Written Evidence from Office of Police and Crime Commissioner
Devon and Cornwall

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Introduction

I welcome this opportunity to submit evidence to the Committee to support its inquiry into drug policy. I appreciate that the primary focus of the Committee is on health issues but as the public’s elected representative on policing and crime in the largest policing area in England I would like to share some observations on the issue of drug related harms and treatment in the context of the criminal justice system. I would encourage the Committee to seek to explore these as part of its work.

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

Substance misuse has become an increasing issue for me as Police and Crime Commissioner, in particular due to the issues raised regularly with me by health practitioners and commissioners in the region. Our criminal justice partners have reported an increase in the number of individuals presenting with multiple and/or complex needs (including dual diagnosis – mental health and substance misuse), compounded by a lack of suitable housing, a shortage of primary care mental health services, and cuts to drugs services. We welcome the additional investment into mental health services and look forward to seeing the results of this investment.

Partners have also reported seeing significant physical and psychological impacts from drug use, not only for the drug user themselves but also health impacts on their families and children, including depression and anxiety caused by living with a drug user in the family i.e. the impacts of managing the erratic behaviour and deterioration of the drug users mental and physical health. The wider future impact of such Adverse Childhood Experience from exposure to drug use in the familial environment is also of concern, both in terms of impact on their own health and on their vulnerability to becoming either a victim or offender in the future.

In Devon and Cornwall we have seen an increase in drug-misuse deaths (up 16% in 2015-17 from 2013-15). Drug service commissioners have also reported an increase in young adults (18-24) presenting with anxiety and depression who are turning to drugs as a coping mechanism, e.g. Xanex.

We are also seeing new psychoactive substances with health harms which have not previously been seen and which are still not fully understood (e.g. Synthetic Cannabinoid Receptor Agonists (SCRAs). The delivery of effective medical interventions for users of these substances can be challenging because manufacturing methods, which vary with the
ingredients used, make symptoms unpredictable.

This drug is prevalent not only in certain areas within Devon and Cornwall but also within our prisons, particularly HMP Channings Wood and HMP Exeter, where SCRAs like Spice are considered to be equivalent to opiates not cannabis. The prevalence of this drug in our prison system is a significant concern and is placing offenders at significant risk. Action to try to stem the flow of SCRAs within the prison system are being taken forward through the Ministry of Justice but the scale and speed of action is slow and there is a need for a more rapid response across the whole prison estate to protect the health of often vulnerable prisoners.

I have advocated for SCRAs to become a Class A drug as placing them in the same class as cannabis is inaccurate as their impacts, physical and psychological, are more comparable to those of class A drugs, such as ketamine or heroine. It is important that users realise the harms involved with taking these drugs. I am pleased that the Minister for Policing has referred this matter to the Advisory Council on the Misuse of Drugs for early consideration of the classification and await with interest their view on this matter.

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.

The reasons behind an individual’s drug use will be personal and often varied. Substance misuse problems have been evidentially linked to deprivation (Spotlight on Substance Misuse – Emerging good practice across PCC areas – Revolving Doors Agency 2018). Despite its picture postcard image Devon and Cornwall has significant pockets of deprivation – in both urban settings like Plymouth and Torbay as well as rural settings such as the China Clay mining area in Cornwall. For example Torbay is the most deprived local authority area in the South West region and around one-in-three of the population live in areas in the top 20% most deprived in England while 17 Cornish neighbourhoods are in the top 10% of most deprived as at 2010 data.

Service commissioners and providers report a range of factors as increasing risk, these include unemployment, indebtedness and homelessness. We have seen an increase in homelessness due to the difference between Housing Allowance rates and private rental charges; the impact of Universal Credits (including the removal of direct payments to landlords); as deprivation has risen; and due to a lack of social housing. A presumption of direct payments to landlords should be considered in certain circumstances, e.g. those with complex or multiple needs. Social isolation (due to mental health, physical health, complex needs, poor family or other relationships) and Adverse Childhood Experiences (ACEs) (especially for children of parents with substance misuse or who have experienced Domestic Abuse) are also other factors.

Our Force saw a 36% increase in drug trafficking offences year ending Sept 2018, largely due to county lines. Drug gangs using transportation and supply lines controlled by a mobile phone (‘deal lines’) have brought trafficking and Class A drugs such as heroin and crack
cocaine to towns, villages and coastal areas within the South West, and drugs are being trafficked into Devon from across the country. Areas with high levels of deprivation, poverty, unemployment and crime have been particularly targeted. Drugs gangs operating in Devon are increasingly seeking to exploit local children, young people and vulnerable adults by forcing them to engage in county lines activities. They are groomed through offers of ‘free’ drugs, causing them to accumulate debts which can only be paid off by participating in county lines activities. Promises of money, power and status, and threats of violence and intimidation are also used as methods of grooming and coercion. People exploited by county lines gangs may act as ‘runners’. This involves moving drugs and money, sometimes across large distances, to maintain the supply of drugs to market locations. Once a new location is identified, drug gangs set up operating bases from which they can produce and sell illegal drugs. These are typically established through taking over the homes of vulnerable adults in a process known as ‘cuckooing’. These properties (also called ‘trap houses’ or ‘safe houses’) may be used for short periods of time before operations move elsewhere. During this time the inhabitant may experience intimidation, violence and abuse.

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.

Service commissioners are encouraging service providers to take a trauma informed approach, but providing a holistic approach when many services still operate in isolation is a significant challenge. There have been some good examples of services working together to provide a whole system approach e.g. the Alliance in Plymouth and Together in Devon (where services are commissioned as one provider) and CoLab in Exeter (service providers co-located together). We have also seen local prevention and early intervention pilots, working with schools to educate children on resilience, healthy relationships and drugs; and upskilling the school staff so they know what resources are available to help. The potential for CJS interventions to play a supportive role in prevention and early intervention is an area worth greater exploration. For example in 2017 Devon and Cornwall launched our Pathfinder diversion programme. The programme offers eligible offenders the opportunity to engage with a 4 month contract of interventions aimed at supporting them to address the origins of their offending behaviour and reduce future harm and risks of reoffending. This project is currently the subject of a randomised control trial with the University of Cambridge and recently won an award at the 2018 Howard League for Penal Reform Awards.

In terms of prevention, a growing cause for concern is the use of drugs at University. The National Union of Students released the findings of a survey in April 2018 which highlighted that institutions are failing to protect students from the potential harm of drugs with 39% of respondents reporting that they currently use drugs. Mental health is a factor in student drug use with 31% of respondents who have used drugs saying they have done so to deal with stress and 22% to self-medicate for an existing mental health problem. Also, students showed largely accepting attitudes towards drugs, with the majority of all respondents (62%) advising they do not have a problem with students taking drugs recreationally. We are seeing this reflected in our universities. We are also seeing cuckooing, as referred to above, where student accommodation is taken over for drug production or dealing. I was approached by the mother of a former University student, her son had become addicted to heroin after his student accommodation was taken over by dealers. She was campaigning for heroin assisted treatment to become a treatment option in Devon and Cornwall as her
son had become an entrenched heroin user and other forms of treatment had proven to be ineffective, she felt her son needed prescribed heroin in a medical setting through a GP.

Expulsion from school is an ineffective and harmful solution for children found with drugs; intervention and coordinated care have proven to be much more effective responses. We have had gang recruitment from pupil referral units in Devon and Cornwall and this makes these vulnerable children even more susceptible to crime and drugs.

A reduction in policing patrols in our streets since austerity has also led to the overt smoking of cannabis in public places. Visible drug use creates concern in communities and impacts on fear of crime and of quality of life.

**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.*

*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.*

Some good practices have emerged as referred to above, where services are co-located or are commissioned as one. Some treatment providers will also make referrals so an individual can address other needs, but in the main they will signpost and as many service users have complex needs this is not always effective. One particular area, which requires joint partnership working is access to mental health services for individuals with dual diagnosis. In terms of effectiveness, Public Health England collate certain data, e.g. unmet need, successful completions without re-presentations and deaths in treatment and ranks a Local Authority area by performance. Partners and service providers argue that this is not truly reflective of the service in place and does not, for example, reflect the quality of service offered, especially for an individual with complex needs. The Local Authorities who commission the drug services have a good understanding of the effectiveness of the service delivered, however funding reductions over recent years are putting pressure on services which is resulting in an increase in the time people will wait to access services, a reduction in face to face client contact and a challenges regarding qualified staff capacity. The risk of disengagement from services in such circumstances is significant and represents a lost opportunity to support individuals to recover.

One particular issue which has been raised is the pressure regarding access to a wide range of options for treatment due to fluctuations in the cost of various treatments. One such example is with regards to the cost of buprenorphine (subutex). This is a NICE recommended medication for opiate dependency which is prescribed by service providers. The cost has risen significantly since responsibility for sourcing this treatment passed to local authorities and commissioners have reported the impact this extra cost has had in maintaining current service provision.

In terms of approaching substance misuse as a health issue, most criminal justice partners
now see harm reduction and prevention as a key focus area.

With regards to policy, the legalisation of Cannabidiol (CBD) and prescription of cannabis for epilepsy, chronic pain and nausea caused by chemotherapy and Sativex (a cannabis-based drug) to relieve the pain of muscle spasms in people suffering from multiple sclerosis; together with national debates about the legalisation of cannabis and cannabis clubs has caused confusion, with society believing cannabis has been legalised.

The safety testing of drugs at festivals such as Boardmasters has also been wrongly interpreted as a message of acceptance and normalisation; when in fact checking the content of drugs helps the user make informed choices about the risks they’re taking so they can be better informed about the potential harm of taking it, and allows harm reduction advice to be tailored to them. With potentially toxic or more potent drugs available at festivals (e.g. super-strength ecstasy), and deaths linked to cocaine laced with the synthetic opioid fentanyl, the Home Office has recognised the health benefits with the first licensed drug-checking service in Weston-Super-Mare.

Best practice:

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

The discussions that I and my team have with service users and providers identify the need for a 24/7 service with immediate access and a whole system approach or joined up care pathways (particularly for those with dual diagnosis), with an outreach support service to engage with those with complex needs or are more difficult to engage in services. Ideally there would be more 1:1 contact, less group work and gender and age specific services would be available. There would also be more qualified staff to reduce the pressure on those supervising and prescribing.

Another blocker to accessing services is that for many users report that they do not feel safe accessing the current services. They have reported feeling vulnerable and concerned that they will be targeted by other users or dealers. Ideally drugs services would be delivered within an appropriate health setting, in a safe space which does not deter an individual from engaging with services. Drugs services should also be able to offer an individualised treatment plan for service users to ensure the response meets their treatment needs. There also needs to be greater access to residential rehabilitation (currently limited due to cost implications) and more supported housing where abstinence from drugs is not a requirement (e.g. the Housing First approach). Unless an individual is suitably housed, even a high quality response will be ineffective.

I have referred above to a lack of primary care services in mental health and an increase in individuals in the Criminal Justice System presenting with complex or multiple needs. In Plymouth we were a testbed site for Mental Health Treatment Requirements (MHTR), clinically supervised mental health practitioners provide an assessment in court and short, individualised psychological interventions have been delivered as primary care. Secondary care mental health services can also be provided, but this provision tends to be available through locally commissioned frameworks. We have seen health, social care and justice
services work together to ensure vulnerable offenders, particularly those with mental health and substance misuse needs, receive the health and wider social support they require. The key objective of this programme is to reduce offending by directly addressing offenders' health and social needs, alongside programmes to address their offending behaviour, thereby reducing short term custodial sentences and providing the courts with information and confidence to sentence community treatment requirements. I would like to see this available in all Courts, so that offenders experiencing mental health and substance misuse problems, have access to treatment requirements as part of a community sentence.

Prisons must be a safe space for those with drug misuse problems, and more needs to be done to ensure community sentences are a robust and effective sentencing option, so that those willing and able to seek treatment are not entering prison unnecessarily. Probation must ensure interventions are timely, punitive and tailored to the offender; the order needs to be closely monitored and swift breach action taken. Sentencers need to be confident that they are an effective means of reducing re-offending.

In relation to an evidence based response to drugs, it is important we also include a moral imperative and not only see results from a statistical perspective, helping people understand that drugs are illegal and not the healthy option. A partner organisation BTheChange has been entering schools with offenders and victims to discuss issues with children and they have found that most children do not understand the consequences of their behaviour. It is important to help children and young people recognise the consequences.