

Release's Response to the

Government's Drug Strategy Consultation Paper 2010

Release is the national centre of expertise on drugs and drugs law – providing free and confidential specialist advice to the public and professionals. Release also campaigns for changes to UK drug policy to bring about a fairer and more compassionate legal framework to manage drug use in our society.

The organisation's response to the Home Office '2010 Drugs Strategy Consultation Paper' (hereinafter 'The Consultation Paper') will not be limited to the questions detailed within the Consultation Paper. It appears from the Consultation Paper that the Coalition Government has already made decisions regarding the direction of a number of policy areas. Release is concerned that there is no scope within the document to really interrogate these policy proposals; however, we are of the view that it is important that the policy points, as well as the issues raised by the questions contained in the paper, are addressed. We are also surprised that many of the policy proposals are already contained within the National Treatment Agency's Business Plan for 2010/11 and have been approved by ministers without public consultation ([http://www.nta.nhs.uk/uploads/nta_business_plan_2010_11\[0\].pdf](http://www.nta.nhs.uk/uploads/nta_business_plan_2010_11[0].pdf)) – published 6 August 2010). Furthermore, the lack of detailed proposals in the Consultation Paper has resulted in some of our response being guided by other public information that has been released by the Home Office; Department of Work and Pensions; and the National Treatment Agency (Department of Health).

It is also important to highlight that the policy proposals contained within the Consultation Paper do not appear to be underpinned by any evidence that supports the policy direction that is clearly being taken. This lack of evidence is central to why this consultation process is not sufficient.

Release is particularly concerned about the consultation process, namely, the failure to adhere to the Cabinet Office's Code of Practice on Consultations. In particular, the Consultation Paper fails to meet a number of criteria including;

- The failure to provide the 12-week minimum recommended period for consultation (Criterion 2). Whilst it is permissible to depart from this principle, clear reasons should be given for such a departure, which the Government has not done.
- The consultation lacks clarity and scope. (Criterion 3) There is simply not enough detail on policy and implementation proposals to properly consult.
- Criterion 3 recommends that there is 'consultation stage impact assessment'. No such impact assessment has been provided to consultees. Further to this a 'race equality impact assessment', which is required by law (s71 Race Relations Act 1976 as amended by the 2000 Act), has not formed part of the process.

Release provides eleven legal surgeries in some of the poorest communities in London, advising nearly 1700 clients a year. Government policies have a direct impact on the individuals we see and the wider communities we work in and often that impact can be negative. We are concerned that some of the policies contained in the Consultation Paper could have significant negative consequences for individuals and families affected by drug use and for the wider public by failing to consider the impact of such policies.

1. Vision for the New Drug Strategy

Release welcomes the proposal to take a more 'holistic approach with drug issues being assessed and tackled alongside other issues such as alcohol abuse, child protection, mental health, employment and housing'. This joined up approach is both sensible and likely to improve outcomes for those who use drugs problematically. Drug treatment cannot be delivered in isolation, and other social problems, such as inadequate housing and debt, often lead to increased drug use which can impact negatively on the individual and their family. Drug treatment services should work closely with advice agencies to ensure that where social or legal problems arise they are addressed immediately on the patient's behalf.

With regards to issues of employment, innovative approaches must be taken to encourage employers to engage someone with a history of problematic drug use – barriers which exist for those seeking employment include long gaps in their employment history; criminal records; if they are engaged in opiate substitute treatment ('OST'); and most importantly the stigma that people who use drugs face. The UKDPC reported in 2008¹ the concerns employers had in respect of employing someone with a history of problem drug use. No action was taken by the last Government to address this issue and with an estimated 80% of

¹ UKDPC, 2008, 'Working towards recovery – getting drug users into jobs', (http://www.ukdpc.org.uk/resources/Working_Towards_Recovery.pdf)

problematic drug users not in employment,² we would urge the current Government to develop a clear strategy to address the problem of discrimination against drug users in the workplace. Recognition must also be given to the fact that continued criminalisation and punitive approaches to drug use underpins much of the stigma experienced by drug users.

The Consultation Paper states the Government's strategy will aim for 'Greater ambition for individual recovery whilst ensuring the crime reduction impact of treatment'. Whilst Release supports this proposal we are concerned that the direction that is being taken will focus on abstinence-based models of treatment at the expense of harm reduction models. Clearly, anyone wishing to enter into an abstinence focussed treatment plan should be supported and encouraged to do so, however this should not be the patient's only option. Evidence for the success of OST both in terms of engaging people and in respect of stabilising their drug use is well established. The concept of recovery in the Consultation Paper is one that should be based on an individual's ability to manage their lives and to contribute to society rather than the simple and ideological approach of being 'drug free'. This response paper will address the issue of abstinence treatment in more detail at point 4.

The Consultation Paper completely fails to properly acknowledge the need to reduce drug harms and, as such, fails to tackle many aspects of both problematic drug use and non-problematic drug use. The term 'harm reduction' is not mentioned once, despite strong evidence for the effectiveness of this public health approach. The decision of the Conservative Government in the mid 1980's to legislate for the use of needles and other paraphernalia used to administer heroin resulted in preventing an AIDS/ HIV epidemic among injecting drug users, and was seen as the vanguard for harm reduction interventions.

The Paper also fails to consider the harms created by the current strategy including harms to individuals and to the wider public; this can range from the criminalisation of young people through to communities devastated by violence associated with the illegal market. Please see point 6 & 7 for further discussion.

2. Preventing Drug Use

The use of the term 'misuse' is ambiguous here. There is a huge difference between a strategy that seeks to prevent occasional, short-term experimentation with drugs and one that seeks to prevent problematic, dependent and chaotic misuse. The latter is a valid goal and would be most effectively tackled by recognising, (though of course not encouraging)

² ibid

short term, infrequent use and analysing carefully what leads such use to become problematic.

The evidence for effective drug prevention programmes is very weak³ and we welcome the Government's recognition that the reasons people use drugs problematically are complex and linked to 'personal, community and societal factors'. These factors can be referred to as 'risk' factors and can include low socio-economic standing, a history of trauma or abuse, a history of drug dependency within the family and exclusion from society.

Any prevention strategy should focus on preventing problematic drug use, and whilst we support good drug education programmes for young people, the evidence has shown that such programmes have very little impact on general rates of drug use. Clearly, the Government should provide drugs education programmes in schools (which include harm reduction information), but resources should also be directed at those groups who are most vulnerable to problem drug use. Recognising that problematic use of drugs is more prevalent in marginalised, excluded and deprived communities should be the first step in developing prevention programmes. Community cohesion and levels of inequalities within a society are usually linked to levels of drug use. For example, the Netherlands and Sweden have very different approaches to drug use but their societies have high level of cohesion and low levels of inequality – both countries experience some of the lowest rates of drug use, especially amongst young people, in Europe.

Furthermore, prevention programmes should also be concerned with reducing the risks associated with drug use; this can be achieved by increasing awareness and supporting practices which limit the potential for harm.

3. Strengthening Enforcement, Criminal Justice and Legal Framework

Release is disappointed that the Consultation Paper fails to consider alternatives to the current criminal justice approach to drug use. With calls for a debate on how we approach drugs in our society coming from various professionals, including Professor Ian Gilmore, Nicholas Green QC, and more recently Tim Hollis, the ACPO lead for drugs, it is surprising

³ Many reports have stated that national prevention programmes have limited impact on preventing drug use: Plant, E. & Plant, M. (1999), 'Primary prevention for young children: a comment on the UK government's 10 year drug strategy'. *International Journal of Drug Policy* 10(5):385–401, [http://www.ijdp.org/article/S0955-3959\(99\)00019-5/abstract](http://www.ijdp.org/article/S0955-3959(99)00019-5/abstract); Cuijpers, P. (2002), 'Effective ingredients of school-based drug prevention programs – A systematic review'. *Addictive Behaviours* 27(6):1009–1023, <http://www.ncbi.nlm.nih.gov/pubmed/12369469>

that the Government did not see this process as an opportunity to engage in this current debate.

Criminal sanctions for minor non-violent drug offences are ineffective and damaging. The harm caused to the individual from his/her criminal record remains with them long after the effects of the drug have worn off. It continues to harm their prospects in life and unnecessarily creates a poor relationship between the police and the community.

Evidence from Portugal, and other countries, demonstrating the positive impacts of decriminalisation is particularly strong and Release would welcome the Government reviewing their decision not to include it as part of the consultation process (please see point 6 for more discussion on decriminalisation).

Whilst we have chosen not to address the questions directly, it is necessary to point out the arbitrary nature of Question C1 – the idea that there is a specific threshold for when drug use becomes problematic shows a lack of understanding about the nature of problem drug use. Whether a person's drug use becomes problematic is specific to the experiences of that individual and no general measurement can be applied.

3.1 Sentencing for drug use helps offenders come off drugs

The Conservative Manifesto 2010 proposed the introduction of 'abstinence based' Community Orders as part of the sentencing powers of the courts. Currently, a Drug Rehabilitation Requirement (DRR) requires that a person subject to the Order reduces or eliminates their drug use⁴. This gives the individual subject to the Order some level of control over the type of treatment that they receive. An abstinence-based Order would remove that choice, a choice that should not be fettered by reason of a criminal conviction – the right to health is universal and cannot be interfered with. Whilst 'The Coalition: Our Programme for Government' document does not recommend abstinence based treatment orders, it does however state it will 'ensure that sentencing for drug use helps offenders come off drugs'. Further to this, the NTA Business Plan 2010/11 states that they will be working with the Ministry of Justice 'to develop a model for commissioning abstinence-focussed treatment in a criminal justice setting'.⁵

If abstinence based treatment orders were introduced it would lead to higher rates of relapse, resulting in people breaching their Community Orders and placing a greater strain on prison and probation resources. As stated, it is important that individuals are able to

⁴ Section 209, Criminal Justice Act 2003

⁵ National Treatment Agency, 'NTA Business Plan 2010/11',
http://www.nta.nhs.uk/uploads/nta_business_plan_2010_11%5B0%5D.pdf at page 4.

determine their own treatment plan. Drug treatment services required to deliver 'abstinence focussed orders' would be further enmeshed in the criminal justice system and this could have a negative impact on the relationship between the patient and the treatment provider. It could deter people from accessing certain services because of the perceived link between the criminal justice system and the coerced nature of the Court Order requiring that a person becomes drug free. The importance of this relationship, long established as a key element of successful drug treatment, was recognised by the NTA in its briefing on treatment for cocaine/crack dependence⁶, where it is stated that:

"...the quality of the client-counsellor and key worker relationship is highly influential in cocaine addiction treatment. US research has shown that counsellors who quickly establish a relationship within which the client feels they are being listened to, understood and being given helpful, positive responses have clients who stay longer and attend more often, improving outcomes. In some studies these experiences (captured by the terms "rapport" or "empathy") were a more important influence on engagement with treatment and abstinence outcomes, than the client's motivation at treatment entry..."

The further blurring of lines between treatment and the CJS could have several negative consequences as highlighted above.

3.2 Temporary ban on legal highs

Interestingly, the Coalition Government has recognised the damage caused by criminalising its citizens. The proposal to place a temporary ban on so-called 'legal highs' will apply to trafficking and supply offences – those caught in possession will not face criminal sanctions. The Home Office press release announcing the ban stated, "possession of a temporarily banned substance for personal use would not be a criminal offence to prevent the unnecessary criminalisation of young people".⁷ Release supports this decision, but would highlight that the number of young people convicted in 2007/08 for drug offences was 3109 – this figure does not include those who would have received a reprimand or warning under the Final Warning Scheme. In 2005 for example 4,888 young people received a reprimand for possession and 2,679 received a warning for possession.⁸ Although these figures are drawn from different years, this represents the criminalisation of approximately 10,000 people under the age of 18 every year for minor drug offences. The figures for 18-24 year olds, still a group that Release considers to be 'young people', would be higher still.

⁶ "Treating cocaine/crack dependence", NHS National Treatment Agency for Substance Misuse, August 2002.

⁷ <http://www.homeoffice.gov.uk/media-centre/press-releases/fight-legal-highs>

⁸ <http://rds.homeoffice.gov.uk/rds/pdfs05/hosb2305.pdf>

Decriminalisation of possession of all controlled drugs should be a serious policy consideration.

In respect of this proposal Release would highlight the significant harm created by continually trying to ban such substances – as the Government moves to ban these ‘legal highs’, a new substance is developed and our recent experience shows that with each new generation of substances comes greater health risks. The Government must work with experts in the field to ensure that any strategy adopted is effective in preventing ever more dangerous substances being sold and supplied in an unregulated manner. As with all substances, Release supports an evidence- based approach rather than a knee jerk response that bows to media pressure. Without greater detail on how the new ban would work in practice it is impossible to properly advise on this matter.

3.3 Alternative Forms of secure, treatment- based accommodation for mentally ill and drug misusing offenders

It is unclear whether this proposal relates to those who would receive community sentences including a drug rehabilitation requirement (DRR) or a mental health treatment order – if this is the proposal then it creates a form of custody through community orders. This would not be possible under current legislation and would go against the principles of sentencing developed through statute law.

If it is proposed that secure, treatment-based accommodation is made available as an alternative to custody then we would support this approach. However it is unlikely to be a cost effective approach. Again, without proper detail it is impossible to properly provide an informed view on this proposal.

3.4 Strengthen enforcement

Some recognition must be given to the failure of law enforcement to tackle the supply of drugs in the UK. Recent studies have shown that despite the level of investment in UK drug enforcement, equating to hundreds of millions of pounds a year, it has had little impact on the drugs market. A recent report in The Journal of Substance Use compared rates of consumption of heroin in Scotland with seizure rates and found that between 2000 and 2006 heroin seizures within Scotland typically amounted to around 1% of the total amount of heroin consumed⁹. Furthermore, supply-focussed law enforcement can have negative impacts on communities and lead to increase violence amongst gangs when their market is threatened – this impacts on the public generally not just on those who use drugs.

⁹McKeganey et al.(2009) Heroin use and heroin seizures in Scotland, Journal of Substance Use

Release has a particularly unique perspective on the impact of enforcement on price and purity, as two members of the senior staff team are expert witnesses registered with the Expert Witness Institute. As individuals regularly involved in providing expert testimony, they have seen that the overwhelming trend for street drug prices is a downward one. The newspaper headlines about a bag of heroin being cheaper than a small round of drinks in a pub, while sensationalist, are not inaccurate. It may interest the Home Office to be reminded that in actual terms, a gram of heroin has effectively dropped from around £100 in the late 1970's to as little as £35 in London at the moment. When one considers the buying power of £100 over thirty years ago – this equates to a ten-fold reduction in price.

The Serious Organised Crime Agency has stated that the rise in the price of cocaine should be an indication of effective law enforcement intervention. However, the rise in the kilo cost of cocaine needs to be seen in the context of the fall of sterling against the dollar. This type of price rise has very little to do with effective enforcement and presents a real problem as the more expensive illegal drugs become the more money needs to be generated by a drug user to support a habit.

Release suggests that the level of investment required to achieve a meaningful reduction in price would be astronomical. Besides the cost, implementing border checks for incoming cargo, within our fast moving global economy, would have a significant impact and could potentially bring the country to a standstill.

Furthermore, law enforcement agencies will point to purity rates as a sign of successful supply side interdiction¹⁰. Again we would dispute this, but to claim a drop in purity is a pyrrhic victory. The more adulterated the drugs that people take, the less aware we can be of the harms of ingesting various drugs. Even the more seemingly 'benign' adulterants can lead to a potential accumulation of substances that can thin the blood, or cause dangerous adverse reactions. Last year according to The Forensic Science Service, in a single three-month period, one in four street cocaine seizures were less than 10% cocaine by weight and the average street seizure fell to 16%. We cannot properly evaluate the effect of adulteration on either health or social terms and this is a direct consequence of an illegal market. The poor quality of such drugs is one of the factors behind the development of new legal high markets.

3.5 Reducing drug related reoffending

¹⁰ <http://www.independent.co.uk/news/uk/crime/were-winning-the-war-against-the-cocaine-industry-police-declare-1684038.html>

The delivery of effective treatment services has had a significant impact on reducing drug related offending. Interventions such as needle exchanges and OST have proved effective methods of getting people into treatment. Evidence has demonstrated for every £1 spent on treatment (and this primarily relates to OST) £2.50 is saved in terms of public health and criminal justice costs¹¹. This benefits society as a whole and is currently the most effective method of reducing drug related offending (please see point 7 for discussion on how the illegal market creates a need for offending). Failure to continue this strategy could see an increase in crime and an increase in health problems for those who use drugs problematically – this would see an increase in pressure on criminal justice and health resources.

3.6 Reduction in drug supply in prison

Clearly, the supply of drugs in prison is a complex matter as indicated by the review undertaken by David Blakey for the Ministry of Justice in 2008. The primary conclusion of his report is that, *“There are ways of disrupting drugs from entering prisons and in the main they are presently being applied with varying degrees of success. Some, probably more effective, ways would have high costs in either financial terms or in legality and decency or both.”*¹² As well as the associated costs of reducing the supply of drugs in prison, it is important to weigh the benefits of using more invasive or draconian measures to disrupt supply against the benefit achieved by, for example comfortable and enjoyable visitor practices.

Evidently there are some people who should not be in prison in the first place and avoiding such scenarios may indeed be more cost effective and fruitful than any supply side interventions. Problematic drug users are often better placed receiving treatment in their community.

Release views the challenge of preventing the supply of drugs in prison as similar to disrupting supply to an island such as the United Kingdom, but on a smaller scale. In both cases, concerted efforts at high costs have been made for many years with success still eluding each of them.

3.7 Impact of proposals on offenders and communities

¹¹ National Audit Office [ref]. A further study carried out stated that the ratio was £1 spent equalled savings of between £9.5 and £18 saved: Christine Godfrey, Duncan Stewart & Michael Gossop (2004) ‘Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS)’ *Addiction*, 99, pp. 697–707

¹² <http://www.justice.gov.uk/publications/docs/blakey-report-disrupting.pdf>

The lack of detail in the Consultation Paper makes it impossible to properly assess the impact the policy proposals would have on both offenders and communities. However, Release would argue that a continued law enforcement approach to tackling drug use results in greater damage to individuals and communities. It does not achieve the aim of reducing the availability of drugs and has little impact on price or purity. Drugs are essentially in the hands of gangsters who control their markets through violence and fear causing huge damage to the communities they operate in.

The focus of using the CJS to force individuals to become drug free could have serious and negative consequences for communities. It is possible such an approach could deter individuals (whether in the criminal justice or not) from accessing treatment services, thereby prolonging their problematic drug use, which will inevitably lead to increased rates of crime and more serious health problems. This will cause direct damage to communities and an increase in pressure on CJS and health resources thereby having a negative economic impact.

4. Rebalance treatment to support drug free outcomes

We welcome that the Consultation Paper recognises that ‘reducing harm is an important component of treatment’, however the NTA Business Strategy 2010/11 outlines that OST should be time limited. The notion of time limited methadone treatment is counter intuitive to the notion of individual care plans and could also result in deterring people from accessing treatment services. It is also surprising that the Government is considering forcing people into going ‘cold turkey’ in light of the compensation that had to be paid to a group of prisoners who were subject to such an approach. Health treatment should be guided by clinical decisions not Government policy. Release would also challenge this notion that people are simply ‘parked on methadone’ – the vast majority of treatment providers work hard to ensure that their patients receive various forms of treatment ranging from OST to complimentary therapies to psychological interventions. Those receiving OST are required to regularly attend with drug workers and their care plan is reviewed on a regular basis.

4.1 What works well and what should be retained

There is no doubt that drug treatment has improved significantly over the last decade, and we should be careful not to throw the baby out with the proverbial bathwater. There is a strong national and international evidence base supporting the use of OST. A very brief list

of the numerous available references may be found below.¹³ Although the new strategy seeks to rebalance the treatment system toward recovery, it should be borne in mind that recovery can take different forms, and should not be exclusively defined by commitments to absolutely ‘drug free’ states, which some people will not or cannot attain. It is perfectly possible to be a productive member of society whilst maintained on OST. The recognition of this fact has characterised a by-and-large successful British response stretching back to the 1920s. OST should certainly be retained, and where necessary its quality improved.

4.2 Areas for improvement

Access to residential rehabilitation facilities should be improved for those who need and want it—however, they must not be imposed on everybody; most scientific and clinical experts now view addiction as a chronic relapsing disease, and the implications of this should be fully understood by policy makers and service providers. An effective treatment system will be characterised by a range of options tailored toward the needs and wishes of those using it, a range that must include abstinence-oriented treatments *and* OST, in addition to counselling and psychological therapies, and environmental measures to assist recovery (decent housing, meaningful employment, etc). OST should not be confined to

¹³ Laura Amatoa,T, Marina Davolia, Carlo A. Peruccia, Marica Ferria, Fabrizio Faggianob, Richard P. Mattick (2008) ‘An overview of systematic reviews of the effectiveness of opiate maintenance therapies: available evidence to inform clinical practice and research’ *Journal of Substance Abuse Treatment* 28 (2005) 321– 329
John Marsden, Brian Eastwood, Colin Bradbury, Annette Dale-Perera, Michael Farrell, Paul Hammond, Jonathan Knight, Kulvir Randhawa, Craig Wright, for the National Drug Treatment Monitoring System Outcomes Study Group ‘Effectiveness of community treatments for heroin and crack cocaine addiction in England: a prospective, in-treatment cohort study’ (2009) The Lancet Volume 374, Issue 9697, Pages 1262 - 1270, 10 October 2009

John Strang, Nicola Metrebian, Nicholas Lintzeris, Laura Potts, Tom Carnwath, Soraya Mayet, Hugh Williams, Deborah Zador, Richard Evers, Teodora Groshkova, Vikki Charles, Anthea Martin, Luciana Forzisi (2010) ‘Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial’ *www.thelancet.com* Vol 375 May 29, 2010

Bronwyn Lind, Shuling Chen, Don Weatherburn and Richard Mattick (2005) ‘The Effectiveness Of Methadone Maintenance Treatment In Controlling Crime: An Australian Aggregate-Level Analysis’ *British Journal of Criminology* Volume 45, Issue 2. 201-211

Karen L. Sees, DO; Kevin L. Delucchi, PhD; Carmen Masson, PhD; Amy Rosen, PsyD; H. Westley Clark, MD; Helen Robillard, RN, MSN, MA; Peter Banys, MD; Sharon M. Hall, PhD (2000) ‘Methadone Maintenance vs 180-Day Psychosocially Enriched Detoxification for Treatment of Opioid Dependence A Randomized Controlled Trial’ *Journal of the American Medical Association* 283:1303-1310

National Institute for Health and Clinical Excellence (2007) *Methadone and buprenorphine for the management of opioid dependence* Nice Technology Appraisal Guidance 114

WHO/UNODC/UNAIDS Position Paper (2004) *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*

methadone, but should include Heroin Assisted Treatment (HAT) and other pharmaceutical adjuncts for those likely to benefit from them.

One part of the strategy that seems unclear is how the Government can possibly afford to find the money to offer residential detoxification or rehabilitation. Some studies may show that the majority of people stop using irrespective of treatment services, when they are ready. The range of detox –rehab services in terms of duration is from 5 days as an inpatient at the controversial but evidenced Rapid Opiate Detox (ROD), which insists on a counselling aftercare component, to the three tiered 2 year residential rehab. Most of these services will cost around £600 a day for the former, plus implant at £1200 and approximately the same for a week at long term inpatient facilities. Recovery from years of drug use, self medicating against life trauma needs to be fully addressed and due to funding reasons (the difficulty of getting it, particularly for a second or third time), the average length of programmes seems to have dropped over the last fifteen years. Even within these parameters, the number of detoxification units within the NHS, often beds on psychiatric wards or a few specialist units, has dropped across the last decade. It would require a considerable effort to re establish these units or find the money to fund even a fraction of the most problematic drug dependent people in our community.

The mindset about residential rehabilitation, or being assessed as a substance-dependent person as suitable for this modality, is a subject of many angry or disappointed calls to our office, possibly due to providers examining the cost against the weak evidence base for their general efficacy on the basis of longitudinal trials.

Release would recommend that in light of these studies a ‘value for money’ exercise is undertaken by the Government.

5. Support recovery to break cycle of drug addiction

Release welcomes that the Government recognises ‘that recovery can mean different things, to different people, at different points in their journey, and is most effective when an individual’s needs and aspirations are placed at the heart of their care’. However we would submit that much of what is proposed in the Consultation Paper is at odds with this principle. The focus on a ‘drug free recovery’ fails to recognise that ‘recovery’ can be achieved by those on long-term opiate maintenance. Recovery should be measured in community participation rather than arbitrary levels of drug use. Failing to recognise the importance of such an approach means that individuals and communities will not benefit from the positive contribution that can be made.

We welcome the importance that is given to employment, housing, education and skills however we would encourage the Government to give meaningful consideration to how this can be achieved. The previous Government in the Drug Strategy 2008 discussed the importance of 'wrap around services' but little was done to ensure this approach was implemented.

5.1 Interventions to better support those returning from prison

According to the Home Office, those released from prison are 40 times more likely to die than the general population in their first week of release – 90% of these deaths are drug related.¹⁴ There are a number of reasons why those being released from prison are more likely to die because of their drug use namely: their tolerance rates will have lowered resulting in overdose; they will have been on OST in prison but problems in continued prescribing in the community mean that they have to use heroin, (again because of tolerance they are at a higher risk of overdose.)

This issue can be easily resolved in a number of ways including: releasing a prisoner mid week rather than on a Friday afternoon when services will have no way to rapidly prescribe; ensure that the person on release has a short term prescription which allows them to pick up methadone/ subutex from the local pharmacy and gives them time to access treatment services; greater coordination between prison treatment services and community treatment services.

Housing provision is very problematic for those serving custodial sentences of more than four months. Housing benefit is only payable for 13 weeks for someone who has been convicted and is serving a custodial sentence. This can often result in people losing their homes due to non-payment of rent – often court proceedings for possession will take place whilst the person is in custody. For those who lose their homes it is often impossible for them to be re-housed by the local authority as they will be deemed as 'intentionally homeless' for the purposes of Part 7 of the Housing Act 1996. Stable accommodation is crucial to reintegration into the community and evidence shows that those who have been convicted of an offence and are subsequently homeless are at a higher risk of re-offending.¹⁵

¹⁴ Drug-related mortality among newly released offenders, (2003)
<http://rds.homeoffice.gov.uk/rds/pdfs2/r187.pdf>

¹⁵ Seymour M, 'The Recurring Cycle: Pathways of Homelessness; Crime and Imprisonment',
<http://www.hmprisonservice.gov.uk/resourcecentre/prisonerservicejournal/index.asp?id=5711,3124,11,3148,0,0> visited 27/09/2010.

5.2. Interventions to address issues of housing

There are a number of issues facing people who use drugs problematically in relation to housing provision and benefits. As identified by the Social Security Advisory Committee, drug users are disproportionately affected by the sanctioning regime within the benefits system due to the chaotic nature of their lives¹⁶. Sanctioning usually occurs because a client has failed to meet conditionality of a benefit or for non-compliance. The usual reasons for benefit being stopped include failure to attend a medical; failure to sign on; failure to complete necessary forms and determination of fitness after a medical assessment. In some cases an appeal can be lodged and a reduced level of benefit is paid however where the issue is non compliance often this will result in a total cessation of benefit payments. For those receiving JSA; ESA or Income Support a decision to stop payment can result in housing benefit not being paid (as passporting benefits these are the condition on which housing benefit is paid). Although, there are measures that can be taken to restore housing benefit, for example, an application based on nil income, those affected are often unaware of these provisions. As a result, people can end up with rent arrears; overpayment of housing benefit; and the threat of possession proceedings and potentially an eviction order. This can cause a great deal of stress and can exacerbate the person's drug use – in some cases it can cause relapse.

Reform of the welfare system (The Welfare System in the 21st Century) should address these types of problems and Release will be submitting a response to this separate consultation process. At the very least, people facing such problems as outlined above should be advised by Jobcentre and local authority benefit departments of alternatives for claiming housing and council tax benefit.

One issue that should be considered as a part of a strategy review is that of closure orders obtained under Part 1 of the Anti Social Behaviour Act 2003. The powers under this legislation allow for the closure of premises where there is nuisance behaviour and 'reasonable suspicion' of Class A drug use. The threshold of evidence required to obtain a closure order is very low and many of those affected by such orders are vulnerable individuals who need support and treatment. Those subject to closure orders either become street homeless or are provided with emergency accommodation by the local authority. Whilst provided with emergency accommodation, rent arrears will accrue at the property subject to the closure order resulting in significant rent arrears and potential possession proceedings. This places a great deal of stress on those affected and can be an expensive intervention for the State.

¹⁶ SSAC, 2010, 'Report of the Social Security Advisory Committee made under section 174(2) of the Social Security Administration Act 1992 on the Social Security (Welfare Reform Drug Recovery Pilots) Regulations 2010', <http://www.ssac.org.uk/pdf/SSAC-drugs-pilot-report.pdf> - visited 27/09/2010

5.3 Opportunities for the acquisition of skills and training

One of the major barriers to accessing external training and education programmes is the stigma suffered by problematic drug users. Work must be done to challenge this stigma and to ensure that those who have a history of drug use are given the opportunities to develop and contribute to society. In particular, the delivery of such services within drug treatment settings tends to result in good outcomes and a high level of engagement.

Many of our clients have had negative experiences with private companies who are contracted to place people in employment with some reporting negative and inappropriate comments about the past being made; an attitude of low aspiration. For example, one woman who was interested in taking a number of courses with a view to becoming a youth worker was told not to raise her hopes and that she should settle for a supermarket job considering her past. The problem with these organisations is that they often work on a commission or incentive based system which sees them rewarded for the numbers of people who are placed in employment. This gives them no motivation to actually assist the people in achieving their aims around education and training. Attitudes of such companies must be challenged and people must be allowed to have the aspiration to develop themselves as they see fit.

5.4 The potential to use the benefit system to offer claimants a choice between sanctions or additional support

The concept of sanctioning problematic drug users for failure to comply with treatment (or other requirements) was a regime that the last Government tried to introduce through the Welfare Reform Act 2009. The notion of mandating people to treatment with the threat of sanctions was criticised by those working in the drugs field and many of those working in Parliament, particularly peers. The work undertaken by Baroness Meacher in the debate on the Welfare Reform Bill was pivotal to the removal of coercive treatment for benefit claimants from the final act. However, the Act did contain a number of coercive/ sanction led interventions including drug testing and required assessments – the regulations pertaining to these provisions were reviewed by the Social Security Advisory Committee and as a result of their review the proposals were shelved. This was a decision of the current administration and one which Release supports wholeheartedly.

However, despite the criticism levelled against the previous Government we are surprised to see that the Coalition Government are considering such an approach. As stated previously, claimants who use drugs problematically are already disproportionately sanctioned and any attempt to apply a further sanctioning regime will result in a number of

negative outcomes. There is an increased risk of poverty and social exclusion for those failing to meet the conditionality that would be linked to such a provision. There is also a potential risk of increased criminal behaviour for those whose benefits have been withdrawn – this would create greater harms for society as a whole.

If the proposal to provide additional support is similar to the ‘treatment allowance’ proposed under the Welfare Act 2009 we would certainly support this – however without proper detail it is impossible to comment further.

5.5 Barriers to employment

It is important to recognise that there are a number of barriers to employment such as:

- criminal records;
- long periods of unemployment;
- lack of skills or formal education;
- lack of confidence.

Release would recommend that action can be taken in respect of those who are on prescribed medication for heroin addiction. Currently, many people who are on methadone or other substitute prescriptions are expected to pick their medication up on a daily basis. This is a serious impediment which needs to be addressed – a more flexible approach must exist within the prescribing regime if those on substitute prescriptions are expected to be able to engage with employment. Employers must be educated in the effects of such medication and be encouraged to take a supportive approach. If addiction was to fall within the ambit of the Disability Discrimination Act 2005 greater protection would be provided to those in employment, ensuring that employers made reasonable adjustments to accommodate those who were on a stable prescribing regime.

We have also noticed a worrying trend amongst drug treatment providers who are disclosing their patient’s confidential details to their employers where the person is receiving OST. Clearly, confidentiality can only legitimately be breached in a number of limited circumstances and in most cases where there is a significant risk of harm to the individual or others. It appears that a number of services equate OST with ‘harm’ which is simply ludicrous. A decision to breach to an employer inevitably results in the person losing their job – placing them at risk of causing greater harm to themselves by using illegal drugs and placing a greater burden on the State. Guidance must be issued to such services about their duty of confidentiality to their clients.

5.6 Clients with children

This area also raises issues of confidentiality – there appears to be a variety of practices, a post code lottery, when it comes to dealing with patients who have children. A recent study by Brunel University¹⁷ found that due to various problems in responding to cases of parental substance use (including the fact that social workers receive little or no training on substance misuse issues), the impact on children is not accurately recorded. Safeguarding children must be a top priority but the use of substances by parents does not necessarily correlate with bad parenting. According to the study, many practitioners in adult services commented on what they perceived as an increasingly punitive approach to pregnant mothers who were users of class A drugs.¹⁸ Further to this, a report undertaken by Bristol's CAAAD specialist drug service, presented at Release's Drug University 2003, clearly pointed out that 'Women who use drugs were less likely to report abuse, domestic violence and even rape to the police as they feared that any contact with social services might place their children on the at risk register.'

6. Decriminalisation of drug possession

Release would urge the Government to give real consideration to the introduction of a civil legal system to address the issue of drug possession. As the Government is aware there have been positive outcomes in other countries which have adopted such a system with Portugal being the most notable example. Portugal decriminalised drug possession in 2001 and since that time a number of studies have analysed the impact of the policy. All of these studies have recorded significant and positive outcomes, the most recent and comprehensive study was undertaken by Professor Alex Stevens and Caitlin Elizabeth Hughes¹⁹. This study concluded, 'contrary to predictions, the Portuguese decriminalization did not lead to major increases in drug use. Indeed, evidence indicates reductions in problematic use, drug-related harms and criminal justice overcrowding'²⁰. In their paper Hughes and Stevens highlight other studies which have been undertaken in other jurisdictions. For example, Lenton et al. (1999) studied the impact of decriminalising cannabis in South Australia found 'that 'decriminalization' led to increased employment prospects and increased trust of police'²¹. Whilst MacCoun and Reuter (2001) concluded that the primary impact of decriminalisation was to reduce 'the burden and cost in the

¹⁷ <http://www.brunel.ac.uk/doc/1320/FDACFeasibilityStudy.pdf>

¹⁸ *ibid*

¹⁹ Hughes C & Stevens A, 2010, 'What can be learned from the Portuguese Decriminalisation of Illicit Drugs?', *British Journal of Criminology Advance Access published July 21, 2010*

²⁰ *Ibid* at page 1

²¹ *Ibid* at page 2

criminal justice system'²². Stevens and Hughes study found that whilst there was a slight increase of drug use in the overall population there was a reduction in use amongst young people and problematic drug users – this went against the trend experienced in other countries in the region. Furthermore, evidence from Portugal has shown that there has been a decrease in drug related deaths; a decrease in HIV transmission rates amongst injecting drug users and more people accessing treatment – this is coupled with an increase in investment in harm reduction programmes. The paper also concludes that decriminalisation 'reduced [the] burden of drug offenders on the criminal justice system.'²³

The Government is well aware of the strong evidence that supports the positive outcomes associated with decriminalisation, and we understand that Government officials have met with their Portuguese counterparts. However, based on announcements by the Home Office and this Consultation Paper there is no indication that the Government is giving real consideration to adopting such a policy. When leading figures such as Professor Ian Gilmore, Nicholas Green QC, and Chief Constable Tim Hollis are calling for a debate on decriminalisation within the UK it is astounding that the Government is not prepared to consider this policy as a potential option. Further to this a report has been submitted to the UN General Assembly by Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, which calls for the decriminalisation of drug possession²⁴. Grover in his report states:

*"People who use drugs may be deterred from accessing services owing to the threat of criminal punishment, or may be denied access to health care altogether. Criminalization and excessive law enforcement practices also undermine health promotion initiatives, perpetuate stigma and increase health risks to which entire populations — not only those who use drugs — may be exposed. Certain countries incarcerate people who use drugs, impose compulsory treatment upon them, or both. The current international drug control regime also unnecessarily limits access to essential medications, which violates the enjoyment of the right to health"*²⁵.

The call for decriminalisation of drugs was central to the International AIDS/ HIV Conference held in Vienna in July 2010. Leading scientists, Nobel prize winners, NGOs, and others signed the Vienna Declaration which called for decriminalisation on the grounds that criminalisation of drug users was 'fuelling' the HIV epidemic.

²² Ibid

²³ Ibid at page 19

²⁴ http://ap.ohchr.org/documents/alldocs.aspx?doc_id=17520 – General Assembly, 65th Session, 06/08/2010, Report A/65/255 accessed at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/477/91/PDF/N1047791.pdf?OpenElement>

²⁵ Ibid at page 3

In light of the above, we would ask the Government to include decriminalisation as part of the Drug Strategy 2010 – at the very least politicians should be debating this policy as a valid alternative to the current system.

7. Debate on regulation

It is time that Governments realised that the ‘war on drugs’ is an absolute policy failure which fails to protect the welfare of its citizens and fails in one of its primary aims to control drugs effectively. The Special Rapporteur in his report to the General Assembly recommends consideration of a regulatory framework to properly control drugs.²⁶

The illegal market abdicates the control of drugs to criminals who are driven by huge profits and who protect their business through high levels of violence and corruption. The global impact of prohibition can be clearly seen with 28,000 people dead in Mexico since 2006; a HIV epidemic raging in Russia; forced detention of drug users in some parts of South East Asia; states such as Guinea Bissau destabilised; and over thirty countries in the world retaining the death penalty for drug offences.

In the UK, communities are destroyed by the illegal drug markets operating within their areas; children as young as thirteen are involved in the supply of drugs acting as couriers for criminals who know they will be treated more leniently by the CJS and consider them as ‘cheap labour’. Individuals are being put at risk through the supply of adulterated products and drug related crime is directly linked to the expensive nature of drugs when we compared to the price of alcohol.

The list of harms and negative consequences of current drug policies are well documented and Release would request that the Government consider the possible alternatives for properly regulating drugs, thus enhancing the safety of individuals and communities worldwide.

29 September 2010

Please contact Niamh Eastwood, Deputy Director & Head of Legal Services, if you wish to discuss any aspect of this response (Direct dial: 020 7324 2980/ niamh@release.org.uk)

²⁶ Ibid at page 23.