520drugs%2520consumption%2520facility.

[4] Ibid, https://www.copfs.gov.uk/about-copfs/news/lord-advocate-s-statement-on-pilot-safer-drug-consumption-facility/#:~:text=Lord%2520Advocate%2520Dorothy%2520Bain%2520KC,pilot%2520safer%2520drugs%2520consumption%2520facility.

Simple possession cases that are based on police surveillance at or near exchange centres should not normally be prosecuted. The need to prevent the spread of serious infections outweighs the normal requirement for prosecution."[5]

11. This illustrates that the issue of possession offences has been considered previously in relation to the provision of health and harm reduction services for people who inject drugs and is not a specific matter for the operation of a SDCF.

12. It also shows that when considering the public interest test the CPS have balanced the need to reduce blood-borne virus (BBV) transmission, and the attendant health harms of contracting HIV or Hepatitis, against the need to bring a prosecution for possession of a controlled drug. It is easy to see how these considerations are similar to the position taken by the Lord Advocate, and in fact the position of the CPS goes further by explicitly stating that possession cases occurring near NSPs "should not normally be prosecuted".

13. However, beyond the offence of possession, both the Home Office and the former Lord Advocate of Scotland (in his evidence to this Committee) articulated concerns as to the legal implications of a safer consumption room citing a broader range of provisions of the MDA 1971 which could be engaged[6], and in addition, a range of common law offences which could also be committed by users, staff and those operating the facility[7].

14. Release has previously provided the Committee with our views of former Lord Advocates' interpretation of the relevant law engaged in such a setting, available here. In relation to the Home Office and its view that the provision of a SDCF engages a range of offences, they have cited a list of potential offences that could be committed in the operation of such a facility[8] – we at Release wholly disagree with this analysis.

15. In his letter to the Committee the then Policing and Crime Minister, Kit Malthouse, states that the following offences **would** be committed by service users and staff:

[5] Drug Offences | The Crown Prosecution Service – see Needle Exchange Schemes and blood borne viruses
[6] (Former) Lord Advocate James Wolffe's oral evidence to the Scottish Affairs Committee, 9 July 2019, available at: https://committees.parliament.uk/oralevidence/9528/html/
[7] (Former) Lord Advocate James Wolffe's oral evidence to the Scottish Affairs Committee, 9 July 2019, available at: https://committees.parliament.uk/oralevidence/9528/html/
[8] Kit Malthouse MP's letter to the Scottish Affairs Select Committee, 5 November 2019, available at: https://committees.parliament.uk/publications/1271/documents/11031/default/

- *possession of a controlled drug;*

- *being involved in the supply of a controlled drug;*

- *knowingly permitting the supply of a controlled drug on the premises;*

- *encouraging and assisting an offence;*

In relation to potential legal risks the former Minister stated that they could involve:

- *manslaughter*

- *offences under other legislation (for instance, smoking)*

- *civil liability linked to negligence or "other civil causes of action"*

16. The issue of s5(2) MDA 1971 and the offence of possession has been dealt with above but in relation to the other offences cited by the former Ministers we deal with these below (some offences cited were also dealt with in the note provided to the Committee in respect of the previous Lord Advocate's evidence[9]).

17. - Being involved in supply of a controlled drug;

There is no reason users or staff would be involved in the supply of a controlled drug in a SDCF. Clear policies would be required to restrict the supply of a drug from one person to another in order for staff and managers to limit the risks that exist under s8 MDA 1971, as discussed below in relation to offences related to premises.

18. Amongst the hundreds of SDCFs globally only one facility in Zurich allows for the supply of drugs in the form of micro dealing, which operates within a strict policy that is agreed with local law enforcement.[10] Therefore, if supply was to occur on premises it would either be done with the permission of the local police, or lawfully permitted through legislative reform, in the absence of these permissions it should be prohibited.

19. - Knowingly permitting the supply of a controlled drug on the premises;

[9] UMD0044 - Evidence on Problem drug use in Scotland
[10] HRI (2022). Harm reduction services in Switzerland. Harm Reduction International. https://hri.global/wp-content/uploads/2022/11/Harm-Reduction-in-Switzerland_FINAL.pdf

This offence relates to s8(b) MDA 1971 which creates a liability for occupiers or managers of premises who commit an offence if they “knowingly permit or suffers” the “supplying or attempting to supply a controlled drug to another in contravention of section 4(1) of this Act, or offering to supply a controlled drug to another in contravention of section 4(1)”.

20. The risk of this offence being engaged is relevant to any premises where there is a risk of supply occurring, this could include nightclubs, bars, hostels, drug treatment services and is why all of these venues and facilities have policies to address this possibility. The risks around s8(b) MDA 1971 are not restricted to SDCFs but are a common issue managed by all those working in drug treatment and harm reduction services, and in wider services that support people who use drugs. As such, policies will be adopted and implemented to reduce the likelihood of supply on a premises, this may include an escalated warning system, being barred from a premises, or involving the police.
21. This is a risk that is already managed by those in the drugs sector and is one that could be easily managed by staff and managers of a SDCF.

22. - Encouraging and assisting an offence (please note the Serious Crime Act does not apply to Scotland);

The Serious Crime Act 2007 creates three separate offences, which can apply to all offences under the MDA:

a) Section 44: A person does an act that is capable of encouraging or assisting another person, intending to encourage or to assist that person to commit an offence;

b) Section 45: A person does an act that is capable of encouraging or assisting another person, believing that the offence by that person will be committed and the person believes that their act will encourage or assist in its commission; and

c) Section 46: A person does an act that is capable of encouraging or assisting the commission of one or more of a number of offences by another person, and believes (i) that one of more of those offences will be committed (without having any belief as to which particular crime); and (ii) that their act will encourage or assist the commission of one or more of them.

23. As outlined already, and in relation to supply risks (including permitting or suffering supply on a premises) policies should be put in place to mitigate this risk. In that

case, the risk of an offence being committed under sections 44 to 46 would be in relation to staff allowing people to be in possession of a controlled drug. However, there is little case law on these provisions as evidenced by the fact that there have only been 91 convictions for “encouraging or assisting in the commission of an either way offence believing it will be committed” in the last 14 years.[11]

24. In addition to the lack of case law outlining how these sections have been interpreted by the Courts, we would also refer the Committee to the public interest test outlined above in respect of possession offences, and the CPS guidance that already acknowledges that staff will necessarily be engaged in offences in the provision of NSPs. So whilst this is a potential risk for staff, it is unlikely it would be in the public interest to bring a prosecution on the basis that a SDCF worker “assisted” a person to “possess” a controlled drug through the running of a facility. In any event, if there was local police permission or amendments to the Misuse of Drugs Regulations that allowed for the lawful running of a SDCF these risks would be reduced significantly.

25. - manslaughter

The occurrence of an overdose death could have substantial implications for the DCR and its staff, although it is worth noting that this risk is extremely low if not negligible given the experiences of SDCFs that operate across the world.

26. If a death results from an unlawful act (e.g. injecting another) then there is the possibility of a charge of unlawful act manslaughter. A full analysis of the offence is not required, but in essence the offence involves: an unlawful act; intentionally performed; in circumstances rendering it dangerous; and causing death.

27. The unlawful act must be an offence, and a relevant example would be the injection of a service user by another, constituting an offence under the Offences Against the Person Act 1861.

28. The final element, of causing death, has been dealt with in substantial detail by the courts. Following R v Kennedy (No 2) [2007] UKHL 38, it is established that it would never be appropriate to find someone guilty of manslaughter if a Class A controlled drug was freely and voluntarily self-administered by a person who died as a result of

[11] https://assets.publishing.service.gov.uk/media/673dc6296d3c337b80acc483/outcomes-by-offence-june-2024.xlsx

that administration. In this case the unlawful act was the supply of heroin to an individual who died as a result of taking it.

29. However, the law in that case is restricted to circumstances where an individual self-administers the drug and does not extend to circumstances where another administers. It is important to note that the legal situation is different in Scotland. In Scotland, it has been found that a deliberate decision/act of reckless conduct by someone would not necessarily break the chain of causation against the individual who supplied it. In MacAngus [2009] ScotHC HCAC_8 the Scottish courts found that a jury, properly directed, could find the supplier of a controlled drug guilty of causing death, where that death follows as a result of the (now deceased) freely consuming the controlled drug. It does not go so far as to say they would be guilty, but that it would be open to the jury to decide this.

30. The case law cited related to the supply of a drug from one person to another where death occurred, given the discussion on supply above and the need to prohibit that activity the risk for a SDCF would be extremely low.

31. A further risk would be a manslaughter prosecution for assisting another with administration of a drug, on the basis of negligence because someone doing this takes on a duty of care to the person. Where that duty is breached (either by doing something or failing to do something), and this causes or significantly contributes to the person's death, that is gross negligence and so a crime.

32. The way of addressing this risk – and we would point the Committee to the extremely, almost rare instances of overdose fatalities in SCDF – is to have clear policies restricting the administration of a controlled drug by another.

33. - offences under other legislation (for instance, smoking)

Specifically addressing the prohibition of smoking under the Health Act 2006 can be dealt with by either not allowing the smoking of controlled drugs on the premises, permitting the activity through police or prosecutorial agreement (as with the wider activities of the SDCF) or amending the legislation. As we are not clear what "other offences" the Minister was referring to we have not gone into further detail but please see paragraphs 84 to 91 for discussion of civil issues.

34. - civil liability linked to negligence or "other civil causes of action"

Please see 84 to 91 for further discussion on civil matters.

35. Fundamentally, it is worth noting that the perceived legal 'barriers' are in fact policy choices; when Ministers state that SDCF's are unlawful that is a political position not a legal one, as it is within their powers to change the law.

36. Paraphernalia laws are also relevant to the operation of a SDCF. Section 9A of the MDA prohibits the supply of drug using equipment where a person believes that equipment will be used for the administration of a controlled drug (even if it is not used for that purpose). Exemptions to Section 9A are found in Regulation 6A of the Misuse of Drugs Regulations 2001 (MDR 2001) which allows for the supply of injecting equipment and related specific items used for injecting, as well as foil. The exemption only operates when the supply is occurring as part of "the legal provision of drug treatment services".

37. A SDCF would have to be operating lawfully in order to meet the legal requirements outlined in Regulation 6A, although this has not been subject to a legal interpretation the position of the Lord Advocate should provide legal cover. Additionally, staff of the SDCF should not provide equipment beyond what is exempted by the Regulations, unless they have police or prosecutorial permission to do so.

38. Beyond the Misuse of Drugs Act 1971 another legal and policy barrier is the fact that drug laws are reserved to Westminster. As highlighted above, Scotland maintains its own criminal legal system, and health is devolved to the Scottish Government. This means the Scottish government is in a position where they can direct health policies and spending in relation to drugs but cannot create a legally enabling environment for SDCFs and for people who use drugs, this is essentially creating the conditions to maximise engagement in services by reducing the fear, risk and stigma created by criminalising people.

39. The WHO[12], UNAIDS[13] and a range of other UN agencies have repeatedly called for the end of the criminalisation of people who use drugs in part to create an

[12] World Health Organization, "Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations," 2016. Available at: https://iris.who.int/bitstream/handle/10665/246200/9789241511124-eng.pdf?sequence=8.
[13] UNAIDS, "Global AIDS Strategy 2021-2026," 2021. Available at: https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf

environment where people can access the support, they need in recognition that the risk of detection and criminalisation can act as barriers to that support. It is the position of the Chief Executive Board of all the UN agencies, that the UN supports decriminalisation of drug use and possession.[14]

40. In Release's view, drug laws should be devolved to Scotland to allow for a more coordinated approach nationally.

41. Given the position of the DCR is based in procedural policy, rather than legislative change, its position should not be mistaken as de jure decriminalization of simple possession or of DCRs. It is therefore better described as 'depenalization' (the "reduction of the use of existing sanctions [...] a de facto intervention because it does not require changes to legislation"[15]). Appreciating this distinction is crucial to understanding some of the broader issues presented by the facility's legal position.

42. Depenalization approaches, such as non-prosecutorial policies like this, have benefits, chiefly the speed at which they can be implemented when compared to longer legislative processes. But there are also well-observed shortcomings insofar as they "leave considerable interpretation and discretion to various actors, creating vulnerability to inequitable application and uncertain outcomes for people who use drugs"[16].If, for example, it is not in the public interest to prosecute "an individual attending the Facility" for a simple possession offence, it follows that it is not in the public interest to prosecute an individual on route to that facility, given the distinction between the activities could be as little as a few metres.

43. However, the statement is clear that the policy extends only to "cases where the controlled substance is recovered within the Facility"; meanwhile, simple possession offences "detected outside the Facility" will be reported to the Procurator Fiscal to determine whether it is in the public interest to prosecute. As a result, for an individual accessing the facility, in the course of their visit their legal position is uncertain.

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[14] United Nations System Chief Executives Board for Coordination, "UN System Common Position on Drug Policy," 2018. Available at: https://unsceb.org/sites/default/files/2021-01/2018%20Nov%20-%20UN%20system%20common%20position%20on%20drug%20policy.pdf

[15] Stevens, A., Hughes, C. E., Hulme, S., & Cassidy, R. (2022). Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession. European Journal of Criminology, 19(1), 29-54. https://doi.org/10.1177/1477370819887514. Available at: https://journals.sagepub.com/doi/10.1177/20503245241239200

[16] Greer, A., Bonn, M., Ritter, A., Shane, C., Stevens, A., & Tousenard, N. (2021). How to decriminalize drugs: the design features of a non-criminal response to the personal possession of drugs. CrimRxiv. https://doi.org/10.21428/cb6ab371.8d4b953c. Available at: https://www.crimrxiv.com/pub/8qgki9ur/release/1

44. As noted, there is no equivalent statement in the Lord Advocate's January 2025 policy as that which can be found in the CPS policy ("simple possession cases that are based on police surveillance at or near exchange centres should not normally be prosecuted").

Political

45. The UK government's current drugs strategy frames people who use drugs as "addicts";[17] a term with derogatory connotations, framing problematic relationships to drug use (often described as 'substance use disorder') as a negative and immoral individual characteristic.[18] Such language, pervasive both in political and media portrayals of drug use, produces implicit biases that reinforce stigma and can undermine the implementation and effectiveness of, and engagement in, public health and social strategies.[19] From Harm to Hope's aim of "breaking down stigma" is incongruent with the strategy's own portrayal of drug use as simultaneously a crime — for which there should be zero tolerance — and a chronic health issue requiring a "world-class treatment and recovery system".[20]

46. Recovery in the context of drug policy is a contested approach.[21] The notion of recovering to a state of health implies a diseased state, reinforcing the medical model of drug dependence. While some use abstinence and recovery interchangeably, others describe abstinence as making a personal choice for improved health and societal contribution.[22] The latter approach takes a more person-centred stance but continues to moralise recovery to becoming a 'good citizen'. Such individualised framing ignores the socioeconomic contributors to problematic relationships with drugs, thus marginalising people who do not conform to the normative form of recovery.

47. Harm reduction evolved as an alternative strategy to abstinence-only interventions, directed towards reducing the harms associated with drug use.[23] Harm reduction

[17] UK Government, "From harm to hope: A 10-year drugs plan to cut crime and save lives", 2021. https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives
[18] Shatter Proof, "Addiction Language Guide", available at: https://www.in.gov/recovery/files/Stigma-AddictionLanguageGuide-v3.pdf
[19] Kelly, Saitz & Wakeman, "Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an "Addiction-ary"". *Alcoholism Treatment Quarterly*, 2016, 34(1), 116–123. https://doi.org/10.1080/07347324.2016.1113103
[20] UK Government, "From harm to hope".
[21] Kelly, Saitz & Wakeman, "Language, Substance Use Disorders, and Policy".
[22] McNeil, "Recovery rhetoric: a critical discourse analysis of substance use recovery". *Critical Discourse Studies*, 2022, 20(4), pp. 396-414. https://doi.org/10.1080/17405904.2022.2072920
[23] "Harm reduction: An approach to reducing risky health behaviours in adolescents". *Pediatrics and Child Health*, 2008, 13(1), pp. 53–56. https://doi.org/10.1093/pch/13.1.53

initiatives, such as SDCFs, can function as low-threshold interventions offering pathways to health and social care services while fostering connection and community empowerment. These spaces can address the alienation and despair that underpin drug-related harm, offering proactive solutions to systemic neglect. Though the Scottish Government's National Drugs Mission Plan departs from Westminster's strategy in committing to a more harm reduction and human rights-focused framework,[24] their ideological differences and the limitations of devolved legislative power (as discussed at paragraph 36) have made implementation challenging.

48. The opening of Glasgow's SDCF is a prime example of stigmatising narratives impeding the implementation of evidence-based public health interventions. A 2019 analysis of news media coverage of this proposal highlighted differences in representations of the 'problem' of injecting drug use depending on underlying assumptions (e.g. harm reduction versus recovery).[25] While proponents positioned the SDCF within a discourse of public health, abstinence and recovery rhetoric was employed in arguments against — the latter of which underpinned the UK Government's rejection of proposals.[26]

49. Negative terminology used to describe people who inject drugs and SDCFs was commonly found in articles that rejected SDCFs, but also in articles in support of the proposal. This normalisation of moralising and othering people who use drugs further embeds abstinence and recovery as a priority, if not the only option for people who use drugs, despite clear evidence that harm reduction interventions such as SDCFs effectively improve health outcomes and access to traditional treatment services.[27]

50. Such evidence in support of changing drug policy in the UK is often avoided through a "moral sidestep" towards normative claims based on conservative morality.[28] Indeed, in spite of their previous acknowledgement of the international public health benefits

[24] Scottish Government, "National Drugs Mission Plan: 2022-2026", 9 August 2022, ISBN: 9781804357095, available here: https://www.gov.scot/publications/national-drugs-mission-plan-2022-2026/
[25] Atkinson, McAuley, Trayner & Sumnall, "'We are still obsessed by this idea of abstinence': A critical analysis of UK news media representations of proposals to introduce drug consumption rooms in Glasgow, UK". *International Journal of Drug Policy*, 2019, 68. pp. 62-74. ISSN 0955-3959
[26] (Former) Minister for Crime, Safeguarding and Vulnerability Victoria Atkins' letter to the ACMD on drug consumption rooms, December 2017, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699825/Letter_from_Victoria_Atkins_MP_to_OBJ.pdf
[27] Timothy W Levengood et al., 'Supervised injection facilities as harm reduction: a systematic review'. *American Journal of Preventive Medicine*. 2021;61(5):738-49. doi:10.1016/j.amepre.2021.04.017
[28] Stevens, "'Being human' and the 'moral sidestep' in drug policy: Explaining government inaction on opioid-related deaths in the UK". *Addictive Behaviors*, 2019, 90, pp. 444-450. https://doi.org/10.1016/j.addbeh.2018.08.036

of SDCFs,[29] the Home Office's letter to the ACMD following the UK government's rejection of the 2017 Glasgow proposal cited legal, ethical, and law enforcement difficulties, while emphasising their commitment to "treatment and sustained recovery".[30]

1b. How can the medical effectiveness or impacts of the pilot facility be measured, and what does 'success' look like?

51. Success measures for the pilot facility could include reduction in overdose deaths, reduced public drug use and drug-related litter in surrounding areas, as well as reduced BBV transmission, and increased voluntary access to health and social care support.

52. Researchers have found that safer consumption sites can reduce and reverse overdoses, reduce injecting risk behaviours, and increase the uptake of drug treatment and health and welfare services.[31] They have also invariably concluded that safer consumption sites are particularly impactful for people experiencing situations of marginalisation and vulnerability.

53. A proof-of-concept, unsanctioned service which operated in Glasgow in 2020–21 successfully intervened in nine overdoses and successfully supervised 894 injecting events providing support and safety to its clients.[32]

54. Reduction in overdose death and increased access to additional services are both measures which should be taken carefully, utilising a comparative model which evaluates the area where the pilot is located against similar areas, as both measures are dependent on factors which the pilot programme does not have direct control over (trends in the illicit drug market and barriers to entry into local services, respectively).

[29] Home Office, "Drugs: International Comparators", October 2014, available here: https://assets.publishing.service.gov.uk/media/5a7d509de5274a33be6486e5/DrugsInternationalComparators.pdf
[30] (Former) Minister for Crime, Safeguarding and Vulnerability Victoria Atkins' letter to the ACMD on drug consumption rooms.
[31] Alex Stevens et al., 'Overdose prevention centres as spaces of safety, trust and inclusion: a causal pathway based on a realist review'. *Drug and Alcohol Review*, 43:6 (2024), 1573-91. doi:10.1111/dar.13908
[32] Gillian W Shorter et al., 'The United Kingdom's first unsanctioned overdose prevention site; A proof-of-concept evaluation'. *International Journal of Drug Policy*. 104:103670 (2022). doi:10.1016/j.drugpo.2022.103670

55. Success measures should also include net improvement in the quality of life of the people utilising the site. This can be captured through using an indicator assessment such as the World Health Organisation Quality of Life (WHOQOL) at the first visit and then in follow up visits. This recommendation is in line with recommendations for individual data collection on entry into an SDCF as mentioned in the DrugScience piece "Overdose Prevention Centres, Safe Consumption Sites, and Drug Consumption Rooms: A Rapid Evidence Review" [Shorter et al., pp. 115].

1c. What lessons can be learned from international contexts, when considering the medical effectiveness of the facility?

56. Evidence gathered from SDCFs internationally supported that these facilities are medically effective, if measured as improvement in health, increased prioritisation of health, or increased access to health services [Shorter et al., pp. 35]. They can also be considered medically effective in that they reduce HIV and hepatitis C transmission (source).

57. A 2021 review of 22 studies found that safer consumption sites are linked to 'significant reductions in opioid overdose morbidity and mortality, significant improvements in injection behaviors and harm reduction, as well as access to drug treatment programs'.[33]

58. A 2023 evidence review of 570 publications on safer consumption sites found a high willingness amongst people who use drugs to make use of safer consumption sites,[34] particularly amongst people in vulnerable situations and at highest risk of experiencing drug use harms. They summarised evidence that such sites help manage and reverse overdoses, lead to safer use practices, and facilitate access to wider healthcare and social services.

[33] Timothy W Levengood et al., 'Supervised injection facilities as harm reduction: a systematic review'. *American Journal of Preventive Medicine*. 2021;61(5):738-49. doi:10.1016/j.amepre.2021.04.017
[34] Gillian W Shorter et al., 'Overdose prevention centres, safe consumption sites, and drug consumption rooms: A rapid evidence review'. Drug Science. (2023). https://www.drugscience.org.uk/overdose-prevention-centres-safe-consumption-sites-and-drug-consumption-rooms-a-rapid-evidence-re

59. A 2024 review of 391 publications found that safer consumption sites 'enable people who live with structural violence and vulnerability to develop feelings of safety and trust that help them stay alive and to build longer term trajectories of social inclusion'.[35]

60. One additional lesson which can be learned from international contexts is that an increased level of involvement and decision-making power held from peers can improve the medical effectiveness of these facilities.

61. One ethnographic study of a peer-led SDCF in Canada showed that peer knowledge of injection techniques was critical to the reduction in HIV transmission risks.[36] Peer involvement is not simply valuable for advertising a SDCF or building trust with potential service users (although it also has that value) but also peers often have specific knowledge of risk management tactics and community-specific language and practices which is vital to promoting behavioral change for better health amongst SDCF service users.

2. What is the current legal position of the SDCF in Glasgow?

62. There are several issues, including in respect of civil liability, that could be presented by the current legal position of the facility or of any DCR seeking to establish itself. However, these legal issues should not be over-exaggerated so as to seem unmanageable, nor should they be treated as an insurmountable barrier to the continuation of this facility or the establishment of further DCRs. Please note the discussion of legal risks under the MDA 1971 at paragraphs 5 to 38 are relevant to the current legal position.

63. The majority of the legal issues presented below are not unique to DCRs and can be mitigated through clear and robust internal policies and procedures, even where the relevant offences are not repealed. As outlined at paragraphs 98 to 101, however, the best approach in regard to the legal position of this facility and others would be decriminalization of all relevant MDA offences and a clear legal framework for the lawful operation of DCRs.

[35] Alex Stevens et al., 'Overdose prevention centres as spaces of safety, trust and inclusion: a causal pathway based on a realist review'. *Drug and Alcohol Review,* 43:6 (2024),1573-91. doi:10.1111/dar.13908
[36] McNeil, Small, Lampkin, Shannon & Kerr, ""People Knew They Could Come Here to Get Help": An Ethnographic Study of Assisted Injection Practices at a Peer-Run 'Unsanctioned' Supervised Drug Consumption Room in a Canadian Setting". *AIDS and Behavior*, 2024, 18, pp. 473–485. https://doi.org/10.1007/s10461-013-0540-y

2a. Is the SDCF's current legal position sustainable to enable the effective operation of the facility in the long-term?

64. There are certainly tensions that exist in relation to the Lord Advocate's Guidelines, policing practices and the operation of the SDCF. The current position is that the possession of drugs is only tolerated on the premises through a non-prosecutorial approach, with the Lord Advocate's guidance explicitly stating "possession of drugs within the Facility will remain a criminal offence"[37]. The Guidance also states, "the statement of prosecution policy does not extend to individuals on their way to and from the Facility".[38]

65. The assumption must be that by taking a non-prosecutorial approach, police will de-prioritise policing of people accessing the facility although it is too early to know if this will be the case. However, the situation still remains that people both in the SDCF and those making the journey to the facility will inevitably be in contravention of the law as they are in possession of a Class A controlled substance.

66. That being said there is a separate guidance from the Lord Advocate on dealing with possession offences, which is relevant to the operation of the SDCF and is instructive in understanding the impact of prosecutorial guidance on policing practices.

67. In 2021, the Lord Advocate extended the use of recorded warnings to possession of Class A drugs, previously they had only applied to Class B and Class C drugs.[39] Meaning in practice police are now able to issue a warning for possession of any controlled drug, as opposed to arresting and charging a person for this offence.

68. Unfortunately, there does not seem to be a central recording of the use of warnings - the only Government analysis is a general overview that found that the use of warnings increased by 5% between 2021/22 (year of policy change) and 2022/23, but there is no breakdown on what offences resulted in the increase.[40]

69. Release submitted a FOI to Police Scotland in 2024 asking for a breakdown of police recorded warnings by demographics and drug type over a four-year period, the request was largely refused, with the response stating that the data is only held over

[37] https://www.copfs.gov.uk/publications/lord-advocate-s-guidelines-safer-drug-consumption-facility/html/
[38] https://www.copfs.gov.uk/publications/lord-advocate-s-guidelines-safer-drug-consumption-facility/html/
[39] https://www.copfs.gov.uk/about-copfs/news/lord-advocate-statement-on-diversion-from-prosecution/#:~:text=I%20have%20considered%20the%20review,for%20all%20classes%20of%20drugs.
[40] https://www.gov.scot/publications/criminal-proceedings-scotland-2022-23/pages/14/

a two-year period, and even then we were only provided with data for 12 months. The data was only broken down by age, no further demographics were provided nor was drug type.

70. Data from a separate FOI found that in 2020/21, 6371 recorded warnings were issued for offences under the Misuse of Drugs Act (presumably for Class B and C drugs as that was the policy at the time, in 2021/22 this fell to 5,312 warnings and in 2022/23 it was 6738 warnings. Unfortunately, this is not broken down by Class of Drug.

71. This lack of data on police recorded warnings means it is difficult for us to understand how the Lord Advocate's policy is working in practice; a similar challenge will exist in relation to the Guidance relating to the SDCF.

72. There is some data on court proceedings where community disposals and custodial sentences are issued for convictions, broken down by offence type - for drugs possession offences are reported separately.[41] That data shows that there was approximately a 50% fall in the number of community orders issued for possession of drugs after the Lord Advocate's statement, from 206 orders in the quarter prior to the policy change to 107 orders in the following quarter (it has remained in the low one hundreds each quarter since).[42] However, this data does not provide information on other types of disposals or proceedings being taken.

73. To fully understand how the Lord Advocate's Guidelines for the SDCF, and in relation to possession offences, will operate in practice more data needs to be provided, and the experience of those subject to drugs policing needs to be part of building a picture of what is working and what is not.

74. Ultimately though it is hard to see how the current position is sustainable. Many SDCFs internationally operate with clear guidelines on how to police these facilities, including the need for tolerance zones in the area around the facility; some

[41] https://scotland.shinyapps.io/sg-criminal-disposals-dashboard/
[42] https://scotland.shinyapps.io/sg-criminal-disposals-dashboard/

jurisdictions also have policies that provide protection for people travelling to the sites.[43] [44]

75. However, even if there were legislative changes (please see paragraphs 101 to 106) to allow for the legal operation of a SDCF there would still be challenges in policing these facilities if possession remains a criminal offence. As such, decriminalisation of possession offences - as previously recommended by the Committee[45] - is fundamental to maximising the effective operation of a SDCF, and to ensuring that people who could benefit from the facility feel confident to access it, without fear of arrest or prosecution (please see paragraphs 98 to 101 on decriminalisation).

2b. How would the Lord Advocate's decision that it would "not be in the public interest" to prosecute users or facilitators of Glasgow's SDCF operate in practice?

76. The Crown Office and Procurator Fiscal Service has published Guidelines in relation to the reporting of offences detected within the Glasgow Health and Social Care Supervised Drug Consumption Facility. These Guidelines outline 'General Principles' of the policy, which, as already highlighted, includes that possession of drugs within the facility remains a criminal offence.

77. The Principles continue with further indications of how the prosecution policy might operate in practice, detailing that:

    - *In no circumstance should drugs seized by police be returned to an individual;*

    - *The statement of prosecution policy does not extend to individuals on their way to and from the Facility;*

[43] Folketinget. (2012a). (Høringsnotat til Folketingets sundheds- og forebyggelsesudvalg om forslag om ændring af lov om euforiserende stoffer (stofindtagelsesrum)) Law no. 185, appendix 1, May 7th, Brief about hearing to the health- and prevention committee of Folketinget about proposal to change the Law on Euphoriant Substances (drug consumption rooms). Sundheds- og forebyggelsesudvalget; Folketinget. (2012b). (L 185 endeligt svar på spørgsmål 15]. July 1st 2012) Law 185 final answer to question 15. Sundheds- og forebyggelsesudvalget; Folketinget. (2024). L 179 Forslag til lov om ændring af lov om euforiserende stoffer. (Tydeliggørelse af advarselsreglen og ændring af ordningen om fritagelse fra strafforfølgning i tilknytning til stofindtagelsesrum). L 179 Proposal for an Act amending the Act on Euphoriant Drugs. (Clarification of the warning rule and amendment of the scheme on exemption from criminal prosecution in connection with drug consumption rooms). Sundheds- og forebyggelsesudvalget.

[44] Shorter GW, McKenna-Plumley PE, Campbell KB, Keemink JR, Scher BD, Cutter S, Khadjesari Z, Stevens A, Artenie A, Vickerman P, Boland P. (2023) Overdose prevention centres, safe consumption sites, and drug consumption rooms: A rapid evidence review. Drug Science. pureadmin.qub.ac.uk/ws/portalfiles/portal/530629435/DS_OPC_Report_V4.pdf

[45] https://publications.parliament.uk/pa/cm201919/cmselect/cmscotaf/44/4402.htm

- *The Facility, and the surrounding areas, do not represent a "tolerance zone" for any type of offending;*

- *The statement does not apply where the possession of the controlled substance is indicative of an individual's intention to supply (or be concerned in the supply) of a controlled substance; and that*

- *Police officers retain the ability to investigate all suspected offences as appropriate.*

78. The Principles both illuminate and confuse when attempting to predict their practical application; one might query if there is no 'tolerance zone' what exactly is being afforded by the change. We understand the *theory* in wanting to emphasise and discourage any perception of laxity in the vicinity, but it must be accepted that it does not seem possible to implement the policy without, in fact, some degree of tolerance in practice. You cannot concurrently invite the use of a facility for the consumption of drugs without risk of prosecution for possession and at the same time suggest that there will be no tolerance for possession offences whilst travelling to said facility.

79. If would-be facility users feel they cannot travel to it without being able to safely rely on the prosecution policy, it defeats its objective; users have no alternative but to travel to the facility with their drugs. We are not aware of any further guidance or indication as to what sort of distance, or radius, might be considered when weighing up a potential prosecution.

80. The Guidelines continue: '[w]here officers detect a s5(2) possession offence and seize a suspected controlled substance, they should submit a request for advice and direction to the Procurator Fiscal' that '[t]here is no requirement for a forensic analysis to be completed, but the suspected nature of the drugs seized should be noted in the request' and that '[t]he connection between an alleged offence and the Facility must be clear from the content of the request.

81. In practice, we anticipate an amount of trial and error in respect of requests to the Procurator Fiscal for advice and direction - likely in respect of distances of travelling users and of quantities being considered possession rather than supply. It is crucial that data on police activity and prosecution decisions in respect of the SCDF are recorded and made publicly available, we would also recommend that a similar

approach is taken in respect of the non-prosecutorial policy in respect of possession offences.

- What issues could be presented by the facility's current legal position, including in respect of civil liability?

82. There will be no novel civil liabilities that arise in relation to this facility. If there is a perception of SDCFs as highly vulnerable to civil liability, this may stem from a preconception that SDCFs are more prone to cause harm, carry unmanageable levels of risks, or cannot be run effectively and safely – preconceptions that are all unsupported by the existing evidence-base.

83. Many of the risks that SDCFs could present in relation to civil liability are already managed by existing drug services, needle and syringe programmes, and homelessness hostels.

84. For example, many of the activities involved in running a SDCF, whether it be supplying sterile syringes or responding to an overdose, are already undertaken in multiple other settings where that risk is managed. Indeed, perhaps the most 'intrusive' of interventions that a staff-member may be required to perform in a SDCF would be to administer naloxone, which reverses an opioid overdose and which is an intervention that any layman is already permitted to administer to save a life in an emergency[46].

85. Thus any issues of civil liability should not be overstated or be used to argue against the existence of SDCFs.

Negligence / employers' liability / occupiers' liability under the Occupiers' Liability (Scotland) Act 1960

86. Liabilities may arise under negligence, employers' or occupier's liability, or nuisance, however, as stated, the risk of these liabilities arising are not unique to SDCF.

87. Naturally, it will be necessary for any SDCF to ensure a safe environment for those using the SDCF. The risks related to this have been previously framed as preventing a SDCF, for example in Kit Malthouse's 2021 letter on the topic, in which the risk that an individual could be liable for "damages in negligence should an individual suffer

[46] See Regulation 238. Available at: https://www.legislation.gov.uk/uksi/2012/1916/regulation/238/made

harm or die in the operation of a SDCF"[47]. The mere fact of harm or death in a SDCF does not give rise to liability under negligence.

88. A negligence claim would necessarily demand a breach of the specific duty of care and legal and factual causation of the damage, and the chance of a breach would be mitigated by clear protocols, trainings, proper staffing, or signing of waivers, as is the approach in the Insite SDCF in Canada[48].

89. Liability may arise for personal injury if, for example, incorrect advice were given to people accessing the site, however again this risk is mitigated through proper training, and staff employed in drug services and harm reduction programmes already routinely offer safe injecting training to people using drugs. Liability that may arise under OL(S)A due to issues with the site itself could likewise be managed through proper protocols for the disposals of syringes and clinical waste.

90. Naturally, it will be necessary for any SDCF to ensure a safe working environment for those staffing the SDCF. Those running a SDCF will have a duty of care to ensure a safe system of work for staff, which will extend to mitigating the risk of foreseeable harm and ensuring proper training and supervision for staff, as well as a duty to provide adequate and safe material and equipment.

91. In the context of a SDCF, this would take the form of clear protocols on the disposal of any controlled drugs that are found, provisions of sharps bins, and clinical waste facilities. Again, much of this will be informed by the wealth of experience already available in existing drug services and harm reduction programmes and thus does not present a significant issue.

Anti-social behaviour and nuisance

92. There may be risks to the SDCF of closure notices or closure orders (the Anti-Social Behaviour Crime and Policing Act (England and Wales) 2014 or the Antisocial Behaviour etc (Scotland) Act 2004 in relation to the facility in question). In Scotland, these can be obtained where there is "antisocial behaviour on the premises" and "the use of the premises is associated with occurrence of relevant harm", meaning

[47] Available at: https://www.parliament.scot/chamber-and-committees/committees/current-and-previous-committees/session-6-criminal-justice-committee/correspondence/2022/drug-consumption-rooms
[48] Fortson, Rudi, Setting Up a Drug Consumption Room Legal Issues (October 28, 2017). Queen Mary School of Law Legal Studies Research Paper No. 262/2017, Available at SSRN: https://ssrn.com/abstract=3061235

significant and persistent disorder or nuisance to the public[49].That is unlikely to be a fatal risk to DCRs and there is no reason to suspect they would pose a greater risk than drug and alcohol services, which exist across the U.K..

93. If anything, DCRs can address concerns of the public relating to public drug use and allegations of antisocial behaviour, in providing people who cannot use in private, whether because of being excluded from public settings or being without stable housing, with a private space in which they can use their drugs. DCRs are not associated with increases in crime; indeed, research has shown that, in one locality of a DCR, there were no increases in drug trafficking or assault but in fact a decrease in vehicle break-ins and thefts[50]. Much the same can be said regarding the risk of claims for private nuisance, which can be easily mitigated through procedures to manage noise and footfall, as with any facility that is public-facing.

2c. What implications does the facility have for local policing?

94. This has been addressed above.

3. What does a long-term, sustainable legal framework for a SDCF look like?

3a. What legal and/or policy changes would be required from the UK Government to implement such a model?

95. The current legal basis for this facility, and others, is uncertain; it would benefit greatly from clarity to ensure that SDCFs can be established, ensuring the longevity of facilities that give respect and dignity to people using drugs and reduce their vulnerability to death and drug-related harms. The current framework for the Thistle does not directly facilitate the creation of other SDCFs or of longer-term projects, as the Lord Advocate's policy is clear in stating that it is limited to this pilot project.

96. Any framework based on discretion or policy, rather than a legislative footing, risks being unwound by changes of government, at great expense to individuals and the public. In Vancouver, Canada, for example, the SDCF Insite initially came into being through an exemption provided by the federal government; following a change of

[49] See Part 4: Closure of premises. Available at: https://www.legislation.gov.uk/asp/2004/8/part/4
[50] Wood, E., Tyndall, M. W., Lai, C., Montaner, J. S. G. and Kerr, T. (2006), 'Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime', Substance Abuse Treatment, Prevention and Policy 4, pp. 1–4.

government, a policy approach risked the closing of Insite, despite extensive evidence of its success[51].

97. The survival of Insite was guaranteed by a Supreme Court judgment in its favour, which observed that the facility had been "proven to save lives with no discernable negative impact on the public safety and health objectives of Canada" and that its potential closure "prevented injection drug users from accessing the health services offered by Insite, threatening their health and indeed their lives"[52]; however, the episode nonetheless serves to illustrate how discretionary, procedural, or policy-based approaches to SDCFs are volatile to political change, which can risk the lives of people who use drugs and disrupt the public benefits of SDCFs.

98. A long-term, sustainable legal framework for a SDCF would be one that creates a legally enabling environment for urgent harm reduction initiatives such as this, rather than one that obscures its legal position or hinders its creation. A key part of this would be implementing drug decriminalisation, which would involve repealing a number of offences in the Misuse of Drugs Act, including drug possession and paraphernalia supply offences.

99. Decriminalisation of drug possession would remove some of the barriers to accessing harm reduction services, as well as creating an environment in which SDCFs can more safely operate.

100. Decriminalisation of personal possession was a recommendation of the House of Commons Scottish Affairs Committee in its 2019 report into problem drug use. The case for decriminalisation is outlined at Chapter 5 of that same report, as well as in numerous other studies[53]. Decriminalisation would go some way to ensure that people using and running DCRs are not at risk of prosecution or of being disrupted from doing life-saving work.

101. Crucially, decriminalisation of the relevant MDA offences would be one part of a long-term, sustainable legal framework for DCRs. It would also be necessary, in

[51] Dan Small, 'Canada's highest court unchains injection drug users; implications for harm reduction *as standard of healthcare' Harm Reduction Journal 2012, 9:34. Available at:* *https://harmreductionjournal.biomedcentral.com/articles/10.1186/1477-7517-9-34*

[52] *Canada (Attorney General) v. PHS Community Services Society, 2011 SCC 44 (CanLII), [2011] 3 SCR 134. Available at: https://www.canlii.org/en/ca/scc/doc/2011/2011scc44/2011scc44.html*

[53] Stevens A, Eastwood N, Douse K. In defence of the decriminalisation of drug possession in the UK. Drug Science, Policy and Law. 2024;10. doi:10.1177/20503245241239200. Available at: https://journals.sagepub.com/doi/10.1177/20503245241239200

time, to have a legal framework specific to DCRs that would respond to the other medico-legal issues that may be involved in running a DCR but will sit outside the provision of the MDA. This would also be able to iron out points of uncertainty in regards to civil liability, this being the legislative approach taken in Ireland's Misuse of Drugs (Supervised Injecting Facilities) Act 2017[54] and the Australian Drug Misuse and Trafficking Act 1985[55], both of which exempt those working in SDCFs from civil liability, albeit in a licence-based system.

102. Any such legal framework embarked upon in the U.K. should focus on facilitating a range of models that respond to the needs of people flexibly, for example mobile DCRs and low-threshold DCRs, which do not necessarily require engagement with other services and focus on supporting people that services may fail to engage.

103. A legal framework should be permissive and facilitative, in particular, of peer-to-peer DCRs, which will be most effective at supporting individuals experiencing the most marginalisation, whether due to homelessness or due to having been excluded from, or mistreated, traditional drug service providers or healthcare providers.

104. In the absence of drug decriminalisation or pending a framework created through primary legislation, there are still clear routes to ensuring it is easier to establish long-term, sustainable DCRs. This could be achieved through amendments to the Misuse of Drugs Regulations (MDR), an approach which has already been called for previously by, among others, the Faculty of Public Health[56].

105. A legal framework achieved through amendments to the MDR would be comparable to that achieved via Regulation 6A of the MDR[57], which has facilitated wider access to crucial harm reduction equipment, despite the prohibition on supplying drug 'paraphernalia' in s9A[58].

[54] See section 9. Liability of licence holder. Available at: https://www.irishstatutebook.ie/eli/2017/act/7/enacted/en/html
[55] See sections 36N-S6P. Available at: https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1985-226#pt.2A-div.4
[56] Faculty of Public Health, 'Call to amend Misuse of Drugs Regulations to make it easier to pilot overdose prevention centres' (June 2022). Available at: https://www.fph.org.uk/news/call-to-amend-misuse-of-drugs-regulations-to-make-it-easier-to-pilot-overdose-prevention-centres/
[57] Available at: https://www.legislation.gov.uk/uksi/2001/3998/regulation/6A
[58] Available at: https://www.legislation.gov.uk/ukpga/1971/38/section/9A

106. An amendment to the MDR could, similarly, permit certain offences to take place in the context of DCRs, thus meeting the basic principle of legal certainty for those using and staffing DCRs. This would be preferable to procedural approaches and would also not require a licensing system; much like Regulation 6A, it could rely on a more permissive arrangement of lawfully provided drug treatment services, rather than licensing systems.

3b. What lessons can be learned from international contexts, when considering a sustainable legal model for a SDCF?"

107. There is a clear need for a range of SDCF models, from mobile, low-threshold SDCFs[59] to more medicalized, brick-and-mortar one stop shops for health and wellbeing support. As addressed above, a long-term, sustainable legal framework for a DCR would be one that creates a legally enabling environment for these harm reduction initiatives, which would then allow individuals accessing these sites to more freely choose the model of SDCF that is best equipped to meet their individual needs.

108. The Canadian Association of People Who Use Drugs (CANPUD) produced a guide in 2017 for organisations and individuals considering opening unsanctioned SDCFs, "This tent saves lives: How to open an overdose prevention site." This guidance outlined legal liabilities which might be incurred in opening a SDCF and stated that 'despite the law change [permitting SDCFs to operate legally], approvals for supervised consumption sites are slow, and [SDCFs] are a lifeline for people at risk of overdose' [CANPUD 2017, pp. 5].

109. Any potential future regulatory process for approval to run a SDCF must consider the obstacles which community-led SDCF initiatives would face in applying for the relevant permissions to operate, and wherever possible reduce these barriers to operating.

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[59] https://www.catie.ca/resource/this-tent-saves-lives-how-to-open-an-overdose-prevention-site