**Analysis of the UK Government’s 10-Year Drugs Strategy – a resource for practitioners and policymakers**

Dr Adam Holland, Honorary Research Fellow, Bristol Medical School, University of Bristol, BS8 2BN, UK

Prof Alex Stevens, Professor, School of Social policy, Sociology and Social Research, University of Kent, CT2 7NZ

Dr Magdalena Harris, Associate Professor, Department of Public Health, Environments and Society, London School of Hygiene & Tropical Medicine, WC1E 7HT, UK

Dr Dan Lewer, Public Health Specialty Registrar, Department of Epidemiology and Public Health, University College London, WC1E 6BT, UK

Prof Harry Sumnall, Professor, Public Health Institute, Liverpool John Moores University, L3 5UX, UK

Mr Daniel Stewart, Public Health Specialty Registrar, Bristol Medical School, University of Bristol, BS8 2BN, UK

Prof Eilish Gilvarry, Honorary Professor, Population Health Sciences Institute, Faculty of Medical Sciences, Newcastle University, NE1 7RU, UK

Ms Alice Wiseman, Alcohol and Drugs Lead, Association of Directors of Public Health, EC4Y 0HA, UK

Dr Joshua Howkins, Public Health Specialty Registrar, NHS Grampian, Aberdeen, AB15 6RE, UK

Prof Jim McManus, President, Association of Directors of Public Health, EC4Y 0HA, UK

Dr Gillian W Shorter, Lecturer, School of Psychology, Queen’s University Belfast, BT7 1NN

Dr James Nicholls, Senior Lecturer, Faculty of Health Sciences and Sport, University of Stirling, FK9 4LA, UK

Dr Jenny Scott, Senior Lecturer, Department of Pharmacy & Pharmacology, University of Bath, BA2 7AY

Dr Kyla Thomas, Consultant Senior Lecturer, Bristol Medical School, University of Bristol, BS8 2BN, UK

Ms Leila Reid, Director of Corporate Services, Hepatitis C Trust, SE1 3YD, UK

Dr Edward Day, Institute of Mental Health, University of Birmingham, B15 2TT

Dr Jason Horsley, Public Health Consultant, National Institute for Health Research Evaluation Trials and Studies Coordinating Centre, University of Southampton, SO17 1BJ, UK

Prof Fiona Measham*,* Professor, Department of Sociology, Social Policy and Criminology, University of Liverpool, L69 3BX

Prof Maggie Rae, President, Faculty of Public Health, NW1 4LB, UK

Prof Matt Hickman, Professor, Bristol Medical School, University of Bristol, BS8 2BN, UK

**Corresponding author:**

Dr Adam Holland – [adam.holland@bristol.ac.uk](mailto:adam.holland@bristol.ac.uk)

**Abstract**

In 2021, in the midst of a drug-related death crisis in the UK, the Government published its ten-year drugs strategy. This article, written in collaboration with the Faculty of Public Health and the Association of Directors of Public Health, assesses whether this Strategy is evidence-based and consistent with international calls to promote public health approaches to drugs, which put ‘people, health and human rights at the centre’. Elements of the Strategy are welcome, including the promise of significant funding for drug treatment services, the effects of which will depend on how it is utilised by services and local commissioners and whether it is sustained. However, unevidenced and harmful measures to deter drug use by means of punishment continue to be promoted, which will have deleterious impacts on people who use drugs. A public health approach to drugs should tackle population level risk factors which predispose to harmful patterns of drug use, including adverse childhood experiences and socioeconomic deprivation, and institute evidence-based measures to mitigate drug-related harm. This would likely be more effective, and just, than the continuation of policies rooted in enforcement. A more dramatic re-orientation of UK drug policy than that offered by the Strategy is overdue.

**Keywords**

Drugs; Policy; Strategy; United Kingdom; Drug-related deaths

**Introduction**

In December 2021, the UK Government published its 10-year drugs strategy, *From Harm to Hope* (1) (hereafter referred to as ‘the Strategy’) following Dame Black’s Independent Review of Drugs (2). The Strategy has been published during a period of escalating drug-related deaths in the UK (3-5) surpassing the rates of many countries (6). The following analysis, undertaken with the Faculty of Public Health and Association of Directors of Public Health, assesses whether the Strategy is evidence-based and consistent with calls from the highest coordination forum of the United Nations to ensure drug strategies promote public health and human rights (7). The Strategy is structured under three strategic priorities: to ‘Break drug supply chains’, ‘Deliver a world-class treatment and recovery system’, and ‘Achieve a generational shift in demand for drugs’. This article discusses drug-related harm in the UK, the Strategy’s three pillars, and highlights missing elements of policy.

**Drug-related harm in the UK**

The Black review was undertaken to explore what could be done to reduce drug-related harm in the UK (2), informing elements of the subsequent drugs strategy. Drug-related harms encompass the negative health and social impacts associated with illicit drug use, and drug market involvement. As acknowledged by the Black review (2) and the Strategy, current policy and practice has not effectively reduced many of these harms. Many health and social issues including socioeconomic deprivation, mental and physical health problems, stigma, trauma, and homelessness are associated with more harmful patterns of drug use. These issues may both predispose to and be exacerbated by drug dependence.

Amongst the health harms directly related to drug use, drug-related deaths provide the most obvious metric. Between 2010 and 2019, age standardised drug-related mortality rates increased in Scotland by 171% (from 90 to 244 per million) (4); Northern Ireland by 149% (from 35 to 87 per million) (5); and England and Wales by 61% (from 31 to 49 per million) (3). It is not clear from the Strategy or previous analyses what has caused these increases (2,8). A common argument is that deaths have increased because people with drug dependencies are older, with comorbidities increasing the risk of overdose. Two recent studies, however, demonstrated ageing alone does not explain the increase (9-10). Other potential contributory factors include: (i) increasing polydrug use, with the risk of opioid overdose increasing with concomitant use of benzodiazepines, gabapentinoids, and alcohol (11-14); (ii) increasing homelessness and incarceration, which are associated with greater risk of mortality, and human immunodeficiency virus (HIV) and hepatitis C (HCV) transmission (15-17); (iii) changing patterns of socioeconomic deprivation, which is strongly associated with drug-related harm (18-20); and (iv) cuts to services that would otherwise protect against all-cause and drug-related mortality (2,20-21).

The Strategy makes some unsupported assumptions about the relationship between drugs and social problems. It suggests that drugs ‘blight’ neighbourhoods, stopping them from reaching their potential. This implies drugs cause socioeconomic deprivation, as opposed to the contrary. Socio-economic deprivation and adverse childhood experiences are inter-related (22), and both are associated with more harmful patterns of drug use (18-19,23). Furthermore, disinvestment in health and social services in socioeconomically deprived areas may have contributed to increasing levels of harm since 2010 (21).

Harms to third parties related to drug use and markets include acquisitive crime and drug-related violence. However, in some instances the Strategy exaggerates the causative relationship between drugs and crime. For example, it states drugs ‘contribute’ to almost half of all homicides. In 2020, 48% of homicides were related to drugs in some way – in most cases, either the victim or perpetrator was known to be a person who uses or deals drugs, and sometimes were under the influence of drugs at the time (24). In a small proportion of cases the suspects’ motives were related to obtaining drugs or stealing drug proceeds (24), but for the most part it is not clear that drugs caused the homicides, and in no cases is it clear that stricter drug controls would have prevented them.

**Breaking drug supply chains**

The first pillar of the Strategy aims to reduce drug availability by targeting supply chains, including international, wholesale, and retail providers; with a particular focus on ‘county lines dealing’ (when illicit drugs are transported from major cities to other areas, and sold using a mobile phone ‘line’). There is some evidence that limiting the supply of a drug increases its purity adjusted price (25), which can reduce demand for that drug (26), thereby reducing hospital attendances and overdoses related to its use (27). There are, however, three issues with enforcement-led approaches to reduce drug supply.

First, there is limited evidence of their effectiveness. The Government’s evaluation of the 2010 Drug Strategy highlighted there is a lack of evaluative research in this area (28) and available evidence does not suggest that arresting dealers or seizing drugs has a long-term impact on supply (29). Internationally, there have been some isolated reductions in drug supply, for example, after global market disruption interrupted heroin supply in Australia in 2000 (30) and Western Europe in 2010 (31); and controls on precursor chemicals in the USA in 1989 and 2006 impacted cocaine availability (32). These reductions were, however, temporary, and it is not clear what caused them when other international efforts have not had the same effect. Despite recent drug seizures, such as those reported in the Strategy, global production and purity of drugs continues to increase (33) and the UK has amongst the cheapest and most affordable heroin and cocaine in Europe (34).

Second, there is limited understanding of how restricting the supply of certain drugs affects the supply of, demand for, and harm related to other drugs. For example, during ‘droughts’ of specific drugs, people may use adulterated drugs, alternative drugs, or resort to polydrug use (35-38).

Third, law enforcement measures to restrict drug supply may have unintended consequences on the drug market and people who use drugs, leading to increased levels of harm. Focussing on the most violent and exploitative forms of drug supply, such as those associated with county lines dealing (39) may shape the market to adopt less harmful practices (40-41). However, as the Black Review highlighted (2), arresting suppliers can create conditions that favour competition, promoting innovation and violence (40-50).

**Delivering a world-class treatment and recovery system**

The second pillar of the Strategy aims to rebuild treatment services following significant public sector cuts; promote integration of drug treatment, health, and criminal justice services; and improve employment and accommodation opportunities.

Additional drug treatment funding promised by the Strategy is welcome, however this follows years of sustained disinvestment (2), which has been associated with reductions in numbers of people in treatment (51), and an increase in the proportion of people who use opioids and crack cocaine not engaged with services (52). Furthermore, drugs workers have experienced increasing caseloads and greater administrative responsibilities, sometimes limiting the capacity of services to provide psychosocial interventions (53).

The Strategy suggests ‘recovery from drug addiction’ is a key aspect of its approach. As the UK Government Recovery Champion highlights, recovery and harm reduction should not be considered as opposing approaches, and it is necessary to provide a full range of evidence-based interventions (54). Opioid agonist therapy (OAT - treatment of opioid dependence with methadone or buprenorphine) reduces the risks of all-cause mortality, overdose, suicide, self-harm, HIV and HCV; and improves quality of life (15,55-60) and duration of OAT improves survival (61-64). Whilst model projections demonstrate that comprehensive OAT and harm reduction programmes reduce drug-related mortality (65-66) this is dependent on retention in treatment, which should be a key performance indicator. Focusing on treatment completion may incentivise premature OAT cessation, limiting the benefits of treatment and the impact of the new funding promised by the Strategy.

Increased funding and targeted commissioning could allow the introduction of innovative interventions, including drug checking services and diamorphine-assisted treatment - neither of which are mentioned in the Strategy. No intervention alone can avert the drug-related death crisis, but in combination with wider treatment systems, these evidence-based interventions could have beneficial impacts on patterns of drug use and harms (67-70). Local areas may need additional funding and technical support to commission diamorphine-assisted treatment, which is more expensive than oral OAT (71). These costs, however, are more than compensated by savings to wider services, including those related to reductions in acquisitive crime (71). Drug checking, on the other hand, is beginning to expand, as the first regular Home Office licensed, local authority funded drug checking service in the UK has recently launched in Bristol (72).

Despite their relevance for drug-related harm, HCV and HIV prevention are not mentioned in the Strategy. 89% of people infected with HCV in the UK have injected drugs (73) and a recent outbreak of HIV occurred amongst people who inject drugs in Glasgow (74). The UK is a leader in providing HCV treatment for people who inject drugs, which has led to clear reductions in chronic infections and liver-related deaths (9,75-78). However, achieving the World Health Organisation (WHO) target of “eliminating HCV as a public health problem” (73) will depend on preventing reinfection among people who inject drugs, with HCV infection a critical indicator for assessing the success of drug treatment and harm reduction systems (79).

People with drug dependence often have co-occurring health problems. People who use drug treatment services are getting older and more deaths are now caused by long-term conditions than by overdoses (9,80). 63% of people starting drug treatment have a mental health need (52) and people with substance dependence are at greater risk of suicide (81). As the Strategy highlights, it is necessary to improve integration and continuity of care between healthcare and drug treatment services. This is highlighted by a recent study demonstrating one in fourteen opioid-related deaths in England occur amongst people recently discharged from hospital (82). Additionally, drug services will need to recruit more clinically trained staff to identify and manage these issues, which will be challenging as the specialised workforce has been impacted by years of disinvestment. Furthermore, hospital care for people with drug dependence requires improvement. Stigmatising attitudes towards people who use drugs and fear of opioid withdrawal are key barriers to healthcare access (83-85), underpinned by hospital policies that create numerous procedural barriers to providing OAT with significant geographical variability (86).

Drug-related harm remains a key issue in prison, with overdose risk substantially elevated in the month following release (87-89) and incarceration a risk factor for HIV and HCV (17). Prison OAT reduces mortality and drug use in prison and critically also mortality following release (90-91). Alternatives to prison OAT proposed in the Strategy, including detoxification, are experimental and it is necessary to demonstrate they do not increase drug-related deaths (in and out of prison) compared to OAT.

The Strategy’s proposed zero-tolerance approach to drugs is inconsistent with the Inspectorate of Prisons acknowledgement of the important role of harm reduction strategies in prison settings (92). Evaluations of previous Drug Recovery Wings, which utilised abstinence and harm reduction-based approaches, highlighted their potential benefits but identified challenges, particularly related to a lack of support on release (93). The Strategy recognises the need for improved inter-agency coordination during and following incarceration, however recommendations from the Advisory Council on the Misuse of Drugs to improve custody-community transitions have not been realised (94).

**Achieving a generational shift in the demand for drugs**

The third pillar of the Strategy aims to reduce the demand for drugs by applying ‘tougher and more meaningful consequences’ to deter use, including ‘tough consequences out of court disposal schemes’; delivering education programmes in schools; and supporting at risk families.

The Strategy suggests that the threat of punishment will reduce demand. This is, however, not supported by evidence, and there is no clear relationship between the stringency of drug laws and drug use prevalence (95-99). The Home Office previously concluded “levels of drug use are influenced by factors more complex and nuanced than legislation and enforcement alone” (100). These include socioeconomic deprivation (18) and adverse childhood experiences (23); predisposing factors that may be exacerbated by the health and social harms associated with contact with the criminal justice system (101). Additionally, the stigma associated with punitive policies may deter people with drug dependence from seeking support (102).

The proposed ‘tough consequences out of court disposal schemes’ provide an opportunity to divert people who use drugs from the criminal justice system. Available evidence tentatively suggests that diversion schemes reduce re-offending more effectively and cost-effectively than criminal sanctions (103-106). However, there is limited research evaluating their impacts on drug-related harms (107). Existing diversion schemes use different approaches, and it is not clear what form the proposed schemes will take. With further detail expected in a forthcoming White Paper, the Strategy proposes sanctions including referrals to drugs awareness courses, curfews, the temporary removal of passports or driving licenses, fines; and in some cases, requirements to attend drug treatment. Whilst these approaches may mitigate some of the harms associated with criminal sanctions, most are designed to have significant negative impacts on people who use drugs, which may exacerbate the issues that predispose to harmful drug use. Furthermore, coerced treatment, and mandatory drug testing, which is also supported by the Strategy, contravene accepted norms in medical ethics (108), and there is limited evidence that coerced treatment reduces future drug use (108-109).

The Strategy proposes to ensure ‘more people face the consequences of their use’. By ‘widening the net’, more people will receive punishments of some kind, which may escalate to criminal sanctions. It remains to be seen how the schemes will contribute to the stigma faced by people who use drugs, and whether they will reproduce the ethnic and socioeconomic disparities apparent in current drug enforcement. People who are black are nearly nine times more likely to be stopped and searched for drugs than people who are white and are more likely to be arrested, prosecuted, and sentenced to immediate custody (110). Whilst the Strategy recognises the problem of disproportionate policing, the conclusion that sanctions should be applied more universally may be difficult to achieve, given the entrenched nature of the problem, thought to be related to officer biases, as well as more frequent patrols in areas with larger populations of people who are black (111).

**What’s missing?**

The Strategy states it is taking a new approach to reducing drug-related harm. Although it includes some new developments, most elements are a continuation of former approaches proposed in the context of existing legislation, rather than allowing for legislative reform that would decriminalise the possession of drugs and facilitate innovative harm reduction interventions.

The Strategy suggests that decriminalisation risks increasing drug use, however this is not supported by evidence (95-99). Whilst criminalisation has no clear benefits, it causes significant harm to people who use drugs (112). Since the Misuse of Drugs Act 1971 was introduced, more than three million criminal records have been generated for drugs offences (113). In 2017, 60% of prosecutions for drug offences in England and Wales were for possession rather than supply, including 36% for the possession of cannabis (110). In the UK, decriminalisation has been recommended by bodies including the 2019 Health and Social Care Committee on Drug Policy (114); the Royal College of Physicians (115); the Royal Society of Public Health, and the Faculty of Public Health (116). Internationally, more than 30 countries have some degree of decriminalisation (99), and it has been recommended by the highest coordination forum of the UN, comprising the Executive Heads of organisations including the WHO and the UN Office for Drugs and Crime (7).

There is also no indication that legislative barriers, which restrict innovation in harm reduction and treatment will be removed. The Government has resisted the introduction of overdose prevention centres (117), despite promising evidence they could reduce drug-related deaths and engage the most marginalised with services (70,118). The introduction of pilot sites has been recommended by numerous health, academic, and third sector organisations (119), the Advisory Council on the Misuse of Drugs (20), the 2019 Health and Social Care Committee on Drugs Policy (114) and the Scottish Drug Deaths Taskforce (120). Although overdose prevention centres may be provided in the UK with agreement with local law enforcement agencies (121), legislative change and governmental endorsement would facilitate pilot sites, allowing UK based research to evaluate their effectiveness and cost-effectiveness (117). Currently, legislation also creates barriers to providing smoking paraphernalia to engage people who use crack cocaine with services (122), as is the case in other countries (123).

There was no opportunity for public consultation in the Strategy’s development. For other health and social policies, in health research and service commissioning, the views of the public are included as a matter of priority (124-125). Generally, the views of people who use drugs, who entreat that there should be “nothing about us without us” (126), have not been adequately considered when planning responses to drugs (127). Communities who use drugs and UN agencies highlight that consideration of human rights, including the right to non-discrimination should be of primary importance when determining drug strategies (7,128-129). The UK Strategy does not mention human rights, and punitive policies and restrictions on access to harm reduction programmes are often at odds with human rights norms (112,130).

Stigma related to drug use and dependence, including stigma propagated by the language used to describe people who use drugs (131) creates barriers to seeking support and treatment (102). The Strategy identifies the need to reduce stigma. However, this is inconsistent with the language it uses, for example referring to acquisitive crime in terms of “[t]he innocent families whose homes are broken into by addicts seeking to feed their habits” and the Government previously suggested that stigma is a valued means to deter drug use initiation (132). Independent campaigns have been launched to tackle stigma (133,134), but in general, the evidence for the effectiveness of stigma-reduction approaches is limited (135), as the sources of stigma are complex (136), and efforts would need to translate into policy and practice to have meaningful impact.

**Conclusion – prioritising people, health, and human rights**

There are significant inconsistencies between the UK Drugs Strategy and the call from the highest coordination forum of the UN to promote public health approaches to drugs, putting “people, health and human rights at the centre” (7). A public health approach would tackle upstream population factors that predispose to harmful patterns of drug use alongside many other health and social disadvantages. Whilst promised investment in drug treatment is welcome and likely to be beneficial, this alone will not solve the drug-related death crisis. Realising the potential benefits of additional funding and achieving the Government’s ambition to develop a ‘world class treatment and recovery system’ will depend on utilising appropriate metrics, with details awaited of the proposed national outcomes framework; and addressing fundamental flaws in the Strategy’s approach. Furthermore, a public health approach would be based on evidence. Whilst the Strategy states evidence is ‘at the heart’ of its approach, this is not always the case as it continues to promote un-evidenced and harmful measures attempting to deter drug use with punishment.

We believe a public health approach to drugs would be more effective than policies rooted in criminalisation and enforcement. Framing drug use as something deserving of punishment promotes stigmatising attitudes which pose a barrier to accessing support; and approaches that do not adequately consider the views and human rights of people who use drugs. For more than fifty years, this has failed to effect improvements and a more dramatic re-orientation of the UK response to drugs is overdue.

**Acronyms**

HCV – Hepatitis C (virus)

HIV – Human immunodeficiency virus

OAT – Opioid agonist therapy

UK – United Kingdom

UN – United Nations

USA – United States of America

**Declarations**

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AH is a volunteer harm reduction adviser for the Loop – a not-for-profit drug checking service provider. AS is a trustee for Harm Reduction International. DS is a volunteer for the Loop. JN is a Trustee at Cranstoun, a third sector drug and alcohol treatment provider. JS works as a pharmacist prescriber with a third sector drug and alcohol treatment provider. LR is Director of Corporate Services for the Hepatitis C Trust. ED is the UK Government Recovery Champion. FM is the Director of the Loop.

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