

New prospects for harm reduction in the UK? A commentary on harm reduction and the new UK drug strategy

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The UK's new drug strategy (HM Government, 2021) does not say a lot explicitly about harm reduction. It may offer some unexpected opportunities to recover some of the losses that Britain has made in harm reduction in the last two decades. It also has significant gaps, and may even increase harms done to people who use drugs by further criminalising them.

A strong history of harm reduction

As so often, if we want to understand the current conjuncture, we need to go back to the past; to the beginning of harm reduction in the UK, and subsequent developments. Harm reduction rose to prominence in British drug policy because of the HIV/AIDS epidemic of the 1980s, but it has a longer history than that. The central principle of harm reduction – that it is possible to reduce harms related to drug use while that use continues (Newcombe, 1987) – was built into British drug policy since the Rolleston committee of 1926 affirmed the practice of prescribing heroin to people who were dependent on it, in what came to be known as 'the British system' (Berridge, 2013).

When HIV/AIDS arrived in the UK, it hit hard in the places where mass unemployment and cheap, brown heroin had produced a cohort of 'new heroin users' (Pearson, 1987). On Merseyside, in the north-west of England, local public health professionals, treatment providers and probation officers learnt from international developments by gay AIDS activists and self-organisations of people who use drugs, such as the Rotterdam Junkiebond (Szakavitz, 2021). They developed the 'Mersey Model' of harm reduction (Ashton & Seymour, 2010). This spread to the rest of the country after the government accepted the view of the Advisory Council on the Misuse of Drugs (ACMD, 1988) that it was more important to limit the spread of the virus than to insist that people stop using heroin.

Despite – or even because of – its success in limiting the spread of HIV, harm reduction fell out of political fashion as the threat of AIDS receded. The New Labour government of 1997 to 2010 focused its rhetorical attention and funding on reducing drug-related crime (MacGregor, 2017; Stevens, 2011a). This brought additional money into the drug treatment sector, enabling a rapid expansion during the 2000s, led by the National Treatment Agency for Substance Misuse (known in the field as the NTA). By 2008, it was estimated that opioid agonist therapy was preventing about 880 fatal opioid overdoses per year (White et al., 2015).

This finding came too late to save opioid agonist therapy from a backlash which focused on the small proportion of patients who stopped using controlled drugs altogether (Ashton, 2008). First Scotland (in 2008) and then England (in 2010) published drug strategies which moved the focus on again to 'recovery' (the Welsh government maintained a focus on harm reduction). Some supporters of recovery repudiated harm reduction as a barrier to achieving abstinence (e.g. Gyngell, 2007). I have described elsewhere (Stevens & Zampini, 2018) how members of the medical establishment were able to absorb harm reduction into the practice of 'recovery-oriented treatment', while not succumbing to political calls to place arbitrary limits on access to opioid agonist therapy (Inter-

Ministerial Group on Drugs, 2012). Harm reduction practices like agonist therapy and needle and syringe programmes continued through the 2010s, but at diminished scale and quality, due to substantial cuts in local authority budgets (ACMD, 2016; Black, 2021).

Meanwhile, a range of new innovations in harm reduction have been developed in other countries. These include provision of naloxone via peers who use drugs and through over-the-counter sale. In at least 14 countries, it also included the establishment of safer injecting facilities, or overdose prevention sites, with New York and Athens being the most recent cities to host them (HRI, 2020). These services have not been officially sanctioned in the UK, despite an ongoing 'public health crisis' of drug-related deaths (Kimber et al., 2019), and the operation of an unsanctioned overdose prevention service in Glasgow in 2020/21 (Shorter et al., 2022).

So the new UK drug strategy was launched in a country with high need for harm reduction, and a strong tradition of providing it, but which has been lagging behind in recent years.

New opportunities for harm reduction

The term harm reduction is only used five times in the drug strategy document, and three of these are in sections contributed by the governments of Wales and Northern Ireland. Nevertheless, there are opportunities here for a revival and renewal of harm reduction in the UK. These come partly from the new money announced in the strategy, and also from the rhetorical and practical space that the strategy allows for local service commissioners to implement harm reduction services.

Financially, the strategy promised £533 million in new investment in drug treatment and recovery services in England over the next three years. This meets the first three years of the five-year plan laid out in the review led by Professor Dame Carol Black (2021) to reverse the deterioration of the British drug treatment system. For the financial year 2022/23, local councils in England have been allocated £85.7 million in addition to the ongoing public health grant, using a formula based on rates of drug-related deaths, estimated prevalence of opiates and crack use, socio-economic deprivation, and rates of crime (HM Government, 2022). By comparison, English local authorities reported budgeting a total of £413 million for adult drug treatment and prevention services in 2021/2022 (MHCLG, 2021). Blackpool, the town with the highest rate of drug-related death in England, has been allocated nearly £2 million, effectively doubling its drugs budget in one year.

There are strings attached. The new money comes with a revival of the managerial control that was exercised by the NTA until its demise in 2013. The initial aims of the NTA were to get more people into treatment and reducing waiting times. This was presented as being necessary to reduce drug-related offending, although it also met recommendations to invest in reducing drug-related deaths (ACMD, 2000). The new targets will include the prevention of drug-related deaths, as well as preventing crime. It is not yet clear how this will be measured. It will be easier to measure inputs, such as the promises of 51,000 new treatment places, rather than these outcomes. For example, we do not yet know what baseline or method will be used to measure progress on the promise to prevent 1,000 drug-related deaths per year. There were 2,996 drug-related deaths registered in England and Wales in 2020 (ONS, 2021). It would be ambitious and risky to promise to cut the absolute number of deaths by a thousand in three years, especially as developments in the market for powerful synthetic opioids are unpredictable. Another way of meeting this target might be to estimate how many deaths are being prevented by drug treatment, as [White et al. (2015) did for

the year 2008, with their estimate of about 880 lives saved. Reaching the target would then only require an increase of 120 on that estimate.

The strategy is deliberately expansive in describing the forms of treatment that will be funded. Alongside the focus on achieving more 'long-term recovery', the document calls for local areas to 'invest in a wide range of evidence-based interventions to meet the needs of their local population, focusing on reducing drug-related death rates and bringing more offenders into treatment'. This includes the 'full range of treatment and harm reduction interventions'.

The mingling of support for recovery and harm reduction is not smoothly done in the strategy document. The section on treatment in prisons, for example, focuses largely on 'zero tolerance' and the promotion of abstinence. But it also incorporates a few sentences on making long-acting buprenorphine and naloxone more available to prisoners. There is potential here for tension between the health agencies that are charged with delivering the drug strategy, and ministers like Dominic Raab (currently Minister of Justice and Deputy Prime Minister) who has called for treatment in prisons to use 'abstinence therapy' to 'get prisoners off drugs for good' (Raab, 2021). This call directly contradicts the strategy's promise to be 'evidence-based'. Continuing opioid agonist therapy for people in prison has been shown to protect them from dying on release (Marsden et al., 2017).

The wide range of services envisaged by the strategy, and the new money it brings, offer the opportunity to move beyond the repetitive and unproductive debate over whether abstinence recovery or harm reduction should be prioritised. Especially in those areas that have been put at the head of the queue for new funding, there may be space to invest in a truly integrated system which provides a continuity of care ranging from life-saving harm reduction measures to holistic support for recovery for those who want it. These prospects are boosted by the strategy's recognition – unlike some previous strategies (Stevens, 2011b) – that this wider support requires investment.

In other areas, the new money may not cover the cuts of the last few years. The public health grant to local authorities was cut by £0.8 billion between 2015/16 and 2020/21 (Black, 2021). There are also fears that the treatment sector may have been so depleted by a decade of austerity that it will struggle to invest the new money effectively. It is not only the treatment workforce that has been cut and deskilled. Local authorities have lost the staff who used to run the sector in their area when the NTA was in charge. Will they have the capacity to do the intelligence gathering, needs assessment and high quality commissioning that will be needed to make the new system work?

Ongoing gaps

The kinds of harm reduction that are explicitly supported by the strategy are those that have been institutionalised into British drug policy by members of the 'medico-penal constellation' of medical and social control agencies who are at the heart of policy making (Stevens & Zampini, 2018). There is continuity in the people as well as the ideas that lead policy on harm reduction, from the NTA, to its incorporation into Public Health England in 2013, and that organisation's replacement in 2021 by the Office for Health Improvement and Disparities (OHID). Many of the personnel have stayed in place as the institutional names and organigrams have changed. The use of the narrative that treatment cuts crime to justify investment in drug services is very familiar to them. It continues to risk stigmatising people who use drugs as inherently criminal, even if it is effective in the short term in reducing morbidity and mortality (Hunt & Stevens, 2004).

A very puzzling gap in the strategy is the almost complete absence of attention to blood-borne viruses, including HIV and Hepatitis C. As mentioned above, blood-borne viruses used to be a main driver of British drug policy. There has recently been an HIV outbreak related to injecting drug use in

Scotland (Trayner et al., 2020). The government is signed up to the international targets to eradicate HCV and HIV transmissions by 2030. The strategy does mention the importance of providing needle and syringe programmes, but gives no indication of how it will meet these targets for eradicating viral transmission between people who inject drugs.¹

Neither does the strategy mention the valuable role that heroin-assisted treatment (HAT) could play in reducing deaths and crime (Strang et al., 2015). There seems to be some doubt at the centre of government that the higher initial cost – compared to other forms of opioid agonist therapy – can be recouped, even if HAT is cost-effective overall (Byford et al., 2013). There is no support in the strategy for more innovative forms of enhanced harm reduction, such as overdose prevention services, provision of pipes to reduce harms related to crack-smoking, drug checking services at nightclubs and festivals, or the provision of naloxone through networks of peers.

It could be argued that this makes sense, given the strategy's ambition to make changes at scale and speed. OHID will need to demonstrate rapid returns on the substantial investment promised for the next three years if it wants the Treasury to continue this support in future spending reviews. It does not have time to go through the process of developing and evaluating new complex interventions (Skivington et al., 2021). And civil servants may not wish to raise the ire of Conservative ministers who have already declared that they will not support more ambitious forms of harm reduction – including the decriminalisation of drug possession – that have been supported by parliamentary groups and public health bodies. These include the Health and Social Care Committee (2019) and the Scottish Affairs Committee (2019) of the House of Commons, as well as the Royal Society of Public Health, the Faculty of Public Health and the Royal College of Physicians (2018). Organisations in the field continue to demand the ability to expand the evidence base by piloting new services.

Another important gap in the strategy is the absence of the voice of people who use drugs. Some people who use drugs have called for 'full decriminalisation' – which would extend to the provision of a safe, regulated supply (Madden et al., 2021). There was no public consultation in the formulation of the strategy, which was very much an internal, Whitehall-based process. The Black review which informed the strategy did include consultation with stakeholders in the field. However, these did not include people who actively use drugs or their representative groups. Professor Black was explicitly excluded by ministers from considering the role of drug legislation in producing harms, or how such harms could be reduced. The Home Affairs Committee of the House of Commons is now carrying out a wider review. It has not yet heard evidence in person from people who use drugs at its parliamentary sessions. The continued exclusion of people who use drugs from policy deliberations prevents drug policy from meeting more recent definitions of harm reduction, which include the important role of respecting the autonomy and democratic rights of the people who are most directly affected (HRI, 2022).

Counter-production of harm

While the drug strategy proclaims its ambition to reduce harm, it risks ramping up the harms that are done by the criminal justice system. The chapter on 'breaking the chains of drug supply' includes a raft of measures that sound tough, but have little evidence that they will do any better than the similar measures announced in previous strategies aimed at cutting supply. The possibility that such measures produce 'criminogenic' harm by incentivising violence in the illicit drug market is not considered (Bowling, 2010).

¹ A few days after the drug strategy was published, the Department of Health and Social Care did publish a plan for reducing HIV infections, including expanding the delivery of pre-exposure prophylaxis in drug and alcohol services (DHSC, 2021).

The strategy's version of diversion schemes also risk backfiring by producing an increase in punishment. Diversion is usually seen as a way of reducing the use of criminal justice sanctions and increasing the support given to people who have drug problems (Monaghan, 2022; Stevens et al., 2022). In the drug strategy, however, diversion has been rebranded as 'tough consequences'. These will be 'rolled out at scale'. As it stands, many people who are caught in possession of drugs – of whom the majority are carrying cannabis - receive an out-of-court disposal that involves no sanction or requirement (Shaw et al., 2022), such as an on-street warning. The strategy promises that first time possession offenders will be required to attend drug awareness courses, and will face punishment for non-compliance or further offences. When community sentence treatment requirements were invented in 1998, in the form of the drug treatment and testing order, the idea was that they would be used as alternatives to imprisonment (Stevens, 2011a). The new strategy states that offences which meet the threshold for a custodial sentence will still result in imprisonment. So treatment orders will be used for people who would otherwise have received a less intrusive community sentence. 'Recreational' drug users will also face 'tougher consequences which will be felt more strongly than today'. These examples of 'net-widening', 'mesh-thinning' (Cohen, 1985) and up-tariffing may increase the scale and intensity of coercive control of people who use drugs.

Conclusion

There is huge appetite in the British drug treatment sector and drug policy reform movement to see more rapid development of harm reduction services in the UK. This would match the country's history of developing harm reduction to curb the previous public health crisis of HIV/AIDS. We could expand and innovate in harm reduction to address the current public health crisis of drug-related deaths. The new drug strategy provides money and some political space to reverse some of the damage that has been done to harm reduction services in the years of austerity. This is largely thanks to the Black review's revival of the NTA's argument that drug treatment cuts crime. Significant gaps remain in the development of British harm reduction services. Much will depend on the capacity of local services to innovate while meeting the demands for centrally managed performance that will come with the new money. Wider debates about the role of drug laws in influencing harms, and of people who use drugs in making drug policy, will continue.

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