

When Everyone Is Responsible, No One Is

Split levers, two standards and the wrong river in Scotland's drug debate

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Standpoint

I began nurse training at the South College of Nursing and Midwifery in May 1987, in the old system, at the age of eighteen. The patient I remember from that first stretch, when I was nineteen, was a man dying of alcohol-related liver disease: jaundiced, a dark purple colouring, and a sweet smell I have never forgotten. He had been sacked from his job because he was an alcoholic, and everything followed from that: his finances, his family, his children. It followed him onto the ward as well. The staff around him had years of experience between them, and some had learned from it that his illness was self-indulgence. There was little sympathy for his family. I decided then that the medical model, as I saw it practised that day, was wrong.

That was the first thing experience taught me: it can teach the wrong lesson, and teach it with complete confidence. In the nearly forty years since, I have worked as a nurse in Scotland, twenty-six of those years in the National Health Service, and between 2009 and 2013 I was part of the work to build peer education and brief interventions into everyday practice. The peer educators I worked alongside brought their own experience into that work, and some of them are no longer with us. They are not in the rooms where this debate now takes place. If experience were a qualification, theirs and mine would settle this debate. It does not, and neither does anyone else's. This piece is written with them in mind.

It is also a debate that too often reduces practitioners to "the system". The people who deliver services and lead organisations in this field carry their own losses: people they could not reach in time, funerals of clients and of colleagues. A style of criticism that casts them as the architects of failure does not make the criticism more accurate. It makes it easier to dismiss the people who hold the most institutional memory, at the moment it is most needed.

Experience, lived or clinical, tells us where to look. It cannot tell us what we will find. When experience is offered as the qualification, the experience of anyone who disagrees is set aside. Neither lived nor clinical experience is a verdict. The evidence is.

The week the figures came

On 23 September 2026, National Records of Scotland reported 1,133 drug-related deaths registered in 2025, an increase of 11 per cent on the previous year. Men accounted for 830 of them, a rise of 19 per cent, while deaths among women fell. Nitazenes, synthetic opioids that can be hundreds of times stronger than heroin, were implicated in 247 deaths, up from 76. Cocaine was implicated in 589, more than half of the total. Drug-related deaths were 15 times higher in the most deprived areas of Scotland than in the least deprived.

In the days that followed, a body of public commentary grew around those figures. It came as posts, infographics, columns, a conference reflection, a ministerial statement and the replies to it. It was widely shared, and it asked hard questions. It also moved blame between the parliaments, governments and services that share responsibility for drugs in Scotland, according to who was speaking. That movement is the subject of what follows.

Movement One: The claim in full

Theorist: George Lakoff, on framing

The most widely shared item was an infographic headed "1,133 people dead". Beneath the figure it placed a line of challenge addressed to a harm reduction charity: "Then show Scotland the results." It listed the questions it wanted answered: how much public money had been spent, which interventions had reduced mortality and by how much, how many people had entered treatment and reached recovery, and why 1,133 people were still dying after years of strategies and investment. It stated its own limit fairly: "Those figures do not establish that harm reduction caused those deaths." Its closing line, in capitals, was "PEOPLE STAYING ALIVE IS THE OUTCOME." It then turned to legislation. The charity had told Members of the Scottish Parliament in May 2025 that it was "still not convinced that going down a legislative path is the right approach" to a right to addiction treatment. It now wanted the Government to challenge outdated drug laws, and the two positions were presented as a contradiction.

A column published the same week described Scotland's drug policy as "an extraordinary ecosystem around failure", in which government funds organisations, organisations advise government, and the same voices return to explain what should happen next. It acknowledged the role of nitazenes and cocaine, then added: "But complexity cannot become an alibi for institutional failure." It called for Scotland to measure recovery rather than activity, and to introduce "consequences for persistent failure". It described addiction as "completely unmanageable".

A second graphic showed three chief executives giving evidence to a Scottish Parliament committee in May 2025, each with a short quotation beneath. The accompanying text accepted that "They didn't create this catastrophe and government ultimately carries responsibility", then continued: "But influence without accountability is not leadership."

A further post revived a 2022 international comparison from the Commonwealth Fund, which ranked Scotland second only to the United States for drug deaths per head of population: 267 per million, against 277.

An article on the Glasgow safer drug consumption facility, the Thistle, asked what happens to the people referred from it into treatment, and challenged the facility's supporters to publish the answer.

A reflection written after a keynote address at the Recovery Capital Conference in Calgary, delivered on 23 September 2026 under the title "From Stabilisation to Recovery: Why System Orientation Determines Outcomes", described the Alberta recovery model with warmth.

On 24 September the First Minister said the Government supported the argument for decriminalising drugs for personal use, while noting that drug law is reserved to Westminster. The reply, published as text and as an infographic, was sharp: "You can blame Westminster for

refusing to change the law. You cannot blame Westminster for failing to build Scotland's treatment system."

The day before the drug figures, the Scottish Government's homelessness statistics had prompted a widely shared post that began "Scotland what's going on?"

The material has features of style as well as argument. One infographic carries the name and logo of the charity it criticises in its top corner, so that a reader scrolling past could take it for the charity's own material. A quotation from that charity's manifesto is presented inside quotation marks in a paraphrased form. The imagery is emotive: a tearful eye with the map of Scotland in its iris, a hooded figure, a clock tower resembling Westminster's. A structural argument about devolved powers is illustrated with a photograph of one politician. Three named chief executives stand in for a policy position, and their answers are set beneath a single question from the committee, "Does the bill in any way address the issues that you have vocalised?" The Official Report shows that the forum's line answered a different question, about whether the Bill could be amended.

The common feature is the addressee. The accountability demanded is addressed to "Scotland", to "the system", to an "ecosystem". Where a tier of government is named, it is usually the one the speaker holds responsible, and only that one.

Feature examined	What it shows	Theorist
Addressee of blame	A tiered system is framed as a single agent	Lakoff: the frame decides which facts fit
Personalised graphics	Structural questions carried by named faces	Lakoff: frames are carried by images as well as words
Paraphrase in quotation marks	The frame shapes the evidence offered for it	Lakoff: once a frame is set, contrary facts bounce off

Movement Two: The map of levers

Theorist: Michel Foucault, on dispersed power

Responsibility for drugs in Scotland sits in three places, and each holds different levers.

Problem	Westminster (reserved)	Holyrood (devolved)	Delivery tier
Drugs	The Misuse of Drugs Act 1971, and the illegal market it shapes	Treatment and health policy; funding	Alcohol and Drug Partnerships; health boards
Homelessness	Welfare; asylum and immigration	Homelessness duties in law; statutory guidance; housing supply funding	Local authorities, which carry the statutory duties
Residential rehabilitation	None directly	Capacity funding and targets	Alcohol and Drug Partnerships commission; providers set prices
Work and protection	Employment law; equality law, including the exclusion of addiction from disability; the civil service	None	Employers, public and private, wherever they are based

The machinery that keeps the levers apart is legal. An Act of the Scottish Parliament that strays outside devolved competence is not law, under section 29 of the Scotland Act 1998. A Bill can be referred to the Supreme Court before it receives Royal Assent, as parts of Holyrood's children's rights incorporation Bill were in 2021. Under section 35, the Secretary of State for Scotland can block a Bill that modifies the law on reserved matters with adverse effect; the power was used for the first time in January 2023, and the Court of Session upheld its use in December of that year. Section 28(7) preserves the power of the United Kingdom Parliament to legislate for Scotland on anything. By convention it does not legislate on devolved matters without consent, but the Supreme Court held in 2017 that the convention cannot be enforced in court.

The Thistle shows the machinery at work. It opened in January 2025 under a Statement of Prosecution Policy issued by the Lord Advocate on 8 January 2025. Prosecutors will not pursue possession for personal use inside the consumption wing, for the duration of the pilot. The protection ends at the edge of the room. Possession remains a criminal offence outside it, including on the way in and the way out. That is why people can register under a chosen name or an identifier made from their initials and date of birth: identification is a deterrent when the act of attending is lawful only inside the building. A demand to track every individual after referral runs into a design that the reserved law made necessary.

The delivery tier is where outcomes vary, and it is the tier the commentary almost never names. The national standard that 90 per cent of people referred to community drug and alcohol treatment start within three weeks was met for 92.7 per cent of people who started treatment in October to December 2025. It was missed in Shetland, the Western Isles, Lothian, Highland and Tayside. At the end of 2025, 537 of 2,149 people waiting for community treatment had waited longer than three weeks. Hepatitis C outcomes among people who inject drugs differ sharply between health boards: by 2022-23, current infection stood at 4 per cent in Tayside and 16 per cent in Greater Glasgow and Clyde. National policy, national funding and the same drug supply produce different results in different places. That variation is accountability waiting to be assigned.

The delivery tier is not obscure to the people in this debate. Local partnerships on alcohol and drugs have existed in Scotland since 1989, and the Alcohol and Drug Partnerships that replaced them were set up under a Scottish Government framework published in April 2009. Since then, the sector has had its own professional posts, such as development co-ordinators, to plan, implement, monitor and evaluate local strategy and delivery. Some of the most prominent voices in the current debate have held posts of exactly that kind, and know from the inside where the outcomes are decided. The map is not unknown. What varies is whether it is used. When the week's messaging named a tier, it named Westminster or Holyrood. The tier with the most direct hold on the outcomes that vary, and the one the sector's own development posts were created to run, was the one left out.

Feature examined	What it shows	Theorist
Three tiers, four problems	No single body holds the levers for any one problem	Foucault: power is exercised from many points, not one centre
The Thistle's legal footing	A reserved law shapes a devolved service's design	Foucault: rules operate through the arrangement of spaces
Variation between boards	Outcomes diverge at the tier nobody names	Foucault: where power is dispersed, so is responsibility

Movement Three: The evidence restored

Theorist: Noam Chomsky, on what is omitted

The figure of 1,133 was reported accurately. What surrounded it in the commentary was thinner than what surrounds it in the record. Drug deaths fell by 13 per cent in 2024, to 1,017. The 2025 total is below the peak of 1,339 in 2020 and is the sixth highest on record. The age-standardised rate, 21.4 per 100,000, was not statistically significantly higher than in 2024, although the number of deaths rose substantially. When the 2024 figures were published, the harm reduction charity at the centre of the week's criticism warned that the fall was probably a blip masking a surge in synthetic opioids. The 2025 figures showed that warning to have been correct. Nitazene-implicated deaths more than tripled in a year.

The Commonwealth Fund comparison used 2020, Scotland's worst year, and the ranking was repeated days after newer official figures had been published. Its authors warned that their data sources "can have important differences in methodology, indicator definition, and population measured, and the findings are not necessarily comparable in all instances." The United States figure counts overdose deaths; European figures count drug-induced deaths; the Canadian figure counts opioid deaths only. The authors also set out why other countries do better, and that was left out: decriminalisation in Portugal, high coverage of opioid substitution treatment, needle exchange, supervised consumption, naloxone and drug checking. Their one point that sits comfortably with a recovery argument, that England's arrest referral scheme helps people reach treatment, was left out too. So was the Fund's newer work. On 3 September 2026 it published a fresh international comparison using 2024 data, which recorded Scotland's 13 per cent fall and described Scotland as "a global standard for naloxone distribution".

The demand to "show Scotland the results" was put as though nothing had been published. Much has been. The national alcohol and drugs plan published in March 2026 is backed by more than £160 million in 2026-27. The three-week treatment standard is met for more than nine in ten community referrals. In 2025-26, at least 1,125 Scottish residents started a publicly funded residential rehabilitation placement, against a target of 1,000 people a year. Public Health Scotland reports that 85 per cent of people last known to have chronic hepatitis C had cleared it by March 2025. In its evaluation of residential rehabilitation, one drug-related death was recorded within six months among 146 people followed up. The genuine gaps are narrower and more useful: recovery outcomes such as housing, employment and sustained remission are measured less well than harm outcomes, and the Thistle publishes no interim figures on what happens after a referral.

On the Thistle, the scrutiny was partly right. Its dashboard records 209 "medical emergencies" between January 2025 and September 2026, defined as any intervention from enhanced

observation to oxygen, naloxone or resuscitation. Describing them all as overdoses is wrong, and the critique said so. The independent evaluation, led from Glasgow Caledonian University and the University of Glasgow, runs until 2029 and will measure treatment uptake, ambulance call-outs and blood-borne virus outcomes against comparison areas. The same critique, having demanded evidence, then offered a guess about how many people had entered treatment through the facility: "probably ZERO". It also asserted that the facility's operators had no intention of publishing. Neither claim was supported.

Feature examined	What it shows	Theorist
A single year without its trend	The rise is real; the trajectory is not the one implied	Chomsky: selection works through what is left out
A comparison stripped of its warning	The ranking travels; the caution does not	Chomsky: the boundaries of debate are set by omission
"Show Scotland the results"	Much is published; the gaps are specific	Chomsky: a question can carry an unstated answer

Movement Four: Measuring the wrong river

Theorist: Tim Rhodes, on the risk environment

There are two rivers in this debate. Recovery measures the individual's journey: treatment entered, abstinence achieved, a life rebuilt. Public health measures what happens across a population: overdoses, infections, deaths. A system needs both. Almost all of the week's commentary counted one.

The outcomes that sit furthest downstream were absent. Emergency attendances for overdose, ambulance call-outs, hepatitis C, the human immunodeficiency virus, liver disease and liver cancer do not appear, save for one passing mention of "longer-term health". Yet the Glasgow case for a consumption facility was built on exactly those outcomes. From 2015, an outbreak of the human immunodeficiency virus spread among people injecting in public places in the city centre. A critique of the Thistle that never mentions it judges the facility against a purpose it was not primarily designed to serve.

Scotland measures that river closely. Public Health Scotland publishes annual statistics on injecting equipment provision. The Needle Exchange Surveillance Initiative has surveyed people who inject drugs since 2008-09, measuring sharing, equipment coverage and blood-borne virus infection anonymously, so that population outcomes are tracked without identifying anyone. The Rapid Action Drug Alerts and Response programme reports quarterly on changes in the drug supply. National Records of Scotland counts the deaths. The National Mission's monitoring report is organised around outcomes. The system reports its own misses as well as its successes. In 2022-23, needle and syringe provision, at a median of 260 items per person who injects each year, exceeded the World Health Organization target of 200, although the number of needles and syringes issued fell in 2024-25 to its lowest level since 2015-16. Public Health Scotland's hepatitis C report puts opioid agonist therapy coverage at around 76 per cent, against a World Health Organization target of 40 per cent. Chronic hepatitis C among people who inject drugs has fallen by 59 per cent since 2015, and deaths from hepatitis C fall within the World Health Organization threshold. New infections, at 3.4 per 100 person-years, remain above the target of 2 or fewer. Treatment starts, at 1,352 in 2024-25, fell short of a target of 2,500.

The clearest result comes from Tayside. Among people who inject drugs there, the proportion with current hepatitis C infection fell from 29 per cent in 2015-16 to 4 per cent in 2022-23, a fall of 86 per cent. The researchers, writing in *Liver International* in 2026, conclude that elimination among people who inject drugs is feasible, and estimate roughly an even chance that Tayside had already met the World Health Organization's target of an 80 per cent reduction. Over the same period the figure fell from 46 to 16 per cent in Greater Glasgow and Clyde, and from 32 to 15 per cent across the rest of Scotland. It was achieved through treatment as prevention: testing and treatment offered through needle exchanges, community pharmacies, prisons and drug services, to people who were still using. That is an outcome, not an activity count, and it was reached through harm reduction channels. It is also a success on a virus, not on drug deaths, which remain high in Tayside. The honest claim is the narrow one.

The same division runs through treatment. Abstinence-based services report abstinence, often among people who completed a programme. Opioid substitution reports retention and survival. Each looks strong by its own measure. The Scottish Government's own review of residential rehabilitation, published in May 2022, found moderate-quality evidence that it improves outcomes, with abstinence at twelve months ranging from 14 to 88 per cent across studies, and one Australian cohort finding residential treatment far more effective than medication-assisted treatment or inpatient withdrawal management at producing abstinence at three years. The same review found a higher risk of death in the year after discharge, and high rates of early departure. The European Union Drugs Agency's summary of the evidence on opioid substitution finds mortality during treatment less than a third of the rate outside it, and a meta-analysis by Sordo and colleagues in 2017 found the risk of death around five times higher in the first four weeks after methadone stops than during stable treatment. A figure of "successes" without a denominator of admissions cannot be compared with anything. The only outcome both approaches share is death, and measured by death, the evidence for opioid substitution is the strongest in the field. That matters when the most widely shared graphic of the week declared that "PEOPLE STAYING ALIVE IS THE OUTCOME".

The evidence that lived experience supplies has its own shape. Testimony comes from people who survived. The people who died are not in the room. Rehabilitation follow-ups rest on those who could be found. None of this discredits lived experience; it places it. The history of the field shows why the placing matters. E. M. Jellinek's 1946 study of the phases of drinking, foundational to the disease model, drew on 98 questionnaires from male members of Alcoholics Anonymous, out of 158 returned, from a questionnaire designed by members. The famous curve that bears his name was drawn by Max Glatt. The modern recovery case rests on stronger ground, including a 2020 Cochrane review of mutual aid, but the habit of generalising from those who made it through is old and persistent.

Alcohol shows how much depends on which deaths are counted and noticed. In 2024, alcohol killed more people in Scotland than illegal drugs did: 1,185 alcohol-specific deaths against 1,017 drug deaths. The alcohol-specific figure counts only conditions caused wholly by alcohol; the full toll, including cancers, heart disease and injuries to which alcohol contributes, is higher. The drug toll is treated as a national emergency. The alcohol toll, of similar size and in 2024 larger, draws far less public attention. The comparison is revealing in both directions. A similar number of deaths came from very different populations. Around a fifth of adults in Scotland drink above 14 units a week, while an estimated 43,600 people were dependent on opioids in 2023-24. Per

person at risk, the illegal market is far deadlier, and it kills younger: the average age at death is 46 for drug deaths in 2025 and 59 for alcohol-specific deaths in 2024.

Alcohol also carries a paradox. People in the least deprived areas are more likely to drink at hazardous levels, 26 per cent against 15 per cent in the most deprived. Yet alcohol-specific death rates are four and a half times higher in the most deprived areas. The same legal, regulated substance does its worst damage where poverty is deepest. Regulation gives a government the tools to reduce harm. Poverty decides where the harm falls.

Scotland's minimum unit price for alcohol is sometimes described as a failure because alcohol deaths rose after it was introduced, reaching 1,277 in 2023, the highest since 2008. That reads the raw count and ignores the comparison. Public Health Scotland's evaluation, published in *The Lancet* in 2023, compared Scotland with England, where no minimum price applied, and estimated that deaths wholly attributable to alcohol were 13.4 per cent lower than they would otherwise have been, around 150 lives a year, with an estimated 4.1 per cent fall in hospital admissions that was not statistically significant. The greatest benefits went to men and to the most deprived communities. What pricing did not do was change the drinking of people already dependent on alcohol, some of whom cut spending on food and heating instead. That is not evidence that pricing failed. It is evidence that prevention and treatment do different jobs, and that a country needs both.

Feature examined	What it shows	Theorist
Downstream outcomes left out	The river the Thistle was built for goes uncounted	Rhodes: harm is produced by environments, not only by individuals
Each model's own measure	Success is defined by whoever is measuring	Rhodes: the environment sets which outcomes are visible
Alcohol against drugs	Legal status changes the tools, not the presence of harm	Rhodes: policy is part of the risk environment

Movement Five: The Bill, and capacity before rights

Theorist: Thomas Szasz, on rights, treatment and coercion

The Right to Addiction Recovery (Scotland) Bill was introduced on 14 May 2024. As the Scottish Parliament's summary describes it, it would have applied to people diagnosed by a health professional as being addicted to alcohol, drugs or both. They would have had a right to treatment, which could include residential rehabilitation, community treatment, detoxification or substitute prescribing, to be provided within three weeks of a treatment determination. A refusal would have had to be explained in writing, with a right to a second opinion, and Ministers would have reported annually to Parliament. On 23 September 2025 a majority of the Health, Social Care and Sport Committee said it could not recommend the Bill's general principles. The committee recognised strong evidence of dissatisfaction with access to services, but was concerned that the Bill's focus was too narrow, that it could push prevention down the list of priorities, and that it might sit awkwardly with the existing legal framework. On 9 October 2025 the Bill fell at Stage 1, by 63 votes to 52.

The case for the Bill rested on an assumption: that the barrier to treatment is will, and that law can supply the will. The record tests that assumption on four grounds.

The first is volume. The target set in 2021 was for at least 1,000 people a year to start a publicly funded residential placement by 2026. In 2025-26, at least 1,125 Scottish residents did so, and publicly funded placements have more than doubled since 2019-20. The claim that residential treatment is simply withheld does not survive this record in its simple form.

The second is access. In a 2025 survey of those able to refer people to rehabilitation, only 30 per cent agreed that residential rehabilitation was easily accessible. Funding, concerns about aftercare, and waits for detoxification and rehabilitation were the barriers named. More people are reaching residential treatment than at any point in the series, and the route to it remains slow and uncertain for many. Both are true.

The third is capacity. In October 2025, 28 residential rehabilitation facilities in Scotland reported a combined maximum of 574 beds, against a target of 650. A right to treatment within three weeks does not create beds. Where demand exceeds capacity, a statutory deadline produces a queue with legal standing.

The fourth is price. Castle Craig, an abstinence-based residential service in the Scottish Borders, publishes a self-funded rate from £650 a day, covering detoxification, therapy, a family programme, accommodation and up to twelve months of aftercare. At that rate a 28-day programme costs £18,200 per person, and 1,125 such placements would cost £20.5 million. At 60 days the total rises to £43.9 million, and at 90 days to £65.8 million. The dedicated commitment to residential rehabilitation was £100 million over five years, from 2021 to 2026, an average of £20 million a year, and more than £38 million of it went directly to eight projects to build capacity. At the self-funded rate, a single year of 28-day placements would consume the whole of an average year's allocation. Castle Craig is listed in a Scottish Government protocol with 82 beds, enough at full occupancy for about 1,070 admissions a year on 28-day stays, 500 on 60-day stays or 330 on 90-day stays. Most residential facilities in Scotland are run by voluntary or not-for-profit providers, whose commissioned rates are not published and are likely to be lower, and some placements end early. These figures are therefore a ceiling. It is the ceiling a guarantee reaches if it is met at the standard its advocates prefer. During scrutiny it was also argued that providers commissioned under a legal duty could raise their prices knowing funding would not be questioned. That is a structural consequence of the design, not a claim about any provider's intentions.

The Bill's three-week timescale is already a national standard. It is met for more than nine in ten community referrals and missed in five health boards. What the Bill offered was to make an existing standard enforceable by individuals.

Its threshold was a diagnosis. During scrutiny, Social Work Scotland warned that requiring one could stigmatise people and become a barrier to support. Harm reduction works for the opposite reason: it asks for no diagnosis at all. A needle exchange, a naloxone kit, a consumption room that accepts a chosen name, all reach people who are not ready, or not willing, to carry a label. In my experience, the shame some families feel about how someone died often begins with that label. A system that serves only the diagnosed will never reach the people most afraid of being named.

The right would also have stopped at the workplace door. It bound health boards, not employers. Employment law is reserved to Westminster under Schedule 5 of the Scotland Act 1998, and so is equality law. The Equality Act 2010 (Disability) Regulations 2010 state that, unless it began with prescribed medical treatment, "addiction to alcohol, nicotine or any other substance is to be treated as not amounting to an impairment for the purposes of the Act." The exclusion covers the addiction itself rather than every condition it causes. One Act cannot rewrite another's definitions. A person could hold a statutory right to a residential place within three weeks and still have no protection under disability discrimination law for the addiction itself, leaving only the ordinary rules on unfair dismissal. No Scottish Act can oblige any employer, Scottish or English, public or private, to hold a job open through a placement of 28 to 90 days. A right to treatment that may cost the patient their livelihood is a right many will not risk using. The diagnosis that unlocks the right would also be a formal record of the very condition equality law declines to protect.

Nor did the Bill say anything about what follows. The risk of death rises after residential rehabilitation ends. A right of entry is not a right to continuity.

In 2022, seven organisations issued a joint statement opposing the proposal. They argued that a legal entitlement could turn the relationship between the person seeking treatment and the treatment provider from a therapeutic one into an oppositional one. One of the signatories added that people with a drug problem would have the rights they need only when they were fully recognised under the Equality Act, which currently excludes them. That was not a refusal to legislate. It was a different legislative route, on the reserved side of the line.

Feature examined	What it shows	Theorist
A deadline without beds	Rights without capacity create legal queues	Szasz: a right the state cannot supply becomes a new form of control
A diagnosis as the threshold	The label that opens the door also marks the person	Szasz: diagnosis confers status as well as care
The workplace door	The right reaches treatment and stops at employment	Szasz: rights granted in one domain can be undone in another

Movement Six: The household behind the statistic

Theorist: Jürgen Habermas, on system and lifeworld

The homelessness figures published on 22 September 2026 are grave. At 31 March 2026, 19,004 households were in temporary accommodation, up 10 per cent on the year, and 10,715 children were living in it, the highest number on record. In 2025-26, 35,002 households were assessed as homeless or threatened with homelessness, up 1 per cent and the highest since 2011-12. The widely shared post that followed described "35,000 people stuck in the system". The figure is households, not people, and the 10 per cent rise applies to open cases waiting for a settled home rather than to the number assessed. The post was right about causes: trauma, poverty, poor mental health, addiction, family breakdown, justice involvement. It was silent about responsibility. Holyrood writes the homelessness duties into law and funds housing supply. Local authorities carry the duties. Westminster holds welfare and asylum. A question addressed to "Scotland" lets each tier point at the others.

The same pattern appears inside the drug debate in human form. When a service closes, the people who used it do not stop using drugs. They fall back on each other. An evidence brief on the closures of consumption sites in Ontario in 2025 records use moving into washrooms and alleys, more people using alone, less access to sterile equipment, and broken relationships between clients and workers. A study of the closure of the supervised consumption site in Lethbridge, Alberta, in 2020 found the replacement site isolated and less used, and the housing and employment support attached to the old one lost. Two risks follow. Closed peer groups share equipment and practices, and blood-borne viruses spread. People using alone have no one to respond to an overdose. Peer reliance also protects: Scotland's peer naloxone programme depends on it. What a closure removes is not the peer group but the bridge between the peer group and the services that keep people alive.

Practitioners are pushed out of the lifeworld of the debate in a different way. The week's material placed three chief executives beneath a caption about "influence without accountability", said that the same professional voices keep being "invited back", and called the result "institutional self-preservation". It also said, fairly, that they did not create the catastrophe. The effect of the style is to cast people who have spent careers in services as interchangeable with the policies they work within. There is a research literature on what that work costs: studies of grief, burnout and repeated overdose response among harm reduction workers describe a workforce carrying loss. Lived experience is presented as knowledge, and practitioner experience as vested interest. Both are experience, and both are fallible.

Feature examined	What it shows	Theorist
Households counted as people	The number grows; the responsible tier disappears	Habermas: the system speaks in categories the lifeworld cannot see through
Withdrawal into peer groups	When services leave, people fall back on each other	Habermas: the lifeworld absorbs what the system withdraws
Practitioners cast as "the system"	Their experience is recoded as interest	Habermas: people inside institutions are treated as the institution

Movement Seven: Two stages, two standards

Theorist: Erving Goffman, on front stage and back stage

In Calgary, the keynote's reflection said: "Keeping somebody alive matters. Stabilisation matters." It said these should be "the beginning of our ambition, not its outer limit." At home in the same week, the column described addiction as "completely unmanagable", and the infographic declared that "PEOPLE STAYING ALIVE IS THE OUTCOME." Abroad, survival was the floor. At home, when the argument needed a hard number, survival became the outcome, and survival is the measure on which the approach under attack is strongest.

The same material treats foreign evidence according to its direction. The Thistle article dismissed endorsements from "systems that bare no resemblance to ours", then relied on San Francisco and the Pacific Northwest. Its source there, a 2024 Brookings report by Keith Humphreys, was cited accurately, and his conclusion warns against extreme swings in policy and asks reformers to fit change to local conditions. The Calgary abstract presented Alberta as a

model now informing and inspiring recovery internationally. The reflection written afterwards was more careful: "Nobody is pretending Alberta has solved addiction."

Alberta deserves the same test as Glasgow. Calgary's only supervised consumption site closed on 30 June 2026, as did Lethbridge's mobile overdose prevention site; Red Deer's had closed in March 2025. The province's model was praised from a conference stage less than three months later, before any data on the consequences of the closures could exist. The evidence on closures elsewhere is contested and should be reported as such. In Ontario, after closures in April 2025, emergency medical responses to opioid toxicity rose by 69.5 per cent in the six months from April 2025, and monthly opioid-related emergency department visits were 67 per cent higher in September than in March. Over the same period the sedative medetomidine spread through the supply, and by early 2026 it was found in about 80 per cent of expected fentanyl samples tested in Toronto. No study has separated the two. In a sedative-contaminated market, emergency calls can rise without deaths rising. Lethbridge reports falls in overdose deaths and emergency events since 2023, which critics dispute the reasons for. A study by the Canadian Centre of Recovery Excellence, set up by the Alberta government, found no rise in deaths or acute care after the Red Deer closure, and was criticised for not reporting opioid deaths at all. Alberta continues to publish monthly mortality and weekly emergency response data. Its own figures will test its own model.

The comparison with England is the strongest point in the reply to the First Minister, and it should be credited. Scotland and England operate under the same Misuse of Drugs Act, and Scotland's drug death rate in 2024 was 2.4 times England's. The drug law cannot explain that gap, and devolved services are part of the answer. But the comparison holds the drug law constant; it does not hold the alignment of levers constant. In England a single government holds drug law, health, employment, equality and welfare. In Scotland those levers are split. Like-for-like comparison requires like-for-like powers. The comparison also leaves deprivation, the ageing group of long-term drug users and the history of each country's drug market to one side.

The Government and its sharpest critic each saw the other's diversion clearly. The First Minister pointed up to Westminster, attributing the crisis to poverty, trauma and synthetic drugs while noting that drug law is reserved. The reply pointed at Holyrood's record on services and rejected the constitutional argument, in an infographic headed "Scotland needs accountability, not another constitutional argument". The reply was itself a constitutional argument, and on its main point a good one. It also presented a quotation attributed to the First Minister, about accepting full responsibility, that could not be traced, in the searches made for this piece, to any published record of his words on drug deaths. It rightly separated the reserved lever from the devolved ones, rightly cautioned against reducing Portugal to a slogan, and rightly asked for an independent review of what happens to people given Recorded Police Warnings. It then folded Holyrood and the delivery tier together as "the Scottish Government". Nobody in the exchange pointed down to the health boards and Alcohol and Drug Partnerships where the published variation sits.

Feature examined	What it shows	Theorist
Survival as floor abroad, outcome at home	The measure shifts with the audience	Goffman: the front stage performance depends on who is watching

Feature examined	What it shows	Theorist
Foreign evidence accepted and dismissed	Comparison is admitted when it agrees	Goffman: impression management selects its props
Government and critic	Each exposes the other's backstage	Goffman: every performance has a region it would rather keep hidden

Movement Eight: Law as obstacle, law as remedy

Theorist: Pierre Bourdieu, on the field and its stakes

One side of the debate calls reserved law the obstacle. The other calls devolved law the remedy. Neither says consistently which legislature holds which law, or what each law can deliver. The international evidence on the reserved law is consistent. A systematic review by Werb and colleagues in 2011 found that 14 of 15 studies associated intensified drug law enforcement with more violence in drug markets. A review by DeBeck and colleagues in 2017, covering 106 studies, found that 85 of them, 80 per cent, reported that criminalising drug use worsened the prevention or treatment of the human immunodeficiency virus. Analysis by the Pew Charitable Trusts of the United States found no statistically significant relationship between states' drug imprisonment rates and their levels of drug use, drug arrests or overdose deaths, while stating that it drew no conclusions about cause. The Lancet Commission on Public Health and International Drug Policy reached the same broad conclusion in 2016. The evidence also sets limits. British Columbia ended its decriminalisation pilot in 2026, its health minister saying it had not delivered the results hoped for. Oregon reversed its decriminalisation law.

The history is older than the Misuse of Drugs Act. Alcohol prohibition in the United States, from 1920 to 1933, turned local gangs into national syndicates. Illegal liquor produced revenues on a scale that allowed bribery of police, judges, juries and politicians to be treated as a business expense. In Chicago's beer wars of the mid-1920s, gangsters killed hundreds of their rivals. The economist Jeffrey Miron, examining a century of American homicide data, found that increases in the enforcement of alcohol and drug prohibition went together with increases in the homicide rate, even after allowing for age structure, incarceration, the economy and gun availability. The United States government required industrial alcohol to be denatured with toxic additives; bootleggers diverted it and tried to strip the poisons out, and people died. The Wickersham Commission reported in 1931 that enforcement was undermined by corruption and by public contempt for the law, but opposed repeal and recommended revising the law and giving it a further trial. One member, Monte Lemann, wrote separately that repeal was the only alternative. Repeal came in 1933. The criminal organisations built under Prohibition outlived it and moved into gambling, labour racketeering and narcotics. Whether Prohibition reduced drinking is still disputed. Its effects on violence and on the danger of the supply are not.

The mechanism has a name. In 1986 the writer Richard Cowan described an "iron law of prohibition": the harder the enforcement, the harder the drugs. Under prohibition, concentrated products are cheaper to move, easier to hide and more profitable. Spirits replaced beer in the 1920s. In 2017, Beletsky and Davis applied the same reasoning to fentanyl. Drug markets also cut and bulk their products according to supply. Retail heroin purity in England and Wales fell to 18 per cent in 2011, after the heroin drought of 2010, and recovered to about 46 per cent by 2018. In a glut, suppliers compete on purity: retail cocaine purity in Europe in 2024

was 44 per cent higher than in 2014. The most dangerous point is where shortage meets synthetics. After the Taliban's ban on opium cultivation, the United Nations reported a 95 per cent fall in Afghan cultivation in 2023, and the European Union Drugs Agency warned that reduced heroin availability could open the way for synthetic opioids. Weak or heavily cut heroin can be restored with a trace of a nitazene that acts in microgram amounts, mixed unevenly by people with no laboratory. The commodity has changed. The market logic has not.

That logic explains why the week's argument about "decriminalisation" was confused. Portugal decriminalised the possession of drugs for personal use in 2001, alongside an expansion of treatment and harm reduction. New cases of the human immunodeficiency virus among people who use drugs fell from 907 in 2000 to 267 in 2008. Treatment clients rose from 23,654 in 1998 to 38,532 in 2008. Criminal drug arrests fell from more than 14,000 a year to around 5,000, and the share of prisoners held for drug offences fell from 44 per cent to 21 per cent. Its evaluators, Hughes and Stevens, cautioned that these changes cannot be credited to decriminalisation alone. Trafficking remained illegal, so the market remained in criminal hands, and there is no evidence that market violence, potency or adulteration fell. Decriminalisation contains two different levers: how the state treats the person, and how the market works. Portugal pulled the first. Both are reserved to Westminster.

There is a third lever, and Scotland already holds part of it. Until 1968, the British system allowed any doctor to prescribe heroin to people dependent on it; since then, only specially licensed doctors can. The Rolleston Committee endorsed the practice in 1926, and for nearly forty years addiction in Britain stayed small and stable. It unravelled in the 1960s, when the second Brain Committee found that a small number of doctors were overprescribing and that their supplies were leaking onto the street. Supervision answers that lesson. The Randomised Injectable Opioid Treatment Trial, published in *The Lancet* in 2010, found that supervised injectable heroin reduced street heroin use more than optimised methadone among people for whom standard treatment had repeatedly failed. Glasgow opened a heroin-assisted treatment service in November 2019. The licensing rules are set in Westminster law, but in Scotland the licences are granted by Scottish Ministers, and funding, scale and clinical delivery are devolved. Every person supplied with a known dose of a pharmaceutical drug is a customer the illicit market loses, and one nobody can sell an adulterated product to. That shrinks the profit in adulteration without ending it. The market remains for everyone outside the scheme, and for cocaine, now implicated in more than half of Scotland's drug deaths, the evidence for prescribing is far weaker.

The debate over the Right to Addiction Recovery Bill turned on the same map. The challenge on legislation treated opposition to one devolved Bill as opposition to legislation itself. At the committee in May 2025, the witnesses who opposed the Bill pointed instead to implementing the existing treatment standards and the Charter of Rights, to commissioning services on human rights principles, and to redesigning services around communities and advocacy. The rights route they pointed to was itself legal. The Charter of Rights for People Affected by Substance Use, published in December 2024, states that it is not itself legally binding, and that the internationally recognised rights it describes, including the right to the highest attainable standard of health, would become enforceable once a Scottish Human Rights Bill became law. The Scottish Government did not bring that Bill forward in its 2024-25 programme, citing the Supreme Court's 2021 ruling on the limits of devolved competence. Its Programme for Government of September 2026 now promises it again, aiming for introduction in the second

year of the new Parliament. The other route, changing the Equality Act, lies with Westminster. Both the proposed remedy and its alternatives met the same wall: where legislative power actually sits.

Feature examined	What it shows	Theorist
Enforcement and the market	Pressure on supply produces violence and potency	Bourdieu: the rules of a field shape the strategies of those in it
Two levers inside "decriminalisation"	The person and the market are different stakes	Bourdieu: positions in a field are defined by what is at stake
Remedies stopped at the boundary	Every route meets the limit of competence	Bourdieu: the field's boundaries are themselves a stake

Synthesis: The scaffold

Theorists: Abraham Maslow, on the full hierarchy of needs; Lev Vygotsky, on the zone of proximal development; David Wood, Jerome Bruner and Gail Ross, on scaffolding

The debate treats harm reduction, treatment, recovery and law reform as rivals. The evidence treats them as stages. Context Matters Consultancy works with a four-stage scaffold: Survival, Stabilisation, Reorientation and Reconstruction. Each stage needs something different, is judged by a different measure, and sits with a different tier of government.

Stage	Maslow's hierarchy	Interventions	Measured by	Who holds the levers
Survival	Physiological needs	Naloxone, consumption rooms, drug checking, and the market conditions the law creates	Deaths; overdose call-outs	Westminster for the market; Holyrood and the delivery tier for services
Stabilisation	Safety	Opioid substitution, injecting equipment, blood-borne virus care, decriminalising the person	Retention; infection	Holyrood; health boards; Alcohol and Drug Partnerships
Reorientation	Belonging and esteem	Community treatment, detoxification, residential rehabilitation, peer support	Treatment starts; waiting times; reduced use or abstinence	Holyrood targets; commissioning; providers
Reconstruction	Self-actualisation and self-transcendence	Housing, work, recovery communities, purpose	Recovery capital; tenancy; employment	Councils; Holyrood for supply; Westminster for welfare, employment and equality

Maslow's hierarchy in its fuller, later form rises beyond self-actualisation to self-transcendence: meaning, purpose and contribution beyond the self, as Koltko-Rivera set out in 2006. That is the language of recovery at its best, and of recovery advocacy's appeals to meaning and to becoming someone new. Harm reduction reports from the base of the hierarchy. Recovery advocacy speaks from its summit. Each is right about its own level and wrong to treat that level as the whole person. Maslow's levels are not gates. His own account treats lower needs as taking priority, not as conditions that must be fully met first, and research across 123 countries

by Tay and Diener in 2011 found the needs universal but not fulfilled in strict order. No one should have to prove abstinence to be housed, or stability to be offered a purpose. The stages overlap; they are not a queue.

Vygotsky's zone of proximal development is the space between what a person can do alone and what they can do with support. Recovery happens in that space. Wood, Bruner and Ross gave the support a name in 1976: scaffolding, calibrated to where the person is, temporary, and withdrawn gradually as they are able to bear their own weight. The deadliest points in the evidence are scaffolds removed rather than faded: the four weeks after opioid substitution stops, when the risk of death is around five times that during stable treatment; the year after residential rehabilitation ends; the week a consumption site closes. The debate argues about which stage matters most. The evidence says the gaps between stages kill.

Lived experience has a clear place in that account. What later writers in Vygotsky's tradition call the "more knowledgeable other" is whoever can support a person just beyond what they can manage alone, and peers who have been through it are often best placed to do that. Recovery organisations are essential scaffolders in the middle stages. What the scaffold rejects is any single stage, or any single measure, claiming to be the whole system.

The scaffold explains what the week's arguments could not. Portugal worked on Stabilisation and Reorientation, which is why infections and imprisonment fell, and left the Survival environment untouched, because the market stayed criminal. Tayside brought a virus close to elimination at the Stabilisation stage without asking anyone to stop using first. Minimum unit pricing works before the stages begin, at the level of the population, and does little for people already dependent. The Bill would have reached Reorientation and stopped at Reconstruction, because the job, the income and the protection of equality law were never Holyrood's to give.

The man I nursed at nineteen fell through every stage in reverse. He lost his work, and with it his standing, then his income, then his family's stability, and then his health. The lever that might have held the first rung was at Westminster. The care that might have caught him lower down was in the hands of people who, that day, did not see him.

The missing measure is progression: whether people move through the scaffold, from survival to a rebuilt life. No published measure reports it. Harm reduction reports survival and infection. Recovery organisations report completion and abstinence among those who finished. Governments report activity and access. Until progression is measured, every side can claim success on its own stage and blame another tier for the rest.

Conclusion: Aligning the levers

The evidence points one way on enforcement. There is little to show that treating possession of drugs as a crime reduces drug use or drug deaths, and consistent evidence that enforcement makes markets more violent, supplies more dangerous, and the people who use them less likely to reach help. Removing criminal penalties for personal possession, alongside treatment, harm reduction and support to rebuild a life, is supported by the strongest evidence available. Where decriminalisation ran ahead of services, as in Oregon, it lost public support and was reversed, and British Columbia ended its pilot in 2026.

Scotland cannot make that change. The drug law, the market it shapes, and the employment and equality protections that decide whether a person can take treatment and keep their job all

sit at Westminster. Holyrood holds the services. Its hands are largely tied on the law and free on the services, and the record shows both: a death rate far above England's under the same law, beds still short of target, five boards missing the treatment standard, and outcomes that vary sharply from one health board to the next.

Alcohol shows what a Scottish government can do when it holds the levers. Alcohol has never been prohibited in Britain. Several countries banned it in the early twentieth century and all of them abandoned the attempt, the United States in 1933. What replaced prohibition was not a free market but a regulated one: licensing, taxation, pricing and public health. Scotland used its own powers to set a minimum unit price and can show the lives it saved. Alcohol still killed 1,185 people in Scotland in 2024, so a legal drug is not a safe one. But a regulated market can be governed. An illegal one can only be policed. For drugs, the levers that would allow Scotland to govern rather than police sit at Westminster, with one exception: supervised prescribing, which Scotland could scale today.

The conclusion is therefore not a choice between harm reduction and recovery, or between Holyrood and Westminster. It is alignment. The law should stop working against the services. The services should be judged on whether people move through them, from survival to a rebuilt life, and not on whichever stage a speaker prefers to count. And every tier should be named for the lever it holds.

The man I nursed at nineteen lost his job before he lost his life. Nearly forty years on, the protection he never had is still withheld by a Westminster regulation, and the care that might have reached him sooner is now Holyrood's to provide. Accountability begins by saying which is which.

What to watch

National Records of Scotland is scheduled to publish alcohol-specific deaths for 2025 on 27 October 2026. Alberta's monthly mortality and weekly emergency response data will show, over time, what followed the closure of its consumption sites, and must be read against changes in its drug supply. Glasgow Caledonian University's independent evaluation of the Thistle reports by 2029. Hepatitis C incidence among people who inject drugs remains above the World Health Organization threshold. Each is a test that will be passed or failed on evidence, not on the strength of the argument made about it this autumn.

References

- Athabasca University. (2022, December). Closure of Lethbridge safe consumption site created safety concerns: Study. <https://www.athabascau.ca/news/research-and-innovation/health-and-well-being/safe-consumption-site-study.html>
- Baumgartner, J. C., Gumas, E. D., & Gunja, M. Z. (2022, May 19). Too many lives lost: Comparing overdose mortality rates and policy solutions across high-income countries [Blog post]. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2022/too-many-lives-lost-comparing-overdose-mortality-rates-policy-solutions>
- Beletsky, L., & Davis, C. S. (2017). Today's fentanyl crisis: Prohibition's Iron Law, revisited. *International Journal of Drug Policy*, 46, 156-159. <https://pubmed.ncbi.nlm.nih.gov/28735773/>
- British Columbia Ministry of Health. (2026). Minister's statement on status of the decriminalization pilot program. <https://news.gov.bc.ca/releases/2026HLTH0003-000031>

- Castle Craig. (2026, September 9). How much does rehab cost? <https://www.castlecraig.co.uk/admissions/rehab-cost/>
- Convention of Scottish Local Authorities. (2026, March). Next phase of alcohol and drugs response. <https://www.cosla.gov.uk/news/2026/march/next-phase-of-alcohol-and-drugs-response>
- Culture Alberta. (2026, July 1). Lethbridge closed its last harm reduction site today after overdose deaths fell 89 percent. <https://www.culturealberta.com/articles/lethbridge-closed-its-last-harm-reduction-site-today-after-overdose-deaths-fell-89-percent-not-every>
- DeBeck, K., Cheng, T., Montaner, J. S., Beyrer, C., Elliott, R., Sherman, S., Wood, E., & Baral, S. (2017). HIV and the criminalisation of drug use among people who inject drugs: A systematic review. *The Lancet HIV*, 4(8), e357-e374. [https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018\(17\)30073-5/abstract](https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(17)30073-5/abstract)
- Drink and Drugs News. (2026, September). Number of Scots starting residential rehab up 60 per cent in six years, says PHS. <https://www.drinkanddrugsnews.com/number-of-scots-starting-residential-rehab-up-60-per-cent-in-six-years-says-phs/>
- DrugWise. (n.d.). How pure are street drugs? <https://www.drugwise.org.uk/how-pure-are-street-drugs/>
- European Union Drugs Agency. (2024). Heroin and other opioids: European drug report 2024. https://www.euda.europa.eu/publications/european-drug-report/2024/heroin-and-other-opioids_en
- European Union Drugs Agency. (2026). Cocaine: European drug report 2026. https://www.euda.europa.eu/publications/european-drug-report/2026/cocaine_en
- European Union Drugs Agency. (n.d.). Opioid substitution treatment to reduce mortality. https://www.euda.europa.eu/best-practice/evidence-summaries/opioid-substitution-treatment-ost-methadone-maintenance-reduce-mortality_en
- Félix, S., Portugal, P., & Tavares, A. S. (2017). The impact of drug decriminalization in Portugal (Discussion Paper No. 10895). IZA Institute of Labor Economics. <https://docs.iza.org/dp10895.pdf>
- Glasgow Caledonian University. (n.d.). ENACT. <https://www.gcu.ac.uk/research/researchcentres/reach/research/enact>
- Glasgow City Health and Social Care Partnership. (2026). Thistle service data. <https://glasgowcity.hscp.scot/thistle-service-data>
- Glasgow City Health and Social Care Partnership. (n.d.). Safer drug consumption facility: Service user information. <https://glasgowcity.hscp.scot/sdcf-service-user-information>
- Gumas, E. D. (2026, September 3). Overdose mortality from a global perspective: Why are rates falling? The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2026/sep/overdose-mortality-global-perspective-why-are-rates-falling>
- Heckle. (2025, October). Scotland deserves a better debate on drugs. <https://heckle.scot/2025/10/scotland-deserves-a-better-debate-on-drugs/>
- Hughes, C. E., & Stevens, A. (2010). What can we learn from the Portuguese decriminalization of illicit drugs? *British Journal of Criminology*, 50(6), 999-1022.
- Humphreys, K. (2024). The rise and fall of Pacific Northwest drug policy reform, 2020-2024. Brookings Institution. <https://www.brookings.edu/articles/the-rise-and-fall-of-pacific-northwest-drug-policy-reform-2020-2024/>
- Institute for Government. (2023). The use of section 35 of the Scotland Act to block the Gender Recognition Reform (Scotland) Bill. <https://www.instituteforgovernment.org.uk/explainer/section-35-scotland-gender-recognition-bill>
- Kelly, J. F., Humphreys, K., & Ferri, M. (2020). Alcoholics Anonymous and other 12-step programs for alcohol use disorder. *Cochrane Database of Systematic Reviews*, (3), CD012880.
- Kolla, G., & Gomes, T. (2026, March). Supervised consumption sites: Evidence brief. <https://www.substanceusehealth.ca/sites/default/files/2026%20Evidence%20brief-closure%20of%20CTS%20in%20Ontario-2026-03-20.pdf>
- Koltko-Rivera, M. E. (2006). Rediscovering the later version of Maslow's hierarchy of needs: Self-transcendence and opportunities for theory, research, and unification. *Review of General Psychology*, 10(4), 302-317.

- Lavoie, J. (2026, January 18). Why animal tranquilizers are taking over Toronto's fentanyl supply. CP24. <https://www.cp24.com/local/toronto/2026/01/18/why-animal-tranquilizers-are-taking-over-torontos-fentanyl-supply>
- Library of Congress, Congressional Research Service. (n.d.). The Twenty-First Amendment and the end of Prohibition, part 2: The Wickersham Commission and the repeal movement. <https://www.congress.gov/crs-product/LSB11066>
- Livingston, E. (2026, September 23). New powerful synthetic opioids behind sharp rise in Scottish drug deaths. *The Guardian*.
- Lord Advocate. (2025, January 8). Safer drug consumption room: Statement of prosecution policy. Scottish Parliament Criminal Justice Committee correspondence.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370-396.
- Miron, J. A. (1999). Violence and the U.S. prohibitions of drugs and alcohol. *American Law and Economics Review*, 1(1-2), 78-114.
- National Collaborative. (2024). Charter of rights for people affected by substance use. <https://www.gov.scot/news/charter-of-rights-for-people-affected-by-substance-use/>
- National Records of Scotland. (2024). Alcohol-specific deaths 2023. <https://www.nrscotland.gov.uk/publications/alcohol-specific-deaths-2023/>
- National Records of Scotland. (2025). Alcohol-specific deaths 2024. <https://www.nrscotland.gov.uk/publications/alcohol-specific-deaths-2024/>
- National Records of Scotland. (2026). Drug-related deaths in Scotland, 2025. <https://www.nrscotland.gov.uk/publications/drug-related-deaths-in-scotland-2025/>
- Palmateer, N. E., et al. (2026). Impact of antiviral therapy scale-up among people who inject drugs in Scotland: Regional evidence of hepatitis C virus elimination. *Liver International*, 46, e70771. <https://onlinelibrary.wiley.com/doi/10.1111/liv.70771>
- Pew Charitable Trusts. (2018). More imprisonment does not reduce state drug problems. <https://www.pew.org/en/research-and-analysis/issue-briefs/2018/03/more-imprisonment-does-not-reduce-state-drug-problems>
- Public Health Scotland. (2022, June). Final report published on the impact of MUP on people drinking at harmful levels, including those dependent on alcohol.
- Public Health Scotland. (2024). Needle Exchange Surveillance Initiative: Monitoring blood-borne viruses and injecting risk behaviours among people who inject drugs in Scotland, 2008-09 to 2022-23.
- Public Health Scotland. (2025, November 25). Surveillance of hepatitis C in Scotland: Progress on elimination of hepatitis C as a major public health concern, 2025 update.
- Public Health Scotland. (2026). Estimated prevalence of opioid dependence in Scotland 2014-15 to 2023-24.
- Public Health Scotland. (2026). Injecting equipment provision in Scotland, 2024 to 2025.
- Public Health Scotland. (2026). National drug and alcohol treatment waiting times, 1 October 2025 to 31 December 2025.
- Public Health Scotland. (2026, September 15). Evaluation of the residential rehabilitation programme: Synthesis report. <https://www.drugsandalcohol.ie/46851/>
- Recovery Capital Conference. (2026). From stabilisation to recovery: Why system orientation determines outcomes [Keynote abstract]. <https://recoverycapitalconference.com/from-stabilisation-to-recovery-why-system-orientation-determines-outcomes/>
- Recovery Review. (2026, September 20). Mission accomplished? Rehab in Scotland, five years on. <https://recoveryreview.blog/2026/09/20/mission-accomplished-rehab-in-scotland-five-years-on/>
- Rhodes, T. (2002). The "risk environment": A framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, 13(2), 85-94. [https://doi.org/10.1016/S0955-3959\(02\)00007-5](https://doi.org/10.1016/S0955-3959(02)00007-5)
- Rutgers University Center of Alcohol Studies. (n.d.). Phases of "Phases of alcohol addiction": The story behind Bunkys doodle. <https://sites.rutgers.edu/alcoholstudies-archives/from-the-cas-archives-phases-of-phases-of-alcohol-addiction-the-story-behind-bunkys-doodle/>

- Scotland Act 1998, c. 46.
- Scottish Drugs Forum. (2022, January 13). Right to Recovery: Joint statement response. <https://sdf.org.uk/members-bill-response/>
- Scottish Drugs Forum. (2026, February 9). A National Mission for Change: Scottish Drugs Forum publishes election manifesto. <https://sdf.org.uk/a-national-mission-for-change-scottish-drugs-forum-publishes-election-manifesto/>
- Scottish Drugs Forum. (2026, September 23). Response to NRS report on drug-related deaths. <https://sdf.org.uk/response-to-nrs-report-on-drug-related-deaths/>
- Scottish Government. (2009, April 20). A new framework for local partnerships on alcohol and drugs. <https://www.gov.scot/publications/new-framework-local-partnerships-alcohol-drugs/>
- Scottish Government. (2022). Residential rehabilitation: Review of existing literature and identification of research gaps within the Scottish context.
- Scottish Government. (2025). Prison to Rehab Protocol: Castle Craig Hospital. <https://www.gov.scot/publications/prison-rehab-protocol-2/pages/8/>
- Scottish Government. (2025). Residential rehabilitation bed capacity in Scotland, October 2025.
- Scottish Government. (2025). The Scottish Health Survey 2024, volume 1: Main report.
- Scottish Government. (2025, August 15). Residential rehabilitation expansion. <https://www.gov.scot/news/residential-rehabilitation-expansion/>
- Scottish Government. (2026). Preventing harm, promoting recovery: Scotland's alcohol and drugs strategic plan 2026 to 2035. <https://www.gov.scot/publications/preventing-harm-promoting-recovery-scotlands-alcohol-drugs-strategic-plan-2026-2035/>
- Scottish Government. (2026, September). Programme for Government 2026 to 2031: First Minister's speech. <https://www.gov.scot/publications/programme-for-government-2026-to-2031-first-ministers-speech/>
- Scottish Government. (n.d.). Licensing to prescribe diamorphine, cocaine and dipipanone: Guidance. <https://www.gov.scot/publications/licensing-to-prescribe-diamorphine-cocaine-and-dipipanone-guidance/>
- Scottish Parliament Health, Social Care and Sport Committee. (2025, May 13). Official report. <https://www.parliament.scot/api/sitecore/CustomMedia/OfficialReport?meetingId=16430>
- Scottish Parliament Information Centre. (2024, November 15). The Human Rights Bill: Why has the Scottish Government not legislated and what happens next? <https://spice-spotlight.scot/2024/11/15/the-human-rights-bill-why-has-the-scottish-government-not-legislated-and-what-happens-next/>
- Scottish Parliament. (2024). Right to Addiction Recovery (Scotland) Bill. <https://www.parliament.scot/bills-and-laws/bills/s6/right-to-addiction-recovery-scotland-bill>
- Social Work Scotland. (2025, January). Right to Addiction Recovery (Scotland) Bill [Consultation response]. <https://socialworkscotland.org/wp-content/uploads/2025/01/FINAL-Right-to-Addiction-Recovery-consultation.pdf>
- Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies. *BMJ*, 357, j1550.
- Strang, J., Metrebian, N., Lintzeris, N., Potts, L., Carnwath, T., Mayet, S., Williams, H., Zador, D., Evers, R., Groshkova, T., Charles, V., Martin, A., & Forzisi, L. (2010). Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): A randomised trial. *The Lancet*, 375(9729), 1885-1895. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60349-2/abstract](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60349-2/abstract)
- STV News. (2026, September 22). Record number of children in temporary accommodation in Scotland. <https://news.stv.tv/scotland/record-number-of-children-in-temporary-accommodation-in-scotland>
- Tay, L., & Diener, E. (2011). Needs and subjective well-being around the world. *Journal of Personality and Social Psychology*, 101(2), 354-365.
- The Equality Act 2010 (Disability) Regulations 2010, Statutory Instrument 2010/2128, regulation 3.

- The Mob Museum. (n.d.). Prohibition profits transformed the mob.
<https://prohibition.themobmuseum.org/the-history/the-rise-of-organized-crime/the-mob-during-prohibition/>
- The Scotsman. (2026, September 24). Swinney backs decriminalisation as drug deaths branded "indefensible".
<https://www.scotsman.com/news/politics/swinney-backs-decriminalisation-as-drug-deaths-branded-indefensible-9173250>
- Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Harvard University Press.
- Werb, D., Rowell, G., Guyatt, G., Kerr, T., Montaner, J., & Wood, E. (2011). Effect of drug law enforcement on drug market violence: A systematic review. *International Journal of Drug Policy*, 22(2), 87-94.
- Wood, D., Bruner, J. S., & Ross, G. (1976). The role of tutoring in problem solving. *Journal of Child Psychology and Psychiatry*, 17(2), 89-100.
- Wyper, G. M. A., Mackay, D. F., Fraser, C., Lewsey, J., Robinson, M., Beeston, C., & Giles, L. (2023). Evaluating the impact of alcohol minimum unit pricing on deaths and hospitalisations in Scotland: A controlled interrupted time series study. *The Lancet*, 401, 1361-1370.
[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(23\)00497-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00497-X/fulltext)

About the author

Jim Storrar is the founder of Context Matters Consultancy and EiE Training. He began nurse training in 1987 and has been a nurse for almost forty years. Twenty-six of those were in clinical and public health practice in the National Health Service in Scotland, across psychiatric, addiction, forensic and public health settings, until he retired from active service in 2013. His nursing career has also included teaching nursing and care skills in further education, and his degree and postgraduate study. Between 2009 and 2013 he was Education and Prevention Specialist with National Health Service Ayrshire and Arran, where he designed and piloted a peer education model under Scotland's Blood Borne Virus Action Plan, evaluated independently by ScotCen Social Research; wrote the theory unit underpinning the Scottish Qualifications Authority's Professional Development Award in Brief Interventions for Substance Misuse; delivered brief interventions training under the Scottish Government's national alcohol target; and was a member of the multidisciplinary team that redesigned addiction services at Her Majesty's Prison Kilmarnock. He holds a Bachelor of Science in Health Studies, a Diploma of Higher Education in Mental Health Nursing, a Postgraduate Diploma in Alcohol and Drug Studies and a Teaching Qualification in Further Education, and is a Specialist Member of the International Society of Substance Use Professionals.

