Release's Written Submission to Professor Dame Carol Black's Independent Review of Drugs

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.

SECTION 1: DRUG USE

1. Are there any types of drug use that you think are not accurately reflected in official data?

Different reasons for using drugs – According to data taken from the United Nations Office on Drugs and Crime's 'World Drug Report 2016'[1], 89 per cent of people who use drugs (PWUDs) do not experience a drug use disorder. It is extremely important to be able to differentiate between non-problematic use (using on occasions for fun, peer bonding, sex, life experience and partying) and people for whom drug problems develop as a symptom of trauma. This trauma will result from emotional (and physical) pain, serious on-going daily problems which are nearly always rooted in early-life difficulties, attachment problems, abuse and neglect, 'learned helplessness' or self-efficacy/self-regard deficits or mental health conditions. Please refer to Question 15 below on Adverse Childhood Experiences (ACEs) and trauma-informed care.

Populations excluded from household surveys – The most robust and widely used prevalence estimates are taken from the Crime Survey for England and Wales (CSEW). However, as a household survey, the CSEW excludes important drug-using populations, such as students in halls of accommodation, people in custodial settings, and rough sleepers. Data on student drug use is available from the Global Drug Survey and the National Union of Students and Release's student drug survey (the latter also reported on trans students)[2], but is not reflected in official data. Data on drug use in custodial settings is based on drug seizures and random mandatory drug testing results in prisons, as well as NDTMS custodial settings data (although this only captures people engaged in treatment), but is not widely used.

Poly drug use – Official data mostly looks at the use of individual drugs, such as in the CSEW (although this was measured in previous years), whereas the experience of PWUDs is to mostly use more than one drug at once. Data on poly drug use is much needed from a harm reduction perspective, especially given that in Scotland "most drug-related deaths are of people who took more than one substance"[3].

Opiate and crack cocaine use – Official data on the estimated prevalence of opiate and crack cocaine use by local authority in England[4] is widely used to monitor local drug treatment provision for people who use these drugs, such as treatment penetration rates and coverage of take-home naloxone[5]. The same level of monitoring does not occur for people who use other drugs, such as powder cocaine and Synthetic Cannabinoid Receptor Agonists, as comparable estimates are not available.

People accessing drug services – Official data on access to drug treatment and harm reduction services is taken from the National Drug Treatment Monitoring System (NDTMS). While the NDTMS offers valuable insights, this dataset is skewed towards people accessing publicly funded services, for example because they cannot afford private services. While there are certainly links between poverty and problematic drug use[6], the absence of data on affluent peoples' access to drug services risks exacerbating the stigma and marginalization of more deprived PWUDs. Essentially, the data is skewed towards those living in deprivation and fails to capture problematic drug use amongst groups that have greater social and economic capital. Another important group that is not accurately reflected in NDTMS data are those who access harm reduction interventions – namely Opioid Substitution Therapy (OST), Needle and Syringe Programmes (NSP) and Take-Home Naloxone (THN) – via shared care GPs or community pharmacies.

LGBT+ PWUDs – LGBT+ PWUDs are completely left out of official data on drug use. The CSEW had estimated prevalence by sexual orientation (although not by gender identity) in previous years[7], but no longer does this. The NDTMS currently records a client's 'sex at registration of birth' but does not record their gender identity or gender reassignment – a protected characteristic under the Equality Act 2010 – which means that there is also no data on transgender, non-binary or genderqueer people's access to drug and alcohol services. Transgender, non-binary and genderqueer clients have specific treatment needs and there is currently no way of monitoring the extent to which transgender and genderqueer clients are accessing drug and alcohol treatment services across England. The wider LGBT+ community have specific treatment and/or healthcare needs in relation to drug use, for example relating to past experience of discrimination in services[8], and yet the needs of this community are largely viewed through the lens of Chemsex[9]. While it is certainly important to address the specific healthcare needs of this group, the term 'Chemsex' can in itself be stigmatising of men who have sex with men, as it is "portrayed as a public health crisis, with an emphasis on the potential for the transmission of HIV. Yet little attention is paid to the sexual violence and exploitation men might well experience in chemsex settings. By contrast, when chemsex is discussed in relation to heterosexual people, the issue of sexual consent moves to the forefront"[10]. Furthermore, the discourse and framing of Chemsex is used to refer almost exclusively to men who have sex with men, despite LGBT+ PWUDs reflecting a variety of genders, sexualities and other factors such as race, ability, citizenship, income and access to safe housing. This means that LBGT+ PWUDs who are not men who have sex with men so often get overlooked and left out both in official data and within the LGBT+ and PWUDs communities. Significantly, people with overlapping or more than one protected characteristic identities are not reflected in data collection. An affluent black transgender woman, for example, does not have access to data that reflects her experience if there is only data available for affluent PWUDs, Black PWUDs, LGBT+PWUDs or women who use drugs.

2. Do you have any suggestions about how the data on these types of drug use can be improved?

As highlighted in Question 1 above, there are a number of gaps in data collection and it is hard to see how some of those gaps could be filled, for example, to capture problematic drug use amongst affluent groups. However, there are a number of practical steps that could be taken to remedy some issues we have raised. Firstly, we would recommend greater using a broader range of research methods (i.e. beyond household surveys using representative sampling), which give insights into populations left out of household surveys and smaller populations with overlapping identities. This would enable a more representative picture of *all peoples'* drug use, in all of its intersections. Secondly, we would recommend that Public Health England includes the following additional question in the NDTMS Core Dataset P: "Is your gender identity the same as the sex you were assigned at birth?" to better understand transgender, non-binary and genderqueer people's use of drug services. Thirdly, we would recommend that Public Health England set up a national system for monitoring NSPs; England is currently the only UK nation which does not monitor NSP coverage and report on this to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[11].

3. What do you think are the main factors which drive people to first take drugs?

4. How, if at all, do you expect these factors to change over the next five years?

It is impossible to predict trends due to complex market dynamics and the fact that this is an illegal trade. However, it is instructive to reflect on previous patterns of drug use to highlight the unpredictable (although sometimes predictable) dynamic nature of this market. The rise in mephedrone use in the late 2000s was driven by a number of factors, often it is thought that the fact that this was a 'legal high' was one of the main drivers although it is more complex than that. During the 2000s there had been a successful law enforcement campaign in South East Asia to eradicate safrole, a precursor used in the production of MDMA, this led to a drought in the availability of the precursor and resulted in low quality MDMA entering the market[12]. PWUDs, like any other consumer, want decent quality products and were unhappy with the weakened psychoactive effect that ecstasy tablets had, this was as a direct result of the reduced availability of safrole. This resulted in many people consuming multiple ecstasy tablets, however, what also occurred was substance displacement whereby people shifted to using mephedrone as it was considered to be of better quality. That displacement ended when a synthetic precursor, PMK ethyl glycidate, was developed by chemists, many of whom were/are based in China.

The use of PMK ethyl glycidate in the production of MDMA has led to very high purity, which is in itself a risk to health, but has resulted in consumers moving back to using ecstasy as evidenced by the CSEW. This is one example of how interdiction of the drugs market can have a direct impact on consumption patterns in the UK. It is also concerning that the Commission of Narcotic Drugs scheduled PMK ethyl glycidate under international control in March 2019, this could lead to a reduction in the production of this precursor and a shift to either substance displacement or a new precursor, outside of international control, being developed. This could lead to greater harms for consumers. This is just one example of how it is difficult to predict changes in the market and the repercussions of law enforcement interventions.

5. **Why do you think we are seeing an increase in Class A drug use (e.g. powder cocaine, ecstasy) among young adults?**

Class A drug use has remained relatively stable over the last decade, with small year on year increases or decreases according to the CSEW, and subject to the limitations highlighted above in respect of the survey. For example, according to the CSEW, prevalence of powder cocaine and MDMA consumption amongst 16 – 24 years ('last year use') in 2017/18 is comparable to levels recorded in 2006/07. Additionally, recent estimates indicate a decrease of people using crack cocaine between 2014/15 and 2016/17, with a statistically significant decrease in London over this period[13]. The narrative of increasing cocaine use – especially amongst certain demographics – is not borne out by the evidence. The question really is why politicians and senior police are promoting this narrative when it is contrary to the data, from our view this is a helpful tool to blame people who use these substances for serious youth violence rather than properly considering factors such as pupil exclusions, cuts to youth services etc.

6. **How, if at all, do you see drug use changing over the next five years?**

Please see our answer to Question 4

SECTION 2: DRUG SUPPLY

7. **What are the characteristics of the individuals involved in the supply of drugs?**

People who supply drugs come from all walks of life and there is no specific characteristic that can be identified to describe this group as a coherent whole. Available data on supply offences does not disaggregate or distinguish the different types of supply, which range from low-level non-commercial supply (i.e. social supply) and minimally commercial supply (i.e. 'user-dealers')[14] to having a leading role in commercial scale supply for substantial financial gain[15]. Nevertheless, the literature offers helpful insights into the characteristics of individuals involved in low-level supply. Moyle et al. (2013) describe a blurring of possession and supply offences for individuals involved in social supply (particularly given the low threshold amounts for possession with intent to supply in the Sentencing Guidelines for Drug Offences), leading to people being at risk of disproportionately harsh supply sentences for this activity[16]. Moyle and Comber have also suggested that so-called 'user-dealers' are better understood as PWUDs rather than people involved in supply, because it is relatively normal for PWUDs to help each other out and buy on behalf of friends and acquaintances[17], and given the lack of legitimate opportunities for some PWUDs to fund their drug use[18].

Furthermore, available data on supply offences only relates to individuals that are *policed and prosecuted* for such offences, rather than all of those actually involved. As such, criminal justice data does not provide a proper analysis of who is involved in the market. This is important because we know that Black and Minority Ethnic (BME) communities are disproportionately targeted by drugs policing[19] and evidence suggests that drug supply may be more common among white people than BME communities[20]. Please refer to Question 12 below on disproportionate policing.

Despite the wide-ranging types of supply and limitations of policing data, society reductively presumes that a certain group is responsible for the supply chain and that 'dealers are bad', a notion which is often based on racist tropes and conscious bias.

8. Is the internet, including the 'dark web' and social media, being used in the purchase and supply of drugs and, if so, how?

The internet is certainly being used in the purchase and supply of drugs. Although it is difficult to estimate the overall percentage of market share – given the challenges with sizing the wider illicit drug market of which cryptomarkets make up a share and with estimating sales volume for other internet-facilitated sales, including via social media and encrypted communication apps – we can be fairly sure that this represents a small fraction of the overall market. Many of our clients, who are from areas of deprivation, cannot use the internet, don't have a computer or smart phone, do not have a reliable delivery addresses and do not have bitcoins or other online methods of payment.

In Release's expert witness work (providing expert testimony in prosecutions for drug offences), we have seen people charged with supplying Viagra and Xanax, 'branded' weed and the Fentanyls that have been obtained via the 'dark web', so quite a range. Interestingly much of the law enforcement detection in this area is a result of carelessness, for example, sending parcels from the same Post Office every day, leaving printed labels around the packaging premises and email and text trails.

9. How, if at all, do you see drug supply changing over the next five years?

In the same way it is impossible to predict how patterns of use will change it is impossible to predict changes in the supply side of the market. Reflecting on the cocaine market in recent years is helpful in evidencing the difficulty of making predictions, if we had been told five years ago that cocaine would be significantly cheaper and purer it is likely that we would have dismissed that assertion. However, that is now a reality of the market. Through our expert witness programme we regularly see the costings and purity of controlled drugs.

In 2013 a kilo of cocaine would cost in the region of £50,000 - £55,000, Release is now regularly seeing cases where a kilo of cocaine at import stage is in the region of £35,000 and can be as low as £30,000. This will be linked with the increased supply of cocaine as highlighted in the UNODC world drug report 2018 which stated "After falling during the period 2005–2013, global cocaine manufacture rose by 56 per cent during the period 2013–2016. The increase from 2015 to 2016 was 25 per cent."[21].

At the same time purity has increased significantly, again in 2013 cocaine at importation stage would be in the region of 75 per cent, after which cutting agents would be added reducing the purity at a street level. However, we are now seeing street level seizures at 90 per cent and crack purity is regularly report at between 70 and 90 per cent purity. The UK Focal Point on Drugs report on this development is helpful[22].

The reduced use of cutting agents may be as a result of increased prosecutions for 'being concerned in the supply of a controlled drug' (section 4 (3) Misuse of Drugs Act 1971). In the last few years we have witnessed increased prosecutions for this offence where the only evidence was the seizure of substances that were not controlled under the legislation but were commonly used to cut controlled drugs, for example, benzocaine. In such prosecutions, defendants were found guilty of the offence under the Misuse of Drugs Act and, even though there were no controlled drugs seized, those prosecuted received the same sentence as if the substance involved was a controlled one. This situation created greater legal risks for suppliers, and with the increased production of cocaine and

heroin, there is little doubt that those involved in the trade would question the value of importing cutting agents considering the risks involved. What we can be confident in predicting is that the main substances of use – cannabis, MDMA, cocaine, ketamine, heroin – will continue to dominate the market as they have done for decades.

10. What factors drive people to first become involved in the supply of drugs?

Please refer to Question 7 above on the characteristics of individuals involved in low-level supply.

11. How, if at all, do you expect these factors to change in the next five years?

Please refer to Questions 4 and 9 on Release's views on attempts to predict the market.

SECTION 3: HARMS OF DRUGS

12. What are the harms to individuals, families and communities resulting from drug use (including physical, mental, social and economic)?

Physical harms – To reiterate, 89 per cent of PWUDs do so without developing a "drug disorder"[23] and the health harms that they experience will largely relate to them accessing drugs in an unregulated market with significant variation in drug potency, purity and adulteration[24]. These health harms are further exacerbated by the government's reluctance to support innovative evidence-based harm reduction interventions in response to the UKs rising number of drug related deaths and outbreaks of bacterial infections and blood-borne viruses (BBVs). Instead, policy displacement continues where law enforcement and drug control is prioritised at the expense of already under-resourced health and drug treatment service. Fear of detection by law enforcement and the possibility of further criminalisation is a crucial driver for high-risk drug taking behaviours, including sharing (and use of) nonsterile injecting equipment[25]; rushed consumption of drugs in unhygienic and unsupervised environments increasing risk of overdose or injury[26]; and pre-loading drugs before entering a venue to evade detection[27]. Furthermore, if someone is present at the scene of an overdose or crime, and they are in possession of drugs, they are less likely to contact emergency services due to worry of police involvement and arrest.

Drug-related deaths – Drug-related deaths are the gravest form of harm experienced by PWUDs. When compared to other EU member states 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"[28]. In 2017, there were 3,756 drug-related overdose deaths registered in England and Wales[29] and 934 drug-related deaths registered in Scotland[30]. In Northern Ireland, there were 136 drug-related deaths registered in 2017 – 60% more than the 86 deaths recorded 10 years ago[31].

Public health – There are also health related harms to individuals, and more broadly communities from drug litter and potential needlestick injury[32]. In Glasgow alone, an estimated 500 people publicly inject drugs between 2012 and 2013, with at least 2,438 needles being discarded on the streets[33]. The EMCDDA recently reported that "In 2017, there were 115 new HIV diagnoses associated with injecting drug use in the United Kingdom, 32 of which were registered in Scotland"[34]. In response to the recent

outbreak of HIV among people who inject drugs (PWIDs) in Glasgow, NHS Greater Glasgow and Clyde recommended "a pilot safer injecting facility" but was later blocked by the Home Office[35].

Criminalisation – Over the last decade, 732,406 people have been criminalised (by criminalised we mean those who have been convicted of being in possession of a controlled drug and/or those that have received a caution -as this can be used against the individual at a later date in the context of Disclosure and Barring Checks which can effect employment and educational opportunities) for simple possession of drugs in England and Wales. In any given year approximately 1,000 people are imprisoned solely for possession of controlled drugs, and in 2017 the number was 1,017[36]. Prison sentences for non-violent possession offences (and in fact for any nonviolent drug offence) are ineffective at reducing recidivism[37]; offers greater exposure to poorer health outcomes[38] and; increases risk of a fatal opioid overdose in the immediate post-release period due to reduced tolerance levels[39]. The prison service is unfit for purpose and should not be used as a punitive tool to penalise people for their drug use.

Disproportionality and BME communities – Drug control is disproportionately enforced against the poor and BME communities. Poorer communities, especially young black people living in areas of deprivation, are subject to more intense drug law enforcement than areas that are considered more affluent (despite similar rates of drug use across all economic groups). In 2016/17, black and Asian people were stopped and searched for drugs at almost 9 times and 3 times the rate of white people, and were convicted of cannabis possession at 12 and 2 times the rate of white people, despite lower rates of self-reported drug use (including cannabis use specifically)[40]. This undermines police legitimacy and breeds distrust – consequentially impacted communities are less likely to contact police due to soured relationships meaning that crime will go unreported and undetected[41]. Furthermore, those who do perceive the police as lacking legitimacy are more likely to 'engage in 'self-help' practices thus, perpetuating the circle of violence[42].

Stigmatisation – Stigma, discrimination and the demonisation of PWUD is reinforced through use of dehumanising language and the fact they are defined as criminals first and foremost. This can present significant barriers to accessing health services, thereby undermining the effectiveness of prevention and drug treatment[43]. 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[44]. Similarly, pregnant women who use drugs and are "accused of endangering the foetus"[45], which can deter them from accessing vital health services. Additionally, people of colour, sex workers and those identifying as LGBTQ+ also face substantial vulnerabilities and are less likely to access drug services citing social exclusion, experience of discrimination and a lack of cultural needs amongst barriers[46]. Employers are also reluctant to hire people with a history of drug use, many of which have a 'zero tolerance' policy and incorporate random drug testing as part of the recruitment processes as well as being grounds for dismissal[47]. This can cause substantial difficulties for those who are undergoing OST.

13. **What are the harms to individuals, families and communities resulting from drug supply (including physical, mental, social and economic)?**

While there is undoubtedly violence associated with drug markets, we have chosen to focus on wider drug market harms which relates to drug policy specifically in our submission, as this aligns with Release's expertise and is likely to be under-reported in other submissions. As highlighted in Question

7 above, those involved in drug supply are not a homogenous group and many will be users, friends, acquaintances who share or supply drugs to people. It is unhelpful to try to characterise this market as a wholly violent one. Where violence is present it is often where organised crime groups are involved or there is an open street market[48]. Closed markets are where the buyer and seller know and trust each other. In recent years suggest that there has been a significant shift from open markets to closed ones, where increasingly people who supply drugs will often deliver to a person's home, this will inevitably reduce the risk of violence. Additionally, evidence shoes that drug law enforcement contributes to increased violence within the market[49].

Please refer to Question 12 above on the harms to individuals, families and communities which specifically relate to criminalisation.

Economic harms – Individuals prosecuted for supply offences (including possession with intent to supply), and consequently their families and communities, can experience additional economic harms. Release has offered expert witness services in numerous Proceeds of Crime Act 2002 (POCA) cases, where often the prosecution inflates the value of the drugs seized, which can exceed the defendant's actual means. As a result, the alleged amount is unpayable and results in additional sentence time[50]. People subject to such proceedings may have to sell their house or car, serve a custodial sentence, and still have major outstanding debts against them (which accrues interest) once they are released from prison. Instead of targeting people at the high end of the supply chain, POCA hits people with the least means the hardest, who can get caught in a cycle of debt and incarceration. This creates a net loss to the taxpayer, due to the cost of court proceedings and holding people in custody for lengthy sentences. Families and loved ones are also affected by POCA. For example, if the defendant jointly owns a house with their partner, by seizing the defendant's share, their partner and children (who likely had no involvement in the offence) will effectively be deprived of their home (even if their partner's share in the house is not seized as proceeds of crime) and may struggle to obtain another mortgage due to the previous property's enforced sale. There is no publicly available data on the characteristics of those subject to POCA proceedings in the UK. However, research from the US indicates that people of colour and low-income communities are disproportionately affected by asset forfeiture proceedings[51].

14. <u>What are the links between serious violence and the supply of drugs?</u>

Drug Law Enforcement – The link made between illicit drug markets and serious violence in the Serious Violence Strategy entirely disregards drug-market violence that is specifically related to drug law enforcement efforts. This is despite the Home Office's evaluation of its previous Drug Strategy noting: *"it is widely acknowledged that violence is an unintended consequence of enforcing drug laws. A systematic review of evaluations of the impact of drug law enforcement on drug law violence found that they were significantly associated and indeed that disrupting supply markets may actually increase violence (Werb et al., 2011). For example, violent conflict may result between a dealer displaced by law enforcement and an established dealer (Benson et al., 1992)."*[52]. Any evidence-based statement on the link between serious violence and the supply of drugs would need to acknowledge violence directly resulting from drug law enforcement.

Drug-Related Homicide – Release is concerned about how the Home Office is classifying drug-related homicides. The Serious Violence Strategy states that there has been an increase in the percentage of

homicides where either the victim or suspect where known to be a person who uses drugs or involved in drug supply. This broad definition will undoubtedly result in homicides being classified as 'drug-related' even if the motive or the circumstances of the offence had nothing to do with the drug trade. For example, Release is aware of a recent murder case in Ipswich where a number of the defendants were involved in the drug trade, however the tragic killing of the victim was more likely linked to personal issues yet this will be classified as a drug related homicide even thought this was not the driver for the offence. Another situation where a homicide would be classified as drug related could be where domestic violence is present, and the victim or the perpetrator tests positive for a controlled substance, even thought this was unrelated to the crime. The problem with the current system of classification is that it does not provide a proper assessment of actual drug-related violence resulting in death.

'County Lines' – The role of so-called 'County Lines' in fuelling drug market violence is arguably overstated and the accuracy of its description is questionable. People using drugs in rural areas, drugs being transported across the country from recognised supply hubs and, sadly, vulnerable people being exploited by others in positions of power are far from new. It is therefore unclear how so-called 'County Lines' are a new phenomenon, bar the technological matters such as the use of mobile phones lines, and how this is being directly attributed to the increase in serious violence. The Modern Slavery Act 2015 also plays into the narrative of exploitation, whereby this new legislation provides law enforcement with additional charging powers. There is little doubt that some young people and vulnerable people will have been previously exploited within the trade however this new legislation is being used to suggest that this is a new phenomenon.

15. <u>Are there any harms from drug use and/or supply that you think are under reported and are not accurately reflected in official data? If so, please give details.</u>

Drug-related deaths data – Release is concerned that in the context of local authority commissioning, reduced funding and a recovery-oriented Drug Strategy, people are being let down by drug services, and this is exacerbating drug-related deaths. In our view, the particular role that government policy has had in exacerbating drug-related deaths is under reported and is not accurately reflected in official data. Please refer to Question 17 below on commissioning, disinvestment and the recovery agenda. Release would also submit that in analysing such deaths it would be helpful to distinguish between underlying health causes, drug overdose and drug toxicity.

Data on supply offences – Currently Ministry of Justice data does not distinguish between the type of supply activity, for example, social supply/ user-dealer/ for profit. Whilst this may be difficult to capture on a routine basis the courts could use the sentencing guidelines as a way of distinguishing the different actors in the trade. Currently, sentencing for drug offences – excluding possession and section 8 offences – determines culpability on the basis of the role of the offender (leading; significant; and lesser) and determines harm based on the quantities involved (Category 1 to 4)[53]. This data could be captured and would provide a more in-depth view of the types of drug offences being prosecuted.

Data on drugs policing – Currently stop and search data does not distinguish between searches for possession offences from supply offences. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) estimates that 70 per cent of all drug searches are for personal possession[54], although this analysis was based on their inspection of 8,000 search records. It would be

helpful if the police powers data required police officers to state whether they are searching someone for possession or for supply. In addition, it would also be helpful to distinguish the Class or Type of substance that was searched for. It is again estimated that a third of all stop and searches, not only drug searches, are for cannabis possession alone[55]. In order for us to understand policing priorities and how this police power is being used this data would be invaluable, considering nearly 60 per cent of all searches are for drugs it is important that a more detailed analysis is provided.

SECTION 4: INTERVENTIONS

16. <u>What are the most effective ways to prevent drug use/dependency?</u>

The reality is that there will never be a 'drug free world', people have used psychoactive substances for millennia. Current assessments of the effectiveness of UK drug policy are overly focused on prevalence of drug use rather than the reduction of harms, for example, reduced drug related deaths. This is a fundamental flaw in policy making in this area.

Criminalisation is the main tool used to attempt to deter use, however the evidence shows us that this is a failed policy which does not deter consumption of controlled drugs. The Home Office 2014 Drug: International Comparators report compared the experiences of countries around the world, some of whom took a punitive approach to drug use (for example, Japan and Sweden) and some who do not criminalise drug use or possession (Uruguay and Portugal). That report concluded that they "did not in our fact-finding observe any obvious relationship between the toughness of a country's enforcement against drug possession, and levels of drug use in that country"[56]. Release's report into decriminalisation looked at 25 countries that had ended criminal sanctions either for all drugs or for cannabis only, none experienced statistically significant increases in prevalence, in some countries it went up slightly in some it went down[57]. Furthermore, Professor Alex Stevens' review into the impact of liberal reforms of cannabis laws on adolescent use found no correlation in levels of use and the change in legislation[58]. As highlighted above this is a failed policy that does not prevent drug use but does create significant harms to health and to social outcomes, as we have outlined in Question 12 above. The question then arises what is the most effective way of reducing the harms associated with drug use, and in particular problematic drug use. Firstly, an effective and evidenced based approach to dealing with drugs in society would be to end criminal sanctions for possession offences, that is, to decriminalise this activity. Release has outlined the positive evidence from countries that have adopted this approach in Question 22 below.

The most effective way to prevent *problematic* drug use, which should be the primary aim, is to ensure approaches are considerate to the lived experiences of PWUD. The Advisory Council on the Misuse of Drugs (ACMD) has recognised that childhood experiences and "stressful negative life events such as emotional violence, abuse and social exclusion" can influence "the development of substance-related harms". Release is in support of a whole-system approach where agencies work collaboratively, to ensure services are trauma-informed and routine screenings for Adverse Childhood Experiences (ACEs) are made in primary and secondary care. As outlined in response to question 1, for the small percentage of people who become develop a drug dependency they have often encountered trauma or ACE in their lifetime - exemplifying the need for prevention to focus on reducing problematic use

or dependency through primary prevention and trauma-informed services. Strategies for early intervention also need to prioritise safety by highlighting the risks associated with drug use, alongside information to reduce these risks, so that individuals may make informed choices about drug use. Furthermore, the government must take steps to support initiatives which prioritise health and divert people away from the criminal justice system to ensure better outcomes.

Beyond scaling up trauma services and mental health counselling for children and young people, an effective strategy must focus on reduction of harms. For those who use problematically this includes high quality, well-funded treatment that respects the autonomy and rights of this group of people. In addition, the Government should introduce as a matter of urgency drug consumptions rooms and drug checking facilities for PWUDs, such as heroin. For people who use non-problematically drug checking facilities should also be available, and harm reduction information for young people should be incorporated into their education in order to try and ensure they use as safely as possible. We no longer teach abstinence as part of sex education, rather we teach young people to take steps to reduce risks and facilitate access to contraception. Why would we not do the same for drug education?

17. <u>What, if any, are the gaps in drug treatment provision?</u>

Disinvestment – Local authorities became responsible for funding and commissioning drug services under the Health and Social Care Act 2012, while facing an estimated 37.3% reduction in central government funding between 2010/11 and 2015/16[59]. As a result, "drug misuse treatment" faced more reductions in funding than any other public health area in 2016/17 with a 14% reduction in funding between 2015/16 and 2016/17[60]. Net expenditure on adult drug and alcohol services has decreased by 19 per cent in real terms between 2014/15 and 2018/19[61]. There was also a 9% reduction in 2016/17 compared to 2015/2016 for specialist young people drug treatment services[62]. 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. Cuts to drug services are a "false economy"[63] – Public Health England estimates that for every £1 invested in drug treatment there is a £4 social return[64]. In its review of commissioning, the Advisory Council on the Misuse of Drugs rightly concluded that *"the quality and effectiveness of drug misuse treatment is being compromised by under-resourcing"* and recommended that *"National and local government should give serious consideration to how current levels of investment can be protected, including mandating drug and alcohol misuse services within local authority budgets and/or placing the commissioning of drug and alcohol treatment within NHS commissioning structures"*[65].

Mental Health – People with coexisting drug and mental health problems are not receiving an appropriate assessment of their needs as the quality of care is undercut by the organisation of services. Despite 41 per cent of people starting drug treatment in England stating they had a mental health need in 2017/18, "contractual arrangements in statutory services block people with a dual diagnosis, forcing them to refer to voluntary sector bodies"[66]. It is important that individuals are not turned away from either drug treatment or mental health services but rather are supported through an open-door policy. Release clients who present with a dual diagnosis will often be told by mental health services that they cannot be treated until they have addressed their drug dependency, despite the fact their drug use is a coping mechanism to deal with their mental health problems. This approach leaves vulnerable, marginalised people without the specialist support they need.

Harm Reduction – Instead of focusing on preventing drug-related deaths, the 2017 Drug Strategy has continued to pursue a "recovery agenda" which defines abstinence as the key goal, therefore leaving everyone else behind. Abstinence is not a realistic or safe treatment goal for everybody. Measuring drug treatment effectiveness with achieving abstinence is inappropriate and impossible particularly since the government cannot even guarantee prisons, the most secure environments, to be drug free. Meanwhile, the quality and accessibility of life-saving harm reduction interventions – namely opioid substitution therapy, take home naloxone, and drug checking – varies considerably across the country[67] and a drug consumption room has still not been established.

Take Home Naloxone (THN) – Research undertaken by Release found that the amount of take-home naloxone – an inexpensive lifesaving medication that reverses the effects of an opioid overdose – given out in England is wholly insufficient and it is not reaching those who most need it. In 2017/18, coverage of THN among people using opiates in community settings was only 16 per cent and coverage among opiate clients in treatment was only 12 per cent. Despite the clear potential for prison THN programmes to prevent further mortality among people released from custody, only 51 per cent (56) of prisons (109) in England had a THN programme in place in 2018/19, including only 1 of the 5 Young Offender Institutions[68]. Moreover, according to National Drug Treatment Monitoring System (NDTMS) data, 46 per cent (53) of prisons (114) did not provide THN to any of its drug treatment clients released from prison in the 2017/18 financial year.

Drug Consumption Room (DCR) – Please refer to Questions 22 and 23 on evidence and recommendations related to DCRs. A DCR would be particularly beneficial in Glasgow, given the high incidence of public injecting and drug-related litter, and the localised HIV outbreak[69], which has been linked to increasing prevalence of cocaine injecting, recent experience of homelessness and frequent incarceration among PWIDs[70].

Prison NSP – PWIDs (PWIDs) in prison should be able to access NSPs, as under international law, they are entitled to enjoy the right to the highest attainable standard of health and to receive health care in prisons equivalent to that in the community[71]. The lack of NSPs in UK prisons leaves PWIDs in prison extremely vulnerable to HIV and viral hepatitis infections and other health harms.

Drug Checking – Drug checking services are currently available in the UK via the Loop[72] and WEDINOS[73]. The Drugs Minister for the Home Office, Victoria Atkins MP, has confirmed that it is for chief constables in local areas to decide whether to roll out drug checking facilities at festivals under local protocols and agreements[74] and the Home Office recently granted Addaction a licence to pilot a drug checking clinic in North Somerset[75]. However, drug checking is still not available to PWUDs or people involved in supply in most areas and is mostly available in festival settings.

18. <u>What are the barriers to receiving effective treatment in the UK? How might they be overcome?</u>
Please refer to Question 12 above on criminalisation and stigma of PWUD.

Drug User involvement – To properly understand barriers to treatment, it is imperative that PWUDs and those who are in treatment settings are consulted with. No one understands the barriers that exist better than people with living and lived experience. Yet, since 2010 we have seen drug user and service user groups undermined and underfunded, with many having their funding completely cut.

This means the voice of those most impacted by drug policy and drug treatment are absent from discussions on how to improve accessibility to services. The move away from involving those with living experience was part of the ideological drive by Government, as evidenced by the 2010 Strategy, which placed recovery, defined as abstinence, at the heart of the strategy with the establishment of local recovery champions. These champions, who had to be abstinent, were held out as examples of what people in treatment had to strive for and created an unhealthy environment whereby people on long term OST were defined as failing. In fact, Release is aware of a number of these champions relapsing due to the pressure placed upon them. This is not how user involvement should operate, PWUDs – both in and outside of treatment – should be involved in every stage of service development from local commissioning, to consulting on how services should look, to being involved in national policy. Only then will treatment become more effective. The fact that so many of those who die from opiate related deaths have not been engaged with services for at least 5 years is fundamental evidence that much more could be done to improve treatment[76]. Crucial to this is recognising that long term OST is an effective and successful treatment outcome and that recovery should be defined by quality of life, not being 'drug free'. Please see Q21 for more information on drug user involvement and activism.

Funding – An already limited service provision is compromised by devastating cuts to drug services across the country. Please refer to Question 17 above on disinvestment. A high-quality, evidence-based response to drugs therefore requires central government to re-invest in, and at the very least mandate, drug services to ensure that they are adequately funded.

Treatment Services – Some treatment services in the UK take a paternalistic approach to this client group, often dictating the terms of the client's treatment plan based on what they think is best and what is in their interest in terms of outcomes. Some local commissioners have introduced payment by results components to local drug treatment contracts, where a certain percentage of the value of the contract is only paid out based on the numbers of people exiting treatment drug free and not returning for a prescribed period, usually 12 months. This is high unethical, especially the element of non-return, and creates a situation where treatment providers have to focus on getting people out of treatment rather than keeping them in treatment which is highly effective in protecting people from drug related death. In some instances, the Release helpline has received calls from patients who are being told they **have** to reduce their OST dose in an attempt by services to move them off methadone or buprenorphine. This is contrary to clinical guidelines and can create a hostile treatment environment. Similarly, if someone has used illicit heroin on top of their OST then they will often be threatened with their medication being stopped. A helpful analogy is diabetes – imagine a person telling their doctor they had consumed a lot of sugar based products and being threatened with their insulin being stopped – we would be outraged, but somehow for people on OST it is apparently reasonable. In addition to the above, treatment services are sometimes inaccessible and inhospitable to clients, where any expression of dissatisfaction by the client can lead to punitive action, such as, temporary exclusion. Some treatment providers are improving their approach and engagement with clients, but more needs to be done.

19. Which groups of people are these barriers most likely to affect?

Please refer to Question 17 above on budget cuts to specialised drug treatment service for young people and to Question 12 above on the barriers to accessing treatment by mothers and LGBT+ people.

Women – Women have specific treatment requirements related to their drug use but encounter a number of barriers accessing drug services[77]. In particular, mixed gender services can hinder women's engagement as, unlike men, women have ACEs such as sexual violence perpetrated by a male. Despite this, drug services for women are woefully inadequate – "only around half of all local authority areas in England (n=74, 49.0%) and five unitary authorities in Wales (22.7% of all authorities in Wales) are home to localised support specifically for women", most of which is single sex groups in generic drug services[78]. In addition, most treatment services will not allow parents to bring their children to the service meaning that child-care needs can also create a barrier to access. Release's Executive Director recently visited a methadone clinic in Casablanca, Morocco, where they had a specific service for women and provided a crèche for their children, begging the question: why is this not available in the UK?

BME Communities – Despite lower overall drug use among BME communities when compared to the white population they are likely to face substantial barriers when accessing drug treatment services. BME groups are known to face multiple and complex disadvantages and require service provision which is both culturally and religiously sensitive[79], and yet, there is a lack of drug treatment options that are appropriate to the needs of BME clients.

20. What are the most effective ways to tackle the supply of drugs?

Drug Strategy – The Drug Strategy 2017 aims to restrict the supply of drugs through its law enforcement driven approach to drug policy. The previous Drug Strategy 2010 adopted the same approach and this was found to be largely ineffective. In an evaluation of its previous Drug Strategy, the Home Office found: "*Illicit drug markets are resilient and can quickly adapt to even significant drug and asset seizures. Even though enforcement may cause wholesale prices to vary, street-level prices are generally maintained through variations in purity. There is evidence that some enforcement activities can contribute to the disruption of drug markets at all levels, thus reducing crime and improving health outcomes, but the effects tend to be short-lived. Activity solely to remove drugs from the market, for example, drug seizures, has little impact on availability. However, there are potential unintended consequences of enforcement activity such as violence related to drug markets and the negative impact of involvement with the criminal justice system.*" (Drug Strategy 2010 Evaluation, page 10). This is despite the fact the UK spent an estimated £1.6 billion on drug law enforcement in 2014/15, whilst the treatment budget for England in 2017/18 was £640 million[80]. This policy displacement with greater focus placed on a failed law enforcement approach at the expense of evidenced based treatment options is just one example of why the current approach has failed. As the current approach to tackling the supply of drugs is largely ineffective, is expensive and creates drug-market violence and other harms in and of itself, Release would respectfully recommend that the government consider reviewing and updating its drug strategy. Please refer to Question 23 below on proposed policy changes.

Diamorphine prescribing – Currently, the cost of Heroin Assisted Treatment (and of diamorphine itself) is very high and has a high threshold in terms of access and supervision of patients. However, if we scaled up diamorphine prescribing for OST, reduced the level of supervision, or considered other medications such as hydromorphone, it could substantially undermine the illegal heroin market – this is just one example of how policy can impact on the supply of drugs.

21. What are the most effective ways to reduce the violence associated with drug supply?

Given that some of the violence associated with drug supply is specifically related to drug law enforcement – the central tenant of the government's approach to drug policy – Release would respectfully recommend that the government consider reviewing and updating its drug policy. Please refer to Question 23 below on proposed policy changes.

22. Are you aware of any approaches – locally, nationally or from other countries – that are effective in reducing the harms of drug use/supply? If so, please provide details, including any evidence of effectiveness.

Decriminalisation –Release advocates for decriminalisation, in recognition that the evidence from other countries demonstrates that this approach can effectively reduce harms. Research undertaken by Release looked at 25 countries across the globe that had decriminalised personal use and possession of drugs[81]. Decriminalisation has been associated with reduced rates of recidivism, reduced burden on police resources and savings to the public purse related to social costs. By decriminalising the possession of controlled drugs for personal use, resources could be diverted from the criminal justice system into health and other services for PWUDs.

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. The drug-related death rate (aged 15-64 years) in Portugal was "4 deaths per million in 2017, which is lower than the most recent European average of 22 deaths per million"[82]. Other 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;[83] and
- Decrease (18 per cent) in the social costs of drug use in the first 10 years of decriminalisation[84].

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; prevalence increased; there were higher rates of initiation of drug use amongst young people; and social costs increased significantly[85].

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[86]. These rates are all significantly lower than the UK's drug related death rate of 74 per million of the population[87]. While the lower rates of drug-related deaths in these countries will not necessarily stem from the legal framework, 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.

Decriminalisation is also associated with positive social outcomes. Research from Australia compared outcomes for individuals who had been criminalised for cannabis possession, to those who had received civil sanctions, under a *de jure* model of decriminalisation. Of those criminalised 32 per cent reported a negative impact on employment compared to 2 per cent who were given civil sanctions, for accommodation it was 16 per cent versus 0 per cent[88].

The United Nations System Chief Executives Board for Coordination (UNCEB) recently called for the decriminalisation of drug possession for personal use[89], joining the likes of the World Health Organisation[90] and the Global Commission on Drug Policy[91].

Diversion schemes – Local and international evidence suggests that police diversion schemes can effectively reduce harms experienced by PWUDs and/or are involved in supply. In the absence of political leadership in the arena of drug policy reform and in recognition of the futility of the current legal approach to PWUDs a number of police forces in the UK have implemented diversion schemes. 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 from the pilot period found lower reoffending rates compared to those who were subject to out of court disposals, such as cautions. Participants in Checkpoint also reported improved outcomes in relation to: substance misuse; alcohol misuse; accommodation; relationships; finances and mental health. 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 of 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. 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. Thames Valley Police have also implemented a street diversion programme for people caught in possession of drugs, and 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.

'Nothing About Us Without Us' – 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[92] and through EuroNPUD's 'Naloxone Access and Advocacy Project'[93]. 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[94];
- '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"[95];
- 'The Urban Survivors Union' is a grassroots coalition of PWUDs ('former and active') in the US[96], who were instrumental in introducing harm reduction services to the US, such as crack pipe distribution to reduce the spread of BBVs[97];
- 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[98]; and
- Activist groups, including drug user groups and other community allies, having played a key role in establishing overdose prevention sites in Canada[99] which have effectively prevented drug-related deaths.

Drug Consumption Room – Drug Consumption Rooms (DCRs) effectively reduce risk of overdose and BBV infections among PWUDs, public injecting and drug-related litter[100]. Additionally, DCRs facilitate access to treatment and healthcare services for PWUDs, including for marginalised groups that would not otherwise have come into contact with such services. There are three models of DCRs: (1) integrated facilities, which are often incorporated into low-threshold facilities where "survival-orientated" services are offered including food, shower and clothing; (2) specialised facilities, offer services directly dedicated to supervised consumption and provide information on health and safer injecting use and; (3) mobile facilities, which are "geographically flexible" and are able to reach those in remote areas where fixed DCRs do not operate[101].

Low-threshold Opioid Substitution Therapy – In response to the drug-related deaths crisis in Canada, the British Colombia Center for Disease Control is piloting hydromorphone dispensing machines to facilitate low-threshold access to prescription opioids for people at risk of fatal opioid overdose[102]. Innovative approaches like this are desperately needed in the UK, where drug-related deaths have

significantly increased in recent years (mostly deaths of people not in or recently in treatment[103] and the high threshold provision of OST makes it extremely challenging for some people to adhere to their prescriptions. Contrary to the UK guidelines on clinical management of 'drug misuse and dependence', and without considering a patient's individual circumstances or clinical needs, people are sometimes made to pick up their OST prescriptions daily and consume their prescription under the supervision of a medical professional. Release has supported a number of clients that have been put onto daily pick-ups and supervised consumption of OST for lengthy periods for no clinical reason; many of these clients experienced detrimental impacts from this, such as having to take time off work or bring their children to the pharmacy every morning, in order to adhere to their prescription. Release is also concerned that, in many cases, OST is not prescribed in optimal dose and duration[104] and the high cost of diamorphine is limiting access to diamorphine prescribing for OST. There are an estimated 46 doctors in England licensed to prescribe diamorphine for OST[105] and the Home Office estimates that only 280 people are prescribed diamorphine for OST in England. Release is also currently advocating for a number of patients who, despite having been prescribed diamorphine for OST for over 20 years – many of whom are in employment – have been informed their prescription will be stopped due to policy rather than individual clinical reasons. This is despite studies consistently finding higher adherence to diamorphine prescribing, compared to other forms of OST, as well as reduced use of illicit 'street' heroin, and criminal behaviour, among people for whom other opioid substitutes have not been effective[106]. The prescribing of hydromorphone could be an effective replacement for HAT.

Prison NSP – The United Nations Office on Drugs and Crime conducted a review of the evidence for prison NSPs and found that they are "feasible and affordable", "effective in decreasing syringe sharing among PWIDs in prison, thereby decreasing the risk of disease transmission", "are not associated with increased attacks on prison staff or other prisoners", "do not lead to increased initiation of drug consumption or injection", "can reduce incidence of abscesses", "facilitate referral to available drug-dependence treatment programmes", among other benefits[107]. Prison NSPs successfully operate in Spain, Germany, Switzerland, Luxembourg and elsewhere outside of Europe[108].

23. <u>What policy changes or improvements do you think would have the biggest impact on reducing the harm from drug use and/or supply?</u>

Decriminalisation and diversion schemes – Release would respectfully recommend that the review consider the evidence for decriminalising the possession of drugs for personal use, as this would have the biggest impact on reducing the harms experienced by PWUDs and criminalised communities. In practice decriminalisation of drug possession offences includes both *de jure* models of the approach, that is, those achieved through legislative reforms or constitutional court decisions, and *de facto* models whereby the offence of possession of controlled drugs for personal use is still contained within the criminal statute but the law is not enforced by police or prosecutors. While *de jure* decriminalisation would require central government to either amend the Misuse of Drugs Act 1971 (or devolve the matter of 'misuse of drugs' to the Scottish government), *de facto* decriminalisation would not require legislative reform. Central, devolved or local government could instead work to implement diversion schemes for PWUDs, such as those operating in some police forces in England. Please refer to Question 22 above on the evidence in favour of decriminalisation and diversion schemes. Whilst we understand that the terms of reference exclude consideration of policies that would require legislative change, if we want to take an approach that is consistent, equitable and evidenced based Government should enact legislation to end the criminalisation of PWUDs.

Funding Drug Services – Further cuts to drug services have been predicted from 2020 when the ring-fenced Public Health Grant for local authorities is due to expire and "local authorities will fund public health work from business rates retention"[109] – although we understand that this still needs to be confirmed However, if enacted, the revenue from business rates may already be inadequate in providing a high-quality service. Further, local authorities are not mandated in law to provide drug treatment services (unlike sexual health services). Central government should urgently re-invest in, and mandate, drug treatment and harm reduction services, to ensure that they are adequately funded and able to deliver high-quality and evidence-based treatment. Consideration should also be given to reverting to centrally funded drug treatment, as was the case under the National Treatment Agency until 2013, as this would avoid a postcode lottery in terms of treatment access and quality. It is worth noting that local public health budgets need to cover a number of areas, from childhood obesity to smoking cessation, this will often lead to a politicisation of budget allocation where those perceived as 'deserving' are more likely to receive funding. PWUDs problematically are marginalised and stigmatised, and are perceived as being responsible for their own drug dependency despite the evidence around the impact of ACEs, they are therefore less likely to be considered 'deserving' of investment – this is borne out by the fact drug treatment funding has experienced the most significant cuts to within public health funding.

Peer Support and Service User Networks – Please refer to Questions 18 and 22 above on evidence related to drug user involvement, peer support and service user networks. To more effectively reduce the harms experienced by PWUDs, people involved in supply, and people affected by the criminal justice led approach to drug policy, it is imperative that these groups are meaningfully involved in shaping the drug policies and drug services that affect their lives[110]. This will require investment in drug user networks/ peer support / service user networks and a commitment to involving marginalised, disenfranchised and under-represented groups, such as womxn, BME communities and sex workers.

Drug Consumption Rooms – There is general reluctance by central government to scale up harm reduction responses – an approach that aligns with the UKs prohibitionist framework. Despite the well-established benefits of DCRs, and in spite of the clear need expressed in Glasgow following a localised HIV outbreak and high incidence of public injecting and drug-related litter, the UK government continues to prevent efforts to implement a DCR in the UK on the grounds of the law. However, many of the legal issues that are raised in relation to DCRs are already managed and tolerated in relation to drug checking indicating that there is a tolerance of some drug users but not others. A DCR could operate if there was agreement from local Police and Crime Commissioners and Chief Constables not to arrest and bring prosecutions for possession, in recognition of the public health outcomes. A similar situation exists for NSPs where national Crown Prosecution Service guidance states that it is not in the public interest to bring prosecutions for possession of controlled substances where a person has been accessing sterile injecting equipment provided by a drug treatment service. That guidance recognises that both people accessing NSPs, and staff of the programmes, will necessarily commit offences under the Misuse of Drugs Act 1971. Please refer to Question 22 above on the evidence in favour of introducing a DCR.

THN Programmes – There should be a presumption to supply THN to any person likely to be at risk of a fatal opioid overdose, likely to witness an overdose (including peers, friends, and emergency services), in addition to any person requesting a kit. Prisons that do not have a THN programme in place should implement such a programme as a matter of urgency, to prevent fatal opioid overdose among people released from their custody. Moreover, NHS England should be responsible for

commissioning prison THN programmes in England and HMIP should regularly inspect and report on THN.

Needle and Syringe Programmes – NSPs are effective at improving health outcomes among PWID and reducing BBV infections but an absence of monitoring makes it difficult to determine whether coverage is sufficient. Public Health England should set up a national system for monitoring NSPs so it can report to the EMCDDA on NSP coverage. Prison NSPs should be rolled out across the UK, and particularly in areas of need, in recognition of the right to health and principle of equivalence of care. A prison NSP might be particularly beneficial in Scotland, given the historical outbreaks of HIV among PWIDs in Scottish prisons[111] and the recent outbreak of HIV among PWIDs in Glasgow which has been linked to frequent incarceration among this group[112].

Low-threshold OST prescribing – Consideration should be given to rolling out low-threshold OST prescribing, including of hydromorphone (as a cheaper alternative to diamorphine), to more effectively prevent opioid-related deaths. Please refer to Question 22 above on international evidence related to low-threshold OST prescribing.

Drug Checking – Access to drug checking services should be expanded, including beyond festival settings and in a DCR facility (see above), to allow PWUDs and people involved in supply to use these services and minimise the health harms associated with an unregulated drug market. Please refer to Question 12 for more information on health harms.

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