BMA

Call for evidence – review of drugs

BMA Policy directorate

June 2019

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In February 2019, the Government announced Dame Carol Black had been appointed to lead a major independent review of illegal drug use and supply in the UK. The review is in two parts: the first summarises the existing evidence relating to drug use, supply and effects, including current trends and future risks, and highlights gaps in the evidence, as well as how to address these gaps. The second part will be determined once the first has reported.

Further information on the scope of the review and its terms of reference can be found here.

The Government is now consulting on the first part of the review. Given the broad scope of the review, only those questions where the BMA has existing policy have been addressed.

Harms of drugs

What are the harms to individuals, families and communities resulting from drug use (including physical, mental, social and economic)?

The use of illicit drugs is associated with a range of physical, psychological and social harms which impact individuals, families and communities. The level of harm varies between individuals and is generally affected by the pharmacological properties of each drug, including any contamination, and the pattern of drug use as well as the mode of administration. Both the cost and addictive nature of illicit drug use can also lead to criminality which can perpetuate the cycle of addiction and crime.

The primary health harms associated with illicit drug use are a result of the acute and chronic toxic effects of individual drugs, as well as dependence. Acute toxicity can lead to short-term harms, ranging from unpleasant side-effects such as vomiting and fainting, to more serious impacts such as seizures, tissue and neural damage or death. In the longer term, repeated drug use can lead to chronic physical and psychological health effects including a range of physical disorders and conditions, illusions, dizziness, anxiety, as well as dependence and in certain cases death.

The BMA has consistently highlighted our concerns about the number of registered deaths resulting from drug use across the UK, which continues to rise. The most recent data show that in 2017, there were 2,503 registered deaths in England and Wales related to drug misuse – a 38% increase since 2007.[i] In Scotland, 934 drug-related deaths were registered in 2017 – the largest number ever recorded, and 105% higher than in 2007.[ii] While in Northern Ireland there were 136 drug related deaths in 2017 – 60% higher than in 2007.[iii] Particular concerns have been raised about the marked increase in older drug users, particularly those taking crack cocaine and strong opiates such as heroin, who have had limited success with traditional treatment interventions.[iv]

Illicit drug use is a particular problem among the prison population. Between 2012/13 and 2017/18, the rate of positive random tests for traditional drugs in prisons increased by 50%, from 7% to 10.6%. The BMA has previously raised concerns about the harms including

hospital admissions, death and violence associated with misuse of psychoactive substances such as synthetic cannabinoids and stimulants, which were found in 4,667 incidents in prisons in 2017/18, or just over 33% of total incidents.[v]

What are the harms to individuals, families and communities resulting from drug supply (including physical, mental, social and economic)?

The illicit drug market is associated with a wide-range of potential harms including deprivation, domestic abuse and violence, family adversity and crime associated with obtaining drugs. Vulnerable populations are particularly exposed to the effects of illicit drug supply including violence and exploitation which can exacerbate health harms. Specific harms associated with supply in prisons include violence and further criminality.

What are the most effective ways to prevent drug use/dependency?

As outlined in the BMA's 2013 report, *Drugs of Dependence: the role of medical professionals*, there are generally three approaches to prevention that are applied. Most preventative drug interventions, commonly referred to as universal interventions, are directed at unselected populations, commonly through mass-media or marketing approaches. Secondly, selective interventions, targeting subsets of the population thought to be at risk can be applied for entire groups thought to be at risk. While finally, indicated interventions can be used when individuals are showing early signs of drug use.

Standards for drug use prevention, published in 2013 by UNODC (United Nations Office of Drug Control), highlighted evidence of positive outcomes for:

- early interventions, particularly generic pre-school programmes, improving literacy and numeracy, having a long-term effect;
- personal and social skills education;
- links to school interventions including school environment improvement programmes, for example promoting a positive ethos, tackling truancy, encouraging participation and academic and social-emotional learning;
- a focus on risk and resilience factors such as deprivation;
- multi-component programmes involving parenting interventions and support for individuals and families, which may require joined up commissioning and planning; and
- empowering qualified staff to deliver these interventions.[vi]

A 2015 PHE (Public Health England) review concluded that in order to be effective, prevention needs to be consistent and coordinated through a range of programmes and across a variety of settings, for example, targeting schools; the home; peers; communities and the media in the round.[vii]

The controlled environments of prisons are more likely to ensure compliance with drug treatment programmes than is possible after discharge. It should offer a valuable opportunity for effective medical treatment of a drug use disorder and the best chance for dependent drug users to be rehabilitated. In reality because of wide-access, violence fuelled by supply and further addiction, the data show the prison environment has become

challenging for providing medical treatment. For example, the BMA has recently highlighted the increase in abuse of pregabalin and gabapentin in prisons. We were pleased to see the Government take action last year to reschedule them under the Misuse of Drugs Regulations.[viii]

What, if any, are the gaps in drug treatment provision?

In recent years the BMA has been repeatedly highlighting the impact that changes to local authority funding have had on public health services, including those tackling drug and alcohol harm.[ix] Spending on drug and alcohol services has reduced by 29% between 2014/15 and 2018/19 to £40m.[x] This has had a detrimental effect on access to and quality of treatment, with the ACMD (Advisory Council on the Misuse of Drugs) concluding that the quality and effectiveness of drug misuse treatment is being compromised by under resourcing.[xi] Meanwhile evidence submitted to a recent House of Commons Health Committee inquiry into the issue highlighted concerns that services were being reduced to the effect of ultimately reducing access.[xii]

Within treatment services, we also have concerns about the availability of specific treatment options. Individuals affected by opiate dependence (including heroin) have the lowest success rate for treatment – according to PHE, only around 28% of those who access treatment, successfully complete.[xiii] And yet, strong evidence consistently supports the use of OST (opioid substitution treatment), the most common form of treatment in addiction services throughout the UK.[xiv]

In recent years the BMA has highlighted other substance treatment services that are available, including supervised consumption rooms and heroin assisted treatment. While not currently routinely used, international evidence shows they are associated with reduced levels of harm.[xv]

Supervised consumption rooms provide a space where illicit drugs can be used under the provision of trained staff in a controlled environment. They are designed to reduce the acute risks of disease transmission through unhygienic injecting, preventing overdose and connecting users with treatment. They have primarily been championed across Europe. There are currently no supervised consumption rooms operating in the UK.

Heroin assisted treatment allows for the provision of pharmacological heroin to dependent individuals who have not previously responded to other forms of treatment. Again, this practice has been rolled out in Europe and North America, including Switzerland, Spain, Germany and Luxembourg. While technically legal in the UK, in practice since the early 1970s, very few doctors have prescribed it. In 2016, the ACMD recommended that, across the UK, central government funding should be provided to support heroin assisted treatment for patients for whom other forms of opioid substitution have not been effective.[xvi]

We are also concerned about the limited availability of treatment services in prisons. It is vital that there is comprehensive and consistent access to services to support drug misuse, as prisons offer a unique setting to address these issues.

What are the barriers to receiving effective treatment in the UK? How might they be overcome?

In light of the recent cuts to public health funding, one of the biggest barriers to effective treatment in the UK is the availability and fragmentation of services. The BMA has called for the cuts to local government funding to be reversed, and a commitment to a long-term multi-year investment in ill-health prevention. This will support local authorities to invest in high-quality treatment services and ensure they are widely available to meet the needs of local populations.

Alongside this, we are concerned that while there is evidence to support the wider availability of heroin assisted treatment and supervised consumption rooms, access across the UK is limited. The UK Government has repeatedly stated their concerns over law enforcement, ethical challenges for medical professionals and risks of disproportionately promoting these facilities. The most high-profile exception to this has been in Glasgow, where the local health and social care partnership is considering proposals to establish a safe drug consumption facility and heroin-assisted treatment service in the city centre. The Scottish Government have asked for amendments to be made to the Misuse of Drugs Act 1971 to facilitate the wider availability of different treatment options, or for the issue to be devolved to national governments. The BMA would support the expanded use of these interventions in cases where other traditional treatment options are not effective.

Finally, the current criminal justice approach to tackling illicit drug use, creates an environment where people are reluctant, rather than encouraged, to access treatment services. This creates obvious complications with the medical management of illicit drug use, as negative attitudes – both on the part of practitioners and patients, can compromise effective care. A survey conducted in 2006 found that 10 per cent of drug users had held back from seeking treatment because of the stigma of illegality.[xvii] This only compounds problems for many individuals, who are already often stigmatised and vulnerable, for example, sex workers, homeless populations and victims of traumatic experiences.[xviii]

Which groups of people are these barriers most likely to affect?

Supervised consumption rooms and heroin assisted treatment are targeted at a specific group of individuals who have not been able to stop using drugs through other means. For example, the specific proposal in Glasgow to introduce supervised consumption rooms has been developed in response to around 500 people who currently self-inject in a public setting. A 2016 ACMD report also highlighted the effectiveness of heroin assisted treatment in helping street heroin users specifically from reducing their usage.[10] Without this targeted support, it is likely these highly dependent individuals will continue their harmful usage and will not have access to support that is effective in their specific case.

Stigmatised groups including sex workers and homeless populations are more likely to be affected by a criminal justice approach. Explanations for this increased risk include criminalisation pushing drug use and supply to the streets and mixing sex and drug markets and environments which are populated by already vulnerable groups. Cuts to service provision have marginalised these groups further as the availability of services becomes more difficult.

Are you aware of any approaches – locally, nationally or from other countries – that are effective in reducing the harms of drug use/supply? If so, please provide details including any evidence of effectiveness?

There are a range of different approaches that have been applied internationally, and an emerging body of evidence to draw on. Portugal is often cited for its approach to decriminalising drug use and possession of small quantities of drugs for personal use, in favour of focusing on harm reduction and health promotion. Instead of facing criminal charges, users are referred to a Commission for the Dissuasion of Drug Addiction. While there have been some mixed results, for example cannabis use has increased in recent years, since refocusing to a public health approach, the harms arising from drug use have largely reduced:

- deaths due to drug overdose have fallen from 98 in 2008 to 27 in 2016;
- HIV diagnoses attributed to injection declined from 500 in 2008 to 30 in 2016; and
- cases of hepatitis C and B have both fallen among drug users.[xix]

Another influential example is the Swiss model, which has led the implementation of evidence-based interventions for illicit drug-use. The national drug policy of Switzerland is based on four key pillars: prevention; therapy; harm reduction; and prohibition and includes specific measures such as heroin assisted treatment and supervised consumption rooms. This approach has shown to be effective in improving health outcomes significantly, reducing the use of street heroin and levels of crime.[xv,xvi]

What policy changes or improvements do you think would have the biggest impact on reducing the harm from drug use and/or supply?

The recent government policy of cutting funding to local authorities has directly impacted vital public health frontline services such as drug treatment services. In order to reverse this trend, the Government must adequately invest in public health to ensure that services are able to meet the complex needs of this population.

The current criminal justice approach to tackling illicit drug use in the UK has had limited effectiveness. Reflecting the significant health harms associated with illicit drug use, the BMA has consistently called for the Government's approach to be refocused to prioritise treatment and support.[xviii] Given the health focus, we suggest such an approach should be led and coordinated by the Department of Health and Social Care, and relevant health departments across the UK. This would have the effect of aligning illicit drug policy with tobacco and alcohol strategies, and facilitating support being focused on cross-cutting issues of addiction and substance use.

As set out throughout this response, our concern is that the current criminal justice approach is having the effect of pushing users away from a system which can help them to prevent further use or recover in a safe-environment. In order to best treat the health-harms of drug use, it is important that individuals feel they can self-refer to support services without fear of legal repercussions and be able to access high quality, evidence-based interventions, such as supervised consumption rooms and heroin assisted treatment.

As part of the submission, the BMA will include previous work on illicit drug policy:

- British Medical Association (2013) *Drugs of Dependence: the role of medical professionals.* London: British Medical Association.
- British Medical Association (2017) *Evidence-based interventions for managing illicit drug dependence.* London: British Medical Association.

i Office for National Statistics (2018) *Deaths related to drug poisoning in England and Wales: 2017 registrations.* London: Office for National Statistics.
[ii] National Records of Scotland (2018) *Drug related deaths in Scotland in 2017.* Edinburgh: National Records of Scotland.
[iii] Northern Ireland Statistics and Research Agency (2019) *Drug related and drug misuse deaths, 2007-2017.* Belfast: Northern Ireland Statistics and Research Agency.
[iv] https://publichealthmatters.blog.gov.uk/2019/03/25/what-the-latest-estimates-on-opiate-and-crack-use-tell-us/ (last accessed on 17.05.2019).
[v] HM Prison and Probation Service (2019) *Prison drugs strategy.* London: HM Prison and Probation Service.
[vi] United Nations Office on Drugs and Crime (2013) *International standards of drug use prevention.* United Nations Office on Drugs and Crime.
[vii] Public Health England (2015) *The international evidence on the prevention of drug and alcohol misuse.* London: Public Health England.
[viii] http://www.pulsetoday.co.uk/clinical/clinical-specialties/prescribing/pregabalin-and-gabapentin-to-be-controlled-as-class-c-drugs-from-april/20037622.article (last accessed on 03.06.2019)
[ix] https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/public-health-budgets (last accessed on 22.05.2019)
[x] The Health Foundation (2018) *Taking our health for granted: plugging the public health grant funding gap.* London: The Health Foundation.
[xi] Advisory Council on the Misuse of Drugs (2017) *Commissioning impact on drug treatment: the extent to which commissioning structures, the financial environment and wider changes to health and social welfare impact on drug misuse treatment and recovery.* London: Advisory Council on the Misuse of Drugs.
[xii] House of Commons Health Committee (2019) *Drugs policy inquiry.* Written evidence submitted by Collective Voice (DRP0046).
[xiii] Public Health England (2017) *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS).* London: Public Health England.
[xiv] British Medical Association (2017) *Evidence-based interventions for managing illicit drug dependence.* London: British Medical Association.
[xv] European Monitoring Centre for Drugs and Drug Addiction (2012) *New heroin-assisted treatment: recent evidence and current practices of current injectable heroin treatment in Europe and beyond.* Lisbon, Portugal; European Monitoring Centre for Drugs and Drug Addiction.
[xvi] Advisory Council on the Misuse of Drugs (2016) *Reducing opioid-related deaths in the UK.* London: Advisory Council on the Misuse of Drugs.
[xvii] Royal Society for the Encouragement of Arts, Manufactures and Commers (2007) *Drugs – facing facts. The report of the RSA commission on illegal drugs, communities and public policy.* London: Royal Society for the Encouragement of Arts, Manufactures and Commerce.
[xviii] British Medical Association (2013) *Drugs of Dependence: the role of medical professionals.* London: British Medical Association.
[xix] European Monitoring Centre for Drugs and Drug Addiction (2018) *Portugal country drug report 2018.* Lisbon, Portugal: European Monitoring Centre for Drugs and Drug Addiction.