Written evidence from Addaction

Addaction

We support people to take control of their lives and make positive changes. We make a difference to people who want to change their relationship with drugs and alcohol and improve their mental health and wellbeing. Our services are delivered in 81 locations in England and Scotland, we reached more than 130,000 people last year. Our specialist treatment services help people find a path to recovery. Our compassionate and professional staff deliver harm reduction advice and information, one-to-one recovery support, access to peer support groups, small group sessions, and residential and clinical treatments for people with drug and alcohol issues.

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

1. We know the majority of people who take drugs will suffer minimal to no drug related health harms. Individuals need to be clearly informed about the risks and harms involved in consuming drugs in order to make informed decisions around risks and how to minimise them. For those who choose to take substances it’s vital they have access to the services and tools capable of reducing harm.

2. We work with over 45,000 people every year who have used drugs in a problematic way. As such, we see first hand the resulting health and societal harms which drug use can cause. We have set out below what we see as being some of the most pressing issues that need to be addressed.

Drug related deaths

3. Drug related deaths (DRD) are at historic highs in the UK. But there are concerns they are yet to peak. In Scotland alone the numbers increased by over 30% the past two years. In 2007 the rate of deaths for women was 48 per 1 million. This increased by almost 50% to 66 in 2017.

4. There are two and a half times more DRDs annually than road traffic accidents in the UK. The UK accounts for 31% of all DRDs in Europe but just over 6% of the road traffic deaths in Europe.

5. Everyday we see people leave their drug issues behind them, build relationships with families and friends, begin to support others with problems and generally work towards a positive future. All too often we see this potential cut short due to preventable deaths.

6. Opiates are involved in over half of DRDs, tackling them needs to be prioritised. Approximately half of opiate DRDs involve people who have never been in treatment or haven’t been in treatment for a long time. Getting people into structured treatment
and keeping them there for as long as they need is vital. Certain groups are particularly at risk of fatal overdoses: people entering and leaving treatment; prison leavers; people who have recently had non fatal-overdoses. Every local area needs to have specific plans in place for these groups to encourage them to access appropriate services.

**Hepatitis C**

7. Approximately 90% of hepatitis C infections diagnosed in the UK are acquired through injecting drug use. Around half of People Who Inject Drugs (PWID) have been infected with hepatitis C.

8. There has been progress testing PWID for hepatitis C. 65% of people in treatment for drug use were offered and accepted a hepatitis C test in 2016, up from 53% in 2010. Public Health Wales has introduced routine opt-out testing for all at-risk individuals in contact with substance misuse and related services across Wales.

9. However, the prevalence of Antibodies-Hep increased from 44% in 2006 to 51% in 2017 among PWID. We need to get more PWID into treatment and improve needle exchange provision.

10. In our Cornwall service we employ a nurse who tests service users for hepatitis C and provides them with treatment directly, meeting with clients in locations convenient to them, improving engagement rates and the proportion of people completing treatment.

11. PWID can be apprehensive about beginning treatment, often wrongly ‘under the impression that it won’t affect them for 15-20 years so you might as well leave it until feeling really rough’. We ran a pilot in one of our service for 12 months on COPD. A facilitator was placed in the service to increase diagnosis of Hepatitis C infection within clients and the engagement of diagnosed individuals into appropriate treatment. The facilitator undertook activities including training key workers, direct interaction with clients, streamlining and support for hepatology appointments and introduction of dried blood-spot testing. It increased engagement of Hepatitis C positive PWID with testing, referral to hepatology and initiation of treatment by over 30%.

12. Improving accessibility to needle exchanges needs to be prioritised to prevent risky sharing of needles and the spread of blood borne viruses like hepatitis C i. The proportion of PWID reporting adequate needle and syringe provision is only 45% nationally and levels of sharing of needles and syringes have remained the same over the last five years. There’s much more which needs to be done here.

13. In some locations lack of funding has reduced access to needle exchange. To combat this we need to be innovative. For example, in Lincolnshire we set up the first needle exchange vending machine, enabling individuals in remote communities to readily access clean needles.

**Chronic Obstructive Pulmonary Disease (COPD)**

14. COPD is the second most common cause of admissions to UK hospitals. Heroin users are at high risk of COPD and its onset is very early in this population, with
people often presenting with severe irreversible disease and dying decades prematurely as a consequence.

15. Our internal statistics finds that chest disease is an increasingly significant cause of morbidity and premature mortality in former and existing heroin users taking methadone. Chest disease was the cause over 50% of historic deaths in our clients (since 2013) and 75% of deaths in the first half of 2016.

16. Heroin smokers engage poorly with traditional healthcare services. In 2016 we ran a pilot testing opiate users for respiratory problems in our Liverpool services. Just under half (47%) of participants in the study had COPD and for 59%, this was a new diagnosis. Those diagnosed were referred to their GP for further management. Treatment and care was tested around the individuals keyworker, at the patients ‘anchor point’, when they were picking up their methadone/buprenorphine prescription. Our recommendation is that work which targets people who potentially have both COPD and heroin dependency be prioritised to reduce drug related mortality and to improve hospital admissions.

What are the reasons for both the initial and the continued, sustained use of drugs?

17. Our focus is primarily on why individuals develop dependence issues with drugs that lead to harm, the correlation between drug related harms, deprivation and trauma and the lack of support available for people trying to address their consumption.

Deprivation

18. Overall drug consumption doesn’t increase with deprivation. For example according to crime and drug survey findings the highest level of cocaine use is by those earning £50,000 or more. However, research has repeatedly shown that deprivation is heavily correlated with the sustained use of more harmful drugs, particularly crack cocaine and heroin, problematic drug use and drug related health and societal harms. Deprivation is more likely to relate to a lower age of first use, progression to dependence, injecting drug use, other risky use, health and social complications from use.

19. In deprived areas there are more likely to be drug misuse risk factors, such as an unstable home, unemployment, school exclusions and adverse childhood experiences. It can be more difficult for individuals from deprived areas to overcome drug problems as they have less access to factors that support recovery such as meaningful employment and suitable housing.

20. Problematic drug use is often to do with structural disadvantages, limited opportunities, alternatives and resources, all of which are more common in deprived areas. For those who experience social exclusion and disadvantage prior to drug use, the onset of excessive drug taking in early adulthood may be a form of escape, a way to deal with the lack of resources available to the rest of society.

21. Drug related deaths increase in areas with the highest levels of deprivation. **The rate of deaths related to drug poisoning in England and Wales is about ten times higher in the most deprived decile than the least deprived decile.**
Trauma

22. One of the many reasons people we work with use drugs is to cope with underlying traumatic issues or forget certain circumstances and events in their lives. This is particularly the case for women.

23. We have found from our services that people misuse substances to address the traumatic stress they experience – including self-medicating to escape invasive memories, or make traumatic relationships more tolerable. This usage can be heightened amongst certain groups, particularly children who face additional complexity in their lives, including; looked after children, those seeking asylum, those witnessing or involved in violence, and those making sense of their gender identity or expression, and sexuality. This is also true of adults who experienced one or more of these issues as a child.

24. People with multiple adverse childhood experiences (ACE) are more likely to develop substance issues, in part to manage the overwhelming emotional and somatic sensations associated with trauma. Children who experience four or more adversities are eleven times more likely to go on to use crack cocaine or heroin. The chances of developing a dependence on substances double if a child has also experienced sexual abuse or other forms of violence.

Lack of support

25. People accessing treatment and support are more likely to reduce their harmful use of substances. Unfortunately far too many people who could benefit from help simply aren’t able to access it at the moment.

26. Last year we carried out a poll of people about a range of issues involving drugs and alcohol. We found that less than one third (31%) of people said they’d know where to go if they or someone they knew needed help with a drug issue. We need to improve awareness so that people know where they can access support.

27. We recently surveyed over 8,000 drug users in Scotland and found that more than two thirds of those showing signs of dependency had never sought any type of support or even advice in the past. There needs to be a big impetus placed on getting more people into treatment and providing more options for those individuals to encourage them to come forward and seek help.

28. The penetration rates of different populations varies widely. For example, approximately 60% of people using heroin are in some kind of treatment. However, according to the latest adult psychiatric morbidity study, 188,000 people had a powder cocaine dependence problem while only 16% received treatment.

29. To reduce the number of people using harmful drugs or taking drugs harmfully we need to do much more to reach people who need advice, treatment and support.

How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use?

30. We have run our Amy Winehouse Foundation Resilience Programme for the past five
years working with 90,000 secondary school pupils. It engages them in universal alcohol and drug education sessions delivered through assemblies and workshops to inform them about substances and the various harms related to them.

31. The programme improves young people’s knowledge of the effects of alcohol and drugs, increases their awareness of risky behaviour and helps them to generally make safer decisions about alcohol and drug use. For example, 78% of pupils said that they would be more likely to avoid risky behaviours relating to substance misuse as a result of participating in the workshops. 93% of pupils said they were now well informed that they could seek confidential help in the event of being concerned about substance use, peer pressure or bullying. 82% of pupils said they would seek out support for alcohol or drug issues. Substance education in schools needs to be included in all PHSE curriculums.

How effective and evidence-based is treatment provision?

32. There is substantial evidence that people entering treatment are more likely to successfully address their drug consumption and reduce their drug related harms. There is a huge amount of evidence about what works, but unfortunately not always enough resources to implement it.

33. Within our services we tailor treatment to the individual, prioritising their health and safety, building trusting relationships that improve engagement and likelihood of retaining people in treatment.

Opioid Substitution Treatment (OST)

34. There is robust evidence that OST is effective at suppressing heroin use. It decreases drug injecting and sharing of injecting equipment, preventing the acquisition of blood borne infections. Studies show a 54% reduced risk of HIV and a 64% reduction in the risk of hepatitis C infection among OST clients who have a recent history of illicit drug injecting.

35. Being in OST protects heroin users from overdose. It is estimated that it prevented approximately 880 deaths per year in England in 2008 to 2011. A review of several countries shows it halves the risk of fatal overdose while clients are in treatment.

36. It is effective in retaining patients in treatment. Research estimated that 73% of patients enrolled in OST were retained in treatment, compared to 16% of those receiving therapies with no medication component. NICE has also highlighted systematic reviews of patients receiving methadone showing patients are between three and four times more likely to stay in treatment than those receiving placebo or no treatment.

37. At a time when drug related deaths are at historic highs it should be a national priority to encourage as many appropriate people as possible to enter OST and make every effort to retain them in it for as long as suitable.

Outcomes for clients

38. It is essential when we discuss the effectiveness of treatment we give due
consideration to the intentions, desires and needs of clients receiving support. It is easy to reduce the effectiveness of treatment into outcomes determined solely by policymaker’s views of what success should look like.

39. Treatment providers record vast amounts of information about individuals using their services and are obligated to report frequently to national bodies on set ‘successful completion’ rates. Our clients have said that successful completions are ‘entirely meaningless’ to most people using service and risk staff ‘chasing’ successful completions to the detriment of certain groups. One service user felt that there is the risk that staff could almost give up on certain people, older chronic opiate users in particular, as they are less likely to meet the centrally set outcomes as opposed to what he himself would like to achieve.

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.

40. The response to drug consumption should be primarily health based. It would reduce stigma around drug use and encourage more people, of all ages and backgrounds, to open up about their drug use and feel confident to come forward for treatment if they have an issue, reducing drug related health harms.

41. We support individuals being diverted away from the criminal justice system when caught in possession of drugs and are working with police forces in certain areas to support this. In Kent we run the Kent Youth Drug Intervention Scheme (KYDIS) programme. It provides an alternate means of dealing with people under the age of 18 found in possession of drugs. During the course of the programme the young person will receive one-to-one interventions, where they can access support, education on illegal drugs and the law, and prevention of drug misuse and harm minimisation advice.

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

42. Problematic drug use should be treated first and foremost as a health issue. Any response to drug use in society must be focused on reducing physical, mental and societal harms. It should involve a deep understanding of the types of drugs people are consuming and why they are consuming them. It would need to involve people who take drugs, both those in and out of services. This would inform the most effective harm reduction approaches and determine an appropriate level of treatment provision by need and not simply resources.

43. Our recent survey of over 8,000 drug users in Scotland provides a wealth of knowledge we previously didn’t have about the levels of consumption of certain drugs, the sheer scale and extent of poly drug use and the proportions of people showing signs of dependence for different drugs.

Resources

44. In order to have a high quality evidence-based response to drugs there needs to be the resources to implement such. There is a huge amount existing evidence, for example in the orange guidelines, but too often it’s a struggle to implement it on the front line because there’s a lack of money to pay for them.
45. From 2008-09 to 2016-17 there were 30–40% cuts in community drug treatment spending. Even in locations with the highest drug related deaths and alcohol harms we are seeing substantial reductions in funding. Between 2014 and 2016 Blackpool had the highest drug related death rate in England. Despite this, between 2016/17 and 2017/18 Blackpool council made cuts of 18% to its budget for the treatment of drug misuse, and 22% to the budget for preventing and reducing harm associated with drug misuse.

46. The 2017 drug strategy states that ‘investing in treatment services to reduce drug misuse and dependency will not only help to save lives but will also substantially reduce the economic and social costs of drug-related harm.’ This is at the same time that there are significant cuts to treatment budgets.

**Naloxone**

47. Any evidence based drug programme would need to guarantee adequate provision of naloxone. A UK study found that take-home naloxone programmes reduce overdose mortality. Priority should be given to people who have recently entered or left treatment or are coming out of prison, when overdose risk is very high and there are avoidable deaths. Research claims that in England and Wales male prisoners were 29 times more likely to die in the first two weeks following release than members of the general population, and female prisoners were 69 times more likely to die in this period than the general population. The prime cause identified was overdose of heroin or other opioids.

**Innovation**

48. Drug consumption habits change regularly. Harm reduction approaches need to be flexible and innovative in order to change with them.

49. **Drug Checking**
   
   We recently started the first ever Home Office licensed drug checking pilot as a way to help save lives and reduce drug related harms. The pilot is running at our North Somerset service in Weston super Mare.

50. Anyone aged 18 or over can come to the service and check a sample of any substance to see what it’s likely to contain without any further conditions or restrictions. Once the results are in, the client will be given tailored harm reduction advice and signposting to the right support.

51. It’s our job to do whatever we can to help people make informed choices about the risks they’re taking. Checking the content of drugs is a sensible and progressive way to do that. If people know what’s in something, they can be better informed about the potential harms and how to minimise them.

52. **Webchat**
   
   We have been providing an anonymous online webchat service across the UK for the past two years that provides support and advice for people who have concerns about their alcohol and drug consumption. We have found that a lot of those using webchat wouldn’t be willing to attend a traditional local treatment service. This might be due to practical reasons or due to concerns of being stigmatised in their communities.
53. We need a drug programme that is designed with everyone in mind. For example all services need to be gender and trauma informed.

54. **Women**

Research has shown that women with substance dependencies are more likely to have a desire to reduce their consumption than men. However, only 31% of service users were female in 2017/2018 (falling to 27% of those in treatment for opiate use, but rising to 40% of those in treatment for alcohol dependency only). It’s estimated only half of all local authority areas in England (49%) and one quarter of unitary authorities in Wales (22.7%) are home to support specifically for women experiencing substance use problems. Almost half of these services are solely aimed at pregnant women. The female mortality rate for deaths related to drug misuse has almost doubled from 13.7 per million in 2007 to 24.6 in 2017, the latest available year for statistics.

55. Treatment provision needs to ensure adequate provision of suitable services for women with substance issues. There should be a greater appreciation of the specific barriers women face when accessing services, for example a history of male perpetrated abuse, childcare, traumatic histories etc. Women are often concerned that they might lose custody of their children if they present to a treatment service for support. They are more likely to be responsible for childcare than men. For some women who have experienced domestic violence/abuse from a man, male-dominated treatment services can be intimidating, meaning they’re less likely to engage.

56. Our webchat service has provided support for thousands of people over the past 18 months. We have found that over 70% of those accessing help through it are women and less than 30% men, the converse to traditional substance treatment services. Studies have found that women with drug dependence issues have a greater desire to change than men.

57. Despite this in the government’s latest clinical guidelines there is little to no mention about specific treatment for women apart from those who are pregnant. The 2017 Drug Strategy only provides passing remarks to women. There was no reference to gender within the 2010 strategy despite well-documented evidence that it is a key factor in understanding patterns of drug use and drug careers.

58. **Veterans**

There should be provision specifically for veterans across the country. Veterans are more likely both to access and respond well to veteran-specific services in the first instance; this removes many of the common barriers to their engagement in services. Consideration and valuing of the military identity in transition facilitates veterans' recognition of their own resilience, their own individual resources and their value to both veteran and civilian communities alike.

59. Our Right Turn veteran-specific project provides a culturally competent, holistic, collective identity-based pathway into support services for veterans. This project is shown to deliver improvements in individual veterans' functioning and wellbeing and increases this cohort's social and community capital, thus aiding veteran integration into the local community and wider civilian society. This identity pathway delivery model operates throughout veterans' recovery journeys: as an attractor into support
services; in enhancing their reciprocal commitment to continued engagement; and in facilitating the emergence of a transformed, but coherent and motivational, military veteran citizenship.