Written evidence submitted by Professor Alex Stevens (DRU0014)

High time for harm reduction, again:
Submission to the 2022 Home Affairs Committee inquiry on drugs

1. I am Professor in Criminal Justice at the University of Kent. I am a former member of the ACMD (Advisory Council on the Misuse of Drugs, 2014 – 2019) and former President of the International Society for the Study of Drug Policy (2015 – 2019). I am currently a member of the scientific committee of Drug Science and a trustee of Harm Reduction International. I also served as special adviser to the 2019 inquiry of the Health and Social Care Committee on drug policy. I provided oral evidence to the Scottish Affairs Committee for its 2019 inquiry on problem drug use in Scotland.

2. I have researched and written extensively on the issues covered by the current inquiry. In this response to the request of the Home Affairs Select Committee for evidence on drugs, I summarise the available evidence under each of the questions posed by the committee, with references to my own and other research.

3. If the committee would like to know more – or receive copies of the referenced documents – please do contact me.

The UK drug framework

4. The current framework is based on two laws (the Misuse of Drugs Act 1971 [MDA] and the Psychoactive Substances Act 2016 [PSA]) and a series of drug strategies, dating back to 1995 (HM Government 1995), and most recently updated in the new government drug strategy for 2021 to 2031 (HM Government 2021).

5. There is an aspect of the UK's approach that has been effective in the past and widely copied abroad. This is the provision of harm reduction services to limit the spread and harm of blood-borne viruses (including HIV and Hepatitis C). Harm reduction recognises that harms can be reduced, even if drug use continues (HRI 2022; Newcombe 1987; Southwell et al. 2019).

6. The UK was an early adopted of this approach, which was initially developed on Merseyside (Ashton and Seymour 2010), and then spread nationally after the government accepted the ACMD's (1988) advice on *AIDS and Drugs Misuse*. This led to the UK having internationally low rates of HIV and Hepatitis C among people who inject drugs.

7. The classic harm reduction interventions are the provision of sterile equipment via needle and syringe programmes, and the engagement of people who use heroin into opioid agonist therapy (including the prescription of methadone, buprenorphine, or heroin itself). More recently, harm reduction interventions have developed to include provision of naloxone (the antidote to opioid overdose), safe spaces to use drugs (known as drug consumption rooms, or overdose prevention sites), and drug checking services which enable people who use drugs to get information about their contents, in order to make safer decisions.

8. Over the years, the emphasis on harm reduction in UK policy declined as the priority placed on crime reduction and abstinent recovery increased (MacGregor 2017). Now that we face an ongoing public health crisis of opioid-related deaths (Kimber et al. 2019), it is once again 'high time for harm reduction' (Newcombe 1987).

- *How effective is the UK drug framework in today's society? This may consider:*
    - *its effectiveness in dealing with drug use and addiction*;

9. The overall framework has not been effective in meeting the stated aims of reducing illicit drug use and related harms. Reported drug use among people aged 16-59 has been stable for the last 25 years, with about 10% of this age group reporting any illicit drug use in the past year (ONS 2020). Among younger people, there is evidence of increasing use since 2013/14 (NHS Digital 2019).

10. The best estimate of the scale of addiction that we have is the estimate of the number of people in England who have used heroin or crack in the past month. The number of these people fell as the 'heroin epidemic' of the 1980s and 90s ended (Morgan 2014). But it has also been fairly stable for about a decade, at about 300,000 people (Black 2021; Hay, Santos, and Swithenbank 2017).

- *its effectiveness in preventing drug related deaths;*

11. The current framework has failed to prevent substantial increases in drug-related deaths in all four countries of the UK since 2012. This is despite the work of the ACMD (2016b) in producing a report on *Reducing Opioid-Related Deaths in the UK*. The main recommendation of this report was to maintain investment in opioid agonist therapy of optimal dosage and duration. Instead, this funding was substantially cut (Black 2021).

- *its effectiveness in deterring drug related offending;*

12. There is little evidence that arresting suppliers or seizing drugs reduces drug availability or related offending (Eggins et al. 2020).

13. Treatment – especially opioid agonist therapy, including heroin assisted treatment – can be very effective in reducing offending by people who have problems with drugs (Egli et al. 2009; Smart and Reuter 2021; Stevens 2011). However, since 2010, funding for these forms of treatment has been cut.

- *drugs classification under the Misuse of Drugs Act 1971*

14. No reform to the MDA classification system has been made since a previous parliamentary committee found that the government was '*Making a Hash of It*' (House of Commons Science and Technology Committee 2006). This committee 'found no convincing evidence for the deterrent effect' of drug classification.

15. There is still little relationship between the classification of drugs under the MDA and scientists' views on the harmfulness of controlled substances (van Amsterdam et al. 2010; Nutt, King, and Phillips 2010).

16. When the ACMD recommends tighter classification of substances, this is usually accepted. But when it recommends lower classification, it is usually ignored; a process known as the 'drug policy ratchet' because it only turns one way (Stevens and Measham 2014).

17. For example, the latest ACMD recommendations are that cannabis should be in class C (ACMD 2008a) and that MDMA should be in class B (ACMD 2008c). They are currently in classes B and A respectively.

- *what (if any) impact the Psychoactive Substances Act 2016 has had since it came into force.*

18. When the Psychoactive Substances Act was still a Bill, some colleagues and I predicted that it would probably succeed in closing high street retailers of novel psychoactive substances (NPS), but the trade would move underground, with harmful effects for marginalised groups (which include people in prison and who are homeless) (Stevens et al. 2015).

19. Open retail of NPS did reduce (Home Office 2018a). But harms related to NPS have indeed been concentrated in prisons and homeless people (Gooch and Treadwell 2020; Ralphs et al. 2021). Deaths related to NPS continued to rise (Deen et al. 2021).

- *Does the current framework, or a particular aspect of the framework, need to be reformed?*

20. The whole framework needs to be reformed (Stevens 2011). There is no good, scientific reason why the regulation of substances that are currently controlled under the MDA and PSA should be separate from the regulation of other potentially harmful psychoactive substances (e.g. alcohol and tobacco).

21. A particular aspect of the current framework that needs reform is the ongoing criminalisation of people for possessing drugs for personal use. This imposes significant harms on people, e.g. criminal records and punishments. It continues the harmful stigmatisation of people who use drugs and discourages honest conversations about drug use.

22. Such offences are also the reason given for the majority of stop and searches, which are highly disproportionately targeted on people who are racialised as Black (Akintoye, Stevens, and Ali in press).

23. Both the Health and Social Care Committee (2019) and the Scottish Affairs Committee (2019) have recommended decriminalisation, as has the ACMD (see below). The government has rejected these recommendations, despite the fact that there is little evidence that removing criminalisation for possession increases drug use or harms (Gabri et al. 2022; Hughes, Matias, and Griffiths 2018; Stevens 2019; Stevens, Hughes, et al. 2022).

- *If so, how?*

24. The last inquiry on drugs by the Home Affairs Committee (2012) recommended the establishment of a Royal Commission. This could review the regulation of all psychoactive substances (including tobacco and alcohol), with deliberation informed by the research evidence, practitioners, people who use drugs and their families, to produce a more coherent and effective approach.

25. Such a commission would need to be insulated from influence from companies who stand to gain from policy changes for alcohol, tobacco and other drugs. Such influence can tilt policy making towards decisions which harm public health (McCambridge, Hawkins, and Holden 2014; Rotering and Apollonio 2022; Venkataraman and Nutt 2018).

26. Decriminalisation of simple drug possession (for personal use with no intent to supply) could be achieved simply by repealing section 5, subsections 1 and 2 of the MDA (Stevens, Eastwood, and Douse in press).

27. This would also have the advantage of reducing the ineffective and institutionally racist use of stop and search on members of Black communities.

28. It would not reduce the ability of the police to intervene in drug supply, as supply and possession with intent to supply would remain as criminal offences. It would not necessarily lead to increases in drug use, as there is little evidence that drug use depends on the harshness of punishment (as acknowledged by the Home Office, 2014).

29. The ACMD made a similar recommendation for decriminalisation of possession in its 2016 report on *Interactions and relationships between the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016* (ACMD 2016a). It recommended repealing the part of the MDA that makes it a criminal offence to possess controlled drugs in order to align it with the PSA, which does not criminalise possession (outside custodial settings). This report remains unpublished, despite the ACMD's code of practice including a presumption of openness (ACMD 2008b).

30. Short of decriminalisation, minor changes to the Misuse of Drugs Regulations 2001 could be made in order to make it easier to run overdose prevention services (e.g. by specifying who can possess drugs in the operation of such services without committing an offence) and expand access to the benefits of cannabis-based medical products (e.g. by moving them from schedule 2 to schedule 4ii, see Stevens, 2018).

31. Greater use could be made of diversion schemes which reduce the use of punishment and increase the use of education and treatment (see below).

- *Could reform align with the UK's international obligations under the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol; the Convention on Psychotropic Substances of 1971; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988?*

32. Yes. Decriminalisation of drug possession would meet the recommendation of the coordinating body of the United Nations that member states should 'promote alternatives to conviction and punishment in appropriate cases, *including the decriminalization of drug possession for personal use'* (UNCEBC, 2019, italics added).

33. Harm reduction is entirely in keeping with the letter and spirit of the UN drug conventions, which are designed to reduce harms associated with the non-medical use of controlled substances. UN bodies including the UNODC, UNAIDS and the World Health Organisation promote the use of harm reduction internationally (WHO, UNODC, and UNAIDS 2012). UN bodies also support the active

involvement of people who use drugs in the development of effective responses (UNODC et al. 2017), which is a crucial feature of contemporary harm reduction (HRI 2022).

34. The International Narcotics Control Board has recommended the Portuguese approach to decriminalisation as an example of 'best practice' (INCB 2015).

35. On drug consumption rooms, the INCB clarified its position in 2018. It stated that these services could be compatible with the international drug control regime, as long as they contributed to 'reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration measures' (INCB 2018). Evidence from other countries suggests that this is, indeed, what these services do.

- *Should a 'right to recovery' (the right of a person dependent on drugs to seek drug treatment and services) be legally enshrined in UK law?*

36. UK citizens who are usually resident in the UK already have a legal right to receive appropriate medical treatment under the Human Rights Act and the Public Sector Equality Duty. In 2006, a group of prisoners won access to opioid agonist therapy by suing the Home Office under existing legislation (Barrett 2006). This led to the development of the Integrated Drug Treatment System and the wider provision of OAT in prison, which was effective in saving lives (Marsden et al. 2017).

37. If a further right is to be enshrined in law, it should include access to those treatments that have been found to be most effective in reducing crime and deaths (including OAT and HAT), as well as respecting the individual and clinical decisions of patients and medical professionals. A priority for funding should be the UK-wide adoption of the Scottish drug deaths taskforce's minimum standards for medication assisted treatment (SDDTF 2021), as well as expanding the health, welfare and employment support that people need in order to recover from drug problems.

UK drug policy

- *What are the trends and patterns in drug use across the four UK nations? Responses to this may speak to some or all of the nations.*

38. Data on this question can best be provided by the relevant public health bodies of each nation.

- *What is your view on the UK Government's 10-Year Drug Strategy for England and Wales, which was published in December 2021?*

39. I have responded more fully to this question with colleagues in an article in the *British Medical Journal* (Winstock, Eastwood, and Stevens 2021).

40. The new strategy provide much-needed investment in drug treatment services. The promise of better coordination and management of drug treatment and recovery services is welcome. The review, however, pays too little attention to the role of harm reduction services – including heroin assisted treatment and drug consumption rooms – in responding to the ongoing public health crisis of drug-related deaths.

41. The new strategy is also limited by the failure to consider alternative legal frameworks for dealing with psychoactive substances. And it contains unevidenced proposals to punish recreational drug users and people from whom treatment does not succeed. These proposal are likely to be both unethical and ineffective (Stevens 2012).

- *Are there particular policies at national or local level across the four UK nations that have been effective in reducing:*
    - *drug use,*

42. Opioid agonist therapy (and particularly heroin assisted treatment) is effective in reducing use of illicit street heroin when large enough doses are prescribed (Mattick et al. 2008, 2009, 2014; Strang et al. 2015; Uchtenhagen 2008).

43. Efforts to prevent wider patterns of drug use have less evidence of having effect. Those programmes that have been shown to be effective in some studies (e.g. whole school and life-skills approaches) have not been implemented at scale in the UK (ACMD Recovery Committee 2015).

44. A word of warning: there is very little evidence that mass media campaigns work in reducing drug use. Some of them may actually increase willingness to take drugs (Erceg-Hurn 2008). And some interventions with young people (e.g. Drug Abuse Resistance Education) may also have counter-productive effects (Caputi and McLellan 2016; Rosenbaum 2007).

- *drug related deaths*

45. See the recommendations of the ACMD (2016) report on *Reducing Opioid-Related Deaths in the UK* which remain valid. These include:

- Investing in opioid agonist treatment of optimal dosage and duration.
- Support effective measures to help people achieve sustained abstinence. This will require a wide range of support, including treatment, housing, welfare and employment support (Black 2021).
- Integrate people with drug problems into the full range of physical and mental health services; another recommendation that is also supported by the Black report.
- Ensuring the widespread provision of naloxone. Since 2016, an intra-nasal preparation has been licensed. This should be made available over-the-counter and regularly carried by first responders, including the police (Lowder et al. 2020). Police use of naloxone is now being trialled in the West Midlands, and rolled out nationally in Scotland.
- Considering the opening of safer drug consumption facilities in places with a high concentration of injecting drug use. The operation of such an overdose prevention service in Glasgow in 2020/21 shows that it is possible to run such a service, despite the objections of Home Office ministers (Shorter et al. In press).
- Provide central funding for heroin assisted treatment. HAT is cost-effective, but is more expensive than other forms of OAT (Byford et al. 2013). Local commissioners need help from central government to ensure its provision in the places that need it most.
- Improving the recording of drug-related deaths.
- Invest in research on the causes of the rise in drug-related deaths, and how to reduce them; another recommendation repeated by the Black (2021) review.

- Reduce the socio-economic deprivation which the ACMD has repeatedly found to be a contributing factor for drug-related deaths (ACMD 2000).

46. More recently, the ACMD (2019) reported on reducing drug-related harms that occur in the transition between custody and community. This report noted the value of providing OAT in prison in reducing the elevated rate of death on release (Degenhardt et al. 2014; Farrell and Marsden 2008; Marsden et al. 2017). The ACMD made recommendations on reducing such harms, including reducing the use of imprisonment (e.g. via short sentences and recalls) for people who use drugs.

47. More recently still, the Scottish government's drugs deaths taskforce published minimum standards for medication assisted treatment, which also focus on optimising access, choice, dosage and duration of OAT (SDDTF 2021). These standards should be adopted across the UK.

- *drug related offending?*

48. The most effective means of reducing drug-related offending is to include people into effective treatment and social support services that help them to stabilise and then recover from drug problems. This can be highly cost-effective (Black 2021; NTA 2012).

49. Between 2009 and 2012, people in drug treatment had similar, lower levels of offending following either community or residential treatment, but residential treatment was estimated to be five times more expensive to provide overall (DWP 2015).

50. Treatment – both in the community and in residential settings - is both more effective and cost-effective than imprisonment (Matrix Knowledge Group 2007).

51. Diverting people from punishment to education and treatment can also be more effective and cost-effective than the usual process of arrest and charge (Neyroud and Slothower 2013; Stevens, Hughes, et al. 2022; Weir, Routledge, and Kilili 2021). The successful UK trials mirrors positive evaluations of diversion schemes in reducing re-offending in the USA (Collins, Lonczak, and Clifasefi 2019; Davis et al. 2021). Diversion schemes are supported by both the Commission on Race and Ethnic Disparities and the new government drug strategy (CRED 2021; HM Government 2021).

52. However, the effectiveness of treatment should not be used to override ethical requirements that treatment must be based on informed consent (Stevens 2012). There is also a danger of limiting (or even reversing) the effect of diversion in reducing costs and harms of punishment by net-widening and mesh-thinning (i.e. increasing the number of people drawn into the criminal justice system, and increasing the obligations placed upon them) (Cohen 1985; Stevens 2011).

The impact of drug use in the UK

- *What is the impact of drug use? In particular, on:*
  - *drug users and their loved ones;*

53. For most people who use drugs, this does not lead to harms to them or their families. The reason that most people take drugs is that they find them pleasurable and enjoyable. However, for some people who use drugs, this can lead to severe harms, including the exacerbation of mental health problems, injection-related infections, dependence, multiple morbidities and death. This obviously

has devastating consequences for the families. These harms are heavily concentrated in our most deprived communities (NRS 2021; ONS 2021).

- *local communities and wider society;*

54. There are places (especially in Scottish cities, south Wales, the north of England and some deprived coastal towns) that are heavily affected by problematic drug use; including by high levels of morbidity, mortality and drug-related offending.

55. Some communities are also heavily affected by activities related to drug supply. However, the common assumptions that drug markets are inherently violent and that much youth violence is directly related to drug markets is not borne out by the evidence in every community (Irwin-Rogers, Muthoo, and Billingham 2020). In particular, the role of county lines in spreading drug use and violence needs closer scrutiny (Spicer 2020). For example, recreational drug use should not be blamed for exploitation and violence in county lines drug distribution. This is because much recreational drug use involved cannabis, MDMA and powder cocaine, while '[t]he current county lines business model remains heavily weighted towards the supply of heroin and crack cocaine' (NCLCC 2021).

56. There is also a danger of exaggerating the contribution that drug use makes to levels of crime (Stevens 2007, 2008, 2011). For example, the new drug strategy makes much of the claim that half of murders are drug-related. This is a questionable extrapolation from an estimate that in half of all murders, either the victim or the perpetrator was known to be involved in using or dealing drugs (Home Office 2018b). This does not prove causation. By the same logic, it could be argued that 100% of murders are water-related. The recently published Homicide Index suggested that the perpetrator had been taking an illicit drugs in only 6% of killings, a much lower level than the 18% in which the killer had been drinking alcohol (ONS 2022).

57. People who are racialised as Black face harms due to over-policing, often in the form of stop-and-search for drugs. The most sophisticated study yet done shows that this cannot be explained by underlying patterns of offending, but can be attributed to the targeting of police resources and to 'officer bias' (Vomfell and Stewart 2021). These harms are especially acute in London, which has high rates of stop and search, and where a large proportion of Black Britons live.

58. There are also places (e.g. the City of London, the Palace of Westminster) where illicit drug use occurs but are not heavily affected by negative consequences (including policing and criminalisation).

- *the economy.*

59. The illicit drug economy forms the majority of illicit global cash flows, accounting for about 3% of global GDP in 2009 (UNODC 2011). The UK market for illicit drugs is estimated to be over £9 billion per year (Black 2020). Billions of drug-related money are laundered through UK financial markets every year, with even more flowing through lightly regulated banks in UK dependencies and overseas territories (HM Treasury 2020). UK banks – including HSBC and NatWest – have faced large fines for such money laundering. This undermines the reputation of the UK banking system, while also boosting the profitability of the banks involved.

60. There is also an economic impact from more mundane forms of crime. The British Retail Consortium estimates losses to business of £900 millionper year from fraud and shoplifting, much of which is committed in order to fund dependent drug use. This has an impact on costs of business and prices charged by retailers, who spend over a billion pounds per year on security measures (BRC 2020).

61. Some economic costs are self-imposed. If the government returned to the plan stated by David Gauke in his time as Minister of Justice to reduce the use of short prison sentences (many of which are for the kind of repetitive acquisitive offending of which a large proportion is done by people with drug problems), then there would be less need to spend £4 billion on expanding the prison estate. This spending is unlikely to produce returns, given the lack of evidence that imprisonment reduces re-offending (Loeffler and Nagin 2022), even when prisoners go through the kind of psychological programmes that are provided in British prisons (Beaudry et al. 2021).

International comparisons

62. Internationally, alternative frameworks for dealing with simple drug possession can be classified as follows (Stevens et al. 2021):

- Depenalisation: the *de facto* removal of punishments for drug possession based on police or prosecutorial discretion, while the offence of possession remains in law.
- Diversion: referring people caught in possession of drugs away from punishment towards educative or therapeutic interventions. This can be either *de facto* or *de jure*.
- Decriminalisation: the *de jure* removal of the criminal offence of possession from the law.

63. With colleagues, I have provided reviews of the international evidence on these alternatives to criminalisation, including in a report for the Irish government (Hughes et al., 2019; Stevens, Hughes, et al., 2022). In short: these alternatives can reduce the costs and harms of drug use and control while also assisting people who need it to access treatment, but this depends on local contexts and processes of implementation.

64. For further discussion of issues in designing such alternatives - including aims, eligibility and drug quantity thresholds for decriminalisation - using international evidence, see my recent commentary with Greer et al. (2022).

65. There are also a variety of alternative frameworks for regulating the supply of drugs. This is not just a two-sided choice between strict prohibition and free-market legalisation (Kilmer 2019; Rolles 2009).

66. For a review of recent research on the public health effects of cannabis legalisation in the USA, see the preprint by Anderson and Rees (2021). In summary, they find little evidence of increased use of cannabis among teenagers in those states that have legalised cannabis for either medical or recreational use. It is too early to draw strong conclusions on the effects of legalising cannabis for recreational use, as these reforms have been too recent to yet enable robust evidence to emerge.

- *Are there laws, policies or approaches adopted in other countries that have been effective in reducing:*
    - *drug use*

67. Much reference is made to the success of Iceland in prevention youth drug use through a range of activities, known as the Iceland Prevention Model. However, caution should be taken in applying lessons from Iceland (a very small country which is a long way from major drug supply routes) to the UK (Koning et al. 2020).

68. The Netherlands has a remarkable record in reducing harms related to heroin use, including the most dangerous mode of drug use, which is by injection. Very low proportions of people who use heroin in the Netherlands now do so by injection. The reason for this is not fully understood, but is likely to include a long-standing commitment to harm reduction (including easy access to drug treatment, provision of drug checking services and drug consumption rooms, relatively high purity of heroin making it more attractive to smoke rather than inject, a reduction in the use of prison, and the cultural influence of migrant communities with low levels of drug use by injection). Over a long period of using harm reduction (including social support) the Netherlands has seen reduction in initiation to heroin use and sustained reductions in HIV and HCV infections and deaths (van Santen et al. 2021).

- *drug related deaths,*

69. The UK has been successful in the recent past in reducing drug-related deaths. After the 2000 ACMD report on this subject, and with the combined intention of reducing crime and improving health, there was major investment in expanding opioid agonist therapy in England between 2000 and 2008. By 2008, this was estimated to be saving approximately 880 lives per year (Pierce et al. 2016).

70. Other countries that have seen dramatic reductions in deaths following expansion of OAT include the Netherlands, Spain, Switzerland and Portugal.

71. The Swiss example combined the provision of high quality OAT – including HAT – alongside drug consumption rooms and high quality health and social care in response to a perceived public health emergency (Kübler 2001).

72. The Portuguese model also included decriminalisation of the possession of drugs alongside the expansion of public health and social welfare measures. This was followed by a dramatic reduction in drug-related deaths and HIV infections (Hughes & Stevens, 2010; Rêgo et al., 2021).

73. Thirteen countries, including Canada and Australia, also provide officially sanctioned drug consumption rooms (HRI 2020). This number now also include the USA, where two officially sanctioned sites in New York City have joined the unsanctioned service that has operated successfully at an undisclosed location for several years (Kral et al. 2020).

74. It is difficult to design research that can demonstrate the effect of such services on deaths (Pardo, Caulkins, and Kilmer 2018). And they are designed to target local issues, not to be provided nationwide. However, they can produce localised reductions in deaths (Milloy et al. 2008).

75. Other potentially life-saving services that are provided in the UK, but only minimally used in the UK, include drug checking. This has a long history in several European countries (EMCDDA 2001). It involves people at nightclubs or festivals being able to get a sample of drugs they intend to use tested to see if it is what they think it is. A recent review of such services in 15 countries showed that

people who find out that their drug contains unexpected substances can change their behaviour, by not using it, by using less of it, or by seeking more information before use (Maghsoudi et al. 2022). Where such services have been provided in the UK – by the charity The Loop – many people who get unexpected results ask for these drugs to be destroyed (Measham 2018).

- *drug related offending?*

76. Again, the UK itself provides an example of successful reduction in drug-related crime. A Home Office study has suggested that reductions in street heroin use – partly achieved by enrolling people in treatment – played a significant role in the crime drop that occurred from 1995 (Morgan 2014).

77. Studies in several countries have shown that opioid agonist therapy (OAT) reduces offending (Egli et al. 2009). Heroin assisted treatment (HAT) is particularly effective in reducing offending among people for whom other forms of OAT do not work. This effect has been demonstrated across studies from the UK, Canada, Switzerland, Germany, Belgium, Spain and the Netherlands (Smart and Reuter 2021). Smart and Reuter note, '[w]hile HAT is more expensive than oral methadone, several studies conclude that HAT has a larger benefit–cost ratio, primarily because HAT more reliably and substantially reduces participants' levels of criminal activity'.

78. International evidence is much weaker on the effect of arresting drug suppliers and seizing drugs in reducing offending (Eggins et al. 2020).

- *If so, could they reasonably be expected to work in the UK?*

79. Such measures *have already worked* in the UK in the recent past. The expansion in treatment and harm reduction that took place in the 2000s was effective in reducing both deaths and offending. The next stage – to help people move on to the forms of recovery that they want to achieve – was hampered by the funding cuts of the 2010s (Black 2021; Stevens 2011), which also reduced the effectiveness of treatment services in saving lives (Lewer et al. 2021). Renewed investment in harm reduction (especially high quality OAT and HAT) would save lives, cut crime and support recovery.

80. These benefits could be enhanced (and made more equitable, especially for Black communities) if we also decriminalised simple drug possession and adopted harm reduction services that have been successful elsewhere (e.g. drug checking and overdose prevention services) in the parts of the UK that need them most (i.e. Scottish cities, northern England, south Wales, some coastal towns, and especially Blackpool).

81. The Home Office will argue that decriminalisation 'sends the wrong message' and that there is no legal basis for overdose prevention sites. Both these arguments are baseless. The Home Offices' own research has shown the lack of a link between the harshness of penalties for drugs offences and levels of drug use and related harms (Home Office 2014). The argument that more liberal, evidence-informed drug policies increase drug use is not supported by the international evidence on depenalisation, diversion or decriminalisation (Stevens, Hughes, et al. 2022).

82. There is no British law which explicitly prohibits the running of drug consumption rooms or overdose prevention sites. Offences under the current Misuse of Drugs Act (e.g. drug possession) would occur in such a service. This can be dealt with either by establishing an agreement with local police and prosecutors that it is not in the public interest to arrest and charge people for such

offences (as currently occurs for needle and syringe programmes), or by informally ignoring these offences, as occurred during the operation of the unsanctioned overdose prevention service in Glasgow in 2020/21 (Shorter et al. in press). It could be facilitated by making changes to the Misuse of Drugs Regulations 2001, which would not require primary legislation.

83. A final note on recovery: there is no need for there to be a conflict between supporting harm reduction and recovery. Both are based on an ethic of compassion and respect for the human dignity and choices of people who use drugs to live the lives that they want to lead. Harm reduction does not encourage, increase or prolong drug use, other than by extending the lives of people who use drugs. In the midst of a public health crisis of drug-related deaths, it is vital that we invest in harm reduction services to save lives. But we must also invest in the other services – including welfare, health, housing and employment – that help people recover from drug problems.

84. To conclude, the main barrier to reducing harms associated with drug use in the UK is not a lack of knowledge. Since both the Westminster and Scottish governments have announced extra funding for drug treatment, it is now not lack of resources. It is the lack of political willingness to do what the evidence from our own and other countries tells us is effective in reducing these harms.

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