Release's Submission to Phase Two of the Black Review

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 drive 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 a NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

Prevention and harm reduction

1) What interventions are the most effective at preventing problematic drug use? Answers can relate to universal or targeted interventions for both adults and young people. Please include any good practice examples

Release welcomes the focus on preventing problematic drug use rather than attempting to prevent drug use per se. The goal of a 'drug free world' is an unrealistic one. Despite decades of repressive policies, drug consumption has continued to rise unabated. The United Nations Office on Drugs and Crime's 'World Drug Report 2020', for example, estimates that the number of people who have used an illicit drug 'in the last year' grew by 12 per cent between 2009 and 2018, from 210 million globally to 269 million people. Despite this evidence, successive UK Governments have focused on eliminating drug use by preventing young people using drugs in the first place, this is frankly unrealistic. However, strategies and programmes could be implemented to significantly reduce the risk of problematic drug use amongst this population. It is estimated that 87 per cent of people who use drugs (PWUDs) are not drug dependent, and for the 13 per cent who do become dependent on drugs it is not about the drug itself, but rather it is linked to a myriad of problems that lead to people 'self-medicating' to relieve the pain and suffering they experience – addressing the problems that lead to drug dependency must be the target of any approach.

For people who develop problems with drugs, including alcohol, it will often be to address trauma(s) that they have experienced, especially as children. Many will have experienced violence (sexual and/ or physical), abuse and neglect, attachment problems, bereavement, abandonment, been in care, or will suffer from mental health conditions. It is these lived experiences of trauma that leads people to 'self-medicate' for the ongoing pain they suffer. Addressing Adverse Childhood experiences ('ACEs') is at the heart of any prevention strategy, the effect of ACEs has been acknowledged by the Advisory Council on the Misuse of Drugs (ACMD), and therefore the focus must be developing and scaling up responses that can help young people to deal with trauma and mental health issues. As stated in our response to Phase 1, we would advocate a whole-system approach where agencies work collaboratively, to ensure services are trauma-informed and routine screenings for ACEs are made in primary and secondary schools, and that children and young people are supported to process and manage their trauma. Not only is this an effective approach to reducing the risk of problematic drug use in later life, it has the potential to improve many aspects of people's lives, and it is the right thing to do.

The UK Government currently spends £1.6 billion a year on drug law enforcement, which has, according to its own evaluation, "little impact" on the supply of drugs, describing the drugs market as "resilient". The expenditure on drug law enforcement should be significantly reduced and reallocated towards trauma informed services and mental health support for children and young people, as well as supporting social and economic programmes that reduce the risk of drug dependency and more

generally improve the lives of people. It is Release's view that this should be the central plank in reducing the risk of young people becoming drug dependent.

In tackling childhood trauma and mental health issues it is also important to engage with families/ carers of children who have experienced such problems. This should be done in a positive and supportive manner. One example for an effective family engagement programme is the Portuguese programme, "Searching for family treasure", which targets families of vulnerable children. The programme engages participants through sessions with parents, child only sessions and sessions with the whole family. The aim is to provide techniques to improve parenting skills and to improve children's life skills. An evaluation of the programme found "that parents reported being satisfied (37.5%), or very satisfied (65.5%), with the programme. In terms of impacts on substance use, while 91% of the participants consumed alcohol four or more times a week before the programme, upon its completion 62.5% of the parents reported total abstinence, 25% used alcohol once a month and only 12.5% consumed alcohol more than twice a month."

In addition, and in relation to prevention programmes for young people, we would submit that spending on implied 'just say no' campaigns should be avoided and that certain school programmes should be viewed with caution, as those who participate often have the social and economic protective factors placing them at less risk of experiencing problematic drug use. For those young people who use drugs recreationally, investment and support for harm reduction interventions that can reduce the risk of harm should be explicitly supported. For too long UK Governments have viewed harm reduction with suspicion, erroneously viewing it as a proxy for condoning drug use. Such interventions are in fact proven to reduce the risks associated with drug use. The main interventions should include drug checking – research has shown that one in five service users who used this facility in a festival setting disposed of the drugs that they had in their possession after receiving the analysis of the substance (and harm reduction advice), and one in six reduced the amount they consumed – along with realistic and practical steps/information to reduce potential harms, including the risk of death due to overdose. At its core, an effective drug strategy should be about saving lives and reducing harms (including drug dependency), rather than an unhelpful and unrealistic goal of less people using drugs – the metric for success should not be prevalence.

For adults who are suffering from problematic drug use the main focus must be a high quality, well-funded treatment system, that provides a range of treatment options and truly is person centred. Beyond treatment, we must also recognise that those accessing community drug treatment services more often than not experience high levels of deprivation and social exclusion. This is not to say that problematic drug use does not exist for those from more affluent backgrounds, it is just that they will not be relying on community drug services. In recognition of the economic and social exclusion experienced by those accessing community services, there must be a whole systems approach addressing people's legal issues, ensuring pathways to housing or support to retain secure housing, access to benefits, and resolution of outstanding problems, such as court fines or debts. This is the work that Release undertakes through our community legal outreach programme, operating in 11 locations in 8 London boroughs, located at drug treatment services, homeless centres and women only projects – we have highlighted this work in more detail below, see Q10. What is vital to the provision of any service is that it respects the autonomy and rights of their clients - user involvement in the development and continued delivery of such services is absolutely crucial.

More broadly, the need for an effective social safety net will also reduce the risk of adults developing drug dependency issues. In addition, at risk adults also need to have access to trauma informed services and mental health support. In particular, we have a number of clients who have experienced sexual violence in adulthood and gone on to use drugs problematically (including alcohol), and it is

therefore imperative that rape survivor services are properly funded and continued support provided to survivors if they require it.

i. What helps to implement them?

The main thing that is needed to implement the proposals above is funding and effective training. In respect of funding, the expenditure on drug law enforcement must be reallocated towards services and programmes that can prevent problematic drug use, and that can support those in treatment. As highlighted above, £1.6 billion is spent on enforcement however the drugs market continues unabated, yet as highlighted in Phase 1 of the Review we spend in the region of £600 million on treatment (which is likely to be reduced as a result of the significant funding cuts to the sector). Also concerning, is that the Home Office estimated spending on early intervention strategies had fallen from £269million in 2010/11 to £215million in 2014/15 (we have not been able to locate more recent figures, this specific intervention was part of the 2010 Drug Strategy. Furthermore, this intervention appears to have disappeared from the most recent 2017 Drug Strategy). The spend on education is even more negligible and thought to be in the hundreds of thousands. It is clear from the budget lines across different interventions that the dominant approach is for the Government to "arrest its way out" of this problem - this is an un-evidenced and counterproductive approach.

To achieve the strategies set out above, there must be a fundamental review of how we approach drug use in society and how we support those who are dependent, or at risk of becoming dependent. We must invest in programmes and policies that improve people's lives. The fact that we spend 8 times more on enforcement than we did on prevention speaks volumes, and if there is to be a serious endeavour to support those at risk then a significant reallocation of resources is needed.

In terms of training, those who work in drug treatment and associated services must receive training directly from people who use drugs problematically. They must learn not only from their experiences and their knowledge in relation to how to deliver effective services but also about drugs, and the drugs market. Of course there should be benchmark qualifications, but to be effective in a role in drug treatment, you must learn from people who have or are experiencing drug dependency. This approach should be supported by services, by professional bodies and people who provide this type of training should be properly remunerated. Numerous studies have shown that the therapeutic relationship between a client and their keyworker/clinician is fundamental to effective treatment outcomes. Central to this is treating the client with respect and listening to their needs. Too often, in treatment services, clients are treated in a paternalistic and controlling manner, with clients often reporting that they are being coerced to reduce the dosage of their opiate substitution treatment ('OST') or that there are conditions attached to their medication, such as attendance at a group therapy session. This is wholly unreasonable and is not a feature of treatment of other health conditions.

At the heart of every service should be a service users forum who are involved in the recruitment of staff, the management, development and delivery of services, and who can advocate on behalf of other users of the service. Service user forums should be separately funded by the local commissioner to allow for autonomy. Proactive steps must be taken to ensure these forums include people of colour and womxn to ensure that services and projects are sensitive to the needs of these groups.

ii. What makes implementation difficult?

The failure to implement the points highlighted above, in relation to what is needed for effective prevention strategies, are also currently barriers to implementation.

For those who are dependent on drugs, the main barrier is how they are viewed by society and politicians, this is a highly stigmatised group. The fundamental driver for the stigmatisation of this population is the fact they are criminalised through our current drug laws. Criminalisation of possession of drugs is an ineffective policy, it does not deter drug use but causes significant health, social and economic harms to individuals who are criminalised and acts as a barrier to seeking treatment. Both the Health and Social Care Select Committee and the Scottish Affairs Committee in their inquiries on drugs in 2019 have recommended that the UK government consult on reforming the law to end criminal sanctions for possession offences. As Assistant Chief Constable Johnson of Police Scotland stated in his evidence to the Scottish Affairs Committee into *Problem Drug Use in Scotland*, the criminal justice policies pursued by the UK Home Office are "deleterious [… in] pushing people into a place where there is more harm". The evidence for decriminalisation reducing harm within vulnerable populations is detailed at Q2.

2) What interventions are most successful at reducing harm, particularly within vulnerable groups? Please give examples of what has worked well and which vulnerable group they relate to.

The most significant harm for people who are dependent on drugs, especially opioids, is the risk of death. The UK has one of the highest rates of drug related deaths in Europe, with deaths at an all-time record high for the seventh year in a row. Despite these alarming facts, little has been done by the UK Government to tackle opioid related deaths. The ACMD's excellent recommendations from *Reducing Opioid Related Deaths in the UK* should be fully adopted, this expert report identifies some of the systematic problems that contribute to such high rates of fatalities amongst this population and puts forward solutions that could save lives. Unfortunately, the UK Government seems unwilling to support the range of harm reduction initiatives recommended by the ACMD. In particular, Release supports the proposal for drug consumption rooms (DCRS), which have the potential to engage those not already in contact with treatment services. This is vital as it is estimated that in 2013, 54 per cent of those who died from an opioid related death had not been in contact with drug services in the preceding five years – DCRs are one way to overcome this problem. DCRs not only reduce risk of overdose and BBV infections among PWUDs, they also reduce public injecting and drug-related litter. These facilities can also provide pathways to treatment and healthcare services.

Core to preventing drug related deaths is the adequate provision of naloxone. Research undertaken by Release in 2019 found that only 16 take home naloxone kits were given out for every 100 people using opiates in 2017/18. Taking that number, along with kits dispensed in the previous two years, the estimated coverage was 34 per cent of people who use opiates (take home naloxone has a shelf life of 3 years). In many areas, take home naloxone kits were not made available to key populations most likely to experience of witness an opioid overdose. Of the 152 local authorities who responded to the Freedom of Information Requests: 11 per cent did not provide kits to the family and friends of people who use opioids; 25 per cent did not provide kits to people in contact with outreach services for homeless populations; 58 per cent did not provide kits to clients accessing opioid-related treatment or services at community pharmacies.

Naloxone must be available to all those who are likely to experience or witness an overdose, provision of this medication should be integrated into all tenders for services, peers programmes should be funded to reach populations who are not in contact with services. The current legislation only allows for take home naloxone to be dispensed as part of drug treatment services, this should be extended to allow any organisation that works with people who are likely to experience or witness an overdose being permitted to supply this life saving medication. Furthermore, consideration should be given to changing the status of naloxone from a 'prescription only' medication, to a pharmacy or general sales list medication to allow for ease of access, but this must be balanced with ensuring clear funding streams are provided to make sure that access is free at the point of distribution. It is worth noting

that the number of kits that have been dispensed increased dramatically just prior to, and under, lockdown and treatment services and peer outreach programmes should be lauded for the work they have done in this area.

In relation to those in treatment, and indeed in attracting new people into drug services, there is limited choice in medications for those who suffer from opioid dependency. The usual medications that are prescribed are methadone and buprenorphine, which work for some but a wider range of OST should be supported. There has been a decline in specialist prescribing of injectable preparations, such as diamorphine and Physeptone, which are well researched and known to be effective with people who inject drugs. The RIOTT trial demonstrated that whist injectable prescribing was associated with higher medication costs, it in fact provides a saving to society which is considerably higher than that of oral Methadone. This is particularly important for those people for whom traditional OST medications have not worked, we would therefore recommend investment in diamorphine prescribing (and other injectable medications) and support for Heroin Assisted Treatment (HAT). The HAT programme in Middlesbrough, set up in October 2019, has already had some hugely successful outcomes. The 11 participants in the programme had committed a total of 943 crimes, the cost of their reoffending was estimated to be £3.7 million, since entering HAT not one participant has reoffended. Participants have also reported significant improvements in their overall wellbeing, and in their physical and psychological health, with attendance rates at the programme reported to be 99 per cent.

Beyond the expansion in medications available to people who are dependent on opioids, Release would also strongly recommend less restrictive prescribing for those in receipt of methadone and burprenorphine. Under COVID-19, treatment providers moved people who were on daily supervised consumption or daily pick-ups of their medication to weekly or fortnightly prescriptions, the response from clients has been overwhelmingly positive. The vast majority of people who have experienced this change in prescribing – of which there are tens of thousands - report feeling more trusted and in control of their treatment, many have reduced illicit use of heroin, and some have reported that they are voluntarily reducing the dose of their medication in consultation with their prescriber. The emerging evidence for this approach is detailed at Q24.

As Phase 1 of the Black Review identified there are approximately 180,000 people who use crack cocaine in the UK, some will also use heroin but some will not. Just 39 per cent of users are estimated to be in treatment. This is largely because treatment services have been focused on opioid users, this is in no way a criticism, and is a result of the fact that we have no substitution medication for this population, with the only real option for support being cognitive behavioural therapy or other similar therapies. The UK must be more ambitious in the treatment of people who do not use opioids but are dependent on other substances, such as, crack cocaine, powder cocaine and benzodiazepines. British Columbia, Canada, has adopted a 'safe supply' model towards all problematic drug use, essentially prescribing substitute medications for a range of illicit use, or transitioning people from illicit drugs to regulated prescribed versions of the same drugs. For example, those dependent on stimulants can be prescribed Dexedrine or methylphenidate. This model was adopted by BC in recognition of the dual public health crisis of COVID-19 and the high rates of opioid overdose deaths. More information on safe supply is detailed at Q10.

Another limitation in attracting people into treatment settings is the laws prohibiting the supply of paraphernalia under section 9A of the Misuse of Drugs Act 1971. The exemptions to the law allow for the provision of specific sterile injecting equipment, to reduce the risk of BBVs. However, the provision of crack pipes to encourage safer use and reduce respiratory harms is illegal, as is the providing of intranasal equipment to promote less sharing of such paraphernalia. Essentially, there are limited reasons as to why someone using stimulants would engage with a needle syringe programme (NSPs)

unless they inject opioids. Yet, NSPs are often the first point of contact for someone engaging in services, and are an opportunity to address other health issues they may be experiencing providing a route for referrals. Therefore, we would recommend that s9A of the MDA 1971 is repealed to allow for effective harm reduction responses across a range of substances.

Moreover, there are concerns that reductions in funding have had an impact on NSP provision and this has impacted on the transmission rate of BBVs amongst people who inject drugs (PWID). UNAIDS estimates that PWID are at 22 times greater risk of contracting a BBV than the general population, this is an avoidable statistic if there is sufficient and easy access to NSPs. The recent outbreak of HIV amongst PWID in Glasgow is of significant concern and demonstrates the importance of NSPs. It is also estimated that over 50 per cent of PWID have Hepatitis C, and that there has been a worrying increase in the number of new infections rising from 45 per cent of this population to 55 per cent in 2018. There are concerns that one of the drivers for this development is inadequate access to harm reduction equipment. This problem may have been compounded by COVID-19 and the lockdown, with recent research indicating that provision of NSP has halved, whether this is due to a reduction in injecting incidents or an increase in sharing of equipment is unclear but considering coverage was inadequate prior to lockdown, this is very concerning.

There are other significant health harms amongst PWID because of inadequate provision of NSP, in particular the supply of water ampoules to ensure sterile injecting practices is limited. Research has shown that for PWID they are routinely not being supplied with water ampoules, leading them to use unsterile equivalents including toilet water, water from puddles, soft drinks, alcohol, spit and other liquids. This is leading to an increase in bacterial infections and puts them at risk of serious health complications, such as blood poisoning. The problem in providing water ampoules is linked to legislation related to pharmaceutical products for prescription only medications (which water ampoules are) not being allowed to be individually supplied as ampoules but rather the whole box has to be prescribed. This is expensive for providers and many PWID do not want to take a whole box even if it is available. The supply of individual ampoules should be encouraged and any relevant legislation should be explicit on this point.

The provision of adequate NSP not only saves money in the long term by reducing the burden on the NHS in relation to treatment of BBVs or hospital admission for bacterial infections, but it also saves lives.

At the core of NSP provision is the need for a range of models to ensure people are able to access the equipment they need. Mobile services, alongside fixed sites, need to be supported, peers must be involved in this work as their knowledge of safer injecting practices and identifying risky practices far outweighs the knowledge of any "professional" who has never injected drugs. Peer to peer outreach should also be supported and should be properly funded and peers remunerated for the work they do. Peers are much more effective at reaching out to communities that inject drugs, including those who are street homeless, and can link them back into treatment settings, if people wish to engage.

In an unregulated market the harms caused by substances themselves can be directly linked to them being mis-sold or being cut with harmful adulterants, Release would therefore also recommend drug checking services being available via NSPs. As outlined at Q1 this intervention can help people make safer decisions about their drug consumption.

In order to reduce drug related deaths, BBVs, and other health harms the legal framework must be addressed. As highlighted in Q1 criminalisation is completely ineffectual in its aim of deterring use and is counterproductive in that it increases harms to individuals. Decriminalisation of possession of all drugs, or cannabis, has been adopted by 29 countries across the world - the majority have ended

criminal sanctions for possession of all substances. None have experienced an increase in drug use linked to the legal reforms. However, a number of countries that have implemented this approach, alongside investment in treatment, harm reduction and prevention, have seen significant and positive outcomes in terms of health, social and economic factors.

Portugal decriminalised by ending criminal sanctions for possession of all controlled drugs in 2001, while also investing in harm reduction initiatives, treatment and prevention. Now people caught in possession are instead referred to a dissuasion committee to see whether they need help to address their substance use – in over 80 per cent of cases proceedings are adjourned. Positive outcomes have included:

- Decrease in use amongst problematic users & young people becoming dependent on drugs such as heroin;
- Decrease (over 40 per cent) of the estimated numbers of PWIDs;
- Increased treatment engagement;
- Significant decrease in HIV and TB transmission;
- Decrease in prison population;
- Reduced burden on criminal justice system allowing police to focus on serious crimes;
- Improved relationship between the community and police; and
- Decrease (18 per cent) in the social costs of drug use in the first 10 years of decriminalisation.

The Czech Republic decriminalised possession of all illicit drugs in 2010. One influencing factor was a cost-benefit analysis of Czech drugs legislation in 2002 that was undertaken by the National Drug Commission. After a two-year evaluation research found that penalisation of controlled drugs: had not affected availability; increased prevalence; resulted in higher rates of initiation of drug use amongst young people; and increased social costs significantly.

The rate of drug-related deaths is 22 per million in the Netherlands, 16 per million in Spain, 5 per million in the Czech Republic, 8 per million in Italy, 4 per million in Portugal and 21 per million in Germany. These rates are all significantly lower than the UK's drug related death rate of 74 per million of the population. While the lower rates of drug-related deaths in these countries will not necessarily stem from the legal framework alone, it is nonetheless noteworthy that all of these countries have ended criminal sanctions for drug possession offences under various models of decriminalisation. Arguably, better health outcomes can be achieved when drug dependency is viewed through the lens of public health rather than criminal justice.

In addition to the issues outlined above, Release would reiterate that problematic drug use cannot be seen in isolation from structural poverty for those accessing community drug services. Social and economic strategies must also be addressed, we deal with those issues in Q10.

i. What helps to implement them?

Many of the implementation issues raised in Q1 are also relevant to this section.

What is needed to implement the approaches outlined in Q2 is more funding for services, some of this could be achieved through a reallocation of resources away from law enforcement to interventions that reduce harms. Political support for evidenced based approaches to drugs, including problematic

drug use, has been absent, rather the focus has been on tired tropes based on moralistic viewpoints that have done nothing to reduce harms and save lives.

ii. What makes implementation difficult?

The woefully inadequate funding for drug services and lack of political support for harm reduction initiatives, highlighted above, are barriers to effective implementation.

One further issue that has led to reduced support for harm reduction, including OST, in recent years has been Government's focus on recovery defined as being abstinent. Recovery can have really positive connotations, as demonstrated in the mental health field, where recovery means adopting strategies to live positively with your condition. However, in the drugs field it is defined as being in a drug free state, for some people this is not possible or desired and the whole recovery environment can be a barrier to accessing services. It also fails to recognise those who are on OST can have full and productive lives. This idea of being 'parked' on methadone is stigmatising and, frankly, would not happen in any other field of medicine. If someone is on insulin but is not adhering to dietary recommendations we do not, and should not, demean them but this is done to people on OST. Methadone is one of the most researched medications in the world, it is on the WHO Essential Medicines list and has been proven, along with burprenorphine, to be the **only** treatment response that can prevent overdose and opioid related death (the research did not include other forms of OST). People on OST should be considered in 'recovery' if they have stable lives measured by engagement with families and community, looking after their children or other care-giving, being in education or employment, volunteering for organisations – these are the kind of outcomes that should be considered "success" - not simply being "drug free".

Discriminatory practices such as promoting the view of drug free as superior to being on a prescription is also present in the treatment field (although many services are working hard to address this). This attitude is seen also in employment practices of treatment providers, not employing workers who are on OST, therefore the medication is seen as a barrier even within the drug treatment field. Anti-discriminatory attitudes and philosophy are an integral part of harm reduction, so the over focus on abstinence has often served to perpetuate the myth that OST is also drug use, rather than part of recovery and/or recovery in itself.

3) What do you think the government could do to support the implementation of harm reduction interventions?

Please see our response to Q2.

i. What do you think the government could do to support drug prevention initiatives and interventions?

Please see Release's response to Q1.

Young people

4) What do you think has caused the recent increase in drug use amongst children and young people?

Release notes that Phase 1 of the Black Review reported that there has been a 40 per cent increase in 11 to 15 year olds using a controlled drug since 2014, using the data from Smoking, Drinking and Drug

Use among Young People in England 2018 [NS]. We would exercise caution as the figures reported for 2014 were the lowest figures reported for any year of this dataset since 2001, therefore this will give an impression of a significant increase in a relatively short period of time. However, the most recent figures for 2018 are lower than the reported levels of drug use amongst young people in 2009 and for every year that precedes that year, so from 2001 to 2009 the proportion of young people reporting using an illicit substance was above the 2018 figure of 14.5 per cent. In fact in 2001, 20.4 per cent was the second highest percentage recorded, so we could say that between 2001 and 2018 there was a fall by 40 per cent in young people's drug use. These surveys are often unhelpful in assessing whether there is an actual problem if we take arbitrary points to assess changes in drug use, what they are helpful for is measuring trends over time.

What can be seen from the dataset is that there are continued and sustained increases across certain drug types, such as ketamine. As highlighted in Q1, Release would suggest that an effective response to this would be a harm reduction campaign. This would highlight the very real health risks, how to reduce those risks and provide sources of support and education. This type of approach should be reflected in the school curriculum. As stated above, implied 'just say no' campaigns are ineffectual and a waste of resources, contributing to a culture of stigma and discrimination towards PWUD.

If we are to address concerns about young people in the current climate, including the risk of some young people becoming dependent on drugs or becoming involved in serious violence or the drugs trade, then we should be addressing: the high rates of school exclusions, which disproportionally affects young black boys; the closure of youth centres due to austerity; the lack of opportunities for employment and advancement in communities that have been further decimated by austerity; the removal of the educational maintenance award; the trauma caused by the financial and housing insecurity faced by many children's parents. It is these issues that place a young person at greater risk of drug dependency and increases the likelihood of a range of health and social harms.

i. What do you think can be done to reduce drug use among children and young people?

Please see Release's response to Q1.

5) Please tell us about any types of drug and alcohol services or inventions for young people that work well. We'd particularly like to hear about services or interventions for types of drug and alcohol use which are increasing such as alprazolam (Xanax), cocaine or Ketamine

We would stress the need for trauma informed services and mental health support to reduce the risk of drug dependency, as outlined in Q1.

In addition, young people are at significant risk of criminalisation through our drug laws, for example in 2019, 6 per cent of those convicted for possession of drugs were under 18, this figure rose to 37 per cent for under 24 years old. In the last ten years, we have convicted 31,908 children (under 18s) for simple possession of drugs. More egregious is the impact on black children, in 2018/19 of those aged 18 and under, who were convicted of cannabis possession, 25 per cent were black and 36 per cent were white. Nearly 2000 young people and children (aged 18 and under) were convicted of this offence in 2018/19 [this data was obtained through a Freedom of Information request and is available on request]. A criminal record negatively affects employment opportunities, educational aspirations, and other life opportunities – all of which act as protective factors against problematic drug use. It is also a significant barrier to accessing support services.

6) What are the gaps in interventions and services for young people using drugs and alcohol?

There are significant gaps in services for young people due to the 9% reduction in funding in 2016/17, compared to 2015/2016, for specialist young people drug treatment services. These services cater for young people and are important given the development needs, legal framework and safeguarding obligations, which adult services may not be equipped to deal with or understand. Often problems with drugs will not develop until young people are in their 20s or 30s, and whilst we wholly support funding for young people's drug and alcohol services, it may be the case that these services would be more effective if in embedded in wider youth community programmes.

Furthermore, specific drug and alcohol services aimed at young people should be redefined in terms of the age category for this target group. Too often young adults are referred to adult treatment services, and are vulnerable and may be targeted by older adults, this is especially so for young women. We would therefore submit that youth services should raise the age of engagement for treatment to 25 years old.

In addition there is poor coverage of these services, and where they are available the opening hours are limited, and many young people have to travel out of area to access them. We would suggest that learning is taken from the Portuguese model which takes services to where young people are at, rather than expecting them to attend a fixed site.

More research is needed to see what young people want and what works elsewhere.

7) How well do specialist drug and alcohol services for young people work with wider children's services and mental health services?

Mental health services have a poor record of working jointly with adult drug services, as highlighted at Q18. A young person's service should have mental health workers as part of the team, dual diagnosis can be worked with at both mental health sites and drug services.

In respect of those leaving care much more must be done to support them, too often we have clients who have come from the care system who have not had continued support post 18.

i. What stops them working well together?

As with other areas highlighted there is a lack of funding and good service planning. Young people must be consulted with in the development and delivery of services.

ii. How could this be improved?

There needs to be better local and national needs assessment. Learning from other countries is vital and the main aim should be to reduce harms rather than drug use, by reducing harm there is more likely to be increased engagement which may lead to a reduction in use.

8) What could the government do to help improve specialist drug and alcohol services and interventions for young people?

Please see our response to Q5. and Q6.

Treatment and recovery

9) What are the barriers to implementing evidence-based drug treatment guidelines and interventions? Answers can relate to specific interventions or services, such as in-patient detoxification or residential rehabilitation.

As highlighted at Q2, the Recovery agenda promoted by the Drug Strategy 2010, and defined as being "drug free", had a significant impact on the sector, and in Release's view is one factor in the high level of drug related deaths we are witnessing. In 2012 a coalition of charities and NGOs, including Release, warned that recovery in the context it was being defined would put people's lives at risk, unfortunately we were right, this approach coupled with austerity has created a public health crisis in drug related deaths.

For a number of years, treatment agencies sought to implement the Government's agenda, however more recently they have done significant work to ensure harm reduction is at the heart of their work - this was as a result of people dying and recognition that services that focused on getting people drug free were not attractive to those who are dependent on drugs. Despite this welcomed shift towards more responsive treatment, Government rhetoric has not caught up, for example, in the Drug Strategy 2017 the term "harm reduction" is used only once and only in relation to smoking. This is an ideological position taken by successive Home Secretaries and needs to change in order to allow for the implementation of evidence based approaches. Recovery should have a broad definition, and should sit side by side with harm reduction within the treatment system, rather than at the expense of harm reduction.

The shift to localism has also been a huge blow to the treatment sector, with ever diminishing budgets that compete with other public health outcomes. As highlighted in Phase 1 of the Black Review, there have been significant cuts to funding, in some areas these cuts have been profound. One study found that Wandsworth Council had cut its drug treatment budget by 98 per cent between 2015/16 and 2018/19; Liverpool Council cut its budget by 72 per cent from £12.8 million in 2015/2016 to £3.6 million in 2018/19. These kind of cuts are unsustainable, and make the delivery of services impossible, potentially placing people at risk, as services struggle to keep people safe. It is also a false economy as every £1 spent on drug treatment results in a cost saving to the state of £4. We note that the Government has committed an extra £23million for drug and alcohol services in 2020/21 as part of the Spring Budget, however this falls severely short of the savage cuts experienced by the treatment sector over the last five years. The public health expenditure for drug treatment (adult services) in 2018/19 was £640million, it is estimated that the cut to funding for this area has fallen by 26 per cent between 2014/15 and 2019/20. It is imperative that funding is significantly scaled up, as highlighted above it will generate savings to the state in the longer term, Release would also advocate for a shift back to a centralised national funding structure as discussed below.

Local commissioning practices have raised some issues. Whilst there are some brilliant commissioners, there are others who simply do not understand this area of public health. For example, we had a report from one client who was seeking funding for rehabilitation treatment and the local Commissioner's response was "well he chooses to use drugs, he can choose to stop". Other areas have adopted 'payment by results' models despite the evidence showing that this approach was "expensive, can delay treatment entry and had fewer treatment completions". Freedom of Information responses [available on request] from 122 local authorities found that in 2019, 30 areas were using Payment by Results as part of the local commissioning practices, with 19 of these areas having "successful completion" as a marker for payment, and one area used a "reduction in the numbers of those in treatment" as a payment marker. These approaches are contrary to the evidence and fail to recognise that drug dependency is a chronic relapsing condition, and that people in

treatment is in fact a positive thing, acting as a protective factor against overdose and other health harms. Clear guidance must be issued by PHE and others that a payment by results model is wholly unacceptable and contrary to the evidence.

Release's view is that as drug treatment is often subject to moralistic assessments - such as discharging people early, before they are ready, being a good thing, or not funding rehabilitation because the person 'chooses to use drugs' - there is a risk that local public health funding decisions become politicized or some areas of public health are seen as more deserving that the needs of PWUDs. As we have said, there are some brilliant commissioners across the country, but that is unfortunately not the case everywhere. As such, there should be a move to centralise the budgets for delivery at a national level. Budgets should be calculated on the numbers needing support, the evidence based interventions that work, and should in no way be linked to discharge numbers or reductions in treatment numbers, this is a dangerous and damaging approach.

We have already highlighted in Q2 some of the stigma faced by people who are drug dependent in the treatment system. We would reiterate here that this is a barrier to implementing evidence based treatment systems. As highlighted in the ACMD report *Reducing Opioid Related Deaths in the UK* , some drug treatment services "may not be providing services in a way that will enable both the reduction of drug-related harm and the achievement of recovery". Examples given by the ACMD include: patients encouraged to reduce their OST dose in the absence of clinical reasons; limiting the period OST can be prescribed contrary to national guidelines; reducing or ending OST as a form of punishment for failing to comply with the requirements of treatment. In addition, Release receives calls from clients of services who have been banned from the service and their OST immediately withdrawn for "bad behaviour", these are often minor incidents but clearly such practices are in breach of clinical guidelines and arguably clinically negligent. These actions by some treatment providers goes to the stigma faced by this population who are often perceived as irresponsible, devious, untrustworthy, drug seeking, and of course, criminals. There is often a power imbalance between providers and clients, with the latter unwilling to complain about the service they are receiving, as they fear it will affect their treatment. To properly implement treatment guidelines, a culture of empathy must be engendered within the treatment system, as well as treating clients with dignity and respect. It must be said that many treatment providers are working tirelessly to address this within their workforces, and learnings from these services need to be shared amongst the whole field. Release wholly supports the new prescribing practices that have arisen in light of COVID-19 – please see Q24 – and we would ask that Dame Black specifically endorse this approach as part of this review.

This sector is also quite risk averse, as evidenced in the above paragraph in relation to OST practices. Innovation in other areas of substitute prescribing is lacking, and the developments highlighted in British Columbia on the safe supply programme discussed at Q2 and Q10 should be researched, trialed and implemented in the UK context.

Finally, and again highlighted at Q2, the laws preventing: the expansion of paraphernalia for the smoking and intranasal use of drugs; drug checking facilities; and drug consumption rooms, need to be reformed immediately.

10) What could the government do to better support the implementation of evidence-based guidelines and improve the effectiveness of drug treatment and recovery interventions to help it realise its ambition to 'level-up' communities?

In terms of drug treatment please see our responses at Q2 and Q9 that specifically relate to the Government's ideological, moralistic approach to drugs and the lack of funding. We also reiterate the

need for a safe supply model to be adopted in the UK. As stated above, The Safe Supply model provides people with prescriptions of pharmaceutical grade drugs to use, as an alternative to sourcing these substances from the illicit market. The European Monitoring Centre for Drugs and Drug Abuse state that the harm faced by PWUD will largely relate to accessing drugs in an unregulated market with significant variations in drug potency, purity and adulteration. Furthermore, fear of detection by law enforcement and the possibility of criminalisation is a crucial driver for high-risk drug taking behaviours, including sharing (and use of) non sterile injecting equipment and rushed consumption of drugs in unhygienic and unsupervised environments, increasing their risk of overdose or injury.

As highlighted above, in British Columbia (BC) health experts properly recognised that both drug-related deaths and Covid-19 were public health emergencies and have responded by expanding the provision of Safe Supply services. The stated purpose of the service was to support patients to self-isolate and avoid substance related harms. We however consider that the model could be easily adapted to reduce substance related harms and become a central pillar of engaging individuals with treatment providers. The BC Clinical Guidance refers to their own earlier experience and guidance that diverting people from the illicit market results in good retention of that person in care, reduces criminal activity, improves health and social functioning and reduces involvement in survival sex work. The decision-making process centralises the individual, ensuring that determinations around dosage and regularity took into account their own preferences. All of these are positive outcomes and demonstrate a levelling-up of communities.

In providing people who are dependent on drugs with a safe supply there are immediate benefits to the individual and communities. Firstly, people are immediately diverted from the unregulated market to treatment services where they can receive additional care from health professionals or seek referrals for mental health support. In our experience of assisting people who are drug dependent, we know that problematic drug misuse is often present with multiple co-occurring health conditions, and there is value for the individual and community of engaging with even just those conditions. The provision of a safe supply also reduces the harms associated with criminalisation as possession of prescribed substances would not be an offence.

Communities stand to benefit, as people are diverted away from the illicit market it will become less profitable, and the anti-social behaviour associated with this market can be anticipated to reduce. Furthermore, those in receipt of a safe supply will now have additional money available to spend locally that would otherwise have been diverted into the illicit market, and acquisitive crimes will be less "necessary" as the supply would no longer come at the same cost.

However, drug treatment should not only focus on addressing the person's substance use but also the wider economic and social inequalities they face. It is this approach – addressing health, social and economic factors – that will start to 'level-up 'communities.

As highlighted above, Release provides outreach legal services at drug treatment centres, homeless services, and womxn only projects across London. The legal matters we address go to the issues of social and economic inequalities faced by those we work with. The vast majority of our clients will have multiple legal problems, and the main issues they seek support for include: homelessness; housing insecurity; access to welfare benefits; and debts (both commercial debts and state debts).

In 2016, Release carried out a social and economic return on investment analysis in relation to local and national government expenditure. This analysis focused on the delivery of the legal surgery in one treatment centre in the borough of Kensington and Chelsea, and concluded that for every £1 spent on the surgery there was a saving/return of £11.12. As part of this work we also surveyed 89 service

users of the project, with eight clients undertaking an in-depth interview as part of the process. The gender divide of respondents was 47 per cent female and 53 per cent male. Notably, it is not uncommon for Release's legal surgeries to see a high level of engagement with female clients, often perceived as a hard to reach group.

Those surveyed presented with 176 issues in total, averaging 2.1 legal matters per client. Of those issues, 20 per cent were related to homelessness/housing insecurity, 26 per cent debt, 40 per cent had problems with accessing welfare benefits they were entitled to, and the remaining 14 per cent presented with a range of other issues (this included actions against the police, criminal matters, and family/child matters). In relation to soft outcomes, 85 per cent of clients believed the legal surgery had a positive effect on their treatment, while other reported improvements included: 66 per cent saw an increased feeling of wellbeing; 44 per cent improved confidence/ empowerment; 29 per cent increased income; 26 per cent improved living environment; and 17 per cent reported enhanced social interaction. Over half of the clients reported improvement in at least two areas, and just under a third said they had experienced a positive impact in at least three areas. It is this aspect of the service outcomes that really matter - it is not just about resolving the legal issue, but by doing so making people feel safer, more stable and more confident. For many that can be life changing.

An evaluation of the service was carried out by one of the host drug treatment centres, CGL in Camden, who collected data on 34 of their clients who accessed our service – 50 per cent reported an improvement in their psychological wellbeing, 64 per cent reported an improvement in quality of life, and 7 per cent reported an improvement in paid work. Across all types of substance use there was reported stabilisation, reduction, or cessation, with 57 per cent of opiate users reporting an improvement, whilst 100 per cent of injecting users and 75 per cent of crack cocaine users reported an improvement in their condition.

This is why a whole systems approach must be taken to drug treatment and to those accessing these services. It is unimaginable that a person will be able to address their substance use problems with serious legal matters hanging over them unresolved. Finally, Release staff have been informed repeatedly by clients that the provision of legal advice and representation at a service was the reason for their initial contact with the treatment centre, and that resolution of their legal problems allowed them to more fully engage in their treatment, thus retaining them in the service.

Homelessness is a significant barrier to 'levelling up'. Two thirds of homeless people cite drug or alcohol use as a reason for first becoming homeless. PWUD and are also homeless are at greater risk of the health harms detailed above, through restricted access to accommodation, sterile injecting equipment and drug potency. The efforts taken to prevent a public health catastrophe amongst the homeless population from COVID-19 will have been in vain if similar efforts are not made to reduce the pre-existing catastrophe of drug-related deaths in the population. The UK has one of the highest rates of drug-related deaths in Europe – with a rate of 74 deaths per million in 2016 – and "9 out of 10 overdose deaths (89%) involved some form of opioid". In 2017 there were 3,756 drug-related overdose deaths registered in England and Wales, 934 in Scotland, and 136 in Northern Ireland, 60% more than recorded 10 years ago.

Among the homeless population we know from 2018 that on average 53.8 people will die from a combination of alcohol-specific deaths (13.2) or drug poisoning (40.6) in each quarter. Drug-related deaths of homeless people have more than doubled in the last 6 years. In 2020 16 homeless people are recorded as having died from a condition involving COVID-19 across March - June, but this represents less than a third of those who died from alcohol or drug poisoning during the same period.

The homeless population, and especially those who use drugs, are at great risk of two public health crises. Urgent action is needed to avoid further preventable deaths and we believe this can be achieved through a Housing First approach, as well as the provision of legal support outlined above.

Release advocates for the development of a Housing First policy, providing support to people who are dependent on drugs and, in turn, benefitting whole communities. In recognising that abstinence is not the only successful outcome of treatment, it must also not be a requirement to access stable accommodation. The early successes of 'everyone in' in response to COVID-19 undoubtedly averted an even greater public health catastrophe among the homeless population, and it is hoped that the funding since made available will allow for a genuine effort to be made to prevent a return to street homelessness for many. The continuing efforts of the Ministry of Housing, Communities and Local Government (MHCLG) and Dame Casey to resolve the homelessness situation must include a Housing First approach, there should be no requirement to be abstinent in order to access or retain housing, otherwise any long-term resolution is destined to fail. Engagement with this population, and maintaining this engagement as time progresses, must be the central aim; the present moment offers a genuine opportunity to not only resolve the pre-existing homelessness and drug-death crises, but put in place the groundwork to ensure they are not repeated.

Given the prevalence of substance use among the homeless population it is understandable that one strategy that arose were pathway services. In this model people move along a pathway of accommodation types; hostels, shared accommodation and then onwards to longer-term housing. However, the continued provision of housing is also reliant on the individual maintaining progress on a treatment pathway. A relapse can therefore have a substantially negative effect not only on a person's health and wellbeing, but their housing status.

We advocate instead for providing individuals with stability on which to progress with treatment at their own speed. The pathways system is at risk of providing individuals with the stability of a house of cards; when a relapse occurs, all other stability falls aside at a moment of significant vulnerability. Instead we must recognise that relapse, and failure to progress beyond a certain point in treatment, are not determinative features of whether an individual should be housed. There are definite and measurable improvements to communities by increasing the quality of life for the PWUD within that community. Where Housing First is provided it has been shown that it ends homelessness for "at least 80% of people with high and complex needs; improves anti-social behaviour; reduces use of emergency and criminal justice systems" and stabilises or reduces problematic substance use. This is an effective approach which can assist the Government in its ambition to level-up communities, and which can coexist and support a policy of safe supply for cumulative improvements.

Finally, the need for a clear employment strategy for this population is core to the government's aim of 'levelling up', as it will help improve the quality of life of one of the most vulnerable groups in society. These interventions should be encouraged to measure effectiveness using a range of socio-economic indicators of quality of life, recognising that the social reintegration of PWUDs and those in recovery benefits society as a whole.

In this regard, the example of the 'Programe Vida Emprego '(Program Life Employment, or PVE), implemented by the Portuguese government, is instructive. Alongside receiving treatment for their drug dependency and help to reduce their drug use, individuals participating in the programme received assistance to re-enter the workforce. Dedicated 'reintegration teams 'worked alongside treatment teams to provide the necessary support and a dedicated 'social mediator 'helped overcome barriers such as stigmatisation. In addition, the government offered a range of financial incentives to employers, including wage support of up to 80% of the national minimum wage for an initial period,

complemented by a one off financial incentive if the employer retained an employee through the scheme on a permanent work contract.

We note the parallels in the present context with aspects of the government response to the COVID-19 pandemic - notably, the 'furlough 'scheme and 'Kickstart 'programme for young people at risk of long-term unemployment - which are based on an acknowledgement that Government intervention to assure jobs and wages in the short-term will pay dividends in the future.

Government should direct spending at those in drug treatment and recovery as an investment in the future and to ensure they form part of the economic recovery. Any scheme could be designed to ensure that industries and employers that participate provide genuine benefit to the community – whether that's decarbonising our economy, public service or helping build skills in vital industries.

The importance of a whole-system approach, whereby individuals are able to access employment and education assistance, mental health services, financial and housing support, and legal advice, are core to dealing with the vulnerable population of people who are drug dependent and reliant on community drug services.

If the Government is serious about 'levelling up 'people and communities, we must accept this cannot be achieved in complex cases to a predetermined timeline. There is more to 'levelling up 'than simply securing a bedsit and a minimum wage role for someone; it may involve rebuilding family relationships or friendships, or offering support to address isolation and loneliness. Given the occurrence of adverse childhood experiences there will be a need to ensure people's wider mental health is being supported where needed.

11) What are the best models for commissioning and providing drug treatment and recovery services?

As stated at Q2 service users and peers must be at the heart of any commissioning of drug services locally. However, this is not a homogenous group. Specific attention should be paid to people of colour and womxn involvement through the commissioning of services that are gender and culturally focused and responsive.

The best models for commissioning and providing drug treatment and recovery services are ones that encompass: locally researched knowledge of drug using patterns and local knowledge of vulnerable groups, including, identifying homeless numbers, poor access to housing and hostels, and lack of after school facilities (placing young people with limited opportunities in education and insecure housing vulnerable to developing drug problems). All these indicators need to be reviewed and accounted for health inequalities in the community and educational and housing inequalities should be considered in funding allocations. Ideally, commissioners should be specialists in drug and alcohol treatment.

Attention needs to be paid to "older" people who use drugs, some of whom have been attending treatment services for many years, and who have witnessed changes in practices and reduction in their choice of treatment. Some of them will have had their treatment changed from a more specialised treatment, for example, injectable medications or oral medications other than Methadone. They are often struggling with loneliness and frightened of further changes and tend to isolate themselves. This can often be seen in drug treatment settings, where these clients are having to work with keyworkers who have little knowledge of how their history has been formed, and how many treatment changes they have had to endure. Services should consider how to retain older people already attending services, and how to attract those not in services. The "Orange" guidance contains evidence based treatment approaches, however they sometimes may not be applied, as dose

reduction and recovery (meaning being taken off OST) leading to 'successful completion of treatment' has become one of the main driver in drug treatment outcomes, as outlined in the Public Health Outcomes Framework document.

i. What are the best ways to secure effective accountability for those services across different organisations at a national and local level?

Locally outcomes should move away from treatment completions and instead focus on reduction of harms including: drug related deaths; BBVs; other health conditions. Instead of success being measured on the numbers leaving treatment it should focus on increasing numbers in treatment (proper funding should be provided to support this). In respect of the latter, and considering that over 50 per cent of those who die from drug related deaths have not been in contact with services in the last five years, it is vital we increase numbers in treatment if we are truly to address this public health crisis.

National accountability should be based on the outcomes highlighted above. There must be a move away from determining success of a drug policy based on prevalence, for too long the Home Office has put out meaningless statements that the UK's drug policy is working because less people are using drugs. At a time of record high drug related deaths (for the seventh year in a row); an increase in HIV transmission in Glasgow and an increase in Hepatitis C rates; and significant increases in homelessness and housing insecurity; a successful drug national drug policy should not focus on levels of drug use but rather be measured against a reduction in harms.

ii. What levers or mechanisms could be introduced to ensure that services are effective and respond to the needs of local populations?

Please see our response to Q11 and Q11(i). Core to any local work should be the involvement in peer led initiatives.

Peer support and service user networks have been decimated across the UK, largely as a result of being de-prioritised in the context of significant funding cuts to drug treatment. The Drug Strategy 2017 has exacerbated under-funding by only recognising the value of "peer-led recovery support" and "service-user led initiatives", while completely neglecting peer support for PWUDs (i.e. that are not in 'recovery' as defined by abstinence) and for those that do not use or engage in services. It also appears as though groups that face barriers to accessing drug services that are largely catered to the needs of white men who inject opiates – namely womxn, people of colour, young people and sex workers – are not adequately represented in service user networks. Despite this challenging environment, Release is aware of relatively strong service user networks operating in Lambeth, Lancashire and Glasgow (albeit noting the abovementioned issues with representativeness), as well as peer provision of take-home naloxone in a handful of local authorities and through EuroNPUD's 'Naloxone Access and Advocacy Project'. There are clearly some excellent examples of innovation in this area internationally, including:

- 'Metzineres' in Spain, which is a low-threshold and integrated harm reduction programme and space exclusively for womxn who use drugs;

- 'Sinners Dinners' in Australia, which is a targeted community event for street based sex workers (SBSWs) who inject drugs, aiming to "boost community capacity, build solidarity, share lived experiences, empower SBSWs, and disseminate information and education, as well as providing an easy pathway for the provision of safer injecting equipment";

- 'The Urban Survivors Union' is a grassroots coalition of PWUDs ('former and active') in the US, who were instrumental in introducing harm reduction services to the US, such as crack pipe distribution to reduce the spread of BBVs;

- The Bergen Community Council in Norway set up a drug policy advisory board, with elected representatives from "civil society, including members of user organisations, next of kin and NGOs working with drugs and addictions", which meets regularly to advise and make recommendations on local drug policy and services for PWUDs; and

- Activist groups, including drug user groups and other community allies, having played a key role in establishing overdose prevention sites in Canada which have effectively prevented drug-related deaths.

At a national level support and funding should be made available to develop a national network of people who use drugs, which would include active drugs users, those in treatment, including those on OST, and those in recovery groups. During COVID-19 Release has established a national monitoring network to assess changes to the drugs market, and to respond with harm reduction advice. This network has included people from all the groups mentioned and it has been so positive to see the working relationships that have been developed. This kind of network would be invaluable in the development and delivery of national policy.

12) What are the most effective ways of commissioning, designing, and providing integrated services for people with multiple and complex needs?

First and foremost, and as we have repeatedly stated, the commission and design of services must have user involvement at the centre of their processes. Service user forums, and other methods of user involvement are well-established methods of engaging with the client group and providing an opportunity to influence its suitability to their needs. Not only can this ensure that the service is one that people wish to use but it also provides clear opportunities for the development of soft-skills. For example, users involved in this work will collect feedback from fellow users, liaise and negotiate with the management, or develop support networks with other service users.

From our work with existing services and users involved in their operation there are matters which we find often arise. A common request through user involvement is the provision of less restrictive practices in regards to Opiate Substitution Therapy (OST), in particular the extended use of daily collections and supervised consumption, which people find to be demeaning and indicative of distrust towards them. The changes to OST prescribing, that is, a less restrictive approach, as a result of COVID-19 have exposed these as being discretionary choices made by prescribers as opposed to medical necessities (please see Q24).

We also advocate for the adequate funding of peer outreach to help establish innovation and best practice at both local and national levels. Commissioned services should not only place user involvement at the centre of the local experience but assist the development of a national forum of service users to encourage the development of new approaches (as highlighted above). This can provide for users involved in one area of the country to learn from others, recognising that the problems encountered are unlikely to be unique and allow wider discussions on best practice and support for service users. These peer outreach groups can also reach substance users who may not currently be engaging with treatment services but may nonetheless benefit from harm reduction interventions. These may be as simple as allowing peers to provide Naloxone to those not in

treatment, or advocating for wider policy changes that could allow for the safe provision of alternative consumption methods, such as crack pipes for those currently injecting.

In our own experience working at treatment services there is a huge demand for legal services and housing support and we would encourage that in commissioning services this is taken into account. Our practice is to provide regular face-to-face appointments at the services available to all engaging with it, but at the minimum, we would encourage the development of referral pathways for service users to access a range of legal services. The treatment services where this is offered do so on the basis that it allows keyworkers to focus on resolving the substance use, while a wider foundation of stability can be achieved through ensuring people are receiving the money they are entitled to, are not paying out on liabilities they do not have to, and are secure in their housing.

It must also be accepted that in designing and providing services for people with multiple and complex needs that what may constitute a successful outcome for one individual may be wholly different to the outcome desired by another. In acknowledging that each individual will have their own needs and goals, it follows that each individual will engage with a service for their own motivations. For some this may well be abstinence but as we have detailed elsewhere this cannot be the only metric of success by which individuals, and commissioned services, are measured against. As we discuss in our other replies we must facilitate, through engagement with treatment services, a transition to stability and this will require the availability of services able to assist with structural impediments in the person's life; housing support, mental health services, benefits advisors, debt advisors, employment support and more.

We reiterate our call for services to be in a position to provide a greater range of treatments than currently available in most settings. In recognising that abstinence may not be the goal of every person, services should be able to meet these other needs. If services were able offer a Safe Supply there would be immediate benefits to all. For the community it diverts people from the illicit market to treatment services, improving the social outcomes through a reduction in anti-social behaviour attributed to the illicit market. For those pursuing abstinence it allows for their engagement to be on their terms, continuing a theme in our call for user involvement in their recovery journey. There are genuine reductions in harm to be achieved for everybody in transferring people's drug use from the illicit market to a prescribed one.

We believe there is also a need to explore the provision of additional mental health services to those engaging with treatment providers. In our outreach work we commonly encounter clients with both problematic substance use and mental health conditions. Individuals with a history of ACE or trauma, and where problematic substance use has arisen through self-medication, will often engage with treatment services with a desire to receive support both with their substance use and underlying mental health condition. We repeatedly work with clients who are rejected from receiving any assistance with their mental health, for example through CBT, until they have secured abstinence for a prescribed period. However, for those who use drugs to self-medicate this perpetuates a cycle they feel unable to break; they use drugs to self-medicate in the absence of therapy, that therapy will not be offered unless they achieve abstinence, and stable abstinence is not possible as they continue to self-medicate in the absence of therapy.

There may well be strong clinical arguments in taking this approach. However, the lived experiences of people who are dependent on drugs, are that this is gatekeeping and a decision which makes their sustained engagement with treatment less likely, and certainly less likely in a context where success means maintained abstinence. These problems are arguably more acute when dealing with the homeless population. For any number of reasons there are people within this population who distrust

services and, once trust is gained, it can be easily lost. It is therefore vital to avoid giving this population a reason to believe they are being unnecessarily 'gatekept 'from accessing the services they have determined they need.

In respect of engaging the homeless population, one commissioned service in the 1990s is worthy of note. The Soho Rapid Access clinic was a drug clinic based within a hostel, that integrated a partnership working approach with specialist substance use nurses, local drug treatment providers, and workers from the hostel. Rough sleepers were referred to the clinic by outreach workers, who attended with them, they were assessed within 24 hours of referral with a full physical and psychiatric assessment, and would be titrated onto OST by the next day. The OST medication would be collected daily by a team member and taken to the clinic, so that the client could consume it there and also get some food and support. Most clients would attend for the whole day, so a top up dose could be provided, and dosage would be increased daily until the person was on a suitable dose level. The service was popular and user involvement was at the heart of this clinic, as was joint working with external agencies, outreach workers and hostel staff. There were also units for people in drug treatment within the local hostels, so it was possible to move into a unit where there was much less drug use happening, once on a script. The clinic did short term intensive work with people, looking at initiation into injecting, experience of witnessed overdose, and blood borne virus testing and education. After a period of around 12 weeks, treatment was transferred to local statutory services.

More broadly, a paternalistic model must give way to consultative engagement with people when determining their own welfare. The current model of commissioned services does not engage a sizeable portion of people who are dependent on drugs. Some of the reforms we call for will require changes to existing legislation; for example, the provision of crack pipes for safer use would contravene the Misuse of Drugs Act 1971 without amendments. Such changes are not without precedent and were previously achieved to allow for the provision of Needle and Syringe Programmes (NSPs), a harm reduction approach which recognised the need to legislate for common sense. Hard to reach populations could also be attracted to treatment were they able to provide a safe supply of alternative substances, services such as Drug Consumption Rooms, and/ or drug checking facilities.

13) How does the way the drug treatment market, in terms of the tendering of services and contracts, impact on outcomes for people and effective service delivery?

Historically the tendering system has been a mess, with contracts often awarded for three years, resulting in services being transferred between the main drug treatment providers who tender for these contracts. This can result in staff changes which can be discombobulating for clients, or staff being TUPE'd over which can be equally distressing for them, or staff redundancies taking place (often the contract will go to pay these redundancies which is a complete waste of tax payers money). By the time a service is properly embedded, it is once again tendering for the new contract, and if they lose, the whole process repeats itself.

We have already highlighted issues with funding, localism and payment by results at Q2. and Q9. However, it is worth noting that as public health budgets have been slashed, this has resulted in tenders having financial thresholds for those applying for these contracts. This has led to some areas receiving no bids for their tenders, as the ceiling for funding is considered too low to safely deliver such services. And when the funding levels are so low, it becomes a race to the bottom for providers. This is a untenable situation both for drug treatment providers, whose financial stability can be impacted, for the clients, who may not be receiving the level of care they deserve and need, and for staff of the providers who feel undervalued and stressed due to the uncertainty.

i. What measures could improve how the market works?

Proper investment in drug treatment is needed, tendering for services should be reviewed and there should be a minimum contract period of at least 6 to 8 years. There should also be a shift to national funding away from localism.

14) Why do some drug users who need treatment not access it?

We have already addressed this issue at a number of questions above but to summarise:

- not attracted to services that place unrealistic expectations on clients or that link the provision of OST to other treatment conditions that have to be applied;
- continued daily pick up or supervised consumption of OST, beyond when it is clinically required;
- services not recognising the specific needs of certain groups including; womxn; people of colour; LGBTIQA+; young people; homeless people; people in poverty.
- fear due to admission of criminal activity, that is possession of drugs, and stigma;
- lack of peer initiatives and service user involvement – this includes limited outreach provision;
- services seen as too paternalistic and controlling and not treating clients as equal with control over their own treatment decisions;
- clients expecting to reduce or come off OST regardless of clinical need;
- lack of services for interventions and treatment (substitute prescribing) for other substances;
- single parents, especially womxn, fearing their children will be taken into care or social services involved;
- lack of services to address social and economic issues, including the provision of legal representation; housing services; and pathways to employment and education.

i. What can be done to address this?

Please see our responses at Q1(i), Q2, Q9, Q10, Q11(ii) and Q12.

We'd particularly like to hear answers about specific groups such as black, Asian and minority ethnic (BAME) communities and women

Despite lower overall drug use among people of colour when compared to the white population, they are likely to face substantial barriers when accessing drug treatment services. People of colour, in particular Black people, are known to face multiple and complex disadvantages and require service provision which is both culturally and religiously sensitive, and yet, there is a lack of drug treatment options that are appropriate to their needs. To overcome this people of colour who are drug dependent should be consulted to help design and implement services that reflect their needs, and

the workforce should also reflect the communities they work with. Significant regard must be given to how health systems more generally fail this population, and that distrust is borne out of this failure, therefore working directly with groups that have been impacted is vital.

For womxn, there are significant issues as outlined at Q15 if they are also parents. More broadly though, womxn are often required to engage in group therapy (as a condition of their OST) where men will also be present, considering the high levels of sexual violence experienced by womxn who use drugs problematically this is wholly inappropriate. More needs to be done to create safe spaces for womxn and survivors of all genders and to ensure crèche facilities are provided to look after children when their parents are accessing services. As with all other groups, womxn should be involved in the design and delivery of services.

15) How well do drug treatment and recovery services meet the needs of parents who are drug users and their children?

We would first make the point that substance use does not, in isolation, give rise to a greater risk of harm to children than many lawful behaviours. It is important to not lose sight of this fact while also acknowledging that intensive or escalating substance use may pose a risk to children through a cumulative increase in risk profiles. For example, a sudden increase in substance use may arise through increased self-medication relating to past trauma, and which may be indicative of a wider deterioration in the wellbeing of the parent, as opposed to the substance use giving rise to a risk in itself.

While all parents may engage with treatment services it must be recognised that single parents will have a greater need for services to take into account the needs of their children. In order to engage with treatment this group will be more reliant on support networks for childcare or need to have suitable facilities at the treatment services in order to allow them to bring their children to the service. Research from Gingerbread found women represent 90% of single parents, and it is known that mothers who have a history of drug use are likely to be hesitant to access treatment due to a fear of losing custody of their children.

We believe immediate progress could be made in overcoming this hesitancy by visibly making treatment services more welcoming to parents and single mothers. This could be achieved through the provision of specific group-therapy sessions for parents and utilising other space at the service to offer a creche during this time. Critically, it would also provide an opportunity to discern with greater certainty whether there were, in fact, any issues of concern that may warrant a more interventionist approach.

We would also suggest looking at how to incorporate alternative models seen as successful elsewhere. Our recommendation for creche facilities is made on the basis of having seen such services implemented successfully at a methadone clinic in Casablanca, Morocco. Elsewhere, the Bronx Defenders in New York State demonstrate the possibilities of holistic services, albeit in a legal as opposed to treatment service. In their model, members of the community who find themselves involved with the justice system are provided with a social worker as a member of their defence team where appropriate. Such provision should also be provided through treatment services here, specifically for parents identified as being at risk of intervention, though it would arguably be of assistance to other service users too.

We envisage a role whereby treatment services provide parents with access to members of staff who have experience of specialism in maintaining the welfare of children. When a parent does engage with

treatment these members of staff would be better placed, through their underlying experience, to make an objective determination as to whether the parent would benefit from a referral to an 'early help 'service. Where support needs are identified then the treatment service can act not only as a conduit to that support, but as an advocate for the parent alongside other keyworkers at the service. Referrals are not a fait accompli, and even where there may be a duty to make a referral, that does not mean that advocacy could not still be made on behalf of the parent.

These proposals would not only remove the disincentive for some parents to seek treatment, but also provide them with early access to the support they may need to retain or regain control of their circumstances.

At Release we have supported women who have children, who have been subjected to onerous conditions linked to their OST. In one area of England, women were transferred onto to daily supervised consumption of methadone due to unfounded fears that presence of the medication in the home was a risk to their children. No incidents had happened, and these women were previously on weekly prescriptions. This change required the women to attend the pharmacy with their children prior to taking them to school, they described the experience as humiliating and led to significant distrust in the service. The decision taken was not a clinical one but rather a blanket policy that had been implemented by the service. We were able to advocate on the women's behalf and get them back onto the previous prescribing regimes, but if that had not been achieved there was a real risk that some of them would have relapsed. These kind of approaches can be incredibly damaging to women's engagement in services, and such decisions should only be based on clinical needs.

i. How could this be improved?

Please see our response above.

16) How could the capacity and competence of the drug treatment and recovery workforce (both providers and commissioners) be improved?

Please see our responses at Q1(i), Q11 and Q11(ii).

Beyond peers being involved in training, commissioning, management, recruitment and delivery of services it is important that the workforce receives education from outside its own service. In particular, we would submit that training from agencies that are in contact with people who might benefit from drug treatment but are not in contact with services is crucial. This would include homelessness charities, organisations such as Release who advocate for those not attending services because of lack of suitable treatment pathways, for example, those needing maintenance treatments and specialised prescribing, that is, injectable prescriptions and those for whom there is currently no prescribing pathways, including people using stimulants and NPS. Training should also be provided on ACEs, trauma, and mental health so that those who work within the drug treatment system understand the drivers for drug dependency and are encouraged to not see this behaviour as a "personal failure". This type of training should be provided to all the workforce not just keyworkers, but prescribers and other staff who deliver services to people who are dependent on drugs.

People who are on OST and who have stable lifestyles should not be excluded from the workforce, their knowledge and enthusiasm is often unparalleled. People with criminal records who have a history of drug use but are stable, should also be provided with employment opportunities, as long as it does not engage safeguarding issues.

At the core of all training is that harm reduction is more than NSP and OST. It is a philosophy, it is not in opposition to the goal of recovery but it does not include stipulation of abstinence, rather it is a respectful health oriented treatment approach.

17) What are the most effective ways of meeting the physical health needs of people in drug treatment?

Having a truly non-judgmental and open approach is vital as many people who use drugs also have some related and unrelated health issues, as discussed above. When the issues are related to drug use, there is often accompanying embarrassment and discomfort in talking about this, as well as fear of both judgement and the aforementioned involuntary medication adjustments or reductions. The importance of positive relationships between treatment providers and clients cannot be underestimated and brings multiple benefits to the person and the service.

Further, providing the correct dose and formulation of OST, assuming this is an opiate cohort: detox, reduction or maintenance medications, oral OST and injectable OST is fundamental. Sub-standard doses with prolonged opiate withdrawal will lead to additional opiate use, which in turn can negatively affect the person's health, both physical and mental.

Release advocates for the provision of health care workers, nurses in particular, who are competent in physical health care nursing present in treatment. Non-healthcare key workers cannot examine patients injection sites, take observations such as blood pressure and other vital basic health screenings; such provisions can lead to earlier discovery of other health problems.

Well-developed links and referrals to other health care services are essential in meeting the physical needs of people in drug treatment. For example, COPD nurses in the community, and hepatology following BBV screening as drug services will see many people with COPD, which leads to premature death. There is a project underway in Liverpool which was set up to facilitate referral to COPD services of people who use heroin.

i. What can prevent their physical health needs being met?

The main problem is once again funding, as drug treatment has experienced savage cuts over the last five years there has been a shift away from having nurses on the staff of these services due to the cost implications. Again, this is no criticism of treatment providers who have had to manage the complex needs of their vulnerable clients with ever diminishing resources.

18) What are the most effective ways of meeting the mental health needs of people in drug treatment?

Co-occurring substance misuse and mental health problems are common and the best treatment providers offer a range of options to meet the mental health needs of service users, such as individual/group therapy and professional psychiatric/psychological support, adapted to the individual's needs.

However, many Release clients who present with a dual diagnosis are told by mental health services that they cannot be treated until they have addressed their drug dependency, yet their drug use is a way of them coping with their mental health problems. On occasion, we also encounter clients who have been discharged by drug treatment providers, despite presenting with mental health needs, because they perceive the person as unwilling to reduce their drug use, rather than acknowledging their untreated mental health issues lead them to self-medicate. The result is a void of care for those

who find themselves turned away by mental health services and drug treatment services alike. In most cases though, the drug treatment service will end up supporting these clients without the requisite expertise to address their mental health problems. This leaves vulnerable, marginalised people without the specialist support they need.

This is a failure in provision and planning to ensure that mental health and substance misuse services provide fully joined up care for those who have co-existing problems. As recommended by the Scottish Advisory Committee on Drug Misuse, which highlighted this very problem, treatment and mental health agencies must share an understanding of what types and sequences of care are appropriate and collaborate flexibly and effectively to meet the needs of those with co-existing problems. This is a key part of the whole-system approach, which we recommended in our response to Phase 1 where agencies work collaboratively.

In addition, it is important that support from mental health professionals is complemented by wraparound services that help to address problems that can exacerbate mental health issues, such as deprivation and instability, insecure housing and legal problems. As mentioned in our response to Question 10, Release undertakes this work through our community legal outreach programme in drug treatment services, homeless centres and womxn's projects. Many service users who are referred by treatment staff for appointments with our legal team are facing personal crises – such as mounting debt, the withdrawal of a benefit or threatened eviction, with the prospect of homelessness, which can lead to worsening mental health symptoms – this represents a barrier to recovery and serious risk of relapse. In our experience, receiving assistance with these issues permits service users to better engage with mental health services and address mental health problems.

i. What can prevent their mental health needs being met?

Please see our response above.

ii. What can prevent their mental health needs being met?

We would urge funding in dual diagnosis to allow specialist trained staff in both mental health and substance use to be utilised in both treatment settings.

19) What current approaches are effective in meeting the employment and housing needs of those in treatment, including people experiencing rough sleeping?

Please see our responses at Q10 and Q12.

Taken as a whole our current systems repeatedly take efforts to gate-keep individuals from accessing services. Local authority Housing teams may insist that homelessness applications can only be made in a certain way, mental health services will require those who problematically use substances to have been substance-free for a period of time, or be subject to waiting lists of six months or more. Any one of these experiences may be sufficient to deter someone from proceeding any further, but to encounter them at each stage will often be insurmountable.

At Connection at St Martins in Westminster, the homeless population are provided access to a day and night shelter (the night shelter has criteria that needs to be met in order to use it and there is a limited period for staying there), with kitchen and laundry facilities. In addition, there are also employment workshops which assist individuals to learn to use computers and undertake other courses. The service also offers appointments with an outreach worker from the Department for Work and Pensions to assist the population there in gaining access to the benefits they are entitled to, as

well as art classes and social clubs to support integration into community. Similar services are also provided by Crisis Skylight in London.

i. What barriers are there to good practice?

Arguably the largest barrier at this time to the good practice we advocate for throughout this response is an unwillingness to place people at the centre of these processes, therefore failing to engage with them on their terms. Early, efficient and effective interventions are needed and are more likely to be successful when they offer treatment options that people want, rather than the ones we wish they wanted. Achieving a notable reduction in harm is a success, tackling poverty and housing insecurity are successes, and we believe the policies advocated for in this response can achieve these notable reductions in harms to the individual and community.

20) How can peer support/mentoring, mutual aid and recovery communities be better supported and improved?

Please see our responses at Q1(i), Q11 and Q11(ii). Essentially, peer support/mentoring and recovery communities need more funding (ideally not from the treatment provider they work with), proper remuneration, and be involved in every aspects of service design and delivery. "Nothing with us, without us" should be a philosophy and goal endorsed and supported by all treatment providers, commissioners and government agencies/departments.

Clearly all peers and recovery workers who deliver services to others will be subject to DBS checks and have safeguarding training. We raise this as one concern we have about some mutual aid groups is the lack of safeguarding, we are not opposed to people independently choosing to use these groups and recognise for many they will be a lifeline. However, we would caution against treatment services providing referral pathways to any organisation/ group that does not have clear safeguarding policies in place. Furthermore, Government should not be promoting organisations or groups that do have robust safeguarding practices in place.

21) What other barriers are there to people achieving and sustaining recovery?

As stated as Q2(ii), recovery should not be defined, it should focus on the quality of someone's life, as determined by that individual, it is the ability to live a meaningful life, rather than the arbitrary and unhelpful goal of being 'drug free'. Much could be learned from mental health advocates on the definition of recovery.

At its core the main barriers to achieving the definition of recovery we posit, is social and economic factors. It is housing and financial insecurity, debt, lack of family contact, feelings of isolation and the legacy of stigma, linked to problematic use, criminalisation, long gaps in employment and lack of educational opportunities.

The Portuguese (PVE) approach (mentioned above) took the innovative approach of making employment one of the end goals of recovery, alongside treatment outcomes. In a study of the programme, (Alcina Branco Ló, "Social integration programs and mediation strategies" March, 2010, research available on request), it was found that out of a sample of 15 individuals who were entered into the programme with similar backgrounds, 13 successfully integrated into the workplace and maintained recovery. The same study found that employment led to increased autonomy and freedom, improved family relationships, improved quality of life and reduced homelessness.

Yet in this country, the current approach tends to ignore employment and focus on abstinence and being 'drug free'. In addition, criminalisation of PWUD (in many cases, for possession of small quantities of drugs for personal use) contributes to stigmatisation and can be a significant disadvantage in the job market. In some cases, access to certain professions may be barred. Other factors, such as gaps in employment resulting from time in rehabilitation/treatment and lack of formal education or training, also make entering the workforce more difficult for many PWUD.

Currently, PWUD in treatment/recovery receive little or no targeted assistance to overcome the additional difficulties they face. The government could learn from the Portuguese example which tells us that interventions which actively encourage and support the employment of PWUD lead to mutual benefit for employers and employees, in addition to better treatment outcomes such as sustained recovery.

i. How could they be addressed?

- Decriminalisation of drug possession offences
- Housing First
- Family support programmes
- Economic opportunities created through tax incentives to employers to hire people who have a history of dependency, including those on OST, and providing micro loans to those who want to start their own business. Think about how apprentice schemes could be utilised.
- The ability to return to the drug treatment service for ancillary support services to address rent arrears; debt; access to benefits. Often once people are discharged they are not allowed to return to the service, unless they are using substances again.

22) What needs to be done to help those in custody address their drug misuse and continue their recovery?

We would firstly suggest that the Government reconsider whether custody is the most effective resolution. Last year, while Secretary of State for Justice, David Gauke recommended instituting a presumption against sentences up to 12 months, and abolishing sentences of under 6 months. A high proportion of people in prison are incarcerated for non-violent drug offences and acquisitive crimes to fundraise to buy drugs. Phase 1 of this Review estimated that 42 per cent of men, and 28 per cent of women entering the prison are dependent on drugs. The think-tank Reform estimates that 15 per cent of people in prison develop a drugs problem whilst they are there.

In 2018, 59,000 people were sent to prison in England and Wales, 69% of these had committed a non-violent offence and 46% were sentenced to six months or less. Convictions for drug offences make up approximately 15% of the prison population, and the Government's own evidence has found that over two thirds of those in prison for under 6 months are considered to misuse substances, with a similar proportion without stable or suitable accommodation.

The imposition of these sentences does not provide an opportunity for rehabilitation, does not address offending behaviours, does not resolve housing problems, and does not 'level up 'individuals or communities by improving employment prospects following release. There is little point in

improving a pathway that continues to fail to lead us anywhere productive, particularly when there is substantial evidence that diversion schemes reduce reoffending.

Regrettably, the Ministry of Justice has now shifted its focus to increasing the available prison places by over 10,000. This offers little more than the likelihood of more missed opportunities for effective interventions. Such failures are in stark contrast to the reported early successes of drug diversion schemes being operated by a number of police forces (please see Q23).

While a carceral approach remains we would recommend that the Government at least takes action to implement the recommendations made by the ACMD over a year ago in regards to custody to community transitions. At that time the ACMD identified substantial harms with custody to community transitions for those with problematic substance use. Among these were a high incidence of homelessness, increased risk of death due to a fatal overdose in the weeks immediately after leaving custody, and that using time in custody as an opportunity to reduce problematic substance use was often squandered through a failure to provide support on release. Particularly damning is that only 32.1% of people assessed as needing treatment when they leave prison enter treatment in the community in the first three weeks after release.

As 89% of drug-related deaths in England and Wales involve opioids, Release call for the urgent provision of Naloxone in all custody settings. It should be made freely available to those who are leaving police custody at the station, at Magistrates and Crown Courts and where needed at custodial institutions such as prisons and YOIs. Where people who use opiates come into contact with the criminal justice system, access to life-saving medication should be made available, in an effort to prevent that person coming into contact with emergency health services shortly after release, or from having no access to life-saving support and harm reduction in general. Examples of this practice can be seen at services such as the Red Hook Community Justice Centre in Brooklyn, New York, where people can be provided with Naloxone while attending court. Custodial institutions must take a responsibility for releasing people into safety. It is vital that we ensure people released from prison are offered Naloxone, at present, only 12% of prisoners who were previously heroin-dependent left an English prison with Naloxone in 2017/18, while only 51% of all prisons in England even have a Take Home Naloxone programme.

For those released on completion of their sentence it is suggested that precautions are taken for those known to use substances. In addition to providing Naloxone to reverse overdose, we highlight the apparent dangers of releasing this population on a Friday, also recognised by the ACMD. Such scheduling raises numerous difficulties. PWUD must not only secure their housing, as others must, but may also need to enrol and engage with a treatment service in order to continue receiving a prescription. There is a clear danger that in releasing people on a Friday that they will be faced without a prescription, enter withdrawal, and be unable to enrol with a service until the following week. Faced with days of withdrawal immediately on leaving custody, there is a substantial risk of relapse setting back treatment, recriminalisation or overdose.

We would advocate that those in receipt of a prescription while in custody be supplied with a quantity of medication to last several days on release. This will provide the them with the opportunity to manage their symptoms until they are able to enrol with a treatment service, minimising the risk of illicit substance use, overdose, or immediate offending behaviour.

i. How can we improve the pathways between prison and community-based drug treatment, including 'through the gate' services when people are released?

Please see our response above.

23) How can treatment work better with the criminal justice system? Including through diversion by police using out of court disposals and community sentence treatment requirements as an alternative to custody?

In the absence of decriminalisation of drug possession offences, Release would strongly support the rolling out of the pre-arrest drug diversion schemes nationally. It is worth noting that the schemes that have been established so far exist due to police leadership, and in the absence of political leadership, on this issue. Many who have implemented these schemes are frustrated by the endless conveyer belt of mainly young, poor, Black, and Asian people being churned through the criminal justice system. They know our drug policy does not work, but diversion schemes are the limit of how far they can go in terms of the law.

Local and international evidence suggests that police diversion schemes can effectively reduce harms experienced by PWUDs and/or are involved in supply. To date, four police forces have implemented specific drug diversion schemes, with West Midlands Police Force due to bring its 'scheme into operation in the next couple of months.

Durham Police force's diversion scheme, "Checkpoint", is for a range of low-level offences, including drug possession and low-level supply offences where the offender is determined to be a user-dealer. 'Checkpoint 'diverts people after arrest on the condition that they undertake a four-month programme to address their offending behaviour. Initial findings found lower reoffending rates and re-arrest rates. Participants in Checkpoint also reported improved outcomes in relation to: substance misuse; alcohol misuse; accommodation; relationships; finances and mental health. Whilst Durham Police Force initially dealt with possession offences through post arrest diversion, they have now adapted the scheme to deal with such offences pre-arrest, and low level supply offences post-arrest.

Avon and Somerset Police force implemented an on-the-street diversion programme in Bristol for those caught in personal possession of drugs. The 'Drug Education Programme '('DEP') was initially launched as a pilot in 2016. Attendees of the DEP are less likely to re-offend when compared to those who had gone through the criminal justice system. The majority of attendees at the DEP reported cessation or reduction in their drug use. The DEP saved police officers significant resources and the reduced burden created by diverting drug possession offences to the DEP meant that it freed them up to focus on other tasks. The success of the DEP in Bristol saw the scheme rolled out across other areas in Avon and Somerset from April 2018.

Thames Valley Police have also implemented a street diversion programme for people caught in possession of drugs, and are already achieving similar results to the experiences of Durham and Avon and Somerset. North Wales police have just launched a mix model of diversion where people caught in possession are diverted at street level and low level drug suppliers are referred to a Checkpoint type scheme.

A 2008 national review of eight jurisdictions 'diversion schemes in Australia demonstrated that a majority of people did not reoffend following diversion, and that in five jurisdictions out of eight, the majority of reoffenders were only charged with one new offending incident.

Release endorses Transform Drug Policy Foundation's submission in respect of their detailed response related to diversion schemes.

We would advocate that diversion is applied to not only possession offences (pre-arrest), and supply offences (post arrest), but also to other low level offending, much of which is driven by drug dependency. These schemes should apply to both young people (under 18's) and adults.

In the absence of diversion schemes, and considering that community sentences have declined by half in the last decade, more must be done to encourage sentencers to use these disposals. Research undertaken by the think tank Reform has shown that the perception of sentencers is that these disposals are not as effective as custody. So the first step is to work with magistrates to help them understand the effectiveness of such sentences in reducing reoffending, and the limitations of custody in relation to supporting the recovery of people who are experiencing drug dependency (as detailed above). Then, funding for treatment providers must be increased to support those diverted away from prison into treatment, and whilst clearly treatment is better than being imprisoned it must also be recognised that "forced" treatment will have significant limitations. Release would argue that a whole systems approach needs to be taken to address people's economic and social needs, including access to benefits, addressing any outstanding legal issues, ensuring stable housing – it is these factors that will help stabilise someone's drug use, alongside will funded and high quality drug services, meaning they are more likely to engage in treatment.

Release would also counsel against the introduction of drug courts. Often drug courts are presented as a solution to addressing offences committed due to drug use, however the evidence for their effectiveness is weak. A review of the efficacy of drug courts in a number of countries, including the UK, found that "on the whole, the courts are not as effective as is often suggested and rarely address the underlying social issues impacting drug involved offenders or the services needed to improve client outcomes". At their core drug courts continue to treat problematic drug use as a crime rather than a health issue, with judges often becoming involved in sentencing decisions related to treatment pathways that are outside their competency. Research from the London School of Economics and Political Science found that in the US drugs courts did not impact on incarceration rates, were expensive to run, and excluded a large section of people who use drugs from the courts. The authors also found that models in the UK and Ireland had been "ultimately unsuccessful".

Cross-cutting issues

24) What lessons can be learned from the way that drug prevention, treatment and recovery services have responded to coronavirus (COVID-19)?

Treatment providers should be applauded for their response to protecting their vulnerable clients during this ongoing crisis. The innovation and good practice adopted must not be lost, however as repeatedly stated the sector needs more funding to ensure that these practices can be maintained.

In the first weeks of the crisis (early March) treatment providers across the UK moved tens of thousands of people off daily supervised consumption of OST or daily pick up of the medication onto longer term prescriptions, usually one or two weeks. Concerns of diversion of OST into the illicit

market or of increased health harms, including overdose, do not appear to have occurred. Instead, the majority of people have reported increased feelings of control over their own treatment, they feel more trusted, less embarrassed about having to go to the pharmacy every day, and describe having a better relationship with their treatment provider. Some have reported using less illicit drugs as their daily routine has changed and others choosing to reduce their medication dosage. For a small minority the change has not been positive and they have asked to return to a more intensive prescribing regime. However, what this demonstrates is that treatment has to be person-centred, and for the vast majority of people the new approach has worked really well and, as such, it is vital that this less restrictive approach to prescribing is retained. A more flexible prescribing approach also has the propensity to attract more people into treatment, which can only be positive. One of our main recommendations from this response is the need to retain this flexible approach to prescribing, which will be at risk if the practice becomes politicised or the media start to negatively report on this development. We urge the Black Review to make this one of the core recommendations of Phase 2.

In terms of contact with keyworkers and other staff during the lockdown, it was a mixed picture. Some preferred the telephone contact, giving them more control over their day and finding it easier to communicate with the service, for others they missed the face-to-face contact. Again, a mixed model should be supported moving forward.

Innovation around NSP was also developed with services providing a delivery service (this also occurred in relation to OST) and some adopting a click and collect scheme. One of the successes of the COVID-19 lockdown was the brilliant work of peers in some parts of the country to provide secondary NSP, Naloxone and support to PWUD. These fantastic developments should be supported and learning from them should be undertaken so similar approaches can be adopted around the country.

Moreover, there is much to embrace from how PWUD have been supported during this time. Treatment services report engagement with populations that have historically been difficult to reach. In Leeds, Dr Gill Kelly has issued a report on the experience of working with their homeless population.

The findings provide insight into the possibility of the models we advocate for above. It recognises that the provision of accommodation through 'everyone in 'has shown what a Housing First model *could* achieve. With housing available and treatment services nearby, the homeless population were provided with an "*opportunity to concentrate on their health and wellbeing*". Those engaged with have also described their own wishes for a post-lockdown service, requesting substance use support; education, training and employment support; mental health support with specific provision for womxn; and peer support.

At Release our work is informed by our direct experience of working with vulnerable and often stigmatised groups. We are glad that the report from Dr Kelly affirms much of what our own experience with this group says is necessary.

If we are to take one lesson from COVID-19, it is that when a consensus exists it is possible to house almost 100% of the homeless population. Such consensus in January 2020 would have been unimaginable. We must now see the possibility of what can be achieved in supporting this population. Housing First has provided stability and a gateway to accessing health services. The population has now identified that support is needed to assist with substance use, for which we would advocate a policy of Safe Supply, mental health support, and the training and skills necessary to gain employment.

i. Looking to the future, how do they need to respond to the impact of the pandemic?

At a national level we need to be preparing for a potential increase in substance use, we are expecting higher levels of unemployment due to the pandemic. High levels of unemployment are known to be associated with increase in heroin use, for example, the change to heroin use in mining communities post the shutdown of the mining industry has been well documented.

More funding, more support for innovation in this field, reforms of laws that create barriers to harm reduction interventions are needed urgently in order to support the community of PWUD problematically, and those who may need support in the coming months and years. Moreover, we must end the criminalisation of people who use drugs. The evidence shows that decriminalisation can achieve more for individuals and communities, whilst saving the Government money in the longer term. As we highlighted earlier, the UK cannot arrest its way out of this problem, and yet, considering the money spent on law enforcement, this appears to be the central plank of the current approach. This must end if we are to achieve a drug policy that saves lives and reduces harms.

25) How effective are drug treatment and recovery services at meeting the needs of black, Asian and minority ethnic (BAME) communities?

Please see Q14 (i) for our response.

26) The Public Sector Equality Duty requires public bodies to help make society fairer by tackling discrimination and providing equality of opportunity for all. How effectively do the commissioners and providers of drug prevention, treatment and recovery services do this and what improvements could be made?

Responses can address any of the protected characters, specified in the duty, which are: race, religion or belief, sex, sexual orientation, age, disability, gender reassignment, pregnancy and maternity.

We have highlighted many of the barriers faced by people with protected characteristics throughout this response and would propose that services and commissioning practices are audited to see what steps are being taken to overcome those barriers. User involvement at a local and national level should be core to this process. Moreover, data collection measuring the scale of drug dependency within the different populations, and how effective engagement is, should be monitored to assess weaknesses within the system in engaging specific populations.