

Home Affairs Committee: Drugs Inquiry

Submission from National AIDS Trust

April 2022



1. Introduction

1.1 National AIDS Trust (NAT) is the UK's HIV rights charity. Our interest in drugs policy follows from the fact that people who inject drugs (PWID) remain an at-risk group for HIV. In 2019 there were 1,887 people accessing HIV care where injecting drug use was reported as the likely route of transmission.¹ This accounts for 1.9% of all people accessing HIV care. While HIV prevalence amongst people who inject drugs in the UK remains low (1.1% in England, Wales and Northern Ireland; and 3.8% in Scotland²), it is significantly higher than in the general population and PWID represent a particularly vulnerable group.

1.2 NAT is committed to maintaining and promoting harm reduction principles in drug treatment policy and practice.³ Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use while also respecting the rights of people who use drugs. It is an approach recommended by the World Health Organisation, UN Drugs, and the Advisory Council on the Misuse of Drugs, as well as HIV organisations the world over.⁴ Harm reduction involves approaching drug use from a health rather than criminal justice perspective, and is vital if we are to meet the Government's commitment to end HIV transmissions in the UK by 2030.

2. The UK drug framework

2.1 The UK's drug framework is outdated and not fit for purpose. This is evident in its failure to reduce drug misuse, drug-related deaths, and drug-related offending. Instead, it acts as a barrier to achieving these aims for reasons that will be explored throughout this submission.

2.2 The overall prevalence of drug use reported in the UK has remained relatively consistent over the past 25 years.⁵ Though the period from 2000 to 2010 saw a slight decline in drug use this has not continued over the decade since, and the most recent surveys covering England, Wales and Scotland report that drug use is at its highest rate in the past 10 years.⁶ The reported prevalence of any drug use in the previous year was 9.4% in England and Wales, 12% in Scotland, and 5.9% in

¹ UK Health Security Agency, Country and Region HIV data tables to end December 2020. Tables No. 1: 2021

² UKHSA, Public Health Scotland, Public Health Wales and Public Health Agency Northern Ireland, 2021, *Shooting Up: infections and other injecting-related harm among people who inject drugs in the UK*.

³ We use the Harm Reduction International definition of harm reduction in this submission:

<https://www.hri.global/what-is-harm-reduction>.

⁴ WHO, UNAIDS, UNDP & International Centre on Human Rights and Drug Policy, 2020, *International Guidelines on Human Rights and Drug Policy*; United Nations Office on Drugs and Crime, 2008, *Reducing the adverse health and social consequences of drug abuse: A comprehensive approach*; Advisory Council for the Misuse of Drugs, 2016, *Reducing Opioid-Related Deaths in the UK*

⁵ Office for National Statistics, Drug misuse in England and Wales: year ending March 2020

[\[https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2020\]](https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2020)

⁶ See: <https://www.gov.uk/government/publications/united-kingdom-drug-situation-focal-point-annual-report/uk-drug-situation-2019-summary>

Northern Ireland. Drug use among 15-year-olds has risen over the past 5 years. In 2018, 38% of 15-year-olds in England, and 21% of 15-year-olds in Scotland, said that they had ever used drugs.

2.3 The failure of the UK's drug framework is best epitomised by the ongoing drug-related deaths crisis. In 2020, there were 4,561 drug-related deaths in England and Wales, the highest rate since records began.⁷ This marks a year-on-year increase in drug-related deaths since 2012. In Scotland the problem is even worse; more than 1,300 people died of drug misuse in Scotland last year, with the country seeing a record number of deaths for the seventh year in a row.⁸ This means that Scotland has the highest drug-related death rate in Europe. The crisis in drug-related deaths, which the Scottish Affairs Committee has called on the UK Government to declare a public health emergency, represents an abject failure of the UK's approach to drugs.

2.4 The UK's drug framework underpins a criminal justice approach to drug use that successive governments have championed, with policy and rhetoric focusing on enforcement and deterrence. Yet police-recorded drug crime figures demonstrate that this punitive approach is not effective in deterring drug-related offending. Available data shows that total drug offences rose between 2004/05 and 2008/09 (from 145,837 to 243,536), declined from 2008/09 to 2017/18 (from 243,536 to 138,369), and then rose significantly again between 2017/18 and 2020/21 (from 138,369 to 208,961).⁹ The reasons for these fluctuations should be explored in detail (particularly how far the rise in offences since 2017/18 can be attributed to the Psychoactive Substances Act 2016), but it is clear that the current framework does not effectively deter offending.

2.5 Arrests for drug-related offences disproportionately impact ethnic minorities. In 2019/20, 16% of those arrested for notifiable drug offences were Black or Black British, despite this group making up just 3.7% of the general population and reporting lower levels of drug use than White people.¹⁰ Similarly, while the proportion of those arrested who identified as White decreased by 15 percentage points between 2014/15 and 2019/20, the proportion who identified as Black or Black British rose by 2 percentage points. This system, and the Misuse of Drugs Act 1971 that underpins it, has been described as 'a tool of systemic racism'; we agree with this assessment.¹¹

2.6 To address the question of how the UK drug framework should be reformed, we support the decriminalisation of all drugs for personal use. While opponents seek to paint this as a radical or dangerous proposal, it is in fact supported by an ever-growing range of national and international bodies, from the United Nations and the World Health Organisation, to the Royal College of Physicians and the European Association for the Study of the Liver.¹² In 2019 the Scottish Affairs Committee added its voice to the call for decriminalisation following an extensive inquiry, while in the same year the Health and Social Care Committee called for a consultation on decriminalisation of drug possession for personal use.¹³

⁷ UKHSA et al, *Shooting Up*, *op. cit.*

⁸ National Records of Scotland, 2021, *Drug-related deaths in Scotland in 2020*

⁹ House of Commons Library, 2021, *Drug Crime: Statistics for England and Wales* [<https://researchbriefings.files.parliament.uk/documents/CBP-9039/CBP-9039.pdf>]

¹⁰ *Ibid.*

¹¹ Wooley S., 2021, 'Our drug laws are racist, and doctors must speak out – an essay by Simon Woolley', *BMJ* 374 :n2147 [<https://www.bmj.com/content/374/bmj.n2147>]

¹² See: <https://www.rsph.org.uk/about-us/news/royal-college-of-physicians-backs-rsph-calls-on-drug-reform.html>; <https://drugpolicy.org/blog/united-nations-and-world-health-organization-call-drug-decriminalization>; <https://easl.eu/news/policy-statement-drug-use-hep-c/>;

¹³ House of Commons Scottish Affairs Committee, 2019, *Problem drug use in Scotland: First Report of Session 2019*; House of Commons Health and Social Care Committee, 2019, *Drugs Policy: First Report of Session 2019*.

2.7 The arguments for decriminalisation are manifold. Not only has the current approach failed in the ways detailed above, criminalisation increases drug-related harms by contributing to stigma associated with drug use and deterring people from seeking and accessing treatment.¹⁴ It is also costly, requiring significant resource to enforce and resulting in criminal records for tens of thousands of people who use drugs each year. Decriminalisation can therefore enable better targeting of resources to tackle the root causes of problem drug use, diverting spending from the criminal justice system to health interventions and other services for people who use drugs.¹⁵ Critically, fears that decriminalisation will lead to a surge in drug use is simply not borne out in the evidence, with drug laws revealed to have a negligible effect on drug use internationally.¹⁶

28 The decriminalisation of drug use however is not a silver bullet. As its advocates make clear, to be effective it must be combined with appropriately funded drug treatment services, public health promotion, and harm reduction interventions.¹⁷ This is explored in the following section.

2.9 In summary, criminalisation of people who use drugs does not deal with the underlying causes and harms associated with problematic drug use and only increases people's exposure to health risks. Conversely, as expert charity Release have argued: "drug decriminalisation, when done correctly, can improve health outcomes, reduce drug-related deaths, reduce offending, and incur minimal increases in drug use - the exact targets of the current government drug strategy."¹⁸

3. UK drug policy

3.1 Harm reduction is vital to an effective response to problematic drug use and as an approach is recommended by all reputable international and national institutions on drug policy. The United Kingdom was at the forefront of effective harm reduction for many years. This has contributed to low incidence and prevalence of HIV amongst people who inject drugs in this country. It is important to guard against complacency and recognise the importance of adequate levels of service provision. The significant outbreak of HIV amongst people who inject drugs in Glasgow in recent years demonstrates how deterioration of services can quickly result in harms and mortality among this cohort.¹⁹ It also highlights how once the system weakens – in spite of renewed efforts to strengthen it once an outbreak has occurred – regaining control is extremely difficult.

3.2 National drug policy in the UK follows a 'recovery' agenda which sees the focus of treatment as securing the abstinence of the individual from drug use rather than freedom from harm. People who use drugs and the support services working with them describe abstinence models as disempowering and bereft of dignity, the focus on treatment completion often resulting in disengagement. A person-centred approach to treatment ensures people who use drugs have a stake in their own recovery with more sustainable and improved outcomes.

3.3 Opioid substitution therapy (OST) is a key treatment intervention that has been proven effective. OST is the substitution of an opioid, such as heroin, with a longer-lasting prescription

¹⁴ HoC HSC Committee, *Problem drug use*, *op. cit.*

¹⁵ HoC Scottish Affairs Committee, *Drugs Policy*, *op. cit.*

¹⁶ Release, 2016, *A Quiet Revolution: Drug Decriminalisation Across the Globe* [<https://www.release.org.uk/sites/default/files/pdf/publications/A%20Quiet%20Revolution%20-%20Decriminalisation%20Across%20the%20Globe.pdf>]

¹⁷ HoC Scottish Affairs Committee, *Drugs Policy*, *op. cit.*

¹⁸ Release, 2021, 'Release's take on the Government's new drug strategy', blog available at: <https://www.release.org.uk/blog/release%E2%80%99s-take-government%E2%80%99s-new-drug-strategy>

¹⁹ National AIDS Trust, 2018, *Policy briefing: HIV outbreak in Glasgow – more needs to be done* [https://www.nat.org.uk/sites/default/files/HIV_outbreak_in_glasgow_1.pdf]

opioid with less potential for abuse, usually methadone and buprenorphine. It is highly effective at supporting people to reduce and end heroin use and has been shown to reduce BBV transmission. It also is important in supporting PWIDs who are living with HIV to adhere to HIV treatment.²⁰ This not only safeguards the health of people living with HIV, but is also vital in preventing onwards transmission (people living with HIV on effective treatment and with an undetectable viral load cannot pass it on).²¹

3.4 One negative effect of the abstinence-based recovery model has been the rise of ‘payment by results’, a system where funding for drug treatment to local authorities is made conditional on rates of treatment exit, meaning that OST is often only provided for a defined period of time such as 6 months. This incentivises treatment by completion, rushing individuals through treatment at a pace they may not be ready for and failing to take wider needs into account. The perverse consequences of this model are risk of disengagement but also increased chance of relapse making individuals more likely to engage in harmful behaviour like criminal activity or needle sharing, and even death. For OST provision to realise its potential adequate coverage must be seen nationally, as part of a fully funded drug treatment plan that focuses on the needs of the individual and empowers them.

3.5 COVID-19 provided an opportunity to demonstrate the effectiveness of such an approach. As delivery of drug services had to adapt over the period, it encouraged and sped up innovations in the system. For example, we have heard the provision of longer methadone scripts that can be taken at home rather than requiring someone to go in daily for monitored use has led to increased trust, active involvement in their own treatment and has led to many people engaging better as a result.

3.6 Naloxone, medication that counteracts the effects of opioid overdose, can also go some way to reduce harms for people who use drugs. Unfortunately there are a series of barriers for provision of take home Naloxone; with coverage nationally being only 12% in 2017/18.²² UK regulations introduced in 2015 and 2019 have increased the ability of drug treatment services to provide injectable and nasal take-home naloxone, but the extent of naloxone availability varies nationally and a number of services/stakeholders are still not able to provide it.²³ Barriers to addressing this have been identified as internal or organisational rather than legal.²⁴ The UK’s new 10-year Drug Strategy must follow through on commitments to expand access to naloxone, and further access to training on overdose prevention must be increased so that those in the wider support network of people who inject drugs are able to reduce harms and possible fatality.

3.7 Needle and syringe programmes (NSPs) provide clean injecting equipment for people who inject drugs and collect used equipment to dispose of safely. These are incredibly vital tools in combating the transmission of blood borne viruses. However, the number of NSPs or needles distributed has not been reported since 2006, with the UK Health Security Agency (UKHSA) acknowledging the need for better understanding of NSP provision.²⁵ Available data from 2020 is concerning; COVID-related service disruption contributed to an increase in sharing and re-use of

²⁰ Nosyk B et al. 2015, ‘The causal effect of opioid substitution treatment on HAART medication refill adherence’ *AIDS* 29(8): 965–973 [<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4583234/>]

²¹ See: <https://www.aidsmap.com/about-hiv/faq/what-does-undetectable-untransmittable-uu-mean>

²² Carre, Z. et al., 2019, *Finding a Needle in a Haystack: Take-Home Naloxone in England 2017/18*

²³ Department of Health and Social Care, 2022, Consultation on expanding access to naloxone [<https://www.gov.uk/government/consultations/consultation-on-expanding-access-to-naloxone/consultation-on-expanding-access-to-naloxone>]

²⁴ Carre, Z et al., *Finding a Needle in a Haystack*, op. cit.

²⁵ UKHSA et al, *Shooting Up*, op. cit.

injecting equipment (reported by 1 in 4 people who had injected in the past month), while a third of PWID reported inadequate provision of needles and syringes.²⁶ If injecting drug users are unable to access clean equipment, the risk of sharing and transmission is significantly increased. Civil society organisations in the UK report that there has been no effort to expand coverage to address this deficiency, and the Government's Drug Strategy makes only vague commitments in this regard.²⁷

3.8 Beyond issues of coverage the standard of NSPs varies greatly across the country. NICE guidelines on needle and syringe programmes exist, but there is widespread concern they are not effectively followed.²⁸ For NSPs to be an effective intervention these guidelines must be fully implemented by directors of public health, commissioners, service providers and those with a remit for infectious disease prevention.

3.9 Drug Consumption Rooms (DCRs) are an intervention that has brought significant benefits internationally when established alongside a comprehensive package of drug treatment.²⁹ DCRs are legally sanctioned facilities where people can use illicit drugs obtained themselves, under the supervision of trained medical staff. Such facilities aim to reduce transmission of blood-borne viruses including HIV through unhygienic injecting, prevent drug-related overdose deaths and link people who inject drugs into drug treatment services and other health and social services.

3.10 There is a significant and growing body of evidence that supports the effectiveness of DCRs internationally and the piloting of them in the UK.³⁰ Internationally there is evidence of DCRs preventing drug-related overdose deaths,ⁱ reducing drug-related harm,ⁱⁱ reducing drug-related litter,^{iv} v reducing transmission of blood-borne viruses through unhygienic injecting,^{vi} and supporting PWIDs to engage with structured drug treatment and connect them with other health and social care services.^{vii} viii The opening of DCRs in the UK is supported by PWIDs themselves (A 2018 UK survey found a high degree of willingness from PWIDs to use a Drug Consumption Room, with 89% saying they would use such a facility³¹), as well as bodies including the Advisory Council on the Misuse of Drugs (ACMD), the Independent Working Group on Drug Consumption rooms, and numerous local authorities and Police and Crime Commissioners.³²

3.11 In Scotland, support for opening a DCR is overwhelming. Stakeholders in Glasgow have long advanced plans to open a DCR in Glasgow to combat the ongoing HIV outbreak amongst local drug users. Scottish Parliament has voted in favour of DCRs (and produced an evidence paper in support of them), the Scottish Affairs Committee has recommended piloting them, and NHS Greater Glasgow

²⁶ *Ibid.*

²⁷ Harm Reduction International, 2018, *Global State of Harm Reduction: Regional overview - 2.3 Western Europe* [<https://www.hri.global/files/2018/12/10/WesternEurope-harm-reduction.pdf>]

²⁸ National Institute for Health and Care Excellence (NICE), 2014, Needle and syringe programmes - Public Health Guideline [PH52] [<https://www.nice.org.uk/guidance/ph52/chapter/1-Recommendations>]

²⁹ European Monitoring Centre for Drugs and Drug Addiction, 2018, 'Drug consumption rooms: an overview of provision and evidence', [<https://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms>]

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³¹ International Drug Policy Consortium, 2019, *Room for improvement: How drug consumption rooms save lives* [<https://idpc.net/publications/2019/04/room-for-improvement-how-drug-consumption-rooms-save-lives>]

³² ACMD, 2016, *Reducing Opioid-Related Deaths in the UK, op. cit.*; Independent Working Group on Drug Consumption Rooms, 2006, *The Report of the Independent Working Group on Drug Consumption Rooms*; National AIDS Trust, 2019, *Drug-related deaths in England: local authorities and how they are responding*; Joint letter available at: [<https://www.northwales-pcc.gov.uk/en/News/Latest-News/2018/Police-bosses-urge-UK-Government-U-turn-on-drug-consumption-rooms-to-save-lives-and-reduce-crime.aspx>]

and Clyde and Glasgow City Council are both in favour of the plans.³³ As drug policy is a reserved matter however, a change in practice in Scotland requires a change in policy by the UK Government.

3.12 The UK Government has so far refused to engage with the idea, blocking the creation of a DCR anywhere in the UK. For provision for DCRs to be made in law, a change in legislation would be needed (Misuse of Drugs Act 1971). This would ensure implementation and use of a DCR are exempt from prosecution. In advance of any change in the law, a DCR could be implemented in a local area if there was guarantee from local police forces that they would not prosecute those delivering or using the service for crimes under the Misuse of Drugs Act 1971. This could also be achieved if the UK Government stated that they would not expect police forces across the UK to prosecute those involved in setting up a DCR (a similar approach to that taken on festival drug testing which the Government supports).³⁴ The continued refusal to consider changes in legislation or policy that would enable DCRs to be opened is therefore both inconsistent and at odds with available evidence.

3.13 To minimise the harms associated with drug use a shift away from criminal justice responses is absolutely crucial, alongside adequate provision of the full range of public health and harm reduction interventions outlined above. The recent publication of the Government's 10-Year Drug Strategy therefore gives cause for both optimism and frustration. Welcome within the strategy is a significant and long overdue increase in spending on drug treatment services.³⁵ This was a core recommendation of Dame Carole Black's independent review of drugs, which found that the current system and provision of prevention and treatment is not fit for purpose; unsurprising given decade-long cuts to spending on drug treatment.³⁶

3.14 Disappointingly, the Drug Strategy combines this new commitment to drug treatment with a continued focus on enforcement and 'law and order'. This is despite Phase 1 of Dame Black's review finding that not only have interventions to restrict supply had limited success, "Even if [the organisations involved] were sufficiently resourced it is not clear that they would be able to bring about a sustained reduction in drug supply."³⁷ The strategy therefore represents a renewed commitment to an approach that is neither effective nor evidence-based. Decriminalisation is dismissed as a "simple solution" that would "leave organised criminals in control while risking an increase in drug use", ignoring both evidence to the contrary and criminalisation's failure to do

³³ The Independent, 2018, '[Scottish Parliament backs creation of UK's first drug consumption room in Glasgow](#)'; Scottish Government, 2021, *Safer drug consumption facilities: evidence paper* [<https://www.gov.scot/publications/safer-drug-consumption-facilities-evidence-paper/pages/6/>]; NHS Greater Glasgow and Clyde, 2016, *Taking away the chaos: The health needs of people who inject drugs in public places in Glasgow city centre* [<http://www.nhs.uk/ggc/238302/nhs.uk/ggc/health-needs-drug-injectors-full.pdf>]; Glasgow City Health and Social Care Partnership, *Safer drug consumption facilities and heroin-assisted treatment* [<https://www.glasgow.gov.uk/CHttpHandler.ashx?id=38604&p=0>]

³⁴ See: <https://www.independent.co.uk/news/uk/home-news/drug-testing-festivals-home-office-nick-hurd-the-loop-thangam-debbonaire-a8438281.html>

³⁵ UK Government, 2021, *From harm to hope: A 10-year drugs plan to cut crime and save lives* [<https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives>]

³⁶ DHSC, 2021, *Independent report: Review of drugs part two: prevention, treatment, and recovery* [<https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery>]

³⁷ Home Office, 2020, *Independent report: Review of drugs: phase one report* [<https://www.gov.uk/government/publications/review-of-drugs-phase-one-report>]

otherwise. HIV (and other blood-borne viruses) are also notably absent from the Strategy, as is any mention of effective intervention including drug consumption rooms and heroin assisted treatment.

3.15 The Drug Strategy therefore has potential to significantly improve the drug treatment system but is undermined by the Government's continued punitive approach and refusal to consider legislative reform. Until this changes, the Strategy will exacerbate as many problems as it solves.

4. The impact of drug use in the UK

4.1 HIV and blood-borne viruses (BBVs)

4.1.1 People who inject drugs (PWIDs) are disproportionately affected by HIV due to the transmission risk involved in sharing needles. While this is true of the UK as elsewhere, the prevalence of HIV amongst PWIDs in the UK is relatively low – 1.1% of drugs users are currently living with HIV in England, Wales and Northern Ireland; and 3.8% in Scotland.³⁸ The low rates amongst this population group are a result of effective harm reduction services and structured drug treatment programmes being introduced early in the HIV epidemic.

4.1.2 However, the situation can change rapidly if such services are defunded and neglected. There is currently an ongoing HIV outbreak amongst PWIDs in Glasgow – where over 150 cases have been diagnosed since 2015.³⁹ The outbreak still hasn't been controlled and is mainly concentrated in a group of 400-500 people known to inject opiates publicly in Glasgow.⁴⁰ This group has complex needs with considerable evidence of social exclusion – analysis from 2018 found that of those diagnosed 40% have a history of incarceration and 45% report ever being homeless.⁴¹ There have also been smaller localised outbreaks in various parts of the UK and Ireland in recent years, including South West England, Wales, Dublin and Birmingham.⁴²

4.1.3 While the prevalence of HIV amongst PWIDs remains relatively low, the prevalence of hepatitis C (HCV) is very high. The UK Health Security Agency report that that 60% of PWIDs sampled in 2020 had HCV antibodies (meaning they are either currently living with HCV or have been in the past).⁴³ Though rates of chronic HCV infection have decreased significantly over the past 5 years, they remain high at 20% of those sampled in 2020.

4.1 Drug-related Deaths

4.2.1 As was discussed in section 2.3, drug-related deaths (DRDs) are at the highest level since records began with 4,561 DRDs in England and Wales in 2020, half (49.6%) of which related to opiate use.⁴⁴ In 2019 (the most recent year for which Europe-wide data is available), there were more drug-

³⁸ UKHSA, *Shooting Up*, *op. cit.*

³⁹ UKHSA et al., 2020, *Accompanying data tables for Shooting Up: infections and other injecting-related harm among people who inject drugs in the UK* [<https://www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk>]

⁴⁰ NHS Greater Glasgow and Clyde, *Taking away the chaos*, *op. cit.*

⁴¹ Metcalfe R et al., 2018, 'An outbreak of HIV amongst homeless people who inject drugs (PWIDs) – describing the epidemic and developing an innovative service model' Fourth Joint Conference of the British HIV Association (BHIVA) with the British Association for Sexual Health and HIV (BASHH), April 2018, abstract 67.

⁴² Public Health England, 2017, *Shooting Up: Infections among people who inject drugs in the UK, 2016*; Health Protection Surveillance Centre, 2015, 'Rise in recently acquired HIV in People who inject Drugs in Dublin'; BBC News, 2018, 'Worrying' increase in HIV cases in West Midlands [<https://www.bbc.co.uk/news/uk-england-birmingham-46404138>]

⁴³ UKHSA, *Shooting Up*, *op. cit.*

⁴⁴ UKHSA, *Shooting Up*, *op. cit.*

related deaths in the UK than in the rest of the European Union combined.⁴⁵ This constitutes a public health and humanitarian crisis which must be addressed urgently.

4.2.2 There has been much discussion on why the DRD rate has risen so dramatically. Public Health England (PHE) state there is an ageing group of people who have used opiates since the 80s (when a heroin epidemic first emerged) who are now more susceptible to ill health and overdose.⁴⁶ The other factor, which is hard to track, but likely to have had a significant impact upon the rate of DRDs, is the significant cuts faced by drug services over the last few years, coupled with the move over the last decade to an abstinence-based 'recovery' model of drug treatment, rather than harm reduction. The Advisory Council on the Misuse of Drugs (ACMD) report that changes in treatment services and commissioning practices may have contributed to the increase in DRDs.⁴⁷

5. International comparisons

5.1 A legal, social and cultural shift towards a public health framework for drug use took place in Portugal and saw HIV transmissions fall from 104.2 new cases per million in 2000 to 4.2 cases per million in 2015.⁴⁸ Portugal complemented its policy of decriminalisation by allocating greater resources across the drugs field, expanding and improving prevention, treatment, harm reduction and social reintegration programmes. Details of this approach can be found in reports by the Scottish Affairs Committee and Health and Social Care Committee, as well as an excellent case study report by Transform Drug Policy Foundation.⁴⁹ This principle underpins all of the harm reduction interventions described above, and provides a clear model for the UK to emulate.

For further information please contact Danny Beales, Head of Policy and Campaigns at danny.beales@nat.org.uk or on 020 7814 6732

⁴⁵ EMCDDA, 2021, *European Drug Report: Trends and Developments*

[https://www.emcdda.europa.eu/publications/edr/trends-developments/2021_en]

⁴⁶ Public Health England, 2016, *Understanding and preventing drug-related deaths*

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669308/Understanding_and_preventing_drug_related_deaths_report.pdf]

⁴⁷ ACMD, *Reducing Opioid-Related Deaths in the UK*, op. cit.

⁴⁸ EMCDDA, 2017, *Portugal: Country Drug Report 2017*

[<https://www.emcdda.europa.eu/system/files/publications/4508/TD0116918ENN.pdf>]

⁴⁹ Transform, 2021, *Drug decriminalisation in Portugal: Setting the record straight*

[<https://transformdrugs.org/publications/drug-decriminalisation-in-portugal-setting-the-record-straight>]

ⁱ Poschadel, S., Höger, R., Schnitzler, J. and Schreckenber, D. (2003), 'Evaluation der Arbeit der Drogenkonsumräume in der Bundesrepublik Deutschland', Nr 149, Schriftenreihe des Bundesministeriums für Gesundheit und Soziale Sicherheit, Baden-Baden.

ⁱⁱ Marshall, B. D., Milloy, M. J., Wood, E., Montaner, J. S. and Kerr, T. (2011), 'Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study', *The Lancet* 23 April, 377(9775), pp. 1429–37.

ⁱⁱⁱ Salmon, A. M., Van Beek, I., Amin, J., Kaldor, J. and Maher, L. (2010), 'The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia', *Addiction* 105, pp. 676–83.

^{iv} Wood, E., Kerr, T., Small, W., et al. (2004), 'Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users', *Canadian Medical Association Journal* 28 September, 171(7), pp. 731–4.

^v Salmon, A. M., Thein, H. H., Kimber, J., Kaldor, J. M. and Maher, L. (2007), 'Five years on: what are the community perceptions of drug-related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre?' *International Journal of Drug Policy* 18(1), pp. 46–53.

^{vi} Bayoumi, A, and Zaric, G, 'The cost-effectiveness of Vancouver's supervised injection facility' *CMAJ*. 2008 Nov 18; 179(11): 1143–1151. Accessed 1st April 2019. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2582765/>

^{vii} Wood, E., Kerr, T., Small, W., et al. (2004), 'Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users', *Canadian Medical Association Journal* 28 September, 171(7), pp. 731–4.

^{viii} DeBeck, K., Kerr, T., Bird, L., et al. (2011), 'Injection drug use cessation and use of North America's first medically supervised safer injecting facility', *Drug and Alcohol Dependence* 15 January, 113(2–3), pp. 172–6.