TRANSFORM
Drug Policy Foundation

Submission to the Scottish Parliament Criminal Justice Committee Drugs Roundtable 2021

Introduction

Transform Drug Policy Foundation[1] is a UK based organisation that operates nationally and internationally, advising and supporting governments, national and local bodies, including holding ECOSOC Special Consultative Status at the UN. We seek a world where drug policy promotes health, protects the vulnerable and puts safety first.

Drugs and crime

Investment in treatment and harm reduction is cost effective with substantial savings to the criminal justice system. But the links between drugs and crime are complex. Some crimes are fuelled by intoxication (particularly alcohol), while others are directly linked to the prohibited status of production, supply and possession of certain drugs under the Misuse of Drugs Act (MDA) 1971. Possession of drugs for personal use is the largest proportion of such offences. 13.5% of the Scottish population report illegal drug use[2]. If lifetime use is considered, around 1 in 4 Scots have committed what remains in law a serious imprisonable offence. There are also less frequently committed, but more severely punishable offences of drug production, trafficking and supply of drugs under the MDA.

There is also a much larger volume of illegal *drug-related* crime. This includes violence and child exploitation associated with the organised crime groups involved in illegal drug markets. There is also a substantial volume of offending associated with people with problematic drug use fundraising to buy drugs - mostly acquisitive property crime or fraud. Yet there is no mass criminalisation of use, and far lower levels of offending related to production and supply or fundraising to buy legal drugs including alcohol and tobacco, or drugs supplied on prescription, emphasising the role of the MDA in fuelling the drug related burden on the criminal justice system. As the evidence pack accompanying Dame Carol Black's review[3] makes clear, this is not a problem enforcement against supply can solve either. In 2003 the Prime Minister's Strategy Unit estimated that removing organised criminals from the drug trade would require consistent seizure rates of 60-80%.[4] In Scotland estimated heroin seizures were around 1% of the supply 2000-06.[5] Seizures are an affordable cost of business, far less than legal tax rates and product losses (supermarkets waste 2% of food, fresh fish retailers 5% of products[6]).

Levels of offending and prison drug use

There were 31,000 drug offences recorded by Police Scotland in 2017-18[7], with 12,000 proceeded against in court[8]. Of these ~4000 were supply offences and 27,171 for drug possession - 22% Class A (of which 2700 were for cocaine, and 2200 heroin); 57.5% were Class B (mainly cannabis); 846 people were sent to prison. Transform research shows from 1997- 2019 there were 139,000 convictions for offences under the MDA in Scotland, with 22,000 sentenced to immediate custody.

Research shows 15% of prisoners said they committed their offence to get money for drugs, and 36% said their drug use was a problem before going into prison. 39% of prisoners reported that they had used illegal drugs in prison, 13% of these said they had started using while in prison.[9] So it is unsurprising that outcomes for people who use drugs sent to prison are poor. While improved services in prisons, and on release, are desirable, a better approach would be to dramatically reduce or stop sending people with drug problems to prison. Prison is a punitive response to problems created by our punitive drug enforcement model. We need to break this cycle; in the short term, other more cost-effective approaches are available that reduce reoffending and deliver better health and social outcomes. In the longer term we need to reform laws that criminalise people who use drugs and drive them into offending behaviours.

In short, attempting to tackle what is primarily an issue of public health - reducing drugs related harms, and addressing problematic use - using primarily criminal justice tools has proved disastrous, with

catastrophic health and criminal justice outcomes. Evidence from the 50 years since the MDA 1971 was passed, and the overwhelming body of expert opinion, point towards a long overdue recalibration of drugs policy away from failed punitive enforcement, towards a public health led approach proven to be cost effective on key health *and* criminal justice metrics. Achieving the much needed changes will require reforms at local, Scottish and UK Government scales. Several key areas are touched on below.

1. Diversion / decriminalisation

"*The Checkpoint Diversion Programme in Durham...seems to me a wholly laudable project*." Kit Malthouse, UK Police Minister, 2019

Criminalisation of people who use drugs creates a major resource burden across the criminal justice system, despite a lack of evidence that it achieves its core purpose of deterring use. In 2014 the Home Office compared approaches around the world, concluding there was no 'obvious relationship between the toughness of a country's enforcement against drug possession, and levels of drug use in that country'.[10] The UK 2016 Drugs Strategy evaluation also noted 'a lack of robust evidence as to whether capture and punishment serves as a deterrent for drug use'.[11] This confirmed research by the Advisory Council on the Misuse of Drugs[12], the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[13], and the World Health Organization, which found 'countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones'.[14] There is, however, strong evidence that criminalisation does increase high risk drug using behaviours, creates obstacles to effective health interventions, housing and employment prospects, while disproportionately impacting on the life chances of vulnerable and marginalised individuals, increasing the risk of future problematic drug use.[15] That is why reducing the burden of criminalisation for people who use drugs has found increasingly widespread support. For example, drug-offence diversion schemes have been recommended by Dame Carol Black's review of Drugs for the UK Government,[16] the Advisory Council on the Misuse of Drugs, and UK Parliamentary Scottish Affairs and Health Select Committees to name just a few.

Diversion can guide people to a treatment assessment, drug education courses, support or treatment, without harming life chances with a criminal record. This can be post-arrest, involving deferred prosecution, or preferably pre-arrest. Some UK police diversion schemes, such as Bristol and Durham, include certain low level supply offences. Evidence from the UK and globally (see Drug Diversion in the UK[17]) shows that drug offence diversion schemes have a wide range of benefits:

- Preventing crime by reducing reoffending
- Reducing costs to police forces, freeing police to spend more time in communities
- Improving the physical and mental health of those diverted
- Improving the social and employment circumstances of those diverted
- Potentially reducing racial disparities in the criminal justice system
- Reducing some high-risk drug use through engagement with drug services

Despite recent comments from some Ministers with regard to Diversion in Scotland, it already has strong UK Government support. Diversion is a key element (one of the 'D's) in the UK Government's ADDER program[18], the Durham 'Checkpoint' scheme won plaudits from Policing Minister Kit Malthouse to the Scottish Affairs Committee[19] and was referenced in the Scottish Conservatives 2018 Drug Strategy.[20] Over a dozen English and Welsh Police Authorities (with Conservative, Labour, and Plaid Police and Crime Commissioners) have diversion schemes with the number growing rapidly.[21]

The operationalisation of diversion schemes, however, remains uneven across the UK, and police discretion to arrest or charge could be exercised in an arbitrary or discriminatory fashion within areas as well. More comprehensive *de jure* decriminalisation - removal of the offence of possession for personal use from the MDA (diversion schemes can at best, be a form of *de-facto* decriminalisation) could

address these concerns. This wider approach is backed by the Royal Society for Public Health, Faculty of Public Health, the Royal College of Physicians,[22] and on the international stage all 31 UN agencies, including the World Health Organisation, UN human rights entities, and the UN Office on Drugs and Crime.[23] Around 30 jurisdictions have decriminalised the possession for personal use of some or all drugs. Transform reviewed the beneficial long term outcomes of the most well-known example - Portugal - for the 20th anniversary of the policy's implementation in May 2021, fact checked by the Portuguese Government's drugs agency.[24]

Calls for decriminalisation approaches often also stress the need to expunge past criminal records.[25] Some decriminalisation models also include low level production and supply offences - such as not-for-profit supply within peer networks, or cultivation of cannabis or other drug plants for personal use (which can have an additional benefit of eroding illegal market profits).

2. Heroin Assisted Treatment (HAT)

Other submissions will no doubt focus on the well-established health and social benefits of HAT for the 10% of people dependent on heroin for whom other treatments do not work. So we will just note that studies[26] looking at long term impacts, found that after 6 years, over half of HAT clients were no longer being prescribed heroin. Both those still in the programme, and those who had left it, had maintained their reductions in illegal drugs use, and illegal income, with sustained improvements in most social variables. These positive outcomes have been widely reproduced, including in all UK trials and reviews by the Cochrane Collaboration[27] and the European Monitoring Centre for Drugs and Drug Addiction[28] (EMCDDA). We will briefly address the criminal justice benefits.

Reducing Illegal Heroin Use and Organised Crime Income

In Switzerland, research[29] suggests that the 10-15% of people eligible for HAT were using 30-60% of all illegal heroin. This is in line with other drug use patterns e.g. the 4% heaviest drinkers in the UK provide 23% of alcohol industry revenue, and the 25% heaviest some 68% of revenue.[30] Taking this very high-using segment of their customer base away from organised criminals could significantly reduce their income, and related harms from the drugs market, with commensurate benefits to communities. All HAT projects show substantial reductions in street heroin use with many patients completely or almost abstinent. In the UK RIOTT trials[31] patients went from spending on average over £300 a week on illegal drugs to under £50 a week at 6 months. For the 40 people on the RIOTT trial being prescribed heroin, total spend fell from £14k a week to £2k per week. So if replicated, 50 people in HAT (the number planned longer term for Glasgow's clinic) could reduce illegal drug revenue by £780k per year. If Scotland introduced HAT at the levels in Switzerland (where ~6% of the heroin-using population is in HAT) the impact on the illegal heroin market, and money flowing to organised crime could be really significant. Take-home HAT (as several hundred people already receive in the UK) should also be expanded where appropriate as a more cost-effective way to expand the programme. The Swiss research cited above concluded: '*It seems likely that users who were admitted to the program accounted for a substantial proportion of consumption of illicit heroin, and that removing them from the illicit market has damaged the market's viability*.'

Reducing Acquisitive Crime

Reducing use of illegal drugs reduces the pressure to commit crime to pay for them. For example, the 40 people prescribed heroin in the RIOTT trials[32] were committing 1731 self-reported crimes in the 30 days prior to entering treatment. After 6 months, this fell to 547 crimes per month - a two-thirds reduction. A substantial number became 'crime-abstinent'. Evaluation of the Middlesbrough clinic outcomes also suggested pronounced crime reduction effects. A Rand report[33] said of one UK project area: "*Initially, the police thought that a whole cohort of criminals had either died or migrated away from the area because there were people they had seen on a very regular basis – apprehending them for crimes – and suddenly they weren't on the police radar at all. Because the heroin-assisted treatment was so effective for them in reducing their criminal activity to fund their habit.*"

Reducing initiation of new heroin users

In Swiss trials, 43% of patients entering HAT sold drugs to finance their own use. This fell to 6% after 12 months. "*The [heroin market] workers no longer sold drugs to existing users, and equally important, no longer recruited new users into the market. The heroin prescription market may thus have had a significant impact on heroin markets in Switzerland.*" Following a shift to a more health-led approach including HAT, the number of new people using heroin in the Zurich area fell from 850 per year to 150[34], and the population of problematic heroin users declined by 4% a year.

Reducing Cocaine use

A significant proportion of people who use crack are also dependent on heroin. HAT provides an opportunity to address both their heroin and crack use at the same time. Prior to entering the UK RIOTT trials, around three quarters of clients were using crack, while at 6 months this proportion had reduced, as had the amount used. In Switzerland, research found only 15% of new HAT clients had not used crack/cocaine in the previous six months; but the proportion of non-cocaine users increased progressively to 28% six months after admission, 35% after 12 months, and 41% after 18 months. Middlesbrough's HAT clinic found clients who were using crack reduced their use, with other illegal drug use also falling. Long term studies on HAT[35] in Germany also found a rapid decline in cocaine use. Dr Thilo Beck, who runs Swiss HAT clinics explains how this works: '*HAT is a very effective way to get a population that is otherwise difficult to reach into regular treatment. Once in treatment...marked psycho-bio-social stabilisation occurs. In this context reduction/better control of use of other substances like cocaine is frequently seen*.'

Cost-effectiveness

Numerous studies have shown HAT to be cost-effective - as the EMCDDA review says - "HAT saves money". Higher costs per client relative to standard opiate substitution therapy are more than matched by savings across health, criminal justice and other services unachievable with other treatments.

3. Overdose Prevention Centres (Supervised Injection Facilities)

There is a substantial body of evidence from across the globe, drawing on decades of experience in 12 countries, and now approaching 200 such facilities that we can provide the Committee with regarding the effectiveness of OPCs. But for concision we will point to two papers. Firstly, the UK Government's own Public Health England March 2019 briefing: "What is the current evidence for the efficacy of drug consumption rooms?"[36] which says:

- *"Local police gained a mechanism to address public injection drug use in a way that promotes public safety.*
- *Crime rates have not increased in areas where DCRs operate.*
- *Areas where DCRs are operating have had reductions in public drug consumption and publicly discarded drug-related litter, e.g. syringes.*
- *Ambulance call-outs for overdoses are generally reduced in the vicinity of a DCR.*
- *Research has found consistent evidence of effectiveness of drug consumption rooms (DCRs) in reducing harms associated with drug use, particularly high-risk injection behaviours. Provision of sterile equipment to reduce infection transmission is a core function.*
- *DCRs have contributed to lower rates of fatal overdoses.*
- *DCRs have been used to provide people who use drugs with education on safer drug use, access to medical services and referrals to other health and social care services."*

Secondly, research[37] showing that 230 'death events' (range 160-350) were averted in 20 months by Overdose Prevention Centres in British Columbia (facing a similar crisis to Scotland) and more when assessed as part of a coordinated set of interventions including OST, Naloxone provision and HAT.

For more references, or information contact Martin Powell martin@transformdrugs.org 07875679301

[1] Staff from Transform Drug Policy Foundation https://transformdrugs.org/ and families from the Transform project Anyone's Child https://anyoneschild.org/ are available to provide further evidence on request.

[2] The illegal drugs included in the Scottish Crime and Justice survey includes poppers and solvents which are not criminalised under the Misuse of Drugs Act.

[3] Dame Carol Black, UK Home Office 2020, 'Review of drugs: phase one report' https://www.gov.uk/government/publications/review-of-drugs-phase-one-report

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[16] Dame Carol Black (2021), UK Home Office 'Review of Drugs Phase 2' https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

[17] Transform Drug Policy Foundation, 'Drug Diversion in the UK' https://transformdrugs.org/drug-policy/uk-drug-policy/diversion-schemes

[18] UK Govt Press release: £148 million to cut drugs crime https://www.gov.uk/government/news/148-million-to-cut-drugs-crime

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[20] Full Scottish Conservatives Drug Strategy 2018 available on request. Press release https://www.scottishconservatives.com/2018/11/scottish-conservatives-unveil-new-strategy-to-reduce-drug-deaths/

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