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Health and Wellbeing Board

Wednesday, 22nd January, 2020
at 5.30 pm

Committee Room 1 - Civic Centre

This meeting is open to the public

Members

Councillor Fielker
Councillor Paffey
Councillor Savage
Councillor Shields
Councillor Taggart

Rob Kurn – Healthwatch
Hilary Brooks – Service Director, Children and Families Services
Stephanie Ramsay – Director of Quality and Integration
Dr J Horsley – Director of Public Health
Dr M Kelsey – Clinical Commissioning Group
Vacancy – NHS England Wessex Local Area Team

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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Responsibilities

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

Smoking policy – The Council operates a no-smoking policy in all civic buildings.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent lives
- Southampton is an attractive modern City, where people are proud to live and work

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take

Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Use of Social Media:- The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.

Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.

Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Dates of Meetings: Municipal Year 2019/20

2019	2020
19 June	22 January

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

RULES OF PROCEDURE
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Board made in accordance with Council Procedure Rule 4.3.

2 STATEMENT FROM THE CHAIR

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 19 June 2019 and to deal with any matters arising.

5 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2018/19

Report of the former Director of Public Health for Portsmouth and Southampton presenting the Director of Public Health's Annual Report 2018/19.

Tuesday, 14 January 2020 Director of Legal and Governance

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 19 JUNE 2019

Present: Councillors Dr Paffey, Savage, Shields (Chair) and Taggart
Hilary Brooks, Harry Dymond, Jason Horsley and Stephanie Ramsey

Apologies: Councillor Fielker, Dr Kelsey and Rob Kurn

1. **ELECTION OF CHAIR**

RESOLVED that Councillor Shields be elected as Chair for the 2019-2020 municipal year

2. **ELECTION OF VICE-CHAIR**

RESOLVED that Dr Kelsey be elected as Vice-Chair for the 2019-2020 municipal year.

3. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Board noted that Harry Dymond from Health Watch was in attendance as a nominated substitute for Rob Kurn.

The apologies of Councillor Fielker, Dr Kelsey and Rob Kurn were noted.

The Board also noted that the Councillors Fielker, Paffey, Savage, Shields and Taggart were appointed as members of the Board at Cabinet on 18 June 2019. NHS England Wessex Local Area Team had not indicated who had been appointed as member to the board for the new municipal year and consideration was given to including someone from the pharmaceutical association on the board.

RESOLVED that the appointment of a member from NHS England Wessex Local Area Team would be made for the next meeting of the board.

4. **STATEMENT FROM THE CHAIR**

The chair noted that the Board had received an invitation to participate in a consultation on plans for the development on Southampton International Airport.

RESOLVED that the representation of the Board at the Southampton International Airport consultation on plans for development, would be agreed by the Chair and Vice Chair.

5. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Shields declared a personal interest in that he was a Council appointed representative of the Clinical Commissioning Group. Councillor Savage declared a personal interest in that his wife worked as a co-ordinator for a counselling service. They remained in the meeting and took part in the consideration and determinations of items on the agenda.

6. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the minutes of the meeting held on 19 December 2018 be approved and signed as a correct record.

7. **SOUTHAMPTON CITY FIVE YEAR HEALTH & CARE STRATEGY**

The Board considered the report of the Director of Quality and Integration detailing the updates to the Southampton City Five Year Health & Care Strategy.

Clare Young - Programme Management Office Manager, NHS Southampton Clinical Commissioning Group; Dan King - Service Lead Intelligence & Strategic Analysis, Southampton City Council; Felicity Ridgeway - Service Lead Policy, Partnerships and Strategic Planning, Southampton City Council; Richard Crouch - Chief Operations Officer (Customer Experience), Southampton City Council and Dave Stewart, Leader and Cabinet Member for Strategic Partnerships, Isle of Wight Council, were present and with the consent of the chair addressed the Board.

The Board noted that the strategy:

- was a draft and remained a work in progress
- looked at how indicators of deprivation had affected health and outcomes in the city, such as impact on life expectancy, respiratory health, diabetes, mental health, depression, breastfeeding, smoking during pregnancy, smoking inactivity, looked after children, unemployment, crime
- looked at how indicators of deprivation had affected health care usage
- identified that the main causes of death were cancer, circulatory disease and respiratory disease
- considered the population forecast, long term conditions forecasting and adult social care forecasting
- had been developed in partnership with NHS Southampton Clinical Commissioning Group, Southampton City Council, health and care service providers and the voluntary sector
- had a strategic framework with four main programmes of work – start well, live well, age well and die well
- Better Care Southampton would be the governance group of the strategy
- was a strategy for the city that was aligned with the Council's Health and Wellbeing Strategy

The Board also noted that there had been reasonable involvement of the public within specific groups and that there would be wider consultation with service users.

RESOLVED that the board members would provide feedback on the draft Southampton City Five Year Health and Care Strategy and their comments would be sent directly to Claire Young – Programme Management Office Manager, NHS Southampton Clinical Commissioning Group.

8. **BETTER CARE END OF YEAR REPORT**

The Board received the report of the Director of Quality and Integration that provided an overview of performance in 2018/19 against Southampton's Better Care programme and pooled fund, including the improved Better Care Fund (iBCF), and highlighted priorities for 2019/20.

Donna Chapman - NHS Southampton Clinical Commissioning Group; Felicity Ridgeway - Service Lead Policy, Partnerships and Strategic Planning, Southampton City Council; and Dave Stewart, Leader and Cabinet Member for Strategic Partnerships, Isle of Wight Council, were present and with the consent of the chair addressed the Board.

The Board particularly noted that:

- the Better Care programme had brought together physical and mental health services, statutory and non-statutory organisations, a strength based approach and a local place based approach
- the Better Care programme included a set of measures so that it could be seen where developments had been effective
- the clinical model was working well, the contractual model needed to catch up
- the pilots had been very successful and achieved great results and the board hoped they could be replicated in a wider area

9. **JOINT STRATEGIC NEEDS ASSESSMENT UPDATE**

The Board received the Report of Director of Public Health that provided an update on the Southampton Joint Strategic Needs Assessment and the Health and Wellbeing Strategy Scorecard.

Southampton City Council officers, Dan King, Service Lead - Intelligence & Strategic Analysis, Intelligence, Insight & Communications and Felicity Ridgeway - Service Lead Policy, Partnerships and Strategic Planning, were present and with the consent of the chair addressed the Board.

The Board noted that the Joint Strategic Needs Assessment had been incorporated into a new Single Needs Assessment with all content available as an online resource.

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		Director of Public Health Annual Report		
DATE OF DECISION:		22 January 2020		
REPORT OF:		Former Director of Public Health for Portsmouth and Southampton		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dr Jason Horsley**	Tel:	023 8083 3310
	E-mail:	strategy.unit@southampton.gov.uk		
Director	**Name:**	**Debbie Chase** **Director of Public Health**	Tel:	023 8083 3694
	E-mail:	debbie.chase@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY		
N/A		
BRIEF SUMMARY		
The Southampton Director of Public Health Annual Report 2018/19 is titled “Tip of the Iceberg: Harm related to illicit drugs”. The report focusses on drugs that are used illegally and the harms they cause.		
This report is an independent review written by Dr Jason Horsley, the Joint Director of Public Health for Southampton and Portsmouth at the time of writing the report. The report reflects the opinions of Dr Horsley in his position as Joint Director for Public Health, unless quoted as otherwise.		
This was the second Annual Report written jointly for both Southampton and Portsmouth, since the introduction of a Joint Director in 2016. The recommendations in the report are therefore applicable to both cities.		
RECOMMENDATIONS:		
	(i)	That the Health and Wellbeing Board note the contents of the report and consider the recommendations.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Director of Public Health has a duty to prepare an annual report on the health of the people of Southampton, and the council has a duty to publish his report under section 73B(5) & (6) of the National Health Service Act 2006, inserted by section 31 of the Health and Social Care Act 2012).	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None	
DETAIL (Including consultation carried out)		
3.	The Director of Public Health Annual Report 2018/19, “Tip of the Iceberg: Harm related to illicit drugs”, focusses on drugs that are used illegally and the harms they cause. It does not discuss the harms caused by legal drugs, such as alcohol and tobacco, or prescription drugs that are being abused by the people they were prescribed for. Different drugs have very different effects,	

	are associated with very different levels of risk, and are used in different situations by different groups of people. Most people who use drugs will do so infrequently and not develop a serious drug habit. However, some people do develop a drug use disorder, which can come with serious health and social consequences.
4.	The Director of Public Health elected to explore the topic of drug related harm specifically in 2018/19 due to levels of drug related problems observed in both cities. Portsmouth and Southampton are both relatively deprived – in the 4th most deprived decile of local authorities and both have pockets with much higher levels of deprivation. In Portsmouth for example, 13% of small areas are in the most deprived 10% of small areas in England. Looking within the cities there is evidence for the association between deprivation and problematic drug use as significantly more people who are admitted to hospital with problems related to drug use live in more deprived areas.
5.	The illicit and secretive nature of drug use means it is difficult to make any firm conclusions on how it is changing. There may be many more people using drugs than we know about who are not admitting use; it is possible that the drug use we are aware of is the tip of the iceberg.
6.	The report explores patterns of drug use, factors which contribute to problematic drug use, the provenance of drug use, health and wider harms, the debate around illegality and alternatives to current drugs policy, what we are currently doing to address drug harm and recommendations for what could be done differently.
RESOURCE IMPLICATIONS	
Capital/Revenue	
7.	None
Property/Other	
8.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
9.	The Director of Public Health has a duty to prepare an annual report on the health of the people in the area of the local authority, and the local authority has a duty to publish the report under section 73B(5) & (6) of the National Health Service Act 2006 , inserted by section 31 of the Health and Social Care Act 2012. The content and structure of the report is decided locally.
Other Legal Implications:	
10.	This is a completely independent report and opinions within it only represent those of the former Director of Public Health for Portsmouth and Southampton unless quoted as otherwise.
RISK MANAGEMENT IMPLICATIONS	
11.	Any recommendations adopted by the Health and Wellbeing Board, Council or other bodies should be considered in a risk management context and steps to respond to recommendations will be reviewed within that organisation's risk management framework.
POLICY FRAMEWORK IMPLICATIONS	

12.	The recommendations in this report should be considered in the context of the Southampton Joint Health and Wellbeing Strategy 2017-2025.

KEY DECISION?	**No**	
WARDS/COMMUNITIES AFFECTED:		
SUPPORTING DOCUMENTATION		
Appendices		
1.	Director of Public Health Annual Report 2018/19: "Tip of the Iceberg: Harm related to illicit drugs".	
Note: the appended version of the report is in draft format. A final version of the report will be published at https://data.southampton.gov.uk/ in due course.		

Documents In Members' Rooms

1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**No**
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.		
2.		

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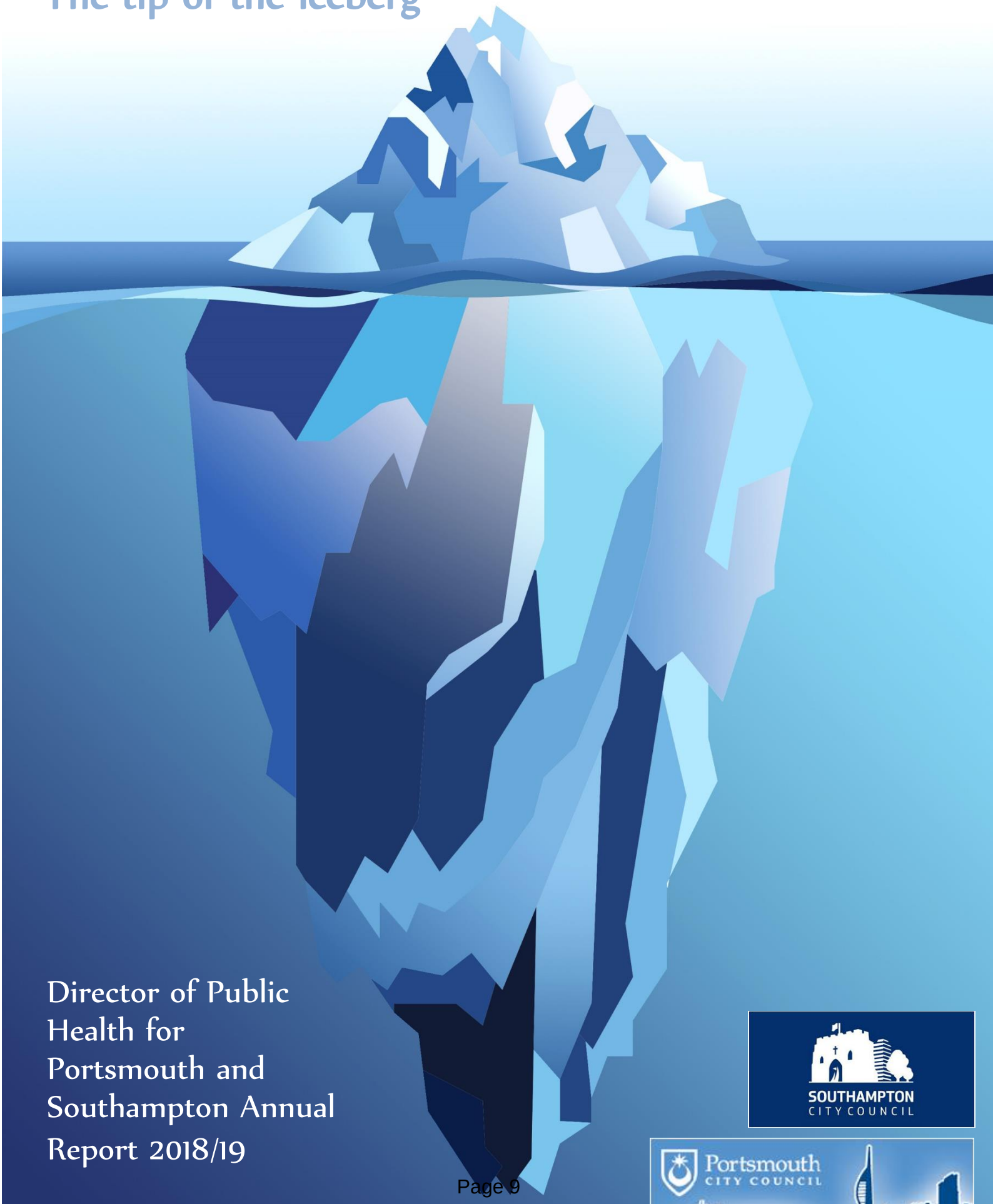
Harm related to illicit drugs

The tip of the iceberg



Director of Public Health for Portsmouth and Southampton Annual Report 2018/19

SOUTHAMPTON CITY COUNCIL

Portsmouth CITY COUNCIL

Thanks to Adam Holland for his work on the report with:

James Hawkins	Colin McAllister	Charlotte Matthews
Vicky Toomey	Claire Currie	Rob Anderson-Weaver
Alan Knobel	Lisa Wills	Mark Sage

Thank you to the following who provided data, information or photos:

Paul Barton	Chantelle Knight	Prun Bijral
Christopher Fox	Sam Graves	Danny Sullivan
Mike Taylor	Emma Richards	Duncan Fortescue-Webb
Nina Driscoll	Cathy Price	Richard Povey
Michael Ellis	Gail Lennan	Aoife Fortescue-Webb
Danny Sullivan	Alison Jeffery	James Clay

Front cover illustration by Christopher Sutherland

Contents

Director's Introduction

Introduction from Jason Horsley to be included here.

Executive Summary

Chapter 1 - Patterns of drug use

- This report focusses on drugs that are used illegally and the harms they cause. It does not discuss the harms caused by legal drugs, such as alcohol and tobacco, or prescription drugs that are being abused by the people they were prescribed for.
- There are many illegal drugs that have very different effects and levels of risk associated with them.
- Most people who use illegal drugs do so infrequently and will not develop a problematic drug habit.

Chapter 2 - Factors that lead people to use drugs problematically

- People who use drugs problematically often also suffer with mental health problems, have experienced adverse childhood experiences and come from deprived backgrounds. These four issues often exist together creating a complex set of health and social care needs.
- In the case of mental health problems, the cause of the association is often unclear. In some cases, people with pre-existing mental health problems could be self-medicating with drugs. In others, drugs may be causing or exacerbating the mental health problems. And in others the person may have predisposing factors, which make them more likely to develop both mental health problems and a problematic drug habit. Mental health services locally and nationally are under significant strain.
- Adverse childhood experiences are episodes of direct abuse or other problems in the environment that somebody grew up in, which are associated with a host of poor health and social outcomes in later life, including a greater likelihood of developing a drug use disorder. Universal and targeted services which support families play a vital role in preventing these experiences from occurring and dealing with them when they do.
- Nationally and locally there is a clear association between deprivation and problematic drug use. It is not clear why this is the case, but the psychology of scarcity may play a role. When somebody is using all of their focus to think about how they can afford to pay their rent or pay for their next meal they have less brain space to think about longer term decisions and living healthily. Some research also shows an association between inequality and problematic drug use, suggesting that the state of society more broadly may play a role.
- The introduction of Universal Credit has made the lives of some vulnerable people in the UK more difficult. Central and local government have work to do in order to mitigate the negative effects of the change to the benefits system.
- The association between deprivation and problematic drug use is seen most obviously amongst people who are homeless. Homelessness in the UK is increasing. The Homelessness Reduction Act has been introduced to combat this trend, but most importantly more housing is needed - particularly social housing.
- A drug use disorder is not the diagnosis, it is a symptom of other problems.

Chapter 3 - Prevalence of drug use

- Because of the illicit nature of drug use, it is difficult to know how many people are using drugs.
- According to the Crime Survey for England and Wales, in 2017/18 one in eleven adults aged 16 to 59 and one in five adults aged 16 to 24 had taken an illegal drug in the last 12 months. Generally, the survey shows that drug use has decreased over the last two decades, but in recent years the amount of 16-24 year olds reporting drug use has increased.
- Data on the amount of drug use locally is not available. Extrapolating from the national data, we can estimate that there are 26,900 16-59 year olds in Portsmouth and Southampton who used an illegal drug in the last year. This is a very rough estimate as drug use is not uniform across the country.
- People who use crack cocaine or opiates are unlikely to respond to surveys as the use of these drugs is often associated with more chaotic lifestyles. In the case of these drugs, the number of people using them is estimated based on data from services including drug treatment providers and the police. These estimates suggest that the number of people using crack cocaine and opiates are increasing nationally, but locally numbers are more or less stable. As these estimates are based on the number of people who have been in contact with services, we cannot be sure that the number of people who have never been in contact with services is not increasing.
- Nationally, the number of people in specialist drug treatment has decreased over the last five years. Locally we have seen a similar picture, however numbers have increased in 2018/19 bucking the national trend (this data will be published later this year). Nonetheless, numbers are still lower than they were five years ago. This decrease is disproportionate with our best estimates of the number of people using drugs problematically, suggesting that there is an increasing number of people using drugs problematically who are not in contact with specialist services.

Chapter 4 - The health harms from drugs

- The use of different illicit drugs comes with very different levels of risk.
- Heroin and other opiates are responsible for by far the greatest proportion of drug related deaths locally, nationally and internationally.
- The UK national drug related death rate is amongst the highest in Europe, with about one third of all the drug related deaths that occurred in Europe in 2017 occurring in the UK. In 2018, England and Wales saw the highest number (4,359) and greatest annual increase (16% more than in 2017) of deaths from drug poisoning on record.
- Portsmouth and Southampton have drug related death rates that are higher than the English average and amongst the highest in the South East. The local rates have increased over the last decade but improved slightly in the last couple of years.
- There are many factors that may be contributing to the drug related death rate being so high in the UK. These include increasing drug purity, people who are using drugs getting older, and increasing budget pressures for drug treatment and other services. The substance misuse budget in Southampton has remained roughly the same since 2013 but in Portsmouth it has decreased by 38%.

Chapter 5 - The wider harms from drugs

- There are many indirect harms from drug use that can affect the person using drugs, their friends and family and wider society.
- People using drugs may be indirectly harmed by their drug use if they for example, get a criminal record, or if it effects their personal or professional relationships.
- The families and friends of people who use drugs may be indirectly harmed by their drug use if it for example, leads to them falling into debt or if children suffer adverse childhood experiences as a result of their parents' drug use.
- Wider society is harmed through being the victims of crime related to drugs (typically theft to fund an addiction), or through criminal networks being funded through income from drugs.
- The ability to effectively police crime is harmed by the war on drugs:
    - Criminals are encouraged to be increasingly violent to reduce the risk of communities cooperating with the police.
    - Communities trust the police less because interventions like stop and search, which are needed to prevent weapon carriage, are likely to detect drug carriage which the community may consider a lesser threat.
- In 2014, the National Treatment Agency estimated that illegal drug use costs UK society £15.4 billion each year – this includes the cost of drug related crime and costs to services such as the NHS, police and courts.
- County lines dealing, where inner-city gangs deal drugs in other cities and rural areas is being recognised as more of an issue as the UK drug market evolves. It is associated with the exploitation and abuse of vulnerable people who are used in drug trafficking networks, including children, people with learning difficulties and people who are dependent on drugs.
- It is estimated that the global illicit drug market is worth $652 billion – this is more than the gross domestic product of all but the 20 richest countries.

Chapter 6 - Why are some drugs illegal?

- Drug use has not always been considered an issue of criminal justice. Drug policy in the UK and internationally has been strongly influenced by USA foreign policy and the 'War on Drugs' waged by presidents Nixon and Reagan, which was arguably fuelled more by political motivations than evidence it would work.
- The level of harm caused by different drugs does not correlate with their legal status.
- There is not clear evidence that the illegality of drugs decreases demand for them. Amongst European Union countries, there is not an obvious relationship between more punitive drug policies and lower drug use. And countries who have decriminalised drugs have not seen skyrocketing drug use as some predicted. A recent international study found that adolescent males in countries with prohibition were actually more likely to have tried cannabis than in countries with more liberal drug laws, perhaps because of a desire to rebel against authority.
- There is not clear evidence that the law stops the supply of drugs. The sale of illicit drugs provides a massive profit margin that can easily absorb the cost of drugs that are seized by authorities. The profits involved incentivise corruption and innovation, which has led to the emergence of county lines dealing and drugs being sold on the dark web. If the war on drugs had been successful, the price of illicit drugs would have increased, making them unaffordable – this has not happened, and some drugs are actually getting cheaper.
- There is not clear evidence that the law helps people who are using drugs. Contact with the criminal justice system is associated with a host of poor outcomes, and even in prison more than

a quarter of inmates report using drugs. Punitive drug policy can encourage riskier behaviours as people using drugs try to avoid detection and do not seek help when they need it. Strikingly nearly all European Union countries where it is not possible to be imprisoned for the possession of drugs have drug related death rates that are below the European average.

Chapter 7 – What are the alternatives to current drugs policy?

- Many countries have some element of decriminalisation, so that possession of drugs for personal use is not considered an issue of criminal justice.
- Notably, Portugal decriminalised the possession of drugs for personal use in 2001. Since then surveys suggest that the recent use of cocaine, amphetamines and ecstasy has decreased. Cannabis use has increased but this is in line with neighbouring countries. According to the best available data, drug related deaths have decreased notably but it is difficult to say for sure as the way that they are recorded has changed. The drug related death rate in the UK is about 17 times higher than that in Portugal, however drug related deaths are not recorded in the same way in both countries and numbers are not directly comparable. HIV infection rates in Portugal have also decreased significantly.
- Decriminalisation is less likely to address the harms caused by the criminal organisations who sell drugs and the illicit nature of the drug market. An alternative to decriminalisation would be to regulate drugs, with the government overseeing their production and distribution. This would allow control to be exerted over their strength, constituents, the mandatory harm reduction advice that would need to be provided at point of sale and their price with taxes being raised from the market to invest back into society. Inevitably, a black market would still exist alongside a regulated market, but any proportion of the market that could be wrestled from criminals could decrease their profits and any associated criminality. The influence of businesses that might profit from the sale of drugs would need to be strictly limited with regulations around advertising, packaging and the way that drugs would be distributed as is the case with cigarettes.
- The Psychoactive Substances Act 2016 made the sale of novel psychoactive substances such as spice illegal. Initially, following its introduction there was a reduction in the number of deaths related to novel psychoactive substances. However, their use became concentrated amongst more vulnerable groups, such as people who are homeless and prisoners and in 2018 there was the highest number of deaths related to novel psychoactive substances on record – even higher than before the introduction of the Psychoactive Substances Act 2016. This highlights that increasingly strict prohibition is not effective in reducing drug related harm.

Chapter 8 - What we are doing to reduce drug related harm and what more can we do?

- Reducing the use of drugs, particularly those that are more dangerous such as heroin and cocaine is an important aim for a drug strategy, but some level of drug use is inevitable in society without a level of authoritarian control that is incompatible with basic British values. Accordingly, approaches to reduce the risk people expose themselves to when they use drugs and to support people who are dependent on drugs or in recovery are also vitally important. Although harm reduction measures are mentioned, these could be significantly strengthened in the UK Home Office drug strategy. Given the harm and costs accruing to health, it would be prudent for The Department of Health to have ownership of future drug strategies. The Home Office would still have a supporting role to play in relation to combating the illegal drug market.
- Important measures locally that aim to reduce problematic drug use and mitigate the factors that make it more likely include:
    - PSHE in schools
    - Services that work with families and children to prevent adverse childhood experiences
    - Young peoples' substance misuse champions
    - The benefits system
- More work is needed by central government to ensure that the funding for services that support families and young people is strengthened and to address the problems that have become apparent with Universal Credit. Additionally, an evidence based national PSHE curriculum would be helpful. In the interim the onus is falling on local authorities to address these issues with the limited resources they have available.
- Important harm reduction measures locally include needle syringe programmes and take-home naloxone services, but more work needs to be done to evaluate their coverage. In other countries, drug consumption rooms exist where people can use drugs in a safe environment and access health and social support services. There is promising evidence in their favour but in the UK the Home Office has stated that drug consumption rooms cannot function under existing legislation. In terms of club drugs, in other areas there are drug checking and harm reduction outreach services. Although historically there were local outreach services, these have been reduced significantly and work is needed to address this gap.
- Structured treatment for people using opiates has been shown to be beneficial for those in treatment, and wider society. Locally, and nationally, the proportion of people using opiates who are not in treatment is increasing and work needs to be done to reverse this trend. There are promising interventions being used elsewhere in the country we could consider locally, particularly heroin assisted therapy, and also contingency management. Other services are under strain, including mental health services and the NHS so opportunities to help people using drugs problematically may be being missed. Neither city has a dedicated hospital liaison service for drugs other than alcohol, and work is needed to assess what the demand for this would be.

Chapter 9 - Conclusion - who needs to do what?

- Enforcing current drug policy is expensive and is likely exacerbating and causing more harm than it is preventing. Decriminalising or regulating drugs will not entirely stop drug related harm, but it is likely to help, and in the first instance it makes sense to stop spending money and energy on efforts that are hampering progress.
- The key recommendations from the report follow – see the full version of the report for more details and rationale.

Central government should:

- Decriminalise the possession of drugs and investigate models of drug regulation.
- Ensure that the Department for Health oversees future drug strategies, which should have harm reduction as a key tenet.
- Monitor the impact of the Homelessness Reduction Act, while pursuing further efforts to reduce homelessness, particularly by ensuring that more affordable and social housing is built.
- Strengthen the progressive taxation system to reduce deprivation and inequality and provide funding for important services.
- Address the problems with Universal Credit.
- Provide adequate funding for local authority Public Health teams in order for them to be able to adequately fund drug treatment services and other interventions to reduce drug related harm.
- Mandate the provision of comprehensive drug treatment services.
- Look into providing central funding for evidence based treatments that are currently under-utilised.
- Clarify the law to allow drug consumption rooms to be established, and in the meantime allow local services to negotiate working agreements to allow them to function.
- Grant licenses and provide funding for publicly accessible drug checking services, and remove the obstacles preventing drug checking at festivals.
- Ensure adequate funding is available for early help and social care services.
- Ensure adequate funding is available for mental health services.
- Commission the development of an evidence based national PSHE curriculum.

Local authorities should:

- Continue to ensure they have strategic oversight of local efforts to reduce drug related harm.
- Lobby central government to decriminalise the possession of drugs, investigate models of drug regulation, and provide adequate funding for important local services.
- Do their best to adequately resource drug treatment services.
- Assess the demand for hospital liaison and drug outreach services.
- Assess the local demand for drug consumption rooms and consider their introduction when the law allows.
- Assess the demand for drug checking services and consider their introduction.
- Ensure safety advisory groups are not providing an obstacle to the provision of harm reduction measures at music events, and instead promote their adoption when drug use is likely at an event.
- Do their best to mitigate the negative impacts of the introduction of Universal Credit.

Police and Crime Commissioners should:

- Provide funding for measures promoting harm reduction and recovery, with longer term outcomes in mind.

Drug treatment services should:

- Continue to monitor changes in local drug trends and work with local authorities to ensure local services are responding to evolving needs.

Police and courts should:

- As far as possible utilise community resolution outcomes in cases of drug possession.

Mental health services should:

- Continue working to establish the best way to treat people with a dual diagnosis of mental health and substance misuse issues and to break down the barriers stopping people from accessing treatment.

Medical practitioners should:

- Continue their hard work promoting healthy behaviours and harm reduction; treating medical and mental health problems related to drug use and advocating for evidence based drug policy.
- Be familiar with the NEPTUNE Guidelines for managing medical issues related to drug use.

Colleges and Universities should:

- Ensure they are promoting harm reduction messaging - not just messages focusing on abstinence, which may be less effective for some groups.
- Consider more intensive harm reduction education when issues with drug use have been identified, for example open access anonymous harm reduction workshops.

Schools should:

- Adopt evidence based PSHE programmes.
- Ensure that they do not utilise unregulated external organisations to provide PSHE lessons that are not endorsed by the PSHE association or the local authority.

Festivals and night life venues should:

- Ensure staff members are trained in drug awareness and know what to do in a drug related emergency. Staff should be aware of and have access to guidelines on when to call an ambulance – see the full version of the report for a link to these guidelines.
- At larger events, ensure the adequate provision of welfare, outreach and drug checking services and the widespread promotion of harm reduction advice.
- Be aware of the potential unintended negative consequences of supply reduction measures and utilise them with care.
- Be familiar with the further guidance available – *Safer Dancing* and *Safer Nightlife*, which are referenced in the main report.

People who are using or thinking about using drugs should:

- Know that **taking drugs is never safe and the best thing you can do is not take them**. If you are still going to take drugs you should:
- Do your research.
    - Follow the harm reduction advice that organisations such as the Loop provide.
    - Find out about the drug you are thinking of taking and decide whether the risks are worth it.
    - Be aware that not much research has been done on drugs, so sometimes information online may not be based on good evidence.
- Make sure your drug taking doesn't harm other people. Don't take drugs in front of your children; don't take them if you're pregnant, if you have to steal to afford them or if you're driving; if you find you are more likely to engage in violent or criminal behaviour when you take drugs then you need to get help.
- Seek help if your drug use is causing problems. You can speak to your GP or contact local services – the contact details for Portsmouth and Southampton services are available in the full version of the report. If you are acutely unwell, you should always go to A&E.

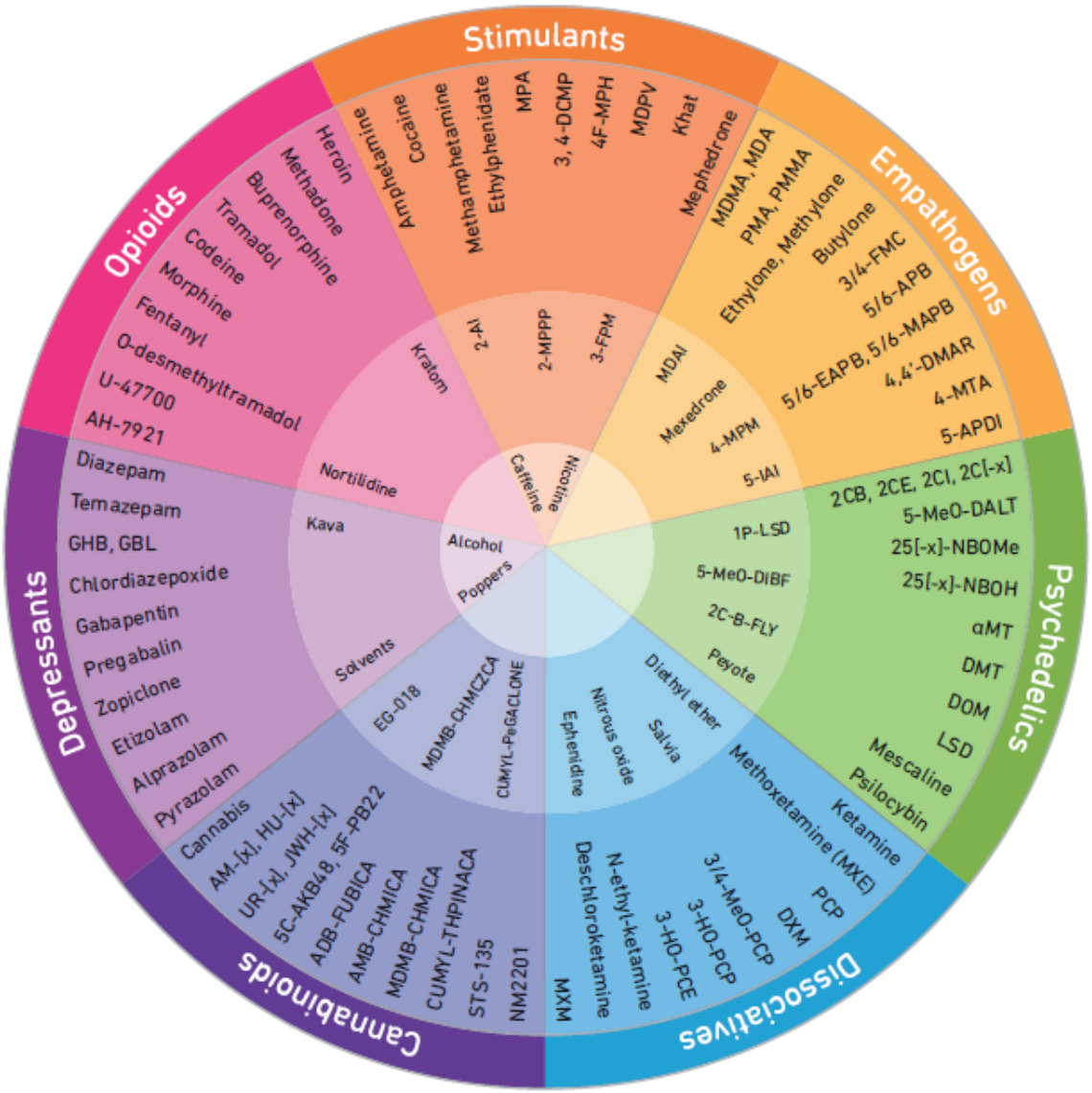
We know what we are doing isn't working.

It's time for a different approach.

Chapter 1 - Patterns of drug use

Different people use the term 'drug' to mean different things. For the purposes of this report, a drug is considered to be a substance that has a physiological effect on the body and often affects how a person feels. There are many different drugs that people use for non-medical purposes - some are shown in the 'drugs wheel' below, split up into the different types of effect they have (Figure 1.1).

Figure 1.1 – The Drug Wheel demonstrating some of the legal and illegal drugs currently in circulation (1)



The outer ring contains substances controlled in the UK under the Misuse of Drugs Act 1971 or the Human Medicines Regulations 2012. The middle ring contains substances controlled under the Psychoactive Substances Act 2016. The inner ring contains legal drugs

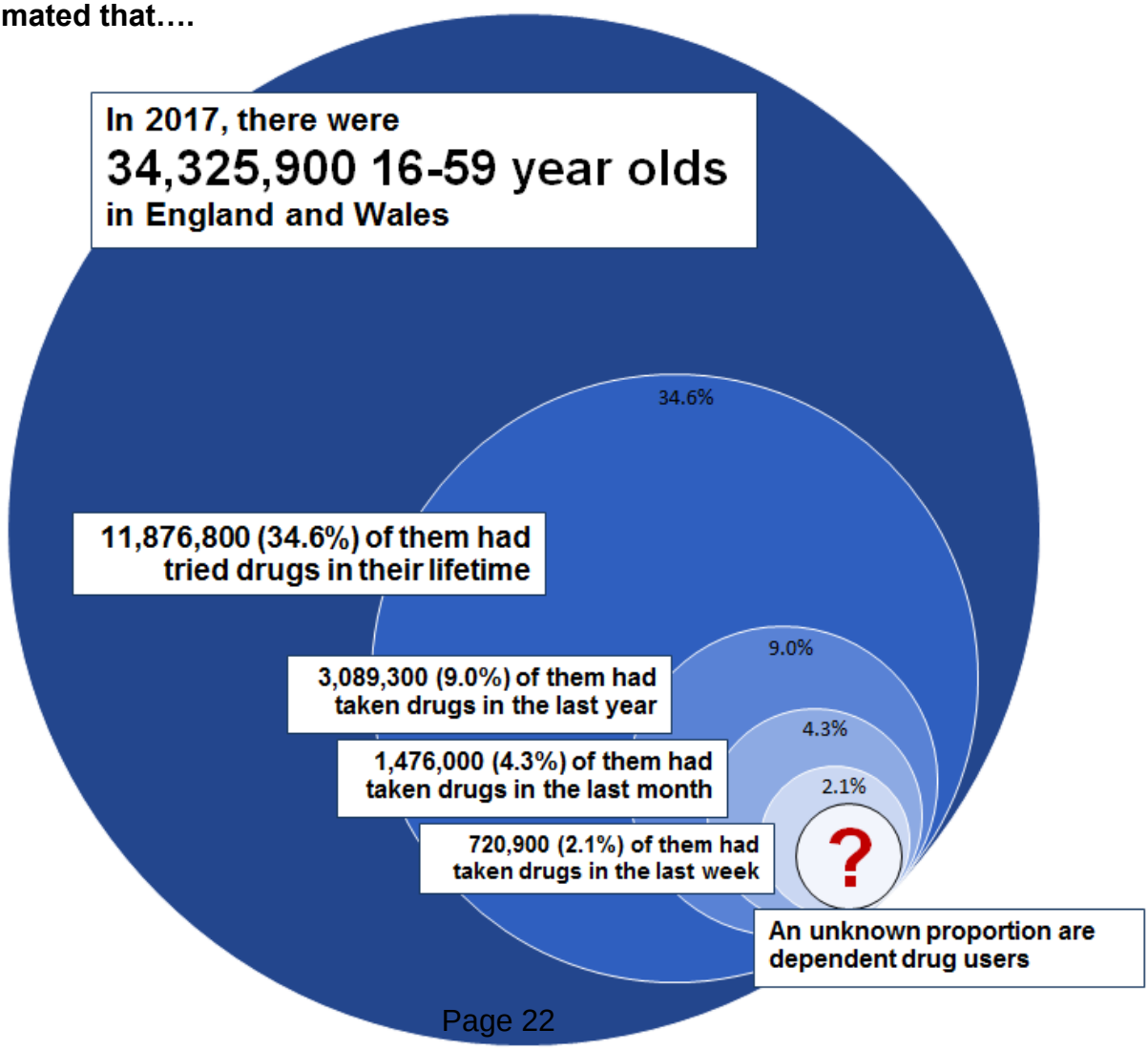
This report focuses on drugs that are used illegally and the harm that they cause. Legal drugs include alcohol, tobacco, caffeine, and many controlled substances when they are used under specific circumstances with a prescription.

Some prescription medications, particularly opiate painkillers can lead to dependence and health problems even when they are used by the people they are prescribed for. The extent of the harm they are causing is only recently being understood and recognised at an international level. This problem is probably greater in the USA where more opiates are prescribed inappropriately, but it is certainly a significant issue for the UK (2). Interestingly research has shown that the factors increasing the likelihood of prescribed opiate use are similar to those increasing the likelihood of problematic drug use, including mental health problems and tellingly deprivation (3).

Different drugs have very different effects, are associated with very different levels of risk, and are used in different situations by different groups of people. Most people who use drugs will do so infrequently and not develop a serious drug habit (Figure 1.2). However, some people do develop a drug use disorder, which can come with serious health and social consequences.

Figure 1.2 - Estimated number of people using drugs in England and Wales based on the 2017 ONS mid-year population estimate and results from the Crime Survey for England and Wales (4) (5)

It is estimated that….



The likelihood of developing problematic drug use depends on the type of drug being used. Heroin and cocaine for example are highly addictive drugs, which people often become dependent on. Other drugs, such as magic mushrooms are more likely to be used recreationally and infrequently.

Over **one third** of those that required specialist drugs treatment in Europe in 2018 were people using heroin and **63%** of them reported **daily heroin use** (6).

Respondents to the Global Drugs Survey 2018 who had taken **magic mushrooms** took them on average **4.3 times in 12 months** (7).

There is very little correlation between the legality of a drug and the harm it causes, with alcohol and tobacco causing more harm than most illegal drugs. Chapter 6 – 'Why are some drugs illegal?' discusses the legal status of drugs in more detail.

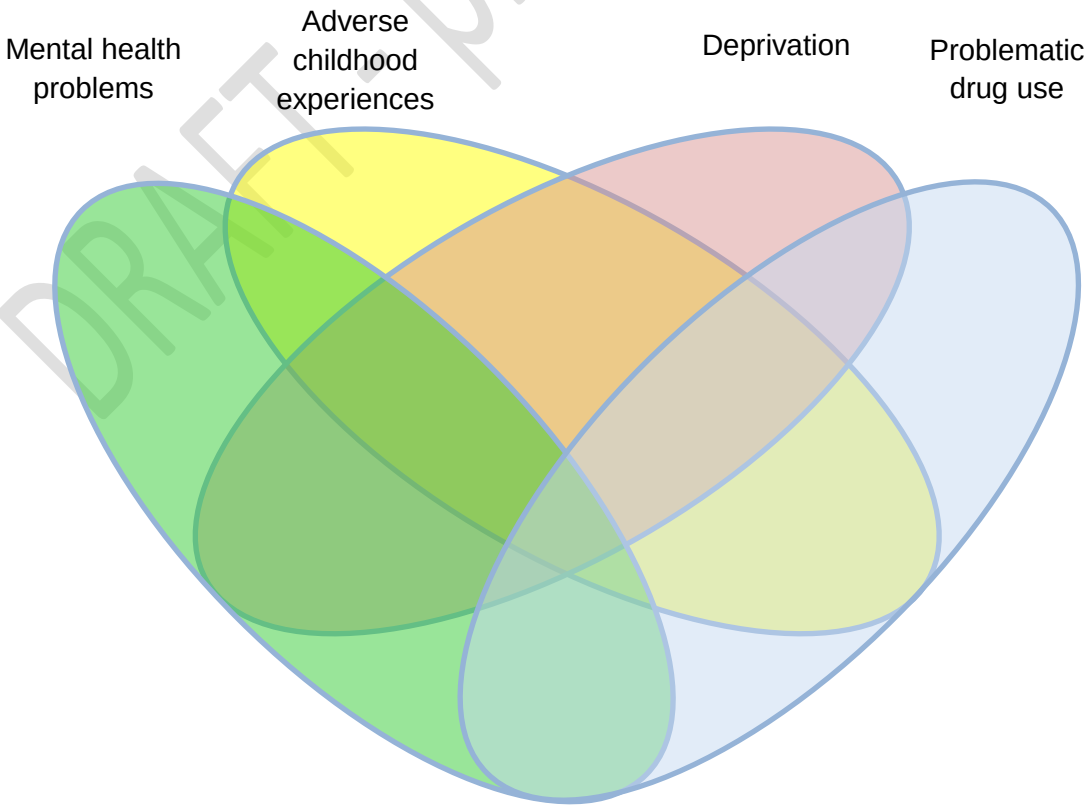
Chapter 2 - Factors that lead people to use drugs problematically

Some people are naturally more likely to use drugs because of their genes (8) and personality traits (9). Research in this area may be helpful to facilitate earlier identification of people at risk of using drugs problematically, which could help direct prevention efforts. However, genes and personality are difficult or impossible to influence. If our focus is on reducing drug related harm, we need to primarily consider circumstances we can change.

Most people who try drugs have opportunities and support structures that protect them from developing a problematic drug habit (10).

People who use drugs problematically often live with deprivation and mental health problems and had adverse experiences in childhood. Sometimes drug use is the cause of these problems but often it is the result. These problems are often closely related; when somebody has one of them, they are more likely to have others leading to a complex combination of health and social care needs that cannot be considered in isolation (Figure 2.1).

Figure 2.1 - A Venn diagram of the associations between problematic drug use and its key drivers



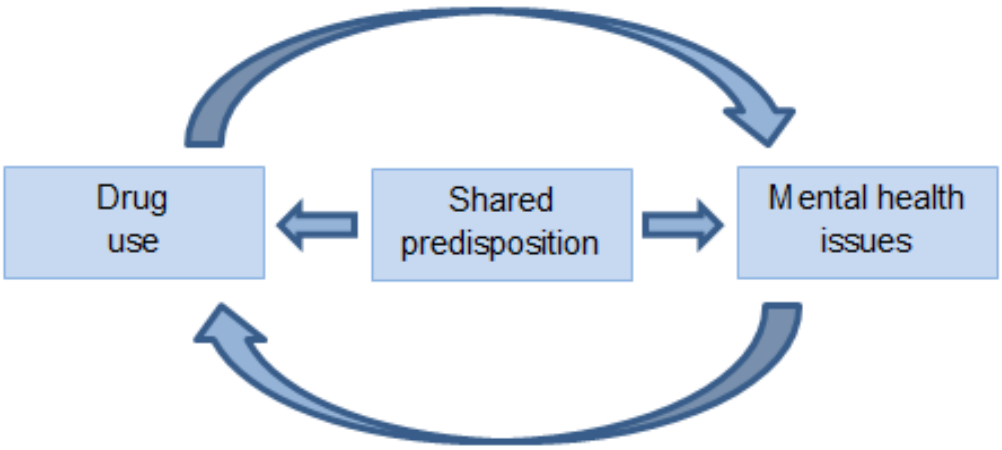
Mental health issues

41% of people entering specialist drugs treatment nationally in 2017/18 were identified as having a mental health treatment need.

In Southampton the situation is similar to the national picture - 39% - and in Portsmouth, the proportion was even higher at 49%.

Various mental health conditions are associated with problematic drug use. The nature of these associations is not always clear. Sometimes, drugs may be the cause of mental health problems. In other instances, people with pre-existing mental health problems could be self-medicating with drugs. And some people might have a shared pre-disposition that makes them more likely to both develop mental health problems and to use drugs problematically (Figure 2.2).

Figure 2.2 - The potential relationships between drug use and mental health issues



Despite there being guidance against it, some mental health services require that people with a dual diagnosis of mental health problems and substance misuse stop using drugs before providing psychiatric support. Often, this is not feasible. Work has been done in this area but there is still much more to do. Mental health services are under strain across the country with long waiting times and limited access to evidence based treatments; even when dual diagnosis is not a barrier it is likely that not everyone is getting help when they need it (11).

Adverse Childhood Experiences (ACEs)

ACEs are stressful experiences during childhood; either direct abuse or factors that impact on the environment the child is growing up in (Figure 2.3).

Figure 2.3 - The different types of ACE (12)

Child maltreatment:

Verbal abuse | Physical abuse | Sexual abuse

Issues in childhood household:

Parental separation | Domestic abuse | Mental illness

Alcohol abuse | Drug use | Incarceration

People who suffer ACEs when they are young are more likely to use drugs and have poor health and social outcomes. In a Welsh study, people who had suffered 4 or more ACEs were (12):

- 11 times more likely to have smoked cannabis
- 14 times more likely to have been a victim of violence in the last year
- 15 times more likely to committed violence in the last year
- 16 times more likely to have used crack cocaine or heroin
- 20 times more likely to have been incarcerated

The relationship between ACEs and drug use was demonstrated in interviews with people from the local area who had used drugs (13):

"All I've done is just take drugs . . . just so I don't have to think about it [abuse as a child]"

"[I take drugs in order to] block out the pain from my childhood and other things"

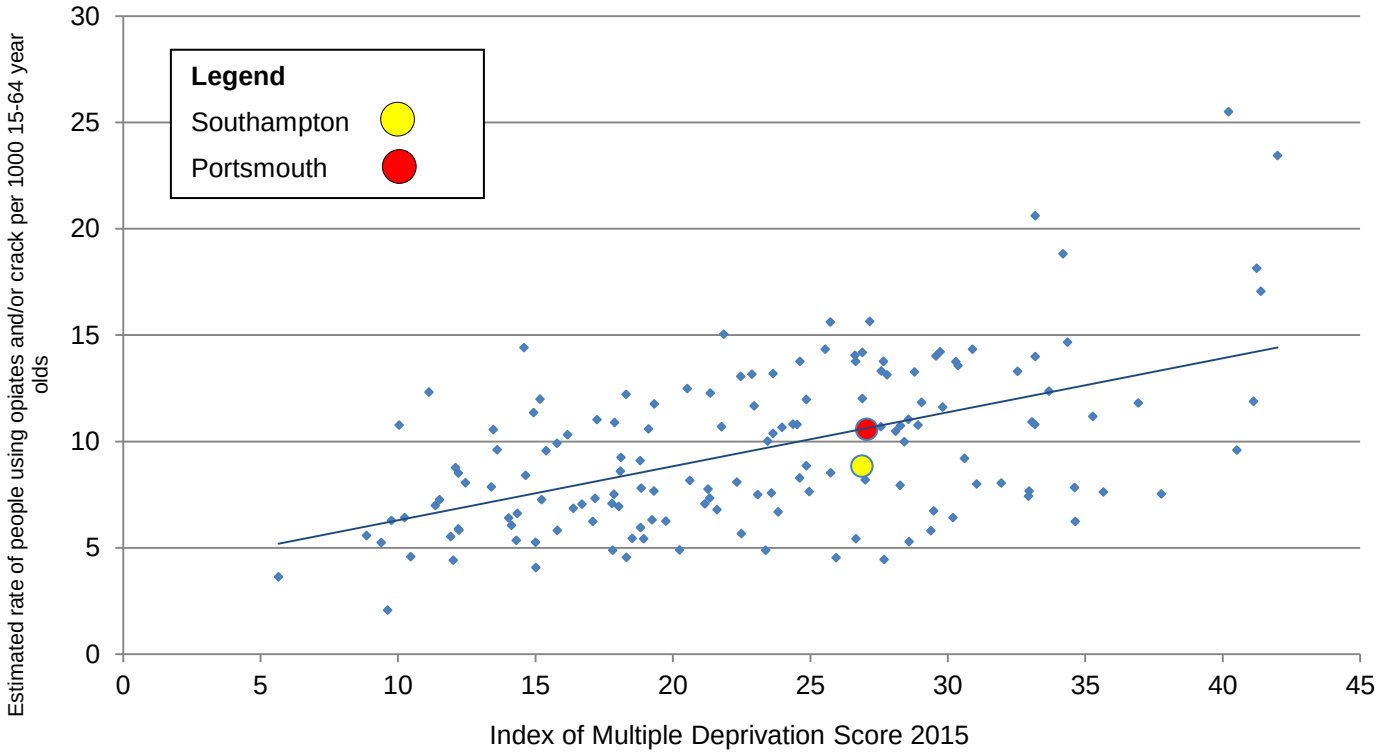
It can be very difficult to deal with the consequences of ACEs after they have occurred, so it is vital that we try to prevent them happening in the first place. Early help services are incredibly important in this respect. This includes social care services, which provide assistance to families who are unable to maintain an environment suitable for children to grow up in and universal or targeted support services, which aim to help families avoid getting to that point. Our local services are working hard and doing fantastic work in a time of spending constraint. It is vital that funding for early help services is maintained and ideally strengthened at times such as these as investment not only reduces suffering, but also likely reduces costs for other services in the future.

It is much less expensive to provide social care and family support services now than it will be to deal with the consequences of ACEs in the future, including costs to drug treatment services, the police and the NHS.

Deprivation

The link between deprivation and problematic drug use is well recognised (14). Looking nationally, local authorities with higher levels of deprivation have higher rates of people using drugs problematically (15) (Figure 2.4).

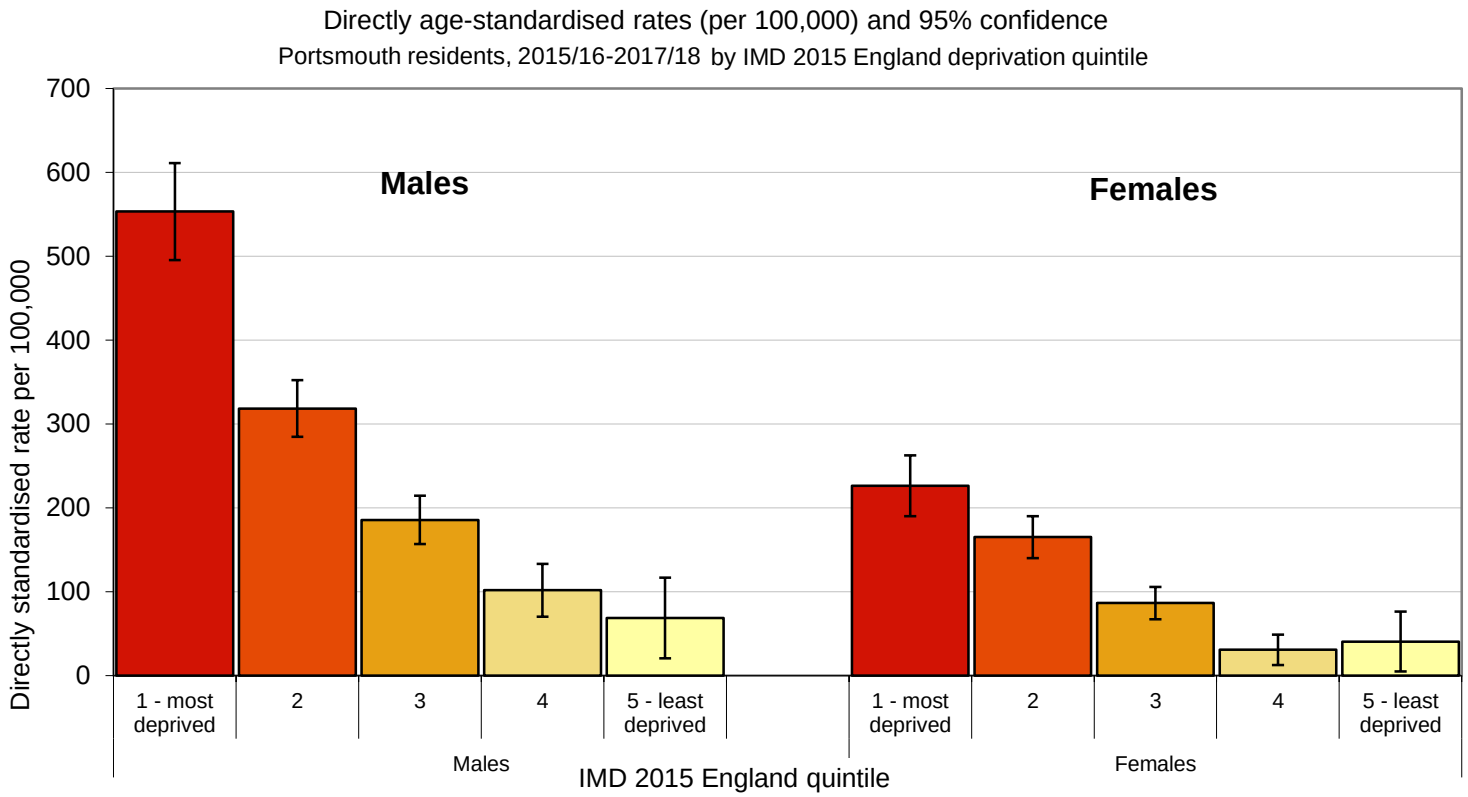
Figure 2.4 - The estimated rate of people using opiates and/or crack cocaine per 1000 15-64 year olds (2016/17) and Index of Multiple Deprivation (2015) in English local authorities (15)



Portsmouth and Southampton are both relatively deprived - in the 4th most deprived decile of local authorities (15) and both have pockets with much higher levels of deprivation. In Portsmouth for example, 13% of small areas are in the most deprived 10% of small areas in England. Looking within the cities there is more evidence for the association between deprivation and problematic drug use as significantly more people who are admitted to hospital with problems related to drug use live in more deprived areas (Figures 2.5-2.6).

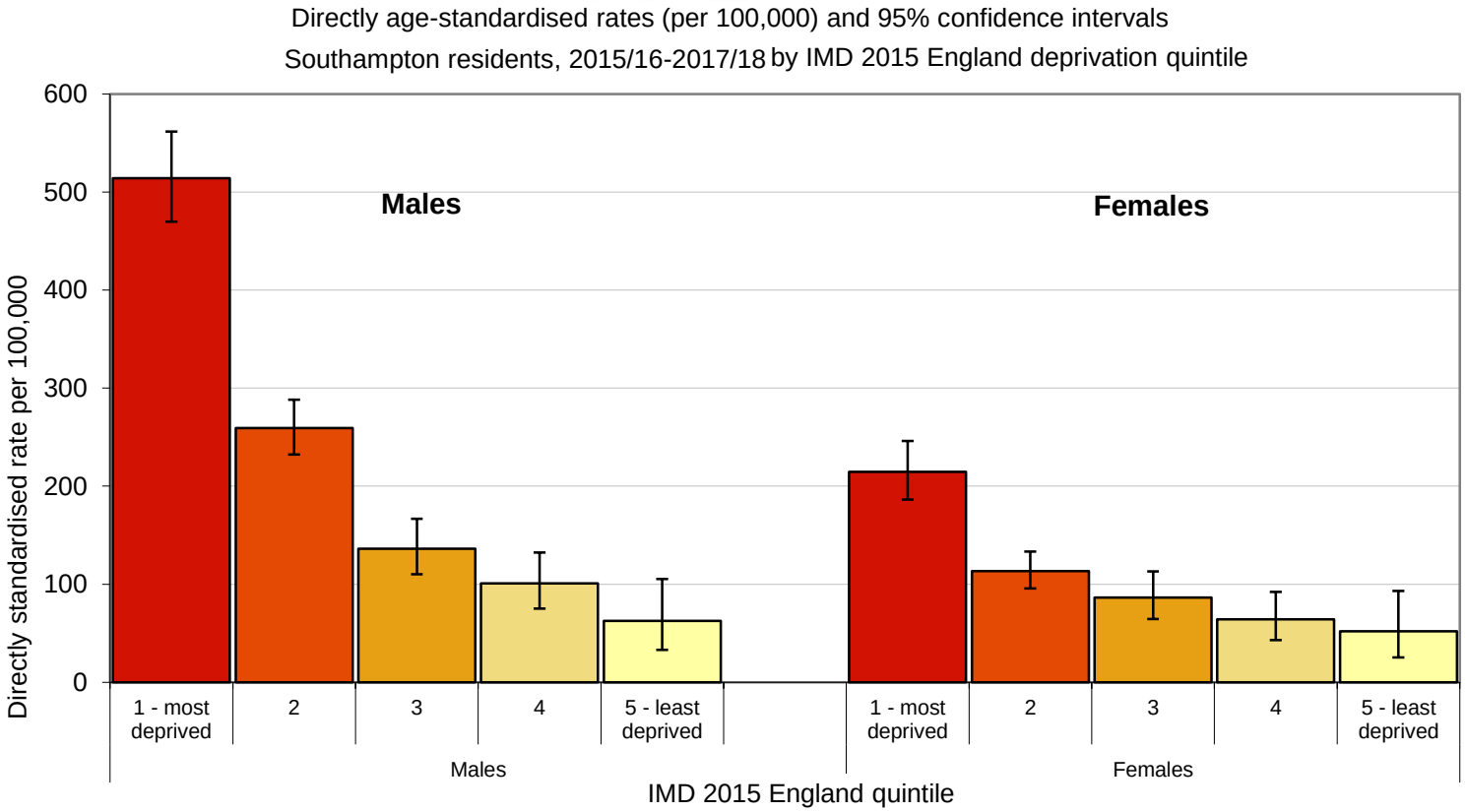
Figures 2.7-2.10 show how rates of drug related hospital admissions vary between areas within both the cities, with some of the most deprived areas having the highest rates of drug related hospital admissions. With the data that are available when considering admissions due to poisoning it is not possible to accurately differentiate between admissions related to recreational drug use and accidental or intentional overdoses with prescription opiates, so both are included.

Figure 2.5 - Hospital admissions for drug related mental and behavioural disorders in Portsmouth



Sources: HDIS2 copyright (c) 2017, re-used with the permission of The Health & Social Care Information Centre. All rights reserved.; & ONS Mid-2015 to Deprivation Source: England LSOA deprivation quintile, based on LSOA IMD 2015 England rank from Department of Communities and Local

Figure 2.6 - Hospital admissions for drug related mental and behavioural disorders in Southampton



Sources: HDIS2 copyright (c) 2017, re-used with the permission of The Health & Social Care Information Centre. All rights reserved.; & ONS Mid-2015 to Deprivation Source: England LSOA deprivation quintile, based on LSOA IMD 2015 England rank from Department of Communities and Local

Figure 2.7

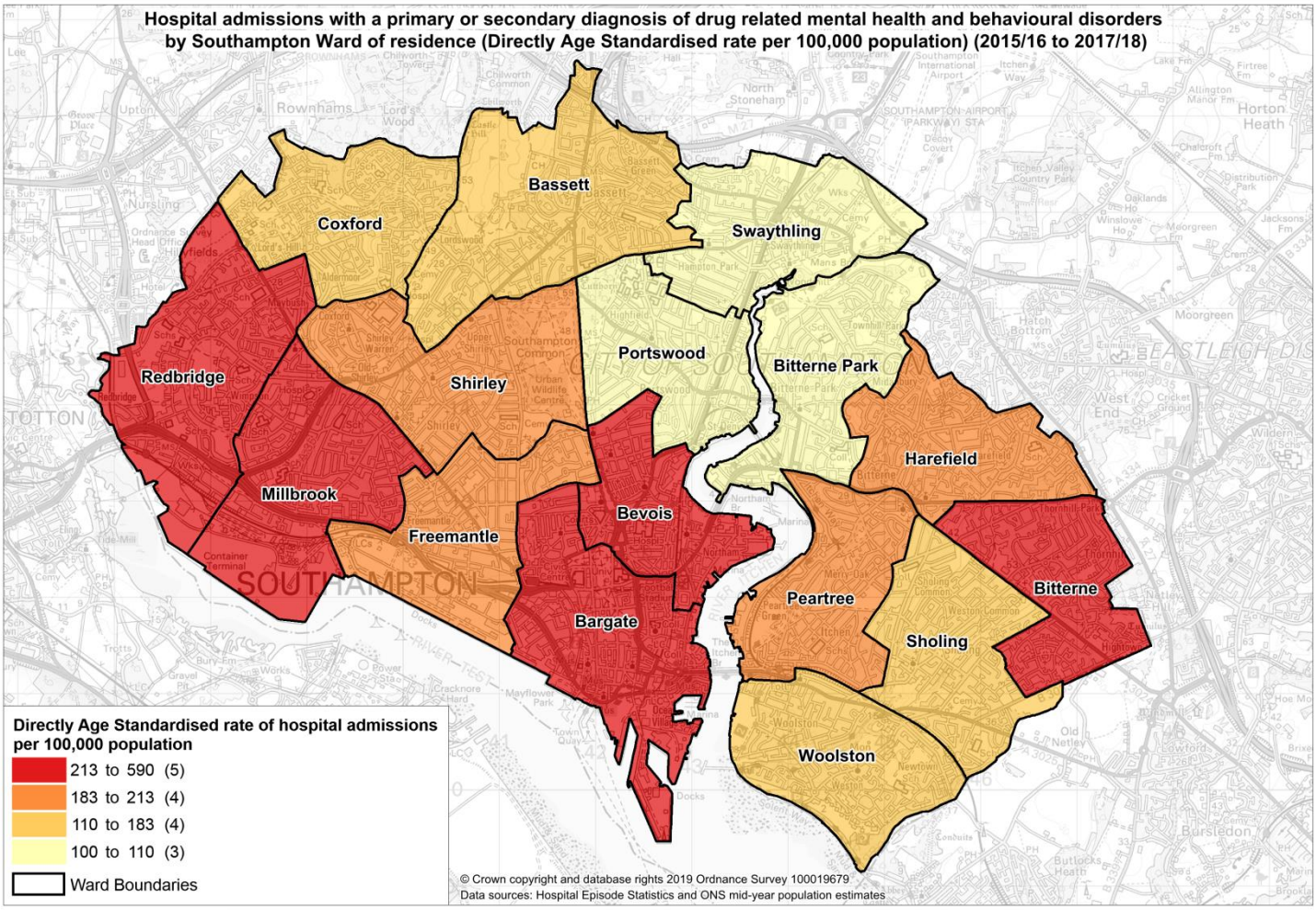


Figure 2.8

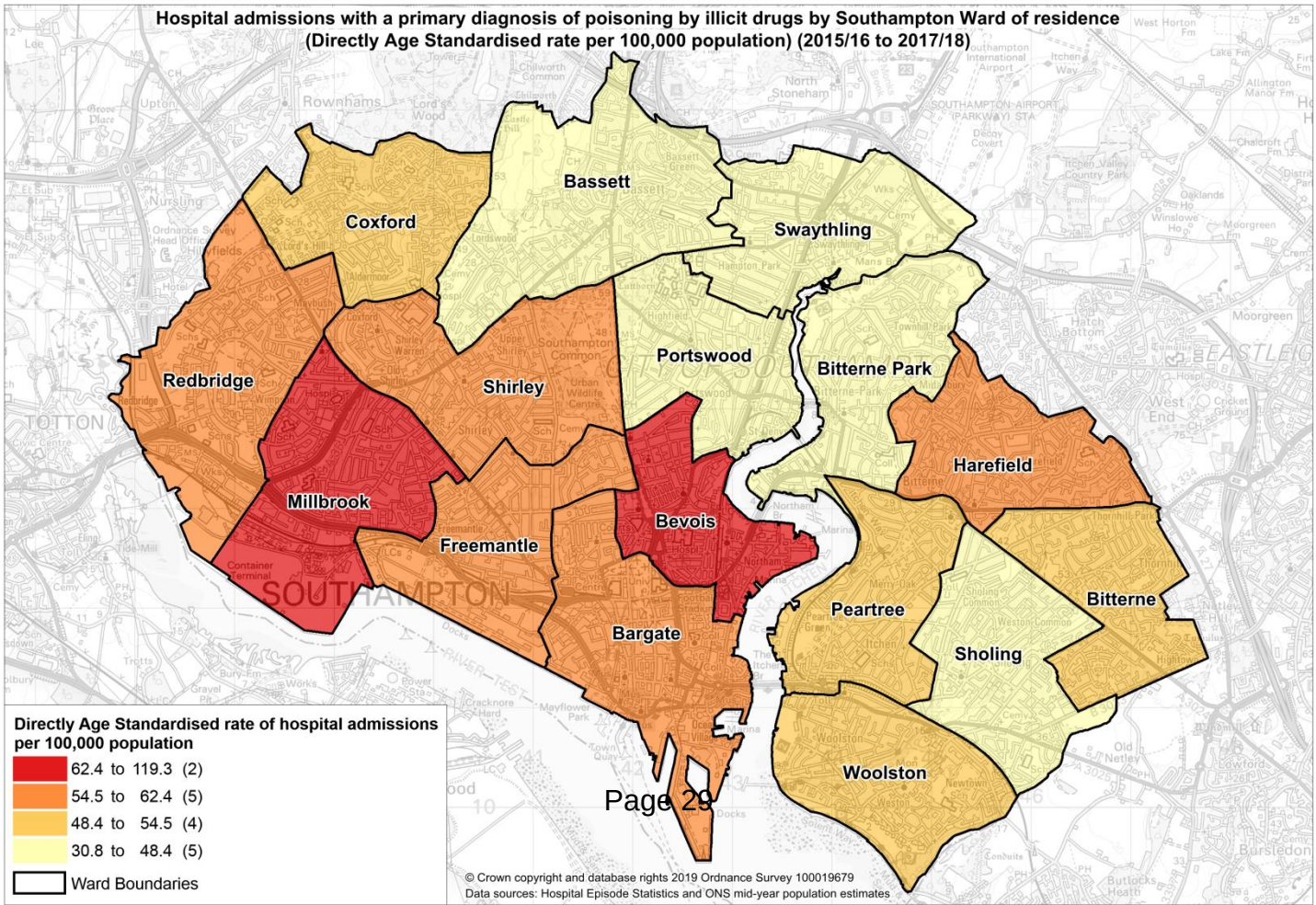


Figure 2.9

Hospital admissions for drug related mental health (primary or secondary diagnosis of ICD10 F11-F16; F18-F19). Directly age-standardised rates (per 100,000 population). Persons, all age Portsmouth residents by electoral ward, 2013/14-2017/18 (5 years pooled)

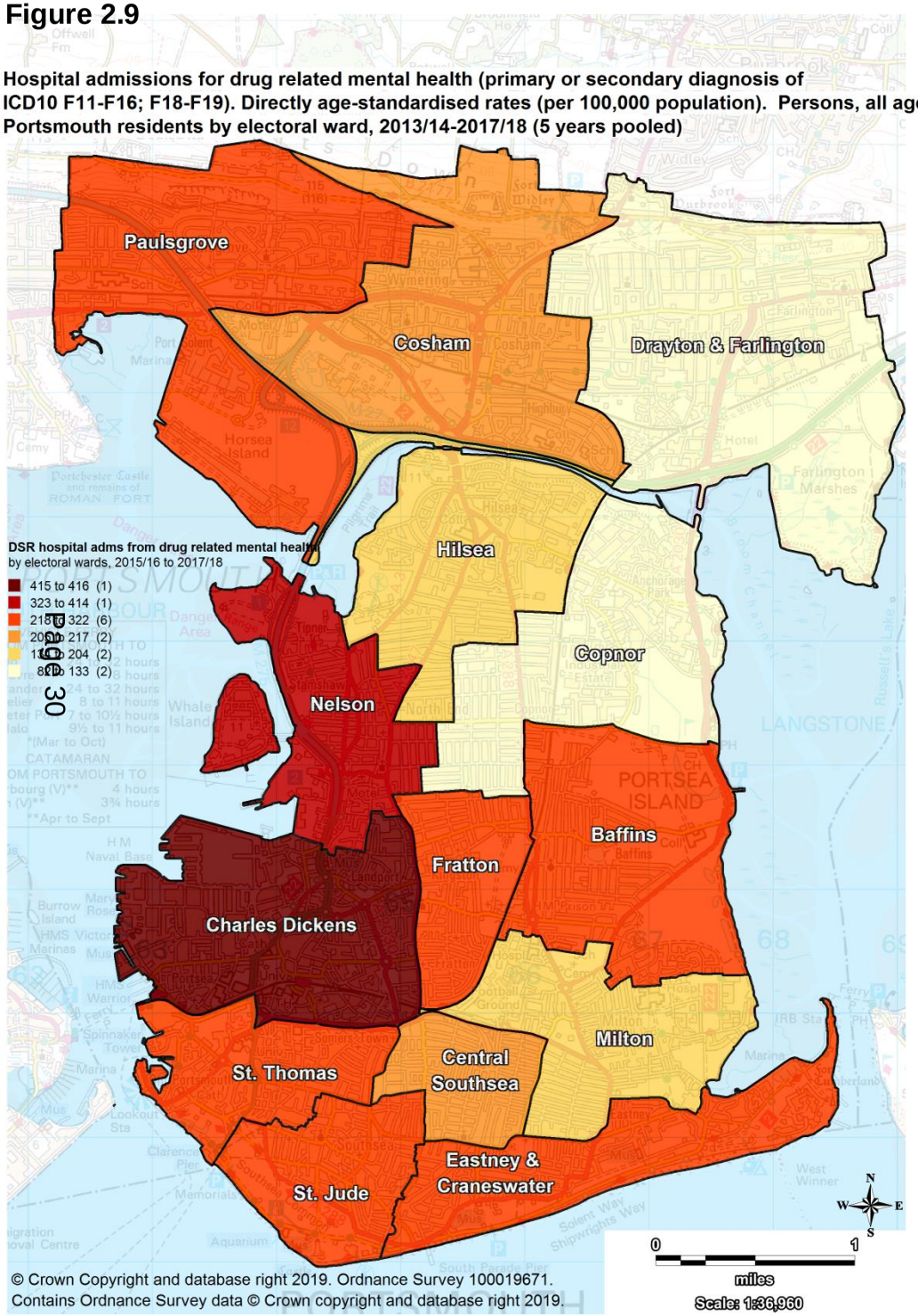
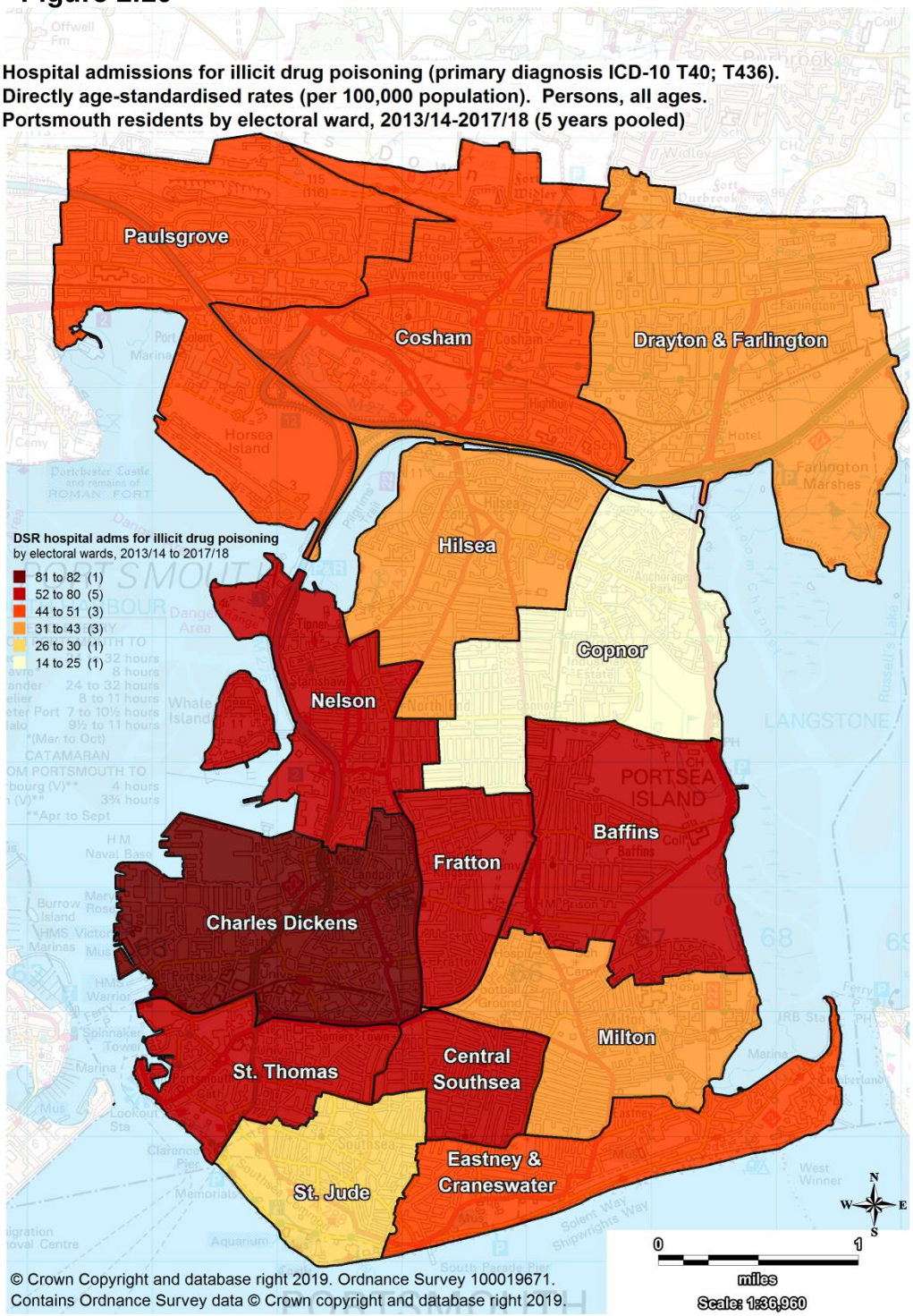


Figure 2.10

Hospital admissions for illicit drug poisoning (primary diagnosis ICD-10 T40; T436). Directly age-standardised rates (per 100,000 population). Persons, all ages. Portsmouth residents by electoral ward, 2013/14-2017/18 (5 years pooled)



Homelessness

The association between deprivation and problematic drug use is seen most profoundly in the homeless population.

In a 2017 survey **in Southampton, 31% of people rough sleeping and/or begging reported dependence on drugs** (16)

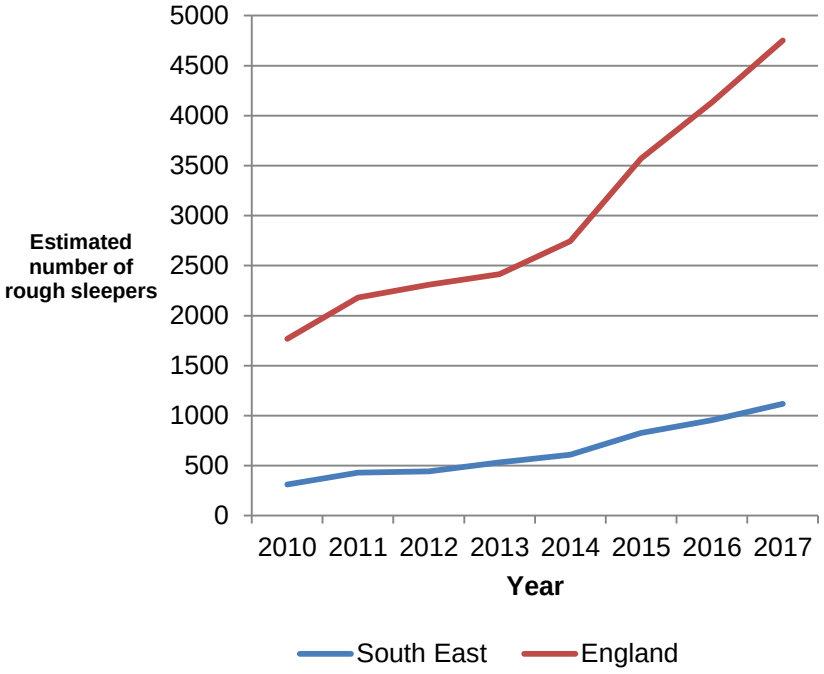
In 2017 190 people who were homeless died from drug poisoning in England and Wales (32% of all deaths of people who were homeless) (17)

In a 2016 survey **in Portsmouth, 50% of rough sleepers were known to substance misuse services** (18)

Aside from issues with substance misuse, people who are homeless are more likely to suffer with a host of physical, mental and social problems. It can be difficult to deliver care to this population for various reasons, for example it can be hard to contact them to arrange follow up appointments or for them to register with a GP if they don't have a fixed address.

The number of people who are homeless in England has increased dramatically in recent years (19) (Figure 2.11). The government has recently instituted the Homelessness Reduction Act, which requires local authorities to take more steps to prevent homelessness in the hope of reversing this trend (20), however this doesn't address the shortage of available social and affordable housing and the lack of resources required for local authorities to perform their duties.

Figure 2.11 - The estimated number of rough sleepers in England and the South East 2010-2017 (19)



The biggest driver in the rise in homelessness is the decreasing affordability of private rented accommodation (21). **Between 2010 and 2017 the cost of accommodation increased three times faster than earnings across England.** This has been compounded by changes to the benefits system, which have meant that people who are at risk of becoming homeless have received less help (21).

The benefits system

A recent UN Special Rapporteur report on extreme poverty paints a damning picture of the current state of affairs in the UK (22). About one in five people in the UK live in absolute and relative poverty after paying for housing costs* (23) and levels of income inequality are above average and potentially the highest in Europe (24). The report notes the role of central government, suggesting that **the social safety net has been "systematically and starkly eroded . . . significantly compromising its ability to help people escape poverty".**

In 2013, the UK government began gradually rolling out Universal Credit, its flagship benefits reform. Problems with how the new system is being implemented, combined with significant reductions in the level of most working age benefits are negatively impacting many claimants. We are seeing these problems locally, and research from other areas raises similar issues (25).

- Some claimants, particularly those that previously received severe disability benefits are finding that they receive less money under Universal Credit.
- Claimants must wait five weeks, and in some cases longer when switching to Universal Credit, which may lead to them taking a Universal Credit Advance. This reduces their monthly entitlement for the following 12 months in most cases.
- Previously, benefits were paid fortnightly, whereas Universal Credit is normally paid monthly. The difficulty for households moving from budgeting fortnightly to monthly increases the risk of claimants using forms of high cost credit such as payday loans to bridge the gap. For people who are addicted to drugs, having a months' worth of money in one go can result in them spending money they need for housing and food on drugs.
- Delays in payments are being caused by system errors, particularly in relation to housing costs.
- The logistics of claiming are more difficult than before, with less assistance available due to reductions in funding for advice and support services.
- Claimants describe a hostile and accusatory atmosphere when trying to claim benefits due to ill health or disability, and punitive sanctions being applied if they don't meet the requirements of their Claimant Commitment.

One claimant said:

"It's not right. I shouldn't have to go to my daughter's and depend on her for something to eat. It should be the other way around . . . It makes you feel so low, especially when you've got to go to the foodbanks. I don't want to be like this for the rest of my life." (25)

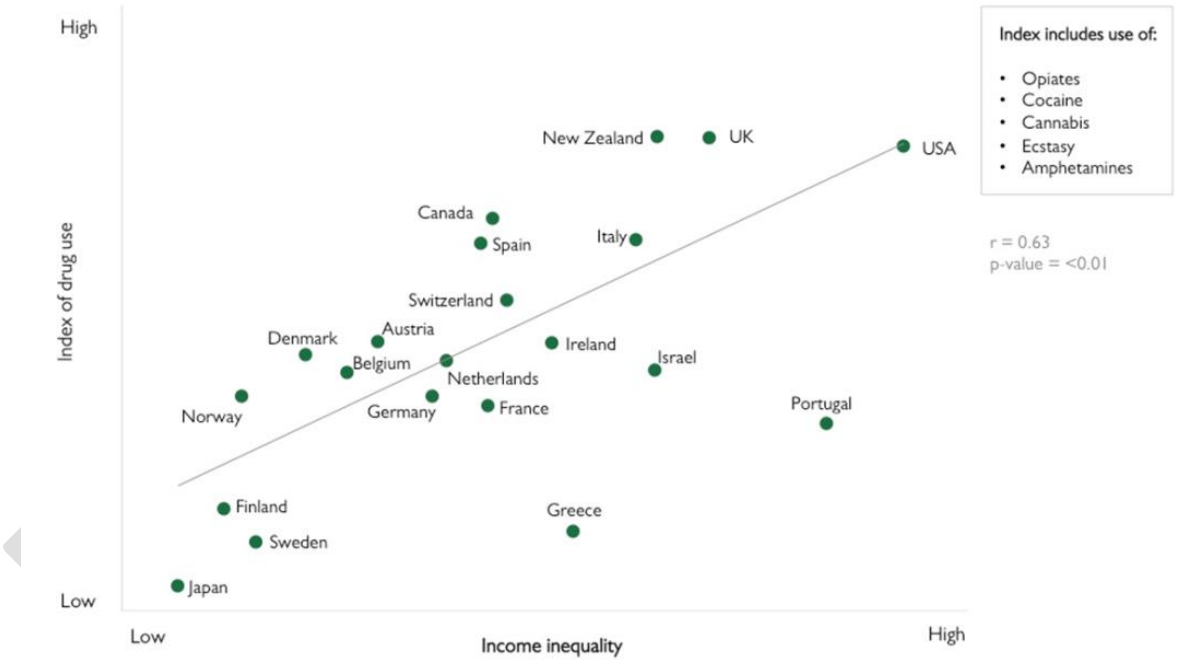
*Absolute poverty is defined as having an income below 60% of inflation-adjusted mean income after paying for housing in a base year. Relative poverty is defined as having an income below 60% of the median income that year.

Why is problematic drug use associated with deprivation?

The association between deprivation and many health and social problems has long been recognised, but it is not always clear why they are related. Recent research on the psychology of scarcity, which explores how peoples' thinking changes when they do not have enough of something has shed light on one contributory explanation (26). When somebody is using all their focus to think about a pressing issue, for example how they are going to afford their next meal, or how to pay the rent they cannot fully consider other aspects of their life. They are less likely to be thinking about the long term and living healthily might not be in the forefront of their mind. When put in an extremely stressful situation of scarcity many people in society might make decisions that they would not otherwise make, and do things that they would not otherwise do, such as using drugs problematically.

Some research suggests that even if an area is not absolutely deprived, higher levels of inequality are associated with higher levels of drug use (27) (Figure 2.12). This suggests there might also be something about the interactions between people and their perceived relative positions in society that affects the likelihood of them using drugs problematically.

Figure 2.12 - The association between prevalence of drug use and income inequality in a country (27)



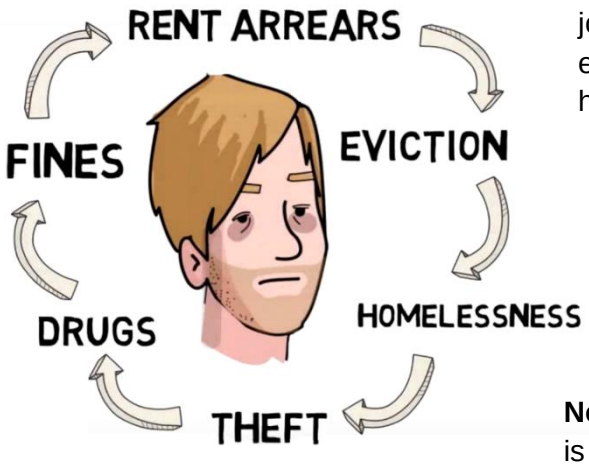
Case study – A life on course for drug dependence

This is Craig. His story is based on the life of a real person who lives locally. Despite the hard work of 15 different local services for children and adults he has had a difficult life and struggled with problematic drug use.

Childhood – At just 5 months old services note that Craig is growing slowly and failing to thrive. He is neglected and physically abused by his father.

Early teens - Craig starts running away from home and sleeping in a churchyard, telling the vicar he is too scared of his dad to go home. At age 15 he is arrested for stealing and his parents refuse to collect him from the police station. He is excluded from school.

Late teens – With few options and no guidance this is when Craig starts regularly using drugs. He continues stealing and has more encounters with the law. At age 19 he is living in a hostel, but when he gets a job, he loses his benefits, is evicted and becomes homeless.



Early twenties – Craig is arrested again for stealing a sandwich. While he is being arrested, he assaults a police officer and security guard so is sent to prison. He is given treatment for his drug problems but is only there for 20 days. At age 21 he is sectioned under the mental health act but doesn't meet the threshold for treatment and is released soon after. Craig finds places to live, but it never lasts long as he misses rent payments, is evicted and once again becomes homeless. He continues stealing and starts dealing drugs.

Now - Craig is 25 years old. He is homeless, dependent on drugs and has been to prison four times. He has complex physical and mental health needs and has no family support. Might we have made the same choices in his situation?

Never accept a label in place of a story

A video of Craig's story can be viewed on the Safer Portsmouth Partnership website http://www.saferportsmouth.org.uk/complex-needs/ (28)

Conclusion

People who use drugs problematically are often doing so in response to their traumatic childhoods and difficult lives. Drug use disorders are not the diagnosis; they are a symptom of other problems.

It is impossible to prevent drug related harm without tackling the wider issues in society – absolute and relative deprivation, mental health problems and adverse childhood experiences. Besides problematic drug use, these issues are associated with a host of other problems, many of which are hidden – the problems we do see are likely **the tip of the iceberg.**

Economic policy should utilise progressive taxation to reduce deprivation and inequality, and to provide adequate funding for children's services that work with families to ensure that everyone has the best possible start in life, and adult services that provide support throughout peoples' lives when they need it most.

People who use drugs problematically require help to deal with the factors that predispose them to drug dependence rather than being punished for the situation they are in.

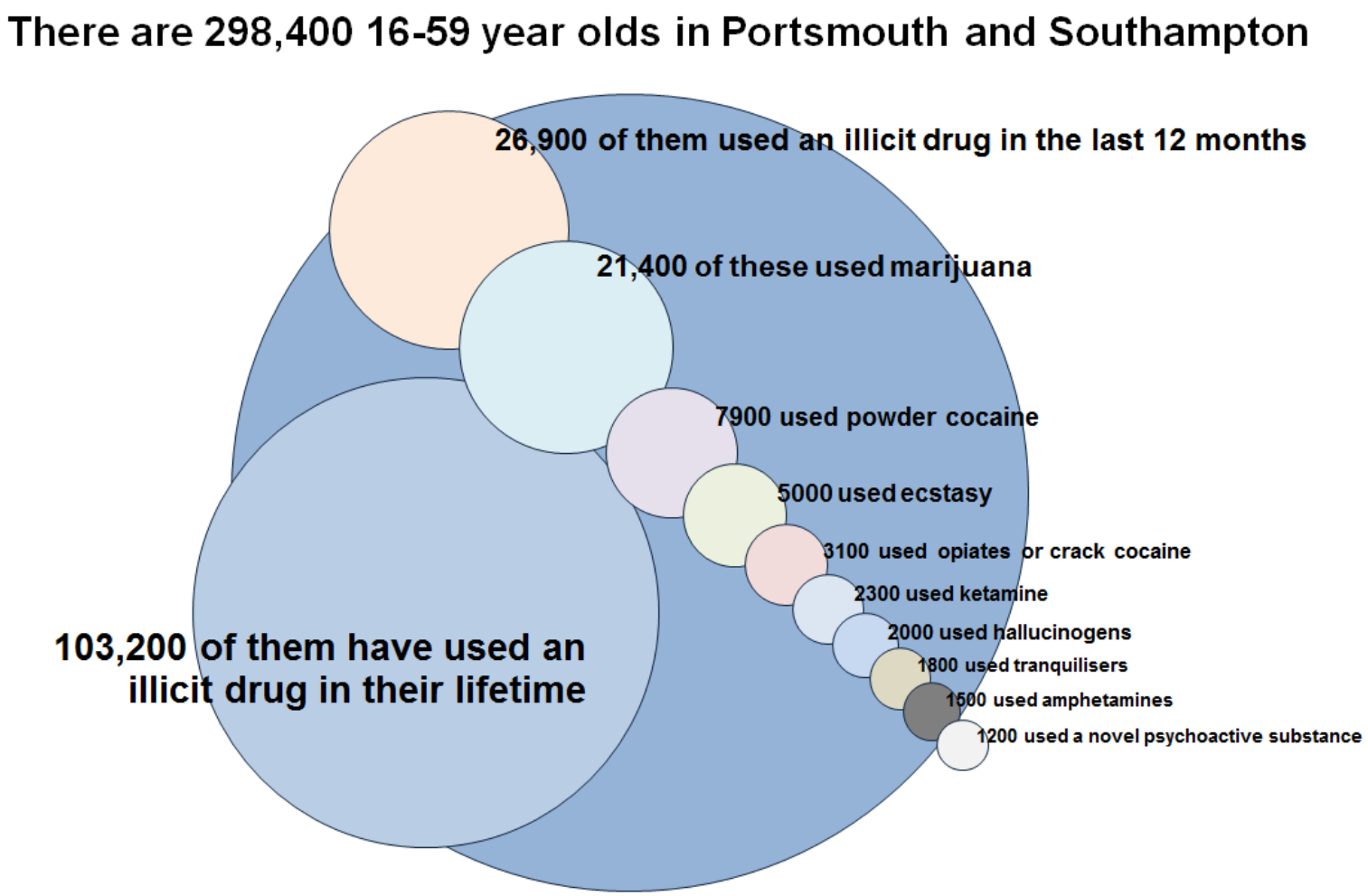
Chapter 3 - Prevalence of drug use

In 2017/18 one in eleven adults aged 16 to 59 and one in five adults aged 16 to 24 had taken a drug in the last 12 months (4).

This is according to the results of the Crime Survey for England and Wales (CSEW). We can use the results of this survey to estimate how many people are using different drugs in Portsmouth and Southampton (Figure 3.1). This is a very rough estimate as in reality drug use is not uniform across the country.

Figure 3.1 – The estimated number of people using different drugs in Portsmouth and Southampton

It is estimated that….



Based on ONS 2017 mid-year population estimates, the proportion of people using drugs apart from opiate or crack cocaine from the 2017 Crime Survey for England and Wales and PHE estimates of the number of people using opiates or crack cocaine in 2016/17 (4) (5) (29)

According to the CSEW, drug use has generally decreased since 2000 but there has been a slight increase in the number of 16-24 year olds taking drugs since 2015 (Figure 3.2).

It is possible that drug use is more common than surveys would suggest. It is likely that many people do not admit that they break the law, and people who use drugs heavily are unlikely to take part in surveys at all.

The numbers in specialist treatment for drug use have decreased both locally and nationally over the last five years (Figure 3.3-3.4) although both cities have bucked the national trend and seen an increase in 2018/19 - the figures showing this will be published later in the year. Nonetheless, there are still less people in treatment than there were five years ago.

Funding pressures have meant that less resources are available to provide drug treatment services (discussed further on page 37). This means that the changing numbers of people in treatment may be due to a decrease in service capacity rather than there being less people using drugs problematically who have a treatment need. An increasing proportion of people using drugs problematically are missing out on the benefits of treatment, which not only disadvantages them, but also wider society with increasing costs for healthcare, criminal justice and social services (discussed further on page 66).

Figure 3.2 - The proportion of 16-24 and 16-59 year olds in England and Wales that report using an illicit drug in the last 12 months 2001-2018 (4)

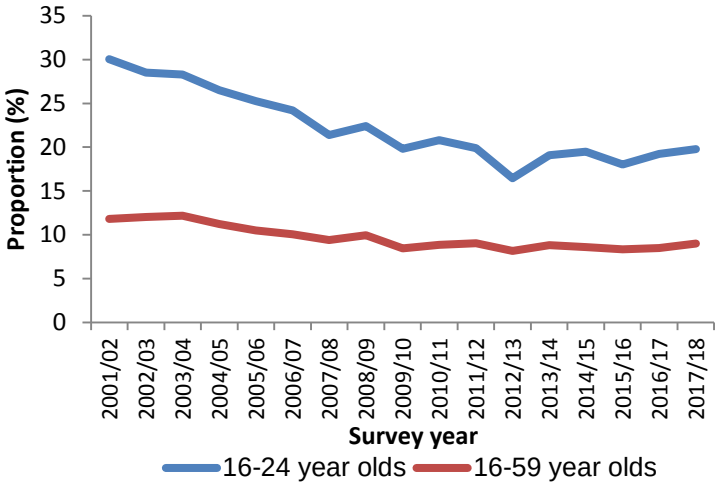


Figure 3.3 - Over 18s in specialist substance misuse services in England from 2013-2018 (30)

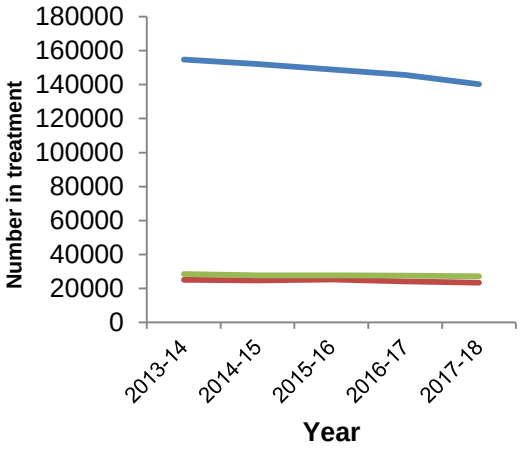
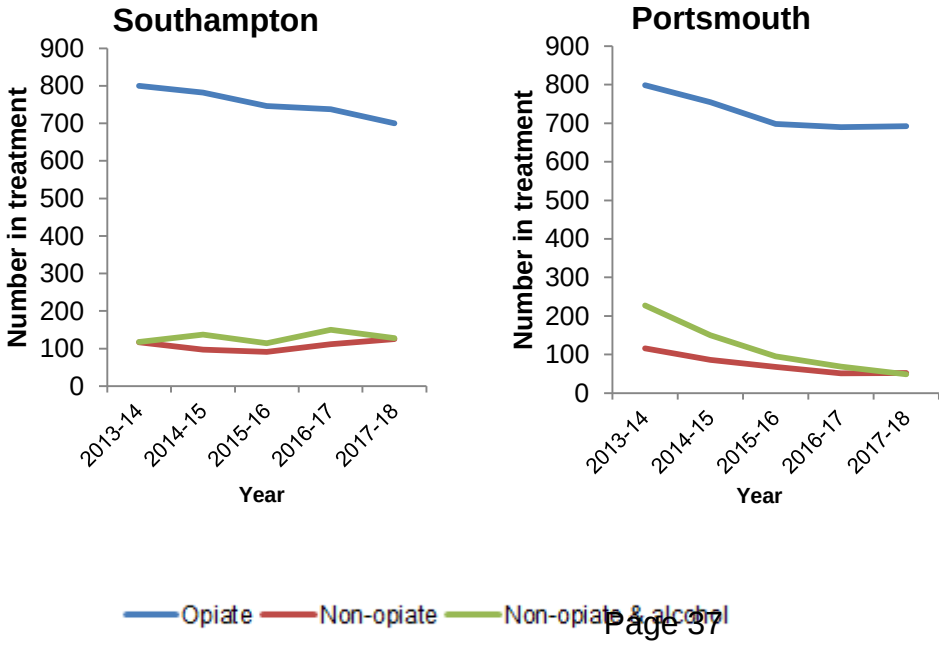


Figure 3.4 - Over 18s in specialist substance misuse services in Portsmouth and Southampton from 2013-2018 (30)



Seizures of illicit drugs have decreased both locally and nationally over the last decade (Figure 3.5) but again this does not mean that drug use has decreased. It is more likely to represent a change in policing practices or a decrease in police resources to look for drugs rather than there being less drugs in circulation.

We know that surveys particularly underestimate crack cocaine and opiate use as the people who use these drugs often live chaotic lifestyles and are less likely to take part in research. For that reason estimates of people using crack cocaine and opiates are calculated using data from various sources, including police and treatment service data. Estimates suggest that numbers locally are fairly stable but in England overall they have increased by about 28,000 between 2012/13 and 2016/2017 (Figure 3.6-3.7).

Because these estimates are based on service use data it is not possible to rule out the existence of an increasing number of people using these drugs who are not in contact with services.

Figure 3.5 - Seizures of illicit drugs in England 2006-2018 (31)

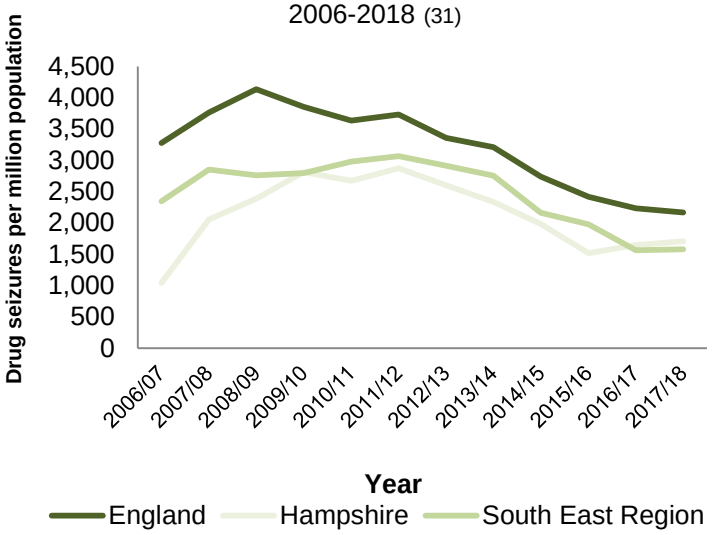


Figure 3.6 - The estimated number of people using crack cocaine and opiates in England from 2011-2017 (29)

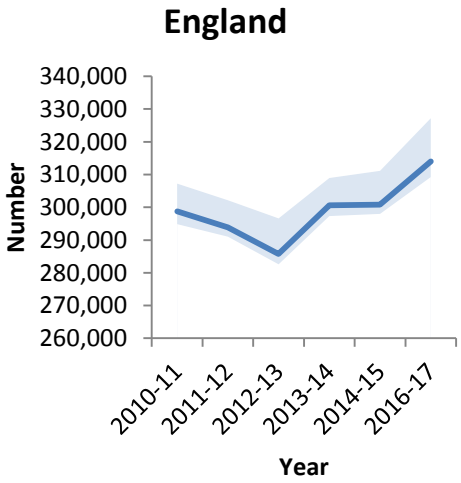
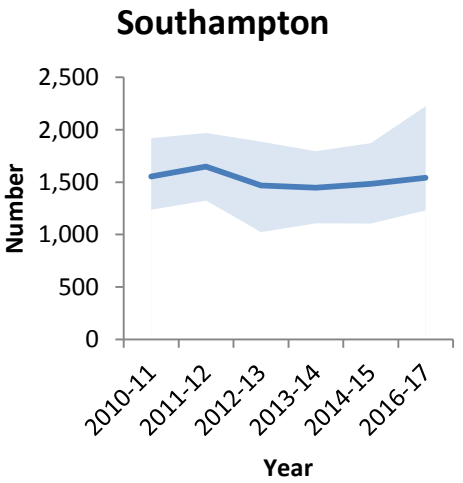
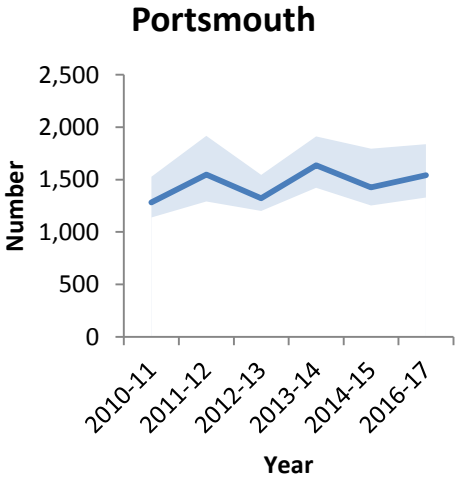


Figure 3.7 - The estimated number of people using crack cocaine and opiates in Portsmouth and Southampton from 2011-2017 (29)





Light blue shaded areas represent 95% confidence intervals

Conclusion

The illicit and secretive nature of drug use means it is difficult to make any firm conclusions on how it is changing. There may be many more people using drugs than we know about who are not admitting use; it is possible that the drug use we are aware of is **the tip of the iceberg.** The number of people in specialist treatment for their drug use has fallen disproportionately compared to drug use estimates suggesting it's likely there is an increasing unmet need for treatment services.

Chapter 4 - The health harms from drugs

The ways that different drugs work on the body vary and so they are harmful to health in different ways. Some health problems can occur quickly, even after one use; others become more likely or only occur with chronic use. The likelihood of harm can depend on various factors including dose and method of administration. Figure 4.1 below shows some, but no means all, of the ways that illicit drugs can be harmful to health.

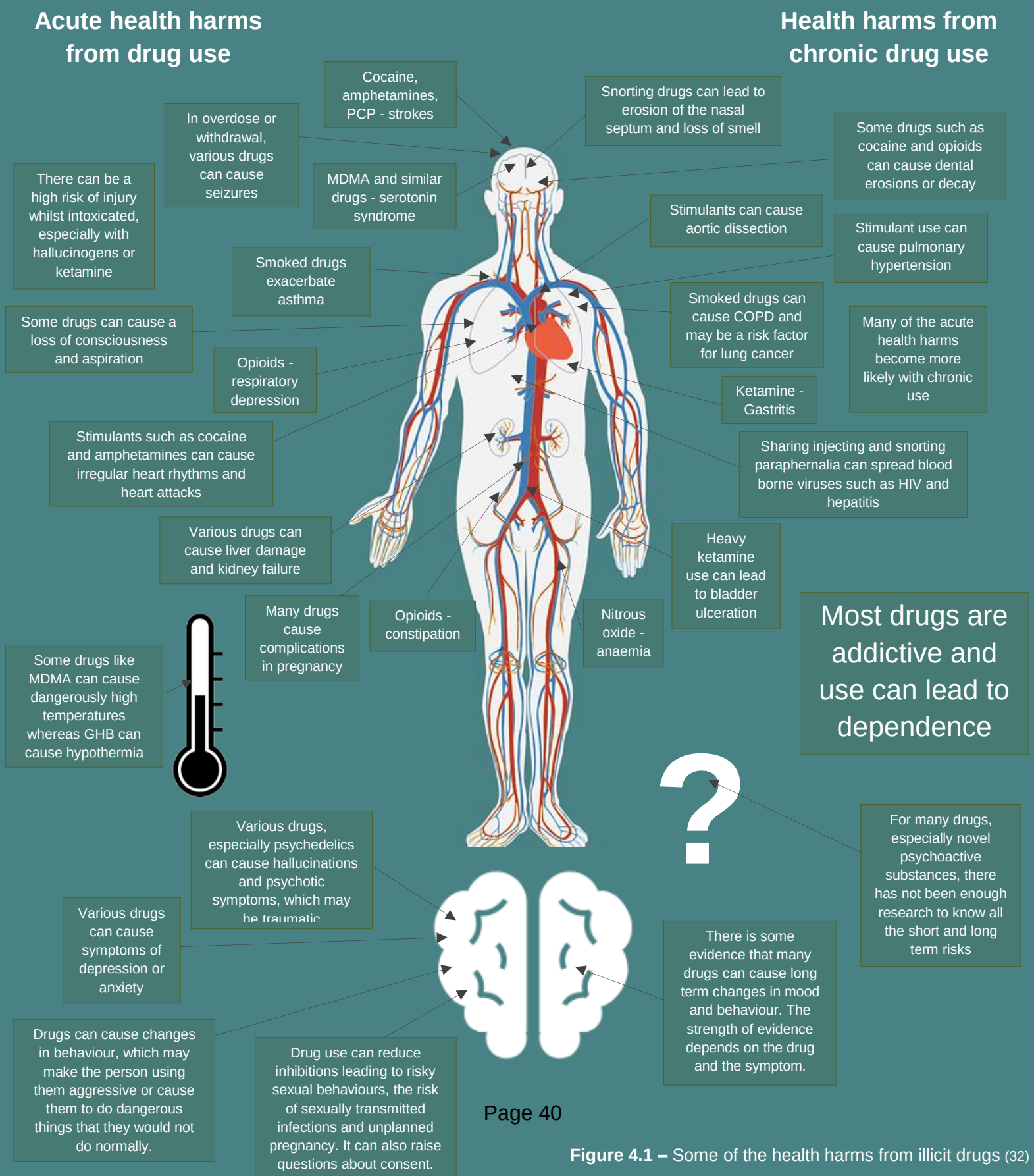


Figure 4.1 – Some of the health harms from illicit drugs (32)

In some cases, the effects of drugs can be serious or fatal – the risk of this varies hugely depending on the drug that is used. Attempts have been made to quantify the risk of death from different drugs using units called '**micromorts**' with one micromort equating to a one in a million chance of dying (Figure 4.2). Although the use of some drugs like cannabis is less likely to lead to death, their other negative health effects should not be underestimated.

Figure 4.2 – The estimated micromorts that the people in England and Wales who use cannabis and heroin are exposed to because of the drugs (33)

Drug related deaths

Heroin and other opiates are responsible for more deaths than any other drugs in the UK, followed by cocaine and benzodiazepines (34) (Figure 4.3). Often in drug related deaths however, a cocktail of different drugs was taken at once.

The drug related death rate in the UK is one of the highest in Europe; with about one third of all European drug related deaths in 2017 occurring in the UK (35) (Figure 4.4). And the situation is getting worse - in 2018, England and Wales saw the highest number and greatest annual increase of drug poisoning deaths on record (4,359 deaths, an increase of 16% from 2017 (36)). For context, this is almost twice the number of people who died on UK roads in 2017 (although some people who died on the roads will also have had drugs in their system).

Portsmouth and Southampton both have drug related death rates that are higher than the English average at a statistically significant level, and amongst the highest rates in the South East (37) (Figure 4.5). The rates in both cities have increased over the last decade but have improved slightly in the last couple of years (37) (Figure 4.6).

Figure 4.3 - The number of times illicit drugs were mentioned on death certificates in England and Wales in 2018 (34)

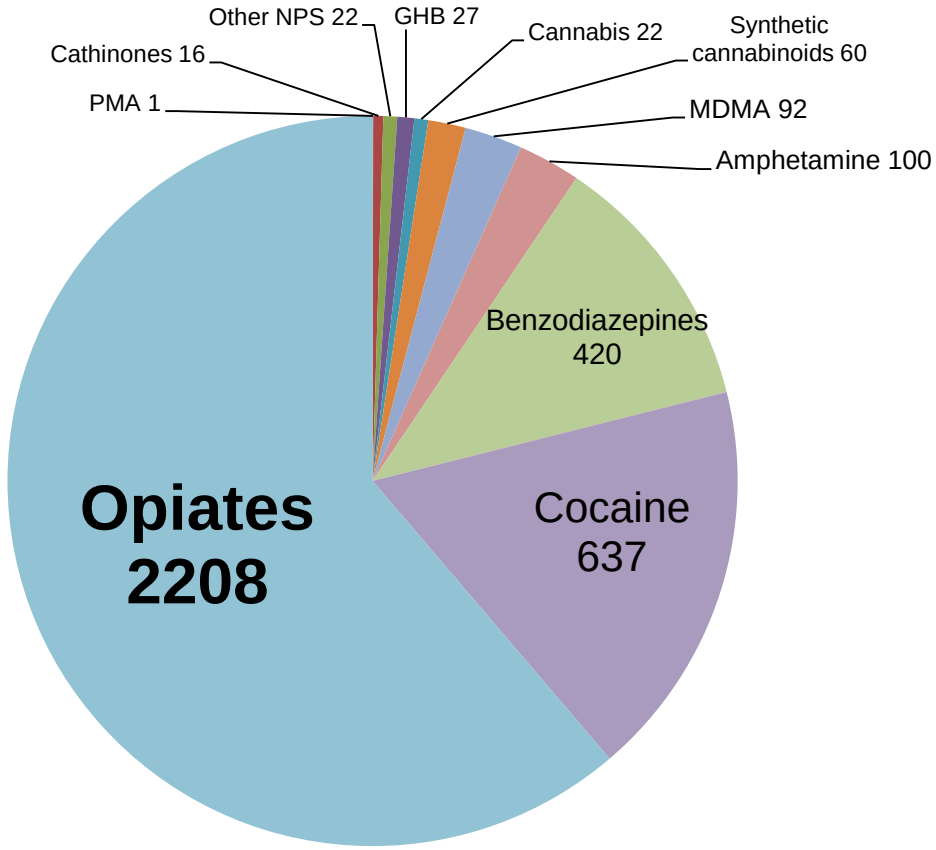


Figure 4.4 – Drug related deaths in the EU, Turkey and Norway in 2017 or from most recent data (35)

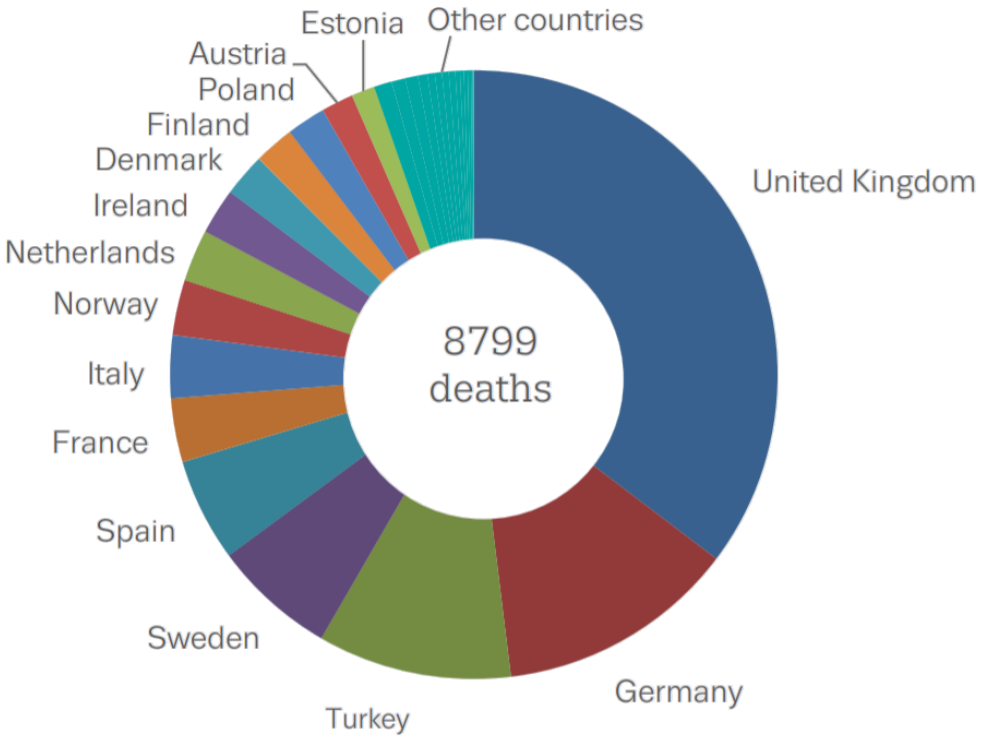


Figure 4.5 - Age standardised mortality rate per 100,000 population for deaths related to drug misuse 2016-18 in the South East (37)

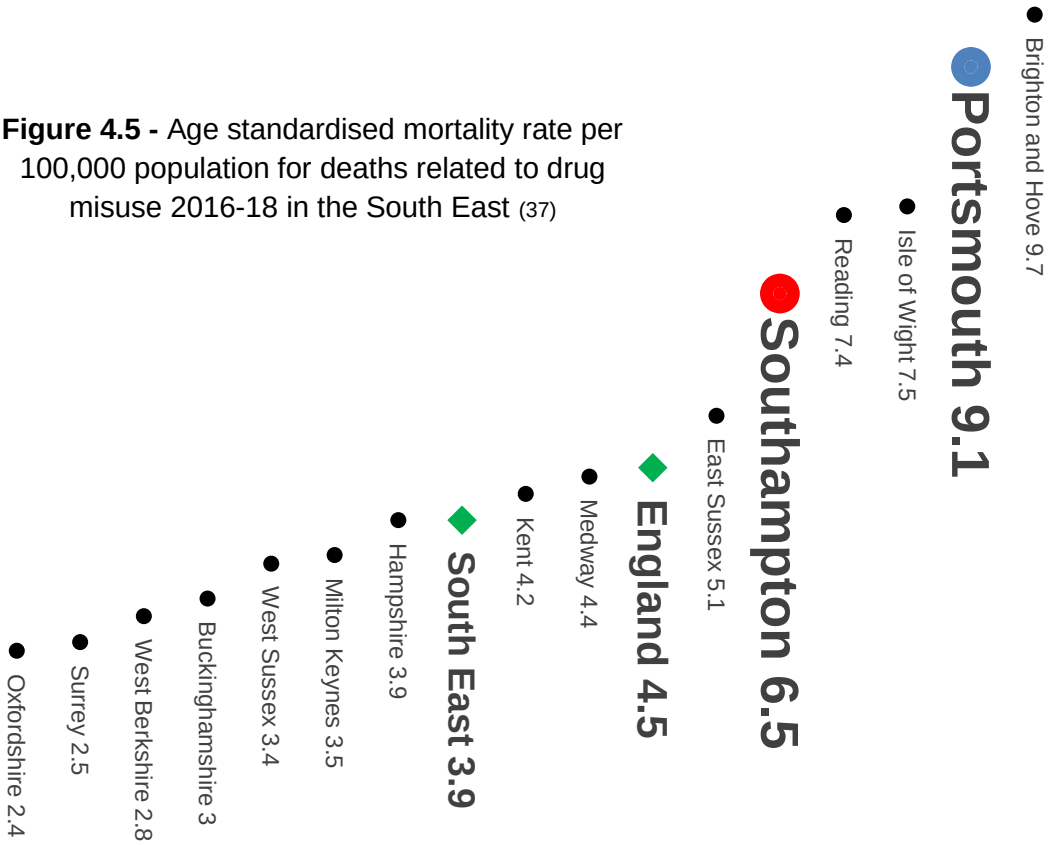
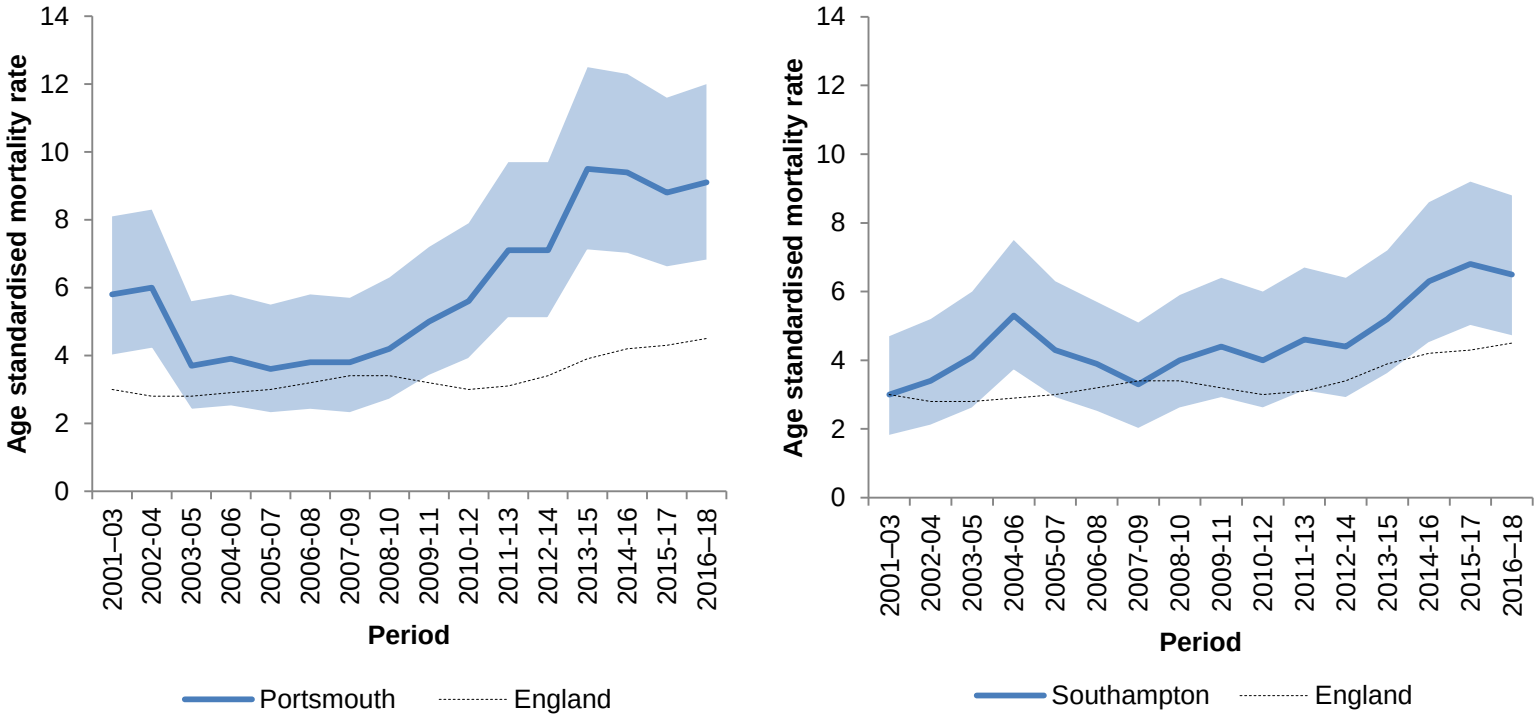


Figure 4.6 - Mortality rate per 100,000 population for deaths related to drug misuse in Southampton and Portsmouth 2001-2018 (37)



Blue shaded area represents 95% confidence intervals

Box 1 - Club drugs and Mutiny festival deaths

At Mutiny festival 2018 in Portsmouth two young people died after taking MDMA and more than 30 others attended hospital for drug related issues.

- The average MDMA pill strength in Europe increased 138% between 2006 and 2016 from 83 mg/pill to 156 mg/pill (6). Pills tested in England have been found to contain more than 300mg of MDMA, double the European average (38).
- Cocaine purity is at its highest level for over a decade (6).
- People who use club drugs are often unable to tell when they have been sold a different drug to what they were expecting (37). Sometimes when people think they are buying MDMA they are actually buying more dangerous drugs such as N-ethyl-pentylone, which can cause insomnia and psychosis or PMA, which has a higher risk of serotonin syndrome and death (38).

Young people who attend festivals and electronic dance music events may be more likely to take drugs than the general population (40) (41) (42) (43) (44) (45). It is likely that most of them will only use drugs for a small proportion of their lives, but sometimes this is long enough to have serious consequences.

Box 2 - Fentanyl - an emerging threat

Fentanyl has similar effects to morphine but is 50-100 times stronger, and related drugs such as carfentanil are even stronger. Drug manufacturers can increase the strength of heroin at little cost by mixing it with one of these drugs, which puts the person using the substance at a much higher risk of overdose. Fentanyl is sometimes also mixed with cocaine or can be used on its own. The USA is facing a 'fentanyl crisis' as fentanyl related deaths have risen dramatically over the last decade (46).

In 2007 there were six deaths in England and Wales related to fentanyl and other closely related drugs. In 2018 there were 105 (34). This is still a relatively small proportion of opiate related deaths, but the trend is concerning.

Also, it is very possible that this number is an underestimate as fentanyl is not routinely tested for by coroners and may be mistaken for other opiates (47).

Why have drug related deaths increased?

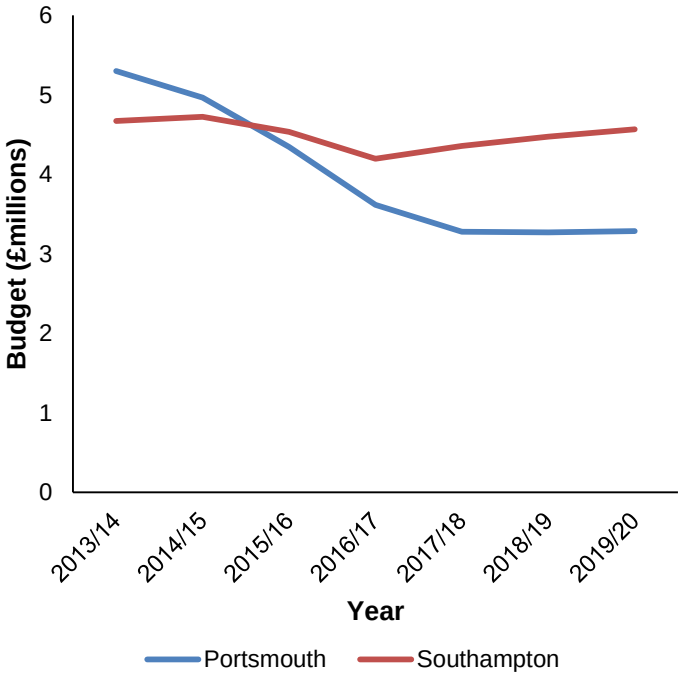
The amount of people using drugs has not dramatically increased as far as we can tell so what has changed so that more people are dying? It may be because….

…the *services* are changing

The resources available have decreased and services are under greater strain:

- Since 2013 the substance misuse service budget in Southampton has remained roughly the same, but in Portsmouth it has decreased by 38% (48) (Figure 4.7). This has affected services in various ways, but in particular there has been a reduction in the amount of money available for rehab placements.
- Various local authorities report that because of a lack of funding they are unable to comprehensively provide evidence based treatments for problematic drug use (49) .
- Although the NHS budget has increased the NHS is facing greater demand and the rate at which the budget is increasing has slowed in recent years (50).

Figure 4.7 - Substance misuse treatment and prevention budget for Portsmouth and Southampton 2013-2020 (46)



…suicides are increasing

- A Public Health England inquiry identified that the number of people using illicit drugs to commit suicide had increased (51). This could be compounded by the increasing strain on mental health services.

…the *drugs* are changing

- The purity of heroin in circulation decreased in 2010 but returned to previous more dangerous levels in 2013/14, which correlated with increased heroin related deaths (6).
- Cocaine and MDMA strength have increased dramatically over the last decade (Box 1, page 36).
- Drugs are being cut with other more dangerous drugs, such as heroin being mixed with fentanyl (Box 2, page 36).
- There has been an increase in the prescription of some medications, such as pregabalin and opioids (51).

…the *people using drugs* are changing

- Nationally, the average age of people dying in drug related deaths is increasing (53). Older people who use opiates may have been using drugs for a longer time, exposing themselves to more risk, and their bodies may be less able to deal with the side effects.
- Homelessness is increasing. People who are homeless are more likely to have other medical problems and difficulties accessing healthcare.

…*how people are taking drugs* is changing

- People may be mixing different illicit drugs together and with alcohol more. Different drugs may interact and become more dangerous when taken together in some circumstances (51). For example, when cocaine and alcohol are used together, they form cocaethylene in the body, which is more cardiotoxic than cocaine alone (52).

…maybe we've got the numbers wrong

- Estimates of the number of people using opiates and crack cocaine are calculated with data from the police and other services. A smaller proportion of the people using opiates and crack cocaine could be being seen by services because of decreasing capacity while the number not being seen and therefore not being counted increases.
- It is possible that reporting is improving, and coroners are getting better at identifying when a death is related to drug use (51).

Conclusion

Different drugs cause different health problems and come with different levels of risk. Many of the health risks associated with drugs are exacerbated by the fact that their production is not regulated, which means they may be excessively strong, or adulterated with other substances. Some health problems develop over time. In other instances, there might be disastrous consequences from using a drug only once. As with estimating the amount of drug use it is difficult to ascertain how much harm drugs cause as harm is likely underreported or not recognised as related to drug use. It is likely that the harm we are seeing is **the tip of the iceberg.**

Chapter 5 - The wider harms from drugs

Drug use is associated with much more harm than the direct health effects of the drugs. The mind map on page 42 shows many of the ways that drugs might cause harm. Drugs related harm could affect….

- **People using drugs** - for example if their drug use leads to them getting arrested, losing their job, falling into debt, making unwise decisions or adds strain to their personal relationships. Becoming dependent on drugs can also make someone more vulnerable to being exploited. This is particularly important as people are forced into sex work or used to sell or traffic drugs by county lines dealers (see page 41).
- **The families and friends of people who use drugs** - for example if their drug use is associated with domestic violence or if children are exposed to adverse childhood experiences related to their parents' drug use.
- **Wider society** - The Home Office in 2011 estimated that illicit drug use costs UK society **£10.7 billion** a year and the National Treatment Agency in 2014 estimated **£15.4 billion** (54) (55). A large proportion of these costs are due to drug related crime with other costs related to policing, health care and drug related deaths.

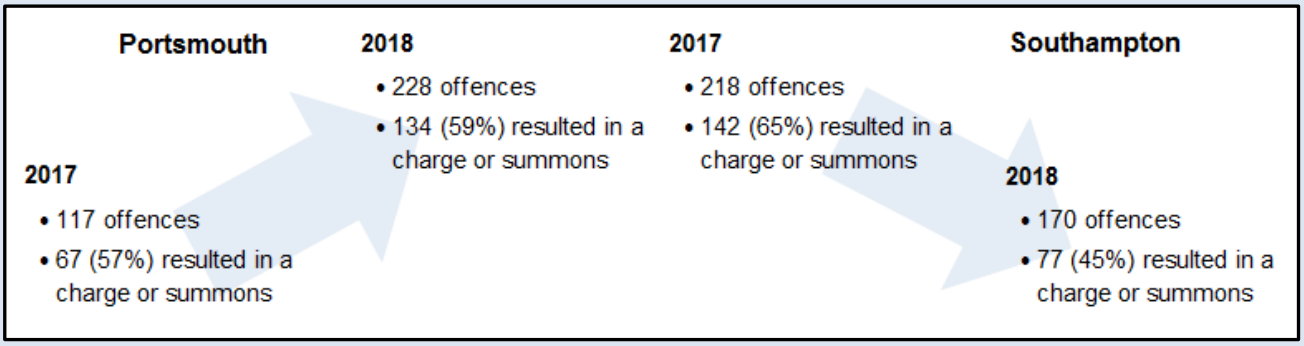
Drugs and crime

Drug use is associated with increased criminal activity in three ways:

1. Crimes perpetrated by drug dealers

Drug trafficking is defined in the UK as transporting, storing, importing, exporting, manufacturing or supplying drugs (53). It is a criminal offence that is orchestrated sometimes by organised gangs, or sometimes by individuals. Between 2017 and 2018 drug trafficking offences increased in Portsmouth and decreased in Southampton (Figure 5.1). This might represent changes in levels of police activity or reporting rather than changes in the illicit drugs market.

Figure 5.1 - Drugs trafficking offences in Portsmouth and Southampton



In the process of trafficking drugs criminals involved in the drugs trade may commit other offences including acts of violence and exploitation against other drug dealers and vulnerable people including children and people who are dependent on drugs who are forced to work for them (see page xx).

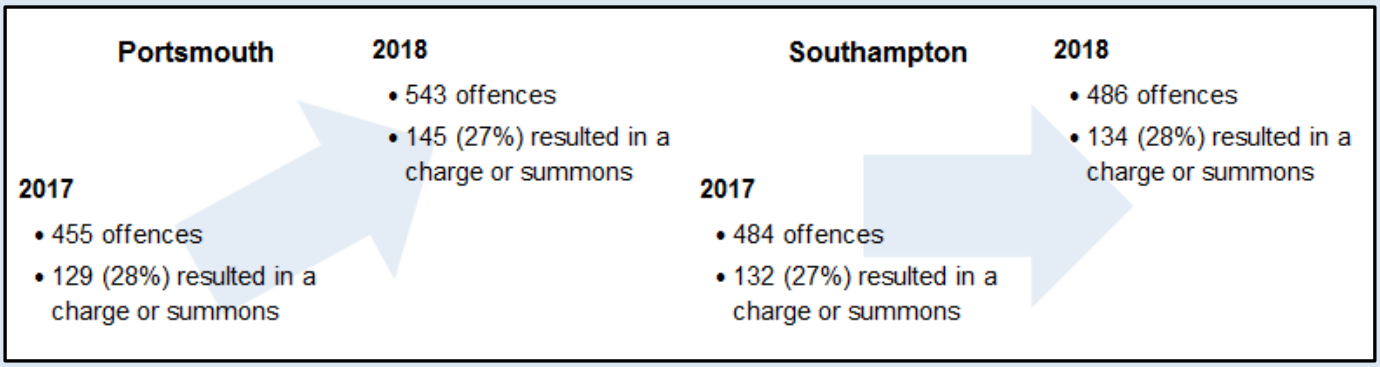
20% of homicide suspects in England and Wales in 2017/18 were known to be drug dealers and 44% of homicides were somehow related to drugs (56).

2. Crimes perpetrated by people who use drugs

People who are dependent on drugs may turn to crime to fund their habit. The Home Office estimated that **45% of acquisitive crime is committed by people who regularly use crack cocaine or heroin** (54).

The possession of drugs is itself a criminal offence. Whether this is the best way to try and reduce drug related harm is discussed in Chapter 6 - 'Why are some drugs illegal?' but enforcing the law costs the police and courts time and money. Between 2017 and 2018 drug possession offences increased in Portsmouth but were largely stable in Southampton (Figure 5.2). Again, changes might be due to changing police activity or reporting rather than changes in the amount drugs used.

Figure 5.2 - Drug possession offences in Portsmouth and Southampton



Drugs can affect the way that the people who use them think and lead them to make decisions that they would not otherwise make. In some cases, this can make it more likely that they commit criminal acts. This may be more likely with certain types of drugs, anecdotally people using cocaine may be more prone to aggression and violence than people using other drugs. Figure 5.3 shows the crimes committed in Southampton and Portsmouth in 2016/17 and 2017/2018 that involved drugs.

In 2017/18 in England and Wales 7% of drivers who had taken an illicit drug in the last 12 months who responded to the Crime Survey for England and Wales reported having driven under the influence of an illicit drug at least once that year (57). Using illicit drugs impairs the ability of the person taking them to drive safely and may make accidents more likely. It is unclear how many road traffic accidents are related to drug driving.

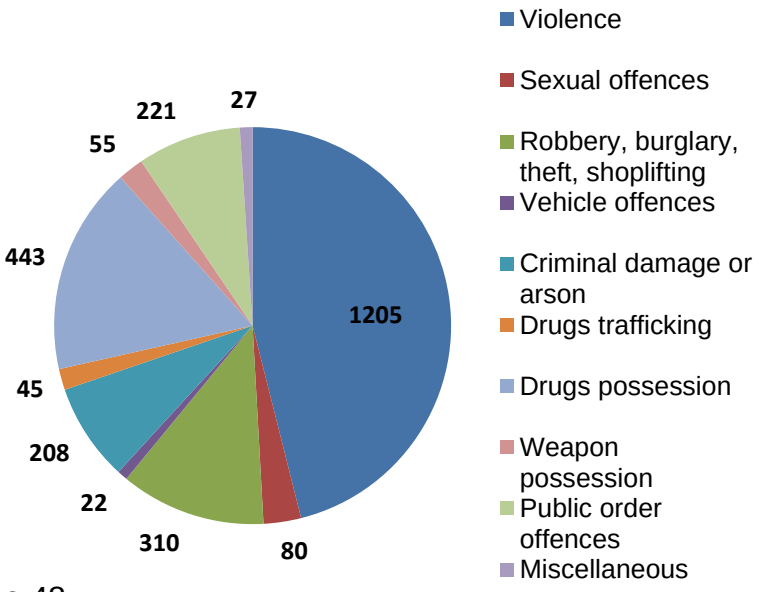
3. Other crime and terrorism funded by the illicit drugs trade

The annual global illicit drug market is estimated to be worth up to $652 billion (58). Only twenty countries in the world had a gross domestic product greater than this in 2017 (59). As well as making criminals richer this money could be used to fund other criminal activities such as people trafficking and terrorism.

It is not possible to be certain that terrorist organisations are funded by drug trafficking but the United Nations Security Council asserts that this is the case (60) and increased levels of drug trafficking have been shown to coincide with increased levels of terrorism in central Asia (61).

People who are using drugs, even only occasionally should be aware of the wider harm that the drugs trade they are financing is associated with.

Figure 5.3 - Offences that involved drugs in Southampton and Portsmouth in 2016/17 and 2017/18



Exploitation and county lines dealing

Vulnerable people including children, people with learning disabilities and people dependent on drugs can be used by dealers to traffic or sell drugs. This has been seen increasingly in recent years with the recognition of county lines dealing.

The drugs trade in the UK is changing. Drug dealers from London and other cities are being found more and more to have operations in other cities and towns throughout the UK - so called 'county lines activity'.

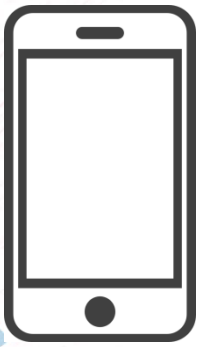
County lines are normally operated by organised gangs, but in some cases are run by individuals.

They allow drug dealers to take advantage of gaps in the market and offer distance and anonymity.

Drug sales can be performed either by:

- 'Commuting' - Travelling to and from another area in a day.
- 'Holidaying' - Spending several days in the target location.
- 'Cuckooing' - Where a base of operation is set up in the house of a vulnerable individual for weeks to months at a time.

People trying to recover from drug dependence describe being bombarded with text messages making it difficult to stay off drugs.



'County lines' activity is named for the phone lines that play an integral part of the operation; being used to arrange drug deals and advertise when drugs are available.

The police estimate there are about 100 county lines operating in Hampshire, but the number fluctuates.

Vulnerable people; children, people with learning difficulties, adults with welfare needs, people who are dependent on drugs and isolated and vulnerable women can be used by gangs in both the home and target areas as drug runners or their houses used for cuckooing.

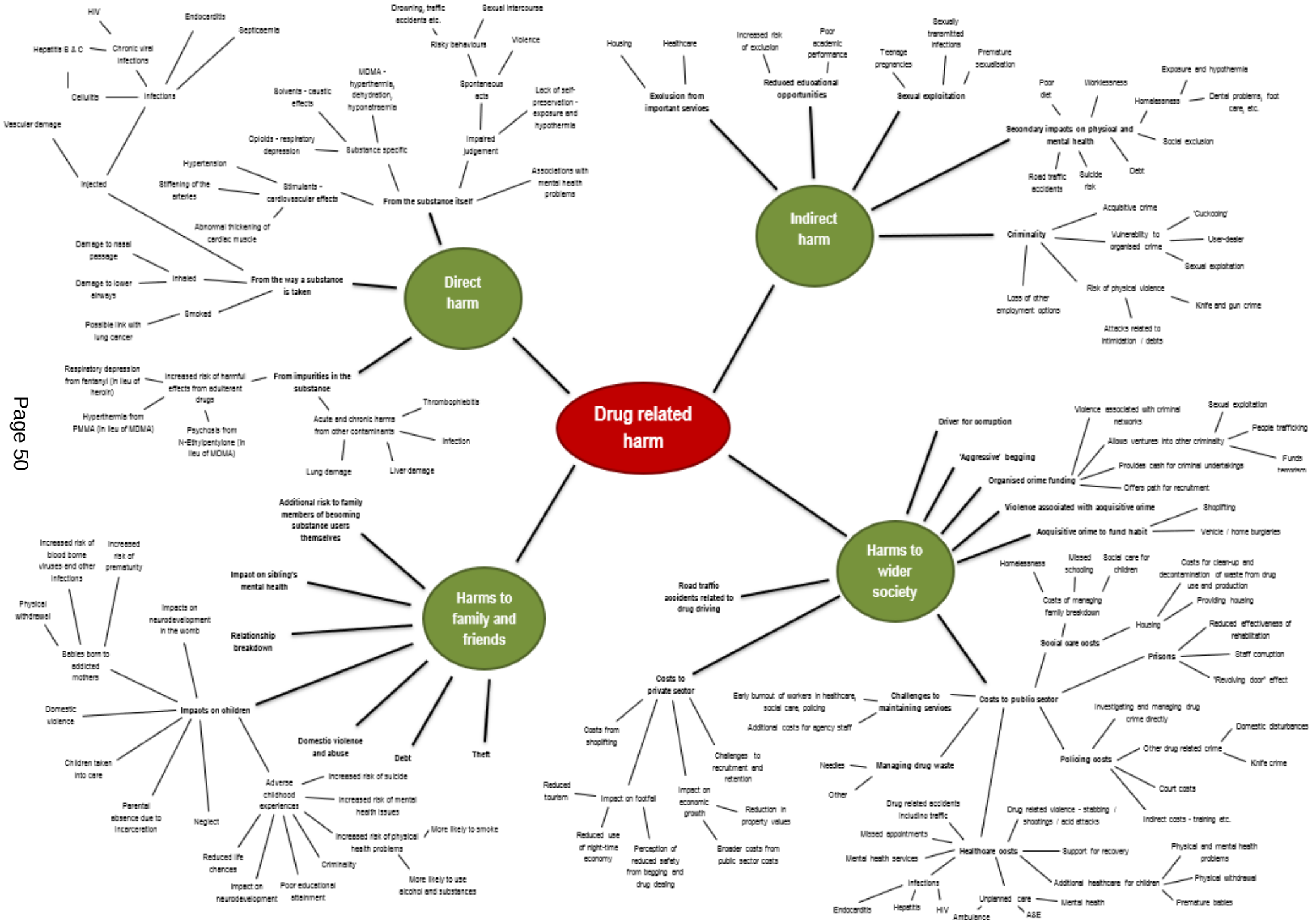
Vulnerable people can be persuaded to work with money and drugs, manipulated or threatened with violence.

Victims have reported stabbings and other violent, sexual and mental abuse.

If you want to know more about county lines the Home Office has published guidance explaining some of the warning signs to look out for in people at risk (62)

Figure 5.4 - County Lines Activity - Information from (63) (62) (64) and discussions with local police.

Some of the direct and indirect harms that drugs cause to people using them, their family and friends and wider society



Conclusion

It is impossible to know how much of an impact drug use and the drugs market is having on the lives of people using drugs, the people they know and everyone else in society. It is likely the harm that we know about is **the tip of the iceberg**. Much of this harm is not a direct result of the use of drugs but related to their illegality and the criminal activity associated with the drugs market.

Chapter 6 - Why are some drugs illegal?

Different people produce, sell and buy drugs. Legislation can be used to make each or all of these steps a criminal offence. Alternatively, it can be used to regulate the production and supply of drugs, for example with a licensing system, advertising bans and age limits on eligible customers.

Drug laws vary in different countries and depend on the drug. In the UK:

- Caffeine is regulated as a food ingredient.
- Alcohol and tobacco have specific legislation to control their production and supply.
- The possession of other psychoactive substances without a prescription is treated as a criminal offence.

The history of UK drugs legislation

Drug use has not always been considered a matter of criminal justice in the UK. In the early 1900s legislation was introduced to control the use of heroin and cocaine and since then the scope of substances controlled has increased with subsequent legislation.

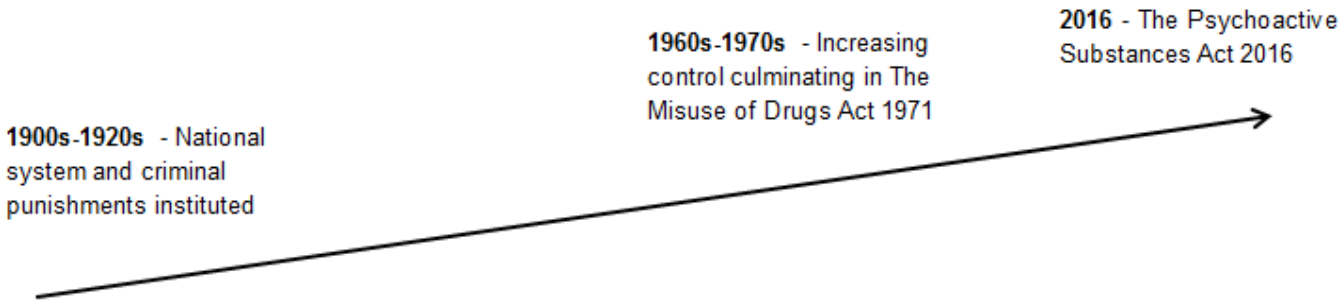
UK drug policy is heavily influenced by international conventions; most notably the 1961 UN Single Convention on Narcotic Drugs, which classifies drugs into schedules allegedly corresponding to the level of harm the drugs cause, although this isn't always accurate (65). This convention made its way into UK law as the Misuse of Drugs Act 1971, which put illegal drugs into classes A, B and C corresponding to the international schedules (Figure 6.1).

Figure 6.1 – The classes of drugs in the UK and punishments for possession and supply/production (66)

Class	Examples	Punishment for possession	Punishment for supply/production
A	Heroin, cocaine, MDMA, LSD, magic mushrooms	Up to 7 years in prison +/- unlimited fine	Up to life in prison +/- unlimited fine
B	Cannabis, ketamine, amphetamines, cathinones, synthetic cannabinoids	Up to 5 years in prison +/- unlimited fine	Up to 14 years in prison +/- unlimited fine
C	GHB, benzodiazepines, piperazines	Up to 2 years in prison +/- unlimited fine	Up to 14 years in prison +/- unlimited fine

The increasing use of novel psychoactive substances (NPS) not controlled under the Misuse of Drugs Act led to the creation of the Psychoactive Substances Act 2016, which makes it a criminal offence to possess or supply any substance deemed to have psychoactive properties, with a few exceptions including caffeine and alcohol (Figure 6.2).

Figure 6.2 - Important milestones in UK drug policy



The USA has had a notable influence on the trajectory of international drugs policy and the formation of the UN drug conventions. Over the last 120 years, to differing degrees, American administrations have advocated for drug prohibition and harsh punishments for drug possession at home and abroad. This was most obvious in the 'War on Drugs' waged by presidents Nixon and Reagan, which was arguably fuelled more by political motivations than by evidence it would work (67).

Figure 6.3 - Richard Nixon meeting Elvis Presley whose drug use may have contributed to his death

Levels of harm and legal status

A panel of experts analysed the harm caused by selected drugs and found that the level of harm a drug is responsible for often does not correspond to its legal status. Alcohol was identified as the drug that causes most harm to society. Given that alcohol is legal, this suggests that current drugs policy is more a product of history and politics than evidence (Figure 6.4-6.5). It is worth noting that this study did not consider spice and other synthetic cannabinoids and opiates apart from heroin, both of which have a significant public health impact.

Figure 6.4 - The harm to people who use drugs and others caused by selected illicit drugs, alcohol and tobacco as determined by multi criteria decision analysis by a panel of experts (68)

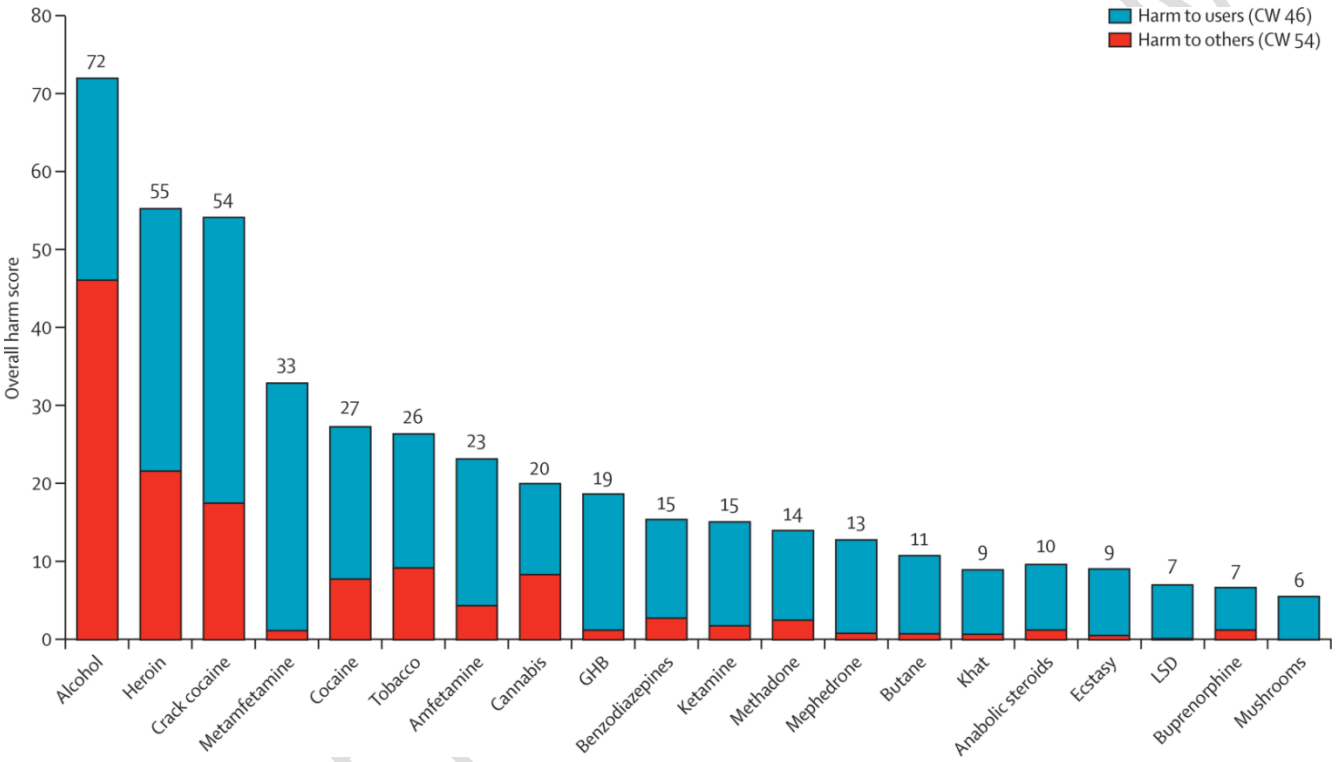
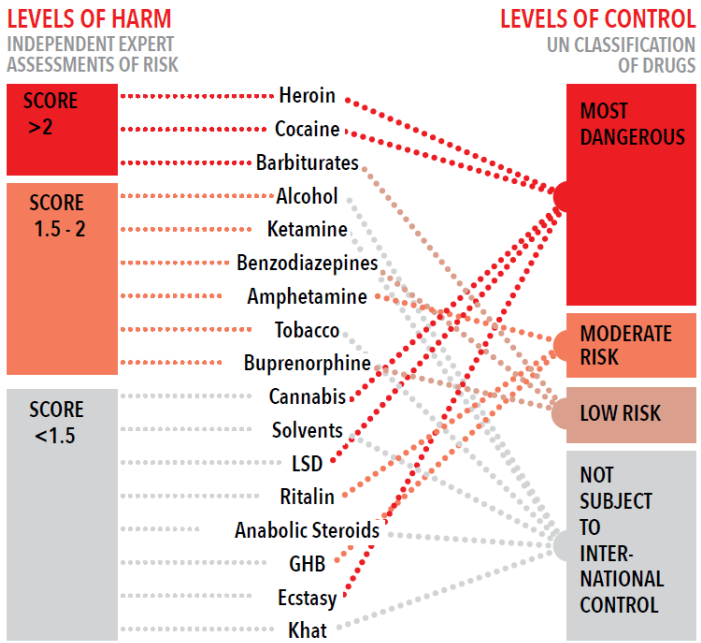


Figure 6.5 - How the harm drugs cause corresponds to their legal classification (69)



Why do we have prohibition?

Enforcing prohibition based drugs policy is expensive, causes significant harm to the individuals who are charged with drug offences and causes harm to wider society as the drugs market is pushed underground providing a source of funding for criminal organisations. For it to be justified it would have to prevent more harm than it causes. Three important questions to try and answer when working out whether this is the case are:

1. Does the law decrease the demand for drugs?
2. Can the law stop the supply of drugs?
3. Does the law help people who use drugs?

1. Does the law decrease the demand for drugs?

Various bodies have questioned the effectiveness of the law in discouraging drug use. The BMA pointed out that although the law likely dissuades some people from drug use, cultural factors and social norms may be more important (32). And the UK Police Foundation inquiry suggested that the law plays only a minor role in reducing the demand for drugs (70).

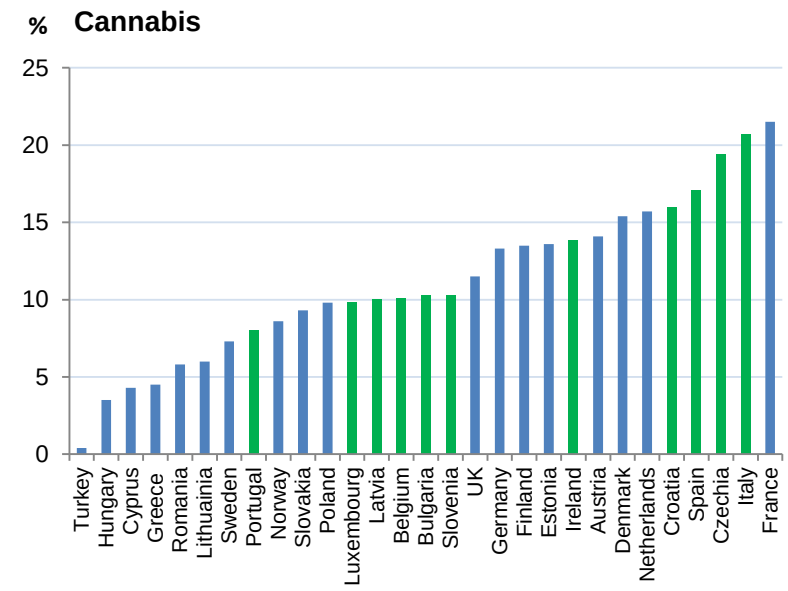
It is difficult to know what things would be like in the UK if the drugs that are currently illegal were decriminalised or regulated but we can get some idea from looking at other countries where the law is different. **According to a recent Home Office report there is no clear relationship between how strict a country's drug laws are and the level of drug use in that country** (71).

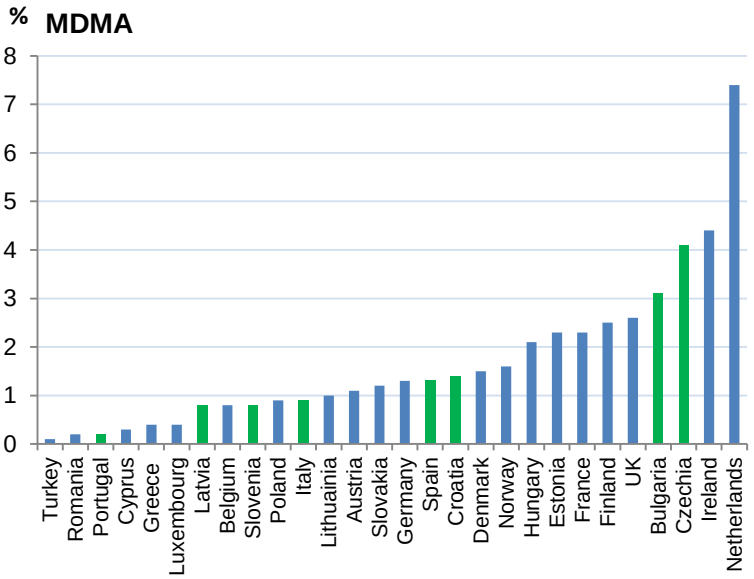
This can be seen in Figure 6.6, which shows the estimated proportion of 15-34 year olds in EU countries who have used cannabis, MDMA, amphetamines and cocaine in the last year and the countries' estimated rate of high risk opioid users. The bars that are green are countries in which it is not possible to be put in prison for possessing that drug. If threats of harsher punishments were effective in stopping people from using drugs the green bars would be clustered to the right of the graphs suggesting that drug use is higher in countries with more lenient laws - this is not the case.

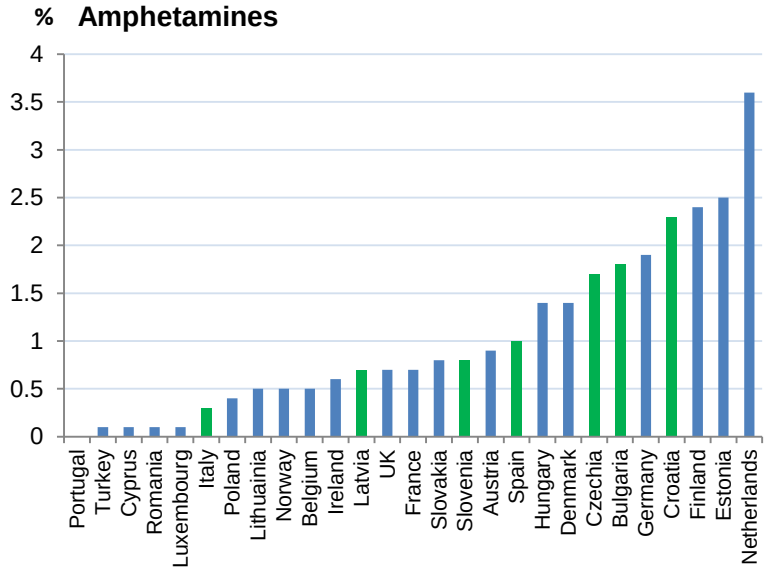
A recent study analysed the level of adolescent cannabis use and policy liberality across 38 countries. It was found that **countries with prohibition do not have less cannabis use to a statistically significant level**. In fact, **in countries with prohibition adolescent males were more likely to have tried cannabis**; perhaps because of a desire to rebel against authority (72).

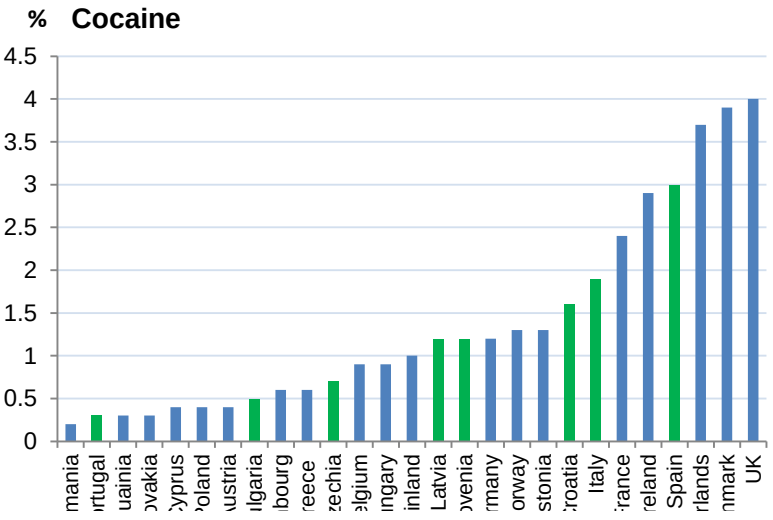
Differences between the cultures and social norms of different countries make it impossible to make firm conclusions about the effect of drugs policies. More information can be gleaned by looking at what happens in countries when drug laws are relaxed. The organisation Release examined drug use prevalence in countries before and after drug possession was decriminalised. They found that in some areas drug use increased, in others it decreased but nowhere did drug use skyrocket as some predicted (73).

Figure 6.6 - The estimated proportions of 15-34 year olds who used cannabis, MDMA, amphetamines and cocaine in the last year and the rate of high risk opioid users per 10,000 15-64 year olds in EU countries based on most recent surveys and estimates - countries with depenalisation policies in green (74)





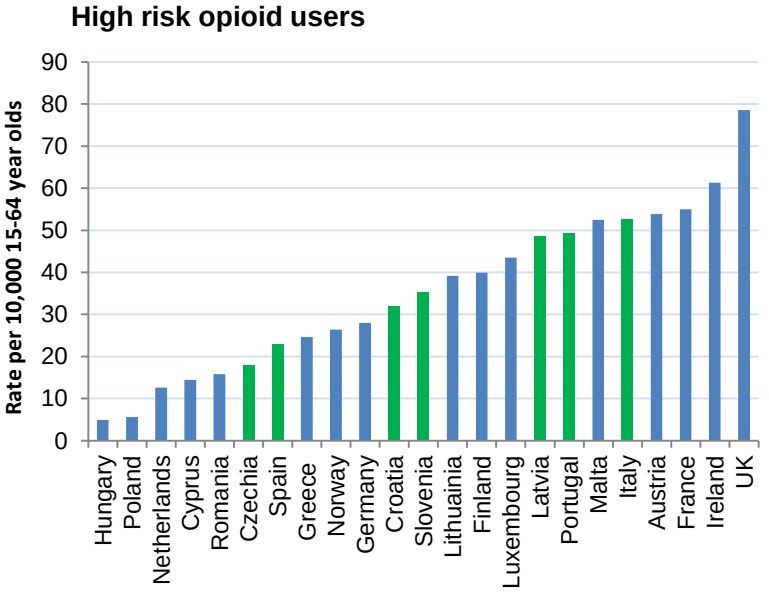




Legend

Countries in which it is possible to be imprisoned for the possession of that drug for personal use

Countries in which it is **not** possible to be imprisoned for the possession of that drug for personal use



Data are taken from the most recent available national surveys and estimates reported by the EMCDDA (74). In some countries, such as Ireland it is not possible to be imprisoned for the possession of cannabis, but it is for other drugs. EU countries for which data are not available are not included. Depenalisation is used as a marker of drug law severity as a clear binary variable, but degrees of decriminalisation vary between countries and in some countries, such as the Netherlands there is de facto decriminalisation, where although strict punishments are theoretically possible, they are not utilised (73). Countries with depenalisation identified from EMCDDA map (53).

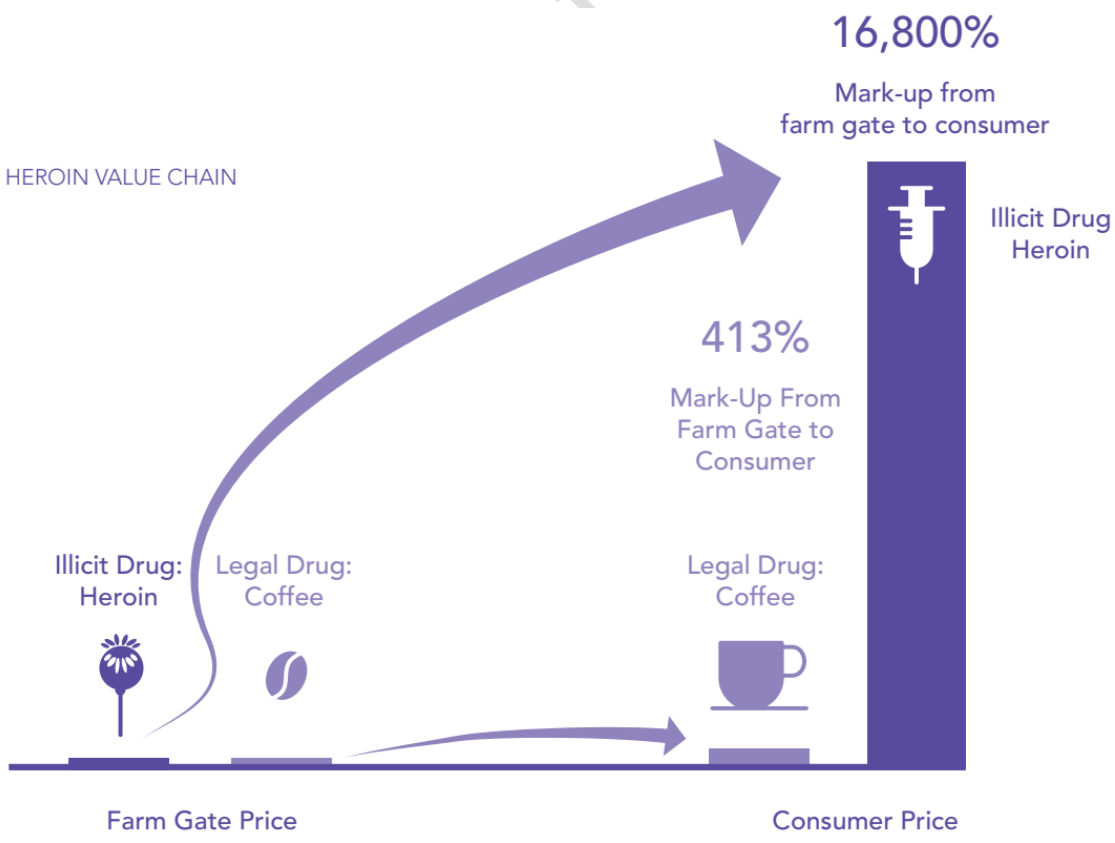
2. Can the law stop the supply of drugs?

Huge amounts of drugs are seized in international efforts to prevent the supply of drugs. This could be pointed to as a sign of success, but as more drugs are seized and routes to transport them are blocked more drugs are produced and routes to transport them established (75). Conflicts with gangs that smuggle drugs can be devastating for the countries the conflicts take place in, for example Colombia and Afghanistan.

Criminals are able to make a massive profit on the drugs they sell - street heroin for example is sold for an estimated 16,800% of its cost of production (76) (Figure 6.7). Drugs that are seized act as a tax easily absorbed by this profit margin and producers are incentivised to risk arrest and come up with new ways to avoid interception. In the UK this has led to both the development of county lines dealing and drugs being sold on the dark web, which means people can get hold of drugs without even leaving their home. Additionally, the profits can be used to bribe officials and encourage corruption.

If the war on drugs was successful, the price of illicit drugs would have increased making them unaffordable. This has not happened, and some drugs are actually getting less expensive (74) (77).

Figure 6.7 – the estimated mark-up in value from the farm gate for illicit heroin, demonstrating the profit margin for drug producers and dealers (76).

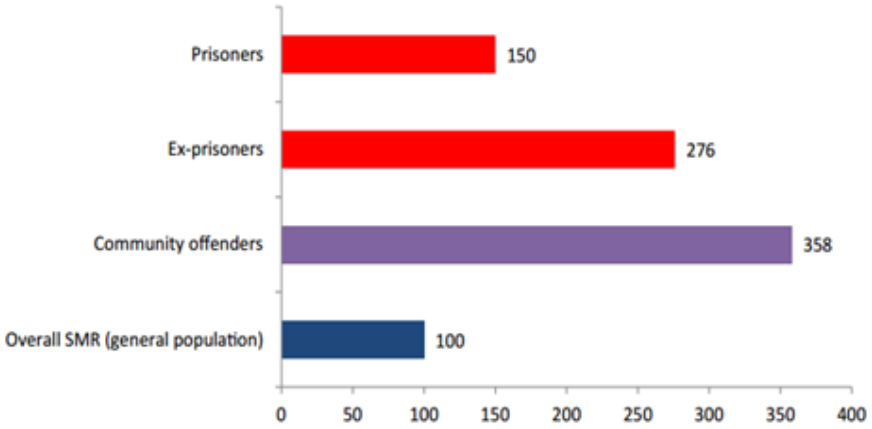


For fifty years concerted efforts to stop the supply of illicit drugs have not been successful and there is no reason to think that they will be in the future.

3. Does the law help people who use drugs?

Contact with the criminal justice system is associated with various poor outcomes. Employment prospects are threatened so socioeconomic deprivation, a well-recognised risk factor for further drug problems becomes more likely. And offenders are more likely to have poor health - those with community probation orders are more than 3.5 times as likely to die compared with age matched individuals in the general population (78) (Figure 6.8).

Figure 6.8 - Standardised mortality ratios of offenders compared to the general population (78)

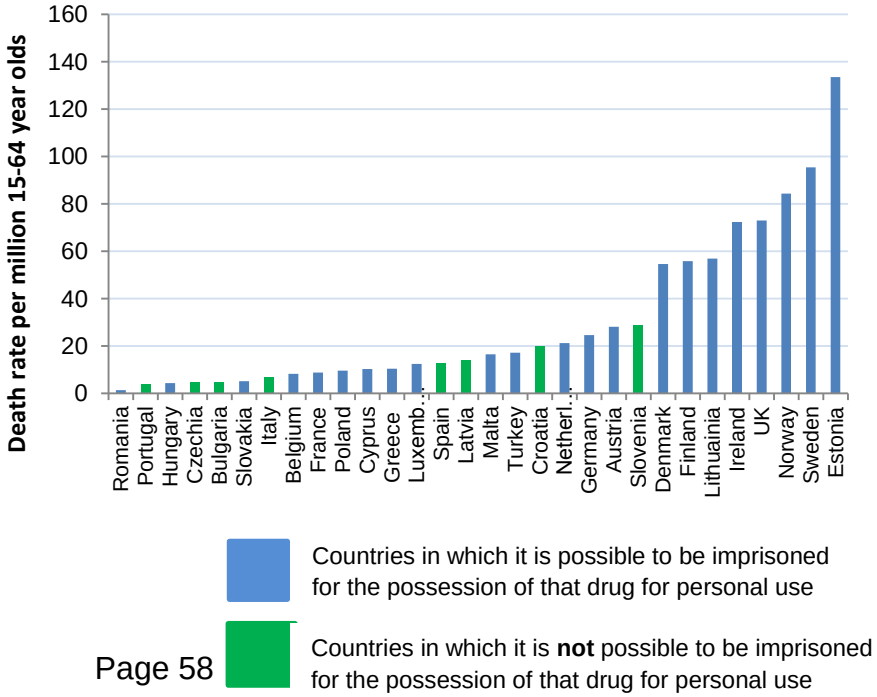


Putting somebody in prison is unlikely to help them stop using drugs. More than a quarter of inmates reported drug use in an HM Inspectorate of Prisons survey (79). This might be because the boredom of being in prison encourages inmates to use drugs.

If people are more worried about the law, they may be less likely to seek help for drug related issues and more likely to adopt maladaptive behaviours that put them at greater risk of drug related harm. For example, one in ten people at music festivals in Australia who had drugs on them when they saw drug detection dogs reported immediately taking them (80). Other studies describe people risking hiding drugs inside body cavities and taking more dangerous drugs they believe are harder to detect in order to avoid security personnel and the police (81) (82).

Strikingly, nearly all EU countries with less punitive drug laws have drug related death rates below the European average (74) (Figure 6.9). Strict laws do not seem to be effectively preventing drug related harm and in fact the opposite may be true.

Figure 6.9 - Drug related deaths per million 15-64 year olds in EMCDDA reporting countries from most recent estimates with countries with depenalisation of all drugs in green (74)



Ethical considerations

Public health ethicists suggest that as far as possible force should not be exerted over anyone if they are not harming other people (83). The act of using drugs does not directly harm other people, dealing them does. From this perspective it makes sense that drug dealers who sell harmful substances should be pursued by the law but punishing people for possessing drugs for their own use is ethically dubious.

It is also ethically troubling that the law is exercised variably, which can lead to punishments being used disproportionately for certain groups, based on the conscious or unconscious prejudices of those exercising it (Box 3).

Box 3 - Racial disparities

Whether somebody is arrested and charged for drug related offences may be determined by the conscious or unconscious prejudices of those responsible for doing so. Research suggests that black people use drugs at a similar level or less than white people, but despite this in England and Wales in 2016/17 compared to white people, black people were:

- Subject to being stopped and searched 8.4 times more.
- Prosecuted for drug offences 8 times more.
- Convicted of cannabis possession 11.8 times more.
- Sentenced to immediate custody for drug offences 9.1 times more.

A quarter of people convicted for cannabis possession in England and Wales in 2016/17 were black, despite black people making up less than 4% of the population.

(84)

It is unjust that some can admit the use of drugs without punishment, including politicians and celebrities, while others are charged with drug possession offences with potentially devastating consequences.

Conclusion

Questions about drug policy often become entangled in questions about the morality of drug use. If the reason for making some drugs illegal is because it is immoral to use them then it is necessary to define what it is about them that makes them morally different to legal drugs such as alcohol and cigarettes. If the only answer to this question is “it is immoral to use them because they are illegal” – and this is the only answer that is readily apparent - then the argument is “drugs are illegal because they are immoral, and they are immoral because they are illegal”. This is a circular argument that has no place in sensible, evidence based policy making.

There is no relationship between how harmful different drugs are and their legal status, which is based more on political and historical considerations than evidence. There is not clear evidence that punitive prohibition-based drug policy reduces the demand for drugs, reduces the supply of drugs, or helps people who are using drugs. Without evidence that it reduces harm, punitive drugs policy is itself at best ethically dubious and at worst morally wrong.

Chapter 7 - What are the alternatives to current drug policy?

In Portugal and lots of other countries the possession of drugs for personal use has been decriminalised. In other countries like Spain it was never considered a criminal offence in the first place (73). Another potential approach would be to regulate drugs, like the UK government does with alcohol and tobacco. Some countries including Uruguay, Canada and parts of the USA have already begun to regulate the sale of cannabis.

The case for decriminalisation - what's happening in Portugal?

In Portugal in 2001, the possession of drugs became an administrative rather than a criminal offence. This means that people can still potentially receive a fine or another penalty if they are caught with drugs, but they are not arrested or sent to court and they don't get a criminal record.

Since decriminalisation in Portugal:

- Recent cocaine, amphetamine and ecstasy use has decreased*, whereas recent cannabis use has increased. A similar increase in cannabis use has been seen in Portugal's neighbouring countries, except for in Spain where use has decreased (74) and where the possession of drugs is not and has never been a criminal offence (73) (Figures 7.1-7.2).
- HIV rates have decreased dramatically (74) (Figure 7.3).
- It is likely that drug related deaths have decreased. The indicators used have changed so it is hard to say for sure, but in recent years there has been a marked decrease in the primary indicator used by the European Monitoring Centre for Drugs and Drug Addiction (74) (Figure 7.4).

*Lifetime use of drugs has increased but this is a poor marker of current drug use and likely represents transitive experimental use that does not become problematic.

Figure 7.1 - Proportion of 15-34 year olds using selected drugs in last 12 months in Portugal (74)

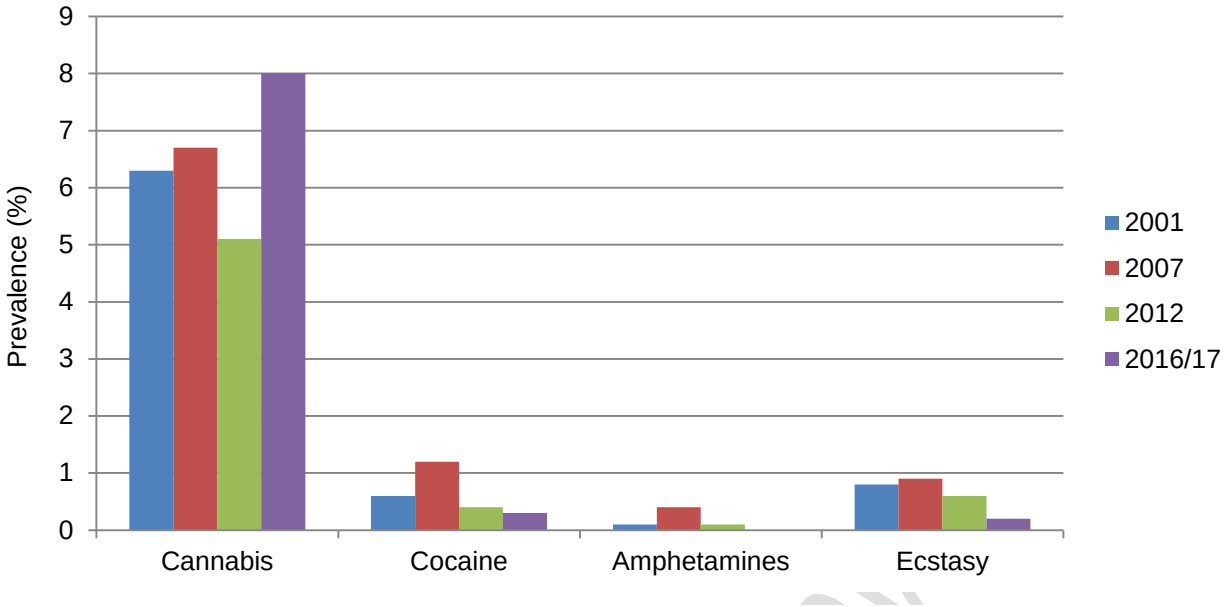


Figure 7.2 - Proportion of 15-64 year olds who used cannabis in the last 12 months in selected European countries from 2001-2017 (74)

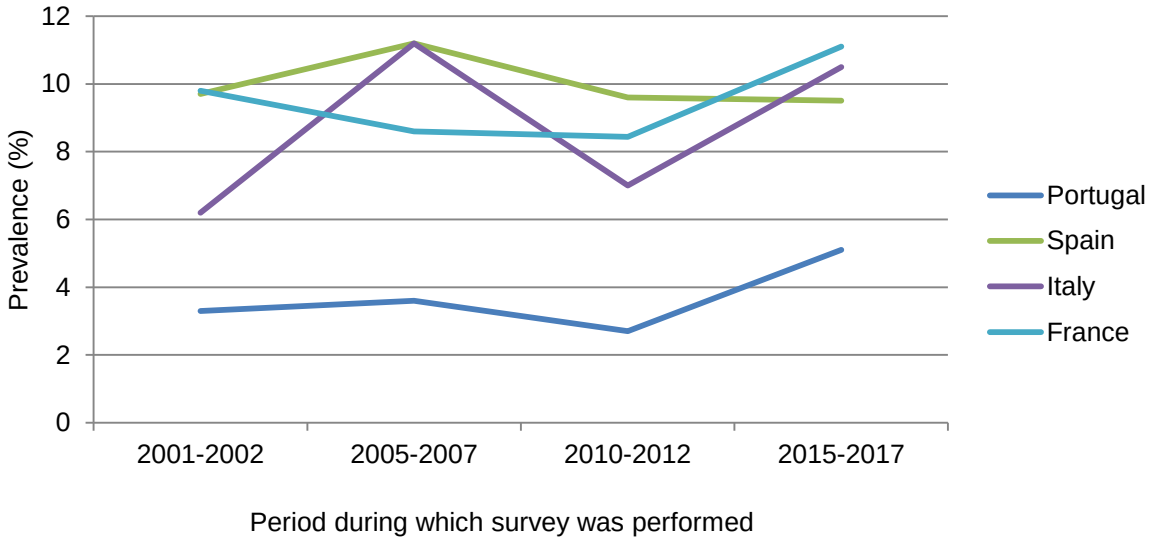


Figure 7.3 - Number of cases of HIV diagnosed in people who have injected drugs in Portugal and the UK from 2007-2016 (74)

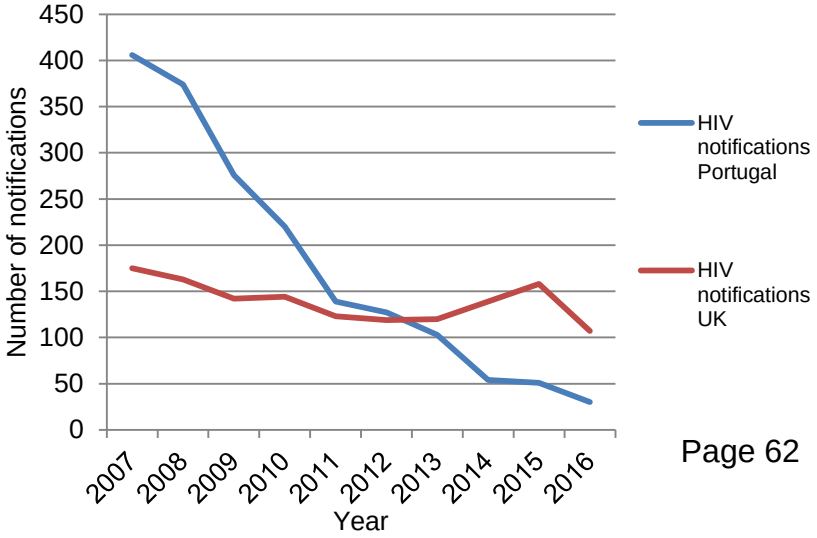
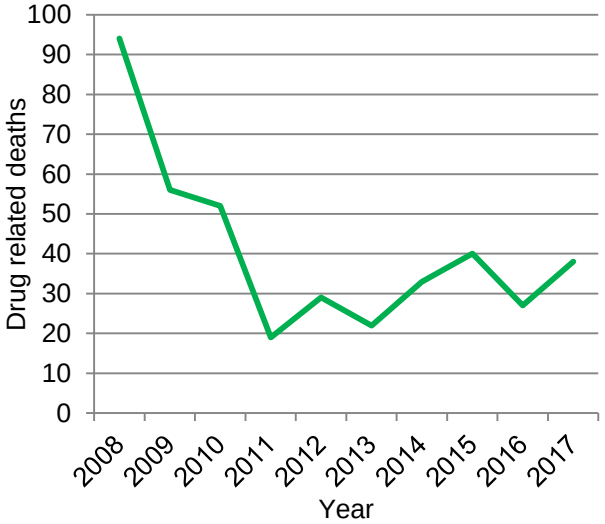


Figure 7.4 - Drug related deaths in Portugal from 2008-2017 from the Portuguese specialist death registry (74)



The way that drug related deaths are recorded is different in the UK and Portugal, so it is not possible to make direct comparisons between drug related death rates in the two countries. However, in 2016, **the drug related death rate in the UK was about 17 times higher than that in Portugal** (3256 deaths, 77.2 per million 15-64 year olds in the UK, 30 deaths, 4.5 per million 15-64 year olds in Portugal in 2016) (71). A difference of this magnitude is unlikely to be explained by recording practices alone.

The impressive changes seen in Portugal are despite the country being hit particularly hard by the global financial crisis - unemployment in Portugal reached 17.5% in 2013 (85). Given the association between deprivation and drug related harm, an increase in drug related harm would have been expected rather than the improvements that have been seen.

The government of Portugal seems to be doing something right. At the same time as drug possession was decriminalised however extra resources were invested in prevention and treatment services and the welfare state was expanded with the provision of a minimum basic income for all citizens. It is therefore difficult to untangle the effect that decriminalisation has had as opposed to these other factors. Nonetheless, decriminalisation has by no means been disastrous and may have been partially responsible for the benefits that have been seen.

The case for regulation

Although the decriminalisation of drug possession in the UK would likely be beneficial it may not address the harms caused by the illicit market for drugs, both in terms of the increasing strength and adulteration of drugs from their illicit production and the other crimes committed during drug trafficking and financed by with the money it raises. This may be possible if the government were to regulate the production and distribution of drugs.

Although this seems counterintuitive it becomes more palatable when considering that **opiate substitution therapy is effectively a highly regulated drugs market and we know that this helps reduce drug related harm.** Parallels can be drawn to the regulation of alcohol production to reduce the risk of blindness from inadvertent methanol contamination.

Different drugs have different risks and are used in different ways by different people and models of regulation should reflect this. Some ways in which drugs could be regulated are explored in box 4 on page 57.

A black market would almost definitely still exist alongside a regulated drug market, but any proportion of the market controlled by the government would decrease the profits that criminals are making. This could perhaps tip the scales for anyone weighing up the pros (financial incentives) and cons (threat of imprisonment) of being a drug dealer thereby reducing the number of people dealing drugs illegally.

Ethically, there are questions about whether it is right for the government to be involved in the production and sale of harmful substances. However, if the involvement could lead to a net reduction in harm then perhaps it is justified, and this is exactly what is done in the case of alcohol and tobacco with overwhelming evidence that it is beneficial.

Box 4 - What could regulation look like?

Much more work would be needed to design systems of drug regulation, but evidence gained from changes in the regulation of alcohol and tobacco gives us a head start. Over the last few decades these industries have been transformed. Whereas it was previously possible for manufacturers to freely advertise and make unscientific claims about the benefits of smoking and drinking they must now follow strict rules that limit their sales. That is not to say there is not still much to be done to limit the ways in which alcohol and tobacco can be sold too.

Some potential ways of regulating the drug market include:

- Strict control over production to prevent excessively strong or adulterated drugs being produced.
- Limits on the quantities that can be purchased, and age limitations placed on eligible customers.
- Mandatory harm reduction interventions at point of sale tailored to individuals based on their medical and drug taking histories, with the opportunity to access further treatment services.
- A strict ban on advertising or the involvement of corporations who may try to increase drug sales, when the aim of regulation would be to reduce them.
- Prices controlled by taxation. Evidence from alcohol and tobacco markets suggest that even in the case of addictive substances people will be less likely to purchase them if they are more expensive. Taxes raised could then be used to finance treatment services and other social goods rather than profits funding other types of crime.
- More dangerous drugs could only be legally accessible with prescription, as is the case with opiate substitution therapy.

A recent report from Health Poverty Action estimated that depending on the model of regulation utilised a legal cannabis market in the UK could raise taxes of between £1.4 billion and £3.5 billion a year (86)

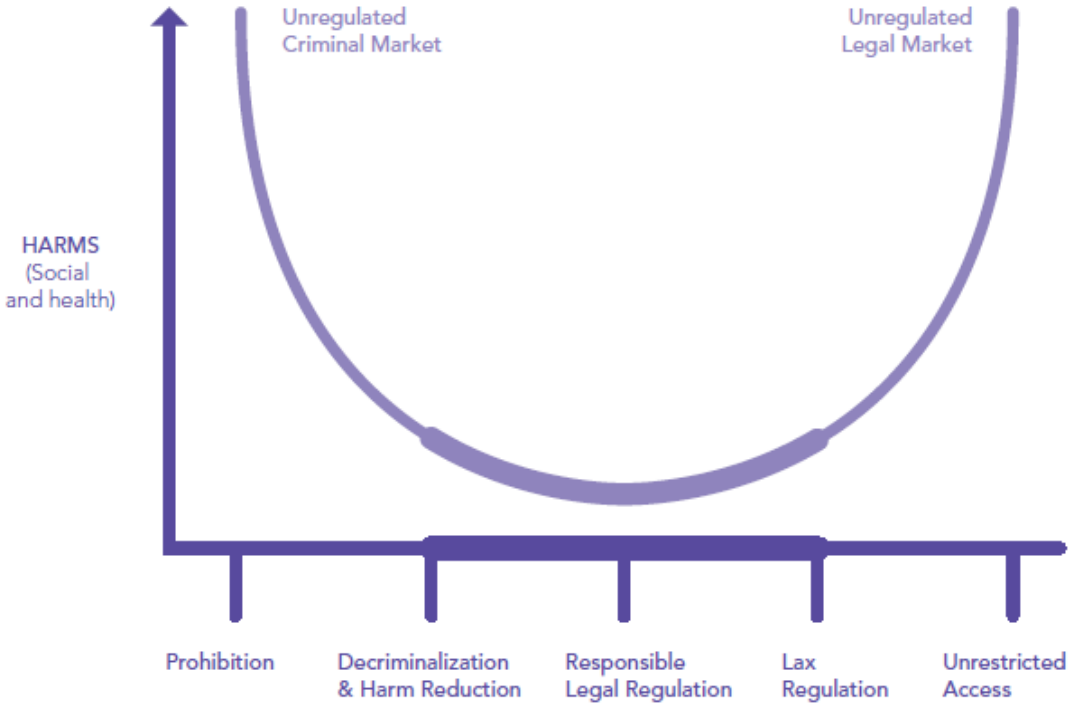
The money that could be raised from the taxation of other drugs would add to this figure. This money could be used to fund drug treatment and harm reduction services as well as health promotion campaigns that encourage people to stop using drugs or reduce their intake.

The effect of the Psychoactive Substances Act 2016

The Psychoactive Substances Act 2016 made the possession of novel psychoactive substances (NPS) such as spice a criminal offence. After its introduction there was a significant fall in deaths related to their use, which proponents of criminalisation might argue is evidence in favour of prohibition based drugs policy. However, after the introduction of the act the use of NPS became more concentrated amongst vulnerable groups, including people who are homeless, and prisoners (87) and in 2018 the number of deaths related to NPS increased to the highest on record, higher than before the introduction of the Psychoactive Substances Act 2016 (34).

The initial reduction in deaths related to NPS is associated with their market changing from a largely unregulated legal market to an unregulated illegal market. Prior to the Psychoactive Substances Act shops had very few limitations on how, when or to whom they could sell substances. There could be greater benefits from their sale, and the sale of all drugs occurring within a ***responsibly regulated market*** (Figure 7.5).

Figure 7.5 - The proposed relationship between regulation and harm (76)



Conclusion

The only reason that drugs should be illegal is if it protects people from their harmful effects and there isn't convincing evidence that this is the case. On the contrary, current drug policy may be exacerbating and causing much of the harm that people are experiencing.

In Portugal the decriminalisation of drugs was associated with significant benefits, which should prompt other countries to follow suit. And even greater benefits could be associated with wholesale drug regulation, provided the influence of private companies and individuals aiming to profit financially from the market was strictly limited.

Chapter 8 - What we are doing to reduce drug related harm and what more can we do?

This chapter highlights some of the good work that is being done locally, points out where refinements may be necessary and suggests other interventions that would likely be beneficial that are not currently in widespread use. First though, it is worth considering what a drug strategy should be trying to achieve.

What should be the key aims of a drug strategy?

If people don't take drugs, they can't be directly harmed by them, so we should try to:

Reduce drug use →

Efforts should focus on reducing the use of more harmful drugs, such as heroin and cocaine and helping people to avoid frequent or dependent use.

There will always be some people using drugs so we should ensure they are as safe as possible when doing so by promoting:

Harm reduction →

Some level of drug use is inevitable in society without a level of authoritarian control that is incompatible with basic British values. This is highlighted by the fact that drug use continues in prisons where inmates can be strictly monitored.

Some of these people will develop problems because of their drug use so we need to:

Support people who are dependent on drugs or in recovery →

Health is a fundamental human right (88) whether or not somebody has done things that the law currently considers illegal. People who use or have used drugs should be helped to lead lives that are as healthy and full as possible.

Although harm reduction measures are mentioned in the UK drug strategy, harm reduction does not feature as one of the four key elements (89). This differs in other countries such as Ireland where the drugs strategy is titled *Reducing Harm, Supporting Recovery* (90).

It is more helpful to consider problematic drug use as a health issue rather than a criminal justice problem. Accordingly, the Department of Health should have primary responsibility for the UK drugs strategy. This is the case in countries with more of a focus on harm reduction such as Portugal.

Reducing drug use

Box 5 - PSHE in schools

The scope and quality of drugs education in schools is mixed. Schools sometimes use unregulated organisations to provide drugs education, and in some cases, there may be concerns about these organisations' motivations (91). The evidence indicates that lessons focusing on social influence and life skills are more effective than those that just give information on drugs, or try to 'scare pupils straight', which may be counterproductive and actually increase the likelihood of drug use (92).

Simply telling young people about the risks of drugs or to "just say no" doesn't work.

Although it has recently been updated, the government guidance for PSHE drugs education is sparse. At the time of writing a comprehensive PSHE programme for Portsmouth is being developed but whether or not it is adopted by schools is determined on a voluntary basis. A national curriculum would help ensure that all children receive adequate, evidence based drugs education.

Box 6 - Ensuring that early help needs are met

There are many different services involved in ensuring that families get the support they need to provide an environment in which children are able to flourish. If children have the best possible start in life, they are less likely to develop problematic drug habits and suffer many other negative outcomes, which are costly for society, but most importantly cause them suffering.

Services range from universal and targeted support services, which give parents and families advice and assistance, and social care services, which are able to provide temporary or permanent alternative living environments for children who are suffering from adverse childhood experiences.

Local services are doing brilliant work, and strategy reviews have been undertaken to strengthen the support that is available. Nonetheless, in a time of spending constraint it is vitally important to at least maintain and ideally increase funding for services such as these, which will likely reduce future costs to other services, such as the NHS and adult social services.

Box 7 - Substance misuse champions

In Portsmouth there are a number of substance misuse champions in social care, colleges, play services and other organisations that are trained to help young people who are using substances stop using them, and stay as safe as possible when they do.

A need was identified that despite this, some young people using drugs were still not being reached early enough or with sufficient reach. In response to this, services for the young people most in need are in the process of being expanded.

Box 8 - Addressing benefits and rising housing costs

More work needs to be done to ensure that deprivation and homelessness do not limit peoples' choices and opportunities. The Homelessness Act 2017 is a step in the right direction, but it does not address the shortage of affordable and social housing or provide local authorities with the extra resources needed to fulfil their new duties.

Changes to the benefits system and the introduction of Universal Credit have made some peoples' financial situations worse. There are issues to do with processes and delivery, which urgently need to be addressed but, in some cases, people are simply unable to claim enough money to meet their basic needs, leading to a higher risk of social harms such as homelessness and the growth of illicit economies.

In some cases, local authorities may be able to offer support around budgeting and access to employment if they have the resources to do so, but ultimately action is needed from central government to improve the new system and provide the funding that is necessary.

Harm reduction

Box 9 - Needle syringe programmes

Sharing and reusing needles to inject drugs increases the risk of wound and blood borne infections, including HIV, hepatitis B, hepatitis C and bacterial infections. This is not only obviously bad for the people who are getting infections, but the treatment is costly for society. An important way of preventing this is providing sterile needles and equipment to inject with.

Taking the most recent needle syringe programme data available for each city (2018/19 for Portsmouth and 2017/18 for Southampton) and the most recent estimates of people using opiates (2016/17 (29)) we can get an idea of needle syringe programme coverage locally.

In Portsmouth in a year there were 154,107 needles dispensed (about 140 per person using opiates)

In Southampton in a year there were 231,364 needles dispensed (about 190 per person using opiates)

Many of the people using opiates will have been receiving treatment and may have not been or rarely injecting drugs but those who were using heroin may have been injecting several times a day. It is likely that there is an unmet need for sterile needles and more work needs to be done to improve the coverage of current provision.

It is estimated that engaging a further 10% of the drug injecting population in England with needle syringe programmes would lead to a net saving of £31 million in terms of hepatitis C treatment alone without considering HIV and other infections (93).

Box 10 - Take-home naloxone

Naloxone is a drug that reverses the effects of heroin and other opiates when somebody has overdosed. It can be given without a prescription to people who are likely to witness overdoses occurring.

Studies have shown that areas with take home naloxone programmes have significantly lower opioid overdose related mortality (94). And local services have reported incidents when naloxone has been used to potentially save lives.

Across the UK only 11% of people who use opiates in treatment received take-home naloxone and training how to use it in 2017/18 (95).

We can use the most recent data from services providing naloxone (2018/19) and the most recent estimates of people using opiates (2016/17 (29)) to estimate coverage locally.

In Portsmouth 255 kits were dispensed (about one kit for every four people using opiates).

In Southampton 361 kits were dispensed (about one kit for every three people using opiates).

More people than this might have kits as naloxone doesn't expire for a few years and some people might have kits they got in 2015-16. On the other hand, multiple kits may have been dispensed to individuals as they lost or used them. More work needs to be done locally and nationally to assess and improve naloxone coverage as one important way of reducing drug related deaths.

Harm reduction - *What else should be done?*

Box 11 - Drug consumption rooms

In various other European countries (Figure 8.1) drug consumption rooms have been used as an intervention to reduce drug related harm since 1986 (96). They provide a space for people who use drugs to inject, smoke or snort drugs under the supervision of trained staff and an opportunity to provide harm reduction advice, sterile injecting equipment, drug checking, counselling and overdose treatment.

An independent working group investigating drug consumption rooms concluded they **"offer a unique and promising way to work with the most problematic users, in order to reduce the risk of overdose, improve their health and lessen the damage and costs to society" and recommended "that pilot DCRs are set up and evaluated in the UK"** (97).

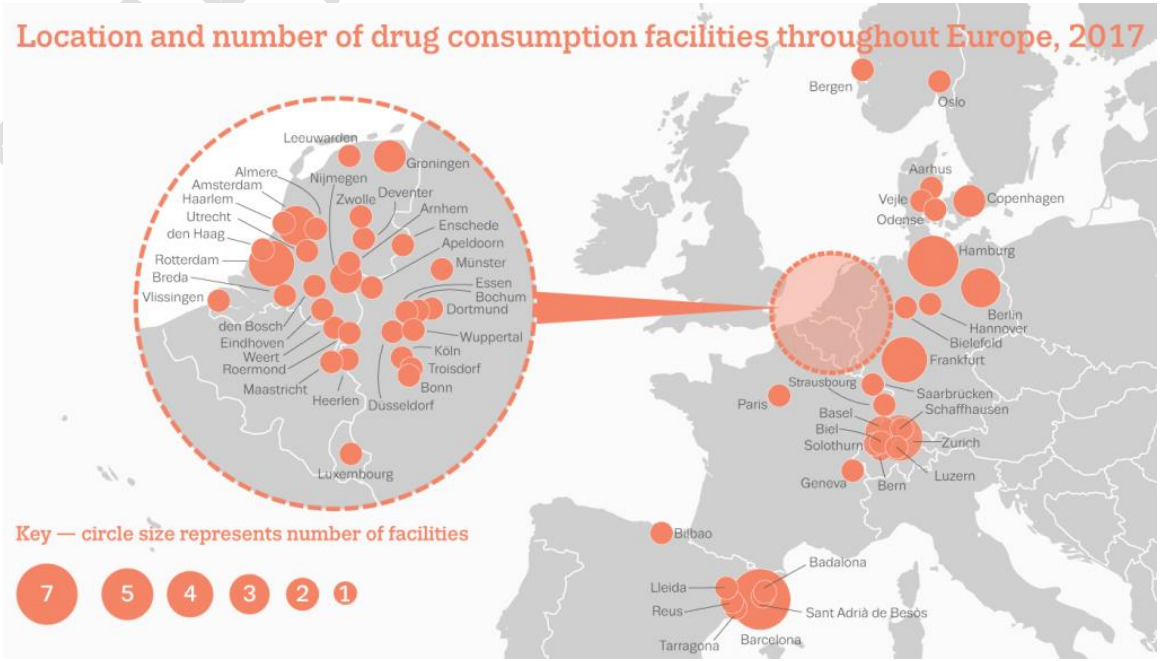
Since then, various bodies including the Advisory Council on the Misuse of Drugs and several local authorities have noted the potential benefits of drug consumption rooms and called for their careful introduction (16) (49) (98) (99) (100). Despite this, the Home Office has stated that they cannot operate in the UK under the Misuse of Drugs Act 1971 (101).

Studies have demonstrated that drug consumption rooms:

- Facilitate the management of overdoses and prevent drug related deaths.
- Encourage safer injecting practices.
- Yield cost savings due to reductions in drug related deaths and transmission of blood borne viruses.
- Increase the uptake of health and social services.
- Reduce drug litter (Figure 8.2) and public injecting.
- Attract people who use drugs riskily and have a high coverage of local people using drugs.
- Do not increase drug use.
- Do not increase crime.

(102)

Figure 8.1 - A map of the drug consumption rooms in Europe (96)



Harm reduction - *What else should be done?*

Figure 8.2 - Drug litter in Six Dials, Southampton (photo courtesy of Nigel Brunsdon (16))

Box 12 - Harm reduction education for club drugs

Researchers and stakeholders involved in the writing of this report who have experience in the field suggest that young people who are already using drugs are more receptive to harm reduction advice than abstinence-based messaging (41) (103).

Although taking drugs is never safe, there are steps that can be taken to dramatically reduce the risk that people expose themselves to, for example taking a lower dose and not mixing certain combinations of drugs. We know that some groups are more likely to have experimented with drugs than the general population, and so may benefit from this sort of advice. This includes people who frequently attend electronic dance music events, festivalgoers and university students (40) (41) (45) (104).

Efforts to promote harm reduction education in these settings are sometimes met with controversy, but it is highly likely that young people who use drugs are going to come to harm more frequently if they aren't aware of the risks and how to reduce them.

Although there has been more provision in the past, there are currently limited local services providing outreach in nightlife settings and more work could be done in this area.

Harm reduction - *What else should be done?*

Box 13 - Drug checking at festivals

Drug checking at festivals is relatively new in the UK but has been used for decades in other countries. People go to the services to have their substances tested and find out what they contain and how strong they are. Then they are given tailored harm reduction advice on how to reduce the risks when they take drugs. One of the most important aspects of drug checking is creating this opportunity to speak to young people who take drugs who are otherwise difficult to engage with.

Drug checking has been shown to:

- Influence short term drug taking behaviour in hypothetical surveys and service data with service users indicating they would not take a drug or would take less of it if the result was unexpected.
- Be associated with reduced drug related medical issues at festivals.
- Potentially decrease longer term riskier drug taking behaviour.
- Potentially influence the drugs market by removing dangerous substances from circulation as warnings about them are distributed and people don't want to buy them.

(40) (103) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115)

Although drug checking services have been provided at multiple UK festivals previously, at the time of writing no UK festivals have been able to provide front of house testing in 2019. Work needs to be done to remove the barriers stopping the provision of drug checking and guidance and regulations should be introduced to ensure that services are provided when there is a need for them.

Box 14 - Drug checking clinics

Not everyone can afford a festival ticket, especially people from more deprived backgrounds who are more likely to use drugs problematically.

Drug checking services have also been provided in a few town centres including Bristol and Weston-Super-Mare. Further clinics in areas where a need is evidenced should be trialled given the promising evidence in their favour.

Supporting people who are dependent on drugs or in recovery

Box 15 - Structured treatment

Local treatment services aim to help people overcome drug dependence and lead healthier lives. By far most of the people who require treatment for drug use are people who use opiates. Treatment involves a host of interventions, including counselling and in the case of people who use heroin, opiate substitution therapy. This means prescribing them methadone or buprenorphine, which are medications that help them to resist the urge to use heroin again.

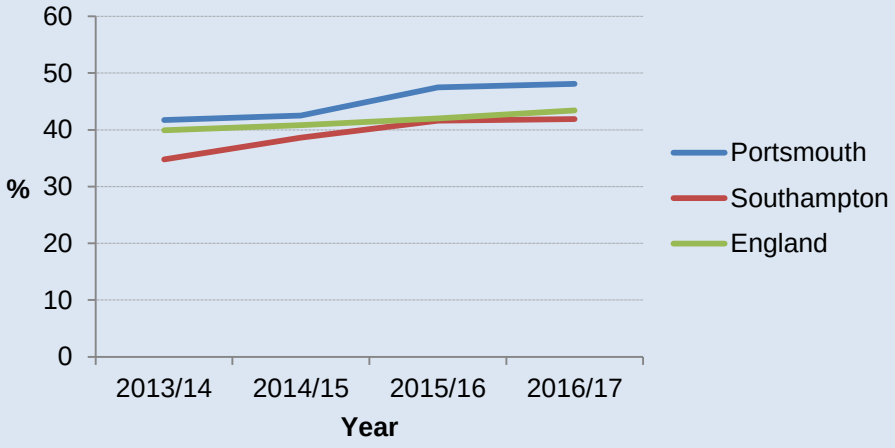
Structured treatment for opiate dependence has been shown to:

- Reduce mortality
- Reduce street drug use
- Reduce criminal behaviour
- Reduce the rates of HIV and other blood borne virus transmission

(116)

Looking at the estimated numbers of people who use opiates and the number in treatment it is likely that nearly half of people using opiates both locally and nationally are not in treatment. The estimated proportion of people using opiates not in treatment has been increasing since 2013 (Figure 8.3), which may be related to the decreasing drug treatment budget discussed in Chapter 4 – 'The health harms from drugs'. Currently, there is no legal mandate for local authorities to provide drug treatment services and in 2020 the ring fence around public health funding could be removed. If this occurs, then the funding situation could get even worse and the unmet treatment need could increase (49).

Figure 8.3 - The estimated proportion of people who use opiates who are not in treatment 2013-17 (14)



Not only do people who use drugs benefit from being in treatment, wider society does too. **It is estimated that each £1 spent on drugs treatment results in £2.50 of savings for society due to reductions in crime and savings to other services** (117)**.**

For some people who use opiates it is feasible that treatment will help them stop using drugs completely, but for others this is not possible. In such cases prolonged prescription of opiate substitution therapy to facilitate normal functioning in society may be preferable to focussing on completing treatment, which could lead to that person quickly relapsing (49) (118).

Supporting people who are dependent on drugs or in recovery

Box 16 - Ensuring that mental health needs are met

Local mental health services are working hard but like elsewhere in the country they are under strain. Some people would likely benefit from more help than services can currently provide (11).

Often, people who have issues with substance misuse also have issues with their mental health – so called dual diagnosis. Dual diagnosis can be difficult to treat, and in some instances, may create barriers for people trying to access services. Although much work has been done on the issue locally, it is a complex problem and it is difficult to know the best way forward. There is more to do and there is likely still room for improvement.

Box 17 - The role of healthcare professionals

Healthcare professionals play an important role identifying people who are using substances, offering advice and directing them to drug services. They are often extremely busy in stretched services however, and opportunities may sometimes be missed.

Local hospitals have alcohol liaison teams, but they do not have dedicated workers to ensure that people presenting to A&E with issues related to other drugs are receiving follow-up support and engaging with appropriate services. More work is needed in this area.

Supporting people who are dependent on drugs or in recovery

Box 18 - Developing opportunities

People who have been dependent on drugs may have trouble finding employment in the future, because of a lack of relevant experience or a criminal record. Without the opportunity to work for a living it is difficult to escape the cycle of socioeconomic deprivation and drug dependence.

Service users in Portsmouth can work in the new Cafe in the Park (Figure 8.4-8.5) giving them the chance to work in the catering and customer service industry. Others work on projects fixing and refitting bicycles or computers, get a job with local partner businesses or work for the drugs treatment service. Many service users receive skill-based training, or enrol in courses, which can help them find a job in the future.

Figure 8.4 - The Cafe in the Park in Victoria park in Portsmouth.

Figure 8.5 - Some of the staff working in the Café in the Park

Box 19 - Peer support and activities

In both cities people who are dependent on drugs can get support from their peers who have been on a similar journey and now live a life free from drugs. This can be valuable for both parties as for those providing support it can give structure and experience of a role of responsibility.

Additionally, there are various support groups, sports and other diversionary activities organised for service users to give them alternative healthy outlets for their time (Figures 8.6-8.8).

Figure 8.6 - A fishing trip organised by the local services

Figure 8.7 - A group of service users at one of the fitness programmes organised locally

Supporting people who are dependent on drugs or in recovery - *What else should be done?*

Box 20 - Heroin assisted therapy

Heroin assisted therapy is the prescription and administration of injectable diamorphine in a medically supervised setting instead of or as well as oral opiate substitution. Diamorphine is a drug sometimes used as a painkiller in hospital that has the same chemical structure as heroin.

Trials from six countries have demonstrated that heroin assisted therapy reduced drug related death and reduced street drug use. Services in Switzerland, Germany and the Netherlands led to annual savings of EUR 6,301-14,807 per service user for reasons including decreased acquisitive crime and a reduction in drug related deaths (119) (120).

Because of the evidence in its favour, heroin assisted therapy is recommended by various expert bodies for use when people did not benefit from first line treatment (98) (121) (122). Despite this, heroin assisted therapy is not commonly used in the UK. This is likely in part because local authorities can't afford it. If they had the initial funds to provide it could lead to savings in the long run, but it is expensive, with services in Switzerland, Germany and the Netherlands costing EUR 13,870, EUR 19,020 and EUR 20,410 per patient per year respectively (119).

Box 21 - Contingency management

Contingency management is the process of offering rewards for positive behaviour that it would be beneficial for people to continue. Behaviours that are rewarded can include abstaining from drugs, receiving a full course of hepatitis B vaccine or getting a job. And rewards could include food vouchers, money, or the freedom to take their prescribed methadone home. When someone takes a drug the brain releases chemicals that make them satisfied, a reward for taking the drug. Contingency management works by interfering with this mechanism by providing a competing reward.

Studies looking at contingency management have mixed results, but there are lots of studies that show it reduces ongoing drug use (123).

Again, it's recommended by various expert bodies, but it's not used very often, likely because of a lack of funds (98) (121) (122).

Chapter 9 - Conclusion - who needs to do what?

Locally, nationally and internationally there is a huge amount of harm associated with the trade and use of drugs. Current drug policy, which treats drug use as an issue of criminal justice pushes the problem underground, makes it difficult to measure drug related harm and stifles efforts to mitigate it. It not only costs society a huge amount of money but is causing harm itself. The next page summarises some of the issues with current drug policy, which have been explored in the other chapters of this report.

What we're doing isn't working. It's time for a different approach.

We could follow in the footsteps of Portugal and many other countries around the world to decriminalise drug possession in order to stop the stigmatisation of people using drugs that are arbitrarily illegal. This could create a more open and productive dialogue about drugs and their dangers and encourage people who are using them problematically to seek help.

We could be braver - we could regulate the production and sale of all drugs. The people who currently control the illicit drug market want to increase the demand for drugs with little regard for the safety of the people who use them. The profits they make fund other criminal activities, while vulnerable people are exploited, and other crimes are committed in the process of drug trafficking. The government could regulate a competing market with the intention of decreasing the demand for drugs and encouraging safer drug use raising taxes to invest back into society. This would wrestle at least a portion of the market away from criminals, thereby reducing their profits and decreasing some of the wider harms associated with the illegal drug market.

Decriminalisation or regulation will not stop people from coming to harm from drugs but based on the available evidence it is likely to help.

We have the evidence to know what prevention and treatment interventions reduce drug related harm but for various reasons this evidence is not always applied in practice. In some cases, this is because of a lack of funding, in others it may be because decision makers are ideologically opposed to taking a different approach, or there are political considerations preventing them from doing so.

Public opinion puts pressure on politicians to promote punitive sanctions and make other decisions that are unlikely to help. More work needs to be done to combat the idea that people who use drugs are morally corrupt outcasts. Most people who use drugs do so unproblematically and lead productive lives in mainstream society. And people who develop problematic habits often do so in response to the other problems in their lives.

The factors that predispose people to problematic drug habits are not under the control of the law.

Drug policy in the UK….

…does not take into account the differences between drugs	• Catastrophising any and all drug use may disenfranchise young people, so that they are less likely to listen to warnings about particularly dangerous drugs or behaviours.	(Chapter 1)
…punishes people who are using drugs problematically because of their difficult lives when what they need is help	• Problematic drug use is associated with deprivation, adverse childhood experiences and mental health problems. Giving someone in this position a criminal record only makes their life more difficult.	(Chapter 2)
…is not reducing the number of people who are taking drugs problematically	• Nationally, the number of people using opiates and crack cocaine is increasing. An estimated one in five 16-24 year olds has taken illicit drugs in the last year.	(Chapter 3)
…is not reducing drug related harm	• Drugs are being produced by criminals, driven by profit rather than concern for peoples' health. The purity of many drugs is increasing to record levels and they are being adulterated with more dangerous substances. Drug related deaths in the UK are the highest on record and are increasing yearly.	(Chapter 4)
…is contributing to many wider harms in society	• Pushing the drugs market underground creates a funding stream for criminal organisations and promotes the exploitation of vulnerable people.	(Chapter 5)
…is arbitrary, not supported by evidence that prohibition based policies work and is ethically dubious	• There is no obvious relationship between the amount of harm different drugs cause and their legal status. • It is not clear that prohibition based drug policy decreases the demand for drugs, stops the supply of drugs or helps people who are using drugs problematically. • Ethicists suggest that punishing people who are not harming anyone else is at best contentious and at worst morally wrong.	(Chapter 6)
…ignores international evidence of more successful approaches	• Since decriminalising the possession of drugs Portugal has seen significant improvements in the amount of drug related harm in the country and there may be even greater benefits from a model of responsible drug regulation.	(Chapter 7)
…limits the use of evidence-based interventions	• Evidence based interventions such as drug consumption rooms and drug checking services are prohibited or hampered by current policy. • Money currently being spent on efforts to punish people for possessing drugs could be redirected to fund stretched drug treatment services and other evidence-based interventions.	(Chapter 8)

Who needs to do what?

It is believed that if the following recommendations were adopted it would be beneficial for the local area and the wider population. Recommendations have been formulated based on the referenced evidence and the knowledge and experience of the stakeholders involved in the writing of the report. They do not necessarily represent the views of the management or elected members of Portsmouth or Southampton City Councils.

Central government

- The possession of drugs for personal use should be decriminalised awaiting a review of potential models of regulation for all currently illegal drugs. Decriminalisation and regulation will not stop drug related harm from occurring, but the available evidence suggests it may reduce it. Current policy is not helping matters, comes with significant expense, and may be making the situation worse. Although there are other important steps to take nationally and locally it makes sense in the first instance to stop spending resources on measures that are hampering progress.
- The Department of Health should oversee and bear primary responsibility for the next drug strategy and ensure that harm reduction is one of the strategy's key tenets. The Home Office's input will still be necessary regarding the criminal market for drugs.
- The impact of the Homelessness Reduction Act should be closely monitored, while further efforts are necessary to combat increasing homelessness, including the building of more affordable and social housing.
- To reduce deprivation and income inequality we should strengthen our progressive taxation system. The problems with Universal Credit should be monitored and addressed to ensure that vulnerable people are not being left with less money overall, or suffering delays in payments that can be crippling without a financial safety net.
- Adequate funding should be provided for local authority public health teams to perform work reducing the demand for drugs and to fund harm reduction and drug treatment services.
- The provision of comprehensive drug treatment services should be mandated.
- The provision of central funding for treatments that are currently under-utilised, including heroin assisted therapy, contingency management and take-home naloxone would be beneficial to ensure stretched local services are providing them.
- The law should be clarified to allow the establishment of drug consumption rooms when local need is evidenced. In the meantime, local agencies including the police should be permitted to negotiate working agreements that would allow trial facilities to be created.
- Licenses should be granted, and funding provided for publicly accessible drug checking clinics when local need is evidenced, and obstacles should be removed that prevent drug checking services operating at festivals.
- Adequate funding is necessary for early help and social care services in order to prevent ACEs occurring and to try and mitigate their negative effects when they do.
- Adequate funding is necessary for mental health services, which are under significant pressure.
- A more comprehensive national PSHE curriculum would be beneficial to ensure that schools are utilising evidence based techniques and to limit the influence of unregulated external organisations.

Local authorities

- Local authorities have a key role in providing strategic leadership and oversight of efforts to reduce drug related harm.
- If they are not already, other local authorities should lobby central government to move to a model of drug decriminalisation or regulation, and to allow, encourage and provide adequate funds for the provision of evidence based interventions.
- Local authorities have a responsibility to try and ensure drug treatment services are adequately resourced, focusing on reach and effectiveness for both adults and young people. Evidence based measures to reduce drug related harm should be comprehensively provided, making harm reduction the principle aim, with recovery and abstinence as additional desirable outcomes. This includes continued efforts to promote needle syringe programmes, opiate substitution therapy and take home naloxone programmes. Additional interventions with promising evidence in their favour not currently being widely utilised should be considered, particularly heroin assisted therapy and also contingency management programmes.
- If not already in place, work to assess the demand for hospital liaison and drug outreach services may demonstrate their potential benefits.
- When the law allows local authority public health teams should consider trialling and commissioning drug consumption rooms and drug checking services when need is evidenced.
- Local authority safety advisory groups should not provide an obstacle to the provision of harm reduction measures. Rather, as well as ensuring the organisers of large music events are providing comprehensive medical and welfare services, they should promote a harm reduction approach and start conversations about the promotion of harm reduction advice, and the provision of drugs outreach workers and drug checking services. Measures should be proportionate to the level of expected drug use, which at any large music event attended by young people without a clear focus not associated with drug use, such as classical music, is likely to be significant. The effectiveness of measures designed to intimidate people carrying drugs such as drug detection dogs and onerous searching is unclear and they may cause people to adopt mal-adaptive behaviours such as panic-dosing, pre-dosing and the smuggling of drugs in body cavities. Accordingly, the latter measures should be recommended and adopted with caution, and further research into their effectiveness encouraged.
- While central government continues the transition from the legacy benefits system to Universal Credit, efforts should be made locally to mitigate the negative effects on those who are struggling with transitioning to the new system, and those experiencing the most detriment from changes to benefit entitlements and assessment processes.

Police and Crime Commissioners

- Available funding should be directed at measures to promote harm reduction and recovery and should be sustained with longer term outcomes in mind.

Drug treatment services

- Drug treatment services are ideally placed to monitor the changing trends in drug supply and use and should continue to work with local authorities to ensure that services are responding to these evolving needs.

Police and courts

- Generally, as far as the current legislative environment permits it would be preferable to not pursue punitive criminal sanctions for people found in possession of drugs if they have not committed other crimes. The use of community resolutions, which should not show up on pre-employment checks would reduce the negative impacts on the lives of vulnerable and deprived people who use drugs problematically.

Mental health services

- Further work is needed to ascertain how best to treat people with a dual diagnosis of substance misuse and mental health problems, and to remove barriers that prevent them accessing services.

Medical practitioners

- Medical practitioners have obvious roles to play in reducing drug related harm including identifying and treating medical and mental health problems related to drug use, explaining the risks of drugs and promoting harm reduction advice. They also have a less obvious role to play as potentially powerful advocates for evidence based drug policy.
- Practitioners, particularly those working for event medical providers and in A&E and other acute settings should be familiar with the NEPTUNE Guidance for the management of medical issues related to club drugs and novel psychoactive substances, developed by the Central and North West London NHS Foundation Trust (124).

Box 22 – Prescription drug related harm

This report did not focus on the problems related to prescription drug use. There is an increasing awareness of people becoming addicted to the drugs prescribed for them, particularly opiates, which can lead to significant health and social problems. More work is required on this subject.

- A formal assessment is required of the scale of the problem locally and the response of local services
- Many of the risk factors for problematic illicit drug use are the same as those for problematic prescription drug use, again highlighting the importance of funding and services to combat deprivation, mental health problems and adverse childhood experiences.
- GPs would likely benefit from more support and training to recognise when the use of prescription drugs is causing problems.
- Greater collaboration between drug treatment services and other healthcare providers may be beneficial.
- More work could be done to highlight the dangers of inappropriate prescription drug use to patients.
- Further research is needed to identify how best to prevent the inappropriate use of prescription drugs and how to mitigate the harm it causes.

Colleges and universities

- Many colleges and universities are already doing valuable work promoting harm reduction advice, recognising that abstinence based health promotion efforts may not be the most effective for young people already using drugs. Despite the controversy that sometimes accompanies these efforts institutions that are already providing harm reduction advice should continue, and those that are not should consider starting to do so.
- Consideration could be given to providing open access anonymous workshops giving students more in depth harm reduction advice if local need is identified.

Schools

- It is strongly recommended that schools adopt evidence based PSHE programmes and do not utilise ineffective 'just say no' campaigns or scare tactics, which may be detrimental.
- Care should be given to ensuring that unregulated external organisations that are not endorsed by the PSHE association or the local authority do not deliver drugs education, as their methods may not be evidence based and their motives are sometimes unclear.

Festivals and night life venues

- Staff members should be trained in drugs awareness and know what to do in a drug related emergency – there should be staff on duty who have had first aid training and have access to the ambulance referral criteria for people using drugs available here https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2429905/figure/F1/?report=objectonly (125)
- For larger events where drug use is likely, the provision of harm reduction interventions - welfare and outreach workers, educational materials and drug checking services is recommended.
- Supply reduction measures, such as routine searching and drug detection dogs are a double-edged sword and may cause people who are using drugs to adopt riskier behaviours to avoid detection, so they should be exercised with caution.
- Further guidance is available on how to reduce drug related harm at events including *Safer Dancing* (126) and *Safer Nightlife* (127).

People who are using or thinking about using drugs

- **Taking drugs is never safe and the best thing you can do is not take them**. However, there are steps that you can take to reduce the risks you're exposing yourself to if you do:

    - **Do your research - *Don't take taking drugs lightly***. Using a drug once could change your life and you should never do so on a whim. The Loop provide information about the effects of drugs and what harm reduction measures you should be taking - https://wearetheloop.org/club-drug-info. Other websites such as drugsand.me, Erowid, Psychonautwiki and Tripsit provide more detailed information on drugs that are less common and on dangerous combinations. It is important to note that not much scientific research has been performed on many illicit drugs so care should be taken when considering the advice being presented. Information may be based on the anecdotes of people who have used the drug, which may not be generalisable; or evidence from experiments on animals, or tissues in test tubes, which might not be relevant for humans. If a source presents information such as this without pointing out its limitations, then any information from that source should be used with caution.

    - **Check your drugs** - The strength of drugs varies within batches. Checking them doesn't make them safe but it could stop you taking some substances that are particularly dangerous. Drug checking services are available at some music festivals and some cities are hosting pilot drug checking clinics. If you're not lucky enough to have a festival ticket, or to live near one of these pilot clinics you can send your drugs to be tested by WEDINOS (http://www.wedinos.org) or Energy Control (http://www.energycontrol-international.org). Alternatively, you can get reagent kits online, which may stop you taking some unexpected substances, but are not as accurate as comprehensive testing. It is important to understand the limitations of reagent tests – they may sometimes be misinterpreted, don't tell you the strength of drugs and may not tell you if your drug is mixed with another substance.

- **Make sure that your drug taking doesn't harm other people.** Don't take drugs in front of your children, if you're pregnant, if you have to steal to afford them or if you're driving. And if you find that when you use drugs you are more likely to engage in violent or criminal behaviour then you need to get help from drugs services.

- **If you feel like your drug use is causing problems, you should seek help.** You can speak to your GP or contact one of the services below. If you are feeling acutely unwell you should always go to A&E.

Seeking Help

- **Portsmouth (19 or under) – Drug and Alcohol Support Services**
  07951497898 or 07557753131
  DASS@portsmouthcc.gov.uk

- **Portsmouth (over 18) - Recovery Hub**
  44-46 Elm Grove, Southsea, PO5 1JG
  02392 294573
  http://ssj.org.uk/sub-service/recovery-hub/

- **Southampton (24 or under) - No Limits**
  13 High Street, SO14 2DF
  02380 224224
  http://www.nolimitshelp.org.uk

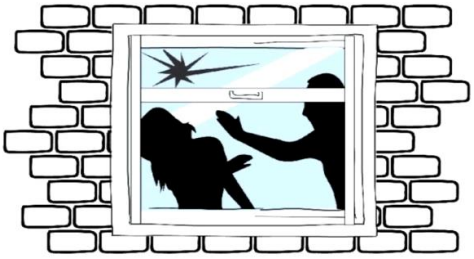
- **Southampton (over 25) - ChangeGrowLive**
  2 The carronades, New Road, SO14 0AA
  02380 717171
  http://www.changegrowlive.org/content/southampton-drug-and-alcohol-recovery-service-dars

Case study - complex problems need complex solutions

This is Sarah. Her story is based on a real person living locally. She has had contact with 27 different local services who have worked hard to help her, but despite their efforts she has had a difficult life and still struggles with problematic drug use.

Early life – As a child, Sarah is sexually abused. She has her first child at 16 years old, and two more before she is 21, one of whom dies soon after. She has to move house frequently because of episodes of domestic abuse.

Adulthood - Sarah develops problems with her mental health, self-harms and is admitted to hospital after taking an overdose. At some point, she starts using illicit drugs. After engaging with drugs treatment services, she manages to detox, but is then raped and starts using drugs again…



…Sarah's children go to live with her mother. She is arrested for burglary, evicted, and becomes homeless. Whilst homeless she is exploited and continues to use drugs problematically.

Now - Sarah is 38 years old. She is homeless, dependent on drugs, has a criminal record, complex physical and mental health needs and is not engaging with services.

Sarah's story is not unusual. People in this position have had extremely difficult lives. They don't need punishment, they need help.

A video of Sarah's story can be viewed on the Safer Portsmouth Partnership website http://www.saferportsmouth.org.uk/complex-needs/ (28)

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In the process of researching this topic Adam Holland has worked in a volunteer capacity for the Loop and observed the work of other organisations involved in drugs harm reduction.