Release and Transform's Submission to Treasury Committee Enquiry on Government's coronavirus financial package

Release[i] and Transform[ii] are both charities working on issues that impact people who use drugs, including those who are drug dependent and those in treatment for this condition. This briefing has also been informed by clinical leads and experts from the drug treatment sector including Change Grow Live and Humankind. This submission is also supported by Harm Reduction International and Recovering Justice.

We understand that the priority for the Treasury Committee is to reduce, as far as is possible, the impact of COVID-19 on the community at large, and to 'flatten the curve' of infections to prevent the healthcare system from being overwhelmed. Protecting those who use drugs is vital for this wider effort to protect society as a whole. We urge the Committee to understand that a failure to increase support and adapt policy to help people who use drugs problematically will disproportionately impact on healthcare capacity nationwide. The vast majority of the 320,000 people who are drug dependent are liable to be more vulnerable to both infection and the worst impacts of the virus. Failure to protect this group will lead to vastly increased pressure on the NHS that costs far more both financially, and in lives lost, than the investment in treatment and the other support suggested in this document would.

Recommendations

1. **People who are dependent on drugs, including alcohol, must be categorised as one of the high-risk populations for COVID-19. Failure to protect the 320,000 people dependent on drugs, most with underlying health issues, will lead to vastly increased pressure on the NHS.**

2. **The coronavirus is expected to lead to an unprecedented increase in demand for drug treatment services. Funding for this area should be increased dramatically to address the needs of some of the most marginalised and vulnerable in society, and reduce the numbers infected with COVID-19.**

3. **Treatment providers will also have to implement prescription and other procedures that operate outside of existing guidelines to reduce social contact and protect the lives of staff and people who use drugs. This approach needs to be supported by Government and relevant agencies.**

4. **The Mayor of London is moving towards securing hotel rooms across the capital for this population of people, funding should be provided to other cities and towns to implement the same approach. This should include accommodation for those not ready or able to stop using drugs.**

5. **We understand that there will be a national prescription delivery service for the vulnerable who are 'shielded'. The delivery of controlled drugs, such as methadone and buprenorphine, must be included in medications that can be delivered.**

6. **Systems must be put in place to ensure that there continues to be an adequate supply of harm reduction supplies, including sterile injecting equipment, that is flexible in the way it is dispensed to ensure social distancing rules are observed.**

7. **Funding must be in place to ensure a significant supply of naloxone (an anti-overdose medication) is available for people who use opiates, particularly if fentanyl enters the market if the heroin supply is constrained.**

8. **Funding should be made available to drug treatment providers to ensure they can fund innovative approaches, including peer outreach programmes, mobile services, and exploring the possibility of using existing and new premises to dispense equipment and medication, including OST (i.e. methadone or buprenorphine) and naloxone.**

9. **All initial conditionality for claiming sickness benefits, including the limited capability for work/work-related activity (LCW/LCWRA) component of Universal Credit (UC), should be suspended for 12 months – this should also apply to work related benefits.**

10. **All social security tribunals should be suspended, and appellants who are currently in receipt of reduced benefit payments as they await the outcome of their appeals, should be switched to full entitlement for 12 months.**

11. **Suspension of eviction proceedings for tenants should be extended beyond the current 3 months and should have an indefinite hold on place. This measure should also apply to those who are already subject to existing possession proceedings. Local authorities should be provided with additional funds for Discretionary Housing Payments to support those with a shortfall in rent.**

12. **There should be a de-prioritisation in drug supply enforcement in order to protect people and to prevent more harmful substances entering the drugs market. Police forces should immediately end the stop and search, and arrest of people who use drugs to focus on more urgent issues related to COVID-19.**

13. **It is imperative that, as other countries have done, prisoners are released where feasible and where there is no risk to society. Funding will be necessary to transition people back into the community, as well as ensuring wraparound services, in particular relating to those who have a history of drug dependency.**

14. Funding for mental health services is crucial, additional resources must be provided to allow for remote counselling services, including phone appointments, especially in light of the deleterious effect the crisis is having on people's mental well-being.

Introduction

Those who have a history of injecting drug use and problematic consumption often suffer from underlying health conditions. This is also a population that has been suffering a public health crisis for the past few years as we have seen drug related deaths soar, they are now the highest on record[iii] for the seventh year in a row and the UK accounts for one in three drug related deaths in Europe[iv]. If action is not taken urgently, including a significant upscaling in funding, there is a serious risk of death amongst this population as well as a possible outbreak in blood borne viruses, including HIV and Hepatitis C, during and post COVID-19.

We understand that Government is under significant pressure at the moment, however this is a large group of vulnerable people (estimated figures are in the region of 300,000) who are often left behind by public policies with negative consequences, if their needs are not addressed in this crisis the consequences will be dire for the population as a whole. As always, investing in drug treatment will offer not only health gains but economic ones. If community drug and alcohol services are not shored up then the impact will be more people having to use acute services – putting even more strain on this system, which it cannot cope with at the moment and must be protected from. In addition, alcohol shortages are already happening, this could leave people who are dependent in withdrawal – this is a significant concern in the sector, especially in light of the risk of death due to withdrawal. We cannot stress how concerned the sector is about this issue and this is one reason why funding must be scaled up as a matter of urgency.

There is also concern about the unregulated supply of drugs within the UK. With the imposition of travel bans and border closures it is likely we will see a drying up of the availability of illicit drugs and an increase in prices. These shortages could lead to: displacement to prescription opioids and other pain killers such as the gabapentinoids (which increase the risk of overdose) and people shifting intentionally or not to other more harmful substances, including fentanyl (this substitution to other drugs has been observed in previous heroin 'droughts' in both the UK and Australia[v]. Now that fentanyl is established as a supplement to the international heroin market, the dangers of such substitution are much greater); increased adulteration of drugs; the price of street methadone and buprenorphine is likely to increase; and there will be increased demand on treatment services who have suffered significant funding cuts over the last ten years. Displacement to alcohol for those dependent upon opioids will increase overdose risk, while dependent drinkers short of funds will be at risk of untreated alcohol withdrawal.

In 2016, the Advisory Council on the Misuse of Drugs noted the need to invest in opiate substitution treatment of optimal dosage and duration in order to reverse the rising tide of drug-related deaths[vi].

We have outlined below the funding needs in this area, as well as some structural issues in the delivery of harm reduction interventions and drug treatment which must be urgently addressed, if it is not it will have a direct impact on acute hospital services placing more strain on the NHS (as such we will be sharing this submission with the Department of Health and Home Office).

To reiterate, many of the measures below will not only reduce drug related mortality and other harms, but also significantly reduce COVID-19 infection rates amongst people who use drugs that would otherwise further build pressure on the NHS and increase infection rates across wider society.

1. Funding for drug and alcohol treatment providers

Local authorities became responsible for funding and commissioning drug and alcohol services (hereon in 'drug treatment services') under the Health and Social Care Act 2012, while facing an estimated 37.3 per cent reduction in central government funding between 2010/11 and 2015/16[vii]. As a result, "drug misuse treatment" faced more reductions in funding than any other public health area in 2016/17 with a 14 per cent reduction in funding between 2015/16 and 2016/17[viii]. Net expenditure on adult drug and alcohol services has decreased by 19 per cent in real terms between 2014/15 and 2018/19.[ix]

Drug treatment providers across the country have moved quickly to ensure that people on methadone and buprenorphine are moved from daily supervised consumption to prescriptions that allow them to collect their medication, or to nominate family and friends to do so. This has been a herculean task for the providers, who have taken extraordinary measures in an extraordinary time, but more needs to be done to support them in this work. The current level of funding for drug treatment services is wholly inadequate, especially at this critical time. Guidance issued last week by PHE on "COVID-19 for hostel or day centre providers of services for people experiencing rough sleeping"[x] advised on the need for service providers to ensure "sufficient treatment capacity is available if people look for withdrawal support or substitute prescribing alternative to using illicit drugs". There is simply not enough money within the drug treatment sector to ensure that all those who need access to services will get support. A particular group who have suffered due to cuts are women, as specific services to meet their needs are now rarely provided. This is especially important for those who are fleeing domestic violence, who will have difficulty engaging in mixed services. There are real concerns that there will be increased incidences of DV during a time where women are forced to remain at home with abusive partners – anecdotally, advocates in some areas of the country have already seen an increase in applications for Domestic Violence Protection Orders. Women who use drugs are at risk of exploitation and coercion around their

substances, and if the predicted increase in DV occurs, the need for women-specific drug services will be even greater.

The 4 per cent increase in public health funding announced in last week's budget is not sufficient, it does not even cover the losses of the last ten years and there is no guarantee that this money will even go to drug treatment services. The reality is that if there is a shortage of drugs, including heroin, crack cocaine and other substances, these services will have to deal with tens of thousands of new clients [please see section 4 for numbers] and there simply are not the resources to do this effectively. Without the necessary funding, people will be put at risk.

We would therefore ask the Committee to make **a specific recommendation that funding for this area is increased dramatically** to address the needs of some of the most marginalised and vulnerable in society and to reduce the demands on the acute NHS services. A recent London-based study[xi] found that of 455 respondents who injected drugs, 137 had been admitted to hospital for a skin and soft tissue infection, and of 206 who reported that they received care for such conditions, 72 per cent advised that A&E was their primary point of contact. Every effort must be taken to reduce pressure on the NHS acute services, and this is why funding for drug and alcohol treatment is crucial.

2. Housing provision for those who are street homeless and access to drug treatment services

We welcome Government's announcement to requisition hotels and other accommodation for people who are homeless and who are showing symptoms of the virus. This does not go far enough, there is an urgent need to house everyone who is living on the streets (this is an especially acute problem in seaside towns like Blackpool and Penzance). This population are obviously at an increased risk of contracting the coronavirus, and again as a population with weak immune systems are vulnerable to the most serious consequences of COVID-19. We note the Mayor of London is moving towards securing hotel rooms across the capital for this population of people, **we ask that funding is provided to other cities and towns** to implement the same approach. There is a high level of problematic drug use amongst people who are homeless. In 2018, 40 per cent of deaths of people who were homeless were as a result of drug poisoning (this was an increase of 55 per cent on the previous year compared to a 16 per cent increase within the general population)[xii] [xiii].

Additionally, with fewer private places to use drugs, as guidance on social distancing and closure of venues is followed, this community will be forced to use in more public spaces. More public injecting in particular will lead to increased needle litter on the streets and expose people to unsanitary, high risk conditions for injecting drug use.

Ensuring that this community are housed will prevent this added nuisance of littering and some of the accompanying personal and community risks from street use. It must also be recognised that many of the individuals requiring accommodation are not ready or able to

stop using drugs at this time. So, as with programmes like Housing First, and some hostels, there should be an explicit acceptance that people will continue to use drugs within their new accommodation. To reduce the risks involved, and to make the most of an opportunity to engage with this group, appropriate treatment, harm reduction and other support services, as well as naloxone provision should be provided as soon as possible.

For more on access to harm reduction services and access to a safe supply of substitute medication – please refer to section 4 & 5.

3. People who are dependent on drugs and alcohol must be categorised as one of the high risk populations for COVID-19

As noted, this is a vulnerable population with comorbid conditions, there are high rates of respiratory illnesses such as COPD amongst people who are have dependency issues. The majority of this cohort suffer from impaired immunity due to a variety of different factors including nutritional status, general lifestyle, and from the immunosuppressive effects of opiates, this places them in the high-risk category for the Coronavirus. As such, it is imperative that people who are dependent on drugs and alcohol are recognised and categorised as a high risk group for COVID-19 – this is currently not the case and immediate action needs to be taken. We would be grateful if the Treasury Committee could make recommendations to this effect. We understand that this is not a budgeting issue and will be sharing this submission with the Health and Social Care Select Committee as well.

4. Safe supply of prescribed medication to those not currently in treatment

With borders across the world shutting down, there will undoubtedly be an impact on the supply of unregulated substances. Whilst it may be counterintuitive to think this is a worrying development, this will be an extremely frightening time for those who are dependent on these substances. The vast majority of people who are dependent on drugs have suffered adverse childhood experiences, often physical or sexual violence, or suffer from mental health conditions. The use of drugs such as crack cocaine and heroin is a form of self-medication to relieve their emotional suffering. One concern within the field is that the heroin market could be replaced by fentanyl or associated derivatives, which are significantly less bulky to import, with smaller quantities of the drug needed for consumption, hence reaching a greater number of people. The overdose crisis in the US and Canada has largely been driven by the fentanyl market and has resulted in significant loss of life. Scotland already has a drug related death rate that is comparable to these countries and some parts of England are not far behind even without fentanyl on the market. If this substance does start to enter the supply chain, it could catastrophic.

We are also concerned there will be increased used of adulterants, some potentially harmful to the person using them, due to dwindling supplies of drugs coming into the country. If this

happens the drug related death crisis we are currently witnessing will increase exponentially[xiv]. As such, we need to ensure that treatment services are supported to get more people into treatment, with rapid prescribing of medications such as buprenorphine. There are currently an estimated 313,971 people who are dependent on opiates and/or crack cocaine[xv], however in 2016/17 there were only 199,339 people in treatment[xvi]. The level of upscaling for treatment providers will be unprecedented, if they are to meet the needs of new treatment presentations, and they must be supported financially to undertake this mammoth task. They will also have to implement procedures for these clients, that operate outside of existing guidelines, whereby new presentations will not be subject to the level of drug testing previously seen and supervised consumption will not be undertaken in order to reduce social contact and protect the lives of people who use drugs. This approach needs to be supported by Government and relevant agencies.

National funding needs to be made available immediately to ensure services can respond and to avoid more needless deaths as well as an increase in serious health harms, such as BBVs. In respect of BBVs it is important that drug treatment providers continue to provide testing and treatment of Hepatitis C, as this is one of the major drivers for death amongst the population we work with, but this will require new ways of delivery and the need for flexibility, which can only be achieved with proper funding.

5. **Access to medications for the treatment of drug dependency.**

We understand that there will be a national prescription delivery service for those who are 'shielded', many of this population will be people who on medication assisted treatment (MAT). It is therefore imperative that the delivery of controlled drugs, such as methadone and buprenorphine, are included in medications that can be delivered. There should also be an urgency to move to electronic prescriptions for controlled drugs used in the treatment of drug dependency.

6. **The provision of harm reduction equipment including sterile injecting equipment and access to naloxone**

The scaling up of harm reduction equipment to people who inject drugs was largely achieved under the Thatcher government to tackle the AIDs crisis in the 1980s. People who inject drugs are at a greater risk of contracting HIV, with UNAIDS estimating that the risk is 22 times greater for this group in society than the general population[xvii]. One significant concern at the moment is that much of the supply of such equipment is through community pharmacies who are already stretched to capacity, and who might end this provision in the coming days and weeks. This will place people at risk of sharing injecting equipment and, therefore, create a real possibility that we could witness an increase in BBVs, including HIV. We have already witnessed an outbreak of HIV in Glasgow in the last few years amongst the population of

people who inject drugs in that city[xviii]. The rate of Hepatitis C amongst people who inject drugs is also extremely high, with over 50 per cent estimated to have the virus. As such, we must ensure that there continues to be supply of such equipment, and we will have to be flexible in the way it is dispensed to ensure social distancing rules are observed.

In addition, we need support to ensure a significant supply of naloxone is available for people who use opiates. Naloxone is an anti-overdose medication that effectively save lives, and the provision of this medication is affected by the same issues related to the supply of harm reduction equipment: if fentanyl does hit the market, naloxone will be one of the first lines of defence in protecting lives. We are also concerned that there will be increased risk of overdose due to stockpiling of drugs and medications, as well as an increase in adulterated drugs due to decreasing supplies. As we have seen with groceries, where people fear there may be restricted supply in future, some will buy excessive amounts now. This will increase the risk that they take too much, either forgetting how much they have already taken, or because they normally restrict their use by buying in smaller quantities to manage and reduce the temptation to increase their intake. Naloxone should be made available to all emergency responders, including the police.

Funding should be made available to drug treatment providers to ensure they can fund innovative approaches, including peer outreach programmes, mobile services, and exploring the possibility of using existing and new premises to dispense equipment and medication, including opioid MAT and naloxone. Responsive harm reduction advice will not only have to be developed for people who use drugs but for suppliers of drugs, as drugs are often transported in unhygienic ways including hiding small quantities in bodily orifices. This work has started but more support is required to expand the reach of the advice being given.

7. Access to benefits and suspension of social security tribunals

Release provides legal representation to people with a history of drug and alcohol use, including for welfare benefit matters. Whilst we welcome the decision by the Department of Work and Pensions to suspend face-to-face assessments, **we would also ask for consideration to be given to remove all initial conditionality for claiming sickness benefits, including the limited capability for work/work-related activity (LCW/LCWRA) component of Universal Credit (UC), for 12 months**, for those making a claim to Employment and Support Allowance, or the LCW/LCWRA element of UC, who would usually be expected to provide a fit note from their GP to establish their initial entitlement to benefits, and submit renewed certificates at least until a Work Capability Assessment (WCA) has been carried out. These requirements would place a greater strain on the NHS, which it simply cannot cope with at this time. There would be no additional financial burden on the state in awarding LCW without a Doctor's note, as for new claimants the amount of benefit is the same as the basic UC payment.

We welcome the Chancellor's decision to abolish the 7 day waiting period before entitlement to UC begins so that people will be paid from their date of claim, but more needs to be done. Payments should be released as soon as possible, and the five week wait for payment of UC should be abolished by moving away from payments being made in arrears. Existing HMRC systems to check income and capital can be used to speed up the process. Whilst advanced payments can be requested, these tend to be insufficient to last 5 weeks, and are then recovered at a high rate from future payments. If the delay in payment cannot be reduced, advance payments must be increased, and recovery of the loans suspended for 12 months before being repaid at a low affordable rate.

Conditionality for continued entitlement to benefits should also be suspended, and no sanctions applied. For job seekers, it will simply not be possible for them to proactively seek work when there is significant unemployment, large-scale closure of businesses, and a policy of social distancing in place.

These proposals would provide a safety net for everyone, and in particular those who rely on income from activities such as sex work and begging which have reduced due to increased social distancing. Providing financial support will reduce the likelihood of people having to engage in such illegal activities to support themselves, which would place further strain on public services.

Additionally, whilst we welcome the decision not to hold in person tribunal hearings, and the recent Pilot Practice Direction for Contingency Arrangements in the First-tier Tribunal, we are concerned that this will create injustice for our clients. Paper hearings are insufficient to determine these sorts of cases. Whilst we always provide detailed written submissions and supporting evidence, how clients present in person has a significant impact – the decision notices we get frequently refer to the cogency of oral evidence received by the claimant at the hearing. Remote hearings go some way to addressing this but are not without their problems. Phone hearings may be possible, but many of our clients do not have telephones or, if they do, frequently don't answer them or struggle to communicate in this way due to mental health issues. Similarly, very few would have access to technology for a video-link hearing. In other circumstances, they could perhaps attend our office or their treatment service were technology may be available. However, in line with guidance many services have closed or at least restricted access – as discussed elsewhere in this document – certainly at Release all staff are working from home and the office will not be open until the advice changes. Clients also comment on how supported they feel having the representative with them – this will be absent if they are expected to engage with a hearing in isolation away from their adviser and any other support workers that may normally attend a hearing with them.

At Release we have six hearings listed between now and the end of April and many of the clients we are representing have specific underlying health conditions placing them in a higher risk category according to government guidance. Prior to the Practice Direction being issued, we had begun requesting postponements on this basis, and despite that risk being removed, we will continue to pursue these applications in the interests of justice. Many of these clients

are on a reduced benefit rate whilst they await the outcome of those hearings. Consideration must also be given to the fact that due to the lack of legal aid for these appeals, representation is provided pro bono by charitable organisations like ours, who will be facing additional pressures as a result of staff being sick or self-isolating, and financial worries as income streams are affected. We therefore urge that a decision to suspend cases is implemented immediately and all of those who are in receipt of a reduced rate are passported onto full benefit entitlement for 12 months. Given that three quarters of appeals are successful, not including those that then go on to be successful at the Upper Tribunal, it is fair to proceed on the presumption of payment. This would not be indefinite, as claimants would be subject to the normal provisions for review of awards.

8. Housing and rent issues

We welcome Government's announcement that landlords will not be able to start proceedings to evict tenants for at least a 3 month period, though this is not long enough, and look forward to reviewing the emergency legislation, however this does not go far enough either. Additional measures must also be introduced to protect those who are already subject to possession proceedings, which may be due to be concluded before new laws are passed. Calling for landlords to be 'compassionate' is insufficient.

Steps must also be taken to ensure that tenants do not accrue rent arrears during this period which will lead to a wave of possession proceedings once the ban ends. One way to do this is to provide local authorities with additional funds to allow them to distribute Discretionary Housing Payment awards where there is a rent shortfall. Where a shortfall has been created by application of the benefit cap, consideration should also be given to lifting the cap temporarily.

9. Monitoring the supply of the drugs market and enforcement approaches

Whilst once again it may be counterintuitive to the Committee, de-prioritisation of supply side enforcement may help in retaining some stability in the drugs market, and could possibly reduce the risk of more harmful substances like the novel synthetic opioids such as fentanyl, as well as increased use of harmful adulterants for drugs used recreationally, such as MDMA. We would therefore recommend that police resources are focused away from drug supply interdiction and towards supporting efforts to tackle the coronavirus. This would go some way to reducing risks to vulnerable users and may help to protect their lives.

In addition, police forces should immediately end criminalising people who use drugs. In the last five days, Release has continued to hear reports of young people being arrested for cannabis possession – this should not be a priority at any time but even more so given the critical situation at the moment. This is not a radical suggestion – several forces have implemented street diversion schemes for possession offences. This does not result in a rise

in consumption of drugs[xix] and the current legislation for novel psychoactive substances (Psychoactive Substances Act 2016) does not criminalise possession except for in custodial settings. Formal guidelines could be developed by the National Police Chiefs Council and would be consistent with advice on dealing for drug possession provided by the World Health Organisation, the United Nations, the Advisory Council on the Misuse of Drugs, the Royal Society for Public Health, and other leading authorities on the matter of drugs. For example, The United Nations Chief Executives Board for Coordination, representing 31 UN agencies including the World Health Organisation, the UNODC, UNICEF and UHOHCHR recently stated its unanimous support for member states to 'promote alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use' and to 'call for changes in laws, policies and practices that threaten the health and human rights of people'[xx]. Decriminalisation is now also the editorial position of the Lancet, and the British Medical Journal, and the policy of the Royal Society for Public Health[xxi], the Royal College of Physicians[xxii], and the British Medical Association. Decriminalisation of some or all drugs is now established policy in more than 25 countries[xxiii]. Useful guidance on best practice has been assembled by the Global Commission on Drug Policy[xxiv].

It is imperative that the drugs market is monitored to assess new trends and new drugs if we are to be able to provide a rapid response to emerging health and social problems. It is especially important that providers of drug treatment and other services are aware of changes in the supply of illicit drugs (and especially opiates) so that they can respond speedily in order to save lives. Many of us in the drugs field are coming together to gather information from the ground but it would useful if a formal network was established through Public Health England, and their counterparts in the devolved regions, to ensure information was being shared and responses are developed. **Funding for this work would be welcomed, especially in light of the fact that Government's "Report Illicit Drug Reactions" dashboard closed earlier this year.** It is also important that the National Crime Agency shares such data (including form monitoring of cryptomarket sales) with drug treatment providers and public health agencies. We will also share this briefing with the Home Affairs Select Committee to ensure they are informed about our concerns in this area.

10. Prisons and COVID-19

The UK Prison Estate is already over capacity and acutely under stress. There are already reported cases of prisoners having the coronavirus[xxv] and hundreds of prison staff self-isolating[xxvi]. Given the overcrowded and unhygienic conditions in our prisons, regularly reported by the Chief Inspector, the advice being offered by PHE is impossible to follow. A major outbreak of the disease is therefore almost certain within our incarcerated population. Given the poor physical and mental health of prisoners overall, coupled with high levels of illicit substance misuse and an ageing population, the effects of the virus in terms of death and serious illness are likely to be profound. Prisoner's access to outside NHS facilities is

already difficult and will get much worse. Medical facilities within prisons are unlikely to be able to cope.

One of the risks in such a scenario is the likelihood of prisoners self-medicating with easily available illicit drugs, many of which in themselves can cause respiratory complications regardless of the added risk of the coronavirus. Clear advice on these risks should already be going out in individual establishments as well as close monitoring of illicit drugs finding their way into prisons.

As well as these obvious health risks there are the added risks of unrest and increased violence within the prison estate, as prisoners become more anxious and frustrated by the current crisis and staff shortages exacerbate the ability of the prison service to offer reasonable regimes, access to visits as well as routine security measures. This is already unfolding in prisons abroad. We should also note that these comments apply not only to prisons but to all places of detention, especially immigration removal centres.

It is imperative that, as other countries have done, prisoners are released where it is feasible to do so and where the risk is acceptable. A high proportion of prisoners are incarcerated for non-violent drug offences and acquisitive crime to fundraise to buy drugs. In 2018, 59,000 people were sent to prison in England and Wales, 69 per cent had committed a non-violent offence and 46 per cent were sentenced to six months or less[xxvii]. Those convicted of drug offences make up approximately 15 per cent of the prison population[xxviii]. We would defer to experts working on prison reform and prisoners' rights about what category of people should be released.

Some suggestions include: all non-violent drug offences, those who have been sentenced to less than 12 months in prison; and all those on remand for non-violent offences, especially women for whom this is the biggest category. We would also urge greater use of existing powers for early release such as Home Detention Curfew. Existing guidelines on the use of bail should also be strictly enforced and consideration given to making those guidelines more flexible. When prisoners do need to go to outside hospital, prisons will need to be more flexible on the use of staff escorts, while again still protecting the public. We would also recommend ending prison recalls due to the high risk of the virus being brought in from community settings.

Funding will be even more important to transition people back into the community, as well as ensuring wrap around services are still functioning, in particular those who have a history of drug dependency. Those who are released on OST must be provided with take-away prescriptions, this is an extremely high risk population for overdose. Take Home Naloxone (THN) is already available for those leaving prisons but in the current crisis it is essential that the policy be strictly adhered to, especially if any plans for executive release are implemented. Extra funding will be needed both for prisons to provide medication and naloxone, and for community treatment providers to take on further clients from this population.

For those remaining in prison, the need to have even greater access to harm reduction and interventions, including access to OST, is essential, as is the provision of staff to deliver them, as prison officers will be severely stretched. Any reduction to essential or 'minimum' regimes should ensure that such support is not seen as anything other than essential.

11. Mental health services

There may be an increased risk of suicide during this time of crisis, and people who use drugs are particularly vulnerable to intentional overdose. Many engage with counselling services through their treatment services, which may cease as a result of reduced access to physical sites. During this time, additional resources must be provided to allow for remote counselling services, including phone appointments.

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[i] Release is the national centre of expertise on drugs and drugs law.
[ii] Transform is dedicated to reducing the risks associated with drugs, promoting evidence-based policy, and improving the lives of those harmed by ineffective drug laws.
[iii] In 2018, there were 4,359 overdose deaths registered in England and Wales. (Source: ONS, 2019)
[iv] http://www.emcdda.europa.eu/publications/topic-overviews/content/faq-drug-overdose-deaths-in-europe_en
[v] ACMD (2016) https://www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk; Degenhardt et al (2006) https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-1-11
[vi] ACMD (2016) https://www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk
[vii] National Audit Office (2014) The impact of funding reductions on local authorities, Local government report by the Comptroller and Auditor General
[viii] ACMD (2017) Commissioning impact on drug treatment.
[ix] The Health Foundation (2018) Briefing: Taking our health for granted.
[x] https://www.gov.uk/government/publications/covid-19-guidance-on-services-for-people-experiencing-rough-sleeping/covid-19-guidance-for-hostel-or-day-centre-providers-of-services-for-people-experiencing-rough-sleeping
[xi] Harris, M., Scott, J., Hope, V., Wright, T., McGowan, C. & Ciccarone, D. (in press). Navigating environmental constraints to injection preparation: the use of saliva and other alternatives to sterile water among unstably housed PWID in London. *Harm Reduction Journal.*

[xii]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018
[xiii] https://www.gov.uk/government/publications/acmd-report-drug-related-harms-in-homeless-populations
[xiv] https://www.gov.uk/government/publications/misuse-of-fentanyl-and-fentanyl-analogues
[xv] https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations
[xvi]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/851815/Shooting_Up_2019_report.pdf
[xvii] https://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf
[xviii]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/851815/Shooting_Up_2019_report.pdf
[xix] https://journals.sagepub.com/doi/full/10.1177/1477370819887514
[xx] United Nations (2019), '*United Nations Chief Executives Board for Coordination - second regular session of 2018*', p. 14. Available at https://www.unsceb.org/CEBPublicFiles/CEB-2018-2-SoD.pdf
[xxi] RSPH (2016) '*Taking a New Line on Drugs'*, https://www.rsph.org.uk/about-us/news/stop-criminalising-drug-users.html
[xxii] RSPH (2018) *'Royal College of Physicians backs RSPH calls on drug reform'* https://www.rsph.org.uk/about-us/news/royal-college-of-physicians-backs-rsph-calls-on-drug-reform.html
[xxiii] Eastwood N, Fox E & Rosmarin A (2016), *'A Quiet Revolution: Drug Decriminalisation Across the Globe'* https://www.release.org.uk/publications/drug-decriminalisation-2016
[xxiv] Global Commission on Drugs Policy (2016), *'Advancing Drug Policy Reform: a new approach to decriminalization'* http://www.globalcommissionondrugs.org/wp-content/uploads/2016/11/GCDP-Report-2016-ENGLISH.pdf
[xxv] https://www.theguardian.com/world/2020/mar/18/first-uk-prisoner-with-covid-19-confirmed-at-strangeways-manchester
[xxvi] https://www.dailymail.co.uk/news/article-8137061/Almost-1-000-prison-officers-self-isolation-cell-searches-drug-tests-scrapped.html
[xxvii]http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Prison%20the%20facts%20Summer%202019.pdf
[xxviii] https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-january-to-march-2019