Written evidence from Dr Jason Horsley

- **Dr Jason Horsley - Director of Public Health for Portsmouth and Southampton**

  In a professional capacity as the Director of Public Health for Portsmouth and Southampton advocating for health promoting policies on behalf of the population of both cities. Please note that these represent my personal and professional views but may not reflect the views of the respective administrations of Portsmouth City Council or Southampton City Council.

**Introduction**

I am submitting this as the Director of Public Health for Portsmouth City Council and Southampton City Council. These two wonderful port cities on the south coast of England both have areas within them of relatively deprived urban living. Consistent with this, and in keeping with many other seaside cities in the UK, homelessness and drug and alcohol addiction are significant problems in both cities. The public health team for both councils’ commissions services for people who have problems as a result of drug and alcohol use.

In my time working in this role I have become increasingly concerned that the policy approach to drugs is not working in the UK, and that we need to take a different path, focussing on managing addiction as a medical and public health problem, rather than criminalising it. Working with policing colleagues has further convinced me that the current policy is providing a steady income stream for violent criminals, fuelling problems such as knife crime and violence, while all to often failing the people who really need help.

I am extremely grateful to Dr Adam Holland who helped with the extensive research of the evidence base for this submission.

This response has four components:

- Figures and secondary analysis of levels of drug use and drug related harm in different countries.
- Primary anecdotal evidence from local service providers.
- A summary of referenced relevant literature.
- Recommendations based on the available evidence and expertise of professionals in Portsmouth and Southampton that it is believed would pose benefits for the inhabitants of both cities and the wider population.
Researcher: Dr Adam Holland (Public Health Registrar)
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACMD</td>
<td>Advisory council on the misuse of drugs</td>
</tr>
<tr>
<td>ACE</td>
<td>Adverse childhood experiences</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood borne virus</td>
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<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>CM</td>
<td>Contingency management</td>
</tr>
<tr>
<td>DCR</td>
<td>Drug consumption room</td>
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<td>DRD</td>
<td>Drug related deaths</td>
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<td>EMCDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<td>HAT</td>
<td>Heroin assisted therapy</td>
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<td>HSCP</td>
<td>Health and Social Care Partnership</td>
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<td>IVDU</td>
<td>Intravenous drug user</td>
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<td>MDMA</td>
<td>3, 4-methylenedioxy-methamphetamine</td>
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<td>NAT</td>
<td>National AIDS (Acquired Immune Deficiency Syndrome) Trust</td>
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<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>NPS</td>
<td>Novel psychoactive substances</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>PSHE</td>
<td>Personal, Social, Health and Economic education</td>
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<tr>
<td>PMMA</td>
<td>Para-Methoxymethamphetamine</td>
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<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
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<tr>
<td>WEDINOS</td>
<td>Welsh Emerging Drugs and Identification of Novel Substances Project</td>
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Executive Summary

1. What is the extent of health harms resulting from drug use?

Drug use directly and indirectly causes many health and non-health harms to users, their contacts and wider society. Many of these are caused or exacerbated by current drugs policy.

2. What are the reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high-risk use to the normalisation of recreational use.

Most people who use drugs do not become dependent or problematic drug users. Some factors that increase the risk of problematic drug use such as genetics and personality traits cannot be modified. Efforts should be focussed on preventing and mitigating those that can; particularly absolute and relative deprivation, adverse childhood experiences and mental health problems.

3. How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.

There is evidence to guide the provision of primary prevention in schools but currently there is no comprehensive national guidance to ensure this is occurring. As a result unregulated organisations may be providing non-evidence based resources. Mental health and social services play an important role but are facing significant financial strain. People with problematic drug use often have complex health and social needs and must be considered holistically as their problems are closely interrelated. Groups of young people with a high prevalence of drug use such as university students would likely benefit from the provision of harm reduction information.

4. How effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

Structured drug treatment has been shown to have a host of benefits and be cost-effective producing savings for health, criminal justice and social services. Only an estimated 42% of high-risk opiate users were receiving opioid substitution therapy in the UK in 2016. Evidence based treatments, especially heroin assisted therapy, contingency management and take-home naloxone are not comprehensively provided. This is likely, at least in part because insufficient funding is available. Whilst DRDs have been increasing, funding has decreased. The situation is likely to get worse with the impending end of the ring-fenced public health grant and no legal mandate for local authorities to provide drug treatment services.

5. Is policy sufficiently geared towards treatment? This includes the extent to which health is prioritised, in the context of the Government’s criminal justice-led approach.

To stop drug use entirely there would have to be a level of authoritarian control that is not compatible with basic British values. The criminalisation of drug use contributes to considerable harm to people who use drugs and wider society that would only be justified
if it prevented greater other harm. There is no clear evidence that criminalisation is beneficial for society, with no clear relationship between the liberality of a country's drug policy and the prevalence of drug use. It is certainly not beneficial for people who use drugs as arrest and involvement with the criminal justice system is associated with a host of negative outcomes. There are potential benefits from the regulation of drug use including control over drug production to prevent drug adulteration, removing funds from organised crime and controlling the advertisement and cost of drugs.

6. What would a high-quality, evidence-based response to drugs look like?

Increased funding is necessary to provide comprehensive structured drugs treatment and prevention services. Drug consumption rooms and drug checking services have mounting bodies of evidence in their favour. Legal clarity is required to allow and encourage their provision.

7. What responses to drugs internationally stand out as particularly innovative and / or relevant, and what evidence is there of impact in these cases?

Portugal decriminalised the possession of all drugs in 2001. Proponents and critics of decriminalisation are both guilty of sometimes misinterpreting the evidence to fit their agenda. Decriminalisation in Portugal has not solved all their problems, but neither has it been disastrous. It has likely contributed to a significant reduction in drug related harm. This supports the assertion that the criminalisation of drugs does not create the benefits that would be necessary to warrant the substantial harms and costs it is associated with.

**Recommendations**

1. Commission the development of an evidence based national PSHE drugs education programme and guidance to prevent the provision of non-evidence based drugs education by unregulated organisations.
2. Stop the use of indicators or incentives that promote shorter periods of opiate replacement therapy.
3. Ensure the provision of adequate ring-fenced funding for local authorities to provide drug treatment and prevention services.
4. Mandate the provision of comprehensive drug treatment services.
5. Provide central funding for HAT, take home naloxone and CM to ensure their provision with ongoing review of their impact.
6. Remove criminal sanctions for the possession of drugs.
7. Investigate models of drug supply regulation.
8. Clarify the law in relation to drug checking services to allow and encourage their provision when need is evidenced.
9. Clarify the law in relation to DCRs and allow local drug treatment commissioners to establish DCRs if local need is evidenced. In the meantime, allow local working agreements to be defined with police and other agencies to allow pilot services to be instituted.

Please see the following full responses to the inquiry’s terms of reference for the evidence and rationale supporting these recommendations.
1. What is the extent of health harms resulting from drug use?

1.1 Drug use directly and indirectly causes many health and non-health harms to users, their contacts and wider society (Figure 1). Many are caused or exacerbated by the criminalisation of drug possession, the unregulated nature of the market, the organised crime perpetuated by it and the stifling of promising interventions such as drug consumption rooms by the current criminal justice approach.
Figure 1 - A mind map demonstrating the multitude of direct and indirect harms to drug users, their family and friends and wider society.
2. What are the reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high-risk use to the normalisation of recreational use.

2.1 Most people who use drugs do not become dependent or problematic users; they go through a brief experimental phase or integrate drug use into their day-to-day lives as they do with legal drugs such as alcohol (Figure 2).

Figure 2 - Estimated number of drug users in England and Wales based on the 2017 ONS mid-year population estimate and results from the Crime Survey for England and Wales (Home Office, 2018; ONS, 2018)
Key drivers of problematic use

2.2 Most people who try drugs have opportunities and support structures that protect them from becoming dependent users\(^1\). Problematic drug use is associated with deprivation, adverse childhood experiences and mental health problems (see below); sometimes it may be the cause of them but in many instances it is the result. Many people have more than one of these problems resulting in a complex set of interrelated health and social needs (Figure 3). Further research should focus on preventing and mitigating these issues rather than reiterating well-documented associations.

![Diagram of associated issues](image)

**Figure 3** - Venn diagram of the associated issues many dependent drug users suffer with. Individuals with a combination of issues in the red and orange segments have particularly complex health and social needs.

Absolute and relative deprivation

2.3 Problematic drug use is more prevalent in deprived populations\(^2\) (Figure 4). 8\% of respondents to the 2014 Adult Psychiatric Morbidity Survey who were on housing benefit reported symptoms of drug dependence compared to 2.5\% of respondents who were not\(^3\).

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\(^1\) Hayes (2015)

\(^2\) Marmot (2010)

\(^3\) This survey considered regular cannabis use to be dependent drug use; this is debateable and why the number of dependent users is so high (NHS Digital, 2016).
This association is most pronounced amongst the most deprived; in a recent survey 50% of rough sleepers in Portsmouth were known to substance misuse services\(^4\).

2.4 Even if an area is not absolutely deprived higher levels of inequality are associated with more drug use\(^5\). About one in five in the UK lives in absolute and relative poverty\(^6\). Levels of income inequality in the UK are above the European average and potentially the highest in Europe\(^7\).

**Mental health problems**

2.5 Various mental illnesses are associated with drug use; it is unclear whether this is a causative link, a shared pre-disposition or individuals self-medicating\(^8\).

**Adverse Childhood Experiences**

2.6 ACEs are stressful experiences during childhood; direct abuse or indirect factors such as parental separation, substance misuse or incarceration. Individuals with four or more ACEs were shown to be eleven times more likely to have used crack or heroin and have various other poor outcomes\(^9\).

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\(^4\) Safer Portsmouth Partnership (2018). The estimated number of rough sleepers in England has increased by 165% between 2010 and 2018 from 1768 to 4677 (Homeless Link, 2018).

\(^5\) Wilkinson and Picket (2010)

\(^6\) This is after paying for housing. Relative poverty is income below 60% of the population's median income that year. Absolute poverty is income below 60% of the inflation-adjusted median income in a base year (McGuinness, 2018a)

\(^7\) McGuinness (2018b)

\(^8\) BMA (2013)

\(^9\) Bond (2017)
2.7 Interviews performed with drug users locally demonstrated the relationship between ACEs and drug use. One interviewee stated "All I've done is just take drugs . . . just so I don't have to think about it [abuse whilst in care]" and another said drugs "block out the pain from my childhood and other things".

2.8 Some other factors that increase the likelihood of problematic drug use such as genetics and personality traits are non-modifiable. The usefulness of researching these areas further is therefore limited.

10 Richards (2018)
11 Tsuang et al. (2001)
12 Belin and Deroche-Gamonet (2012)
3. How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.

**Primary prevention**

3.1 Education in schools and youth clubs has an important role to play preventing problematic drug use by discouraging initial use. Evidence indicates the benefit of lessons focusing on social influence and life skills rather than attempts to 'scare pupils straight', which may be detrimental. PSHE guidance is currently sparse and as a result many schools are likely not using effective techniques. Unregulated organisations are providing drugs education in schools around the country and this has led to concerns about their motivations.

**Harm reduction**

3.2 Many young people have taken or are at high risk of taking drugs despite primary prevention efforts. Harm reduction information delivered to groups with a higher prevalence of drug use, such as university students, may reduce acute health harms.

3.3 Risk based messaging encouraging abstinence is unlikely to be effective for many drug users; one survey demonstrated that 73% of MDMA users knew taking MDMA was risky but took it anyway. Authors performing fieldwork have noted users are more likely to respond favorably to harm reduction messaging.

3.4 Different types of drugs and patterns of use come with very different levels of risk. The large proportion of the public who have experience of recreational drug use may be less likely to trust health promotion and legislation that treats all drug use as if it is the same.

**Managing and countering drivers of use**

3.5 The key drivers of problematic drug use mentioned are risk factors for many other poor outcomes and are important issues in themselves. Their interrelated nature means a concerted system-wide approach must be taken to confront them simultaneously.

3.6 There is limited evidence on how to deal with the consequences of ACEs after they have occurred. More research is needed in this area. Adequately funded social services and early years support are needed to protect children from experiencing them in the first instance.

3.7 Mental health services are under strain with long waiting times and limited access to evidence based treatments. Investments in mental health and social services are highly likely to lead to greater longer term savings for other services.

3.8 Historically, diagnostic criteria have hindered work with individuals with a dual diagnosis of drug problems and mental illness. Some services require patients to stop using substances.

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13 EMCDDA (2017)
14 Moore-Bridger (2017)
15 56% of respondents to a recent NUS survey reported having used drugs; although it was an online survey and drug users may have been more likely to respond (NUS, 2018)
16 Gamma et al. (2005)
18 Anandaciva (2018)
before receiving help for other issues; for many this is not feasible. Anecdotal evidence from Portsmouth and Southampton has demonstrated this issue and we believe it to be a national problem. Work has been done to combat it but more is required.

3.9 Alongside fiscal policy and progressive taxation to fund services and combat deprivation particular attention must be given to ensuring dependent users have employment opportunities and financial support to facilitate recovery\textsuperscript{19}.

\textsuperscript{19} Birkinshaw et al. (2017)
4. How effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

4.1 NICE produce guidelines for treatment including opiate substitution therapy, psychosocial interventions and needle exchange. There is evidence that treatment increases abstinence and decreases DRDs, street drug consumption, BBV transmission and criminal activity.\(^{20}\)

4.2 Funding for adult drug and alcohol services has decreased by 19% between 2014/15 and 2018/19.\(^{21}\) There is no legal mandate to provide drugs treatment; if the Public Health Grant ring fence is removed in 2020 services may deteriorate. Each £1 spent on drug treatment is estimated to result in £2.50 worth of savings to society, so short term savings will likely be costly in the long term.

4.3 Various local authorities have reported they cannot afford to comprehensively offer evidence based services\(^{24}\):

4.3.1 Only an estimated 42% of high risk UK opiate users were receiving opiate substitution therapy in 2016.\(^{25}\)

4.3.2 Since 2015, naloxone, a potentially lifesaving medication, can be supplied without prescription to individuals likely to witness opiate overdoses. Only 12% of high risk users were estimated to be covered by provision in 2017.\(^{26}\)

4.3.3 Heroin assisted therapy\(^{27}\) is uncommonly provided in the UK despite recommendations from august bodies and RCTs from six countries\(^{29}\) demonstrating that the use of HAT decreased mortality, street drug use and crime and led to annual savings of EUR 6,301-14,807 per user.

4.3.4 Contingency management\(^{31}\) is not routinely utilised by many services despite recommendations from august bodies\(^{32}\) and various studies demonstrating reductions in ongoing drug use and the EMCDDA concluding it is "a feasible and promising adjunct to treatment interventions for drug users".\(^{33}\)

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\(^{20}\) NICE (2019)  
\(^{21}\) Finch et al. (2018)  
\(^{22}\) NAT (2019)  
\(^{23}\) Davies et al. (2009)  
\(^{24}\) NAT (2018)  
\(^{25}\) EMCDDA (2018c)  
\(^{26}\) Release (2017) - Aside from funding Release identify various other barriers to its provision that should be addressed.  
\(^{27}\) HAT is the prescription and administration of injectable diamorphine in a medically supervised setting for IVDUs who did not benefit from first-line treatment.  
\(^{29}\) EMCDDA (2012), Ferri et al. (2011)  
\(^{30}\) The results of four trials pooled together showed a 35% reduction in mortality during follow up. This was not statistically significant (95% confidence intervals of relative risk were 0.25-1.69), however the effect would likely be greater with longer follow up.  
\(^{31}\) CM is the process of offering rewards to drug users, which are contingent on the fulfilment a particular task. Rewards include food vouchers, money or the freedom to take methadone doses home. The task could be for example, abstaining from drugs, getting a job or receiving a full course of hepatitis B vaccine. CM aims to interfere with drug-related reward reinforcement by introducing a competing reward.  
\(^{33}\) EMCDDA (2016a)
4.4 For some drug users detoxification to achieve abstinence is practicable but for others is unlikely to be successful. Prolonged prescription of opioids to facilitate functioning in society is preferable to giving a short course and the user quickly relapsing\textsuperscript{34}. Incentivizing services to provide shorter courses, for example by using indicators such as 'treatment completion' is therefore inappropriate\textsuperscript{35}.

\textsuperscript{34} NAT (2019)
\textsuperscript{35} Birkinshaw (2017), NAT (2018)
5. Is policy sufficiently geared towards treatment? This includes the extent to which health is prioritised, in the context of the Government’s criminal justice-led approach.

Does the criminalisation of possession decrease use?

5.1 The Police Federation have stated there is only 'very limited' evidence for a deterrent effect of the law\(^{36}\). And the BMA suggested that although the law probably deters some from using drugs it is likely that social norms are more important\(^{37}\).

5.2 More than thirty countries have some level of decriminalisation, either in law (de jure) or due to the de-prioritisation of law enforcement related to drug possession (de facto)\(^{38}\). In some of these countries drug possession still warrants administrative sanctions, like a parking ticket.

5.3 There is no clear relationship between a country's drug policy and levels of drug use (Figures 5-9). This was the conclusion of a previous Home Office report\(^{39}\).

5.4 Stevens (2019) found that there was no statistically significant association between policy liberality and prevalence of adolescent cannabis use. In countries with prohibition adolescent males were actually more likely to have tried cannabis; which may be explained by a desire to rebel\(^{40}\).

5.5 A multitude of factors in a country may affect levels of drug use precluding firm conclusions on the effect of policy. More information can be gleaned from considering countries before and after decriminalisation was introduced. In some areas drug use has increased, in others it has decreased but Eastwood et al. (2016) suggest that in no instance has it skyrocketed\(^{41}\).

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\(^{36}\) The Police Federation (2000)

\(^{37}\) BMA (2013)

\(^{38}\) Eastwood et al. (2016).

\(^{39}\) Home Office (2014).

\(^{40}\) Stevens (2019)

\(^{41}\) Eastwood et al. (2016)
Countries where incarceration for minor drug offences is not possible
Does the criminalisation of possession help drug users?

5.6 Contact with the criminal justice system is associated with various poor outcomes. Employment prospects are threatened making socioeconomic deprivation more likely, which is a well-recognised risk factor for further drug problems. Offenders are more likely to have poor health; those with community probation orders are more than 3.5 times as likely to die compared to age matched individuals in the general population\(^{42}\) (Figure 10).

5.7 Incarcerating someone is unlikely to help them abstain from drugs. Drug use in prison is common; boredom may incentivise use and more than a quarter of inmates reported drug use in a HM Inspectorate of Prisons survey\(^ {43}\). Even if prisoners can avoid drugs sentence durations for possession are unlikely to be long enough for an effective course of treatment to be delivered.

5.8 The fact that drug use continues in prisons where inmates can be strictly monitored and close attention is given to what is entering the prison highlights that some level of drug use is inevitable in wider society without a level of authoritarian control that is incompatible with basic British values.

\(^{42}\) It should be noted that a proportion of these deaths are related to drug use; which may have been the reason for the probation order (Revolving Doors, 2017)

\(^{43}\) HM Inspectorate of Prisons (2015). It is possible in reality use may be higher as prisoners are averse to admitting prohibited behaviour.
5.9 Strikingly, nearly all countries in Europe with less punitive drug laws have DRD rates below the European average\textsuperscript{44} (Figure 11). This could be because drug users are more likely to seek help without fear of reprisal. Additionally, resources saved from enforcement may be spent on prevention and treatment programmes.

\textbf{Figure 10} - Standardised mortality rates of offenders compared to the general population (Revolving Doors, 2017)

\textbf{Figure 11} - Drug related deaths per million 15-64 year olds in EMCDDA reporting countries (EMCDDA, 2018a)

\textsuperscript{44} European average is 21.8 per million 15-64 year olds. Of countries with depenalisation only Slovenia has a DRD rate higher; 29 per million 15-64 year olds (EMCDDA, 2018a).
Arguments for regulation

5.10 There is no clear relationship between the harm caused by drugs and their legal status, with alcohol and tobacco causing more harm than many illicit drugs\(^{45}\) (Figure 12).

![Figure 12 - The harms caused by different drugs determined by a panel of experts using multi criteria decision analysis (Nutt, 2010).](image)

5.11 Opiate replacement therapy is essentially a highly regulated market that we know reduces drug related harm. When considered as such the regulation of other drugs becomes more palatable.

5.12 There are a variety of potential approaches to drug regulation that lie between prescribed and supervised opiate consumption and the licensing and advertisement limitations that are utilised for cigarettes and tobacco currently. Different drugs are used in different ways, by different people with difficult risks. Individual modes of regulation for each drug should reflect this.

5.13 Potential benefits of regulation include:

5.13.1 **Control of production**: To reduce the circulation of particularly strong and adulterated drugs.

5.13.2 **Reducing criminal funding**: The EU illicit drug market is estimated to be worth EUR 24 billion\(^ {46}\). A black market would certainly exist alongside a regulated market as it does with tobacco and alcohol, but profits would be limited. Street heroin is currently sold for an estimated 16,800\% of its cost of production\(^ {47}\). The risk of

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\(^{45}\) Nutt et al. (2010)

\(^{46}\) EMCDDA (2016b)

\(^{47}\) Global Commission on Drugs Policy (2018).
incarceration would be more likely to outweigh the incentives for potential drug dealers if the incentives were less impressive.

5.13.3 Advertisement rules and financial disincentives: Anecdotes from police and the literature\textsuperscript{48} describe recovering drug users being aggressively targeted by county lines dealers. Pushing the drugs market underground does not protect people from exposure to drugs but allows marketing techniques that are prohibited in regulated markets. Additionally, there is strong evidence for the effectiveness of financial disincentives to combat alcohol and tobacco use; tools we are unable to use to combat drug use in the current legislative climate.

5.14 NPS related deaths decreased following the introduction of the Psychoactive Substances Act 2016. This may be inaccurately used to support criminalisation. The reduction in deaths was a result of transferring the sale of NPS from an unregulated legal market to an unregulated illegal market. There could be greater benefits from a responsibly regulated market (Figure 13).

\textbf{Figure 13} - The suggested relationship between regulation and harm (Global Commission for Drugs Policy, 2018).

5.15 In modern times it is a bold policy approach to punish drug users for doing something to their own bodies\textsuperscript{49}. There is little evidence that the criminalisation of drug possession causes the

\begin{itemize}
  \item\textsuperscript{48} Coomber (2017)
  \item\textsuperscript{49} The Nuffield Council of Bioethics (2007) developed the intervention ladder to guide policy decisions when balancing decisions that impact on liberty and health. This is built on the philosophy of Mill, whose harm principle states “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others” (Mill, 1859).
\end{itemize}
benefits that would be necessary to justify the resources spent enforcing it and the harms it causes.
6 What would a high-quality, evidence-based response to drugs look like?

6.1 More funding is required to comprehensively provide the prevention and treatment services mentioned in earlier sections. Additionally, changes in legislation are necessary to allow and encourage the use of drug consumption rooms and drug checking services.

Drug consumption rooms

6.2 DCRs provide vulnerable drug users a space to inject, smoke or snort drugs under the supervision of trained staff; which may include nurses, social workers, peers, counsellors and doctors. Harm reduction advice and materials, sterile injecting equipment, counselling and overdose treatment can be provided. Additionally, drug checking for adulterants such as fentanyl can be provided as in Canada\(^50\). DCRs have functioned in EU countries since 1986, and there were 78 DCRs in EMCDDA reporting countries in 2018\(^51\) (Figure 14).

A detailed analysis of DCRs was performed by an Independent Working Group in 2006, which concluded "[DCRs] offer a unique and promising way to work with the most problematic users, in order to reduce the risk of overdose, improve their health and lessen the damage and costs to society" and recommended "that pilot DCRs are set up and evaluated in the UK"\(^52\). Since then various bodies and local authorities have recommended their careful introduction including a 2012 select committee and the ACMD\(^53\). Despite this,  

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\(^50\) Vancouver Coastal Health (2016)  
\(^51\) EMCDDA (2018b)  
\(^52\) Joseph Rowntree Foundation (2006)  
and evidence continuing to mount in their favor, the Home Office has stated DCRs are illegal under The Misuse of Drugs Act 1971.

6.4 Belackova and Salmon (2017) give a detailed overview of the evidence in favour of DCRs, which demonstrates DCRs:

- Facilitate the management of overdoses and prevent DRDs.
- Encourage safe injecting practices, thereby reducing the risk of BBV transmission.
- Yield cost savings due to reductions in DRDs and BBV transmission.
- Increase uptake of health and social services.
- Reduce drug litter and public injecting.
- Attract high risk users and have a high coverage of local drug users.
- Do not increase drug use.
- Do not increase crime.

Drug checking services

6.5 The first drug checking service was founded in the Netherlands in 1992 leading the way for the foundation of similar services in at least 16 countries, including the Loop in England and WEDINOS in Wales. Users submit substances to find out their strength and composition, providing an opportunity for engagement and the provision of harm reduction advice.

6.6 The recent announcement of a Home Office licensed drug checking clinic is welcomed. As was the allowance from Nick Hurd that local agencies could come to working agreements to institute services in festivals. Locally, and elsewhere however confusion around the legislation has hampered efforts to introduce services and clarification is required.

6.7 Drug checking services have been shown to:

- Influence short term drug taking both in hypothetical surveys and service data with users indicating they would not take a drug or they would otherwise alter their behaviour if a test result was unexpected with a significant proportion directly submitting their substance for disposal.
- Be associated with reduced drug related medical issues at festivals.
- Potentially decrease longer term riskier drug taking behaviour.
- Potentially influence the drugs market by removing dangerous substances.

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54 See Drug and Alcohol Findings (2016) for a history of the calls for and barriers to the introduction of DCRs in the UK.
55 HC Deb, 6 July 2018, c677
58 There was a 95% reduction in drug related hospital admissions following the introduction of drug checking at Secret Garden Party (Measham, 2018). There have been additional anecdotal reports of the same at other festivals in the press (Bushby, 2018) and from discussions with event organisers.
59 Service users had greater knowledge of unsafe doses (Benschop et al., 2002). Frequent and poly-drug use became less prevalent amongst users of a fixed Swiss drug checking clinic (Hungerbuehler et al., 2011).
60 Substances for which warnings were publicised stopped being submitted for testing in the Netherlands suggesting they were no longer in circulation (Spruit, 2001).
A note on evidence

6.8 In the traditional hierarchy of evidence, RCTs and reviews of RCTs are considered the gold standard of research (Figure 15). Often in the drugs field RCTs are not available. This is because they are logistically difficult to perform or it may be unethical to perform them as there is not clinical equipoise\textsuperscript{61}. We know that taking untested drugs in a dirty environment is more harmful than not so it would be inappropriate to design an experiment in which some drug users are actively placed in this situation. It is precisely because it is so likely that these interventions reduce harm that there is no gold standard evidence to demonstrate the fact.

\textsuperscript{61} Clinical equipoise is when there is doubt over which treatment is superior.
7. What responses to drugs internationally stand out as particularly innovative and/or relevant, and what evidence is there of impact in these cases?

7.1 In Portugal in 2001 the possession of drugs for personal consumption became an administrative rather than a criminal offence. Since decriminalisation:

7.1.1 According to national surveys there has been a sustained reduction in recent use of cocaine, amphetamines and ecstasy. In the decade following decriminalisation cannabis use decreased but it has increased in a 2016/17 survey (Figure 16). Comparing Portugal with adjacent countries, cannabis use similarly increased in Italy and France but decreased in Spain. In Spain drug possession has never been a criminal offence and over 500 cannabis clubs operate (Figure 17).

7.1.2 HIV rates have decreased dramatically (Figure 18).

7.1.3 The way DRDs are recorded has altered so it is not possible to make firm conclusions on trends. According to neither of the relevant indicators have DRDs increased since decriminalisation and it is possible there has been a substantial reduction. This is despite the impact of the global financial crisis, which hit Portugal particularly hard. In 2015, there were about 40-50 drug related deaths in Portugal and over 3000 in the UK (Figure 19).

Figure 16 - Proportion of 15-34 year olds reporting the use of selected drugs in the last 12 months in Portugal in surveys from 2001-2017 (EMCDDA, 2018a)

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62 EMCDDA (2018a). Lifetime drug use has increased, however this is a poor measure of current levels of drug use. An increase in lifetime drug use with a decrease in recent drug use likely represents transitive experimental use that does not become problematic. Additionally the usefulness of ‘lifetime drug use’ as an indicator is hampered by a cohort effect. All it takes is for a person to use drugs once and they are included in the lifetime use category for the rest of their life regardless of whether they are at risk of ongoing drug related harm.

63 EMCDDA (2018a)
64 EMCDDA (2018a)
65 Eastwood et al. (2016)
66 EMCDDA (2018a)
68 Unemployment in Portugal reached 17.5% in 2013 (Trading Economics, 2019).
Figure 17 - Proportion of 15-64 year olds who used cannabis in the last 12 months in selected European countries from 2001-2017 (EMCDDA, 2018a)

![Graph showing the proportion of 15-64 year olds who used cannabis in the last 12 months in Portugal, Spain, Italy, and France from 2001-2017.]

Figure 18 - HIV notifications in Portugal and the UK from 2007-2016 (EMCDDA, 2018a)

![Graph showing the number of HIV notifications in Portugal and the UK from 2007 to 2016.]

Period during which survey was performed

Year

Number of notifications

HIV notification:
7.2 At the same time as possession was decriminalised in Portugal extra resources were invested in prevention and treatment services and the welfare state was expanded with the provision of a minimum basic income for all citizens\textsuperscript{69}. Therefore it is not possible to say whether decriminalisation was directly responsible for the positive effects following the reforms.

7.3 Both proponents and critics of decriminalisation are sometimes guilty of misinterpreting the data coming out of Portugal to fit their agenda. Untangling the effect that decriminalisation has had as opposed to other factors is complex if not impossible. By no account however has it been disastrous, and it has more likely been associated with significant benefits.

\textsuperscript{69} Transform (2014)
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