Written evidence from Mr Sunny Dhadley

Health Consequences of Illicit Drugs Policy

‘Many genetic, environmental and social factors contribute to the determination of a person’s unique susceptibility to using drugs initially, sustaining drug use, and undergoing the progressive changes in the brain that characterise addiction’ (Volkow et al, 2016)

People have been using drugs for thousands of years. The likelihood that a person will build a dependency is based on the situation that the person is in, how they feel and who they are with when they are first exposed to drugs. The majority of those that use illicit drugs continue to live a life with meaning and purpose and enjoy using drugs recreationally. For others, their use of drugs will result in dependency which can have a substantial negative impact on their ability to progress in life.

Health harms resulting from the use of drugs vary depending upon the socio-economic circumstances of the individual or community. For example, if an individual who is using drugs is living in poverty, then their health may already be compromised and therefore the use of drugs can further adversely impact upon their health. However, if an individual is living a more prosperous life, then they may be more likely to have a better quality of life and better health.

The different types of drugs being used will be associated with differing health implications. By putting the supply of drugs into the hands of criminals, profits are the primary priority, with quality secondary (if even considered at all). This means that the person using drugs is putting their health at risk each time they purchase drugs from the black market.

Also the route of transmission will determine the level by which health is affected and whether not they use drugs socially or in isolation. For example, if someone is injecting drugs (like heroin), then of course there will be an increased risk to their health as a result of intravenous use and their well-being will depend on whether they are using sterile equipment each time, and not sharing equipment with others. Naloxone has been available in the UK for a number of years to tackle opiate overdoses, but there is still nowhere near enough coverage to halt the shocking number of drug related deaths that are occurring. Therefore harm reduction is a crucial approach that is missing in the UK, with strategies instead being dominated by an abstinence focus – which is often not a viable choice for many people who are use drugs.

Regardless of the drug, or how someone is using it, it is important that health is the preferred pathway, as opposed to criminal justice. Criminalising a person that uses drugs compounds the stigma that already exists and further marginalises them, meaning that they are far less likely to access healthcare (and other) services. The current policy approach also unfairly creates labels and stereotypes in society, which, whether consciously or subconsciously, affects the experiences of someone that uses drugs. This can result in their needs not being met, which can lead to poorer health and quality of life.

I was an individual who battled with class a drug addiction for nearly a decade. This affected all aspects of my life (employment, housing, mental health, finances, relationships etc.). After overcoming my addiction, I set out to support others suffering from addiction in moving forwards. Very quickly, I learned that there were deep rooted social harms that disproportionately affected my peers who used drugs. These included :- poverty and deprivation, low confidence, gaps in employment related skills, over-reliance upon the welfare system and social housing, the impact of criminal records etc. In addition to this, my peers from BAME communities were being disproportionately accounted for within the criminal justice system. Furthermore, I became aware that services and systems were not working cohesively to meet their needs of people that used drugs.

I therefore developed an organisation (charity) and peer led delivery model to support people that used drugs, in order to circumnavigate these complex and cumbersome systems. The following example is based on a twelve month period (with 2.4% of the local funding, which is equivalent to incarcerating one adult in a category b prison for twelve months) – 856 individuals were supported, 3816 interventions were delivered, 76 areas of need were met by collaborating with 486 services and organisations (public and private sector). This meant that each intervention that was delivered cost the British taxpayer just £34.07.
Although not contracted to do so, during this time period we also supported twenty two people into sustainable employment. In addition to case management, our team of people with lived experience of addiction attended one hundred and twenty two separate strategic meetings and events, in order to share their lived expertise, professional insights and to support the development of improved services and systems. This overall approach was awarded the Queens Award for Voluntary Service in 2014 and in 2018 was twice cited as a European model of best practice.

In my experience, treatment services do help in improving the health and well-being of those that use drugs, but are stifled by a) punitive treatment outcome measures, and b) inadequate levels of funding.

Treatment is a singular intervention that aims to tackle a single issue and is dominated by clinical input, which is important but does create a system imbalance. For many years treatment services have been asked to collate data (taken from those that use drugs and recorded on NDTMS) on wider determinates, such as employment, education, housing status etc. but this information collation is merely for the purposes of monitoring. I don't believe that it is enough to merely examine data, we should be aspiring to provide a multitude of interventions that cross sectors and disciplines so that the ‘whole person’ is supported in improving the overall quality of their life and that their future prospects can be enhanced. This data would then prove much more useful in not only understanding the circumstances of those that use drugs, but would also demonstrate the solutions required in order to achieve greater outcomes for the individual and overall system.

I have learned that not all people want to stop taking drugs and some have even questioned whether enforcing people to stop taking drugs infringes upon their human rights. Rather than taking a punitive approach to tackling drug use, I would call for a shift from criminalisation (particularly for non-violent offences) to a social and health based approach. Individual sanctions for the use of drugs serve as an inappropriate and unjust response. Focus instead should be placed on tackling organised crime syndicates who amass huge amounts of profits from the production and trafficking of illicit drugs worldwide.

Many countries have adopted a decriminalisation approach, which has not increased the use of drugs, but has positively impacted upon health, reduced anti-social behaviour and increased social well-being.

In summary, here in the UK, incarceration has become the staple intervention for people with social, economic and mental health needs (including people who use drugs) – this must change! Money should be re-allocated from the criminal justice system to reconfigured harm reduction health based treatment services. Many of the additional required resources and assets already exist within the UK, but we must utilise them more effectively. In order to achieve this, we must ensure – innovation, strong co-ordination, joint planning (between numerous stakeholders) and considering co-commissioning services.

Communities have a substantial role to play, as they have the ability to quickly find solutions on issues that affect them. Therefore it is very important to ensure that people with lived (or living) experience of using drugs are included throughout the consultation, strategy development, delivery and evaluation of such progressive approaches.