Date: 12th December 2017
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WEST MIDLANDS DRUG POLICY CALL FOR EVIDENCE - REPORT

Report of consultation responses to inform the agenda of the West Midlands Drug Policy Summit taking place on 15th December 2017

"I am very grateful to all those who responded to my call for evidence, which demonstrates both the scale of the issue and a range of options that could address it.

"The annual cost of substance misuse to the region is estimated as £1.4bn every year.

"Despite the good work being done by many, collectively drug policy is failing. This failure means the public put up with more crime, public services are put under more strain, and not enough is done to reduce the harm of those suffering from addiction.

"Many of the proposals in the call for evidence will be explored at the Drug Policy Summit. As we combine our ideas and resources, we can all work together to reduce the crime and harm of drugs in the West Midlands."

- **David Jamieson**, West Midlands Police and Crime Commissioner

Submissions, themes and full responses are detailed below:

<table>
<tr><th colspan="3">PCC's Drug Policy Call for Evidence</th></tr>
<tr><td>65 submissions</td><td>Open for 2 months</td><td>15th September – 17th November 2017</td></tr>
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• Council Chief Executives
• a Council Leader
• Public Health England
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• local medical and pharmaceutical committees
• drug and alcohol treatment providers
• a drug testing charity
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• a coalition of homelessness and mental health charities
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• a behavioural therapist
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• a large number of people in recovery for addiction
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• concerned parents
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The call for evidence responses were from a wide range of organisations and individuals, with varied perspectives and experiences. However, there were a number of clear themes that developed. These themes are listed below. These are suggestions to the PCC, not by the PCC. The inclusion of ideas in this list does not mean that the PCC or any agency endorses them, but instead offers a reflection of the links between consultation responses.

Call for evidence submission themes		
• Diversion • Underlying issues or multiple needs • Drug Consumption Rooms • Mental health • The need to work together • Education and early prevention • Decriminalisation	• 'Through the gate' support from prisons • Maintaining funding for treatment • Different treatment options • New Psychoactive Substances • Not in Education, Employment or Training • Tackling organised crime differently	• Legalisation • Heroin Assisted Treatment Adverse Childhood Experiences • Stigma and shame • Naloxone • Needle litter • On-site testing of drugs at festivals or nightclubs • Medical Cannabis • Homelessness

Diversion is the most common theme identified in our analysis, with submissions calling for greater emphasis on diverting people away from the criminal justice system and into treatment or education programmes for drug-related offending. Many submissions emphasise that the criminal justice system has at times had adverse consequences for tackling addiction, while also limiting the life chances of those who are caught in possession of drugs. Many submissions suggest a clearer police role in diversion, with some discussing the legacy of the 'Drugs Interventions Programme' (DIP) which continues to offer diversionary work in the West Midlands. There is also a discussion of creative alternatives to criminality, including art or sport programmes.

Underlying issues or multiple needs are the second most common theme, with submissions urging their consideration alongside drug addiction. While it is recognised that drug addiction drives crime, other factors can drive addiction or entrench it. These include poor mental health, adverse childhood experiences, homelessness and lack of education, employment or skills. These are all listed separately below as common themes.

Drug Consumption Rooms (DCRs), sometimes referred to as Supervised Injection Facilities (SIFs), are advocated for in a large number of submissions. These are safe spaces in which injecting drug users can access clean equipment with medical staff available to supervise injecting. Submissions highlight international evidence as to the benefits of such a space, including their impact on drug related deaths and needle litter in the region. One submission expresses concerns that this should not be pursued, but with this taken into account, it is the third most frequently proposed consideration.

Mental health is referred to frequently, generally as part of the wider picture of addressing the multiple needs of those suffering from addiction. Improving the interface between drug treatment services and mental health services is emphasised as an area for action.

The need to work together is included in many submissions, and a willingness is expressed by many organisations to do more in linking up our approach to drugs. Risks around becoming too inward-looking were highlighted in the context of reducing budgets in the public and third sector.

Education and early prevention are stressed as crucial to any effective drug policy. Any new initiatives should consider how they interact with ongoing work to reduce harm at the earliest opportunity, seeking a generational reduction in the negative impact of drugs.

Decriminalisation of drug possession is suggested by many, often supported by international examples and in particular the experience of Portugal.

'Through the gate' support from prisons is flagged for addressing major risks associated with drug users recently released from prison. This includes particularly the risk of reoffending or drug-related deaths.

Maintaining funding for treatment is recounted in many submissions as a significant current pressure on drug policy. This is often linked to the need to consider the knock-on effect of declining drug treatment budgets on other services including policing, health, social services and the care system.

Different treatment options are emphasised in a number of submissions, frequently with the recognition that for individuals to recover they require a programme tailored to their needs. Abstinence based mutual aid programmes such as Narcotics Anonymous (NA) and Cocaine Anonymous (CA), methadone and heroin prescribing are all discussed, with the latter being listed as a stand-alone theme below.

New Psychoactive Substances (NPS) are a common concern in the call for evidence, with emphasis on the changing nature of drugs and their increasing strengths. Synthetic cannabis (e.g. 'spice' or 'mamba') and synthetic heroin (e.g. fentanyl) appear to be of the greatest concern, with links to the need for a consistent process for sharing warnings about dangerous new trends. This is also linked to the testing of drugs, which currently happens in settings that are 'post-harm' such as custody, A&E or the Coroner's office. An idea for 'pre-harm' testing of drugs at festivals or nightclubs is discussed below.

Not in Education, Employment or Training (NEET) is a label that can be applied to roughly half of all prisoners in the UK at the time of their offence. This is frequently referenced in submissions, emphasising the need for a wider economic development agenda to give people better opportunities.

Tackling organised crime differently, with a range of suggestions offered, appears in the submissions. A key point discussed is the need to consider being more creative in addressing issues of supply and demand, where enforcement alone is ineffective.

Legalisation of the illicit drugs trade, from possession to production and supply, is suggested in some submissions. Others refer to the need to review the Misuse of Drugs Act 1971, which has never been formally evaluated.

Heroin Assisted Treatment (HAT) appears as an evidenced treatment option in a number of submissions. In recent years, a trial conducted in locations across England found that prescribing medical grade injectable heroin (diamorphine) to certain chaotic heroin users is significantly more effective than methadone-prescription in supporting their recovery. Other benefits cited, which also refer to international evidence, include significant reductions in organised crime profits, fewer acquisitive crimes to pay for drugs, and a decline in needle litter. As with DCRs, one submission expresses concerns that this should not be pursued.

Adverse Childhood Experiences (ACEs) are stressful or traumatic events which can have a profound effect on a person's development, as well as their risk of developing a drug addiction. This is raised as a targeted aspect of the early prevention work cited in so many submissions and listed above. Evidence around effective ACE interventions is still developing, and it is suggested that the West Midlands follow these developments closely and seek opportunities for a more ambitious and impactful approach to ACEs.

Stigma and shame is mostly discussed by two types of respondent. Firstly those responding who are addicted to drugs, most of whom are in recovery, continue to experience the stigma and shame associated with addiction. They discuss how this has affected their ability to engage with treatment and reintegrate into communities. Secondly, those family members bereaved by their loved one's drug addiction also speak of stigma and shame. They see this is a barrier to their reaching out for help, and restricting their ability to help their loved one before it was too late. These submissions call on us to think about ways to remove the stigma and shame associated with addiction in order to better support those in need of help.

Naloxone is a medication used to block the effects of opioids, most frequently associated with preventing heroin overdose. Submissions highlight its effectiveness in preventing overdose deaths and call for both wider use and more consistent provision in the West Midlands.

Needle litter is an issue raised, with some submissions referring to the negative image of local areas created by visible drug paraphernalia. Needle stick injuries and associated risks of blood-borne virus infection are also referred to as driving the need for an improved drug policy response.

On-site testing of drugs at festivals or nightclubs is mostly referred to in relation to the work of 'The Loop' charity, and their 'Multi-Agency Safety Testing'. People attending some festivals in recent years have legally had their pills or powders tested for content, purity or strength before receiving impartial harm reduction advice from drug workers. After that, they were given the choice to dispose of their remaining drugs or keep them. They did not have their samples returned. Evidence of drugs chemical content is also shared with partners to identify risks and trends. Some submissions suggest the benefits of delivering a similar service, either front or back of house, in nightclubs or city centres on particular nights.

Medical Cannabis is discussed in a number of submissions, and relates to the scheduling of cannabis under the Misuse of Drugs Act as possessing "no medical value". Various people and organisations dispute this, arguing that cannabis can be used medicinally and in such circumstances should not be subject to criminal sanction.

Homelessness as a consequence of drug addiction, or as a cause of greater dependency is raised in numerous submissions. The issues facing rough sleepers in particular are acutely related to a vast number of the concerns listed above. Submissions urge consideration of how drug policy can interact with targeted support to address the multiple needs of homeless people in the West Midlands.

See below the submissions to the PCC's drug policy call for evidence in full.

Contents

Cllr Bob Sleigh and Nick Page

Leader of Solihull MBC.

Solihull METROPOLITAN BOROUGH COUNCIL

URBS IN RURE

Mr David Jamieson
WM Police and Crime Commissioner
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NICK PAGE
CHIEF EXECUTIVE

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Your Ref: [redacted]

Our Ref: [redacted]

Please ask for: Nick Page

Date: 20 September 2017

Dear Mr Jamieson

Firstly, we welcome your report and you raising the issues of the impact of drug use on our communities; this initiative is timely given the recent publication of the National Drug Strategy. We note that the focus of your report is controlled substances, whereas there is a crossover with other substances such as alcohol and NPS (Legal Highs) which should also be addressed.

Drug use in Solihull is of concern to us. In summary, 23,440 people in the borough are estimated to be using drugs, or are adult relatives or children affected by misuse; 740 are opiate and crack cocaine users (this has decreased over a number of years in line with national and West midlands trends). In 2016/17 our commissioned services, SIAS (Solihull Integrated Addiction Services) worked with a total of 679 drug users (of which 467 were opiate users and 212 non opiate users (including cannabis and non-psychoactive substances). Performance as measured by key national indicators is good (e.g. high penetration rate). Drug related crime in Solihull appears to have reduced recently although the explanations for this are not clear.

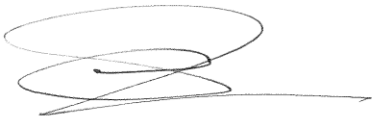
In Solihull we have maintained a joint approach to commissioning and delivering drug and alcohol services, working closely with WMP and Solihull LPU; this collaboration is extremely important to ensuring our success. Our approach includes: education and prevention, targeted prevention, treatment and recovery – very consistent with what is highlighted in your report. Clearly, our approach includes targeted groups such as drug using offenders through our multi-agency Criminal Justice service that focuses on case management of known offenders and their families.

We share the report's concerns about the risks related to reduced levels of funding. Clearly we need to take a 'system wide' view of this given the wide ranging impact that drug abuse has within our communities e.g. within the criminal justice system, the

police, health service, social care. Funding received from Police and Crime Commissioner is of critical importance to maintaining our prevention and early help approach to reducing the consequences of drug abuse.

In conclusion, the multi agency approach recommended in your report is being delivered here in Solihull through our joint strategies, commissioning and service delivery; we recognise the points in your report's conclusion. We support your proposal to hold a summit with the purpose of identifying practical solutions to tackle substance misuse and its consequences and look forward to working with you on this challenging agenda.

Yours sincerely



Nick Page
Chief Executive

Councillor Bob Sleigh OBE
Leader of the Council

LiveinHope
IRIS Partnership Feedback form.

How long have you been using substances?

0-12 months

3-6 years

10-15 years X

What is your main problem substance?

Heroin and crack

Are you?

Currently using drugs/alcohol

In recovery/abstinent X

In your opinion how does the police's drug and alcohol policy impact people with drug and alcohol problems?

In my opinion police had no policies in place. There were a number of times I was held in custody and told that I will amount to nothing but at least I keep them in a job. There were also a number of times where I was treated unfairly because I was a drug addict.

Has this ever affected you personally? Tell us about your experiences

Yes this did affect me in active addiction and my outlook on police was that they was just there to harass me, make me feel bad about myself and attack me when they had the chance.

What new initiatives or changes could the police or health providers make to prevent harm and/or reduce crime related to drugs?'

Police need training on how to support those who have an addiction issue and not use bullying techniques. In my eyes police officers are the first port of call to help those with a drug addiction issue. If drug addicts had confidence and felt supported by the police then those people may find it easier to ask for help.

LiveinHope

An experienced drugs worker.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Current policies on substance misuse has been effective in reducing the cost of addiction through related crime, NHS response to accidents, diseases, A&E responses to OD, injecting related infections, broken families, cost to Social services, children in addiction families damaged for life, lifelong cost welfare to look after the extended families, frequent deaths, mental illness, homelessness, poverty trap, social exclusion to mention but a few. Forceful treatment through probation services has not been as effective as we previously expected, however, prescription maintenance drugs with a view of abstinence may be achieved with informed, dedicated individuals working in the field. This must be carried through in the aftercare until the person settled in a drug free lifestyle.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Firstly, a shift in public and professional perception of the people who fell into the addiction abyss for the common reasons of childhood abuse, poverty, unemployment, trauma.
Harm minimisation is a very effective, and intelligent way to control infection spreading, but also a great tool to engage and retain addicts in treatment.

Henry Fisher: The Loop
On behalf of an organisation.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Use of party drugs (cocaine, ecstasy, MDMA, ketamine) at festivals and night time venues creates a unique set of challenges and harms. Use of these drugs in these environments is far less likely to be problematic/addictive in nature compared to use typical of opioids, crack and Spice. However, significant health harms arise from the variable purity and mis-selling of these drugs, which are compounded both by the environment: hot, crowded, late night, and the characteristics of this demographic of drug users: young, inexperienced and more likely to engage in risky behaviour. This young drug using cohort is largely uneducated on simple harm reduction practices and basic information on how to reduce the harms of party drugs, and as they are unlikely to interact with drug treatment services, they are a hard to reach group to educate.

Trends in party drugs in recent years have seen the typical purity of both cocaine and MDMA crystal rise dramatically, often to purities of 80-90%, while the typical amounts of MDMA contained in in ecstasy pills has also risen dramatically year on year. It is now not unusual for pills to contain in excess of 200-250mg MDMA, over four times the typical amounts found in 2010. Recent years have also seen a rise in mis-selling of NPS at more well-known party drugs, which can lead to significant negative outcomes as users are unaware of what they are taking, the effect it will have, or what may result in an overdose. Deaths due to MDMA are currently at the highest ever recorded at 63 in England and Wales in 2016, up from only 5 in 2010. Cocaine related deaths are also rising year on year, reaching a figure of 371 in 2016, a rise of 16% fro he previous year. Equally significant is that many of these deaths happen to young people, who are particularly vulnerable to overdose due to inexperience with drug use and smaller body mass.

As well as being tragic events, deaths of young people in night time and festival environments cause significant emotional damage to families and communities, and economic damage to night time industries, which may have their licence removed or punitive licensing conditions enforced upon them following a death on their premises. Party drug deaths are typically the focus of expensive police investigations, which rare result in the arrest of high level criminals, but frequently result in the arrest of a friend of the deceased, who was equally naive to the content of their drugs and consequences of use.

Many of these deaths are made all the more tragic as they are avoidable through educating this cohort on drug harm reduction practices. Party drug use is endemic in many night time and festival environments, to the extent that supply targeted strategies will be limited in their ability to combat the above problems, and the focus should also be on reducing the harm from the drug use that will inevitably occur in these environments.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Drug testing services, such as those offered by harm reduction organisation The Loop, provide an effective solution to many of the harms associated with party drug use, by providing vital information on drugs circulating onsite at festival and night time events, and by providing a uniquely engaging and respected avenue for delivering effective harm reduction information to party drug users.

Drug testing services can take multiple forms, such as back of house testing, where drug samples from police seizures and amnesty bins are tests, halfway house testing, where samples from medical and welfare incidents are tested, and front of house, where samples from the general public are tested. The Loop's on MAST services is front of house testing, and was in operation at three festivals this year. This service allowed festival attendees to hand over samples of drugs directly to The Loop, where its team of expert chemists analyse their identity, purity and strength. An experienced team of healthcare professionals then deliver these results back to service users within individually tailored harm reduction brief interventions, providing a vital avenue for life saving harm reduction education.

The Loop provided MAST at three UK festivals this year, analysing 2500 individual samples of concern, and delivering direct harm reduction interventions to over 4000 festival attendees, 9 out of 10 of whom had never spoken to a healthcare professional about their drug use before. While official figures have not yet been published, all festivals The Loop operated at reported significantly reduced numbers of welfare and medical incidents, including fewer hospitalisations, one festival reporting a dramatic 25% reduction in drug related medical incidents. The chief medical officer from another event reported that at least two lives were saved at their event due to information provided by The Loop. Police reports have also stated that they were better able to focus on theft, sexual assault and drug dealing with the Loop was present, as less time was spent caring for vulnerable and distressed members of the public.

Upon receiving interventions, four in ten service users said they would reduce their intake, and between 10 and 20 percent of service users disposed of the remains of their drugs, removing the most dangerous samples from circulation. The Loop also identified the emergence of pentylone analogues sold as MDMA. Swift identification by The Loop allowed festival staff to be briefed and prepared in advance.

At each festival The Loop raised a series of alerts on samples of particular concern, in partnership with event organisers and police. These included high strength ecstasy pills and samples sold as MDMA but containing pentylone analogues. Alerts on social media were seen by thousands and shared widely, resulting in festival attendees handing over concerning samples simply from seeing alerts.

Delivering city centre testing would also benefit night time economy and wider community, and is commonplace in The Netherlands and Switzerland, but so far this has not been possible in the UK due to overly cautious Local Authorities.

Ruth Wallbank: Midlands Partnerships Manager- MEAM (Making Every Adult Matter Coalition)

Responding on behalf of MEAM.

This submission outlines our local and national information MEAM is able to contribute to the conversation.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Making Every Adult Matter (MEAM) is a coalition of Clinks, Homeless Link and Mind. It was formed in 2008 to improve policy and services for people facing multiple needs and represents over 1,300 frontline organisations.[i]

People with multiple needs face a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health. They fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives.

Working together, the MEAM coalition supports local areas across England to develop effective, coordinated approaches to multiple needs that can increase wellbeing, reduce costs to public services and improve people's lives.

We do this using the MEAM Approach (see further information below). We also provide support to the Big Lottery Fund's Fulfilling Lives Partnerships of which *Birmingham Changing Futures Together* is one. To date, MEAM has worked with over 27 local authority areas to support the development of local interventions around multiple needs.

In February 2017, the MEAM Coalition welcomed £2.78 million in new funding from the Big Lottery Fund to significantly expand the number of areas we work with. And are in the coming days will announce the 19 areas we will be working with as part of our new cohort, this includes one West Midlands area.

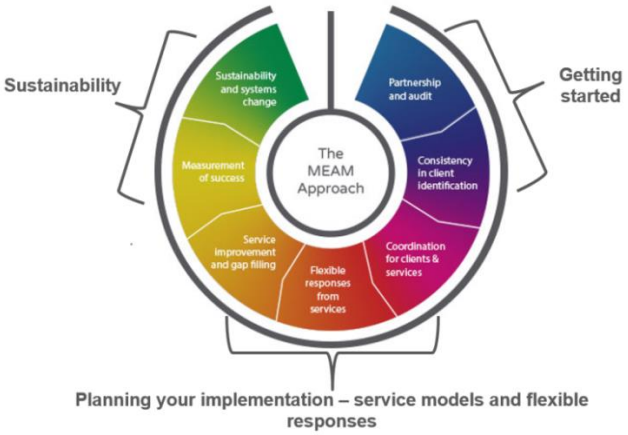
2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Links to the MEAM Approach and Fulfilling Lives:

The barriers identified by the strategy are very similar to those found in local areas using the MEAM Approach or which are part of the Fulfilling Lives programme.

The MEAM Approach provides local areas with a non-prescriptive framework for addressing these barriers and draws on similar underlying approaches to those identified in the Manchester strategy.

MEAM Approach areas are supported to look at seven elements, and to design and deliver a new way of working that reflects their local environment and current service structure.



The seven elements of the MEAM Approach are:

- **Partnership and audit:** The right people at the table and a shared understanding of the problem
- **Consistency:** Being consistent about identification, referral processes and caseloads
- **Coordination:** The practical resource to link individuals to existing services and to broker engagement from local agencies
- **Flexible responses and system change:** Ensuring flexible responses from all statutory and voluntary agencies
- **Service improvement and gap filling:** Filling any gaps in services and seeking continuous improvement
- **Measurement:** A commitment to measuring social and economic outcomes
- **Sustainability:** Making sure your intervention is sustainable through systemic change

The twelve Fulfilling Lives areas (including *Birmingham Changing Futures Together*) are similar in many respects to MEAM Approach areas. The principle difference is that the Fulfilling Lives areas are funded externally by the Big Lottery Fund for a period of eight years and tend to be dealing with a much larger caseload of individuals.

What we offer to local areas:

Our role in MEAM Approach and Fulfilling Lives areas is to work alongside local partnerships, providing 'critical friend' support around the design and delivery of better coordinated interventions. At all times, the work remains owned and driven by the local partnerships. Due to our new strategic funding from the Big Lottery Fund and other funders, we can support MEAM Approach and Fulfilling Lives areas with:

- Dedicated resource from regional partnership managers who support and guide local areas to co-produce, design, deliver and evaluate their interventions

- Participation in a programme wide evaluation, evidencing impact both locally and nationally
- Policy resource to support influencing and policy work, at local and national level
- Access to co-ordinated and resourced shared learning hubs and networks, regionally and nationally
- Support to improve outcomes for people with multiple needs in each area, and in developing systemic and sustainable changes

Potential impact:

MEAM Approach areas that have conducted evaluation of their work have reported improvements in wellbeing for individuals and reductions in wider service use costs:

- Average reduction in wider service use costs of 23% over two years
- Average improvement in outcomes for clients of 44% over two years[ii].

These outcomes reflect the benefits of people moving away from the damaging and risky circumstances associated with rough sleeping.

As outlined above, a national evaluation will follow the work of the new MEAM Approach areas for the next five years. The evaluation will explore wellbeing and economic outcomes and 'compare and contrast' these with the national evaluation of the Fulfilling Lives programme. Through this we will create a comprehensive picture of what works in tackling multiple needs and share this nationally.

Policy work:

MEAM has a strong interest in policy and supporting people with lived experience to have their voices heard. Our policy work is delivered by an embedded team of staff drawn from across the coalition partners. This allows us to draw on the wide range of expertise and knowledge of staff from each organisation.

We draw on our shared local knowledge and practical experience to change policy, so that everyone experiencing multiple needs can reach their full potential and contribute to their communities. It is important that our work is informed by the views and experiences of people with multiple needs and those who support them.

Last year, we developed a paper on devolution, exploring the opportunities devolution may bring for local areas to better support people with multiple needs.

Release

On behalf of organisation

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

One of the ultimate costs of current drug policy in the UK is the high rate of drug poisoning deaths, the highest since records began, outstripping traffic fatalities, with heroin/ morphine deaths increasing by 109% in the last four years. While some of these deaths could be prevented, the criminalization of people who use drugs is a barrier to accessing support (particularly for women and people of colour) and increases their marginalization. Since 2001, drug related deaths in the West Midlands have increased by 66%, with 356 deaths recorded for the period 2014-16 compared to 214 for the period 2001-2003. The use of stop and search by the West Midland's Police focuses primarily on drug searches, with 51% of all searches for drugs (this pattern reflects most police forces in England).

The use of this power disproportionality targets the black and Asian communities, with black people being searched at a rate of 5 times that of white people and Asian people searched at 3 times the rate, despite national data showing that people of colour use drugs at a lesser rate than white people.

The arrest rate for drug offences in the West Midlands police force is 16% (this does not include the use of cannabis/khat warnings or PNDs) demonstrating the vast majority being searched for drugs are not in possession of a controlled substance. Furthermore, the data from West Midlands shows that drug searches are driving racial disparity in the criminal justice system with the rates of disproportionality higher for this type of search than for other grounds.

Another harm created by drug policing is the fact that young people also tend to be the focus of drugs searches, analysis of police.uk data from the area shows that young people (18-24-year-olds) are searched at 7 times the rate of those aged over 25. It is not surprising that there are higher levels of searches for young people as drug consumption is higher amongst this group, however based on national prevalence data we would not expect such high rates of disproportionality.

For young people caught in possession of drugs a criminal record can have a devastating impact on their employment and educational opportunities, it can also increase the risk of recidivism as demonstrated by research from Australia.

It is also important to note that street stop and searches for drugs are not about disrupting the drugs trade but rather targets people suspected of using drugs, this has been confirmed by Her Majesty's Inspectorate of Constabulary who stated that such searches were for 'low level possession'. The damage of stop and search, especially when it is being targeted against particular communities, can have a negative impact on police legitimacy and the trust that communities have for the police. As such, people often will avoid engaging with the police even when they are victims of crime or witnesses, undermining police work in often serious matters such a property crime, violent and/or sexual crime.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

The first proposal would be to extend the cannabis policing scheme to under 18's. Currently, if someone is caught in possession of cannabis for the first time and meets the specific conditions of the scheme they can receive a cannabis warning, on the second occasion they can receive a PND – neither form part of a criminal record. However, the scheme is not applicable to under 18's and perversely this means that they can end up with a criminal record for an offence that an adult would not. Secondly, we would recommend that the West Midlands police implement a diversion scheme for all those caught in possession of drugs for their own personal use regardless of previous convictions for this specific offence. As highlighted, a criminal record can have a devastating impact on an individual and increase the risk of re-contact with the criminal justice system. Research from Australia compared outcomes for individuals in one state that were criminalised for possession of cannabis against those who were subject to civil sanctions for the same offence in another state. This research found that those who were criminalised had increased negative experiences in terms of accommodation, employment, and their relationships.

Moreover, those criminalised were more likely to come back into to contact with the criminal justice system (McLaren, J. & Mattick, R.P. 2007). Both Durham police and Avon and Somerset police have implemented such schemes and have had positive outcomes as a result, reducing the rates of recidivism and the financial burden on their police forces. The Avon and Somerset scheme which operates in Bristol diverts people caught in possession of drugs for personal use at the street level, doing away with the need to arrest them, this is the type of scheme we would recommend is implemented.

Research from Australia also identified significant cost savings to police forces when diversion schemes are put in place. For example, the cost of charging someone for a cannabis offence was $1981.10 (Aus) compared to $122.60 (Aus) when someone was warned for the offence (Shanahan M., Hughes C., and McSweeney T. June 2017). It is quite easy to extrapolate that these cost savings would be applied if a diversion/ warning scheme was implemented in relation to all drugs.

Finally, we would recommend the Police and Crime Commissioner supports evidence-based harm reduction interventions including a safer injecting facility (especially in Birmingham where there is a high incidence of public injecting), a heroin assisted treatment programme for people who previous treatment experiences have failed for them, widespread provision of take home naloxone and implementing a drug testing service for people locally to find out the purity of their drugs and whether it is adulterated, this is of particular importance in light of the risk of fentanyl and carfentanyl entering the heroin market.

Anonymous

Worker with Youth Offending Teams in West Midlands.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

Happy to engage with OPCC and provide information advice and evidence as available as to costs to the public, effective interventions and any other aspect of substance misuse / youth offending.

Important to note that Substance Misuse is well documented and evidenced as being an adverse childhood experience: features strongly in analysis of offending and reoffending.

Important to note also that substance misuse is not "stand alone", can be and usually is, linked to other aspects of lifestyle and offending: education exclusion, mental health and violence for example.

From Ministry of Justice Bulletin: (page 12)

The impact of community-based drug and alcohol treatment on re-offending

This experimental statistical report contains initial findings from a project that has linked data from the National Drug Treatment Monitoring System (NDTMS) held by Public Health England (PHE) with data on offenders held by the Ministry of Justice (MoJ). The aim of this report is to improve the evidence base of the links between community-based treatment for substance misuse and changes in reoffending. This report contains initial findings from analysing the final matched dataset to support policy development and is intended to demonstrate the potential utility in linking treatment and offending data. This is joint publication from Public Health England (PHE) and the Ministry of Justice (MoJ).

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Each Youth Offending Team in the West Midlands produces an annual Youth Justice Plan: They are publicly available: Birmingham's in particular has a whole section on Substance Misuse and it is referenced in the other: YJB maintain an Effective Practice Library of Effective interventions and some that show promise re Substance Misuse, again, local YJB would be happy to work with you to review practice, look at "what works" , local initiatives and opportunities for joint working. I am aware several PCCs across the country are engaging with this agenda and am pleased that the West Midlands PCC is directly addressing this agenda.

Edmund Azu

Black Country Partnership NHS Foundation Trust - BCPFT

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

A BBC Report in 2002 estimated that drug abuse costs UK society up to £18.8bn a year, about £300 per person - in England and Wales. This includes the costs of crime, social security and bringing drugs offenders to justice, as well as the bill to the NHS.

Drug use is often cited as a precursor to the development of mental health problems in those prone to it. It has also been linked to offending behaviour; findings by the Home Office by the Research, Development and Statistics Directorate concluded that, 60% of arrestees who reported using one or more illegal drugs in the last 12 months and committing one or more acquisitive crimes acknowledged a link between their drug use and offending behaviour. This proportion rose to 89% among arrestees who said that they had committed one or more acquisitive crimes and that they had used heroin and cocaine and crack in the last 12 months.

Homelessness can exacerbate mental health problems coupled with fact that some of those with severe and enduring mental health needs find it difficult to maintain their tenancies without support and or are denied access to supported accommodation due to the risks they are perceived to pose in relation to their drug use.

The effects of some drugs can mimic symptoms of mental ill health, making initial diagnosis problematic and therefore effecting subsequent care pathways. Where individual have both mental health and drug addiction (dual diagnosis) problems, there is a wrangle between services as to which “comes first”, the drug addiction or the mental health need, this can impact on subsequent care pathways.

The introduction of Mental Health Treatment Requirements (MHTR) in 2005 allows offenders with mental health conditions to engage with treatment and support in the community whilst also serving a sentence for their offence. Some 40% of offenders on Community Orders are thought to have a diagnosable mental health condition and yet MHTR is rarely used, it is said to represent less than 1% of all requirements issued.

It may be that such orders can be difficult to implement as offender managers are reluctant to recall someone on either MHTR or a Drug Rehabilitation Requirement (DRR) back to prison for breaching such orders by using drugs.

Majority of Addictions Services previously provided by NHS Mental Health Trusts are now being provided by other agencies outside the NHS. With its focus on result, except that motivation of the individual to engagement is key, and we know that the motivation to change for those with addiction problems is low, and they are prematurely discharged from service because they have failed to attend appointment, as such they feels no one really cares and so will continue with their lifestyle, the consequences is a spiral of never ending wheel of offending, violence, prison, homelessness and mental health.

More often than not, Community Treatment Orders (CTO) are imposed on patients discharged from hospital, following detention under the Mental Health Act – more often than not, it is problematic to recall someone to hospital on the grounds that they have used drugs making CTOs unenforceable.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

The United Nation's Reflections on Drug Policy and its Impact on Human Development: Innovative Approaches (2016) identified that without effective drug control strategies that counter or prevent drug-related harms, poverty, inequality and exclusion will persist and we will not deliver on the 2030 Agenda for Sustainable Development.

Decriminalisation: Offences related to drug possession for personal use comprise more than 80 percent of total global drug-related offences, according to a UNODC (2013) study. Too much police effort is targeted at individuals who are easy to arrest, with 'flagrant' offences i.e. open drug use and small-scale dealing or trafficking. The case of Portugal decriminalising drugs in 2001 and treating drug use as a health issue rather than a criminal one. The Transform Drug Policy Institute says of its analysis of Portugal's drug laws, "The reality is that Portugal's drug situation has improved significantly in several key areas. Most notably, HIV infections and drug-related deaths have decreased, while the dramatic rise in use feared by some has failed to materialise." Portugal is said to have 3 drug overdose deaths per million citizens, as compared to the European average of 17.3.

Drug consumption centres: Provision of legitimate and supervised drug consumption clinics/centres to stop people using "drug dens", becoming vulnerable and being exploited.

Meaningful activities/lifestyles: Diverting those offenders who come into contact with the criminal justice system on drug related offences to meaningful employment. This will involve partnership with industries/employers that may be reluctant to employ people with a history of drug addiction; the government may consider subsidizing employers pay to either get those targeted back into work and or to keep them in work. Being in employment increases self-esteem and promotes aspiration as an alternative to drug use.

Non-Governmental Organisation (NGO's): Funding for third sector organisations with focus on drug addiction and mental health to be made available. This will obviously need to be policed to ensure the money is used for its intended purposes.

Psychoeducation: It should be part of the curriculum from primary school education about the harmful cost to life, relationships and society of drug use.

Social Influence Approaches: Most mental health trust will have a psychology department; an Improving Access to Psychological Therapies (IAPT) service or a Community Mental Health Team (CMHT) that uses Cognitive Behaviour Therapy (CBT) to treat common mental health

problems such as anxiety and depression. The cognitive-behavioural model is based on the assumption that substance use results from the combined influences of social and psychological factors. The work by Schinke and colleagues on pregnancy prevention (Schinke and Gilchrest, 1977; Schinke, 1982), has been adapted to smoking and other substances. Alcohol and drug use is viewed as instrumental in meeting the developmental needs of youth (e.g., reducing stress, peer group acceptance, establishing independence). The strategy for drug prevention emphasizes the development of enabling skills, the acquisition of decision-making and problem-solving skills to equip youth to make informed decisions about alcohol and drug use. The focus is on the development of cognitive, behavioural, and interpersonal skills.

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Stephanie Kilili

Durham Police: Crime and Victims' Commissioner.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

The social and economic costs considered by our organisation include public spend directly aimed at tackling illegal drugs supply and demand in the UK. This is the additional cost to resolve the issue and can be divided between short term small resource implications, and long term large resource implications.

In particular, this includes the cost of:

- Enforcing drug offences under the Misuse of Drugs Act 1971 (possession and supply),
- Drug-related crime (i.e. acquisitive crime to fund addiction),
- health harms (including acute treatment for the primary effects of drug use and secondary effects such as behavioural and mental disorders, hospital admissions, neonatal care, treating drug-related HIV),
- drug treatment,
- Drug-related deaths (drug-specific and drug-related mortality and morbidity).

The report "Understanding Organised Crime: Estimating the scale and the social and economic costs" published by the Home Office in 2013 includes an analysis of the costs of organised crime. This predicts that an estimated £370 million is spent by the police enforcing drug offences, and the total costs of drugs enforcement in the UK is approximately £1.1 billion. The total social and economic costs of organising illicit drug supply in the UK are estimated at £10.7 billion.

In 2008, Addaction estimated that illegal drug use is costing the taxpayer £16.4 billion a year; the medical costs have hit £560 million while taking criminals through the courts added £2.6 billion.

In addition, there are costs associated with providing support to victims and witnesses of drug-related crime as well as costs posed to wider criminal justice agencies (i.e CPS, courts, probation, prison), and costs associated with support services for families and carers of people who use drugs.

The IOMU Cohort in County Durham and Darlington worked with a total of 194 individual offenders from 1st April 2016 to 31 March 2017 and these offenders have been responsible for a total of 453 offences. 83% of the whole IOMU cohort either currently use or have used before Class A drugs including Heroin, Cocaine and Amphetamine, this increases to 94% for

the female IOMU cohort. The most common type of crime committed by the cohort (April to April) remains acquisitive crime i.e. Shoplifting, Theft, Burglary, Vehicle crime (Primarily TFMV). There are also a number of drug and violence related offences recorded.

Drug dependency continues to be a significant driver of acquisitive crime. National estimates suggest that up to half of acquisitive crime may be committed by drugs users in order to help fund there addiction. For Durham Constabulary, this would equate to around 8,500 crimes per annum.

Based on the public health 2016-17 investment in substance misuse treatment PHE social return on investment of adult alcohol and drug intervention tool, it is estimated that 204,411 crimes were committed by drug clients before entering treatment and the average crime-related cost in County Durham and Darlington is £26,727 (£3,520 social costs, and £23,207 economic costs). This is reduced to £18,900 after starting treatment. There are 2334 drug dependent people in treatment in our police force area. It is estimated that around 30% of the drug using population is not in treatment, in Durham, and 50% isn't in treatment in Darlington.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Hold a fundamental review of the Misuse of Drugs Act 1971, and of UK Drug Policy

The effectiveness of the Misuse of Drugs Act 1971 has never been formally evaluated, despite overwhelming indications of failure. The current legal framework is confusing for the public, and does not correlate with evidence-based assessment of relative drug harm. The review should consider all international experiences in order to ascertain a more effective way forward. The Government's own evaluation of the past strategy, published on the 14th July, says it did nothing to reduce crime and restrict the availability of drugs, and in crucial respects, made things worse. The report stated:

- "Activity solely to remove drugs from the market, for example, drug seizures, has little impact on availability."
- "There is, in general, a lack of robust evidence as to whether capture and punishment serves as a deterrent for drug use."
- "There are potential unintended consequences of enforcement activity such as violence related to drug markets and the negative impact of involvement with the Criminal Justice System."

Support fully funded effective education and prevention.

The provision of drugs education that is available to all young people must be in line with best practice. Prevention measures with a strong evidence base need to be promoted in

schools and our community in order to build resilience and reduce the harm to young people. Adequate investment in prevention helps prevent today's troubled young people becoming tomorrow's dependent alcohol and drug users.

Promote cost-effective, evidence-based specialist drug treatment and recovery as a proven way to reduce crime and make communities safer.

If the aim is to reduce demand and make our communities safer, we must encourage and support people to receive treatment and recover from their addiction. Reductions in substance misuse service budgets in the short term will only result in long-term costs for the health, social care, and Criminal Justice systems. A thorough review of the process for determining budgets for commissioning substance misuse services in England is required.

For drug-related crime, reducing the number of heroin and crack users is likely to have the largest impact on volume crime levels. One initiative which is proven to do this is Heroin Assisted Treatment. The evaluation can be found here: https://www.kcl.ac.uk/ioppn/depts/addictions/research/drugs/riott.aspx

Protect the vulnerable by supporting alternatives to the criminalisation of people who use drugs and focus efforts on tackling the organised crime groups.

Alternatives to punishment and the protection of vulnerable drug addicts and their families - the victims of the organised crime groups - are the pathways to liberate both individuals and communities from the grip of organised crime. We must intervene at the earliest opportunity and provide credible alternatives to prosecution so that we can improve their life chances such as the Checkpoint Diversion scheme, whilst focusing resources on tackling the organised crime groups - the real criminals making money and causing harm from others' misery.

Anonymous

A community worker and organisation.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

I see locally much more people taking substances I don't see funded organisations on the ground out and about. Even though I know it goes on its often to late treatment Get more mentors doing one to one work supporting people to make a curve or behaviour change work volunteering doing something reduce service offer supported opportunities go with that person to the volunteering opportunity or work experience
Go to that sporting or art opportunity offer the fix somewhere else. Listen to voices in the community if criminal behaviour is taking place then treat as such but offer another fix alternative.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Have family hubs across the for all families from 0-16yrs. There is no where for parents to go and get advice for children or young people or for parents to turn to which is neutral at local level
Children centres are only up to 5ys and under what about older children School aren't the best place they have to deal with the problems. We need places or community spaces where families can be strengthened attached to the support and additional expert presence when needed. We respond to late what about new drugs can't we have another counter offer skiing . Abseiling high ropes which can give that high and extends opportunity take people to a different zone with a progression pathway There is no sense of aspiration at a grass root level just people with leaflet of the next service or ideas on which group to target

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SIAS

Criminal Justice Drug Worker

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

The cost of drugs within the West Midlands in relation to SIAS have been taken from the crime commissioner report.

Any heroin or crack cocaine user not in treatment commits crime costing an average of £26,074 a year. The annual cost of each problematic drug user is estimated at £62,320.

In SIAS Criminal Justice Team we currently fast track offenders into treatment, with waiting times for treatment, within one week. In the offender manager unit at Chelmsley Wood Police Station we work in partnership with Probation and West Midlands Police to offer support to offenders.

They are offered full access to SIAS services such as, Substitute prescribing, Structured Day Care, onsite and home detoxing, counselling service, talking therapies and motivational interviewing and services for under 18s.

In the West Midlands in 2016/17, 10,466 drug tests were administered on arrestees who met the required conditions. Of these tests 64% were positive.

SIAS Criminal Justice team operates with Solihull custody suite to ensure that all arrestees who test positive have access to a drug worker. This enables the team to fast track offenders into services to reduce their offending. Offenders then have access to the full range of services that SIAS offers and to support in their recovery.
Evidence has shown that rehabilitation, including treatment, housing, employment and positive social networks can cut crime significantly, preventing an estimated 4.9 million crimes nationally every year.

SIAS offers a holistic approach in rehabilitation for people with issues of substance misuse. SIAS has a dedicated homelessness worker who works in partnership with Solihull Housing to enable offenders to access housing provision.
The Solihull DASS (Detoxification Assessment and Stabilisation Service) offers home, on site and hospital detoxification from drugs and alcohol.

We have a dedicated number of peer support volunteers who support service users in treatment and recovery.

SIAS recognises the impact of substance misuse on Families and friends and have developed services to support and empower families. This includes information programmes, family and friends clinic. Recovery planning and peer support.

SIAS supports young people using substances and young people affected by parental substance users with its Str8 up team. This enables SIAS to offer early intervention to young people between 9 – 18 years old in Solihull

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

SIAS Criminal Justice Team offers a specialist service to clients who have been referred after contact with the police or had restrictions on bail imposed from court, been given DRR or ATR, or those needed treatment on release from prison.

After 12 weeks, criminal justice clients move to mainstream treatment under the care of SIAS, although their keyworker can still oversee more complex cases of required.

The Criminal Justice Team completes cell sweeps to offer support to anybody who has issues with substance misuse or gambling. The team also receives referrals from West Midlands Police, probation and other community organisation.

In the last 18 months the Criminal Justice Team has introduced a conditional caution scheme in partnership with West Midlands Police.

Criminal Justice Team receives referrals from dedicated police officer (single point of contact) within Solihull police station for offenders who have received a conditional caution. The offender has to complete the conditional caution within three months.

Criminal Justice Team contacts the offender and completes an assessment within five days of the referral and looks at the support and services that are available.

Criminal Justice Team gives regular feedback to the single point of contact on the offender's treatment and provides information regarding if offenders have completed the conditional caution.

The client, whilst on a conditional caution, accesses a wider range of services including substitute medication, housing support, detox, counselling and peer support.

After completing the conditional caution offenders can still access mainstream SIAS services to assist with their recovery.

Since the introduction of this scheme 95% of all conditional cautions have achieved successful outcomes. This includes clients who have gone into Mainstream services or have felt the intervention received have benefited them.

The Criminal Justice Team offers, in partnership with probation team, a weekly group for offenders to discuss their substance misuse and offending. This enables the group to give peer support to other members of the group in their recovery.

SIAS Criminal Justice has introduced Brief Intervention for offenders with Substance Misuse issues. SIAS intended to target offenders who feel their Substance Misuse is not an issue and have historically not entered mainstream treatment.
They are mainly recreational cocaine or cannabis users. SIAS offers two to three appointments in which harm reduction advice and offending behaviour in relation to their substance misuse are covered.

This has enabled SIAS to offer early interventions and support for offenders who have not historically entered mainstream Drug services.

Narcotics Anonymous

Mutual Aid Program

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

   We have no opinion on this matter

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

   We have no opinion on this matter

Public Health England

CJ lead Alcohol, Drug and Tobacco team

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Financial and economic costs
The social and economic cost of drug supply in England and Wales is estimated to be £10.7billion a year – just over half of which (£6 billion) is attributed to drug-related acquisitive crime (Mills, H., Skodbo, S. and Blyth, P. 2013). Offenders who regularly use heroin or crack cocaine are estimated to commit around 45% of all acquisitive crime. (Home Office 2008
NTA publication "Treat addiction, cut crime" graphically illustrates the cost of drug related crime both in monetary terms and also in relation to crimes committed and impact on individuals, families and communities (http://www.nta.nhs.uk/uploads/vfm-crimepresentationvfinal.pdf)
The joint experimental statistical report from the Ministry of Justice and Public Health England showed that in the two-year period following the start of treatment, offending reduced by 33% amongst the treatment cohort with prior convictions in the two-year before treatment. The full report can be found here:
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/655101/PHE-MoJ-experimental-MoJ-publication-version.pdf)
The human cost
There were 2,383 drug misuse deaths in 2016 in England. 54% of all drug poisoning deaths involved an opiate and the highest rate of drug misuse deaths was in 40-49 year olds. Drug misuse accounts for 12% of all deaths among people in their 20s and 30s and heroin and cocaine deaths have more than doubled since 2012. (ONS 2017)
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations)
Parental drug dependence significantly affects the lives, and harms the wellbeing of children. Adverse consequences can include: poor physical health and wellbeing, an increased risk of early substance misuse; higher risk of offending behaviour; lower educational attainment; neglect; and taking on inappropriate caring roles (Adamson, J., Templeton, L. and Clifton, J. (2012) Silent Voices)
Even non-dependent parental drug or alcohol misuse increases the likelihood that the child will use substances and use at an earlier age.
Substance misuse is rarely the sole cause of family difficulties. It is usually part of a complex web of co-existing problems
Cost savings
Effective substance misuse interventions contribute to improved health and wellbeing, better educational attainment, reductions in young people not in education, employment or training (NEET) and reduces risk taking behaviour such as offending
• Young people's drug and alcohol interventions result in £4.3m health savings and £100m crime savings per year
• Substance misuse interventions can help young people get into education, employment and training bringing a total lifetime benefit of up to £159m

• £200 for OCU injectors and can provide £22,000-£41,000 saving per annum for every prevented case of hepatitis C treatment
• £10,000-£42,000 saving (depending on disease progression) per annum for every prevented case

of HIV treatment
• Plus reduced A&E attendance/bed days costs for injecting site injuries/infections
• Patient outcomes can improve and NHS savings can be made by preventing and treating addiction to medicines – prescription costs can reduce by 29% (pregabalin example)
• Every £1 spent on drug treatment saves £2.50 to society

What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime? 500 words max. Links to reports or supporting evidence are welcome.:

Naloxone
Local authorities can prevent premature deaths from heroin and other opioid use by ensuring that naloxone is widely available. The 2017 clinical guidelines say "Systematic reviews conclude that pre-provision of naloxone to heroin users can be helpful in reversing heroin overdoses. There is also evidence for the effectiveness of training family members or peers in how to administer the drug."
PHE have produced some key guidance documents to support the wider availability of Naloxone.
• Take-home naloxone for opioid overdose in people who use drugs. Advice for local authorities and local partners on widening the availability of naloxone to reduce overdose deaths from heroin and other opiate drugs. (http://www.nta.nhs.uk/uploads/phetake-homenaloxoneforopioidoverdoseaug2017.pdf)
• Guidance: Widening the availability of naloxone. Updated 1 August 2017 (https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone)
• Drug misuse and dependence: UK guidelines on clinical management (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628634/clinical_guidelines_2017.pdf)

Community Sentence Treatment Requirements programme

Many offenders suffer from mental health and substance misuse problems but the use of treatment requirements as part of a community order is very low.
A protocol has been developed setting out the action required by health and justice staff to ensure pathways are developed into timely and appropriate treatment
This protocol along with improved partnership working should increase uptake of treatment requirements with a view to reducing short term sentences for those with multiple vulnerabilities that could be managed within a community setting.

The aim of the programme is to:

• Reduce reoffending and improve health and social outcomes
• Reduce short-term custodial sentencing through the use of integrated partnerships
The Programme will:

• Test and evaluate the effectiveness of the protocol
• Evaluate in a number of testbed sites
• Be for adults 18 years + who's offence falls within a community/SS order range
• Involve Local testbeds : partnership with L&D, NPS, CRC , SM , HMCTS, Health providers ,

LA and Police

- Be supported by CSTR Programme Board and local programme support

Supporting Doc- Yes- Treat addiction cut crime, NHS.

Anonymous

A homeless outreach nurse.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

- Preventable deaths
- Preventable disablement – e.g. following overdose (potential for brain injury resulting from hypoxia); amputations.
- Chronic health conditions – e.g. respiratory problems from smoking substances; circulatory problems from injecting drug use; chronic leg ulcers.
- Acute health conditions – numerous.
- Cost to individual in terms of harms to health.
- Cost to family – loss of loved ones.
- Cost to community – loss of employment potential if unable to work.
- Cost to NHS – treating resulting health conditions in primary care, mental health services and hospital services; ambulance call outs (particularly in relation to NPS).
- Cost to criminal justice system.
- Cost to taxpayer – clearing of needle litter.

I frequently encounter serious health harms associated with substance use. Sometimes these health conditions may be potentially life-threatening. Over the past few weeks alone I have encountered people with serious infections and other conditions that have required urgent hospitalisation. Without medical intervention it is possible that some of these individuals may have died - their admissions have been facilitated through initial engagement and intervention at street level. I am now regularly attending to individuals unconscious in the street through their use of 'mamba', on occasions in life-threatening situations requiring resuscitation.

When doing street outreach I regularly encounter areas within the city centre where individuals appear to be injecting in public. I see discarded used needles and other drug paraphernalia in shop doorways, on the pavements, in retail delivery or refuse areas. This drug paraphernalia is often alongside debris from rough sleeping (cardboard, sleeping bags etc.) and, not uncommonly, there may be faeces or vomit in the vicinity. Sometimes there is evidence of blood. In some of these areas I have seen rats. The drug paraphernalia that is visible suggests that individuals are injecting in these environments. It is frightening to consider that individuals are preparing drugs for use and then injecting them into their bodies in such unhygienic environments. I often speak to individuals whose hands are ingrained with dirt and it concerns me that without handwashing facilities easily accessible they may be preparing their drugs and injecting these into their veins without being able to clean their hands. It is perhaps easy to see how injecting in such insanitary conditions can increase the risk of infections developing. The sadness of this for me is that some of these risks could potentially be reduced by simply improving basic hygiene measures – such as the opportunity to wash hands and clean the injecting site. However, it is perhaps obvious that if an individual is rough sleeping such basic steps could be difficult to attain. As a health professional it is shocking to me that in the current age individuals' lives are being placed at increased risk of harm due to 'dirt'.

It is commonplace in my role to encounter individuals who are unable to find veins in their arms to inject into as these have been previously damaged by past injecting drug use and this places the individual in a position of having to use veins in riskier sites on their body - such as their neck and groins. Individuals have reported to me how they have had to repeatedly 'stab' themselves in the neck, for example, as they struggle to locate their neck veins. Each 'stab' clearly places them at risk of harm. I have known individuals who have hit their arteries, instead of their veins, and as a result their lives have been placed at risk. Some individuals have had limbs amputated due to their injecting drug use.

A significant number of the individuals I encounter are not accessing drug treatment services and therefore may have limited access to support, advice and health interventions related to their substance use.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

<u>Naloxone –</u> to reduce number of deaths and risk of disablement as a result of opiate overdose.

- 'Take home naloxone' needs to be issued systematically to anyone at risk on release from prison (there is a current programme but more needs to be done to ensure more kits are issued).
- It needs to be standard for hostels /supported housing projects to hold naloxone on site.
- It needs to be standard practice for workers who are likely to encounter people in opiate overdose to carry naloxone. This includes: police officers, fire service, street outreach workers, antisocial behaviour officers (BCC and the 'Bids') in city centre, street wardens, PCSOs, street triage car.
- Take home naloxone needs to be key performance indicator for all drug treatment services.

<u>Drug Consumption Room</u> – to reduce harms related to street injecting/smoking drug use

This would:

- Enable access to support services, including healthcare and drug treatment for individuals not accessing health care or drug treatment services.
- Provide opportunity for individuals to use drugs in a more hygienic environment (wash hands, clean injecting site and access clean equipment) and potentially reduce risk of infections developing and therefore also potentially reducing rates of hospital admissions.
- Provide opportunity for individuals to use drugs in a warm environment and therefore reduce risk of injuries related to difficulties in finding veins when injecting outside in the cold.
- Provide opportunity for individuals to take time to find veins and therefore avoid rushing (resulting in injuries) due to fear of being seen when injecting in public.
- Enable individuals to be in well-lit environment when using drugs and therefore avoid injuries sustained when attempting to inject in poor lighting.
- Provide privacy and afford dignity when using drugs.
- Ensure help is always on hand if something goes wrong.
- Reduce needle and paraphernalia litter and resulting risks of this within community.

Improve access in to drug treatment for homeless

- Homeless particularly at risk group within the community (**average age of death of homeless person = 47 years of age**, ref: Crisis)
- Homeless individuals enabled to access drug treatment, including commencement on opiate substitution therapy (OST), within 24 hours of referral.
- 'One stop shop' appointments for new referrals.
- Regular support appointments from drug service for homeless individuals – to be offered fortnightly if required.
- Offering screening for blood borne viruses (hepatitis B and C and HIV) to be key performance indicator for drug treatment services.
- Eradicate inappropriate low dose prescribing of OST and therefore reduce risks.

Increase access to quality healthcare for homeless substance users – thereby reducing harms and risk of death

- Enhance specialist homeless primary care service – increase hours of nurse input on Street Intervention Team to increase access to healthcare and treatment for street substance users.

Novel Psychoactive Substance (NPS) Use

- For drug treatment services to develop clear approach to providing support and treatment for NPS users (as I feel there is a lack of clarity and engagement around this).
- Gather key individuals from a number of partners to discuss/share intelligence around NPS, including police, health, ambulance service, homeless providers, drug treatment service, coroner, toxicology.

It is my experience that homelessness and street substance use can sit alongside poor physical health, mental health concerns, traumatic past experiences, low self-esteem, lack of trust in services. This complex array of factors mean that a range of support is often required and opportunities to engage with these individuals need to be created and maximised in order to provide the chances for individuals to begin to engage in the process of improving their circumstances, reducing the harm to themselves with the overarching aim of helping people work towards rebuilding their lives.

Birmingham Local Pharmaceutical Committee

Chair of Pharmaceutical organisation that represents all 300 community pharmacies across Birmingham including those providing Needle, Syringe Programme, Supervision services and Naloxone supply.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

   Your paper identifies the cost and supporting evidence of the substance misuse problem in Birmingham

   I know my pharmacy contractors work closely with CGL to provide a service to clients in treatment together with being an access point for substance misusers NOT in treatment. There is pressure on funding across the system.

   Strategically, I would like to see some transformational funding changes which INVESTS money in prevention, harm reduction and education which comes from FUTURE reduction in treatment costs. This will take radical thinking in many organisations and I hope you have the vision and resilience to facilitate this process over several years. Holding the summit is only the first step.

What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime? 500 words max. Links to reports or supporting evidence are welcome.:

Structured education in schools for the young
Community accessed support
Prison release to follow a pathway a long the lines of hospital discharge.

Sarah Norman: Dudley MBC

Chief Executive, Dudley Council and Lead Chief Executive for Wellbeing including Thrive West Midlands

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Not applicable

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

The key initiatives picked up from attendance at the I-Circle (International City & Urban Regional Collaborative, Supporting Mental Health and Wellbeing to Enable Citizens to Thrive) conference include:

• Stepping Up programme in prisons in Philadelphia, a pilot on recovery based treatments such as Cognitive Behavioural Therapy (CBT) to both reduce offending and improve prisoner behaviour. Here in Britain it is very difficult for prisoners to access therapies like CBT which means we may be missing opportunities to address mental health issues that may be the basis of an individual's offending behaviour.

• Mayor of Philadelphia established a "Forensic Task Force" in the city to coordinate a plan to reduce opioid abuse, dependence and overdose. Whilst opioid addiction is less of a problem in the West Midlands, it parallels here with some of our own substance misuse challenges.

The plan made several recommendations under four main themes:
– Prevention & Education, inc consumer directed media campaigns, a public education campaign and improved health care professional education
– Treatment, inc expanding treatment access and capacity and providing safe housing and support
– Overdose Prevention, inc user engagement, coordinated rapid response to outbreaks and addressing homelessness among opioid users
– Involvement of the Criminal Justice System, inc expand court capacity for diversion to treatment and expand enforcement capacity in key areas

Please see link to final report and recommendations for further information:
http://dbhids.org/wp-content/uploads/2017/05/OTF_Report.pdf
Key Contact: Roland Lamb, Deputy Commissioner
City of Philadelphia Department of Behavioural Health & Intellectual Disability Services, Email: roland.lamb@phila.gov

• The US government has a programme to encourage "Drug Free Communities". http://www.cadca.org/drug-free-communities-dfc-program These are very local communities (ward sized) that have established a grass roots ambition and action plan to become drug free and which in return receive $125,000 / year for 5 years. Philadelphia has proactively supported communities to become part of the programme and see it as a very successful way to engage

with local communities on substance misuse.
Drug Free Community grantees have seen reduced drug usage and abuse to levels lowers than national averages because they are organised, data driven and take a multi sector approach to solving and addressing local drug issues.
• Philadelphia Mural Arts Programme, created more than 4,000 murals in the city over the last 30 years. The programme has been used as a vehicle to engage with communities on mental health and to improve the urban environment but has also been an integral part of work with offenders and recovering addicts.

This has included prison programmes and work with victims and it has collected lots of evidence of the impact on reoffending and drug recovery. Requested by and designed with communities, the murals have remained virtually graffiti free. The programme also creates lots of employment for young artists.

It costs £9m / year to run but much of that is commissioned as part of drug recovery and restorative justice programmes and raised through sponsorship and donations. It also gets substantial income from running mural art tours.

Key Contact: Jane Golden, Executive Director
Email: jane.golden@muralarts.org, Website: https://www.muralarts.org/

• Work in Philadelphia has identified that many people who have substance misuse problems as adults suffered trauma early in their lives. As a result they have established PACTS (The Philadelphia Alliance for Child Trauma services).

The PACTS develop a system of care, based around Trauma Focused Cognitive Behavioural Therapy and evidence based treatments, effective in traumatised children aged 3-18 years. Training is also provided to a number of agencies in Child and Family Traumatic Stress Intervention, the only evidence based practice shown to prevent Post Traumatic Stress Syndrome in children.

This could be very relevant to our work on addressing Adverse Childhood Experiences.

Key Contact: Artuto Zinny, Project Manager
Further information on this and other programmes can be found on the link:
http://www.philadelphiapacts.org/
• Pennsylvania is implementing a 'warm hand-off' process to help overdose survivors who appear in emergency services to be transferred directly to a drug treatment facility. The process has been incorporated into contractual agreements with providers to ensure overdose survivors are treated as priority cases.

Further information on this and other programmes can be found on the link below:
http://www.ddap.pa.gov/overdose/Pages/Department%20Focus%20on%20Addressing%20Overdose.aspx

Please see link to the Thrive West Midlands, an action plan to drive better mental health and wellbeing in the West Midlands:
https://www.wmca.org.uk/media/1420/wmca-mental-health-commission-thrive-full-doc.pdf

Supporting Doc- Yes- WMCA Board paper on Global I-Thrive Network.

Transform Drug Policy Foundation

Transform Drug policy Foundation - seeking more just and effective drug policy and law.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Police enforcement pressure on the supply of prohibited drugs in the context of high and growing demand has inflated prices, providing an increasingly lucrative opportunity for criminal entrepreneurs. The 'war on drugs' has created an illegal trade with an annual turnover of more than $300 billion globally, £6-10 billion in UK alone. The level of criminality associated with the illegal trade is in stark contrast to the parallel legal trade for medical uses of many of the same drugs.

• A significant proportion of street crime is related to the illegal drug trade: rival gangs fighting for control of the market, and robbery committed by people with drug dependencies fundraising to support their habit. The Government has estimated over 50% of acquisitive property crime is dependent users of heroin and cocaine raising funds to support their habit
• Millions of otherwise law-abiding, consenting adults who use drugs are criminalised for their lifestyle choices – more than 2 million people use illegal drugs in the UK every year.
• The criminal justice-led approach has caused an rapid expansion in the prison population of drug and drug-related offenders – fuelling the current multifaceted prison crisis – that includes overcrowding, violence, inadequate treatment and mental health provision
• Drugs are now the world's largest illegal commodity market, enriching organised crime groups and fuelling money laundering and corruption in the UK and across the world
• Violence is inherent to the illegal drug trade. Aside from conflicts between drug gangs and drug law enforcers, violence is used to enforce the payment of debts and to protect or expand criminal enterprises
• Evidence suggests that more vigorous enforcement exacerbates violence. Profits from drugs sold in the UK are also fuelling regional conflict by helping to arm insurgent, paramilitary and terrorist groups in primary drug producer and transit countries
• The costs of proactive drug law enforcement are dwarfed by the reactive costs of dealing with the crime it fuels – Home Office research in 2006 estimated the crime costs of heroin and cocaine alone in England and Wales (including costs to the CJS and victim costs of crime) at £13.9billion annually.

There is little evidence of a deterrent effect from drug law enforcement targeted at people who use drugs, or of significant impacts in reducing long-term drug availability from supply-side enforcement – displacement is the best that can be achieved. Using drug-related crime as a justification for the war on drugs is unsustainable given the key role of prohibition, and its enforcement, in fuelling the illegal trade and related criminality in the first place. Separating the health and social costs created by drug misuse from the crime costs created by drug policy is a vital first step towards improving community safety.

For background, discussion and stats, see;

A Comparison of the Cost-effectiveness of Prohibition and Regulation of Drugs
http://www.tdpf.org.uk/resources/publications/comparison-cost-effectiveness-prohibition-and-regulation-drugs

Will drug use rise? Exploring a key concern about decriminalising or regulating drugs
http://www.tdpf.org.uk/resources/publications/will-drug-use-rise-exploring-key-concern-about-decriminalising-or-regulating

The Alternative World Drug Report, 2nd edition (in particular, chpt 5)
http://www.countthecosts.org/sites/default/files/AWDR-2nd-edition.pdf

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

There are a number of well-established interventions and policy shifts that can be taken at the police authority level, and should be actively explored as part of the wider drug policy debate:

Supervised Drug Consumption Facilities.

UK drug-related death rates are among the highest in Europe and are increasing dramatically. Supervised Injection Facilities (SIFs - also called Drug Consumption Rooms - DCRs) are proven to significantly reduce fatal overdoses and needle sharing that can lead to infections, including HIV and hepatitis; high-risk street injecting; and discarded needles, while increasing numbers entering treatment.
See Transform briefing here: http://www.tdpf.org.uk/blog/supervised-injection-facilities-saving-lives-making-communities-safer-0
Heroin Assisted Treatment

Prescribing heroin for some dependent users, usually for use in clinics under medical supervision, is called heroin-assisted treatment (HAT). The practice is well established, already legal under UK (and international) law, and has a long history, including in the UK, Switzerland, Germany, the Netherlands and Canada.

It has successfully reduced fatal overdoses and needle sharing that can lead to infections, including HIV and hepatitis; high-risk street injecting; fundraising driven acquisitive crime and street sex-work; and discarded needles, while increasing take-up and retention in treatment. Both the UK government and its official advisers - the Advisory Council on the Misuse of Drugs (ACMD) - actively support HAT. The ACMD from a health perspective, the UK Home Office from a crime reduction viewpoint as well

See Transform Briefing here: http://www.tdpf.org.uk/resources/publications/heroin-assisted-treatment-hat-saving-lives-improving-health-reducing-crime

Ending the criminalisation of people who use drugs

Also called decriminalisation or diversion schemes – this involves ending criminal sanctions

for small-scale possession of drugs for personal use, with an option for civil or administrative sanctions such as fines, education courses or treatment assessments. Criminalisation has not been shown to deter use but it does fuel stigma, discrimination and inequality, reduce access to drug services for vulnerable people and encourage risky forms of drug use. Ending criminalisation can reduce these problems as well as freeing up CJS resources – creating a better environment for a health and harm reduction based drug policy.

See Transform briefing here:
http://www.tdpf.org.uk/resources/publications/decriminalisation-people-who-use-drugs-reducing-harm-improving-health-helping

For a more detailed exploration of impacts of decriminalisation see also:

Will drug use rise? Exploring a key concern about decriminalising or regulating drugs
http://www.tdpf.org.uk/resources/publications/will-drug-use-rise-exploring-key-concern-about-decriminalising-or-regulating

Drug Decriminalisation Policies in Practice: A Global Summary
http://www.tdpf.org.uk/resources/publications/drug-decriminalisation-policies-practice-global-summary

Multi-Agency Safety Testing (MAST)

Knowing what is in any drug, and how strong it is, can reduce the risk of overdose, poisoning or long-term damage. So 'drug safety testing' involves people handing over a sample of their drugs voluntarily, and without fear of arrest, for testing to identify what it contains, including any contaminants and its strength. People are also given advice on how to minimise the harms from taking drugs. Testing – arranged in agreement with local police and health agencies - is either carried out on the spot (at festivals, in city centres, or in drug services) or results are provided within a few days.

See Transform briefing: http://www.tdpf.org.uk/blog/drug-safety-testing-saving-lives-increasing-awareness

Whilst more far-reaching reforms – such as changes to the law to allow for strictly regulated markets in cannabis or other drugs - are beyond the powers of police, it is entirely appropriate for them to be a subject of debate and dialogue between police and relevant stakeholders and policy makers. Transform is happy to inform and facilitate such dialogue.

Dr Stephen William Strange (aka Bill Strange)

Chair Birmingham LMC

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

Drug Consumption Rooms- Good for the individual user: treated with compassion, safe setting, access to other services, harm reduction, less fatal ODs

Good for Society: less drug litter in public areas, infection risks, unacceptable behaviour visible, and knowledge that acting compassionately

Good for Birmingham; cleaner city centre etc.

Good for the police; I am not an expert here but I imagine less calls from public/businesses, folks having better access to support services (police not needing intervene as much) providing a realistic option for officers to promote " why are you choosing to use drugs in street there is a DCR available"

So I think it is safer, more compassionate and cheaper as an option-- hence a long supporter of this initiative. It already works in other European cities.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Establish DCR

Establish working principles to promote their use by clients i.e. positive support from all stakeholders.

Identify funding for this project.

Advertise new service.

I don't think it is necessary to structure this as a pilot/research to see if cost effective as numerous international bench marks now.

KIKIT Pathways to Recovery CIC.

Drug and alcohol treatment provider.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

   KIKIT provides BME specialist drug and alcohol support services in Birmingham and we are part of the supply chain of change grow Live (CGL).
   We know the cost and effect of what drug and alcohol dependency has on individuals and communities if funding is cut any further. Crime, health etc would get worse and this would end up costing alot more to address.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

We need more services that cater for the needs of BME communities like KIKIT offering culturally sensitive bilingual support from grass roots communities.
The impact grassroots services make is cost effective and produces outcomes to reduce crime and prevent harm.

National Probation Service

On behalf of probation.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

We see a significant link between drug misuse and crime, either in terms of our service users committing acquisitive crime to fund drug misuse or from networks of organised criminals managing the distribution of drugs, frequently with the involvement of firearms and violence. We are part of a specialised multi-agency gang unit where the drugs trade is a major motivator, and people with a range of vulnerabilities can be drawn in and exploited (used as runners, or their homes may be utilised by dealers). More recently our Approved Premises (probation hostels for high risk offenders) have found themselves increasing trying to manage residents who use psychoactive substances. This can create management problems whereby their conduct becomes aggressive and unpredictable and it also creates major health risks, with the potential of residents dying.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

How do we stop the drug trade being such a lucrative business, fuelling violence on our streets, but also luring a large number of young men into a criminal lifestyle - sorry, I don't have the answers.

New psychoactive substances - do we know yet how to respond and provide 'treatment' for users? Really important that we progress on this.

Selfishly, from an agency point of view, I need to forge closer links with treatment providers and ideally secure a presence in probation offices as drug misuse is so prevalent on our caseload.

City of Wolverhampton Council

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

In the 2015 Indices of Deprivation, Wolverhampton was ranked as the 17th most deprived of England's 326 local authorities. According to 2015 estimates, it has a population of 254,406 and an adult population (aged 16 and over) of 202,434.

Wolverhampton is also a very diverse city, according to the Wolverhampton migrant health needs assessment (2017) 16.4% of the population in 2011 were born outside of the UK.

Alcohol misuse in Wolverhampton

- Of the adult population who drink (105,265) 44% (23,127) of men score higher than 5 on AUDIT C. 26% (12,098) of women score higher than 5 on AUDIT C (an indication of higher risk drinking) (Source: extrapolated figures from Wolverhampton lifestyle survey of 9,000 in 2016).
- Significant inequalities present with respect to age, gender, socio economic deprivation and ward. For example, although higher risk drinking occurs across all socio-economic groups in the population, deaths are predominantly from the more deprived areas and predominantly affect men aged 45 – 69.
- Alcohol specific mortality in Wolverhampton has decreased since 2006-08, from 24.28 per 100,000 to 20.17 in 2013-15. This is an increase from 17.9 in 2012-15 but it is still too early to see if this is a trend. However, this is still significantly higher compared to England (11.48 per 100,000). Compared to other local authorities within England, Wolverhampton ranks 12 out of 153 local authorities with rank 1 being the highest. This equates to 160 deaths in 2006-08 and 139 deaths in 2013-15.

Drug misuse in Wolverhampton

- In 2011/12, there were 14.03 per 1000 population users of opiate and/or cocaine in Wolverhampton. This is significantly higher compared to England (8.4 per 1000 population. Compared to other local authorities in England, Wolverhampton ranks 18 out of 152 local authorities (for whom the data was available); with rank 1 being the highest.
- In 2013-15, there were 3.59 deaths per 100,000 population due to drugs misuse in Wolverhampton. This is lower compared to 3.89 deaths per 100,000 population in England and 4.02 deaths per 100,000 in West Midlands in the same time period. The rate of deaths due to drug misuse has however increased in Wolverhampton from 3.5 per 100,000 population in 2012-14 to 3.59 per 100,000 population in 2013-15.
- In Wolverhampton, 16.4% of all violent crimes involved alcohol, 2.3% violent crimes involved drugs and 0.8% violent crimes involved both drugs and alcohol in 2016. Compared to 2015, violent crime involving alcohol has increased in number (n=1142); however, it has reduced as a proportion of all violent crime, from 18% in 2015 to 16% in 2016. There has been an increase in violent crime involving drugs,

from 2% in 2015 to 2.3% in 2016. Similarly, there has been a slight increase in violent crime with both alcohol and drug involvement.

The prevalence of alcohol and drug misuse in Wolverhampton is higher than England and this is most notably so for alcohol. Both issues impact on local health, criminal justice and social care resources however our investment in treatment shows the following benefits (*Table 1);

*Table 1: 2016 17 Investment benefit from treatment: Wolverhampton

Offence type	Estimated number of crimes committed before treatment entry
Shoplifting	45,768
Theft of a vehicle	617
Theft from a vehicle	1,850
Domestic burglary	370
Non-domestic burglary	2,344
Robbery	740
Fraud	987
Criminal damage and arson	42
Violence against the person	109
Sexual offences	0
Begging	5,798
Drink/ drug driving	9
Other theft	4,688
Drug offences	26,276
Prostitution	6,045
Breach offences	110
Public order	16
Other	67
Total	95,836

Estimated % change after starting treatment	**-30%**
Estimated crimes prevented per year after starting treatment	**29,100**

Average crime-related cost		Before starting treatment		After starting treatment
Social costs	£	3,246	£	2,261
Economic costs	£	23,193	£	16,150
Social and economic	£	26,439	£	18,411

Average benefits		Gross benefits
Social benefits	£	1,165,125
Economic benefits	£	8,323,823
Social and economic	£	9,488,948

Other benefits resulting from treatment		
NHS and LA	£	1,147,089
Quality adjusted life years (QALYs)	£	3,168,645

*PHE's Social Return on Investment (SROI) of Adult Alcohol and Drug Interventions and the Adult Alcohol and Drug Treatment Commissioning Tool.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Wolverhampton's Tobacco and Substance Misuse Alliance developed an action plan around the partnerships identified priorities earlier this year. Enhancing criminal justice pathways is part of the harm reduction strand of the plan.

A multi-agency approach to focus efforts on increasing the knowledge and use of court orders particularly Drug Rehabilitation Requirements (DRRs) and Alcohol Treatment Requirements (ATRs) is underway locally. The use of these orders has previously delivered positive outcomes around reducing reoffending rates and engagement in treatment. Positive progress to date has included:

- A local treatment worker within Walsall courts to provide speedy assessments and pre-sentence reports recommending ATRs/DRRs where appropriate. This arrangement has also reduced breach of RA's (required assessments)
- A new criminal justice pathway for lower level interventions (pre court) has been adopted, and been piloted in the city centre

- Treatment appointments are now booked for community resolutions which were previously missed as these individuals did not essentially enter the criminal justice processes
- First time arrests for crack/cocaine/heroin are offered brief advice. Repeat arrests result in a structured treatment offer. Correlation of arrests and previous substance use were not historically monitored by treatment services and depended on defendants disclosure.
- Assessments are now completed in prison prior to release for those previously known to treatment services. Prisons covered include Hewell, Oakwood, Brinsford, Winson Green and Foston Hall (women's prison)
- A project is now running in the community supporting women offenders recently released from prison
- Police custody block sweeps continue to take place reducing the likelihood of missing a person requiring support with substance/alcohol.

Wolverhampton Public Health have also recently tendered all Drug and Alcohol services in the City. Prior to this a public consultation was held for 12 weeks between April– July 2017. The consultation process sought to obtain the views of key stakeholders on current services and to identify the best future service model to include in outcomes for individuals and families. During this process over 400 adults, young people, professionals and parents were consulted, including service users to inform the development of the proposed service model. What respondents fed back on criminal justice was;

- A need for early intervention and prevention initiatives to reduce offending rates including alternatives to criminal sanctions for heroin addicts.
- Greater support and resilience building in prisons to stay drug free following release.
- Support for vulnerable families in breaking the cycle of generational substance misuse and crime.
- Support provided through probation and mental health services including person centred, and more intense supervision for those deemed to be highly vulnerable.

The new treatment service model commences on 1 April 2018 and the Alliance have agreed the future development of a strategy to formalise work to tackle tobacco and substance misuse in the City. This will be reviewed in the new year.

The four Black Country areas of Wolverhampton, Walsall, Dudley and Sandwell are working together to develop a reducing reoffending strategy for launch April 2018. Recognising the link between drugs, alcohol and offending behaviour, there will be scope to identify efficiencies, share good practice and consider new approaches to strengthen our collective response to reduce the prevalence of crimes linked to substance misuse.

Tony M

Person in long term recovery.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

   The human cost of addiction to families and friends of the addict are immense and often result in adverse experiences for children and young people, repeating the cycle of addiction in future generations.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

   Public health England have been promoting the role of "mutual aid" organisations such as Cocaine Anonymous and Narcotics Anonymous and encouraging treatment workers and other professionals to encourage clients attending these groups because of the strong evidence base. Everyone working with drug users should be providing "Mutual Aid Facilitation" to encourage clients to try a mutual aid group. PHE's evidence guide for mutual aid attached.

Supporting Doc- Yes- PHE- Briefing on the evidence based drug and alcohol treatment guidance recommendations on mutual aid, Dec, 2013.

United patients alliance

As a member of a medical cannabis campaigning group.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

2016, is a complete study of over 20,000 research papers proving the medical benefits of cannabis. The reality is that patients are reporting what cannabis does for them in their fight for an acceptable quality of life.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Decriminalize cannabis, by not enforcing prohibition of a person's human right to an effective medicine.

Anonymous

Treatment worker in a prison

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

Within all prisons there is a huge issue with drugs. In particular at the moment Novel Psychoactive Substances (NPS). In the year Jul 2016-Jun 2017 there were 514 Healthcare recorded NPS related events within our prison. This equates to 1.41 per day across the year on 276 separate days – 75% of the year. During that time the highest number of emergency calls was 18 in one day which has since been surpassed with a total of 22 – 3 times for one individual on that day.

It is likely that these figures are an under representation as officers and patients are now so used to dealing with NPS usage they are not calling for healthcare assistance for any but the most serious. When NPS events were less frequent there may have been a lower threshold for reporting.

This data also does not capture the intensity of the healthcare interactions. Healthcare have become adept at addressing issues without the need for external support. Some of these examples may be extremely time or resource intensive. In addition there have been many reports where patients have become aggressive either when recovering from NPS or as peers of the patient trying to become involved in the treatment. There were several reports of medical equipment being taken or tampered with by other prisoners whilst medical attention was focussed on treatment.

There is a systematic approach to follow up from NPS use and creative methods used for educational initiatives. One patient who had been on life support following NPS use gave consent and was filmed describing his NPS experience and this was used for education as well as group talks from a patient who had suffered severe physical health difficulties after using NPS.

These initiatives appear to have short term effects on NPS use It may also be worth noting that there is some indication from patient feedback that there is a perceived degree of safety in using NPS within the prison as there is rapid healthcare response (as opposed to waiting for an ambulance in the community).

The author of the report saw one cellmate being transferred to hospital following NPS; when the other cell mate was allowed to return to the cell, he too required healthcare attendance within 5 minutes having used the same product that had made his peer so unwell.
Each event takes resource away from day to day tasks.

Nursing staff attend, plus resource from the prison in terms of staffing, accompanying nursing staff whilst attending incidents, security, additional escorts to hospital etc. Whilst any service should expect to meet changing demand, NPS use has created a whole layer of requirement. This has needed to be sourced within existing services and the cost of this in both resources provided and the loss or redirection of resource from other service aspects should not be under-estimated.

Martine Evans

Ex-service user and currently working in addictions.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

I often see more people coming into our services with psychosis which seems to be caused by excessive Cannabis use - it seems to be the types with the higher THC levels that are causing this. We support harm reduction within addictions with regards to class A drugs and I just feel that if we could also give harm reduction/education regarding which types of cannabis are not as bad for your mental health (Higher CBD lower THC types) this may reduce the psychotic episodes that people (especially young people) are experiencing.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Possibly legalise or more tolerance the lesser class of drugs (B/C) and concentrate on getting the class As off the streets as I would like to think this will free up some of the police force to crack down on the class A dealers - I also think that the NPS (so called Legal highs) should be looked into and maybe being reclassified - I understand the classification is based on the harm it can cause to the user and society and upon walking through the city centre I see more harm caused by NPS than anyone I see on class A's

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Emma Atkinson

Drug treatment worker

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

Effect on services - probation, police, prison service, GP's, drug treatment services, A&E, hospitals, job centres - benefits
Effect of drugs on the community - thefts, burglaries, robberies, assaults, instilling fear
Effect of drugs on family - robbed of peace of mind, feeling unsafe, financially abused, stress and poor health, safeguarding concerns, domestic abuse
Effect on the individual - low self esteem, low self worth, lung and chest problems, deep vein thrombosis, abscesses, vein damage, blood bourne virus's, mental health issues, no fixed abode, committing crime, arrests, prison sentences, poor dental health, poor physical health, lack of personal hygiene, feeling judged and isolated from the community, services and their families

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Early intervention - improved school education about drugs and consequences
More courses like Princes Trust
Information about self-help groups like Narcotics Anonymous and Families Anonymous to be available
Rehabilitation places instead of prison sentences
More therapeutic communities in prison
HOUSING!!! stable housing - supported
Housing and benefit support before being released from prison

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Anonymous

Organisation / Midlands Partnership Manager (Substance Misuse)

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

I am the Midlands Partnerships Manager for the Making Every Adult Matter (MEAM) coalition. We area coalition of National organisations, Clinks, Homeless Link and Mind, formed to improve policy and services for people facing multiple needs.

By multiple needs we generally mean people experiencing two or more of the following needs at the same time: homelessness, substance misuse, mental health problems and contact with the criminal justice system.

People experiencing multiple needs often have ineffective contact with services, as in most cases they are designed to deal with one problem at a time and to support people with single, severe conditions. This can mean that people experiencing multiple needs are more likely to access emergency, rather than planned services, such as going to accident and emergency rather than the local GP and are more likely to become involved in the criminal justice system.

This has a negative impact on both their individual wellbeing and experience of services, as well as leading to the accumulation high service use costs, with little or no impact on their wellbeing or motivation.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

The MEAM coalition has recently expanded and are working with 19 local areas across the country and several in the West Midlands, supporting them to use the MEAM approach to gather data, evidence, learning and improve outcomes for people experiencing multiple needs.

We would be really keen to attend the summit and contribute information and learning from both our national and local policy and practice teams and discuss how the MEAM approach might be able to help develop the West Midland's response to this issue.

Linda Thompson

Parent/family member/financial abuse.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

Would like to say this is not addressing the full picture. There is an invisible army of family members suffering financial physical and mental abuse. The only way forward is for everyone to be educated on the big picture around addiction. Drug services need to open their doors and minds to realise people living with the addiction and those living with them do understand the full impact on all. Person/families/children.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

A structure across all services with the same ends not just ticking pretend boxes to make things look good. Recording the deaths brought on to family members and children from living with the daily influence of a drug user.

Gareth Hopkins

Substance Misuse Policy Lead, South Wales Police and Crime Commissioner.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

3000 heroin and crack cocaine users in the South Wales are estimated to be costing the South Wales area at least £186 million a year.

The average heroin or crack cocaine user not in treatment commits crime costing £26,074 a year. The annual cost of each problematic drug user is estimated at £62,320 when considering only four indicators: drug-related crime; health service use; drug-related deaths; and social care.

Every day in the Wales somebody dies from 'Class A/B/C' drug poisoning, with a death every 18 hour in Wales in 2014/15. This has been rising since 2013 and has been the highest since records began. South Wales has the highest proportion of drug deaths in Wales. The majority of those who died 2014/15 were aged under 40, 76% were men, 24% women.

An estimated 1:20 children in the South Wales have a parent or parents with serious drug problems.

Most organised crime groups in the South Wales are heavily involved in the drugs trade. Those organised criminals involved in drugs are more likely to be operating internationally, and more likely to have links to firearms. Organised criminals in the South Wales are profiting from a drug market worth millions of pounds.

1.Home Office, 'Drug misuse: findings from the 2015 to 2016 (CSEW second edition, Drug misuse statistics, Alcohol and drug statistics and Crime statistics, July 2016)

2. Office for National Statistics (ONS), 'Drug misuse deaths by local authority', 2 August 2017

3. M. Bryan, E. Del Bono, S. Pudney, 'Drug-related crime', (Institute for Social and Economic Research University of Essex) July 2013.

4. Home Office, 'Understanding organised crime: estimating the scale and the social and economic costs', International Crime and Policing Conference 2015: papers, 7 October 2013.

5. Home Office, 'Findings 187: Drug-related mortality among newly released offenders', 2013,

6. National Crime Agency, 'County Lines Gang Violence, Exploitation & Drug Supply 2016, (0346-CAD National Briefing Report)', November 201

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

South Wales has, in common with the West Midlands, a substantial problem with the impact of drug and alcohol dependency on community wellbeing and cohesion, including crime. Alun Michael, South Wales Police and Crime Commissioner recognised that an enforcement only approach against substance misuse would not reduce harm and improve community cohesion.

To enable the reduction of harm caused by substance misuse needed a reboot of how we approached the issue as criminal justice system partners, and how our activity interacted with the wider statutory, private and third sector, as well as individuals and communities.

In 2014/15 it was agreed with the local HMPPS Cymru leads that we need to look at the following key areas:

- Moving away from number counting of people in treatment and focusing on shared positive and aspirational outcomes for drugs *and* alcohol
- Ensuring we commissioned treatment and support systems and not treatment and support services
- Pooling budgets for treatment and support from within the Prison estate, Community (DIP) and statutory mandated Court engagement functions (eg DRRs and ATRs etc)
- Ensuring harm reduction and diversion, where possible given the seriousness of the offence, was key to delivery of a vulnerability based arrest referral system that identified the need for the provision and recognition of the needs of 18-25s, women, BAME, LGBTQ, mental health, learning difficulties, sex workers and over 40s.
- Ensuring all offenders entering into the CJS treatment and support system had in house prescribing and medical provisions that engaged them in a rapid access system, crucially, ensuring their offending risk and social risk, was as important as their perceived clinical risk.
- Using police estates and resources, such as the custody suite, as an intervention opportunity as well as processing place – eg- the provision of injecting equipment to high risk individuals on demand, not exchange, on release.
- Ensuring one consortium delivers all CJS treatment and support functions in all Courts, Custody suites, Communities and Prisons in South Wales. Avoiding the need to regenerate information, allowing for a treatment continuum from arrest to release, with person cantered services that benefit individuals and communities.
- The resulting treatment and support system was called ‘Dyfodol’ (Welsh for ‘future’) and is delivered by a consortium of the private, statutory and third sector on an 8-year contract awarded in April 2016. The Dyfodol system is funded by the South Wales Police and Crime Commissioner and HMPPS Cymru. There are 120 staff working in 5 prisons, 4 Courts, 4Custody Suites and 7 community delivery hubs across South Wales.
- The Dyfodol system was designed, costed and developed by Gareth Hopkins, South Wales PCC Substance misuse policy lead and Dyfodol contract manager. Gareth would be happy to speak with you on gareth.hopkins2@south-wales.pnn.police.uk or regmanager@dipsouthwales.org.uk if you have any questions about the Dyfodol system.

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420 Wolverhampton UK

Drug treatment worker.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

The cost of class a drugs, heroin, crack, cocaine and most pharmaceutical drugs and your legal highs have a huge impact on lives, crime rate and health impacts, can no longer be ignored , my oils aid the bodies ability to heal and recover from the abuse from these drugs

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Treatment, both with the most effective and least toxic cannabis oils, both cbd to heal and thc to treat pain, please don't hesitate to get in touch

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Anonymous

Concerned citizen

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Innocent citizens lives ruined. By theft. Vandalism. Drug related debris in public space. ASB. Violence. Run down residential areas. Speeding cars/drug intoxicated drivers. Disrespect. Zero consideration to others. Fear among communities.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

It must NOT BE decriminalised. Higher sentences. Including for personal use. To include hippy crack/formerly know as legal highs as illegal to sell. Involve NHS AND SOCIAL CARE. increase residential units/secure units for rehabilitation to get people clean. Imposed by criminal sentencing. Not by individuals voluntary if they have committed crime or pose danger to life of others or self. Tighter security airport checks searches and sea crossing borders; channel tunnel. Easier access for police to obtain search warrants on suspected drug factories dealers properties. Stricter landlord regulations. .

Rose Humphries / Anyone's Child: Families for Safer Drug Control

A mother twice-bereaved by heroin.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Our drug policies give organised crime an opportunity to make vast amounts of money from the drugs trade. People want drugs. Nobody can sell them legally so the illegal market flourishes. The drug gangs don't care who they sell to. They make drugs widely available to any customers, whoever they are and whatever their ages. So it is too easy for young teenagers to get started on drugs. All too often it costs them their chances to do well in school and later.

Our drug policies cause young people to be criminalised unnecessarily for possession of drugs. When they have criminal records it messes up their later chances in life. It puts difficulties in their way when applying for jobs - even many years later if enhanced criminal record disclosure is required. It blights their lives.

The criminalisation of drug use causes it to be surrounded by stigma and shame – not only for the users themselves but also for their families. This shame makes it doubly hard when families feel they have to keep their loved ones' behaviour secret and are unable to talk about it.

Drug dealers encourage or coerce users into using more or harder drugs, sometimes threatening their customers and causing them to steal in order to pay. And so families of users, and the general public, suffer by being the victims of this stealing.

Families also suffer from the lying and manipulation that becomes second nature to those that have got too heavily involved in illegal drugs. This behaviour causes great stress and often rifts in the family.

After a user becomes addicted help is not easily available. If he decides he wants to give up, the help is not there immediately when it needs to be.

Someone addicted to heroin, if he's not ready to give up or can't get the help he needs, has no choice but to keep getting heroin from the dealer. Illegal heroin is dangerous because the strength and purity are unknown, and it might have other dangerous substances in it.

The criminality of drug use means that someone who is with a person accidentally overdosing on heroin can fail to call for help in time, because he's afraid of being implicated in the drug use.

A lack of any safe place to inject or smoke heroin means that the addicted person will often use alone. If he accidentally overdoses with nobody around to save him he will die.

When addicted people resort to using public spaces, their drug paraphernalia is frequently left littering the area, spoiling the neighbourhood and being a hazard to others.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Until we achieve my ideal world of decriminalisation of drug users and legal regulation of drugs, there are some initiatives that would prevent harm and reduce crime.
- More time to be given to better and truthful drugs education including harm reduction. http://volteface.me/features/drugs-education-uk/
- Publicity to be given to the fact that people who are with the victim of a heroin overdose will not get into trouble with the law if they call for medical help.
- Naloxone kits for reversing the effects of heroin overdose to be more freely available to those who are likely to be with someone who is addicted. Many deaths from overdose could thus be prevented. https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone
- Safe injecting facilities to be set up, providing a safe place to use drugs, with clean needles preventing infection, medical staff supervising and preventing overdose deaths, removing the need to inject in public places so that the surrounding area becomes cleaned up, providing an environment for advice and counselling leading to treatment. http://www.tdpf.org.uk/blog/supervised-injection-facilities-saving-lives-making-communities-safer-0
- Heroin assisted treatment (which is actually not illegal currently) for those where other treatments have failed, where heroin is prescribed and administered under the supervision of medical staff, possibly in a clinic, and so is much safer. It would reduce crime from those who habitually steal to pay for illegal heroin. Also it would reduce prostitution as a means to pay for the drug. http://www.tdpf.org.uk/resources/publications/heroin-assisted-treatment-hat-saving-lives-improving-health-reducing-crime

Decriminalisation of drug users would reduce harms. http://www.tdpf.org.uk/blog/drug-decriminalisation-portugal-setting-record-straight
- Those who do no harm to others would not have their lives disrupted by the criminal justice system and their life chances spoiled by a criminal record or adverse influences on them in prison.

Legally regulating drugs would prevent harm and reduce crime.
http://www.tdpf.org.uk/resources/legal-regulation
- Drugs would be produced to regulated standards, in labelled packaging with information and dosage, making them as safe as possible. People would not die as a result of using substances of unknown purity and strength. They would not have to go to unsafe environments and mix with criminals in order to obtain their drugs. The licensed premises that would be allowed to sell the drugs would be strictly regulated and would require ID so that they couldn't sell to anyone under age. Some who are addicted would receive their drugs on prescription. Also sellers would have no incentive to persuade customers into trying harder drugs or buying more than they needed, and they would be providers of truthful information and advice about the substances.
- Much shop lifting and other theft, and prostitution, happens so that people can pay their dealers. So crime and prostitution would be reduced when users were no longer buying from criminals and having to pay drug debts they'd been coerced into. People addicted to drugs would no longer have to steal or prostitute themselves because they would be given prescriptions.

Anonymous

Police Officer

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

In 27 years of policing I have seen numerous lives blighted by addiction to drugs and the pain and the hardship that it causes to not only the individuals and their families but also the numerous victims of crime caused as a result of the addiction. I can give evidence of that prescription Methadone is traded for heroin and although the statistics for drug intervention work in custody are not easily available anecdotally the same people with addiction keep coming into custody. I would be interested to see how many people who have gone through the programme and got clear of opiates in the long term. On the streets addicts are at the mercy of the dealers whose vested interest is to encourage drug use and I do not feel that at the moment there is a viable option available.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Twenty years ago I can remember having a conversation with a Police Doctor, who was passionate about helping people with addiction. He said that injection clinics were the only real solution to the problem. In the subsequent twenty years I don't feel that anything has changed and I am heartened by the fact that people are at last discussing specialist clinics. Specialist clinics would be a safe clean environment where treatments can be prescribed. This will allow interventions at a single point of contact and would ensure that the criminal element is largely removed from the equation. People registering can be offered a range of support under one roof and they would be treated as victims/patients rather than the criminalising of their addiction.

Anonymous

Former drug worker in Wolverhampton

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

The costs of the current drugs policy are far too big for it to be effective, the strain on NHS and Police to deal with it is too big also

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Drug users will always be around and I think that de-criminalization of the policy would help everyone: the user by offering them clean needles, a safe place to inject whilst medical staff is on hand if needed. The Police and Prisons by not being under the strain of dealing with the criminality of it; and the NHS by not having that many OD's and bad drugs reactions to attend to.

Anonymous

Team Manager in the substance misuse field and independent psychotherapist.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

The damage to families that perpetuates the issues for the generations to follow. With users being criminalised and marred with convictions that prevent most employment opportunities, cause time away from families and being influenced by 'harder' criminals within the justice system without any time to rehabilitate or the programmes in place for shorter sentences to offer any improvement on pre-incarceration circumstances.

Drug treatment now is also so steeped in bureaucracy that the focus is more on form filling than giving that 1-2-1 intervention, longer term therapeutic work so desperately needed to effect lasting change and create upliftment of the individual, to the point where their past demons (most often passed down to them), no longer leave a footprint in the lives of their progeny.

If drug and alcohol addiction were treated as mental health is now, with more champions of recovery on the public eye and the focus on need to help over need to punish, the stigma would be reduced, the belief in recovery increased and the earlier access to psycho-social interventions achieved.

An increase to access to good quality, funded psychotherapy (not 6 weeks of CBT) to look at and process the deep rooted causes of reliance on substances would then also provide the necessary psychological repair to begin.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Funding to be pushed into services providing substance misuse specifically to enable better training for staff to a higher, recognised standard so the quality of psycho-social interventions is measurable. Non-trained individuals working with the psyche can add rather than reduce the self-efficacy and self-worth of the client group. Not taking away from the tireless effort of those in the field but rather a focussed redirection what that support looks like.

Sunny Dhadley: SUIT

Service Lead (Drug Service User Involvement Organisation)

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

   Drug policy drives many people further away from seeking treatment and help. The current measures are too punitive and punish those that require help. DRR (Drug Rehabilitation Requirements) have seen a 90% decrease in the last decade, with the preferred method of dealing with the situation being incarceration. This would not be too if treatment in prison was consistent and resettlement effective - I'm afraid both fail miserably.
   We need to move away from using incarceration as a staple intervention for social problems. There is a deep underlying current of social injustice, poverty and depravation that underpins associated with problematic lifestyles (inc. addiction).
   Whilst treatment is evidence based and effective to a degree, there needs to be a whole person approach to effectively meeting the wide range of needs of those affected by addiction. Policy MUST be addressed in order to fulfil this point.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

A shift from punishment, to health based interventions that also cover socio-economic development. There is solid evidence on how decriminalisation reduces the harms of drug use and the numbers of people taking drugs - this should not be ignored. Also through international links, I feel that Safe Consumption Rooms should be considered.

In relation to the work of my organisation, which is a peer led support & advocacy service (initially set up as a Drug Service User Involvement Project) called SUIT, in 2016/17 we did the following - with just 2.4% (£130K) of the local budget, we supported 1072 individuals affected by addiction on 4266 occasions. We delivered 5283 interventions spanning 72 areas of need (from addiction to desistance from crime). To do this we worked in collaboration with 426 separate organisations, companies and resources. Each intervention delivered cost the taxpayer £24.76. We have helped 170 of our peers in to work in 6 years. This person centred approach and true collaborative working is helping the lives of our communities and this is a model that should be considered. (www.suiteam.com)

Supporting Doc- Yes- Wolverhampton Voluntary Sector Council, Service User Involvement Team summary

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Telford aftercare team.

Someone who has been to prison many times, 20 year addiction to drink and drugs and started a peer lead company to support people with addictions and mental health problems in Telford.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

I don't need 500 words for this, for me it was the wasted years. For me getting clean was easy it was staying clean and keeping out of trouble which was hard, what happens after treatment, to help people change?

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Aftercare, aftercare, aftercare , what's next?
Use the people who have been through it. to support the ones going through it Telford has a large peer lead community and its working

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Chris Paling

Individual in long term recovery - member of LEAP(UK)

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

Drug related deaths are the highest they have been since records began as direct result of cuts to services, no investment in harm reduction focusing on abstinence with poorly implemented recovery orientated systems. Services not offering treatment to the broad spectrum of drugs that people use. No investment to tackle the issues of OTC and prescribed medication dependence and misuse. Government has no idea about the success, failure or cost of drug policy.

http://www.tdpf.org.uk/case-for-reform

http://blogs.bmj.com/bmj/2017/05/25/colin-drummond-cuts-to-addiction-services-in-england-are-a-false-economy/

http://www.independent.co.uk/news/uk/home-news/spending-on-drug-and-alcohol-treatment-slashed-by-105m-in-four-years-a7912531.html

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

At the very least all drug use be decriminalised and treated as a health issue. At governmental level there needs to be wholesale reform working towards a full regulated market and the ending of prohibition.

We need a Safer Injecting Facility/Drug Consumption Room. Heroin assisted treatment, and a fully resourced Naloxone programme.

http://www.tdpf.org.uk/blog/heroin-assisted-treatment-hat-saving-lives-improving-health-reducing-crime

http://www.tdpf.org.uk/blog/supervised-injection-facilities-saving-lives-making-communities-safer-0

https://www.theguardian.com/society/2017/mar/05/durham-police-heroin-addicts-treatment-shooting-galleries

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Anonymous

User of medical cannabis.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Drug prohibition is an abject failure, it's costing the country billions to police and everyone who wants drugs knows where to get them. Addicts of hard drugs risk their lives and their liberty to try to cope with an evil addiction. Once they're hooked they're repeat customers, but what they're buying could be adulterated with anything.
If police just decided that there isn't the money in their budget to deal with cannabis related crimes the government would be forced to think again. A £6bn black market could be brought out of the shadows and a portion of that money would reach the treasury if we regulate and tax it. As this revenue would be considerable it could be used to help provide safe places for heroine users to use a pharmaceutical product instead of whatever the dealers are pushing, whilst also getting help to beat their addiction.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Legalise, regulate and tax drugs across the board. Prohibition has failed, all it does is create an underground. People will always look for an altered state of consciousness. We may as well make sure they're doing it safely. Another popular drug is MDMA, in its pure form its s very safe and well tolerated drug, its when it's adulterated with things like PMMA & PMA that the problems arise. A properly regulated market would see that end.
We've seen an explosion in the use of so called legal highs. All of which are out to mimic all of the drugs people have used for centuries. Thing is these aren't tested in humans and so people take them and become ill which puts pressure on the health service. We could end all of these problems in one go if we had s more progressive attitude.

British Isles DBT Training.

British Isles DBT Training trains multidisciplinary teams of healthcare professionals treating complex and enduring behavioural disorders in a range of settings using Dialectical Behaviour Therapy.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

The principal human costs for users arising from prolonged over-consumption of drugs are (1) becoming locked in a cycle of addiction with all the attendant economic disbenefits and (2) in extreme cases suicide, intentional or otherwise.

Significant costs also accrue to those most intimately connected with the problematic user, especially parents and children, employers and other users. These hidden victim costs are frequently overlooked in extreme 'harm reduction' initiatives which over-emphasise the welfare of the individual addict, and invalidating talk of 'victimless crimes'.

The behavioural function of taking drugs is analogous to the function of self-harm in regulating emotional pain, and indeed other coping mechanisms that are ultimately maladaptive. Our task as compassionate individuals is to introduce the problematic user to psychosocial skills which facilitate his/her transition towards a new repertoire of adaptive behaviours, whilst validating the stark problems they face, in order to achieve a life worth living (Eg https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797106/).

Much of the current drug policy debate is based on a false dichotomy between criminal and public health approaches, when what we are in fact often dealing with are complex behavioural disorders that require specialist psychosocial interventions.

From a behavioural perspective, talk of drug consumption rooms, HAT etc. for those for whom treatment has 'failed', is moreover dangerously counterproductive. Rewarding failure drives a coach and horses through contingency management - addicts will quickly learn to 'fail' in treatment throughout the system to obtain their reward.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Sentencing for drug offences should be much more carefully calibrated, and put in the hands of a stipendiary magistrate operating contingency management principles and diversion from custody wherever possible - entering prison can serve as a reward rather than a punishment in view of accessibility of NPS in conditions of enforced idleness.

Comprehensive personality disorder services for CAMHS and adults which have the capacity to accept the most complex dual diagnosis referrals from primary and secondary care settings, and the courts, would reduce the frequency of contact between CJS, police and the subgroup within the community of addicts whose drug use is linked to enduring mental illness. Multi-disciplinary co-located teams offering multi-modal interventions are indicated by the term 'comprehensive service' in the context of personality disorder. A number of treatments have been found to be effective (https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-

behavioural-conditions/personality-disorders) but the fact is that despite promises of investment it is still much easier to obtain drugs than treatment both inside and outside CJS.

Dr Julian Buchanan

Drug Policy Expert

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

Serious financial gains in police and court time

Gains in freeing up police time to support victims by catching the perpetrators of nasty crimes such as rape, burglary and assault.

Huge benefits to young people whose life opportunities in respect of housing, employment, education, insurance and travel would be serious damaged by a drug possession conviction.

Potential reductions in addiction, fatal overdose and HIV

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Decriminalise all possession of illicit drug use for personal use.

This was advised and adopted in Portugal in 2001 and has resulted in fewer fatal overdoses, fewer people with addiction, less HIV among drug using population and more people seeking help.

Supporting Doc- Yes- CCJ- Prohibition, privilege and the drug apartheid: The failure of drug policy reform to address the underlying fallacies of drug prohibition., S. Taylor, J. Buchanan, T. Ayres., 2016.

Frankley Street Champions

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

We have a series of overlapping community groups in New Frankley. I have chosen Frankley Street Champions for convenience and profile.
We have problems with both drugs and alcohol. Drugs are obtained from a variety of places and individuals within and close to Frankley. In the last 2 to 3 years there seems to have been a takeover bid by city gangs of the supply chain. Local growers and retailers supplied the market. Recently well organised gangs have move into the area and are using aggressive tactics to oust the local suppliers. Alcohol is supplied by local shops. we have a particular problem at the Arden Road shopping centre, B45 0JA. A group of around 6 alcoholics are present throughout opening hours. Many local residents avoid the shops; shoppers and shops are constantly harassed by the alcoholics. This creates a culture of bad behaviour. Petty shoplifting by family groups and individuals adds to the lowering of standards. Our police, headed by Sgt Lee Howard, do what they can but are poorly supported by shopkeepers and their staff. We are hoping to get PSPO in the near future but that is only as good as the time our police can spend here. No complaint about our police is implied here, nor is there a demand to have an officer under every lamppost; along with a fire engine, an ambulance and anything else that the public can think of but is not prepared to pay for.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

The most obvious answer is to legalise low level drugs such as old style cannabis. However that is not going to happen in the foreseeable future so we must consider what is possible. Current CCTV by statutory bodies is impossibly expensive for low level crime centres such as New Frankley. We are looking at ways of using private CCTV. the issue there is that the people who own the cameras must be prepared to be identified in court; there are not many people prepared to take the low level risks that used to prevail. Now that gangs are running the business that has become almost impossible. CCTV can still be used to gather intel and perhaps that is where the local community can help. We are prepared to help with this but we are busy doing a wide variety of other community work. If we were supported by experts who now how and what equipment to use perhaps we could help. The underlying problem is that officialdom has no realistic concept of working with community groups. Try us, you could be surprised.

Mark

Former heroin addict.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**
   The war on drugs has failed from to get go. 46 years of the same blind policies. Change is needed. Not all drug use is problematic. Until the law arrests someone with them and ruin their lives with a drug charge for wanting to enjoy themselves the same way people do with alcohol and sugar. In reality prohibition is state sponsored hate crime. Aimed at the free minded, the poor & I'm some cases medical users.
   Yes the people who does burglaries & other crimes where theres no victims are criminal minded. And will blame drugs to get away with their crimes. And should be treated as CRIMINALS in a fair & just way.
   Prohibition keeps otherwise honest people at loggerheads with the police & less real crime gets reported threw fear of being arrested themselves.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Ending prohibition! Putting substances under government/chemist control via a card system & age limit of 21 & over. Strong error prison sentence for black market drugs.
The tax could fund NHS Police Education and Fire Service.
A annual licence for growing your own cannabis with strict rules allowing police entry to check abiding to conditions.
Here's 1 state in the USA https://www.colorado.gov/pacific/revenue/colorado-marijuana-tax-data
Plus with fentanyl/carfentanyl now in out nation it's time for change for the children's sake.
Remembering 46 years of prohibition/failure has done nothing but fill prisons, cemeteries & that's a crime in itself.

Anonymous

A Medical Cannabis user.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

People are paying approx. £8.00 per day for cannabis that a lot of revenue that if taxed sensibly could bring in 100`s of new businesses all paying business rates

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Legalize the home consumption of cannabis and use the money saved to help fund better policing of hard drugs.

Allow coffee houses to run legitimate tax paying businesses which can contribute to the quality of the cannabis being smoked or eaten.

Take the crime off the street by putting a lot of criminals out of business as well as saving the casual user the chance of being hurt from drug debts.

Shropshire CSC.

Former drug addict and medical cannabis user.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

Lots of psychological and health issues and illegal drugs became my medicine. I have spent time in prison as a direct result of my need of illegal drugs. I have now been clean 10 years and it was cannabis that made that possible.

I have now had to move from Telford to Spain to legally heal myself and now support medical users in Spain and the UK.

I should be in the UK with my family but I am a cannabis refugee in Spain!

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

I think taking cannabis of the schedule of drugs and place it in line with tobacco and alcohol would:

1: Allow the finite resources of the police to be used in the right areas
2: Remove billions of pounds from criminals hands
3: Reduction on drug related deaths
4: Put an estimate 1.5b in taxes into the treasury
5: Remove a huge burden on the NHS in treating pain and accidental overdose of pain medications

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OP8S / Board member Methadone Alliance

Drug user

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

For every £1 spent on Treatment many more are saved by the public purse. We need only look at forward & progressive policies being used in various European countries & also Canada, some US states regarding marijuana , look at evidence based research, the findings of LEAP, PROF. NUTT, PROF.STRANG & anyone who has taken a pragmatic approach to the real truth concerning prohibition of any substance. Be it the historical prohibition of alcohol in the states early 20th cent. Or the recent & utterly futile War Against Drugs to realise that we need to forget the moral & racist propaganda. Instead we need to accept that substances have & always will be useful to the citizens of the world, nothing will change so let's legalise & regulate drug sales/markets whether it be prescribed by Dr's or purchased OTC. MAKE DRUG USE SAFE!!

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

Prescribed injectables, HAT, MMT Oral or injectable. Regulate the sale of marijuana similar to alcohol & tobacco. Pharmaceutical grade cocaine, MDMA etc. either sold by licenced pharmacies or prescribed by health professionals who specialise in substance use.
Support & help those (the minority) who will develop any problematic use of any substances.

Radical. Could that scenario be any worse than the situation at present where everything is supplied by organised criminals who care only for profit? NO.

Any costs would be covered by the prescription & taxed sale of substances.

It really is that simple.

Michael Linnell

Co-ordinator Greater Manchester Drug Early warning System.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

The Greater Manchester Drugs Early Warning System is designed to be a low cost system. The system relies on the input of its Professional Information Network and Alert panel members. The total cost for 24/7 coverage including costs of establishing system, costs of co-ordinator and Tic Tac drug information data-base is under £20,000 per year.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Context

The last decade has seen the unprecedented emergence of large numbers of New Psychoactive Substances (NPS) together with significant changes to the potency and/or adulteration of traditional drugs of misuse. Nationally, drug related deaths have for the third year running reached record levels.[1] The complexity of this situation has made it difficult for professionals to keep up to date with current trends and knowledge.[2]

Drug alerts

Throughout England there are a number of local drug early warnings systems or ad-hoc ways of responding to local incidents of potent, dangerous, contaminated, adulterated or new drugs, however there is no consistent approach used to process, grade and communicate alerts and in some cases drug alerts may even be counter-productive and increase risk. [3,4]

Greater Manchester Drugs Early Warning System

As a response to this situation the Office for Greater Manchester Police and Crime Commission has established a drugs early warning system. The system is based on Public Health England (PHE) national guidelines[5] and builds upon the pilot developed for Salford City Council.[6] The system is designed to utilize the experience and expertise of local professionals; be low cost; to take up as little staff time and resources as necessary; to be used only when needed; to be sustainable and adaptable to further change rather than following a rigidly adhered to format. The system will comprise of two main parts: A professional Information Network (PIN) and A Drug Alert Panel.

Professional Information Network (PIN)

The PIN will operate as an online group open to relevant professionals. PINs involving hundreds of local professionals are now operational in all ten local authority areas across Greater Manchester, which exchange Information, observations, details of incidents, and questions relating to new, adulterated or problematic drugs or patterns of drug use seen in local or relevant surrounding areas.

The PINs are closed groups that can only be used by professionals and are not viewable to those outside these groups. The PINs do not keep databases and all information exchanged is anonymous. A Greater Manchester wide coordinator facilitates the operation of the PINs and the alert panel.

Drug Alert Panel

When incidents occur an online multi-disciplinary panel of experts assess the available information and using a grading system decided on an appropriate response. Existing Communications teams from public health, police and health providers work jointly to communicate appropriate message to selected target audiences and when needed to the general public.

The system is the first system of its size to operate within the national guidelines in England.[5] It is intended Greater Manchester LDIS will link in with regional and national systems working with the same consistent approach as these develop.

Anonymous

Bereaved family member from drug overdose.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

With current drug policy there is no information or education around the consumption of drugs. Human beings consume any and all kinds of substances. Just because a substance is illegal doesn't mean people won't consume it. Quite the opposite, if you hand the opportunity to sell drugs to criminals then they will use unscrupulous methods to get more people taking their drugs or to make their drugs/products more addictive.

Unfortunately my cousin died 4 months ago from taking synthetic 'Spice' that had been mixed with crushed sleeping pills by a drug dealer. My cousin would not have died had the UK Government legalised and regulated much safer, organic, natural Cannabis. 'Spice' was created by John W Huffman because Cannabis was illegal in the first place. now it turns out that 'Spice' is actually more detrimental to health than natural, organic Cannabis is.

On top of that the social stigma by the Police towards our family because of the association with drugs was horrendous. Just because someone died from a drug overdose does not mean the Police can treat you with disdain/contempt, but they do. My opinion of the police and its staff is now worse due to the prejudices and disgust shown towards my family by said Police.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Harm Reduction policies can be put in place: Supervised Injection sites should be put in place for Heroin addicts/abusers. Police should effectively be told that natural Cannabis is a decriminalised substance and not to prosecute/arrest those caught with possession of less than 10 grams, especially when Burglars/terrorists/rapists/violent-drunks are not arrested. An overall policy of prioritising arrests of Burglars/rapists/murderers/terrorists/violent-criminals, instead of focusing on prosecuting drug addicts/abusers. There should also be a policy of not arresting people under the age of 25, due to the awful consequences of having a criminal conviction. When giving a criminal conviction to someone under 30, you essentially render them unemployable, guaranteeing they'll be claiming benefits, and being on the dole. If a police officer is so keen on arresting a drug addict rather than offering rehabilitation then I believe that that Police officer should cover the costs of ruining that young persons life, by covering the cost of benefits, housing, and mental health as a cost of imposing a criminal conviction on said individual.
Simple message is: Arresting people for drug offences is more expensive than offering rehabilitation services. I am not happy for my taxpayers money to be wasted on prison sentences when drug abuse/addiction is a health issue, rather than criminal issue.

Jason Smith

Concerned parent

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

The cost is tackling drug related crime in the UK is £1.4B. The estimated revenue generated from legalization and regulation of cannabis is in excess of £1B (citing Tim Farron 2017 election campaign). Therefore the net positive effect to the UK economy is £2.4B but this is not why I would see cannabis regulated, I firmly believe cannabis is more dangerous to my child on the black market than as a regulated product.

As an example I am convinced that if cigarettes were banned completely tomorrow then minors would have easier access than they do today. With regulation there will be a significant if not entire removal of the black market dealer. Whilst I disagree that cannabis use causes use of harder drugs I do accept that many users of class A drugs will have started with cannabis thus by regulating it and making it harder for minors to access you are removing the first rung of the ladder. Finally the money saved and generated needs to be allocated to supporting that minority group who have genuine addiction issues, issues which often have strong links to childhood abuse and thus a need to escape.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

The war on drugs is hurting more people than it is helping, I'm not saying drugs aren't dangerous, some are, others are much less dangerous than alcohol or nicotine, so we need to have a long term strategy in place to stop the suffering where possible.

We need to start listening to the evidence on cannabis, no recorded deaths, minimal related injuries and arguably a better social activity that heavy drinking. I'd like to propose legalisation of cannabis for over 21s, heavily regulate and educate using the taxes generated from the sale of this product.

Explore the successes seen in America, Portugal, Switzerland where use by minors along with drug related crime has dropped across the board. Holland has long standing success in this area and from next year Canada will also legalise the recreational use of cannabis.

I'd passionately support an impartial, evidenced based discussion with leading experts who would then be able to guide policy.

Please help me make a safer country for my child to grow up in, please, please help me make the people hear sense.

Anonymous

Police Officer

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

Drug use should be treated as a public health problem rather than a criminal one. Evidence from across the globe supports legalisation and regulation. Prohibition creates crime and victims. Our focus should be on creating informed choices not criminalising vulnerable addicts. The cost to policing /cjs is huge, as is the cost to nhs armband support services. The human cost of allowing criminal organisations to profiteer from outdated prohibition is greatest of all.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

See Portuguese model.

Mary Bailey
Substance Misuse Commissioner, Sandwell Metropolitan Borough Council.

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?**

The most obvious cost I see in my role as commissioner is the money we spend on treatment and prevention services for substance misuse. We realise that patterns of substance misuse are changing and we need to ensure services are ready and capable of responding to this together in partnership with other relevant agencies.

We quite rightly look to numbers accessing prevention and support services for substance misuse but we must remember that behind each of those individuals is a parent, a child, a carer etc.. who will also be impacted by the secondary impact of harmful behaviours.

Not only that but the impact is also seen and felt throughout the community – we have substance misuse related litter as a very visible sign of drug misuse in our communities.

In terms of evidence PHE has a host of economic impacts related to drug misuse –you can google the 'why invest' slides from PHE which give costings in relation to drug related crime, health harms, social care impacts, child support etc.

2) **What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?**

There is a host of evidence and interventions out there which are not recognised by the current national drug strategy. We have to be mindful also that we are working within the constraints of shrinking funding budgets, including commissioning of treatment services within a politically driven Local Authority environment. Existing interventions such as prevention focussed and diversionary interventions have been in place for years but struggle to be delivered locally.

Taj Singh

Inclusion, a drug and alcohol service provider.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

The human cost of drugs that we see day to day is the detrimental impact this has on individuals, both in terms of their quality of life which is informed often by poor physical and mental health, poor economic outcomes including low levels of employment and often increased levels of criminality. This impacts negatively on those around them, including their families and children. It can have a contributing factor to the quality of lives and outcomes for these individuals also. For the community they may experience an impact in terms of criminality but also due to the impact of drugs individuals' ability to be active citizens making a positive contribution is limited, this often compounds their situation. However, it should be noted that as a treatment provider those we work with have often experienced trauma and disadvantage which have created circumstances where the use of drugs and its consequential impacts are heightened and more likely.

The economic cost is significant, the impact of crime both in terms of its effect on the victim but also in terms of the administration of the criminal justice system and the consequences applied as a result of criminality is significant. Also, there are costs associated with treating those directly affected by problematic drug use but also families, carers and children who often are in a position where they have to cope with the impact on the individual and any behaviours that result due to a problematic use of drugs.

The direct costs of drugs/policy in relation to the capacity as a social/healthcare provider is namely on prevention and treatment costs, health-care and hospital costs, increased morbidity and mortality.

- **Costs of drug prevention and treatment**

Significant funds have been directed towards drug treatment which has led to the creation of a treatment system that is amongst, if not, the world's best. In recent years, with the transition for responsibility of commissioning drug services moving into local authorities under the auspices of Public Health and the squeeze on local authority budgets the financial contribution has heavily reduced in many areas. For example, Birmingham saw a significant reduction.

In a climate of less financial contribution services should be resourced effectively with focus on evidence-based prevention, education and interventions, including treatment and rehabilitation.

- **Health care and hospitals**

Visits to hospitals are costly to society, as result of overdoses, There are strong associated links with substance misuse, adverse reactions, psychotic episodes and symptoms of Infectious diseases that can be transmitted through, injecting drug use, such as hepatitis B and C, HIV/AIDS, tuberculosis, and

other illnesses related to drug use. Hospitals often need to treat victims of drug-related crimes and accidents.

- **Impact on public safety**

Substance misuse pose many risks along with costs to individuals and the environment i.e. drug related driving offences. •The abuse of drugs affects perception, attention, cognition, coordination and reaction time, among other neurological functions, which affect safe driving.

- **Impact on the environment**

The emergence of illicit drug cultivation and manufacture in residential areas, leading to potentially a reduced quality of life for residents, neighbourhood decay and criminal activity.

- **Relationship with crime:**

3 areas that substance misuse affects in relation to crime is namely:-

- Drugs/crime relate to violence, (there is a distinct association with drug use and pharmacological crime).
- The second is drugs/crime link is economic- compulsive crime, as substance misuse users engage in crime to support their drug consumption and addiction.
- The third is a link to systemic crime: the violence that occurs, for example, as a result of disputes over “drug turfs”.

All those costs are related to burdens placed on criminal justice systems, in addition to the increased incarceration rates resulting from behaviour related to drug use.

- **Impact on productivity**

A further cost of drug abuse is the loss in productivity that can occur when drug users are under the influence of drugs or are experiencing the consequences of their drug use (e.g., while in treatment, incarceration or hospital).

- **Impact on governance**

Traffickers establish new transit routes by exploiting, governing institutions, financing corruption and terrorism with the gains made by engaging in illicit activity.

- **Impact on specific populations**

- ❖ Children: Prenatal exposure to drugs can result in an array of emotional, psychological and physical disorders.
- ❖ Women: Gender differences have been identified as determinants in the onset of addictive behaviours, including drug abuse.
- ❖ Low-income populations: Drug abuse and poverty are often linked in many ways. Drug abuse may occur to relieve the stress associated with poverty, chronic social strain and other difficult events.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

The new drug strategy infers, but is not explicit in rebalancing and acknowledging the balance and between recovery and harm reduction. They are complimentary approaches which often are part of an individual's treatment journey.

There is an emphasis is on tackling issues caused by drugs via the criminal justice system, as opposed through the health system. In a nutshell the strategy aimed at cutting illicit drug use and improving dependence recovery rates. However, the move towards linking system outcomes; e.g. with mental health, housing and employment is positive as they are inter dependent. The jury is out on the new cross government strategy board for drugs and alcohol chaired by the Home Secretary but hopefully this will have some significant influence on strategy and funding in local authorities supported by PHE. However, the nature of the fragmented system makes this all the more challenging.

Areas to be considered are:

- The decriminalization, or any reforms to the Misuse of Drugs Act;
- Addressing issues associated with Spice (prisons/community);
- Further funding within drug treatment;
- Provide effective, evidence-based drug prevention and education to young people (resilience training);
- With cuts to local authority public health budgets totaling £85m this year, and ring-fenced drug treatment budgets expected to be cut by £22m, budgets may be reduced in services such as needle exchanges. (retain such)
- Adoption of drug consumption rooms and a national roll-out of heroin-assisted treatment for addicts? (developments in Glasgow to monitor developments)
- December 2016, as response to the rise in drug related deaths (heroin) the AMCD noted several recommendations including maintenance programmes?
- Drug -testing facilities are rolling out across festivals nationwide, and police forces in both Bristol and Durham are continuing with successful pilots of drug diversion schemes.

http://volteface.me/uk-decriminalisation/

(Police forces in Durham and Avon & Somerset have been operating pilot schemes where those caught in possession of drugs are diverted to local drug education workshops, rather than being prosecuted).

- More work on evidence based harm reduction policies.

Adrian Philips

Director of Public Health, Birmingham City Council

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

I write as Director of Public Health in Birmingham. We are seeing a shift in the type of drug used as well as the populations affected. Nationally there has been a dramatic decline of Class A drug use in young people and this is mirrored in this city. I note you quote figures in para 21 based on 2012 – I understand the national rate has dropped further and this is true for younger adults. It is important to recognise this huge change, especially with relation to cannaboids and the home grown supply.

The content of the report "Hard Edges" has to be read in conjunction with your document. In addition the body of work relating to Adverse Childhood Experiences (ACEs) is important. This group of people were often themselves children of parents who abused drugs and it is likely that their children will also abuse drugs. We need to break the generational cycle of extreme disadvantage that such addiction creates.

Your report highlights that there are major economic gains to be made in the sale and distribution of such substances – likewise your report shows the effect on the public purse of activity related to such substances is huge.

But there are major opportunities to be gained – for example recovering "users" are hardworking and anxious "to make up for lost time".

We have looked at drug-related deaths in the city. Over 5 years there were 143 such fatalities. The peak was in2014 (42) with a reducing number in the following years (30 in 2016). We don't know whether these unfortunate victims were known to services, recently released from prison or just "experimenting". It may be useful to look more closely at drug related deaths.

I believe that there are three strategic issues to be addressed:

- Firstly we need to break the link with prisons as it is here that illegal substances are hard currency and where profit and dependence is to be made.
- Secondly we need to break the generational cycle especially through better recovery especially employment.
- Thirdly we need to increase the resilience of young people and those around them as well as offering "hope" or real alternatives.

In terms of the first issue there are numerous problems. There is the increasing tenacity of gangs to make a profit, drones etc. There is also the fact that often treatment providers aren't given notice of either release date (in advance) or where the prisoner is being released to. This is compounded by the fact that prisoners may be placed in non-local prisons. This could be addressed through far better use of technology.

Employers do not want to employ people with either a previous drug problem or have been in prison. This risk can be mitigated by organisations which specifically offer support to the

individual. However we have too few of these mainly third sector groups. We could stimulate this market and link to the Social Value Act.

Finally we need to offer better options to young people who are experiencing many ACEs as well as those around them. This has been done with violence in certain schools although there are other approaches such as that provided by “Evolve”. The models are similar in offering some kind of mentoring. There is the real option of offering parenting programmes to affected families especially now that there is an on-line version available. An early study shows that “gamification” of an on line parenting programme had real success in vulnerable women leaving prison with big reductions in re-offending and abnormal behaviour of their children (it is of course one of the commonest reasons to take a child into care).

There is useful evidence on the Dartington Social Research Unit website and I will not replicate this suffice to say that I agree that we need to do different things to get different results, but that the situation is shifting markedly.

Collective Voice

On behalf of organisation

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

The recognition that drug addiction is a major driver of acquisitive crime, and the link between illegal drug markets and violent crime, has been at the heart of UK drug policy for over 30 years.

Nick Morgan's highly influential review of the evidence[ii] which concluded that the heroin epidemic of the 1980s was responsible for half of the dramatic increase in burglary and theft and other acquisitive crime types seen during the 1980s and 90s provided a clear rationale for government to invest in treatment during the early years of this century, exploiting its potential to reduce crime of all types. Between 2001 and 2008, total investment in drug treatment from all government departments and agencies increased from £250m p.a. to £750m p.a. Morgan's analysis attributes 30% of the reduction in acquisitive crime since the turn of the century to the impact of this investment, in part by reducing the scale of offending of those in treatment by an average of 50%, but also by reducing the number of active dealers recruiting the next generation of dependent users. The impact of this has been to reduce the total number of heroin addicts from an estimated 450,000 at the height of the epidemic to around 250,000 today, with an even more dramatic reduction in the number of young people from 66,000 to 30,000.[ii] Alongside this, more effective police action was taken against gun crime and drug-related gang activity which, although it didn't eliminate the violence associated with illegal markets completely, did prevent escalation towards the levels of violence commonplace in US cities, which had been a legitimate concern in the 1990s.

Although there are a range of harms flowing from illegal drug use, the drug-crime link continues to dominate the government's approach to policy, and the Home Office as the lead department continue to be powerful advocates within Whitehall for treatment as a cost-effective means to control drug-related crime. The 2016 Modern Crime Prevention Strategy[ii], the 2017 Drug Strategy[ii], and the recently published Public Health England/Ministry of Justice analysis on the impact of treatment on reoffending[ii] all confirm the government's continuing belief, well supported by evidence, that whilst in treatment drug-dependent individuals will commit significantly fewer offences than they would outside treatment.

However in 2013, the government ceded control of drug treatment spend to local authorities placing the crime reduction benefits of treatment at risk. Between 2001 and 2013, a ring-fenced Pooled Treatment Budget had been made available to local partnerships of the local authority, NHS, police, and probation who had used these resources alongside their own funds to commission local treatment systems. Partnerships shared responsibility for both community and prison treatment and were collectively accountable to ministers via the National Treatment Agency, nominally an NHS body, but in practice a joint Department of Health/Home Office quango. Since 2013, drug and alcohol treatment has been the sole responsibility of the local authority as part of their wider remit for public health. Drug treatment has not fared well in this new environment. Although the Public Health Grant allocated to local authorities each year by the Department of Health is ring-fenced, apportioning the grant between competing public health demands is entirely a local authority decision. Drug users are not popular with local electorates, and drug treatment is not a natural priority for local Directors of Public Health who prefer, not unreasonably, to invest scarce resources in the big population level causes of ill-health and early death: smoking, obesity, and non-dependent

alcohol use. The cumulative effect of this has been a national reduction in spend on drug treatment in the community since 2013 of 26% in cash terms i.e. £611m to £452m, equating to a real terms decrease of 30%.[ii] The cuts have not been uniform across the country with some authorities e.g. Birmingham planning to reduce budgets by up to 50%.

As budgets are reduced, local treatment systems' capacity to respond to the needs of the criminal justice system have been compromised. Drug treatment in prison is separated from treatment in the community and is commissioned by NHS England within large multipurpose healthcare contracts spanning a number of establishments. Neither NHS England nor the Ministry of Justice know how much is allocated within these contracts to drug treatment, but the Ministry of Justice estimates that the spend is around £80 million annually which suggests a level of reduction since 2013 of 25%, similar to that experienced in the community. Alongside managing reducing budgets, prison staff have been distracted from focusing on the needs of their traditional heroin and crack using population who present the greatest crime risk to communities on release, by the internal challenges created by a relatively small number of chaotic users of synthetic cannabinoids, generically known as spice. The most troubling consequence of disinvestment, distraction, and the fracturing of the links between prison and community systems, is that only one in three of the individuals, mostly heroin and crack users, assessed as needing treatment on release actually establish contact with a community service. Two thirds of those at risk of death from overdose on release do not establish contact with a community service at the time of greatest vulnerability. Failure to maintain continuity of care also increases the risk of reoffending.

Within the community the capacity to identify drug-related offenders on arrest and directly refer them to treatment facilitated by the Drug Intervention Programme has become fragmented. The crisis in probation caused by the so-called Rehabilitation Revolution and the creation of Community Rehabilitation Companies has undermined effective partnership working across much of the country as CRCs have failed to engage effectively with health, local authority and CJS partners. One of the consequences of this is that the Ministry of Justice is increasingly concerned that courts do not have access to sufficient treatment provision to enable them to use Drug Rehabilitation Requirements, resulting in unnecessary and expensive prison sentences.

The diminishing capacity of the treatment system to respond to the legitimate expectations of the criminal justice system has largely gone unremarked by the police service and Police and Crime Commissioners. A decade ago, Chief Constables were powerful advocates for investment in treatment and integration between drug treatment services and the criminal justice system, as is increasingly the case with mental health provision today. However drugs seem to have increasingly slipped down the priority list for both Chief Constables and PCCs as policing has focused on new crime types such as cyber and modern day slavery, and prioritised long neglected offences such as violence against women and girls. As acquisitive crime has fallen, not least because of the success of investment in treatment, the need for police to champion drug treatment has receded. Not only has the volume of acquisitive crime been seen to be in long-term decline, but drug use itself was no longer seen as presenting a direct threat to society. Use of cannabis halved and then remained stable, use of the most dangerous drugs was increasingly concentrated among the ageing cohort of heroin and/or crack users who were the legacy of the late 20th century epidemic. In these circumstances, it is not surprising that local police commanders did not see it as politic for them to challenge their local authority public health colleagues' decisions to disinvest.

Within Whitehall, drugs had never been a priority for the Department of Health and drug treatment was seen as something of a cuckoo in the nest by PHE senior leadership. Only the Home Office expressed concern that the new arrangements for commissioning treatment risked dangerous levels

of disinvestment and disengagement. The Home Office's policy prescription for this was to advocate for a statutory role for PCCs on Health and Wellbeing Boards, created as part of the Lansley reforms of the NHS to integrate local authority and NHS provision. This had always been opposed by DH and was included in the Conservative manifesto for the 2017 election to overcome this, but has subsequently been dropped. In practice, it is unlikely that this would have made any real impact as Health and Wellbeing Boards are generally acknowledged to have failed to carve out a role for themselves beyond addressing the ongoing crisis in social care which dominates the shared NHS and local authority agenda.

The absence of an effective means to link local authority commissioned drug treatment into wider NHS provision is the single biggest flaw in the new landscape created in 2013. In particular, the fractured relationship between NHS and local authority provision is a major contributor to the increase in drug-related deaths over the past four years as marginalised drug-dependent individuals struggle to access the mainstream NHS services they increasingly need as they age and become prematurely frail.[ii]

The Home Secretary's continuing concern about declining treatment capacity and its impact on crime and other drug related harm is evident in the 2017 Drug Strategy. Not only is the drugs-crime link explicitly highlighted, alongside the crime reduction benefits of treatment, but by creating a cross-government Home Secretary-chaired board to drive performance, the Home Office is signalling a shift away from the high watermark of localism, towards increased transparency, and accountability of local areas to the centre. The Home Secretary, supported by the newly appointed Recovery Champion, will use metrics provided by PHE to review the performance of local authorities and their partners, including PCCs and Chief Constables.

Following a lengthy period of stability, PHE and the Home Office are becoming increasingly concerned about small but consistent movements in all the key indicators available to them suggesting that disinvestment and fragmentation are beginning to feed into declining performance. Accompanying this is growing awareness of the cumulative impact of a decade of austerity on the functioning of the existing treatment population and the resilience of wider society to emerging drug threats.

The dramatic increase in drug-related deaths since 2013[ii] has now been joined by increases in heroin and crack prevalence[ii], increasing demand for crack treatment[ii], the first increase in drug use among schoolchildren for a decade[ii], increasing concern not least in the West Midlands about drug-related gang violence, and an apparent reawakening of traditional acquisitive crime.[ii]

Collective Voice would suggest that to ignore these indicators of a resurgence in drug-related harm is to risk repeating the mistake of the 1980s when society responded much too late to the emerging epidemic, with consequences for individuals and communities that continue to this day. It is timely for the West Midlands PCC to be refocusing on these issues.

Dr Prun Bijral

Medical Director and Addiction Psychiatrist, responding on behalf of CGL.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

1. Human costs
   - Impact of substance misuse on families/friends communities
   - Impact on peoples short and long term physical and mental health
   - Impact on families – specifically around adverse childhood experiences
   - Worsened life chances for people who use drugs due to the criminalisation of certain drugs, and the disproportionate impacts on minority communities
   - Stigma affecting people who use drugs, and prejudice against drug use in general, which leads to barriers to seeking help from commissioned services as well as mainstream health and social services

2. Economic costs
   - Cost on the health/social care system such as A&E admissions
   - Cost through criminal justice approaches which are likely less cost effective at reducing overall drug use and the related costs. Detrimental impact on a locations reputation which can impact nightlife/tourism etc.
   - Policy doesn't address to issue of clients increasing in age and complexity against reduced budgets.

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

1. Introducing more drug testing initiatives in clubs and services, this could include front of house testing of substances, as well as better collaboration with forces to share intelligence around drug seizures for the purposes of improving community safety.
2. Merging KPI's across multiple providers to help collaborative working
3. Mandate that providers must co-locate
4. Reduce the disruption caused to service users by increasing tender contract periods.
5. Introduction of contingency management as a behavioural intervention to optimise treatment and engagement
6. Consideration of new initiatives such as HAT to support those who fail to benefit from existing treatments
7. Increase support to those hardest to reach and most at risk of overdose through DCRs

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Max Vaughan: Birmingham City Council

Nic Adamson: Change Grow Live

Joint response on behalf of:

Commissioner (BCC) for Adult Drug and Alcohol Treatment and Recovery Service Lead Provider (CGL) for Adult Drug and Alcohol Treatment and Recovery Service

1) **What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which you respond?**

Children's experiences in their early years strongly influence their outcomes in later life. The contribution of parents and carers to a child's development is invaluable; a child's progress depends on positive interaction in a safe environment. Children affected by parental substance misuse are a significant public health concern.

Parental substance misuse is a key indicator of adverse childhood experiences (ACE) recognising that the harm associated with parental substance misuse is cumulative, with long lasting and shattering consequences on the child and family environment. Serious and chaotic substance misuse is incompatible with effective parenting and we see the effect of this locally where almost 1 in 3 children in need have experienced parental drug use compared to 1 in 5 children in need nationally[ii].

Problematic drug use limits a person's chance of entering or remaining in employment and ability to sustain suitable accommodation. Given the lower than average income and high unemployment rates in the city, entering the workforce and maintaining a home that is of suitable, affordable quality is already challenging, particularly for young people. Experiencing failure to find adequate employment or accommodation in the first place further exacerbates drug use, creating a vicious cycle.

It is well understood that problematic drug users are at high risk of homelessness, and the complex interaction between these multiple vulnerability factors requires specialist, trauma informed, multi-agency response. The forthcoming Birmingham Homelessness Prevention Strategy 2017+ recognises problematic drug users as a priority group for targeted prevention and support. It also recognises that families at risk of domestic abuse, which is the second highest reason for homelessness in the city, can often need specialist support to manage a drug dependency alongside recovering from domestic abuse.

The cohort of service users with problematic drug use in Birmingham, as elsewhere, is becoming increasingly complex. They are getting older, are in poor health, and their long history of problematic drug use exacerbates conditions associated with ageing. The health

and social care needs of this cohort of service users are becoming increasingly challenging at the same time as treatment budgets have been reduced.

The cost is far reaching for the individual and the health and social care system. Individually, the range of physical and mental health issues experienced by this cohort severely impacts their quality of life and ability to engage with family and social networks, employment and support services. At the same time provision of a holistic treatment and care response is expensive, complex and requires multi-agency, multi-professional involvement for intensive and often sustained periods of time.

The cost of drug and alcohol treatment in Birmingham is c.£15m per annum – a significant proportion of the Public Health budget. However, the ultimate cost of drugs is loss of life. In 2016, there were 72 drug related deaths, of which 58 were directly related to drug misuse[ii]. As with the national picture, locally there has been an increase in drug related deaths in the city. As described above, the cohort of problematic drug users is getting older and they generally identify with multiple health problems , as recognised by Public Health England, and this increase could be in part explained by the 'cohort effect' of older heroin users dying in increasing numbers.[ii]

2) What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Nationally, there are few public awareness and information campaigns covering the issues caused by problematic drug use. This should include recognition of the inter-relationships between different issues for example drug use and child safety, alcohol and violence.

Due to the complexity of need of problematic drug users, it is critical that key service providers including mental health, sexual health, adult social care, early years, children's services and housing, commit to working together more closely to respond to service users and support them holistically into treatment and through recovery. There are multiple benefits to this. Due to current arrangements, it is likely that the same person has multiple appointments- and are more likely to engage if only had to come to one appointment.

Sharing KPIS around working together and collocation.

The NPS and homelessness agenda is a high priority for the city. To drive change to policy and / or practice, we must prioritise NPS so that it is upon everyone's agenda. Currently far too much reliance is placed upon drug and alcohol treatment providers to effect change. Whether it is tackling supply and demand, reducing harm or providing treatment, the response required is multifaceted and will require a strategic commitment from key partners such as criminal justice, housing and health to: a) better understand the scale of the issue and b) create a strategic partnership plan to tackle it.

The Drug Intervention Programme should be reviewed to evaluate effectiveness and return on investment. DIP is an expensive programme however, the impact that it has on outcomes of service users is considered minimal. In a time of ever reducing budgets, these resources could be better directed into areas of service that are higher priority and are considered to have greater impact such as:

- Testing in clubs – festival testing
- Fentanyl testing
- Strengthen the pathways and communication with criminal justice in particular Prison release
- Evidence Based Drug & Alcohol education and prevention for schools and practitioners to implement best practice

Volteface

Capacity in which responding: On behalf of organisation.

Drug Consumption Room Stakeholder Overview

A drug consumption room (DCR) is a professionally supervised health care facility where people can consume drugs in safer conditions. Additional services include sterile injecting equipment, counselling services before, during and after drug consumption, emergency care in the event of an overdose, primary medical care, and a referral to appropriate social healthcare and addiction treatment services. 95 facilities operate worldwide and in Glasgow and Dublin the establishment of a drug consumption room is in progress.

Evidence	Community Benefit
Reduce self-reported injection risk behaviours, such as syringe sharing	Reduced BBV infections among PWUD and the wider community; reduced spending on BBV treatments including Hepatitis C and lifetime HIV antiviral therapy.
Reach and stay in contact with highly marginalised target populations	Improved access to support services for PWUD, including health, housing, employment and treatment.
Reduce drug-related deaths at a city level, where coverage is adequate	Lives saved; reduced emotional harm to those who would otherwise be grieving; reduced distress among community agencies who may discover the deceased person; managing overdoses in a drug consumption rooms reduces ambulance call outs and associated burden on local health budgets.
Increase uptake of detoxification and drug dependence treatment, including opioid substitution	Recovery opportunities for PWUD; increased life chances for those in recovery who are more likely to find employment and contribute to the local economy; reduction in acquisitive crime- any heroin or crack user not in treatment commits crime costing an average £26,074 a year.
Enhance access to primary care	Earlier health interventions for PWUD leading to reduction in the number of interventions required and a reduction in the severity of interventions which would otherwise have been provided by hospitals, A&E services and ambulance services; reduced associated economic burden on local health budgets.
Promoting safer injecting conditions	Reduced risk of injecting-related complications, such as abscesses, wounds, and deep vein thrombosis; reduced associated economic burden on local health budgets; reduced drug-related deaths.
Decrease public injecting	Improved health among PWUD as public injecting has been identified as a risk factor for blood borne viruses, overdose, drug-related death and other injecting-related complications, such as abscesses, wounds, and deep vein thrombosis; reduced associated economic burden on local health budgets; undetermined costs associated with fear from both locals and visitors within the community; improved public amenity strengthening the local economy; less community resistance against proposed site locations for drug addiction services; reduced stigma and negative community attitudes towards PWUD.

Reduce the number of syringes discarded in the vicinity	Reduced public health risk of BBV infection from discarded needles; reduced cost of removing drug-related litter; reduced cost of administering prophylactic medication for needle stick injuries; undetermined costs of stress/anxiety of those having received needlestick injuries and the detrimental effect it has on their lifestyle and their immediate families; undetermined costs associated with fear from both locals and visitors within the community; improved public amenity strengthening the local economy; less community resistance against proposed site locations for drug addiction service; reduced stigma and negative community attitudes towards PWUD.

The evidence does not suggest that a DCR increases drug use, frequency of injecting, drug dealing drug trafficking or drug-related crime in the surrounding environment.

Political Support

Politicians are more likely to be supportive of drug consumption rooms if they are championed by their peers and framed as an humanitarian, evidence-based intervention, rather than as a wider call for drug reform. It is also advantageous for structures to be in place which ensure politicians are involved and consulted with throughout the planning and development process and prior to key political decisions.

Community Resistance

Despite evidence demonstrating that DCRs have a beneficial impact on local communities, residents are likely to have concerns that a DCR will create more drug-related disorder. If a DCR succeeds in delivering on its promises, it is likely that levels of community support will increase, as evidenced elsewhere. Until that time, the community should be continually engaged in the proposal and clear communication channels with the local authority should be provided. The recruitment of an individual with a designated position to do so could be an effective way of maximising engagement.

Media Engagement

Media engagement is essential for facilitating community acceptance of DCRs and advocates are advised to seek out media opportunities to promote DCRs. Radio interviews are cited as a highly persuasive communication tool, with the voice of lived experience and families powerful in early work and for softening the way for informed discussion. Local commentators and stakeholders should be engaged in the proposal prior to the media release to ensure that the locality presents a united front. Press releases should be detailed, newsworthy and shared and drafted with all partners. Any additional information and FAQs should be in an easily accessible format.

Legal Barriers

There are legal barriers which would challenge the operation of a DCR in the UK. However, there is flexibility within the law for the police to take a reasonable approach to law enforcement, exercising discretion in the public interest. A DCR could operate through a discretionary model, pursuant to guidance given by the police and prosecution service. Such guidance would be susceptible to changes of policy and senior personnel within the police or prosecution service and is also vulnerable to legal challenge as the guidance would not have the force of law. However, the courts will not lightly interfere with the exercise of discretion that is reasonable and rational. Alternatively, a discretionary model could operate without legal guidance from the prosecution service and instead rely solely on multi-agency support, with local stakeholders signing a document regarding

the establishment and running of the DCR. Though feasible, such a protocol would be exposed to the potential for political, legal and administrative challenges. A legislative route entails a longer process but is a more stable and permanent legal solution. However, evaluations of a facility, operating on a discretionary model, could be used to build the case for legislative change.

Policing

The success of a DCR relies to a large extent on collaboration and strong working relationships with the police. It is likely that police procedure will not be a significant departure from existing procedure for policing drug addiction services but forces would benefit from observing models of practice in countries where DCRs have been in place for some time. Clear guidance or legislation would make it less likely that any law enforcement issue would impact negatively on the facility.

Supporting Doc- No.

Arfon Jones

North Wales Police and Crime Commissioner.

1) What are the costs of drugs and/or drug policy (human and/or economic) as you see it in relation to the capacity in which your respond?

The social and economic costs of drugs and drug policy have a considerable effect on the public and private sector, the wider community and also the users themselves. The cost of drug policy to our society is extensive and below is a few examples of this:

a) Enforcing drug offences under the Misuse of Drugs Act 1971 (this includes possession and supplying)
b) Drug-related crime (funding addiction, public order offences and violent offences)
c) Drug treatment (how to treat the addiction)
d) Demand on health (number of admissions for overdoses, blood borne viruses and mental health issues).
e) Drug related death (affects not only the emergency services but also the impact for the wider community.)

Cost of those suffering from addiction in the Criminal Justice System

According to NTORS (National Treatment Outcomes Research Study) problem drug users will spend 36 days in prison per year out of treatment; 34 days in prison per year in the first year of treatment and 39 days in prison per year for those in treatment more than a year. This yields the estimate of the number of days in prison of 8,096,400 for those out of treatment, 1,911,650 for those in treatment less than one year and 2,192,775 for those in treatment more than one year.

This is a huge cost to our society, there is a need for reform and there is a need for new initiatives to prevent vulnerable people suffering from addiction from continuing the cycle of being in and out of prison. According to the Home Office report in 2013 “Understanding Organised Crime; Estimating the scale and the social and economic costs” an estimated £370 million is spent by the police to enforce drug offences. This does not include the costs incurred at court nor does it include the costs of imprisonment.

What practical new initiatives or changes to drug policy could be introduced to prevent harm and/or reduce crime?

Review of the Misuse of Drugs Act 1971
There is a real need to review the outdated Misuse of Drugs Act 1971 which has increased the prohibition of drugs in Britain over the last four decades. The current drug problem in

the UK demonstrates how prohibition doesn't work and there is a need to tackle this issue in a different way.
I have visited Geneva and Lisbon and witnessed their innovative efforts to reduce the drug problem. I would like to see similar projects being developed here in the UK, at present however, the Misuse of Drugs Act limits the scope of these initiatives.

Reduce crime by tackling the underlying issues of drug use

Between a third and a half of acquisitive crime is committed by offenders who use crack cocaine, cocaine and heroin. A high proportion of problematic drug users have underlying issues which prevent them from tackling their addiction. By treating these underlying issues such as mental health, homelessness or historical tragedy the user is able to focus on tackling their addiction.

Some examples of possible treatments include:

Enhanced Harm Reduction Centre

Having visited similar a similar facility in Geneva there are a number of benefits for an enhanced harm reduction centre which include:

a) Making the streets safer. By providing a designated facility for users it will reduce the number using in public places and in turn reduce the number of discarded needles.
b) Reduce the spread of disease. EHRC's provide users with clean needles and syringes in a hygienic environment which will reduce the risk of acquiring and spreading infection and disease.
c) Saves lives. By providing a facility which includes medical professionals, drug testing and additional support services it will reduce the number of those overdosing and losing their lives.

Heroin Assisted Treatment

Heroin Assisted Treatment has been proved to reduce the number of drug related crime as it removes the need for users to locate and purchase their fix. The Randomised Injectable Opiate Treatment Trial or RIOTT as it is better known demonstrated the benefits of heroin assisted treatment and the positive impact that it had on users.

Keeping the most vulnerable in our societies out of the Criminal Justice System and giving them the chance to address their issues.

For many years those who suffer from addiction have been in and out of the Criminal Justice System. Each time they return to their communities their offending behaviour returns due to the side effects of their addiction. It is the organised crime groups that need to be incarcerated not the vulnerable people that they target.

There are a number of early intervention programmes being introduced across the country. The two most notable projects are the Bristol Education Programme and the Durham Checkpoint programme. Both provide an option for users from entering the criminal justice system.

Decriminalisation in Portugal

The use of substances for personal use was decriminalised in Portugal in 2001. As opposed to arresting users a Dissuasion Committee assesses whether the user is deemed problematic

or non-problematic (uses substances for recreational reasons). Recreational users are given a warning and no further action is taken. Problematic users on the other hand are given access to services and a place on a harm reduction programme. The harm reduction programme provides users with clean facilities to take their substances and for those unable to travel a mobile opioid replacement therapy is available. It is estimated that up to 18% of police resources were saved in Portugal once substance misuse was treated as a health issue as opposed to a policing issue.

From my perspective only those that cause harm to our local communities that should be prosecuted. It is estimated that around 90% of users are non-problematic, with the only harm being caused to themselves. There is no need for these people to be criminalised if they are not causing harm to the wider community.

RiS Partnership

Police and Crime Commissioner Feedback Form

How long have you been using substances?

- ☐ 0-12 months
- ☐ 1-3 years
- ☐ 3-6 years
- ☐ 6-10 years
- ☐ 10-15 years
- ☑ 15+ years

What is your main problem substance? .....

Are you?

- ☐ Currently using drugs/alcohol
- ☑ In recovery/abstinent
- ☐ Female
- ☑ Male

In your opinion how does the police's drug and alcohol policy impact people with drug and alcohol problems? In my opinion its out of date and does its self no favours only compounds an already great social problem. There is no distinction between the criminal and the addicted.

Has this ever affected you personally? Tell us about your experiences

It has affected me greatly as I was a class A addict and went to great lengths to fund my addiction. I was imprisoned for a very long time and came out with the same addiction I went in with and a lot more criminal knowledge.

What new initiatives or changes could the police or health providers make to prevent harm and/or reduce crime related to drugs?'

As an addict I believe if addicts get in trouble give them a sentence yes! But also give them a chance at rehab first if this fails they go to jail to complete sentence.

Continue on next page

The costs would be similar and at least this way you are giving the addict every chance to sort out the issue that makes them commit crime. Its a win win. for the same if not less cost.
I got 9 years custardy for drug offences if I had the option to go rehab sort myself out for a year and get monitored and tested in the community there after I believe I would of. Instead I went to jail still took drugs never delt with the addiction and learint more about being a criminal and left even more capable of crime and tricks etc. And more important I left jail addicted and resentfull.
You need to address the problem "ADDICTION" even if a small % sorted themselves out it would save a fortune. In both jail time and future crime.
Its a no brainer for the addicted where as the proper criminal IE ~~the~~ the money makers need longer jail. The addict gets used and abused and preyed on due to there need for drugs. The real criminals take advantage

How long have you been using substances?

- ☐ 0-12 months
- ☒ 1-3 years
- ☐ 3-6 years
- ☐ 6-10 years
- ☐ 10-15 years
- ☐ 15+ years

What is your main problem substance? Cannabis

Are you?

- ☐ Currently using drugs/alcohol
- ☐ Female
- ☒ In recovery/abstinent
- ☒ Male

In your opinion how does the police's drug and alcohol policy impact people with drug and alcohol problems?

Police need to understand the reasons why people use whether it's recreational, medicinal or as a product of addiction. They should punish destructive behaviour caused by drugs but not drug use instead. A focus on rehabilitation at places like Iris and identifying the reasons for use is a much better remedy.

Has this ever affected you personally? Tell us about your experiences

I have been arrested taking a large sum of Class A and Class B into a Digbeth rave. I am awaiting charges. Since my rehabilitation, I have stopped all drug use and criminal activity. I work 4 days a week voluntary and are applying for other jobs. My arrest absolutely destroyed my ego, even to the point of being suicidal.

What new initiatives or changes could the police or health providers make to prevent harm and/or reduce crime related to drugs?'

when arrests happen, instantly send them to rehab.

Continue on next page

How long have you been using substances?

- ☐ 0-12 months
- ☐ 1-3 years
- ☐ 3-6 years
- ☐ 6-10 years
- ☒ 10-15 years
- ☐ 15+ years

What is your main problem substance? .....heroin.....

Are you?

- ☒ Currently using drugs/alcohol
- ☐ In recovery/abstinent
- ☐ Female
- ☒ Male

In your opinion how does the police's drug and alcohol policy impact people with drug and alcohol problems?

it doesn't work, yes I commit crime to feed my habit, I need the right help instead of jail.

Has this ever affected you personally? Tell us about your experiences

Yes, jail deh bothe me anymore it like a second home

What new initiatives or changes could the police or health providers make to prevent harm and/or reduce crime related to drugs?'

I don't see a light, at the end of my tunel,

Continue on next page

How long have you been using substances?

- ☐ 0-12 months
- ☐ 1-3 years
- ☐ 3-6 years
- ☑ 6-10 years
- ☐ 10-15 years
- ☐ 15+ years

What is your main problem substance? .....Heroin.....

Are you?

- ☑ Currently using drugs/alcohol
- ☐ In recovery/abstinent
- ☑ Female
- ☐ Male

In your opinion how does the police's drug and alcohol policy impact people with drug and alcohol problems?

I feel as if police and their policys are not about us, we are treated like scum

Has this ever affected you personally? Tell us about your experiences

Yes

What new initiatives or changes could the police or health providers make to prevent harm and/or reduce crime related to drugs?'

Better programmes and aftercare instead of jail and cells

Continue on next page

How long have you been using substances?

- ☐ 0-12 months
- ☐ 3-6 years
- ☑ 10-15 years
- ☐ 1-3 years
- ☐ 6-10 years
- ☐ 15+ years

What is your main problem substance? .....Both e Beer.....

Are you?

- ☑ Currently using drugs/alcohol
- ☐ In recovery/abstinent
- ☐ Female
- ☑ Male

In your opinion how does the police's drug and alcohol policy impact people with drug and alcohol problems?

when getting locked up its an all day wait for the Doctor. Just for a OF tablet when on a Good Methadone Script. there is a form to fill in aswell for the police to get our meds. but they tell you NO !!

Has this ever affected you personally? Tell us about your experiences

of course its unessesery suffering.

What new initiatives or changes could the police or health providers make to prevent harm and/or reduce crime related to drugs?'

give us More Chip get our Script.

Continue on next page

How long have you been using substances?

- ☐ 0-12 months
- ☐ 3-6 years
- ☑ 10-15 years
- ☐ 1-3 years
- ☐ 6-10 years
- ☐ 15+ years

What is your main problem substance? .....Cannabis.....

Are you?

- ☐ Currently using drugs/alcohol
- ☑ In recovery/abstinent
- ☑ Female
- ☐ Male

In your opinion how does the police's drug and alcohol policy impact people with drug and alcohol problems?

not really sure not experienced it

Has this ever affected you personally? Tell us about your experiences

no

What new initiatives or changes could the police or health providers make to prevent harm and/or reduce crime related to drugs?'

Work Together. to help people.

Continue on next page

How long have you been using substances?

- ☐ 0-12 months
- ☐ 1-3 years
- ☐ 3-6 years
- ☐ 6-10 years
- ☐ 10-15 years
- ☑ 15+ years

What is your main problem substance? Alcohol

Are you?

- ☑ Currently using drugs/alcohol
- ☐ In recovery/abstinent
- ☐ Female
- ☐ Male

In your opinion how does the police's drug and alcohol policy impact people with drug and alcohol problems?

Does not affect me.

Has this ever affected you personally? Tell us about your experiences

NO

What new initiatives or changes could the police or health providers make to prevent harm and/or reduce crime related to drugs?'

I have had my driving licence revoke ever thro + have not drink + drive.

Continue on next page