



## **Harm Reduction Group response to the Health and Social Care Committee Inquiry on Drugs Policy**

The Harm Reduction Group (HRG) is an alliance of concerned organisations and individuals in England who are working to maintain and promote harm reduction principles in drug treatment policy and practice. Please find below our submission to the Health and Social Care Select Committee inquiry on drugs policy.

### **Policy context**

Harm reduction interventions are extremely cost effective, saving not only lives, but money too.<sup>i</sup> Yet despite compelling and extensive evidence, political and financial support for harm reduction has sharply declined in England. There has been some controversy around national drugs policy in England with the promotion of a 'recovery' agenda which sees the focus of treatment as securing the abstinence of the individual from drug use rather than freedom from harm. The Government failed to adequately include harm reduction in the 2017 Drug Strategy.<sup>ii</sup>

This worrying shift in policy coincided with the Health and Social Care Act 2012 and a massive shake-up in how drug services are commissioned. A number of dangers arise from this shift – a lack of transparency as to what each of the 152 local authorities is doing on harm reduction; the risk of political/ideological opposition at a local level to harm reduction; and inconsistency of policy and practice across the country leading to a postcode lottery in terms of treatment quality.

### **Our positions on specific policy issues and harm reduction interventions:**

#### **Funding and commissioning of drug treatment**

Reductions in the Public Health Grant are heavily impacting upon drug treatment services. 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 overall in spend on drug and alcohol services from 2014/15 to 2019/2020. This is in excess of the reductions in spend on nearly all other services in the Public Health Grant and is not responsive to changing need. Overall, the Health Foundation predict that the total fall in public health spend per person between 2014/15 and 2019/20 is expected to reach 23.5%.<sup>iii</sup>

Drug treatment services, along with sexual health services, are the two elements of clinical care which have been taken out of the remit of NHS commissioning, meaning they have not benefited from NHS funding increases. This difference in commissioning arrangements and funding settlements has resulted in a profound health inequality which requires urgent action.

**It is imperative that, as a minimum, cuts to drug treatment services over the last few years are reversed through a significant uplift to the Public Health Grant in the forthcoming spending**

**review. Furthermore, funding should be sufficient to allow harm reduction services to align with need. We also strongly recommend that the Public Health Grant to local authorities is maintained.**

**In relation to commissioning, we note that the NHS Long Term Plan mentions a review of the future of sexual health commissioning arrangements but not of those for drugs and alcohol services. If these services are to remain commissioned by local authorities, we then recommend that local authorities are mandated in law to provide drug treatment services (which would protect against complete decommissioning).**

### Opioid Substitution Therapy (OST)

OST is the substitution of an opioid, such as heroin, with a longer-lasting prescription opioid. The HRG is concerned about sub-optimal dosing of OST which has been stated as an issue in the UK<sup>iv</sup>, and current guidance seeks to clarify what optimal dosing looks like.<sup>vi</sup> 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. 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.<sup>vii</sup>

In a recent report, local authorities were asked whether their providers were supplying OST in line with 'Drug misuse and dependence: UK guidelines on clinical management, 2017'.<sup>viii</sup> Nearly all the local authorities stated that their providers are abiding by current guidelines. What this means in practice though remains somewhat unclear. **Local authorities should take a more active role in ensuring optimal OST provision through enhanced auditing and accountability.**

The danger that funding cuts will impact upon OST provision is worrying. **We agree with the statement in the Advisory Council on Misuse of Drug's (ACMD) report on reducing opiate-related deaths when they state 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."**<sup>ix</sup>

*International context:* In 2017, almost two-thirds of drug-related deaths in Europe took place in Germany, Turkey and the United Kingdom.<sup>x</sup> According to data covering the European Union, Norway and Turkey, approximately 84% of the 9,138 drug-related deaths in the region in 2016 involved opioids.<sup>xi</sup>

*Good practice:* Sustained high coverage of OST in Switzerland has been credited with substantially reducing the number of drug-related deaths (largely attributed to opioids) since 1995.<sup>xii</sup> According to data from the Federal Office of Public Health, the overall number of drug-related deaths in the country fell by 64% from 1995 to 2016, from 376 to 136.<sup>xiii</sup> For comparison, the number of drug-related deaths in England and Wales increased by 250% over the same period.<sup>xiv</sup>

### Naloxone

Naloxone is a life-saving medication that counteracts the effects of opioids, such as heroin. The following bodies have recommended that take-home naloxone is made widely available to people likely to witness or experience an opioid overdose: The Department of Health and Social Care<sup>xv</sup>, Public Health England (PHE)<sup>xvi</sup>, the ACMD<sup>xvii</sup>, the World Health Organisation<sup>xviii</sup>, and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).<sup>xix</sup> Take-Home Naloxone (THN) should be

provided in a variety of settings such as prisons, amongst police forces, hostels, homeless shelters, and probation services.

Despite this, a recent report found that while 149 of 152 local authorities had a THN programme in place, coverage of THN among people who use opiates remains poor. Release reported “of the 152 local authorities in England, 145 reported dispensing a total of 40,033 THN kits in community settings in 2017/18 for an estimated 244,457 people using opiates in these areas. On this basis, the estimated national coverage of THN among people who use opiates in 2017/18 was 16 per cent”. The report also found that only 51 per cent of prisons in England had a THN programme in place.<sup>xx</sup>

Some local authorities have restrictions on who can access naloxone, such as only providing it to those currently in drug treatment caused by a lack of funding.<sup>xxi</sup> Some police forces and prisons are hesitant about providing naloxone, with some confusion on policy in this area.<sup>xxii</sup> Blenheim, a drug service, found that hardly any of their service users were being released from prison having been provided with Naloxone – partly due to a lack of clarity on commissioner responsibility for this service.<sup>xxiii</sup> **Funding for naloxone in England must be increased and proactive work should be done by PHE with other public bodies to ensure important settings feel confident in using and providing take-home naloxone.**

#### Needle and Syringe Programmes (NSPs)

NSPs provide people who inject drugs (PWIDs) with sterile needles with the aim of reducing viruses and infections. Prevalence of hepatitis C (HCV) amongst PWIDs is very high.<sup>xxiv</sup> Prevalence of HIV remains low – though the continuation of this success can only be guaranteed if NSPs are adequately provided.<sup>xxv</sup> The recent HIV outbreak in Glasgow is indicative of what services must be prepared for.<sup>xxvi</sup> There are also preliminary signs of an HIV outbreak in Birmingham.<sup>xxvii</sup>

NSPs are vital to improving performance on reducing HCV. NSPs are already hard hit, with a number of drop-in sites closing across the UK and others being forced to streamline their services. Data on the number of NSPs isn't centrally held by PHE, which makes it difficult to assess the extent of site closures. The Government also does not monitor and report on NSP coverage to the EMCDDA. **It is important that the Government improves in monitoring NSP coverage to increase transparency and accountability.**

However, recent PHE data shows that the number of PWIDs reporting adequate needle and syringe provision is suboptimal, with less than one half of those surveyed indicating adequate provision for their needs (45% in 2016).<sup>xxviii</sup> **The UK Government must ensure that provision of NSPs meets need, without which our aim to eliminate HCV as a public health threat and end all new HIV transmissions by 2030 will be unattainable.**

#### Drug Consumption Rooms (DCRs)

DCRs are legally sanctioned facilities where people can use illicit drugs obtained themselves, under the medical supervision of trained staff. There is a wealth of evidence that DCRs can reduce drug-related deaths, drug-related harm, drug-related litter, the sharing of injecting equipment, and blood-borne viruses, and encourage people to engage in structured drug treatment.<sup>xxix</sup> Despite this, the UK Government is refusing to allow a DCR to open anywhere in the UK.

Glasgow is the furthest along in preparations to open a DCR. This is because Glasgow is experiencing the worst ongoing HIV outbreak amongst PWIDs there that we have seen in the UK for a long time and the city has one of the highest rates of DRDs across Europe. Despite all key stakeholders including NHS Greater Glasgow and Clyde, Glasgow City Council, Scottish Parliament, and voluntary

sector organisations being in favour of one opening the UK Government position on DCRs has remain unchanged. **It is imperative that the Health Committee holds ministers to account on their policy to not allow DCRs to open.**

*International context:* 88 DCRs exist across eight countries in Western Europe (Belgium, Denmark, France, Germany, the Netherlands, Norway, Spain and Switzerland). These constitute 75% of the total number of DCRs around the world, with Australia and Canada the other countries outside the region hosting officially designated DCRs.

In 2016, 1,717 people used DCRs in Luxembourg,<sup>xxx</sup> 3,110 people used Spanish DCRs<sup>xxxii</sup> and 7,155 people used Danish DCRs.<sup>xxxiii</sup> Frankfurt's four DCRs oversee 200,000 injections annually<sup>xxxiii</sup> and the Oslo DCR in Norway has supervised more than 300,000 injections since opening.<sup>xxxiv</sup> Even with this large volume of use, there have been no reported deaths in any of the DCRs in Western Europe.

*Good practice:* Dutch DCRs, such as the Princehof facility in Amsterdam, also provide clients with access to social workers, referrals to mental and physical healthcare, and housing and employment advice. This is supplemented with warm meals, tea and coffee, showers and recreational activities, and low-threshold work opportunities such as cooking, cleaning and bicycle repair. The result is a welcoming environment for people who use drugs. Dutch DCRs have expanded into intensive housing support facilities, such as the one at Schurmannstraat in Rotterdam. This facility, accessible only to those with a professional referral, can house up to 20 people at a time, and contains a living room that also serves as a DCR.<sup>xxxv</sup> Integrated services such as those in the Netherlands not only reduce the direct health harms of drug use but can also strengthen DCRs' function as a starting point for engagement between people who use drugs and other health and social services.

### Heroin Assisted Treatment (HAT)

HAT is an evidence-based harm reduction intervention, which has been shown to be cost-effective<sup>xxxvi</sup>, and is supported by the ACMD<sup>xxxvii</sup> and the British Medical Association.<sup>xxxviii</sup> It is most effective for people who use opiates who have not responded to first line OST medications. A recent FOI to PHE brought to light how only 280 individuals across England were receiving HAT in 2017/18.<sup>xxxix</sup> We also know from an FOI to the Home Office that "there are currently 164 doctors who hold a diamorphine prescribing licence", which appears to be less than in 2012.<sup>xl</sup>

The main block to wider implementation of HAT is that there is currently no direct funding to local authorities to commission these services. **We agree with the ACMD's recommendation that "central government funding should be provided to support HAT for patients for whom other forms of OST have not been effective."**<sup>xli</sup>

### Decriminalisation

The HRG supports decriminalisation of the possession of all drugs for personal use. 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 DRDs.<sup>xlii</sup> Such improvements are not solely the result of a decriminalisation policy but matched by a shift towards a more health-focused approach to drugs.

The criminalisation of people who use drugs (PWUDs) 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.<sup>xliii</sup> The Global Commission on Drug Policy has called for decriminalisation since 2011.<sup>xliiv</sup> More recently the

World Health Organisation<sup>xlv</sup> and UN organisations<sup>xlvi</sup> have voiced support for decriminalisation and alternatives to conviction and punishment for possession. **We urge the committee to look at whether decriminalisation should be implemented in the UK.**

### Drug checking

In the UK, The Loop provides drug-checking services at festivals and Addaction recently received the first Home Office license for a fixed-site drug checking service; the pilot will run at North Somerset, one day a week for four weeks. This allows people to understand both the purity and adulteration of the substance they might take. **Drug checking services need to be embraced and scaled up to support people to make safer decisions in relation to their drug use.**

*International Context:* In Western Europe, a number of countries are significantly reducing the harms of drug use through innovative drug-checking interventions. Drug-checking is carried out in a number of ways, the most common being on-site and mobile drug-checking services at nightclubs and festivals, such as those operated by Pipapo in Luxembourg and CheckIn in Portugal.<sup>xlvii</sup> Fixed-site drug-checking services are accessible either by post or by attending the facility in the Netherlands.

An additional key function of drug-checking projects is to contribute to national monitoring and early warning systems. For example, the primary objective of the service in the Netherlands is to monitor new and existing drug markets and to issue warnings when a particularly dangerous substance is identified in the drug market.<sup>xlviii</sup>

*Good practice:* In Bern (Rave It Safe) and Zurich (saferparty), walk-in services are offered on a weekly and twice-weekly basis respectively. Each testing occasion is accompanied by a compulsory counselling session and data collection through an optional questionnaire. At both centres, test results are communicated in person, by phone or by email several days later. Both centres report that after several years, people who access the services are now better informed about the risks of drug consumption and harm reduction strategies than they were when the services began operating.<sup>xlix</sup>

### Conclusion

Fundamentally, the failings of the Government's current approach to drugs policy can be seen clearly in the high rate of drug-related deaths and drug-related harm across the UK, the high prevalence of blood-borne viruses such as hepatitis C, the continual warnings by drug treatment providers that they are facing a funding cliff edge, the low coverage of interventions such as naloxone, and the refusal to implement harm reduction interventions that come with a wealth of evidence to prove their effectiveness in reducing drug-related harm and death such as DCRs. A harm reduction approach that is supported by adequate funding is vital if we are to build a more effective drugs policy.

Thank you for taking the time to read our submission. If we can provide further information then please do not hesitate to contact Christopher Hicks, Senior Policy & Campaigns Officer, NAT (National AIDS Trust), on [christopher.hicks@nat.org.uk](mailto:christopher.hicks@nat.org.uk)

**HRG**  
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