UK DRUG POLICY COMMISSION

A Response to the 2010 Drug Strategy Consultation Paper

Briefing

Kings Place
90 York Way
London
N1 9AG

020 7812 3790
info@ukdpc.org.uk
www.ukdpc.org.uk

The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

UKDPC is a company limited by guarantee registered in England and Wales No. 5823583 and is a charity registered in England No. 1118203. The UKDPC is grateful to the Esmée Fairbairn Foundation for its support.

The UKDPC brings together senior figures from policing, public policy and the media along with leading experts from the drug treatment and medical research fields:

John Varley (President)
Dame Ruth Runciman (Chair)
Professor Baroness Haleh Afshar OBE
Professor Colin Blakemore FRS
David Blakey CBE QPM
Tracey Brown
Annette Dale-Perera
Baroness Finlay of Llandaff
Daniel Finkelstein OBE
Jeremy Hardie CBE
Professor Alan Maynard
Vivienne Parry
Adam Samson
Professor John Strang
UKDPC Chief Executive: Roger Howard

The short timeframe for this consultation and the very broad nature of the questions has made in difficult to prepare a comprehensive response. As a result, we have focused on outlining the evidence from our work programme relevant to each of the broad themes.

VISION FOR THE NEW DRUG STRATEGY

We welcome the inclusion of alcohol in the areas of prevention, treatment and recovery, as well as moving beyond primary concerns of heroin and crack use. However, especially given the financial climate, it is important to ensure that this does not result in any diminution of resources or effort to address the harms associated with controlled drugs.

In addition to the laudable aims outlined, we believe the strategy should:

(i) be visibly based on proven evidence of impact, effectiveness and value for money and contain a dedicated programme for developing the evidence and knowledge base[1]; and
(ii) continue to address the major public health harms associated with certain types of drug use.

However, much of the drug strategy to date has not been based on adequate evaluation of impacts (as made clear in the recent NAO report "Tackling Problem Drug Use"[2]) or value for money. There is a need for much more research and evaluation in the area of delivery of interventions. In a time of austerity investing such evidence is essential to ensure limited funds are invested wisely.

A range of treatment interventions and programmes have internationally proven efficacy and recognition in Nice guidance, as is discussed in more detail below. Public health (harm reduction) programmes to alleviate the risks from drug use, such as those introduced in the 1980's under Mrs Thatcher's government, have been universally acclaimed as the reason why this country has had a significantly lower prevalence of HIV among injecting drug users than most other European countries. The strength of the evidence in support of these measures has led to their adoption as recommended practice by the UNODC, WHO and UNAIDS.[3]

[1] This issue was discussed at length in our submission to the previous drug strategy consultation, including a suggested framework for development of the knowledge base and the evaluation of the strategy as called for by the NAO and the National Accounts Committee. This is available at: http://www.ukdpc.org.uk/resources/Drug_Strategy_Consultation_Response.pdf)
[2] NAO (2010) *Tackling Problem Drug Use.* London: The Stationery Office (available at: http://www.nao.org.uk/publications/0910/problem_drug_use.aspx)
[3] Reuter, P. & Stevens, A. (2007) *An Analysis of UK Drug Policy*. London: UK Drug Policy Commission (available at: http://www.ukdpc.org.uk/publications.shtml#Analysis_Drug_Policy)
WHO, UNODC, UNAIDS (2009) *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva: World Health Organisation (available at: http://data.unaids.org/pub/Manual/2010/idu_target_setting_guide_en.pdf)

PREVENT DRUG USE

While we support efforts to prevent use and misuse of controlled drugs and alcohol, it is important to be realistic about what can be achieved through (some) interventions and programmes.

International evidence of prevention education has shown there is only limited impact on drug-using behaviour although these modest incremental benefits might be cost-effective over the longer term and when implemented on a wide scale.

The evidence for universal school-based education programmes points to better outcomes derived from multi-component programmes, i.e. those involving families and the community, as well as those based on a social-influence model (providing knowledge and skills in a wider social context) rather than those that just provide knowledge or 'just say no'. In these programmes substance use need not be the primary focus but rather just one of a range of risky behaviours that young people need to consider and develop the skills to understand and make choices about.[4]

As with school-based programmes, there is only limited evidence for effectiveness of prevention programmes delivered in non-school settings and most reported evaluations have methodological problems, in particular high levels of loss to follow-up. The best evidence is for whole family focused interventions, such as the Strengthening Families Programme, and for motivational interviewing.

International evidence shows targeted interventions with vulnerable young people experiencing 'risk factors' can have a positive impact on behaviour. Such programmes typically target at-risk youth (recognising that this is not a homogenous group both in terms of the risk factors they are experiencing and other cultural differences) and their families with generic interventions aimed at preventing a range of negative outcomes, not solely drug use, through the promotion of protective factors and resilience. Currently there is some evidence that such broad programmes may be effective, but few methodologically robust evaluations that show the extent to which they have a specific impact in preventing drug use or misuse.

It is essential that any prevention programmes include rigorous evaluation, covering both process and outcomes, as part of the implementation process to develop the knowledge base in this area.

The evidence for the effectiveness of the role and contribution of communities is unfortunately thin. That is not the same as concluding they have no impact but rather the very limited intervention efforts have been under-evaluated. The most information comes from the US. Some years ago the Home Office ran drug prevention initiatives in a number of localities and there are some learning points to emerge from these. One of the challenges facing communities is how they can be facilitated to be more inclusive for those people who develop addiction problems and then need to rebuild their lives. Stigma is a huge barrier to preventing recovering drug users reducing their habits and moving on in their lives.

---

[4] Jones L, Sumnall H, Burrell K, McVeigh, J & Bellis M (2006) *Universal Drug Prevention* Liverpool: National Collaborating Centre for Drug Prevention;
McGrath Y, Sumnall H, McVeigh J, Bellis M (2006) *Drug use prevention among young people: a review of reviews*. National Institute for Health and Clinical Excellence

STRENGTHEN ENFORCEMENT, CRIMINAL JUSTICE AND LEGAL FRAMEWORK

Effective sentencing (Questions C1 & C2)

There are two main types of drug-related offences: offences against the drug laws; and offences committed as a result of drug use, such as acquisitive crime committed in order to obtain drugs; and the issues around sentencing differ between these groups.

While firm action against those involved in extensive drug dealing, particularly organised crime gang members, is appropriate, a number of countries across Europe consider that possession of drugs for personal use should not be dealt with as a crime (e.g. Spain, Italy and more recently Portugal and Luxembourg). This is also reflected in other countries (eg Brazil, parts of Australia). Other countries such as The Netherlands, Germany and the Czech Republic (and Britain) maintain guidelines for the police, public prosecution or courts to avoid imposing punishment, or limit this to small fines for some drugs, if the amount is insignificant or for personal consumption. Such approaches have not led to increases in drug use and avoid the potential harm from criminalizing and unnecessary criminal justice system costs while encouraging access to treatment.

It is also clear from international evidence that some interventions can be effective in reducing illicit drug use and offending among drug-dependent offenders. Coerced (as distinct from compulsory) treatment can have a positive impact although a degree of caution is necessary in the expectations for the crime reduction benefits that can be achieved. Our review of the evidence concerning interventions for drug-dependent offenders concluded that community punishments are likely to lead to better outcomes than imprisonment for most problem drug-using offenders[5].

Any review of sentencing policy should seek to ensure that:

(i) no-one is sentenced to a period of imprisonment for simple possession cases for any controlled substances; and
(ii) those people identified as being drug dependent and who committed (other) associated non-violent offences should be subject to a non-custodial sentence (with or without corresponding requirements to engage with treatment).

Responding to new psychoactive substances (Question C3)

On the control of 'legal-highs', the UKDPC has proposed a new drug control category - *Category X*, as an interim measure to enable a full risk assessment to be made by the ACMD. We are broadly sympathetic to the government's proposals, although we have reservations about doing this through the Misuse of Drugs Act and the time allowed for the ACMD to undertake a proper risk assessment, given that information about harms will, inevitably, be limited.

It is important to recognise that controlling new drugs under the MDA may not reduce the harms associated with these drugs, for example if the law cannot be enforced, organized crime becomes involved and/or users switch (back) to more harmful substances.[6] It also restricts the collection of information about the effects of

---

[5] UKDPC (2008) *Reducing Drug Use, Reducing Reoffending.* London: UK Drug Policy Commission (available at: http://www.ukdpc.org.uk/publications.shtml#RDURR_report)

[6] EMCDDA (2010) *Risk assessment report of a new psychoactive substance: 4-methylmethcathinone (mephedrone)*. Lisbon: EMCDDA

the drugs in question, which is necessary for making informed decisions about harms and the provision of appropriate treatments and advice. We believe there would be benefits at looking at alternative options for preventing the harms associated with these new substances, such as making better use of trading standards law. The Intoxicating Substances Supply Act (1985) provides a potential legislative vehicle, with suitable amendment, through which new substances could be controlled without the full weight of the Misuse of Drugs Act being invoked.

Strengthening enforcement (Questions C5 to C8)

As we found in our reviews of activities aimed at drug markets[7] and as highlighted by the NAO, there is very little robust evidence on the impact of much drug-related enforcement activity and on the relative cost-effectiveness of different approaches. Therefore, and especially in the light of the financial pressures on enforcement services, we draw the following conclusions[8]:

- New, harm-focused measures should be used to measure the impact of drug-related enforcement activity. Traditional measures of success, such as seizures and arrests, are of limited value, and even proxy measures for availability, such as price and purity levels, are insufficient.
- The impact on drug harms of all drug enforcement operations should be assessed to demonstrate proven positive impact on communities and to allow for continuous improvements and ensure value for money.
- There is a need to improve understanding of the scale and nature of the full range of drug market harms.
- Research on the impact of different approaches to enforcement on drug-related harms should be undertaken to show what works under what circumstances and what approaches provide the best value for money.
- A series of pilots should be developed to test the approach suggested in our reviews and to encourage new and innovative approaches to delivering Real Impact Drug Enforcement.

Incentivising joint-working & cost-effective services (Questions C7 & C8)

Interventions aimed at reducing drug-related re-offending should not be viewed in isolation from other services. The reduction in offending that is sought is just one part of the process of recovery from drug problems and progress is necessary on many fronts if recovery and integration into society is to be achieved and sustained. As we indicated in our work on promoting recovery, there is a need to recognise that recovery is a process that will differ between individuals, rather than an easily achievable single end state. For some improvement (and 'distance travelled') will be achieved through abstinence from all drugs of dependency, whilst for others such progress will be achieved through proven clinically prescribed medications. The need for particular interventions will also vary between individuals depending on their personal and social circumstances.

In terms of practical results which should be paid for we would propose they include four core outcome areas:

- Reduction in the use of illicit drugs;
- Improved health & social functioning;

[7] UKDPC (2009) *Refocusing Drug-Related Law Enforcement to Address Harms.* London: UK Drug Policy Commission (available at: http://www.ukdpc.org.uk/resources/Refocusing_Enforcement_Full.pdf)
[8] UKDPC (2009) *Moving towards Real Impact Drug Enforcement.* London: UK Drug Policy Commission (available at: http://www.ukdpc.org.uk/resources/HR_Enforce_Policy_Briefing.pdf)

- Reduced criminal activity;
- Improved employability and engagement in work (paid or unpaid) or education.

Reducing drug supply in prisons (Question C9 & C10)
Many attempts have been made to reduce the supply of drugs in prisons and complete success is unlikely to be achievable. The Government should ensure that the proposals in the Blakey Review (2008) are fully implemented and we would suggest that attention is also needed on reducing demand. It is also important to recognise the broader issues for drug-dependent prisoners, including increased risk of self-harm on admission if detoxification is not properly delivered and the risk of death on release after loss of tolerance during incarceration.

The evidence suggests that drug supply in prisons will best be reduced through a judicious mix of:

(i) fewer people sentenced to imprisonment, thereby relieving pressure on an already overloaded system;
(ii) better and more purposeful regimes;
(iii) substantially enhanced through-care and after-care;
(iv) a broader range of substance use treatment programmes which continue to include substitute medication programmes for the shorter stay prisoners; and
(v) robust and regular enforcement efforts which involve local police.

Reliance on the last set of actions alone will inevitably bring limited results.

REBALANCE TREATMENT TO SUPPORT DRUG FREE OUTCOMES

Questions D1 & D2

The evidence for the effectiveness of a range of treatments in reducing drug use and drug-related harms is good. As a result there is a range of NICE guidance and technology assessments relating to: opioid detoxification; psychosocial intervention; methadone, buprenorphne and naltrexone use, as well as other clinical guidelines.

However, it should be noted that there is an absence of robust evidence in the UK which would point to residential rehabilitation being more effective and potentially better value for money than other treatments. As the recently published evidence from the Treatment Outcomes Profile now being included in the NDTMS is showing, all types of treatment can bring positive results. Where some outcomes appear marginally better than others, this may be down to a range of potentially confounding factors, such as the types of individuals treated, their stage in the recovery process, the quality of the treatment provided and the wider social and economic context. One cannot automatically deduce it is down to one intervention being 'better' than another. As mentioned earlier, people with drug problems will have different needs and resources available to them and their needs will vary over time. However, at the moment we do not have proven ways of effectively identifying who will benefit from which types of services. Therefore it is likely that the greatest return on investment is likely to be found by improving the availability, quality and choice of drug treatment and harm reduction programmes across the board providing greater choice and ensuring drug-dependent users are able to access the services they need.

To ensure maximum effectiveness, more attention needs to be given to understanding how to deliver tailored packages and ensure that treatment is appropriate to individual need. This must be coupled with a marked improvement in understanding the requirements for recovery, focusing on 'wrap-around' provision to support community reintegration as discussed in the section on reintegration below.

Promising innovations, particularly in the harm reduction field (e.g. heroin assisted treatment, drug consumption rooms, new treatments for cocaine and crack users), should be trialled and, when and if proven successful, adopted. The body of evidence in support of heroin-assisted treatment for people with opiate-dependence for which other treatments have failed is now considerable[9].

Question D4

Although the focus on treatment for heroin and crack use was valuable in the past, we agree it would be appropriate to expand the focus now. Our recent reviews of the evidence concerning the impact of drugs on diverse groups[10] indicate that the previous focus on heroin and crack use within the drug strategy may have led to treatment services being unresponsive to the needs of minority groups for whom other drugs may be the chief source of problems.

For example, lesbian, gay, bisexual and transgender people have far higher rates of drug use than the rest of the population and tend to use different drugs in different

---

[9] Ferri M, Davoli M, Perucci CA. Heroin maintenance for chronic heroin-dependent individuals. *Cochrane Database of Systematic Reviews* 2010, Issue 8. Art. No.: CD003410. DOI: 10.1002/14651858.CD003410.pub3

[10] Available at: http://www.ukdpc.org.uk/publications.shtml#Diversity

contexts: stimulants, such as 'poppers', ketamine, GHB and methamphetamine, and also Viagra and anabolic steroids. Therefore they require services that are able to respond to their specific problems.

Similarly, our review on issues facing disabled people, although hampered by a dearth of evidence, highlighted potential problems around self-medication for both pain relief and to counter feelings of isolation, using both prescribed medication and illicit drugs such as cannabis.

Questions D8 & D9

As you suggest, delivering services that effectively promote recovery for people with drug problems will require better continuity of care and the integration of a range of different services.

In our report *Working towards recovery* we suggest that if all individuals had a single recovery plan used by all services this might provide a focus for a more holistic approach. In addition, a recent UKDPC seminar, which brought together academic experts, policy makers and a range of service providers and commissioners to consider the issues for Payment by Results for drug services, highlighted the importance of a key worker and advocate to help individuals navigate the system and access appropriate services as required over time. This seminar also highlighted a number of other relevant issues[11], including:

- as mentioned earlier, recovery encompasses progress within a range of domains and progress in all of these needs to be rewarded;
- many different services will contribute to an individual's recovery and it may be difficult to attribute progress to any one service;
- independent and effective assessment of needs will be essential to both providing the right services for the individual and ensuring that providers do not cherry-pick those who are easiest to help;
- services for sustaining recovery are also important;
- commissioning a 'recovery system' in a local area rather than individual services may be a good way to incentivise integration and joint-working;
- there are some innovative commissioning and service delivery approaches already being adopted – a systematic evaluation of these would provide a firm basis on which to develop the new strategy;
- considerable risks would be involved in introducing Payment by Results, including the potential for "creaming" and "parking", overspending, destabilization of the treatment system and the loss of smaller voluntary sector providers, therefore if introduced it should be the subject of rigorous piloting and evaluation.

[11] A report of the issues raised at the seminar will be available soon on our website at: http://www.ukdpc.org.uk/reports.shtml

SUPPORT RECOVERY TO BREAK CYCLE OF DRUG ADDICTION

Questions E1 to E8

As is recognised in the consultation paper, recovery means different things to different people at different points in their journey. Recovery is not the same as abstinence and that recovery is supported and enabled through the provision of housing, training and work[12].

We believe the areas of housing, employment and practical support to other members of the family offer a major opportunity for a step-change in outcomes for the next strategy.

Our research on employment for problem drug users included a small survey of employers which showed that two-thirds of respondents would not employ a former heroin and/or crack user even if they were qualified for the job. This reluctance was not based on experience of employing drug users but on social stigma or concerns about risks associated with business reputation. Our research also found evidence that many recovered drug users are excellent employees.

Employers and others need to be supported and encouraged to create training and work opportunities. In the current economic climate this may not be easy. But as the economy recovers and jobs and training opportunities are created, we need to ensure that a greater proportion of employers have the confidence to recruit someone with a known history of problem drug use. With more support and encouragement, and concerted action to shift attitudes and challenge stigma, recovering drug users can improve their chances of obtaining jobs and making a sustained contribution to society. To support this we made a number of recommendations including:

- Support to increase volunteering opportunities - these provide a good mechanism for building trust and confidence on both sides;
- Peer mentoring and other programmes to help recovering users both before and after entry into the job market;
- Support for employers, especially in small and medium-sized enterprises who may not have confidence in handling potential HR issues should problems emerge;
- Promotion of positive examples to raise confidence and aspirations among drug users, services and employers alike.

We would also advocate a major initiative to examine and develop intermediate labour market options as a key element of the new drugs strategy, given the likely state of the employment market over the next few years.

We have examined the evidence concerning reforming welfare benefits for drug users in response to previous consultations[13]. In summary, we found that there is no robust and reliable evidence to suggest that introducing financial benefit sanctions will impact on peoples' willingness to address their substance use dependency. Incremental incentives to assist people take advantage of help to address their

---

[12] This is well evidenced in the recent report by Best et al (2010) *Research for Recovery: A Review of the Drugs Evidence Base* Edinburgh: The Scottish Government

[13] Available at:
http://www.ukdpc.org.uk/resources/UKDPCresponse_SSAC_welfare_reform_pilot_Consultation.pdf and
http://www.ukdpc.org.uk/resources/Response_to_NOWO_Oct08.pdf

addiction and gain access to work are likely to prove more beneficial. Consideration should also be given to introducing some time-limited financial incentives to employers for recruiting the most marginalised groups (eg through limited and targeted tax or NI relief).

The challenges faced by those in recovery are substantial, especially the wider societal attitudes and stigma towards them which have to be addressed if recovery prospects are to be improved. This will inevitably include revisiting such practical barriers as criminal records, the Rehabilitation of Offenders and Equalities legislation and opportunities for recovering drug users to enter the employment market through work placements and coaching/mentoring schemes.

We have not done specific work on housing issues but these have been consistently raised in our other research projects. The lack of appropriate housing is a major obstacle for many recovering drug users and occurs at all stages of recovery. There is a clear need to identify and develop models of good practice to address this issue.

Families (Question E10)

Our research on adult family members of people with drug problems[14] has demonstrated the enormous costs they bear, both in terms of the harms they suffer but also in terms of the contribution they make in supporting their relative.

There is evidence that, where appropriate, involving families in the treatment and rehabilitation of someone with drug problems can improve outcomes and help to sustain recovery. From our research, however, it would appear that families often feel excluded by treatment services and hence do not know how best to support their relative. This suggests that there is a lot of scope for improvement in this area, ranging from promoting good practice in providing appropriate information to adult relatives through to therapies, such as Behavioural Couples therapy, in which the relative is actively involved.

However, in addition to this there is a need to provide support to the family members in their own right. They experience a range of harms, including mental and physical health problems, and there are a range of appropriate support services that can help ameliorate these. Here again this can range from peer support through to therapies such as the 5-step programme but our research suggests provision is very patchy, information about services that do exist is poor, so many people struggle on their own.

Parents with drug problems (Questions E11 & E12)

The research that we are currently conducting into the stigma associated with drug use, although not complete, has indicated to us the importance of this area. In our focus groups with current and former drug users and their families a number of relevant issues have come up time and again. We will be reporting on these fully later in the year but it would appear that issue of access to children is a key concern for many users, both men and women, and their families. There is a perception that all transgressions, such as missed appointments, are assumed to be due to drug use and counted as examples of unfitness to care for their child in a way that would not apply to non-drug users. Worryingly many women expressed a fear of attending treatment services because of concerns that their children will be taken away (in

[14] UKDPC (2009) *Supporting the Supporters.* London: UK Drug Policy Commission. (Available at: http://www.ukdpc.org.uk/resources/UKDPC_Supporting_the_supporters_Policy_Briefing.pdf)

some cases based on experience). Failure to make progress in gaining more access to their children is also a barrier to recovery and a cause of relapse. Clearly child protection is essential but it appears that many social workers have little understanding of addiction and hold stereotypical views about drug users. This could be tackled through improvements to social worker training and on-going in-service training.

The difficulties posed by the potentially conflicting appointments from the multitude of agencies involved was also a common theme, since missed appointments can count heavily against people but juggling them is challenging. The use of a key worker/advocate and a single recovery plan (which individuals might carry with them) as described above might help to mitigate this.

The issues facing kin carers and the lack of support they receive are well documented[15] and were again raised in our focus groups. They need to be addressed in the new strategy.

---

[15] Adfam and Grandparents Plus (2006) *Forgotten Families.* (available at: http://www.grandparentsplus.org.uk/publications_files/Forgotten%20Families%20Full%20Report.pdf)