

Written evidence from Law Enforcement Action Partnership UK (LEAP UK)

History:

The Inquiry has requested submissions on the health consequences of illicit drugs policy. Law Enforcement Action Partnership UK (LEAP UK) are extremely well placed to respond to the inquiry. LEAP UK is an organisation whose membership represents a broad pool of Law Enforcement professionals who worked to enforce the UK and International law dealing with illicit drugs, most obviously the Misuse of Drugs Act 1971. Our members include intelligence operatives who dealt with drug trafficking to fund Terrorism and Organised Crime on the global stage and military personnel from the British Army and the Royal Navy who were charged with physically disrupting international drug trafficking routes. The vast majority of the LEAP UK membership, however, have served or are currently serving as police officers in the United Kingdom. Virtually every rank from Special Constable through to Chief Constable is represented. Many of the members have extensive experience working in Drugs Units, including as level 2 undercover operatives where the nature of their work brought them into daily contact with the most vulnerable drugs users. They have witnessed first-hand the detrimental impact of UK policy on the health of these individuals.

“Our current drug laws address the issue of drug use with shame and criminalisation, it shames those who use non-problematically into secrecy, and those who use problematically - who need treatment and help - into a system that only compounds their problems.” - Suzanne Sharkey, former Constable and Undercover Operative, CID

There is a time in living memory for some people in the UK when there was no crime associated with drugs at all. Our nation was globally recognised as leaders of a health focused approach to drugs. In a policy known as the ‘British System’, problematic heroin users could report to their doctor and be prescribed clinically produced heroin which they would collect from a local pharmacy. The negative health implications associated with the illicit market were non-existent. The spread of addiction across the population was controlled because there was no incentive to convert non-users into customers in the way our members regularly encounter with the illicit market today. In the final year before the Misuse of Drugs Act 1971 (MoDA) was introduced, there were 1,049 recorded instances of people suffering from heroin addiction – 20 years later this number had risen to 300,000 people. This is not evidence of a policy that is protecting the health of British people.

In the 48 years since the MoDA became law, UK police forces have had a great deal of success in investigating and disrupting Organised Crime networks. Drug dealers and traffickers at all levels of the criminal hierarchy are arrested on a daily basis. Some of our members have been instrumental in developing investigative techniques that have contributed to thousands of years of successful drug convictions. Nevertheless, drug-related deaths in the UK are at record levels and are amongst the

highest percentage of deaths per population in Europe. According to the ONS there were 3,756 deaths in England and Wales in 2017 due to drug poisonings – the highest since records began. It is clear that our accomplishments have not translated into a positive impact on mortality rates. We contend that they are largely to blame for the increase in drug-related health harms as users are forced into criminality and suffer from all the related harmful behaviours that stem from illicit substance use. What we can say without a shadow of a doubt is that we have failed to curtail the illicit market. Instead, we have witnessed it become increasingly violent and exploitative in response to our ability to disrupt it.

Present:

Through our members' work and personal experiences policing illicit drugs we can establish a huge variety of health harms that would not exist but for laws prohibiting these substances. For the benefit of this submission we have identified them into three groupings: 1. Health implications directly related to illicit substance use; 2. Health implications arising from criminality and the illicit market; 3. Health implications impacting law enforcement officers.

"Governments should not harm people as a way to stop them harming themselves."

- Bård Dyrdal, Superintendent, Oslo Police District, Chairman LEAP Scandinavia

1. Health implications relating to substance use

Most police officers will agree the worst task they will ever have to carry out in the performance of their duty is having to inform a family of a death, particularly when their loved one has died under tragic circumstances. The reasons for these deaths are many and complex but so often in the event of a drug-related death, the circumstance is directly related to the nature of the illicit market. Drugs can be adulterated with unknown substances that are even more toxic than substances they purport to be. Purity can be higher than anticipated. In both instances an overdose could have been prevented if the user had better knowledge of what they were consuming. A marked rise in the purity of cocaine seized in recent years coincides with an increase of approximately 300% in cocaine related deaths in England and Wales between 2011 and 2017. The illicit market today continues to expand at such a rate, under a model where users become user-dealers and seek out new potential users to finance their own problematic use, that drug-gangs and Organised Crime Groups have little concern for protecting the health of their customers. Where licit suppliers have requirements to meet health and safety standards for substances they produce, the illicit market has no such obligations. Our members report cases where witnesses have confirmed drug gangs deliberately sold adulterated heroin to suspected informants to cause overdose and thereby confirm their silence. In many instances that we attended over the years, the cohorts of overdose victims fail to notify emergency services in time to stop a preventable death out of fear of recriminations from police. Our drug laws do not act as a sufficient deterrent to stop people consuming drugs but they do deter people from responding swiftly when something goes wrong. This cuts across all drug use. We see the same behaviour in homeless problematic heroin users as we do with young people consuming ecstasy at a party or older wealthy individuals consuming cocaine.

“Far from making communities safer, current drug laws have the unintended consequence of placing barriers between the police and often vulnerable individuals.”
- **Paul Whitehouse, Chief Constable (ret.)**

2. Health implications arising from criminality

It is unlikely in this day and age that we need to provide evidence to the Committee of the dangers to life and health associated with being a member of a criminal drugs network. The nature of how these operations are controlled and enforced is widely understood. Intimidation, punishment beatings and even murder have been reported in every nation from the activities of the mafia in twentieth century USA to the street gangs of London today. With regards the latter, our members report that the methods of control have become even more vicious in recent years. In addition to defending rivalries and intimidating communities into silence, violence and torture are inflicted by gang leaders on their own members to ensure loyalty. We are aware of cases of gangs recording videos of male and female teenagers being raped. The recruit is blackmailed with the threat of the video getting circulated among their family and associates. None of this barbarity would exist without the illicit market. We must accept that our drug laws are complicit in creating the environment for this kind of destructive violence to occur.

“We are putting the future of our youth in danger by being stuck with the idea that prohibiting drugs is the only option. There has never been more risk of young people becoming sucked into illegal activities and organised criminal gangs.” - **James Joseph, former Drugs Unit Constable, Undercover Operative**

Recent media attention has focused on a perceived rise in knife crime attacks in cities across the UK. What began as gangs protecting a territory in order to control the sale of drugs in an area has spilled over into an upsurge in violence among a wider, mostly young, population. With our experiences, we have no doubt that this violence is a result of learned behaviour. Where once dealers and gang members had to be ferocious to protect their businesses where the law could not, we have seen that ferociousness take root in whole communities. Some individuals report that a lack of trust in police to adequately protect them means they have to protect themselves, and they do this by carrying a weapon. Others are determined to make a name for themselves and attract kudos among their peers and local criminal networks through violence. While people can point to all manner of social issues that lead these young people to engage in knife crime (poverty and lack of opportunity among them), it is the drug gangs that have taught them how to respond. And, again, it is prohibitive drug policy that creates the environment where this reaction is deemed acceptable and necessary.

3. Health implications impacting law enforcement officers

Prime Minister Theresa May refers to a “war against drugs” and we agree this is a very accurate description of the duties our members committed and continue to commit their working lives to. The only difference is that this “war” is not being fought by soldiers. It is being fought by frontline police officers. The vast amounts of money involved in the illicit drugs trade has emboldened Organised Criminals to make premeditated attacks on police officers who are considered a danger to their illicit drugs operations. All of our members with drugs unit experience have had their lives

threatened. Some have had to relocate with their families as a result of being attacked in their own homes.

It should not be a huge surprise that LEAP UK receives a substantial number of approaches from former undercover drugs operatives. They have seen the damaging impact of our drug laws more closely than most as they move through the hierarchy of users to user-dealers to senior dealers in the course of their investigations. They come to us to express the futility of the career they have devoted years of their lives to. Many of them suffer with poor mental health as a result of their work. PTSD has become widespread in the police service in the UK and internationally - another thing they have in common with soldiers of a more traditional war. Our members explain that responding to the drug-crime violence, and the impact of making the lives of vulnerable people dealing with trauma and addiction even worse by manipulating them and arresting them when they needed help, has led to police officers themselves becoming incredibly damaged.

"I spent many hours over many, many years working very hard on the front line of the 'war on drugs'. There was no benefit at all to the work that I did. All I did was make the lives of the vulnerable more unbearable.". – **Neil Woods, former Undercover Drugs Detective Sergeant, Chair of LEAP UK**

The Future:

We recently contributed an article to the British Medical Journal (BMJ) describing our vision for the future with drug policy that will reduce harm and limit the damage caused by our enforcement led approach. These policies will establish evidence-led regulation and support a health based strategy. The article led the BMJ to [asserting their own editorial stance](#) that drugs should be legalised, regulated, and taxed.

"When law enforcement officers call for drugs to be legalised, we have to listen. So too when doctors speak up." - **Fiona Godlee, editor in chief, BMJ**

Some police forces are already taking different approaches to drug enforcement within the law. The police and crime commissioner (PCC) of Durham, Ron Hogg, who gave a speech in support of LEAP UK at its launch in 2016, has successfully maintained a policy of not arresting people for drug possession and low level dealing. This approach helped Durham to be recognised as the top performing police force in the country for three years running, receiving the grade of "outstanding" from Her Majesty's Inspectorate of Constabulary.

Durham's approach is to advocate for education and intervention, to develop responses to reduce the harms associated with drugs, and to promote drug treatment and recovery programmes as well as to support alternatives to criminalisation, which mostly impact vulnerable groups. Arfon Jones, a member of LEAP UK and PCC of North Wales, has also received public support for the reprioritisation of resources away from arrests for drug possession to a focus on supportive services, such as drug testing facilities at nightclubs and festivals. Despite PCCs having different priorities, the Home Office has consistently called for the full application of current law.

International examples show that Heroin Assisted Treatment (HAT) for drug users resistant to other treatments costs around a third of housing someone in a UK prison for a year, often with less acquisitive crime and markedly improved health outcomes.

“We need to listen: There is no recovery from addiction without harm reduction. Current drug policy is killing those who we are trying to protect.” - **Chris Paling, Royal Navy and Harm Reduction Worker**

Proponents of prohibition argue that deviation from criminal sanctions may lead to increased consumption, but international examples suggest otherwise. In Portugal, for example, drug supply is still illegal, but in 2001 criminal sanctions were removed for non-violent possession of small amounts of drugs. There has been no increase in consumption, but a huge drop in overdose deaths. Arrests and criminal court appearances fell from 14 000 people in 2000 to 5500-6000 a year after reform.

LEAP UK is careful about terminology: we are not only calling for legalisation, but also for control and regulation. We need a range of legal, regulatory models for all drugs that focus on quality control, child protection, and taxation to fund education and treatment services.

Existing legal markets, such as tobacco and alcohol, show the need for restrictions on marketing and for sensible distribution models, such as those seen in Canada’s emerging legal cannabis industry. The UK now has the ironic accolade of being the largest exporter of legal cannabis and yet hypocritically still criminalises responsible adult consumers and medical users, leading to a violent black market.

To reduce the violence from illegal trade we should replace our enforcement led approach with regulation, taxation, support, and education in a health based strategy.

“We need to provide help to those who suffer with dependency, not persecution. Let’s redirect police resources into harm reduction strategies and give the public the service they deserve.”- **Nicholas Castle, former Constable and Undercover Operative**

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Appendices

ONS figures found that opiates, most commonly illicit heroin, are responsible for over 53% of drug-related deaths in the UK. Regulating the heroin trade needs to be an urgent priority of any new health-focused policy. In our appendices we provide a brief academic examination of the aetiology of heroin and the evidenced benefits to reducing harm and improving health with HAT services.

Aetiology of Heroin Use

The aetiology of heroin use is multifactorial (Thomas, 2007). However, there are correlates which are more prominent than others. There are strong associations between childhood abuse and substance misuse which have been demonstrated across a range of settings (Heffernan et al, 2000). For example, 2/3 of parenteral (intravenous) drug use can be attributed to traumatic childhood experiences. A stronger correlation is seen with both physical and sexual abuse in childhood contributing to opiate addiction, with 27% of respondents stating they had experienced this, compared to 24.1% for physical abuse alone and 8.8% for childhood sexual abuse alone. This results in high levels of comorbidity between Post Traumatic Stress Disorder (PTSD) and substance use (Dube et al, 2003; Heffernan et al, 2000; Khoury et al, 2010)

Poverty also has a role in the development of opiate addictions as unemployment quadruples the likelihood of an individual developing a substance use disorder (Murali & Oyebode, 2004). Also, survivors of multiple traumatic childhood events are three times more likely to fall below the national poverty line and are twice as likely to develop mental health issues such as depression in later life (Zielinski, 2009). However, deindustrialisation also had a causal effect on rates of heroin use. In the North of England where the employment market was characterised by manual labour, rates of heroin use are still disproportionately higher than in other areas of the country as it can be seen to mirror increases in poverty and unemployment (Foster, 2000; Witton, Keaney and Strang, 2005; La Guilla, 2013). These effects are still visible in Yorkshire and the Humber which has the highest estimated prevalence rate of opiate use per 1000 population at 9.32, compared with 4.99 in the South East (Hay, Rael Dos Santos and Worsley, 2013). Clearly, social disadvantage and exclusion precede problematic drug use and the structural factors which underpin this phenomenon must be recognised alongside social inequalities in the United Kingdom (UK) (Buchanan, 2004).

Heroin Assisted Treatment

Whilst funding for local rehabilitation services has seen a 55% reduction in funding from local councils (Centre for Social Justice (CSJ), 2013); HM Govt (2010) sought to see a reduction in Methadone prescribing, arguing that too many people are left on these prescriptions for life. However, the numbers of people in receipt of a methadone prescription for over ten years has increased by 40% since 2010 (CSJ, 2013). Although, methadone is more physically addictive than heroin, enforcing dependency on street addicts which places them at the lower end of the hierarchy of statuses of street-based drug users, leading to feelings such as anger and depression (Bourgeois, 2000).

Whilst methadone treatment raises many issues in terms of control and a lowering of status among users (Bourgeois, 2000), HM Govt (2010) stated that they would examine the role of diamorphine prescribing in enabling long term heroin users to enter recovery. For example, over 5-10% of individuals do not benefit from traditional treatments such as methadone. However, upon the

adoption of models used by Switzerland whereby individuals were given supervised injections of diamorphine by health professionals, over 1/2 of them achieved full abstinence (Strang et al, 2010; Shaw, 2009). Please see figures 1-3 for tables relating to the Swiss and German rates of success with Heroin Assisted Treatment (HAT) versus Methadone treatment.

Figure One

Quality of Life for HAT Participants in Switzerland

	Baseline	18 Months
Unstable Housing	43%	21%
Homelessness	18%	1%
Unemployment	73%	45%
Welfare Recipients	63%	54%

Figure Two

Switzerland: Significant Reductions in Criminal Charges in Comparison to Opiate Substitution Therapy

Crime	Methadone Group	HAT Group
Drug Use/Possession	38%	11%
Property Theft	24%	4%
Other offense or charge in Prior 6 months	57%	19%

Figure Three

Germany: Significant Reductions in Criminal Charges in Comparison to Opiate Substitution Therapy

Crime	Methadone	HAT
Fewer reported days of crime	37.5	10.3
Less frequent arrests per year	2.8 times per year	2.1 times per year
Less frequent convictions	0.54 times	0.25 times
% of individuals committing at least one offence per year	79% decreasing to 63% during trial	79% to 45% during trial
Average number of offences	Declined to 49%	Declined to 26.8%

(Figures 1-3 sourced from Wooldridge, 2017)

One of the most famous examples of Heroin Assisted Treatment (HAT) came from Dr. John Marks who prescribed diamorphine to 400 patients referred to him by GP's (Cohen, 1995). Many of Marks's patients were in employment or training and between 1982 –1995 there were no injection site infections or deaths from overdose and the area as a whole saw a 93% fall in theft and burglary (Hari, 2015). This is furthered by Shaw (2009) who found that after six months of HAT crimes overall fell by 2/3 leading to this form of treatment at £15,000 per year per person to be far cheaper than prison at £44,000. However, sadly in 1995 Mark's clinic was closed and within 6 months 20 of his patients had died from overdose rising to 41 dead after two years (Hari, 2015).

In many respects HAT can be seen to relieve the strains on individuals that led to them using heroin in the first place and ameliorate levels of mistrust in significant institutions (Carson et al, 2008). The supervised injection practice associated with this method can be seen to create positive stimuli as people are treated with respect (Hari, 2015). Also, as the success rate of HAT is so high it can be seen to enable people to achieve positively valued goals (Agnew & White, 1992) such as sobriety (Please see figure 2 and figure 3). However, the main benefit of HAT is that it removes the need to commit crime to fund heroin habits (Bourgois, 2000). Despite all of the evidence demonstrating that HAT is an effective form of treatment, the current government has done little to engage with this method, despite it forming part of their drug policy (Cornelia, 2014; HM Govt, 2010).

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