Written evidence from Change Grow Live

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

Drug-related mortality

The UK has the highest drug-related death rate on record and this exceeds the rate of most other European countries. While opioids are implicated in the majority of deaths there has been an increase in deaths related to stimulant drugs such as cocaine, and from novel psychoactive substances.

There has been an increase in mortality associated with synthetic opioids such as fentanyl and related analogues; there were 58 deaths in 2016 and 75 deaths in 2017. Illicit fentanyl is now ubiquitous in the North American drug markets, driven by a very high demand for opioids that has developed over the last two decades. To understand the UK situation Change grow live (CGL) conducted their 2018 pilot-prevalence study in conjunction with the University of Manchester, which showed a fentanyl-positive rate in adults receiving treatment for opioid use of three per cent.

Of those who tested positive for the presence of fentanyl, a majority (80 per cent) was unaware of having purchased or used fentanyl. There are now plans in place to extend this surveillance approach across the sector and in conjunction with Public Health England.

Blood-borne viruses (BBV)

BBV transmission is a recognised harm associated with drug use, particularly with respect to people who inject drugs. Reducing this risk through a harm-reduction approach has been shown to be very effective e.g. providing sterile injecting equipment (with safe disposal methods to reduce needle litter), and optimising medication assisted-treatment to reduce drug use. Hepatitis C, and the associated complications, is one of the leading causes of mortality associated with drug use worldwide. It is worth noting that recent advances in treatment for Hepatitis C are now available which offer a more accessible and effective solution to eradicate this particular virus.

Increasing prevalence of Synthetic Cannabinoid Receptor Antagonists

Synthetic Cannabinoid Receptor Antagonists are novel psychoactive substances that have become an established and increasing concern among vulnerable populations; this includes prisoners, the homeless, and young people (particularly individuals involved in the care system). There can be significant harm associated with these substances; this includes the development of dependence, and serious physical and mental health consequences which often require an emergency response.
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.

Illicit drugs are widely available and, at least for opioid and stimulants, prevalence of can be directly correlated with levels of deprivation. The routes into drug use are many and varied, however trauma, together with unresolved mental health problems do play a significant role.

Demand for drugs is not a new phenomenon, whether it be for recreational or other purposes. Traditional drug supply markets can be disrupted through enforcement, however it is debatable how effective this approach is. There are other novel routes available now for people to access drugs, including the internet and through social media channels; the UK is responsible for the largest share of darknet sales of fentanyls in Europe, and is estimated to account for 9% of all global sales of fentanyls.

Therefore understanding the reasons for initiation and continued drug use requires a systems approach to acknowledge the complexity of the issue.

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 a lack of effective and evidence-based approaches to prevention and early intervention. Drug use among younger people had been reducing year on year, however the most recent NHS survey suggests this may be changing. In 2016 24 per cent of pupils reported they had ever taken drugs. This compares to 15 per cent in 2014. Part of the increase since 2014 may be explained by the addition of questions on nitrous oxide and new psychoactive substances. After allowing for this however, it still represents a large increase which has not been observed in other data sources.

Evidence from Mentor (2015), the strategic partner of the Department of Education commissioned to provide national alcohol and drug education advice and support to schools, suggests that there are some significant issues:

- Low frequency of drug education delivery: 48% students received drug education once per year or less
- Inconsistent adherence to evidence-based standards: 3 in 10 teachers favour ‘hard-hitting messages’, which can have a negative impact. Less than half of teachers use ‘challenge myths and misconceptions’, a key component of quality drug education
• Only 68% of students ‘trust the drug education they get in school’
• Schools are constrained by a lack of curriculum time, a lack of financial capacity, and the impact of non-specialist teacher training
• There is a need both to enhance the status of drug education within the curriculum, as part of statutory Personal, Social, Health and Economic education, and to provide centralised guidance and support

There is clearly an absence of resource, funding and priority given to provide credible information to our young people. This would likely lead to a future lack of confidence in trusting reliable information, and then on the ability of young people to make informed decisions about their behaviour.

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.

We had in this country the framework available to provide good treatment provision for problematic substance use. There is a significant body of guidance available to support treatment delivery, although reviews of treatment have shown that there is room for improvement with respect to medication-assisted treatment for opioid use disorder. Equally, it appears that there are issues with accessing treatment, with almost half of all people requiring treatment not currently accessing the same; treatment penetration is even more of an issue for those with alcohol problems. Provision of the life-saving opioid overdose antidote, Naloxone, has also increased over the years, although more could be done to improve coverage for those most at risk. Recognising that some people may require long-term or life-long treatment must also be considered, and that successful completion of treatment is just one metric of success. Provision of holistic evidence-based interventions is seriously under threat due to disinvestment, and further reductions in funding will make it impossible to deliver some of the elements of care required to deliver a recovery-oriented system.

Joined-up care is variable; on the one hand we have far more access to specialist services to treat Hepatitis, primarily due to a significant increase in associated funding and co-location. However access to mental health services for this cohort of people remains a perennial challenge, as mental health services increase their threshold for access. Stigma, and reduced resource across the health economy, are likely important factors when considering the challenges faced in engaging drug users with wider health care services.
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.

The purpose of current criminal-justice and enforcement approaches is to limit availability and act as a deterrent to use, however there is limited evidence to support the ‘legal impact hypothesis’, which states that criminalization of people who use drugs leads to reduced prevalence of drug use. Recently all 31 UN agencies, including the WHO and UNODC, have adopted a common position directing member states to end criminalisation of people who use drugs. In 2014, the Home Office concluded that they did not “observe any obvious relationship between the toughness of a country’s enforcement against drug possession, and levels of drug use in that country”. There is a substantial body of evidence demonstrating that people who use drugs and have a mental illness face stigma and discrimination. It is possible that criminalising these people may reinforce prejudice, act as a barrier to accessing professional support, and impact mental health and wellbeing.

The policy approach to drugs is, in the main, guided by health, and recently a number of innovative criminal justice diversion schemes have further supported this principle. There have been a few notable instances where the current legislation around drugs has possibly been a barrier to prioritising health; the recent proposal for a safer consumption room in Glasgow was blocked and, until recently, services that tested drugs for people operated in something of a legal grey area.

It is of significant concern that there have been substantial cuts to drug treatment budgets over the last decade, putting significant pressure on the treatment system. The UK drug treatment system was developing into what could have been a world-class service, but repeated disinvestment has essentially stripped away much of the recovery-oriented and quality provision. Effective psychosocial interventions are the hallmark of a quality treatment system, yet it has been increasingly difficult to deliver these evidence-based components of care. If funding pressures continue the treatment system will move further towards an overtly medical model, putting at threat much of the effort and progress that had been made in rebalancing the overall system.

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

**Effective Outreach**

- Improve treatment penetration for all, especially for those groups who are most at risk and least likely to access services
- Treatment should be accessible and attractive, with minimal waits for access to the evidence-based intervention
- Promotion of Needle Exchange as a crucial access point to treatment and to reduce injecting-related harms
• Consider the particular requirements for hard to access groups eg low-threshold access to medication-assisted treatment for homeless
• Potential role for Safer Consumption Rooms to reduce on-street use and increase uptake of health and social interventions for those most at risk
• Existence of an engaged and independent network of peers, who can support those out of treatment with provision of Take-Home Naloxone, encourage access to BBV testing and treatment, and can act as a proper stakeholder in the design and delivery of services.
• Visible recovery present throughout the treatment system

Quality Treatment

• Treatment systems that are balanced; delivering effective harm reduction interventions that provide a foundation from which to develop further recovery capital
• Competent staff who are able to develop therapeutic relationships, and facilitate the development of personalised recovery plans
• Availability of other options for those failing to benefit from first-line treatment e.g Heroin-Assisted Treatment
• Innovation that is informed by national and international practice and research.
• Psychosocial interventions that have a solid evidence-base eg Contingency Management.
• Holistic assessment of need, with agreed pathways into other health and social care services as required
• Optimised evidence-based interventions that are tailored to the individual, with active monitoring of treatment quality and effectiveness
• Access to peer-support and mutual aid for all

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

Independent Peer Networks: People who Use Drugs

There are a number of examples around the world of self-organising and independent networks of people who use drugs. These networks are present in many countries, with varying degrees of state-support and/or funding. In Denmark the Union of Drug Users (Brugerforningen) delivers Needle and Syringe patrols in the city of Copenhagen, ensuring that there is rapid response to resolve any issues with drug-litter. The Nigerian Network of People who use Drugs (NNPUD) is regarded as an important stakeholder and were directly involved in the development of the country’s drug treatment guidelines. There are International and European networks that work to bring these groups together, however there is currently no UK equivalent group who could represent the voice of people who use drugs.
Europe, Australia, North America: Drug Consumption Rooms

Recent reviews of the evidence base conclude that DCRs can be efficacious in:

- Reducing drug-related mortality at a city level, where coverage is adequate
- Reducing self-reported injection risk behaviours, such as syringe sharing
- Promoting safer injecting conditions
- Reaching and staying in contact with highly marginalised target populations
- Increasing uptake of detoxification and drug dependence treatment, including opioid substitution
- Enhancing access to primary healthcare
- Decreasing public injecting
- Reducing the number of syringes discarded in the vicinity

UK and Europe - Heroin Assisted Treatment or Diamorphine Medication-Assisted Treatment

Heroin Assisted Treatment (HAT) involves prescribing pharmaceutical grade heroin, diamorphine, and is typically used as a second line treatment, for those who have proven unresponsive to other forms of treatment.

HAT has been shown to be an effective and evidence-based intervention for the minority of chronic, dependent heroin users who fail to derive benefit from standard treatment modalities such as methadone maintenance and residential rehabilitation.

Currently in the UK, interest is growing in the potential for introducing HAT facilities. There remains a legal basis for the treatment and recent guidance from both the Department of health and the Advisory Council on the Misuse of Drugs recommended consideration of this method for the appropriate target population. There are currently no designated facilities available in the UK following the closure of the three RIOTT trial clinics in 2015, however plans are underway in Glasgow and Middlesbrough to set up HAT services and various police forces have expressed an interest in supporting HAT.

Review of the literature has confirmed that HAT is a feasible, cost-effective and evidence-based intervention for the target population. The evidence suggests that it increases retention in treatment, reduces illicit drug use, reduces the rate of criminal activity and risk of prison and is beneficial to a number of health and social domains. HAT may also prove to be an effective method of reaching vulnerable, hard-to-reach adults with a variety of health and social needs. It may prove to be a useful base for other targeted interventions, health promotion and co-location of related services. Follow up studies have helped to demonstrate continued benefits in terms of health and social benefits and reduced illicit drug use in those remaining in treatment, however retention rates were variable. Research analysis has thus far confirmed this to be a cost-effective method, despite
the fact that it is more expensive, because of the increased savings elsewhere particularly in the legal/criminal domain.

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