1. **Background**

1.1. NAT is the UK’s HIV policy and campaigning charity. NAT is committed to maintaining and promoting harm reduction principles in drug treatment policy and practice. Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use while also respecting the rights of people who use drugs. Critical to harm reduction is approaching drug use from a health rather than criminal justice perspective.

1.2. Since 2012, NAT has convened and provided policy and administrative support to the Harm Reduction Group, which consists of English organisations and individuals committed to advocating for harm reduction.

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

2.1. **HIV and blood-borne viruses (BBVs)**

2.1.1. People who inject drugs (PWIDs) are disproportionately affected by HIV as needle sharing is a key HIV transmission risk. The prevalence of HIV amongst PWIDs in the UK remains low – 1.7% of PWIDs are currently living with HIV. The low rates amongst this population group are a result of effective harm reduction services and accessible structured drug treatment programmes being introduced from the beginning of the epidemic. There are currently 1,900 PWIDs living with HIV accessing HIV care.

2.1.2. However, the situation can change rapidly if such services are defunded and neglected. There is currently an HIV outbreak amongst PWIDs in Glasgow – where over 120 cases have been diagnosed since 2015. The outbreak still hasn’t been controlled and is mainly concentrated in a group of 400-500 people known to inject opiates publicly in Glasgow. This group has complex needs with considerable evidence of social exclusion – of those diagnosed 40% have a history of incarceration and 45% report ever being homeless. There have also been smaller localised outbreaks in various parts of the UK and Ireland recently (South West England, Wales, Dublin, Birmingham).

2.1.3. While the prevalence of HIV amongst PWIDs remains relatively low, the prevalence of hepatitis C (HCV) is very high. The UAM survey found that 51% of PWIDs sampled had HCV antibodies (meaning they are either currently living with HCV or have been in the past).

2.2. **Drug-related Deaths**

2.2.1. Drug-related deaths (DRDs) are at the highest level since records began in 1993 with 3,756 DRDs in England and Wales last year, 53% of which related to opiate use. Almost a third of all deaths from overdose in 2016 in Europe happened in the UK. This constitutes a public health and humanitarian crisis which must be addressed urgently.
2.2.2. Recent PHE data found that the mortality rate amongst PWIDs living with HIV compared to other population groups affected by HIV was significantly higher. The mortality rate for gay and bisexual men and heterosexuals living with HIV stood at 3.08 per 1,000 and 3.15 per 1,000 respectively. This rose to 14.21 per 1,000 amongst PWIDs living with HIV.\textsuperscript{xiv}

2.2.3. There has been much discussion on why the DRD rate has risen so dramatically. Public Health England (PHE) state there is an ageing group of people who have used opiates since the 80s (when a heroin epidemic first emerged) who are now more susceptible to ill health and overdose.\textsuperscript{v} The other factor, which is hard to track, but likely to have had a significant impact upon the rate of DRDs, is the significant cuts faced by drug services over the last few years, coupled with the move over the last decade to an abstinence-based ‘recovery’ model of drug treatment, rather than harm reduction. The Advisory Council on the Misuse of Drugs (ACMD) report that changes in treatment services and commissioning practices may have contributed to the increase in DRDs.\textsuperscript{xvi}

3. Treatment and harm reduction

3.1. 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.

3.1.1. Drug services, when fully funded, and offering a full range of harm reduction interventions, are highly effective at supporting people with problematic drug use.

3.1.2. However, we are aware of a number of issues currently facing drug services. In 2018, NAT undertook a project on DRDs, sending an FOI request to all English local authorities with worse than benchmarked DRD rates, asking what they were doing to address the situation. This resulted in NAT’s report ‘Drug-Related Deaths in England: local authorities and how they are responding’.\textsuperscript{xvii} We refer the Committee to the findings of that report which identifies local authority good practice but also some significant policy barriers which need to be addressed urgently.

3.2. Funding

3.2.1. Without sufficient funding drug services cannot realise their full potential. Reductions in the Public Health Grant have continued to impact drug services heavily. From 2014/15 to 2018/19, the Health Foundation report that there has been a 19% decrease in spend on adult drug and alcohol services. There is predicted to be a 26% decrease in spend on drug and alcohol services by 2019/20 (from 2014/15 levels).\textsuperscript{xviii} This is in excess of the overall reductions in the Public Health Grant and is not responsive to changing need.

3.2.2. Local authorities fund drug services through the Public Health Grant awarded by central Government, which has been ring-fenced. This ring-fenced budget is due to end in 2020, meaning uncertainty over future funding for drug services. The proposal that instead local authorities fund all of their public health work from business rate retention could have severe repercussions on levels of funding available for drugs services, especially in areas of significant need where business rate revenues may also be relatively low. We strongly recommend that public health cuts are reversed, funding is aligned with need
in the forthcoming Spending Review, and the Public Health Grant is retained and continues to be ring-fenced.

3.3. Mandation

3.3.1. Uncertainty is further compounded by local authorities not currently being mandated in law to provide drug services (unlike sexual health services).\textsuperscript{xix} This means no protection exists for these clinical services in legislation. The Public Health Grant stipulates that commissioners must “have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services”\textsuperscript{xx}. This will not apply once the Public Health Grant ends, meaning local authorities could choose to fully decommission their drug services. Mandation would also mean some nationwide consistency in the components of drug services which are commissioned. \textbf{Local authorities should be mandated in law to provide drug services.}

3.4. Opioid Substitution Therapy (OST)

3.4.1. OST is the substitution of an opioid, such as heroin, with a longer-lasting prescription opioid with less potential for abuse, usually methadone and buprenorphine. It is highly effective at supporting people to reduce and end heroin use and has been shown to reduce BBV transmission. It also is important in supporting PWIDs who are living with HIV in the essential adherence to their medication.\textsuperscript{xxi}

3.4.2. ACMD states that sub-optimal dosing may be an issue in the UK.\textsuperscript{xxii} Sub-optimal dosing often leads to people in treatment using heroin and other opiates on top of their OST, increasing the risk of overdose and treatment failure. \textbf{We would recommend that all local authorities audit their OST provision to ensure that clinical prescribing is actually in line with clinical guidelines and is not resulting in worsened health outcomes and deaths. PHE should take an active role in supporting local authorities to provide OST in line with clinical guidelines.}

3.4.3. We have historically also voiced concern that the move to a more abstinence-based model of drug treatment has meant that people have been moved off OST too quickly. UK clinical guidance states quite clearly that for some people recovery will mean lifelong OST. However, local authorities are not incentivised to keep people in structured treatment, rather they are measured against an indicator that rewards completion of OST.

3.4.4. Finally, the ACMD stated in their report on reducing opiate-related deaths that “the most important recommendation in this report is that government ensures that investment in OST of optimal dosage and duration is, at least, maintained”.\textsuperscript{xxiii} In NAT’s report ‘Drug-Related Deaths in England’, local authorities raised issues around funding, and Bournemouth, Poole & Dorset raised concerns specifically on OST, stating that maintaining funding for OST is dependent on the continuation of the Public Health Grant.\textsuperscript{xxiv} \textbf{The UK Government should ensure that funding is maintained and increased for key initiatives that are known to reduce DRDs such as OST.}

3.5. Needle and syringe programmes
3.5.1. NSPs provide PWIDs with sterile needles with the aim of reducing viruses and infections. Prevalence of hepatitis C (HCV) amongst PWIDs is very high.\textsuperscript{xxiv} Prevalence of HIV remains low – though the continuation of this success can only be guaranteed if needle and syringe programmes are adequately provided.\textsuperscript{xxvi} The recent HIV outbreak in Glasgow is indicative of what services must be prepared for.

3.5.2. NSPs are vital to improving performance on reducing HCV, however, they have been hard hit by cuts. While we have heard anecdotally that there have been a number of NSPs closing, data on the number of NSPs isn’t centrally held by PHE, which makes it difficult to assess the extent of site closures. However, recent PHE data shows that the number of PWIDs reporting adequate needle and syringe provision is poor, with only 61% of PWIDs in England, Wales and Northern Ireland reporting adequate provision in 2017.\textsuperscript{xxvii} The UK Government must ensure that provision of NSPs meets need, without which the aim to eliminate HCV as a public health threat and eliminate all new HIV transmissions by 2030 will be unattainable.

3.6. Blood-borne virus (BBV) testing

3.6.1. NICE guidance recommends HIV testing for all service users in drug services\textsuperscript{xxviii} and recommends regular testing for HCV for service users in drug services deemed at ongoing risk of acquiring BBVs.\textsuperscript{xxix}

3.6.2. Despite this, we know that coverage of HIV testing amongst PWIDs needs to be improved as late diagnosis of HIV is still high. In 2017, 47% of PWIDs who were diagnosed with HIV were diagnosed late (compared with 33% of gay and bisexual men).\textsuperscript{xxx} Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV.\textsuperscript{xxxi} Those diagnosed late are also more likely to pass HIV on – as they will spend longer periods of times not on effective HIV medication that prevents transmission. 25% of PWIDs are currently undiagnosed.\textsuperscript{xxxii}

3.6.3. Data from the UAM survey shows there are missed opportunities for HIV testing. The majority of PWIDs who report never being tested for HIV or not testing recently (>2 years ago), reported that they had attended their GP, had been prescribed a substitution drug, or had used a needle and syringe programme in the previous year.\textsuperscript{xxxiii}

3.6.4. Approximately half of people living with HCV in the UK are unaware of their infection.\textsuperscript{xxxiv} With the advent of Direct Acting Antivirals (DAAs), which have a cure rate of over 95% and are more manageable than previous HCV treatments, the need to rapidly upscale HCV testing amongst PWIDs is vital in curtailing the epidemic.

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

3.8.1. The criminalisation of people who use drugs does not deal with the underlying causes and harms associated with problematic drug use and only increases people’s exposure to health risks. Continued incarceration of PWUDs has not led, and will not lead, to a decrease in drug use. xxxv

3.9. Abstinence-based models of care

3.9.1. There has in recent Government policy been a move away from commitment to harm reduction in favour of abstinence-based models of care. As signalled in the Government’s policy paper ‘Putting Full Recovery First’ published in 2012 – there has been a significant change in the approach to drug policy over the last decade, with more focus on pushing people through drug treatment more quickly, bringing people off OST. xxxvi

3.9.2. While we agree that some people will be able to end OST and services should be ambitious in what they aim for, there must be recognition that many people can lead fulfilling lives on OST, and for some ending OST is dangerous. People are at considerable risk of relapse when ending OST and clinical guidelines clearly state that for some life-long OST is a legitimate and successful aim.xxxvii A balanced approach is required.

3.9.3. While the 2017 Drug Strategy is less abstinence-focused than its predecessor, the Government is still not giving sufficient resource to harm reduction, which is only mentioned once in the 2017 Drug Strategy.xxxviii In contrast, the recently published Drug Strategy from the Republic of Ireland entitled ‘Reducing Harm, Supporting Recovery’ includes a wealth of information on the provision of harm reduction initiatives including supporting GP involvement in prescribing OST.xxxix

3.10. Drug Consumption Rooms (DCRs)

3.10.1. A sign of the UK Government’s weak commitment to harm reduction can be seen in their approach to DCRs. DCRs are legally sanctioned facilities where people can inject illicit drugs obtained themselves, under the medical supervision of trained staff. These facilities are highly effective at preventing drug-related overdose deaths,xx reducing drug-related harm,xxi drug-related litter, and transmission of blood-borne viruses through unhygienic injecting,xxii and supporting PWIDs to engage with structured drug treatment and link with other health and social services.xxx There has also never been a death in any DCR across the world.xxxiv

3.10.2. Despite evidence of DCRs effectiveness the UK Government has blocked the creation of one anywhere in the UK. For provision for DCRs to be made in law, a change in legislation would be needed (Misuse of Drugs Act 1971).xlv This would ensure implementation and use of a DCR are exempt from prosecution. The Misuse of Drugs Act 1971 does not make DCRs unlawful in and of themselves, but rather it is the crimes that would take place within a DCR that could lead to potential prosecution. In advance of any change in the law, a DCR could be implemented in a local area if there was guarantee from local police forces that they would not prosecute those delivering or
using the service for crimes under the Misuse of Drugs Act 1971. This could also be achieved if the UK Government stated that they would not expect police forces across the UK to prosecute those involved in setting up a DCR (a similar approach to that taken on festival drug testing).

3.10.3. The UK Government have continued to simply state that they are not prepared to condone activity that promotes the illegal drug trade. However, as international evidence shows, DCRs support people into structured drug treatment that takes them away from the illicit drug trade. EMCDDA has stated that the evidence shows that DCRs do not increase criminal behaviour or illicit drug taking, reporting that these facilities “facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime”. They are wraparound services that protect people from overdose and death but can also act as a first-point-of-care service that allows health professionals to engage people who require further support. If we want to protect people from the illegal drug trade, DCRs are an effective way of bringing people into care.

3.10.4. In particular, stakeholders in Glasgow have advanced plans to open a DCR in Glasgow to combat the HIV outbreak. Scottish Parliament has voted in favour of DCRs, and NHS Greater Glasgow and Clyde and Glasgow City Council are both in favour of the plans. A change in practice in Scotland requires a change in policy by the UK Government because drugs policy is a reserved matter.

3.10.5. In NAT’s ‘Drug-Related Deaths in England’ report, five local authorities in England in response to our FOI mentioned their interest in DCRs, with some expressing their frustrations at the Government’s position.

3.10.6. The UK Government’s approach to drug policy is mired in inconsistency. We question how DCRs differ from other harm reduction interventions such as festival drug testing that the Government supports, or interventions such as needle and syringe programmes, that recognise that there is a duty to protect people from the most severe drug-related harm before and while they are being supported to recover from drug addiction. Drug Consumption Rooms are a key harm reduction intervention that should be permitted to operate where local stakeholders believe they can reduce drug-related harms and help people into treatment. We hope the Committee will challenge Ministers on their stubborn and inconsistent refusal even to countenance a pilot DCR in Glasgow where there is an urgent need to protect vulnerable people from an HIV outbreak.

3.11. LGBT needs and Chemsex

3.11.1. It is important to that consideration of drugs policy is not confined to opiate use. LGBT people have elevated levels of recreational drug use and in some cases this can be problematic. Inadequate attention is paid to the drug-related needs of LGBT communities in government policy and service provision.

3.11.2. NAT brought the Committee’s inquiry to the attention of London Friend, whose submission we commend to the Committee and fully support. We would add that there
is especially high Chemsex use amongst gay and bisexual men living with HIV. The Positive Voices Survey 2017 found that 23% of PLWH reported recreational drug use (compared with 9% in the general population). This rose to 40% amongst gay and bisexual men living with HIV. For this community, integrated provision across HIV, sexual health, and drug services is essential, given HIV/sexual health clinics will be where many will be more likely to attend for healthcare and feel most comfortable discussing sexualised drug use.

3.11.3. Consistent and appropriate screening for drug-related needs and brief, and extended-brief, interventions in HIV and sexual health clinics need to be universally available and properly funded. Year-on-year public health cuts mean sexual health clinics are less able to fund such important services. It is important that drug services are competent to meet the needs of LGBT communities and address problematic Chemsex. In this context, we refer the Committee to the NEPTUNE ‘Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances’.

3.11.4. Public Health England should undertake an assessment nationally of the extent to which people can access clinical services as set out in NEPTUNE Guidance, and make appropriate recommendations for improvements in commissioning and service provision. Sexual health services should be properly funded to provide necessary screenings, brief interventions, and extended brief interventions, in clinic for LGBT people with problematic drug use. All STP plans should consider how best to integrate HIV, sexual health and drug services across a larger footprint to effectively meet need.

4. **Best practice**

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

4.2. **Full range of accessible harm reduction interventions**

4.2.1. A full range of harm reduction interventions should be accessible for all service users: optimal dosing OST programmes, heroin-assisted treatment for those not responding to OST, wide coverage of naloxone, adequate coverage of NSPs, regular BBV testing, and access to DCRs. Funding should be aligned with need to ensure all these interventions are available across the UK.

4.2.2. This would also include sufficient funding so that drug services can develop comprehensive outreach programmes to bring people into treatment who are not currently engaged with it. Over half of DRDs happen to those outside drug treatment and rates of DRDs will not improve until treatment penetration rates improve.

4.3. **Treating problematic drug use as a health issue rather than a criminal justice one**

4.3.1. Evidence suggests that decriminalisation can result in vast improvements – for example, Portugal (a country that decriminalised drugs in 2001) has seen their drug situation improve significantly in several key areas such as drug-related deaths and HIV transmissions. Such improvements are not solely the result of a decriminalisation policy but matched by a shift towards a more health-focused approach to drugs.
4.3.2. Portugal complemented its policy of decriminalisation by allocating greater resources across the drugs field, expanding and improving prevention, treatment, harm reduction and social reintegration programmes. The Government should implement decriminalisation and focus on drug policy as a health issue rather than a criminal justice one.

4.4. Drug services integrated with other services

4.4.1. Evidence shows that a whole systems approach is needed to support people to recover from problematic drug use. This approach would include wider support on issues such as homelessness and housing, employment, mental health, physical health, and the involvement of disparate parts of the system such as social care. For example, nearly a fifth of people in treatment who reported their living situation said they had a housing problem (rising to 31% for opiate users).

4.4.2. Drug services should have connections with support services in these other areas, with clear pathways for engagement and referral on these issues for service users. The current commissioning system should be assessed to understand how its complex landscape can better meet the needs of PWIDs.

4.5. Meaningful involvement of people who use drugs in service design

4.5.1. Services can only improve with the meaningful involvement of people who use drugs, who understand the needs of the drug using community better than anyone.

4.5.2. Meaningful involvement would include sufficient resource committed to this area (which could include, for example, a dedicated worker on involvement, budget, remuneration, training, discussion forums) and proactive efforts to engage with groups under-represented in involvement such as people not ‘in recovery’, women, BME people, LGBT+ people, young people, and those with a dual diagnosis. Service users should be included at every stage of the commissioning process for drug services (e.g. needs assessment, awarding of contracts, performance management) and not just the designing of services.

NAT
March 2019

2 Ibid.
5 NHS Greater Glasgow and Clyde, """"Taking away the chaos"" The health needs of people who inject drugs in public places in Glasgow city centre'. Available here: http://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf
6 Metcalfe R et al. An outbreak of HIV amongst homeless people who inject drugs (PWIDs) – describing the epidemic and developing an innovative service model. Fourth Joint Conference of the British HIV Association (BHIVA) with the British Association for Sexual Health and HIV (BASHH), Edinburgh, April 2018, abstract 67.