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Health and Social Care Committee

Drugs policy

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Summary

Every drug death is avoidable. However, the United Kingdom, and in particular Scotland, have amongst the highest drug death rates in Europe. The evidence we have heard leads us to conclude that UK drugs policy is failing.

The rate of drug-related deaths has now risen to the scale of a public health emergency. In England in 2018 there were 2,670 deaths directly attributed to drug misuse, an increase of 16% since 2017—if other causes of premature death amongst people who use drugs were included, it is likely that this figure would approximately double.

Radically changing the approach to drugs policy

We recommend a radical change in UK drugs policy from a criminal justice to a health approach. **A health focused and harm reduction approach** would not only benefit those who are using drugs but reduce harm to and the costs for their wider communities. Responsibility for drugs policy should move from the Home Office to the Department of Health and Social Care.

We recommend that **the Government should consult on the decriminalisation of drug possession for personal use from a criminal offence to a civil matter**. The Government should examine the Portuguese system, where decriminalisation was implemented as **one part of a comprehensive approach to drugs**, including improving treatment services, introducing harm reduction interventions, and better education, prevention and social support. Decriminalisation of possession for personal use saves money from the criminal justice system that is more effectively invested in prevention and treatment.

Decriminalisation will not be effective without investing in holistic harm reduction, support and treatment services for drug addiction. Doing so would save lives and provide better protection for communities.

Improving treatment

Evidence based guidelines for treating people with drug dependency do exist, but there is an unacceptable gap between best practice and what services are actually able to deliver to people, as well as wide variation.

Many people using drug treatment services are growing older and living with complex illnesses. Those living with both addiction and **underlying mental illness** find it difficult to access adequate treatment and services.

Drug treatment services have faced **funding cuts of 27% over the past three years**, at a time when costs are rising.

Although our inquiry has focused on the harms caused by illicit drugs, **dependency on prescription medicines** is an emerging and worrying issue which requires greater attention from government.

Reducing harm

Harm reduction interventions–including needle and syringe programmes, drug checking services, naloxone, drug consumption rooms and heroin assisted treatment–can all play an important role in preventing deaths amongst drug users as well as protecting their communities by reducing the harm from discarded syringes and drug related crime.

We call on the Government to direct **significant investment** into drug treatment services as a matter of urgency, and to also make sufficient funding available to ensure that heroin assisted treatment, naloxone, and needle and syringe programmes are available. Drug consumption rooms should be piloted in areas of high need. There should be greater efforts to support those at higher risk, including people in prison and at the point of release from prison.

Commissioning and the workforce

We recommend that the Government conduct a review of the **commissioning** of drug treatment services to consider how they should be strengthened to enable them to co-ordinate and deliver the much-needed improvements to drug treatment services as effectively as possible. The Government should also address the current and predicted future **workforce** shortfall.

Comprehensive education, prevention and social support

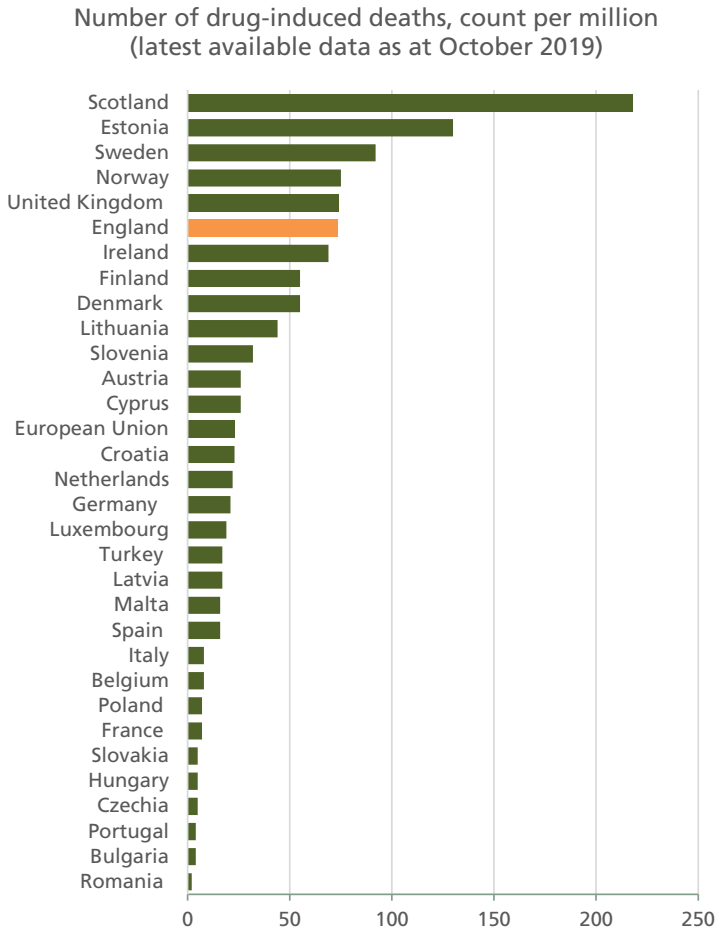
The first priority in developing a comprehensive response to drugs must be to invest in existing **drug treatment services**, and extend and develop **harm reduction initiatives**.

The Government also needs to fund a comprehensive package of **education, prevention and support** measures focused both on prevention of drug use amongst young people, and on improving the life chances of people who are recovering from drug use.

1 The scale of the problem

1. Every drug death is avoidable. However, the United Kingdom, and in particular Scotland, have amongst the highest drug death rates in Europe. The evidence we have heard leads us to conclude that UK drugs policy is failing.

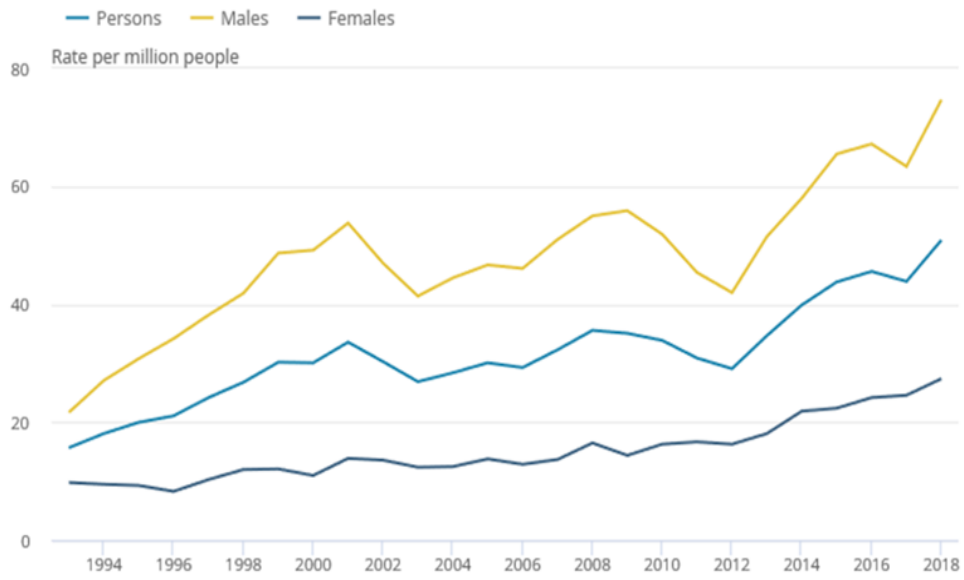
2. This year drug related deaths in the UK rose to their highest ever levels, placing the UK near the top of all European countries, and more than three times the European average.[1] In England in 2018 there were 2,670 deaths directly attributed to drug misuse, an increase of 16% since 2017. This figure underestimates the true harm caused by illicit drug use (e.g. overdose): if other causes of premature death amongst people who use drugs were included, it is likely that this figure would approximately double.[2] Our view of the evidence we have seen is that this issue has now escalated to the proportions of a public health emergency, and the scale of the problem the UK faces requires similarly large-scale solutions.



1 EMCDDA, European Drug Report - trends and developments, 2019; England rate of 73.5 sourced from ONS drug poisoning dataset; differences between countries in investigating and recording drug related deaths mean comparisons should be treated with caution.

2 ONS, 2019; Lewer et al, Causes of hospital admission and mortality among 6683 people who use heroin: A cohort study comparing relative and absolute risks, Drug and Alcohol Dependence, 2019

Age-standardised mortality rates for deaths related to drug misuse, by sex, England and Wales, registered between 1993 to 2018



Source: Office for National Statistics

3. The vast majority of drug-related deaths involve opiates. While nearly half of these deaths are caused by overdose, people who use drugs are far more vulnerable to other illnesses and other causes of death as well–cancer, cardiovascular disease, respiratory disease, liver disease, suicide and homicide–and opiate users are 12 times more likely to be the victim of homicide than the general population.[3]

4. While statistics on the health harms associated with drug use are stark and compelling, an even bleaker picture of the wider impact is painted by those who have suffered from drug addition, as we heard from Kerrie Hudson, a recovered drug user and operational lead at the Well:

> It is the damage to self-esteem, the damage to self-respect, the unresolved trauma, the lack of ambition, the stigmatisation, the going to places for help and getting the wrong kind of help and the wrong kind of support. That then perpetuates the feeling of uselessness and hopelessness because you cannot do what people are asking you to do or what people are expecting of you. There is the damage to your family members. It is knowing: people are fully aware of the damage that they cause when they are in addiction but they are just incapable of stopping it. You go against your conscience; you go against what you know to be right and wrong.[4]

5. Drug use has profound impacts beyond the individual user, on families, carers, as catalogued for us by ADFAM, a charity that supports the families of drug users:

3 Q2, Professor Tim Millar
4 Q284, Kerrie Hudson - the Well is an addiction recovery support service

> Relationship difficulties; family breakdown; issues with communication; severe mental ill health, and isolation from friends and family, financial impacts, physical violence and abuse, missing work on a regular basis because of caring responsibilities; and physical health impacts.[5]

6. And there are wider social impacts. The Modern Crime Prevention Strategy states that offenders who regularly use heroin, cocaine and crack cocaine commit an estimated 45% of acquisitive crime,[6] and we heard that the illegal drugs trade involves exploitation of young or very vulnerable people, from production all the way through to transportation and delivery in the UK.[7] The cartels and dealers leave a worldwide trail of misery, death and corruption.

7. Statistics from the last ten years paint a varied and complex picture of drug use–there have been decreases in drug use overall, particularly amongst young adults, with a fall in cannabis use, but increasing use of cocaine. Whilst heroin use amongst young people is notably lower than ten years ago, the UK still has much higher rates of illicit opiate use than elsewhere in Europe.[8] Our inquiry has focused on the harms caused by illicit drug use, but we have also heard about the growing health threat caused by addiction to prescription medicines. This threat is discussed further in the next chapter.

8. Problematic drug use is concentrated in areas that suffer from poverty and multiple deprivation, so the pressure is on areas that have the least capacity to respond to them.[9] And whilst poverty and lack of opportunity do not inevitably lead to drug use, they are factors that can drive experimental use onto a higher risk of dependency.[10]

9. The overall cost of illicit drug use is estimated to be about £10.7 billion per year.[11] There is a considerable cost benefit to investing in drug treatment–with every £1 spent on treatment estimated to save £4. Yet despite this, spending on drug treatment has fallen by nearly 30%.[12]

10. We write this report only half way through what was planned as a longer and more detailed inquiry. We are indebted to all those who contributed to this inquiry, including those who provided us with their views through written and oral evidence; our specialist

5 Q287, Emily Giles, ADFAM
6 Department of Health and Social Care (DRP0065) written evidence
7 Q253, Q241, Jason Harwin
8 Q23, Q29, Professor Tim Millar
9 Q8, Professor Suzanne MacGregor
10 Q44, Professor Tim Millar
11 Public Health England, Alcohol and Drug prevention, treatment and recovery: why invest? February 2018
12 Q186, Danny Hames

advisers Rosalie Weetman and Alex Stevens;[13] the FCO in Frankfurt and Lisbon; and all those who generously gave us their time on our visits. We have regrettably had to cancel a fact-finding visit to Teesside, the area with England's highest rates of drug deaths, and have not yet heard from many important groups, or had the opportunity to question Government ministers. However, we have been so concerned by the evidence we have received to date that we feel compelled to publish a short report with recommendations so that the evidence we have heard is brought to the Government's attention as soon as possible. It is clear to us and to many others who have examined the international evidence that this is a problem that requires swift, bold action on a number of fronts. **There is a clear need for evidence-led policy on drugs. We urge the Government and other policy makers not to shy away from the lessons from Portugal and Frankfurt, but to take a harm reduction approach and implement the recommendations set out in this report without delay.**

13 Professor Alex Stevens declared the following interests:

- In addition to my employment at the University of Kent, I am paid as Senior Editor of the International Journal of Drug Policy. The University is paid for my time as a consultant, currently with RAND Europe.
- I am an unpaid member of Advisory Council on the Misuse of Drugs, the Advisory Boards of the Global Drug Policy Observatory (Swansea University) and of the Swiss Institute for Addiction and Health Research (University of Zurich), the International Society for the Study of Drug Policy (as President and trustee), the European Society of Criminology, the Society for the Study of Addiction, and the Green Party.

Rosalie Weetman declared the following interests:

- Derbyshire County Council Public Health Lead for alcohol, drugs and tobacco (remunerated role).
- Member of Advisory Council on the Misuse of Drugs (unremunerated role).
- Portman Group Independent Complaints Panel (remunerated role) and Company Director.

2 Putting health first

Improving treatment

11. From the evidence we have heard, it is clear that, for a variety of reasons, treatment for people with problematic drug use is currently inadequate. In the words of Professor Matthew Hickman, an epidemiologist at Bristol University specialising in drugs policy,

> We need to call for a public health crisis to be declared around opioid-related deaths. They are the highest they have ever been and they are going up annually. The services are not working.[14]

12. Drug treatment takes a wide variety of forms. Clinical intervention often involves providing a substitute for the drug being used - for example methadone - and thereby reducing the harms associated with that drug use. Clinical intervention can also involve reducing the substitution and misused drug over time. Psychosocial interventions can support people through motivational interviewing or other psychological interventions. The social interventions can include supporting people with basic needs such as food and housing, and developing positive relationships with families and communities.[15] We were also told that clear, evidence-based guidelines exist for managing drug dependency - Drug Misuse and dependence: UK guidelines on clinical management - or the 'orange book' as it is known to practitioners. However, we were told that in some places there can be a wide gap between what is set out as evidence-based best practice, and what is being delivered on the ground.[16] There is no national oversight of commissioning practice, nor minimum national standards.

13. We heard of the frustrations when psychosocial interventions helping people change behaviour and integrate back into their locally communities were not consistently available.[17] Residential rehabilitation and inpatient detox services–highlighted by two of our witnesses with lived experience as essential to their recovery–are in sharp decline. There are only a very small number of NHS inpatient centres remaining across England and even those are under threat of closure by 2020. Although people who are dependent on drugs are still able to access third sector and independent sector provision in some areas, in others there is no provision at all.[18]

14. And perhaps even more concerningly, we were also told that current provision of opiate substitution therapy–which is the core element of treatment for most heroin users with entrenched problems - is inadequate:

> the reality of our provision is that a lot of the opiate substitution treatment we provide would be regarded as quite low quality on a number of measures … Most of the prescribing that we do is probably below the bottom end of the recommended dose window. There is a diminishing investment in helping to make sure that people get engaged with the treatment.[19]

14 Q124, Professor Matthew Hickman
15 Q76, Karen Biggs
16 Q86, Mike Flanagan
17 Q204
18 Q199
19 Q173, Professor Sir John Strang

15. Witnesses described users being on cycles in and out of treatment–and concern that particularly on release from prison, they are at considerable risk from overdose.[20] This echoes the findings of a report on community-custody transitions, published by the Advisory Council on the Misuse of Drugs (ACMD), the Government's advisory body on the misuse of drugs.[21]

16. We were also told that there is now an ageing cohort of patients whose physical and mental health is declining through from having lived with chronic conditions and risk factors for many years. The complexity of care that services are having to cope with has therefore escalated rapidly.[22] Again, this repeats the recent findings of the Government's advisory body on the misuse of drugs (the ACMD) in its report on ageing drug users.[23]

17. On our visit to Portugal we saw a system marked by a positive attitude to service users which recognised the impact that chaotic lifestyles could have on engagement with support and treatment. There was a striking ethos of holistic, non-judgemental treatment and access to services focused on the needs of individuals rather than the convenience of the system. English treatment providers share a similar ethos, but their capacity to deliver is compromised by inadequate funding and the policy framework.[24]

18. Many service users in England are living with drug addiction and underlying mental illness, and we were told that these people do not receive adequate mental health services.[25] Witnesses suggested that this was due to changes in commissioning which mean that substance misuse services are now commissioned separately from mental health services; at the same time, the threshold for referral into community mental health services has become higher.[26]

19. We were also warned by witnesses of the increasing threat being posed by dependency both on prescribed medicines and on non-prescribed prescription medicines.[27] The current US epidemic–there were 47,600 opioid-related deaths in 2017, equating to some 130 deaths a day[28]–is largely agreed to have been triggered by significant increases in medical prescribing of opioids in the 1990s; some commentators argue that this harmful overprescribing is still continuing in the US.[29] Public Health England has recently published a review of dependence on prescription medicines in England, examining five different classes of medicines that can cause dependence. While the scale and nature of opioid prescribing is not equivalent to the current situation in the US, PHE concluded that the NHS needs to take action now to protect patients. The review found that 1 in 4 adults had been prescribed at least one potentially addictive medicine, and that long term prescribing of these medicines was widespread–half had been continuously prescribed it for at least the previous 12 months, and between 22% and 32% had received a prescription for at least the previous 3 years.[30] It has also been reported that regulatory loopholes enable medicines to be obtained from online GP practices and pharmacies without adequate

20 Q124, Professor Matthew Hickman
21 ACMD, Custody-community transitions, June 2019
22 Q174, Dr Arun Dhandayudham,
23 ACMD, Ageing cohort of drug users, June 2019
24 Q79
25 Q206, Dr Arun Dhandayudham; Q212, Professor Sir John Strang
26 Q211, Dr Arun Dhandayudham, Q206; Professor Sir John Strang,
27 Q80, Mike Flanagan; Q168, Josie Smith
28 CNN, Opioid crisis fast facts, October 2019
29 BMJ Editorial, What we must learn from the US opioid crisis, October 2017
30 Public Health England, Dependence on prescription medicines linked to deprivation, September 2019

checks.[31] PHE has made a series of recommendations, including improving training for clinicians to ensure their prescribing adheres to best practice, and the establishment of a national helpline for patients.

20. Witnesses were united in ascribing the falling standards of care to falling funding.[32] Funding for drug treatment services fell by 27% between 2015–16 and 2018–19.[33] Funding reductions are not evenly distributed between local authorities, with some local authorities having maintained budgets, and others having made large cuts. Cost pressures have been compounded by the rising prices of medicines, with one opiate substitute increasing in price by 600%.[34] Mike Flanagan, Consultant Nurse and Clinical Lead for Drug and Alcohol Services at Surrey and Borders Partnership NHS Foundation Trust, told us:

> One of the major challenges, which is the elephant in the room, is the cuts that drug treatment systems have had to endure for six or seven years or more. They have had an absolutely profound effect. The extent to which we can innovate, design and deliver very responsive services that respond to the changing patterns of drug consumption has been taken away from us. We are struggling to remain standing at the moment, with the cuts that we have taken …. All those things exist, but they are hanging on by the skin of their teeth at the moment.[35]

21. Concerns about cuts to funding for drug treatment were also raised by the police, including Hardyal Dhindsa, representing the Association of Police and Crime Commissioners:

> If you are convicted and have a treatment order, how do local public health departments commission those services? The reality is that funding has been going down and down, and therefore the number of people getting drug rehabilitation has been going down, and there is a risk that it could go further if the ringfence for public health funding is removed in May 2020.[36]

22. The ACMD's 2017 report on commissioning supports this view, referring to funding cuts as the most serious threat to the quality and coverage of drug treatment services.[37] This followed its 2016 report on reducing opioid related deaths, which recommended maintaining investment in drug treatment services.[38]

23. **We have heard that clear, evidence-based guidelines exist for drug treatment services, but that current practice does not deliver them. People on opiate substitution therapy are not consistently receiving optimal doses for the correct durations, placing their lives at risk. Psychosocial services and mental health services are not available to all those who need them, and inpatient services are also under threat.**

31 BBC News, Safety concerns over websites selling prescription drugs, August 2018
32 Q126, Matthew Hickman, Yusef Azad; Q174, Dr Arun Dhandayudham; Q101, Adrian Crossley; Q80, Mike Flanagan
33 Q186; Towards Sustainable Drug Treatment Services, Camurus, July 2019
34 Q174, Dr Arun Dhandayudham
35 Q80, Mike Flanagan
36 Q254
37 ACMD, Commissioning impact on drug treatment, September 2017
38 ACMD, Reducing opioid related deaths in the UK, December 2016

24. **Holistic, non-judgemental harm reduction approaches are needed which facilitate access to services. Following budget cuts of nearly 30% over the past three years, the Government must now direct significant investment into drug treatment services as a matter of urgency. This investment should be accompanied by centrally co-ordinated clinical audit to ensure that guidelines are being followed in the best interests of vulnerable patients.**

Reducing harm

25. For most drug users, the ultimate goal is to recover fully from their addiction and be free of drug dependency. But this can be a long and difficult process and for those with highly entrenched problems, interventions can be put in place to protect them whilst they are still coping with addiction.

Needle and syringe programmes

26. Needle and syringe programmes are perhaps the best known and longest established of these practices, which aim to stop the transmission of viruses such as HIV and Hep C if people use contaminated equipment to inject drugs. Only 61% of people who inject drugs report that their access to clean needles and syringes is adequate, and 18% of people report needle sharing.[39] We were also told that fewer needle and syringe exchanges are now offering testing for infections that can be spread through injecting drugs, including HIV and Hepatitis C.[40]

Naloxone

27. Naloxone is a life-saving drug which can be administered if someone is suffering from an opiate overdose, and can now be given to drug users for emergency use at home. However, our witnesses told us that provision is currently inadequate. Only half of prisons have a take-home naloxone programme to support prisoners with opiate problems through the high risk period following release from prison; and take home naloxone kits were only given on release to 12% of prisoners who need them.[41] Witnesses suggested that this is because of disagreements over whether NHS England or local authorities should fund it, arguing that 'it is not expensive, so this really should not happen'.[42] Witnesses highlighted the advantages of national, centralised naloxone provision programmes, as have been established in Scotland and Wales.[43] This was recommended by the ACMD report on community-custody transitions.[44] In the absence of such programmes, our witnesses argued that more consistency was needed:

> We need more central direction, good practice and monitoring from Public Health England to ensure that there is at least some consistency in naloxone provision across the country.[45]

39 Q123, Yusef Azad
40 Qq135–136, Yusef Azad
41 Q126, Yusef Azad
42 Q126, Yusef Azad
43 Q125, Josie Smith; Q138, Yusef Azad
44 ACMD, Custody-community transitions, June 2019
45 Q138, Yusef Azad

Drug consumption rooms

28. To reduce harm even further, drug consumption rooms (DCRs) can be introduced–facilities where people can use drugs with sterile equipment in a clean environment, with medical supervision on hand in case of emergency. In common with needle and syringe exchanges, these facilities also give an opportunity for health professionals to offer other types of support to drug users, including screening tests and connection to other services. DCRs reduce drug use in public places and the unsafe discarding of needles that then pose a risk to others,[46] therefore reducing harm to wider communities.

Case example 1 - the 'Frankfurt Way'

The Frankfurt Way was developed in the early 1990s in response to the open drug scene near Frankfurt's central station, coupled with very high numbers of drug-related deaths in Frankfurt and high rates of acquisitive crime.

A 4-pillar approach was designed–incorporating prevention, crisis and survival, drug free programs, and law enforcement. There was an official commitment, as part of a 'public health approach,' that a person with a drug addiction would be not taken into the criminal justice system until they had had a medical examination. We heard from the police about the cultural change that took place in thinking about drug addiction not as a crime but as an illness. Funding was provided by the European Central Bank, which had recently moved its HQ to the area with high rates of drug use. We heard from the police that robberies have more than halved since institution of these changes. Drug death rates have fallen dramatically in Frankfurt since the early 1990s, as have broader drug-related health problems and drug-related street crime. Drugs death rates in the wider Hesse region are 44% lower than in neighbouring Bavaria, which has maintained a traditional policy approach.

Frankfurt has a number of well-established drug consumption rooms. Drug users bring their own drugs to consume, and are provided with health care (with doctors on site at specified times), prevention of infection, first aid in case of overdose, needle and syringe substitution, connection to other services, detoxication, opioid substitution treatment, drug counselling, therapy, medical treatment and rehab. Heroin Assisted Treatment is available for people with the most problematic addiction to heroin. As well as health advantages, we heard that DCRs offer advantages for the police: there is a central contact for police matters; and there is less of a concentration of drug users in public places–which we heard has been associated with reductions in violence and drug-related crime. However, with three quarters of DCRs located in areas with flats, shops and offices, complaints do arise from residents. We also saw that drug use is more concentrated (even in the street) in the area of the DCR. As in England, public budget cuts are putting a strain on services.

The approach to harm reduction and treatment varies between different states in Germany: we heard that Hesse has a much more expansive offer than neighbouring Bavaria, which has a higher rate of drug related deaths. We were told that drug users travel from Bavaria to Hesse (predominantly Frankfurt) to access drug services.

29. Jason Harwin, Deputy Chief Constable of the National Police Chief Council, gave the following helpful explanation of DCRs:

> Drug consumption rooms have an evidence base showing that they work, but again it has to be part of a wider whole-system approach and a public health response. It has to be done with an understanding of what you

46 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Drug consumption rooms: an overview of provision and evidence, June 2018

> are trying to achieve from a drug consumption room. It is not just about allowing people to take illicit drugs: it is about safety; it is about stopping drug overdoses; and, importantly, it is about the wraparound of other services to try, ultimately, to take the person away from illicit drugs, to manage their need for drugs and put them into other services … I always argue that drug consumption rooms exist, without the title, in some people's houses, realistically, and people are dying there.[47]

Heroin-assisted treatment (HAT)

30. Heroin-assisted treatment is an evidence-based intervention where people who have not responded successfully to any other type of treatment can be prescribed heroin to use in a supervised clinical setting. These are individuals who are at particularly high risk. Despite trials showing evidence of clinical effectiveness and cost effectiveness, services at the three pilot sites at which HAT has been introduced as part of a clinical trial have been terminated, although a new service has just started in the North East.[48]

Drug checking services

31. We also heard from witnesses about the benefits of different drug checking services now being introduced, including at festivals, and a postal service offered in Wales.[49] At these services, people who use drugs can submit a small sample for testing, and are then sent results about what the substance actually contains. Witnesses told us that these 'are already having an impact, and there is a lot of international evidence that it works'.[50] We head that as well as having a health benefit to the individual–if people get information about adulterance to the drug, they may be less likely to take it - such testing can also provide an effective early warning for the public health system about particular batches of drugs and the dangers they might pose, enabling public health messages to be put out to reduce wider harm.[51]

International approaches to harm reduction

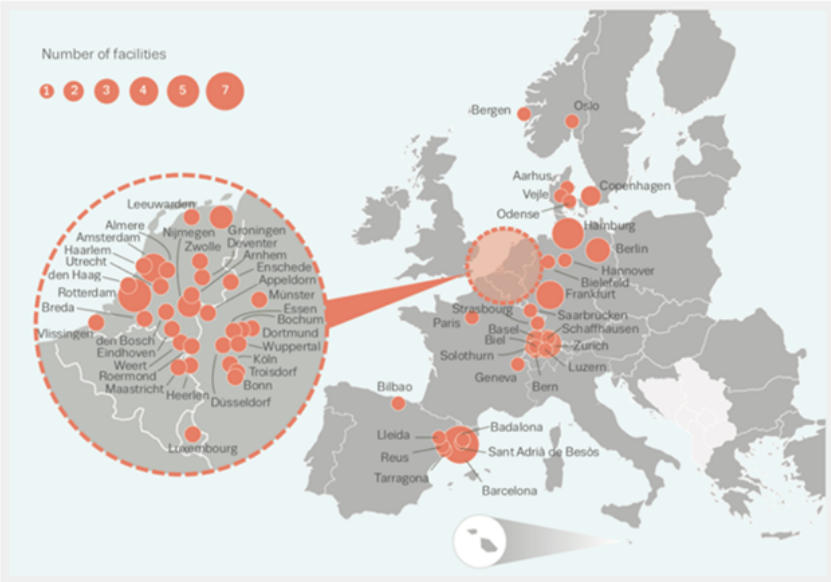
32. International evidence shows that harm reduction interventions are both effective and cost effective.[52] The 2015 Lancet Commission on drugs policy, coinciding with a UN summit on this subject, concluded that:

> Scaling up of health services for people who use drugs can demonstrate the value to society of responding with support rather than punishment to people who commit minor drug infractions … In Switzerland and Vancouver, Canada, substantial improvements in access to comprehensive harm-reduction services, including supervised injection sites and heroin-

47 Q252, Jason Harwin
48 Q196, Professor Sir John Strang
49 Q143, Yusef Azad; Q146, Josie Smith
50 Q127, Yusef Azad
51 Q143, Yusef Azad
52 David Wilson et al, The cost effectiveness of harm reduction, International Journal of Drug Policy, February 2015

> assisted therapy (ie, prescription of heroin for therapeutic purposes under controlled conditions), have transformed the health picture for people who inject drugs.[53]

33. Recent systematic reviews of the effectiveness of take-home naloxone programmes have found evidence that its provision in combination with educational and training interventions reduces overdose-related mortality.[54] In 2018, community-based take-home naloxone programmes were operating in 10 European countries. These programmes are commonly run by drugs and health services, with the exception of Italy, where naloxone is an over-the-counter medication, and service providers are able to distribute it to bystanders.[55] Denmark, Germany, and the Netherlands all provide heroin assisted treatment.[56] In the European Union and Norway, Drug Consumption Rooms operate in 51 cities, with a total of 72 facilities in operation.[57]



Summary

34. Witnesses were clear that both treatment services and harm reduction initiatives are needed, but that there has not been sufficient investment or focus in either.

> Fundamentally, you have to have proper investment in the spine of opioid agonist treatment and all of the other add-ons—take-home Naloxone and needle and syringe programmes—at an adequate level that will make a difference to the population. We have not had that focus or that investment.[58]

35. **The potential value of these interventions is well established, with the Government's own advisory body recommending their introduction over three years ago. The ACMD's 2016 report on reducing opioid related deaths recommended the scale-up of**

53 The Lancet Commission on Public health and international drug policy, the Lancet, March 2016
54 EMCDDA, European Drug Report - trends and developments, 2019
55 EMCDDA, European Drug Report - trends and developments, 2019
56 EMCDDA, Health and social responses to drug problems - a European Guide, 2017
57 EMCDDA, Perspectives on Drug consumption rooms: an overview of provision and evidence, 2018
58 Q139, Professor Matthew Hickman

naloxone provision, central funding of heroin assisted treatment, and consideration of the establishment of safer drug consumption rooms in areas with high concentrations of injecting drug use.[59]

36. **We have heard that existing good practice in harm reduction such as needle and syringe exchanges is now being eroded; Heroin Assisted Treatment is proven to be both clinically- and cost-effective as a treatment for a small number of people but is not available. Giving at-risk drug users take-home naloxone to protect them from overdose is a simple and life-saving intervention that again is not available to all those who could benefit. We saw first-hand the benefits of Drug Consumption Rooms in Frankfurt. Police representatives told us that these facilities should not be viewed simply as allowing people to take illicit drugs–they are about safety, stopping drug overdoses, and very importantly, providing access to a wraparound of other services to eventually stop that person's drug use. Harm reduction approaches such as DCRs reduce the wider harms to local communities as well as for those using drugs.**

37. **Sufficient funding should be made available to ensure that HAT, Naloxone, and needle and syringe exchanges are accessible to all those who could benefit from them. We also support the introduction of on-site drug checking services at festivals and in night time economies. Drug Consumption Rooms should be introduced on a pilot basis in areas of high need, accompanied by robust evaluation of their outcomes. If changes to current legislation are required to facilitate the piloting of DCRs, they should be made at the earliest opportunity and the Government must set out where the barriers exist to these evidence-based approaches being taken forward.**

Commissioning and the workforce

Commissioning

38. Since 2013, drug treatment services have been commissioned by local authorities as part of their public health responsibilities. Public Health England point out that 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).[60]

39. The LGA argue that local authorities are well-placed to lead the treatment and recovery agenda, as the role of local authorities in supporting social reintegration, addressing social inequalities and developing local initiatives across public health is well known.[61] The Association of Directors of Public Health provides further detail on the importance of a multi-agency approach, drawing together drug treatment services with the wider prevention agenda, encompassing other local authority led services including education, social services and housing:

> Drug users are likely to have complex needs that should be met through co-ordinated, whole system approaches and commissioning that addresses health inequalities. It is important that local authorities take a whole life course, multi-agency approach working closely with the criminal justice

59 ACMD, Reducing opioid related deaths in the UK, December 2016
60 Public Health England (DRP0062) written evidence
61 Local Government Association (DRP0042) written evidence

> system as well as partners in social services, education, housing and the NHS. Shared learning between those who have contact with the vulnerable is key for preventing and addressing drug misuse.[62]

40. The role of education and prevention is discussed in more detail in the following chapter.

41. Whilst our witnesses working in drug treatment services reported pockets of good commissioning practice, and some recent improvements, on the whole the providers we heard from felt that there were major problems with the commissioning of drug services.[63] They cited the difficulties caused by frequent retendering, and competing for funding against other local priorities, in the context of ever-shrinking local authority budgets.[64] Some witnesses described the positive impact of a centralised agency and argued for the return to more centralised oversight of commissioning, as in the days of the National Treatment Agency.[65] Others called for commissioning to be returned to the NHS.[66]

42. While these are in some ways similar issues and arguments to those that we considered during our recent inquiry into sexual health,[67] witnesses pointed out that drug treatment differs from sexual health provision. Sexual health services deliver more episodic service focused on the treatment of infectious diseases. While drug treatment services do deliver some short-term advice and guidance for individuals using non-opiates, they tend to see more complex opiate users with multiple needs who require longer-term interventions.[68]

43. The centralised agency model was frequently mentioned during our trip to Portugal as a critical factor in the success of that country's drug policy. SICAD (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências; General-Directorate for Intervention on Addictive Behaviours and Dependencies) is a central agency with responsibility for all aspects of drug policy which has an umbrella structure encompassing 1) campaigning, 2) housing, 3) NGOs and 4) treatment. Having one central organisation responsible for bringing everything together—including both funding and leadership on drug policy—was seen as particularly helpful.

44. As our inquiry has been cut short, we were regretfully not able to hear from commissioners of services, nor from their representative bodies - the LGA or the ADPH - or Public Health England. It is therefore not possible for us to make conclusions or recommendations on this point. However, it is clear that these concerns warrant further consideration by the Government.

45. In 2017, the ACMD considered issues related to the commissioning of drug treatment services. Its report concluded that 'reductions in local funding are the single biggest threat to drug misuse treatment recovery outcomes being achieved in local areas' and that the 'quality and effectiveness of drug misuse treatment is being compromised by under-resourcing'. It recommended how the Government could protect investment in treatment services by mandating local authorities to provide them or by moving commissioning

62 Association of Directors of Public Health (DRP0057) written evidence
63 Q126, Q136, Yusef Azad; Q139, Professor Matthew Hickman; Q173, Q184, Qq191–193, Professor Sir John Strang; Q79, Karen Biggs; Qq176–177, Danny Hames
64 Q54, Professor Tim Millar; Q126, Yusef Azad
65 Q85, Karen Biggs; Q51, Professor Suzanne MacGregor; Q182, Danny Hames.
66 Q216, Professor Sir John Strang; Q125, Professor Matthew Hickman
67 Health and Social Care Committee, Sexual Health Services, June 2019
68 Q139, Professor Matthew Hickman

of these services back into the NHS. The ACMD also recommended increasing the transparency of drug treatment funding, and its coordination with other health services, as well as a review of the drug treatment workforce.[69]

Workforce

46. There are serious concerns about the drug treatment service workforce, with a 24% reduction in consultant addiction psychiatrists in drug treatment services.[70] Mike Flanagan, Consultant Nurse and Clinical Lead for Drug and Alcohol Services at Surrey and Borders Partnership NHS Foundation Trust, explained the reasons:

> The drug treatment sector has become a less attractive option for a whole variety of reasons. First, its reprocurement cycles make it an unattractive option. The increasing involvement of the third sector has been positive for the field in its ability to deliver good, evidence-based psychosocial interventions and being rooted in communities, but newly qualified doctors and nurses often do not want to work for third sector providers; they prefer to work for the NHS, where they get pensions, CPD and so on.[71]

47. In his view, the current workforce shortages not only made it harder to deliver a good service, but also posed a grave threat to the future of drug treatment services, as fewer and fewer clinicians were available to train and develop the next generation.[72]

48. **Drug treatment services are commissioned by local authorities, which are arguably well placed to do so, given their links with other relevant services including housing, social services and education. However, the way this localised model of commissioning is currently working is a cause of concern to many providers of drug treatment services. We recommend that the Government conduct a review of the commissioning of drug treatment services to consider how they should be strengthened to enable them to co-ordinate and deliver the much-needed improvements to drug treatment services as effectively as possible. The review should consider whether improvements should be made to the current localised model, or whether, alternatively, a national agency to oversee commissioning should be established, to provide and ensure adherence to a minimum set of national standards. The review should also explicitly consider and address the clear and present crisis in the drug treatment workforce**.

69 ACMD, Commissioning impact on drug treatment, September 2017

70 Q174, Q220 Dr Arun Dhandayudham; Q201, Danny Hames; Royal College of Psychiatrists (DRP0037) written evidence

71 Q87

72 Q201, Danny Hames; Q220, Dr Arun Dhandayudham; Q221, Professor Sir John Strang

3 A comprehensive response to drugs

Comprehensive education, prevention and social support

49. It is essential that treatment and harm reduction services for those currently using drugs are improved in order to save lives and reverse the shockingly high rates of drug deaths. However, effort should also be focused more widely on improving prevention, education and social support–both to prevent people from using drugs in the first place, and to help improve people's life chances as they recover from drug use.

50. We heard compelling evidence from those involved in educating young people about drugs about the importance of education which is founded on open dialogue, honesty and trust.[73] However, too often parents lack the confidence to speak to children about drugs, leaving them to seek information on the internet, which firstly may give them unhelpful information, and secondly, does not give them the opportunity to ask questions.[74] Stigma can make children reluctant to ask questions about drugs, for fear of being thought to be a user.[75] Teachers have an important role to play, but may not be able to do so effectively - recent research showed that less than a third of them feel that their school is providing drugs education well, and fewer than half of teachers even know their own school's drug policy.[76]

51. In its 2015 report on Prevention of Drug and Alcohol Dependence, the ACMD found evidence of approaches that are not effective, including "information provision (standalone school-based curricula designed only to increase knowledge about illegal drugs), fear arousal approaches (including 'scared straight' approaches), and stand-alone mass media campaigns". In contrast, promising prevention programmes include "pre-school family programmes; multi-sectoral programmes with multiple components (including the school and community) and some skills-development-based school programmes". The ACMD found that these effective programmes were not being widely delivered. It recommended that policy makers and commissioners should be realistic about what prevention services can achieve (e.g. seeking reductions in drug use, or delaying its onset, rather than creating complete abstinence). However, even these more limited aims can be highly cost effective by reducing the long-term consequences of problematic substance use.[77]

52. Prevention requires a deeper consideration of the circumstances surrounding a person's drug use, and what might be done to support that person, rather than treating it solely as a clinical issue. Kerrie Hudson, operational lead at addiction recovery support service the Well and a person with a history of problem drug use, told us that when she was first treated for drug addiction as a teenager, this did not happen at all:

> My experience of coming into a service was that I left school a heroin addict; I had my first methadone script at 17 years old but not a single person ever asked me, "What's happened?"[78]

73 Q59, Boris Pomroy
74 Q59, Boris Pomroy
75 Q59, Boris Pomroy
76 Q62, Boris Pomroy
77 ACMD, Prevention of Drug and Alcohol Dependence, 2015
78 Q284

53. This matters at the end of people's recovery journeys as well as at the beginning. Peter Yarwood of Red Rose Recovery described a 'disconnect' between the services and the communities they serve:

> The first thing they want to celebrate is the fact that they are coming down the table in their medication–they are getting off it. When I ask them, "Have you managed to secure decent accommodation yet?", the answer is often, "No, I am still in supported accommodation." When I ask, "Have you secured employment yet?", the answer is, "No, I am not employed. I'm still claiming benefits." Recovery and social capital is in no way aligned to this drive to exit treatment. Where it has worked well, some of the resources have been ploughed into bringing the service users and the community with us on this journey.[79]

54. Tim Millar, Professor of Substance Use and Addictions, University of Manchester, echoed the importance of looking at the wider circumstances of a person's life to help them with recovery:

> If you have been using heroin for 30 years and have, at best, a patchy employment record and probably quite a substantial criminal record, it is difficult to reintegrate yourself. If we can support people to get jobs, friends and houses … that is highly likely to be productive.[80]

55. We also heard from witnesses about the links between trauma and addiction. Addiction explain these in their written evidence:

> People with multiple adverse childhood experiences (ACE) are more likely to develop substance issues, in part to manage the overwhelming emotional and somatic sensations associated with trauma. Children who experience four or more adversities are eleven times more likely to go on to use crack cocaine or heroin. The chances of developing a dependence on substances double if a child has also experienced sexual abuse or other forms of violence.[81]

56. In Portugal we visited an outreach project focused first and foremost on giving drug users their own homes–the Portuguese experience is that once they are well-housed, people are far more able to take steps to recover from drug addiction and then towards other goals such as employment.

57. **The first priority in developing a comprehensive response to drugs must be to improve existing drug treatment services, and extend and develop harm reduction initiatives. The Government needs to develop and fund a comprehensive package of education, prevention and support measures focused on prevention of drug use amongst young people. A comprehensive response should also include a focus on improving the life chances of people who are recovering from drug use. To do this, the Government should actively consider the re-establishment of a central drugs policy agency, drawing on lessons from both the Drug Treatment Agency and the Portuguese experience of SICAD (the central Directorate-General for Intervention on Addictive Behaviours**

79 Q174
80 Q45
81 Addaction (DRP0034)

and Dependencies). As well as funding and directing drug treatment services, it could play an important role in co-ordinating the multiple strands of drug policy, including policing, social care, education, housing and employment, and developing a truly joined-up, cross Governmental approach to drugs.

Reframing the approach to drugs policy

58. The first steps in developing a comprehensive approach to drugs must be to improve the funding, quality and availability of drug treatment and harm reduction services to save the lives of vulnerable people addicted to drugs, who are dying unnecessarily in unacceptably high numbers. As we stated at the start of this report, every drug death is preventable, and both policy and services should acknowledge that fact.

59. Next, it is essential to make wider improvements in prevention, education and social support. These measures should be strengthened and underpinned by reframing drugs as a health rather than a criminal justice issue. There is strong evidence that this reduces stigma and increases access to treatment and recovery. Moving responsibility for drugs policy from the Home Office to the Department of Health and Social Care is supported by the evidence, including from police representatives. International evidence has shown harm reduction approaches not only save lives but reduce the cost and burden on criminal justice systems.[82]

60. In some parts of England, the police have already begun to take steps towards reframing drugs as a health rather than a criminal justice matter. DS Woijeck Spyt explained the reasons for this:

> Irrespective of your views on how effective prohibition is, prohibition has failed for the people the police come into contact with. The deterrent effect has not worked, otherwise those people would not be in possession of drugs. For the people with drugs that we come across, we need an alternative policy or an alternative strategy to address their drug use. The police are not medical professionals, so we are not equipped to deal with that drug use.[83]

61. Under the Durham Checkpoint scheme, first introduced in 2015, people caught in possession of drugs or involved in low level drug dealing are offered a 'suspended prosecution', giving them the opportunity to address the underlying causes of their drug use by encouraging them to engage with services designed to address their problems instead of receiving a caution or going to court. Early indications from an evaluation currently under way are that it reduces reoffending rates.[84] Under Thames Valley Police's approach, individuals found in possession of drugs are offered a 'community resolution outcome', which includes referral to, attendance, and engagement with a drug service provider. Drawing on the small pilot, projected savings to Thames Valley Police over

82 The Lancet Commission on Public health and international drug policy, the Lancet, March 2016; Caitlin Hughes and Alex Stevens, What can we learn from the Portuguese decriminalisation of illicit drugs, British Journal of Criminology, July 2010; David Wilson et al, The cost effectiveness of harm reduction, International Journal of Drug Policy, February 2015; Ricardo Goncalves, A social cost perspective in the wake of the Portuguese strategy for the fight against drugs, International Journal of Drug Policy, February 2015

83 Q235

84 Mr Ron Hogg (DRP0027) written evidence; Hardyal Dhindsa, Q266

a year are nearly £27,000. 42% of people referred completed their treatment (an initial assessment and three follow up sessions) but this rose to 78% of children and young people referred under the scheme.[85]

62. Hardyal Dhindsa of the National Association of Police and Crime Commissioners felt that the only disadvantage of these schemes was that they were not yet more widely available:

> Diversion schemes can help reduce harm because you get people into treatment and recovery, as opposed to the criminal justice route … The problem from a police and crime commissioner strategic perspective is that it is ad hoc. In some places it is happening and in others it is not. We need a mechanism by which we understand the good practice and the evidence, and have a framework that enables it to be done consistently right across the country.[86]

Case example 2 - decriminalisation of possession in Portugal

In Portugal, possession of small amounts of illicit drugs for personal use has been reclassified as an 'administrative' rather than a criminal offence, and offenders are dealt with by statutory bodies called Dissuasion Commissions rather than the police or courts. These statutory administrative bodies, which are found in every region of Portugal, have powers to offer advice, refer for treatment, or refer to courts where necessary. Drugs are still illegal, and supplying and trafficking drugs is still illegal–we were told by the Vice-President of a Dissuasion Commission that the changes have not made it any easier to obtain drugs. We were also told that, as a result of the establishment of this system, resources have shifted from the criminal justice system to the health system. The number of people arrested for drug-related offences more than halved between 2000 - 2012.

Since 2002, Portugal's drug death rates and HIV rates have fallen dramatically. While there were fears of 'drug tourism', this has not materialised, and drug use rates have remained stable. Academics and drug service workers we spoke to felt that the stigma attached to drug use had fallen, and that treatment was able to be provided in a more holistic, non-judgemental way. All those we met in Portugal involved in this policy area were very positive about their model. On introduction, there had been significant opposition, but there is now political consensus and nobody would want to go back. Some of those we met were now of the view that the next step should be legalisation and regulation, to enable the generation of taxation revenue and quality control.

However, we heard repeatedly that decriminalisation alone has not been responsible for these positive outcomes and that legal reforms cannot be considered in isolation from the wider, holistic package of measures that was introduced at the same time, including sustained investment in treatment service–without this wider package the outcome would have been totally different.

85 Thames Valley Police (DRP0073) written evidence
86 Q254

Decriminalisation was in fact only one of 80 recommendations made by the Portuguese Commission on Drugs in 2002. Interestingly, the Commission also recommended DCRs and take-home naloxone provision, but these recommendations were highly controversial and were not implemented, although Lisbon has recently established a mobile DCR.

We heard that Portugal is still facing challenges, many of which are linked to under-funding. These included a lack of access to drug treatment and psychological support in areas–some people we met reported that users could have to wait up to 2–3 months for treatment in some cases; prolonged dependence on methadone, in some cases over 20 years; and persistent problems in prisons.

63. Release, an organisation that provides information and advice on drug use and to drug law and campaigns on these issues, argued that the current illegal status of drugs prevents people from accessing treatment, and that decriminalisation could also play a role in reducing stigma and encouraging more people to seek treatment.[87] Release also pointed out that only one in ten people who use drugs do so problematically,[88] a point also emphasised by Police and Crime Commissioner Ron Hogg.[89] We heard from health professionals that people with entrenched drugs problems often become 'completely inured' to the illegal nature of their behaviour, but that the illegality additionally complicates the lives of already extremely disadvantaged, disfranchised and stigmatised people.[90] Professionals working with young people reported anecdotal evidence that the illegal status of drugs is a barrier to honesty and openness about drugs amongst young people, which can put them in more vulnerable situations.[91] The stigma associated with drug use because of its illegality can also be a block to people living the lives they want to after recovery, and has an impact on the families of those using drugs as well, who often suffer from ostracization and isolation.[92]

64. We did not specifically examine the evidence relating to the legalisation of currently illicit drugs ("legalisation" in this context referring to making currently illicit drugs legal to supply and purchase, and potentially subject to regulation and taxation). However, we did consider approaches that move away from the current criminal-justice led approach to drugs, including diversion schemes, as described above, and decriminalisation - where the possession of small quantities of drugs for personal use is reclassified as an 'administrative' offence rather than a criminal offence.

65. In Portugal we heard that the decriminalisation approach has had an impact on stigma. There has also been, as would be expected, a reduction in arrests for personal possession drug offences, saving resources. Every person arrested for drugs possession now has a full risk assessment carried out, and is provided with advice, education and a treatment referral where necessary. Figures show a dramatic drop in drug related deaths in Portugal in the times since their reforms were implemented, without significant increases in drug use.[93] Research suggests that in the eleven years following introduction of their

87 Q90, Kirstie Douse
88 Q100, Kirstie Douse
89 Mr Ron Hogg (DRP0027)
90 Q70, Mike Flanagan
91 Q71, Boris Pomroy
92 Q88, Karen Biggs; Q287, Emily Giles
93 The Lancet Commission on Public health and international drug policy, the Lancet, March 2016

new strategy, the cost to society of drugs fell by 18%. Whilst the reduction of legal system costs was one of the main explanatory factors, a reduction in health-related costs has also played an important role.[94]

66. However, a message we have heard very clearly and repeatedly, both on our visit to Portugal and from commentators in this country, is that decriminalisation alone was not responsible for these outcomes, and that the a major investment in drug treatment services, together with a wider holistic package of measures including education, community support and Dissuasion Commissions, was needed to achieve this change. Marta Pinto, an academic from the University of Porto whom we met during our visit to Lisbon, was clear in her presentation to us that it would be a mistake to consider the Portuguese legal reforms in isolation from the full holistic model, and that the outcomes in Portugal would have been very different had decriminalisation been introduced without an enhanced treatment offer and other supporting measures.

67. We heard that, from a very low base, it took two years of sustained investment and development to get treatment services to the necessary level. And the services have to be in place to support the increased demand from increased referrals, as the experience of English diversion schemes shows. Dr Wojkek Spyt of Thames Valley Police told us:

> One of the biggest challenges in drugs diversion was to find the funding for the additional people we were referring. The local authority worked hard to alter the [key performance indicators] that had been set in the contract for the drug service provider, to enable them to deal with the additional demand we were sending their way. We are a gateway, so, if that gateway becomes bigger, the services we are referring to need more resources.[95]

68. **Efforts to improve the unacceptably high rates of drug-related deaths would be strengthened by explicitly reframing drug use as a health rather than a criminal justice issue. Much of our evidence recommended that policy responsibility for drugs should move from the Home Office to the Department of Health and Social Care, and we strongly recommend this move. A health focused and harm reduction approach would not only benefit those who are using drugs but reduce harm to and the costs for their wider communities.**

69. **We support consultation on decriminalisation of drug possession for personal use, by changing it from a criminal offence to a civil matter. We recommend that the Government should look closely at how decriminalisation has been underpinned by a strong system of monitoring and referral for those who use illegal drugs through the Dissuasion Committees in Portugal, as well as the experience of police diversion schemes in England. Decriminalisation must only be introduced as one part of a full, comprehensive approach to drugs, the central plank of which is improving treatment and harm reduction services, underpinned by better education, prevention and social support. Any reforms should also be supported by rigorous evaluation which gathers longitudinal data on defined outcome measures.**

94 Ricardo Goncalves, A social cost perspective in the wake of the Portuguese strategy for the fight against drugs, International Journal of Drug Policy, February 2015

95 Q274

Conclusions and recommendations

The scale of the problem

1. There is a clear need for evidence-led policy on drugs. We urge the Government and other policy makers not to shy away from the lessons from Portugal and Frankfurt, but to take a harm reduction approach and implement the recommendations set out in this report without delay. (Paragraph 10)

Putting health first

2. Holistic, non-judgemental harm reduction approaches are needed which facilitate access to services. Following budget cuts of nearly 30% over the past three years, the Government must now direct significant investment into drug treatment services as a matter of urgency. This investment should be accompanied by centrally co-ordinated clinical audit to ensure that guidelines are being followed in the best interests of vulnerable patients. (Paragraph 24)

3. Sufficient funding should be made available to ensure that HAT, Naloxone, and needle and syringe exchanges are accessible to all those who could benefit from them. We also support the introduction of on-site drug checking services at festivals and in night time economies. Drug Consumption Rooms should be introduced on a pilot basis in areas of high need, accompanied by robust evaluation of their outcomes. If changes to current legislation are required to facilitate the piloting of DCRs, they should be made at the earliest opportunity and the Government must set out where the barriers exist to these evidence-based approaches being taken forward. (Paragraph 37)

4. We recommend that the Government conduct a review of the commissioning of drug treatment services to consider how they should be strengthened to enable them to co-ordinate and deliver the much-needed improvements to drug treatment services as effectively as possible. The review should consider whether improvements should be made to the current localised model, or whether, alternatively, a national agency to oversee commissioning should be established, to provide and ensure adherence to a minimum set of national standards. The review should also explicitly consider and address the clear and present crisis in the drug treatment workforce. (Paragraph 48)

A comprehensive response to drugs

5. The first priority in developing a comprehensive response to drugs must be to improve existing drug treatment services, and extend and develop harm reduction initiatives. The Government needs to develop and fund a comprehensive package of education, prevention and support measures focused on prevention of drug use amongst young people. A comprehensive response should also include a focus on improving the life chances of people who are recovering from drug use. To do this, the Government should actively consider the re-establishment of a central drugs policy agency, drawing on lessons from both the Drug Treatment Agency and the Portuguese experience of SICAD (the central Directorate-General for Intervention

on Addictive Behaviours and Dependencies). As well as funding and directing drug treatment services, it could play an important role in co-ordinating the multiple strands of drug policy, including policing, social care, education, housing and employment, and developing a truly joined-up, cross Governmental approach to drugs. (Paragraph 57)

6. Efforts to improve the unacceptably high rates of drug-related deaths would be strengthened by explicitly reframing drug use as a health rather than a criminal justice issue. Much of our evidence recommended that policy responsibility for drugs should move from the Home Office to the Department of Health and Social Care, and we strongly recommend this move. A health focused and harm reduction approach would not only benefit those who are using drugs but reduce harm to and the costs for their wider communities. (Paragraph 68)

7. We support consultation on decriminalisation of drug possession for personal use, by changing it from a criminal offence to a civil matter. We recommend that the Government should look closely at how decriminalisation has been underpinned by a strong system of monitoring and referral for those who use illegal drugs through the Dissuasion Committees in Portugal, as well as the experience of police diversion schemes in England. Decriminalisation must only be introduced as one part of a full, comprehensive approach to drugs, the central plank of which is improving treatment and harm reduction services, underpinned by better education, prevention and social support. Any reforms should also be supported by rigorous evaluation which gathers longitudinal data on defined outcome measures. (Paragraph 69)

Formal minutes

Tuesday 15 October 2019

Members present:

Dr Sarah Wollaston, in the Chair

Luciana Berger	Anne Marie Morris
Mr Ben Bradshaw	Andrew Selous
Angela Crawley	Dr Paul Williams

Draft Report (*Drugs policy*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 69 read and agreed to.

Summary agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 22 October at 2pm.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 7 May 2019

Mark Johnson, Chief Executive Officer, User Voice, **Professor Susanne MacGregor**, Honorary Professor of Social Policy, London School of Hygiene and Tropical Medicine, **Professor Tim Millar**, Professor of Substance Use and Addictions, University of Manchester — Q1–55

Karen Biggs, Chair, Collective Voice, **Boris Pomroy**, Chief Executive, Mentor, **Professor Harry Sumnall**, Professor in Substance Use, Liverpool John Moores University, **Mike Flanagan**, Consultant Nurse and Clinical Lead, Drug and Alcohol Services, Surrey and Borders Partnership NHS Foundation Trust — Q56–88

Kirstie Douse, Head of Legal Services, Release, **Adrian Crossley**, Head of Addiction, Centre for Social Justice — Q89–116

Tuesday 11 June 2019

Josie Smith, Head of Substance Misuse Programme, Public Health Wales, **Yusef Azad**, Director of Strategy, National AIDS Trust, **Matthew Hickman**, Professor in Public Health and Epidemiology, University of Bristol — Q117–170

Dr Arun Dhandayudham, Joint CEO and Medical Director, Westminster Drugs Project, **Danny Hames**, Chair, NHS Substance Misuse Providers Alliance, **Peter Yarwood**, Chief Executive Officer, Red Rose Recovery & Lancashire User Forum, **Professor Sir John Strang**, Head of the Addictions Department, Kings College London — Q171–223

Tuesday 2 July 2019

Jason Harwin, Deputy Chief Constable, National Police Chief Council, **Dr Wojciech Spyt**, Detective Sergeant, Thames Valley Police, **Hardyal Dhindsa**, Association of Police and Crime Commissioners, **Stephanie Kilili**, Policy Advisor, Office of the Durham Police, Crime and Victims' Commissioner — Q223–282

Mark Johnson, Chief Executive Officer, User Voice, **Emily Giles**, Policy and Communications Coordinator, ADFAM, **Kerrie Hudson**, Operational Lead, The Well — Q283–324

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

DRP numbers are generated by the evidence processing system and so may not be complete.

1 Addaction (DRP0034)

2 Agenda (DRP0036)

3 Association of Directors of Public Health (DRP0057)

4 British Medical Association (BMA) (DRP0035)

5 British Psychological Society (DRP0060)

6 Build on Belief (DRP0022)

7 Camurus (DRP0063)

8 Cannabis Skunk Sense (DRP0013)

9 Centre for History in Public Health LSHTM (DRP0015)

10 The Centre for Social Justice (DRP0067)

11 Change Grow Live (DRP0040)

12 Collaborate Centre for Inclusion Health (UCL) and Find & Treat (University College London Hospitals NHS Foundation Trust) (DRP0048)

13 Collective Voice (DRP0046)

14 Department of Health and Social Care (DRP0065)

15 Dhadley, Mr Sunny (DRP0014)

16 Drug Equality Alliance (DRP0026)

17 Drugs, Alcohol & Justice Cross-Party Parliamentary Group (DRP0050)

18 DrugScience (DRP0056)

19 East Riding of Yorkshire Council (DRP0011)

20 Expert Faculty on Commissioning (DRP0023)

21 Farmer, Connor (DRP0024)

22 FORWARD TRUST (DRP0021)

23 Frary, Ms Kavita (DRP0058)

24 Gleeson, B.A. Lic. T.C.M. Frank (DRP0002)

25 Hansom, Mr Steven (DRP0010)

26 Harm Reduction Group (DRP0043)

27 Harm Reduction Group (DRP0072)

28 Harm Reduction Group (DRP0074)

29 Health Poverty Action (DRP0071)

30 The Hepatitis C Trust (DRP0049)

31 HIV Scotland (DRP0055)

32 Hogg, Mr Ron (DRP0027)

33 Horsley, Dr Jason (DRP0025)

34 Humphreys, Esther Ting Memorial Professor Keith (DRP0009)
35 Humphreys, Mrs Hope (DRP0069)
36 The International Drugs Policy Unit, LSE (DRP0059)
37 Kelly, Mr James (DRP0001)
38 Law Enforcement Action Partnership UK (LEAP UK) (DRP0033)
39 LGBT Foundation (DRP0038)
40 Local Government Association (DRP0042)
41 London Friend (DRP0020)
42 MacGregor, Honorary Professor Susanne (DRP0068)
43 MacGregor, Honorary Professor Susanne (DRP0070)
44 MacGregor, Professor Susanne (DRP0019)
45 Marsden, Professor John (DRP0007)
46 May, Dr Tom (DRP0031)
47 Mentor UK (DRP0030)
48 Metrebian, Dr Nicola (DRP0051)
49 NAT (National AIDS Trust) (DRP0044)
50 National Pharmacy Association (DRP0066)
51 NHS Substance Misuse Providers Alliance (DRP0032)
52 North Wales Police and Crime Commissioner (DRP0029)
53 NPCC - National Police Chiefs Council (DRP0041)
54 Office of Police and Crime Commissioner Devon and Cornwall (DRP0061)
55 Public Health England (DRP0062)
56 Release (DRP0045)
57 Royal College of Psychiatrists (DRP0037)
58 Royal Society for Public Health (DRP0052)
59 Simmons, Mr Peter (DRP0005)
60 St Mungo's (DRP0054)
61 Stevenson, Dr Richard (DRP0018)
62 Sumnall, Professor Harry (DRP0016)
63 Thames Valley Police (DRP0073)
64 Transform Drug policy Foundation (DRP0008)
65 Transform Drug Policy Foundation (DRP0047)
66 Twomey, Mr Ben (DRP0064)
67 University of East London (DRP0017)
68 Volteface (DRP0028)
69 West Midlands Police and Crime Commissioner (DRP0012)
70 Westwell, Professor Andrew (DRP0039)
71 Yates, Dr Judith (DRP0053)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353 (Cm 9669)
Third Report	Improving air quality	HC 433 (HC 1149)
Fourth Report	Brexit: medicines,medical devices and substances of human origin	HC 392 (Cm 9620)
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation: First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642 (Cm 9627)
Seventh Report	Integrated care: organisations, partnerships and systems	HC 650 (Cm 9695)
Eighth Report	Childhood obesity: Time for action	HC 882 (CP23)
Ninth Report	Long-term funding of adult social care	HC 768
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Twelfth Report	Prison health	HC 963 (CP 4)
Thirteenth Report	First 1000 days of life	HC 1496 (CP112)
Fourteenth Report	Sexual health	HC 1419
Fifteenth Report	NHS Long-term Plan: legislative proposals	HC 2000
Sixteenth Report	Drugs policy: medicinal cannabis	HC 1821 (CP171)
First Joint Special Report	Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17	HC 451