Written Evidence from Public Health England
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Drug misuse and dependency is associated with a range of physical, mental and social harms. Drug misuse is a significant cause of premature mortality. Heroin-related deaths doubled from 2012 to 2015 and the number of drug-related death remains very high.

People who inject drugs face an increased risk of infections, including those caused by blood-borne viruses such as human immunodeficiency virus (HIV) and hepatitis B and C. Bacterial infections are also a serious and increasing risk for injectors.

There has been a statistically significant increase in the estimated number of people using crack cocaine (a drug associated with a high level of harm) in the most recent published figures.

Health harms are significant among individuals who are homeless and sleeping rough, many of whom also experience co-occurring substance dependence and mental ill health. In 2017, 190 deaths (32% of the total) recorded among homeless people were due to drug poisoning.

There are signs that drug use is increasing among younger users. The last national survey of drug use among school children in England showed a large and statistically significant increase in use among 11 to 15-year olds.

Public Health England (PHE) advocates evidence-based prevention strategies which emphasise tackling the root causes of health harms and dependence, placing risk and resilience at their centre.

England has a well-established network of locally commissioned and run public systems and services that provide drug treatment based on extensive international research evidence on the interventions they offer. A treatment evidence review conducted by PHE in 2017 found that, for most comparators, the English treatment system achieved similar or better outcomes when compared to the results reported in research studies internationally.

The Public Health Grant (£3.2 billion in 2018-19) funds core public health services commissioned by local government. Between 2015-16 and 2020-21, the public health grant will have decreased by 23% in real terms (by 7.5% in cash terms).

Local government expenditure on drug and alcohol interventions has fallen by 14% since 2014-15 and the numbers of people accessing treatment have fallen by 10% over this same period leading to increased unmet need among the prevalent population.
Improvements are needed in care for people with co-occurring mental health and drug and alcohol problems, who are often excluded from services. Similarly, people who sleep rough struggle to access effective and joined up healthcare provision that meets their needs and further work is underway with the aim of improving this.

National policy in recent years has increasingly focused on health and treatment as is reflected in the 2017 Drug Strategy. The provision of treatment is devolved to local authorities and they are responsible for meeting local need and, while many local areas deliver good outcomes for their population, there are inevitably local variations in priorities and adherence to guidance.

The return on investment of drug treatment is partly accrued by the National Health Service (NHS). It is therefore vital that strategic alignment and partnerships between local authorities and the NHS are in place if local authorities are to invest adequately to realise the full return on investment delivered by drug treatment.
1. Health Harms

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

1.1 Drug misuse and dependency is associated with a range of harms including poor physical and mental health, unemployment, homelessness, family breakdown and criminal activity. The health and wellbeing of children, family members and carers can also be affected.\textsuperscript{i}

1.2 Drug misuse is a significant cause of premature mortality in England. Opioids, like heroin, are particularly associated with a high risk of premature death due to the respiratory depression and drop in blood pressure causing respiratory arrest. Drug-related deaths have risen substantially in recent years, with heroin deaths doubling from 2012 to 2015. Although the number fell slightly in 2017 (from 2,596 to 2,503 in England and Wales) it remains at a very high level. The numbers of deaths involving cocaine, new psychoactive substances, gabapentin and opioid pain medicines have also risen.\textsuperscript{ii}

1.3 People who inject drugs and share needles and other injecting equipment face an increased risk of infections, including those caused by blood-borne viruses such as human immunodeficiency virus (HIV) and hepatitis B and C. Injecting drug use continues to be the most important risk factor for hepatitis C and prevalence in England has remained high among people who inject drugs with a quarter currently infected, while nearly half of those currently infected do not know that they are.\textsuperscript{iii}

1.4 Bacterial infections such as Staphylococcus aureus and Group A streptococci in people who inject drugs are often related to poor general hygiene and unsterile injection practices. Morbidity can be severe for bacterial infections, with severity compounded by delays in seeking healthcare in response to the initial symptoms, and mortality can occur from invasive infections. Bacterial infections in people who inject drugs are an increasing problem in recent years. In 2017, half of people who inject drugs reported symptoms of an injecting site infection in the past year.\textsuperscript{iv}

1.5 There has been a statistically significant increase in the estimated number of crack cocaine users between 2011-12 and the most recent published figures for 2014-15 (166,640 to 182,828)\textsuperscript{v}. Injecting crack has also increased in recent years with 51% of those who had injected in the preceding four weeks reporting injecting crack in 2017 (compared to 37% in 2013). Death and health harms among people who inject crack appear to be linked to factors associated with high-risk injecting practices, such as more frequent use and higher levels of sharing needles and other injecting equipment, and higher levels of cocaine dependence.\textsuperscript{vi}

1.6 Health harms are significant among individuals who are homeless and sleeping rough, many of whom also experience co-occurring substance dependence and mental ill health. The recent Office for National Statistics experimental statistics report ‘Deaths of homeless people in England and Wales: 2013 to 2017’\textsuperscript{vii} illustrates the extent of health inequalities
faced by this group, with the average age of death 30 years earlier than for the general population.

Out of the 2017 deaths:

- 190 deaths (32% of the total) were due to drug poisoning (compared to 0.7% in the general population)
- 62 deaths (10%) were due to alcohol-specific causes (compared to 1.2% in the general population)
- 78 deaths (13%) were due to suicide (compared to 0.9% in the general population)

1.7 The use of new psychoactive substances, particularly synthetic cannabinoid receptor agonists (SCRAs), is particularly prevalent among the homeless and rough sleeping population, with an associated range of health harms, such as mental health problems.
2. 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.

2.1 The 2017 Government Drug Strategy, drawing on the Advisory Council on the Misuse of Drugs report, highlighted that drug use is “both a cause and consequence of wider factors including physical and mental ill-health, problems relating to employment, housing, family life and crime issues”.

2.2 Social factors are important influences on treatment effectiveness. Drug use and misuse tend to be clustered. Areas of relatively high social deprivation have a higher prevalence of illicit opiate and crack cocaine use and larger numbers of people in drug treatment. Unemployment and housing problems have a marked negative impact on treatment outcomes and exacerbate the risk that someone will relapse after treatment. Alongside other benefits, employment support and achieving good employment may lead to improvements in treatment outcomes and reduced relapse.

2.3 The prevalence of drug use among the general population in England is lower now than it was ten years ago, however, there are signs that the trend is reversing, particularly among younger users. The last national survey of drug use among school children in England showed a large and statistically significant increase in 11 to 15-year olds who had ever taken drugs, from 15% in 2014 to 21% in 2016.

2.4 Similarly, Department for Education data on school exclusions shows that exclusions for alcohol and drug use have increased substantially in recent years, with fixed term exclusions up by 34% (to 9,075) since 2012-13 and permanent exclusions up by 95% (to 565) since 2010-11, potentially putting more vulnerable young people at risk of involvement in gangs and ‘county lines’ a term used when drug gangs from big cities expand their operations to smaller towns, often using violence to drive out local dealers and exploiting children and vulnerable people to sell drugs.

2.5 The use of Class A drugs among 16 to 24-year olds has also increased in recent years and is currently 8.4%. The most commonly used Class A drug is powder cocaine, prevalence of which among 16 to 24-year olds has risen from 3% in 2012-13 to 6% in 2017-18. The United Kingdom (UK) is not alone in having seen increased use of powder cocaine. The European Union’s drugs agency has suggested that greater availability of higher purity cocaine resulting from increased global production and new supply methods may be driving increased levels of use across Europe.

2.6 The recent increase seen in the prevalence of crack cocaine also appears to be concentrated among younger users. Increasing availability of high quality cocaine is likely to be a common factor for increasing use of each form. Although the markets for crack and powder cocaine have traditionally been largely separate, there is anecdotal
evidence that crack is becoming more acceptable, there is more aggressive dealing and that this might be leading to powder cocaine users transitioning to crack.

2.7 As well as crack being particularly associated with problematic use and the effects it has on the user’s life, such as social, financial, psychological, physical or legal problems, its increasing prevalence is a further cause for concern as it may lead to new users being introduced to heroin. There is understood to be a common practice used by dealers of giving away free heroin to their crack customers.\textsuperscript{xv}

**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.**

2.8 Preventing harmful drug use is central to a public health approach. PHE advocates evidence-based prevention strategies which emphasise tackling the root causes of health harms and dependence, placing risk and resilience at their centre.

2.9 Alcohol and drug prevention interventions can have a broad range of aims from preventing any use at all, through to reducing use and preventing dependency.

2.10 Prevention interventions that influence drug use are often not drug specific and may already exist as broader interventions aimed at improving people’s life chances and developing their personal and social resources. Deprivation and health and social inequalities play an important role.

2.11 It is vital that people have access to accurate and relevant information about the health harms of drugs. Although, there is little to no evidence that information alone changes the prevalence of use, it can however help to reduce harm and inform choice. In 2015, PHE published a summary of the international evidence on prevention to assist local areas to deliver effective prevention interventions\textsuperscript{xvi}. 
3. 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.

3.1 A high-quality, evidence-based treatment system is in place in England. In 2017 PHE conducted, ‘An evidence review of the outcomes that can be expected of drug misuse treatment in England’\(^\text{xvii}\) which found that, for most comparators, the English treatment system achieved similar or better outcomes when compared to the results reported in research studies and internationally.

3.2 The pressure that local authorities face with competing demands on their public health grants (PHG) does present a challenge for the sector in maintaining both the level of access to and the quality of treatment services. Between 2015-16 and 2020-21, the PHG will have decreased by 23% in real terms (by 7.5% in cash terms). Total PHG expenditure on drug and alcohol interventions has fallen by 14% since 2014-15\(^\text{xviii}\). Numbers accessing treatment have fallen by 10% over this period leading to increased unmet need among the prevalent population\(^\text{xix}\). Stakeholders have raised concerns on the retention of expertise within the workforce and whether there is enough capability and capacity to provide interventions effectively to the entire treatment population.

3.3 Another significant concern on the quality of treatment relates to the care of those with co-occurring mental health and drug and alcohol use conditions. Despite the shared responsibility that the NHS and local authority commissioners have to provide treatment, care and support, there is a persistent and widespread issue of people with co-occurring conditions often being excluded from services. Evidence suggests that the recommendations contained in the Department of Health 2002 national guidance ‘Dual diagnosis policy and implementation guide’\(^\text{xx}\) and the 2009 Department of Health and Ministry of Justice publication ‘A guide for management of dual diagnosis in prisons’\(^\text{xxi}\) have not been widely implemented.\(^\text{xxii}\)

3.4 PHE published a guide for commissioners and service providers in 2017 on ‘Better care for people with co-occurring mental health and alcohol/drug use conditions’\(^\text{xxiii}\). While the guidance was well received by the field, there is consensus among professionals that the aligned commissioning and delivery of mental health and drug and alcohol treatment services is rarely achieved in practice.

3.5 Further work is being undertaken across PHE, NHS England, the Department of Health and Social Care and the Ministry for Housing, Communities and Local Government since the publication of the government’s Rough Sleeping Strategy\(^\text{xxiv}\) in August 2017 to improve the accessibility of drug and alcohol treatment services, mental and physical health care services for homeless people and rough sleepers with co-occurring substance misuse and mental health services. Although available, there is broad agreement that people who sleep rough struggle to access effective and joined up health care provision that meets their needs.
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.

3.6 Policy in recent years has increasingly focused on health and treatment, and the 2017 Drug Strategy\textsuperscript{xv} has a greater focus on treatment and health issues than the previous strategy. It gives prominence to reducing drug-related deaths and the spread of drug-related infections and enabling effective interventions for related physical and mental health problems.

3.7 The Public Health Outcomes Framework (PHOF) includes an indicator on drug misuse related death rates for each local authority. The PHOF is health focussed and drug treatment and prevention interventions contribute to range of its indicators, aside from those which are specifically related to drug and alcohol use, for example blood-borne virus indicators.

3.8 PHE provides a wide range of resources and support for local authorities in providing effective evidence-based health focussed drug treatment responses. This includes briefings, toolkits, data and supporting materials for commissioners. PHE recently launched its Opioid Substitution Treatment Good Practice Programme\textsuperscript{xxvi}.

3.9 While PHE is confident national policy and support has a sufficient treatment and health focus, the provision of treatment is devolved to local authorities and they are responsible for meeting local need. While many local areas deliver good outcomes for their population, there are inevitably local variations in priorities and adherence to guidance.

3.10 The Care Quality Commission has enhanced its regulation approach and focus on substance misuse services, and now individually rates each service. It has a vital role in maintaining high quality treatment provision and helps to ensure local areas and services focus on treatment, clinical governance and quality.

3.11 Although the Drug Strategy stipulates that Health and Wellbeing Boards should ensure all partners are engaged in drug treatment commission, partnership engagement varies from area to area and the alignment of local authority, criminal justice partners and Clinical Commissioning Group commissioning in relation to drug misuse is inconsistent. The return on investment of drug treatment is partly accrued by the NHS and it is therefore vital that strategic alignment and partnerships between local authorities and the NHS are in place, if local authorities are to invest adequately to realise the full return on investment delivered by drug treatment.
4. Best practice

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

4.1 There is extensive international research evidence on the interventions provided by drug treatment services and how people can be helped to tackle drug misuse and recover. This evidence forms the basis of guidance for local treatment systems, including National Institute of Health and Care Excellence guidance and 'Drug misuse and dependence: UK guidelines on clinical management' published by the Department of Health and the devolved administrations in 2017.

4.2 Opioid substitution treatment (typically using methadone or buprenorphine) is the most widely studied medical intervention for heroin dependence, with consistent reports of reduced drug use, injecting and mortality. Several types of psychosocial intervention have also been evaluated, with mixed results.

4.3 More detail on the evidence base for, and performance of, the English treatment system can be found in 'An evidence review of the outcomes that can be expected of drug misuse treatment in England'.

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