Written evidence from Mr Ron Hogg

Written Evidence Submitted by Ron Hogg, Police, Crime and Victims' Commissioner for Durham

Ron Hogg is the Police, Crime and Victims' Commissioner for Durham. He is submitting evidence to raise concerns around the Government's current policy stance on drug use and interventions in practice, in order to improve drug policy which will benefit the communities he serves.

Executive Summary

1. The Government should:
   - move the responsibility of drug policy to the Department of Health—drug use should be a public health issue, not a criminal justice issue;
   - carry out a thorough review of the process for determining budgets for commissioning substance misuse services in England;
   - ensure that Local Authorities re-invest in and protect drug treatment budgets;
   - explore the role of PCCs in relation to public health, and the delivery of the Drug Strategy objectives, in order for effective liaison and joined up action, including an assessment of options to consider shifting substance misuse public health budgets to PCCs, given the known links between drugs and crime;
   - support fully funded effective education and prevention initiatives;
   - develop a more evidence-based public health approach which puts harm reduction and recovery at the forefront of its agenda—this includes increased Needle and Syringe programmes, increased funding for Opioid Substitution Therapy (OST), Heroin-Assisted Therapy (HAT), and increased provision of Naloxone;
   - promote cost-effective specialist drug treatment and recovery as a proven way to reduce crime, improve health and make communities safer;
   - support alternatives to the criminalisation of vulnerable people who use drugs in order to increase access to treatment and recovery.
Health Harm

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

2. Health harms associated with drug use include physical and mental health issues to the individual, the family, the physical and mental health harms to children who live with parents who misuse drugs, and the wider community, in terms of loss of quality of life in areas of drug dealing, and loss of productivity, in terms of days off from work.

3. This list is not exhaustive:
   a) mental and behavioural disorder due to illicit drug use;
   b) neonatal diagnoses due to illicit drug use;
   c) other physical health harms such as COPD, ulcers;
   d) drug related infectious diseases;
   e) HIV/AIDS for injecting drug users;
   f) physical injuries sustained through assaults and violence;
   g) seizures and poisonings; and
   h) deaths due to illicit drug misuse (resulting from overdose, suicide or homicide).

4. The extent of these health harms can be found in National intelligence network on drug health harms briefing December 2018, Towards-a-Safer-UK-Drug-Policy 2017, Department of Health: A summary of the health harms from drugs, and NHS Digital Statistics on Drugs Misuse.

5. According to the National Treatment Agency for Substance Misuse, 1.2m people are affected by drug addiction in their families and 120,000 children have a parent currently engaged in treatment services. The consequences of having addicted parents can be hard to bear for the children. These children can grow to emulate their parents so continuing the cycle of poverty, addiction, health harms and poor money management. The annual cost of looking after children who have been taken into care because of their parents’ drug using activities is estimated to be £42.5m.

6. Opioids, particularly heroin, remain associated with the highest health and social harm caused by illicit drugs in the UK. There are current concerns about changes in the patterns of drug injection in the UK, in particular the increased injection of amphetamines and the emergence of injection of NPS.

Prevention and early intervention:

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.
7. The United Nations Office on Drugs and Crime estimates that 9 in 10 people who use drugs do not suffer from drug use disorders. Those who do may have complex needs and face significant obstacles to accessing support.

8. Drug use and misuse tend to be clustered; for example, areas of relatively high social deprivation have a higher prevalence of illicit opiate and crack cocaine use and larger numbers of people in treatment. This link between areas of deprivation and the high prevalence of drug use indicates that addressing issues to do with health inequality and social exclusion, unemployment and housing problems are fundamental to improving treatment outcomes, and to helping people to recover from their drug addiction. There is therefore an increased link between the likelihood of using drugs and adverse childhood experiences.

9. Austerity across all public sector organisations and the lack of re-investment in public health services has contributed to the sustained use of drugs.

10. The current prohibitionist approach in England and the criminalisation of drug users has resulted in increased harm and increased barriers and cost to social services. A systematic cross country review of drug policy carried out by LSE’s International Drug Policy Unit, has shown no correlation between criminalisation and consumption of drugs indicating a failure on the current approach to drug use in terms of reducing use.

11. The increased availability of drugs via the internet, and the dark web also contributes to a certain extent to the normalisation of recreational drug use.

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.

12. The ACMD has previously warned Ministers that many popular prevention techniques are ‘ineffective at changing behaviour’ and ‘may even increase the risks of drug use’ and called on officials to consider holding back funding programmes unless there is clear evidence that they work: “The ACMD regards evaluation an important part of any prevention project as international evidence suggests many popular types of prevention activity are ineffective at changing behaviour, and a small number may even increase the risks of drug use”.

13. This review should consider the recommendations and scientific research which support drug prevention activities as part of wider strategies to promote healthy development and well-being, as outlined in the Advisory Council on the Misuse of Drugs 2015 Briefing to the Government.

14. The Checkpoint deferred prosecution project, in Durham Constabulary, provides some early evidence that early intervention and diversion away from the criminal justice system can address the reasons why people use drugs if a holistic approach is taken to address all criminogenic needs, rather than just the drug use. This is grounded in research suggesting that deterrence, with supported desistance is more likely to reduce people’s offending. Such schemes would put a much greater focus on early intervention with offenders to tackle the underlying problems that contribute to their offending. For drug possession offences, such a framework would enable individuals to be referred to drug treatment workers who would have a range of health interventions at their disposal, such as brief interventions. The framework
could also help to refer on those who would benefit from more structured treatment whilst addressing the reasons, e.g. trauma, why people take drugs in the first place.

Treatment and harm reduction:

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.

15. The evidence base for drug treatment is strong. The Clinical Guidelines are designed to support clinicians and commissioners in meeting their responsibility to ensure evidence-based treatments are available and competently delivered in order to have the greatest likelihood to produce individual benefit and public good. The Clinical Guidelines also enable the clinician to assess whether a proposed treatment plan departs, and to what extent it departs, from evidence-based guidance on the specific treatment.

16. Public Health England (PHE) estimates that providing ready access to treatment for around 200,000 individuals (more than twice as many as in 2001) prevents 4.9m crimes each year. The PHE Drugs Review, 2017, highlighted that with every £1 spent on treatment a £2.50 saving is recuperated on the social costs of drug misuse, making sound sense for local authorities to continue to invest in helping people to get into recovery.

17. The challenge is ensuring the commitment of investment in good quality, evidence-based treatment at times of reduced funding across all public sector organisations. Local authorities need to re-invest in and protect drug treatment budgets. The Advisory Council on the Misuse of Drugs has recommended: “mandating drug and alcohol misuse services within local authority budgets and/or placing the commissioning of drug and alcohol treatment within NHS commissioning structures” to protect current levels of investment in drug treatment.

18. In this current climate, there is a focus on the volatility of funding, with the continuous drive to reassess and retender services. The treatment sector as it currently stands, is in constant flux from retendering, there has been a race to the bottom for skills and remuneration of the workforce. There are currently too many Commissioners involved, leading to issues at senior levels within PHE, Clinical Commissioning Group (CCGs) and Local Authorities.

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.

19. The Government should seek a more evidence-based public health approach which puts harm reduction and recovery at the forefront of its agenda. The United Nations Office on Drugs and Crime estimates that 9 in 10 people who use drugs do not suffer from drug use disorders. Those who do may have complex needs and face significant obstacles to accessing support. Criminalising drug possession perpetuates stigma and marginalisation of people who use drugs, making it more difficult for them to access vital healthcare services and to seek support and is ineffective at getting people into treatment.
20. Policy on drug addiction should be moved to the Department of Health, in order for the focus to be on treating rather than punishing. The evidence for this is overwhelming. The recently published Home Office review indicated that introducing an alternative to prohibition would not, contrary to some claims, boost drug use, and it could save millions of pounds if users were treated for addiction rather than sent to prison.

21. The Modern Crime Prevention Strategy also states that “Full recovery from dependence should be the aim of treatment and evidence suggests that recovery is more likely to be achieved and sustained if users are given support to improve their ‘recovery capital’—particularly around housing and meaningful employment”.

22. The then Association of Chief Police Officers (ACPO, now NPCC) emphasised the value it places on the importance of effective drug treatment services to the criminal justice agenda and the need to ensure any reductions in investment or changes to current provision do not reduce the effectiveness of services, as this could prejudice the crime-reduction benefits of the current approach.

23. The role of the PCC in policing clearly also incorporates a capability in monitoring public service delivery, commissioning services and providing accountability. Conversations with the Home Office and PHE have identified an interest in exploring the role of PCCs in relation to public health, and the delivery of the Drug Strategy objectives. The Serious Violence Strategy confirms this direction of travel with the following paragraph: “Police and Crime Commissioners and Public Health: There are strong links between policing and public health, particularly with regards to drug and alcohol treatment and prevention services. It is imperative that those links are as strong as possible, and that PCCs and Directors of Public Health work as closely together as possible. Those links must also take account of the emerging picture with regards to the devolution settlements across England and the creation of mayors, some of whom are also PCCs. These developments, and publication of this strategy, provide a useful opportunity to test the strength of the relationships between public health and PCCs, and look at how those links can be strengthened and how and whether the role of PCCs can be expanded so that they play more of a role in discussions about public health.”

24. However, the experience of local partnerships is mixed, and there are concerns from some PCCs about the effectiveness of existing structures such as Community Safety Partnerships (CSPs) and Health and Wellbeing Boards (HWBs). Therefore, in terms of health being prioritised, in the context of the Government’s criminal justice-led approach, the Government needs to review the process for determining budgets for commissioning substance misuse services in England, ensure the re-invest in and protection of drug treatment budgets, and explore the role of PCCs in relation to public health.

**Best practice:**

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

25. The Government must develop a more evidence-based public health approach based on harm reduction. This includes:
- increased Needle and Syringe programmes to support a reduction in transmission of blood-borne viruses
- increased funding for Opioid Substitution Therapy (OST) such as methadone and buprenorphine, which is one of the most evidence-based treatment there
is and has been proven to reduce illicit opiate use, overdoses and transmission of HIV and viral hepatitis

- Heroin-Assisted Therapy (HAT), where people are prescribed heroin (otherwise known as diamorphine) and is used for people who don’t respond to OST, and has been shown to improve health outcomes in some of the most dependent of those people who inject drugs
- Increased provision of Naloxone, a lifesaving drug that reverses the effects of opiates when people have overdosed
- Policies that decriminalise drug possession and use

26. More than 90 countries – including the Netherlands, Canada, Switzerland, Uruguay, Spain, Australia and some US States – have adopted an approach to drug policy that specifically includes a focus on harm reduction. Countries that have long subscribed to heavy enforcement and punishment for those caught using drugs are beginning to reconcile elements of harm reduction within their frameworks, or pioneering totally new frameworks, with encouraging results. These policies have come with positive outcomes and the evidence shows no significant increase in drug use in countries that have adopted non-punitive responses to drug use. The Government must therefore promote cost-effective specialist drug treatment and recovery as a proven way to reduce crime and make communities safer.

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

27. The evidence from around the world is fairly conclusive. Wherever drug policy has been moved away from law enforcement, the positive outcomes have overwhelmingly outweighed the negative. The UK Government has acknowledged this, stating in their 2014 UK Home Office, International Comparators Report, which reviewed the drug policies of thirteen countries who took different approaches to tackling drug use, that the deterrent effect of criminalisation is negligible. “Looking across different countries, there is no apparent correlation between the toughness of a country’s approach and the prevalence of adult drug use”. The report concluded that drug use was influenced by factors ‘more complex and nuanced than legislation and enforcement alone’.

28. More meaningful improvements to drug policy can be achieved by ending criminal sanctions for possession offences though legislative reform. Research undertaken by Release looked at 25 countries across the world that no longer criminalised use or possession of drugs; none experienced increases in drug consumption linked to policy. Some countries – such as Australia (which has decriminalised cannabis possession in three states and have diversion schemes for all controlled substances in every State), Portugal, and the Czech Republic (Czechia)— reported improved physical and mental health outcomes when compared to individuals who were criminalised. Decriminalisation has also been associated with reduced rates of recidivism, reduced burden on police resources and savings to the public purse related to social costs.

29. 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 people who use drugs, thus ensuring a greater return on investment for communities and criminal justice agencies.
30. With drug related deaths at an all-time high across the UK, and accounting for one in three of such deaths in the whole of Europe, the UK could learn from Portugal. As an example, Portugal decriminalised the use and personal possession of all drugs in 2001, whilst also investing in harm reduction and treatment programmes. The number of annual drug overdose deaths has reduced from 318 in 2000 to 40 in 2015. Portugal’s rate of drug related deaths is 4 per million compared to the UK’s which is 66 per million. A 2015 study found an 18% reduction in the social costs of drug use in the first ten years of decriminalisation in Portugal. In the last 15 years, they have witnessed significant declines in HIV transmission rates, increased numbers in treatment, reduced illicit drug use among adolescents, at least since 2003, reduced number of young problem drug users compared to neighbouring countries, reduced burden of drug offenders on the criminal justice system, reductions in the prevalence of injecting drug use, increases in the amounts of seized drugs, reductions in the retail prices of drugs, and increased efficiency of Police and Customs.

31. A number of countries – including Switzerland, Germany, the Netherlands and Canada – prescribe heroin for use under medical supervision, as part of successful programmes to treat long-term users of illicit opioids. Despite its relatively limited availability, there is now a substantial body of evidence demonstrating the effectiveness of HAT. Every HAT trial has shown a marked decrease in illicit ’street’ heroin use. HAT is not just more effective at reducing street drug use than methadone, but it has also proven to be more cost-effective. While HAT does cost more than methadone initially, cost-benefit studies demonstrate that these higher costs are more than offset by savings in criminal justice and health care.

32. Public Health England also concluded: “There is compelling evidence for making IOT, usually diamorphine, available for those who continue to be at risk. A section of the Opioid Substitution Therapy (OST) (i.e methadone) treatment population, despite being given access to optimised treatment with oral opioid maintenance, can fail to make adequate progress and continue to be involved in high levels of injecting drug misuse and other risk-taking behaviour” (p113, Orange Guidelines, 2017). The Government must do more to promote and support areas looking to introduce Heroin Assisted Treatment in order to reduce the harms caused by illicit drugs.