Written evidence from the British Medical Association

About the BMA
The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Overview

- The BMA is greatly concerned that the number of registered deaths resulting from illicit drug use across the UK continues to rise and believes it is critical that a health in all policies approach is developed and implemented in relation to drug misuse and prevention.
- All prevention approaches to drug misuse should be evidence based and that government should work with local authorities and the NHS to share best practice.
- Medical students and doctors need to be equipped with the right educational resources to allow them to identify potential use early and prevent issues from emerging.
- Medical professionals have a key role in managing the harms associated with illicit drug dependence. This can be in a clinical setting or in advocating for the provision of evidence-based interventions in local areas.
- There are currently a limited number of treatment options available for individuals dependent on illicit drugs in the UK. We believe that government should carefully consider evidence, particularly at an international level, of successful interventions and to use these when developing UK approaches.
- Successive governments have prioritised a criminal justice approach to tackling illicit drug use in the UK. In light of the significant health harms, the BMA believes this should be refocused to prioritise treatment and support over criminalisation and punishment of drug users.
- In England, due to national cuts, local authorities have made significant reductions overall to their budgets for the treatment and prevention of drug misuse, with cuts of over 5% for adult treatment services for drug misuse and over 8% for adult prevention services between 2016/17 and 2017/18.
- The government should reduce barriers to research into currently banned substances. National and local monitoring of drug treatment should be improved, as highlight by PHE’s 2017 review of the outcomes of treatment.

1. What is the extent of health harms resulting from drug use?
1.1 The BMA is greatly concerned that the number of registered deaths resulting from drug use across the UK continues to rise. In 2017 there were 2,503 registered deaths in England and Wales related to drug misuse, an increase of 38% since 2007. In Scotland, 934 drug-related deaths were registered in 2017, the largest number ever recorded, and 105% higher than for 2007. Northern Ireland showed a similarly concerning trend with 126 drug-related deaths in in

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2016, 38.5% more than in 2006. Furthermore, the increase in mortality rates from accidental overdose of illicit drugs for people aged between 20-44 has been linked with the UK’s slowdown in increasing life expectancy.

2. How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.

2.1 Traditionally the two main aims of illicit drug prevention initiatives are either primary prevention, where the aim is to avert or delay the initial use of the drug, or secondary prevention, where the aim is to minimise hazards, or actual harms, among those who have already begun using drugs. Reducing the number of people using drugs by delaying their initiation into drug use and preventing the transition from experimental or recreational drug use to problematic or dependent use also has a key role to play in drug prevention.

2.2 We welcome the government’s recent identification of prevention as one of its three priority areas for improving the health of the nation. This includes recognition of the impact of unhealthy lifestyle factors such as illicit drug use. Their accompanying vision sets out an approach which aims to prevent problems occurring in the first place and then intervening early to address them. The BMA supports the use of prevention and believes that there are economic consequences of failing to prioritise prevention.

2.3 There is, however, mixed evidence of the effectiveness of different prevention approaches including education and drug testing. To be effective in preventing substance misuse, education approaches need to be interactive and focus more broadly on developing resilience, self-efficacy, impulse control and life skills in relation to risk taking behaviour. We recommend that all approaches should be evidence based and that government should work with local authorities and the NHS to share best practice.

2.4 We recognise that medical students and doctors, throughout their careers, need to be equipped with the right educational resources to allow them to identify potential use early and prevent issues from emerging. The Royal Society of Public Health have argued that current legal classification of drugs as Class A, B and C influences perceptions of the harms of drugs relative to each other and does not provide a full picture of the harm each drug can cause. The use of opportunistic brief interventions by doctors, for example, providing information and advice when attending a needle and syringe sharing exchange or primary care setting, can support patients in stopping drug use, or using drugs in less harmful ways.

3. How effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

3.1 Medical professionals have a key role in managing the harms associated with illicit drug dependence. This can be in a clinical setting (ie. directly managing withdrawal and relapse and in maintenance prescribing), or in advocating for the provision of evidence-based interventions in local areas with a high level of need. Users of illicit drugs, and their families or dependants, often have complex lifestyles and needs, meaning that the medical management of drug dependence is often more difficult and challenging than many other chronic disorders. For example, users

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who present for treatment are often socially marginalised, lead chaotic lifestyles and have little
to motivate them towards recovery.

3.2 There are a limited number of treatment options available for individuals dependent on illicit
drugs. While opioid substitution treatment is routinely available (including for those with heroin
use problems), other treatments associated with reduced levels of harm, such as supervised
consumption rooms and heroin assisted treatment are not currently widely available in the UK.8

3.3 We believe that government should carefully consider evidence, particularly at an international
level, of successful interventions and to use these when developing UK approaches. Within drug
and alcohol treatment services, opiate dependence (including heroin) has the lowest rate of
successful treatment, around 28% of those who access services. Despite this, there is strong and
consistent evidence to support the approach of opioid substitution treatment.

3.4 **Supervised consumption rooms:** Supervised consumption rooms provide a space where illicit
drugs can be used under the provision of trained staff. Their primary aim is to reduce the acute
risks of disease transmission through unhygienic injecting, preventing overdose and connecting
users with treatment. The degree of benefit of a supervised consumption room is largely
dependent on the nature of the injecting episodes that would otherwise have taken place. The
health impacts are higher if, in the absence of supervised facilities, use is more likely to take
place in an unhygienic, unsupervised and ultimately unsafe environment.

3.5 **Heroin assisted treatment:** Heroin assisted treatment allows for the provision of
pharmacological heroin to dependent individuals who have not previously responded to other
forms of treatment. Typically, patients receive injectable or inhalable heroin 2-3 times a day
from a doctor in a clinical setting under strict controls. In 2016 the Advisory Council on the
Misuse of Drugs 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 therapy have not been effective.9

3.6 **Drug use in the secure estate:** More than 1000 people are imprisoned for personal drug use in
England and Wales each year.10 There is a high prevalence of drug use among prisoners in the
UK, and high rates of first initiation of drug use, with particular concerns about the use of novel
psychoactive substances. Opioid substitution therapy has been shown to have an important role
in reducing transmission of HIV in the prison setting.11 Methadone treatment in prisons has also
been shown to significantly reduce heroin use among those treated; retention in treatment is
associated with reduced mortality, reincarceration and hepatitis C infection.12

4. **Is policy sufficiently geared towards treatment? This includes the extent to which health is
prioritised, in the context of the Government’s criminal justice-led approach / What would a
high-quality, evidence-based response to drugs look like?**

4.1 Successive governments have prioritised a criminal justice approach to tackling illicit drug use in
the UK. In light of the significant health harms, this should be refocused to prioritise treatment
and support over criminalisation and punishment of drug users. Such an approach should be
coordinated and led by the relevant health departments across the UK, helping to align illicit
drug policy with tobacco and alcohol strategies. This will provide a set of common principles in
order to address the cross-cutting issues of addiction and substance misuse.

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4.2 Criminalisation risks pushing users away from the system which can help them to prevent further use or recover in a safe-environment. The criminal status of drug use may deter people from coming forward for treatment and increases the health risks by encouraging use in unsafe environments and through dangerous methods of administration. Drug users should feel they can self-refer to support services without fear of legal repercussions. A high-quality and evidence-based response to drugs would focus on harm reduction, with treatment and support for drug users easily accessible.

4.3 Treatment must be adequately resourced and consistently delivered across the UK. In England, the BMA has highlighted how, due to national cuts, local authorities have made significant reductions overall to their budgets for the treatment and prevention of drug misuse. For example, with cuts of over 5% for adult treatment services for drug misuse and over 8% for adult prevention services. Between 2014 and 2016 Blackpool had the highest rate of deaths associated with drug misuse out of all local authority areas in England, with over 20 per 100,000. This compares to 4.2 deaths per 100,000 across the whole of England over the same time. Between 2016/17 and 2017/18 Blackpool council made cuts of 18% to its budget for the treatment of drug misuse, and 22% to the budget for preventing and reducing harm associated with drug misuse.

4.4 A high-quality evidence-based resource should invest in ongoing research and evaluation to ensure that the quality of drug treatment is continually evaluated and improved. The government should reduce barriers to research into currently banned substances. National and local monitoring of drug treatment should be improved, as highlight by PHEs 2017 review of the outcomes of treatment.

5. What responses to drugs internationally stand out as particularly innovative and / or relevant, and what evidence is there of impact in these cases?

5.1 There is a spectrum of alternative legal frameworks available, and a useful, if incomplete body of evidence to draw on. The options for alternatives range from harshly enforced absolutist prohibition, through a series of regulatory market models, through to free market models.

5.2 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. This is an administrative body composed of health, social, and legal experts which helps participants to address issues related to their drug use.

- Deaths due to drug overdose fell from 94 in 2008 to 27 in 2016.
- HIV diagnoses attributed to injecting drugs declined from 500 in 2008 to 30 in 2016.
- Problem drug use has declined in 15-24-year olds
- Cases of hepatitis C and B have both fallen in the drug using population.

5.3 Canada’s illicit drug strategy recognises problematic substance use as a health condition that can be managed and treated. The Canadian federal government adopted a new drug strategy, with a core pillar of harm reduction in 2016, including the legalisation and regulation of cannabis. The strategy is led by the Minister of Health and introduced extended support for supervised consumption facilities and needle exchange programmes.

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5.4 Switzerland has been at the forefront of pioneering evidence-based interventions for managing illicit drug use. The Swiss national drug policy, introduced in the 1990s, is comprised of four pillars: prevention, therapy, harm reduction and prohibition. Specific harm reduction interventions include heroin assisted treatment and supervised consumption facilities. 17

5.5 Supervised consumption facilities have been found to be effective in maintaining contact with marginalised groups with associated improvements in hygiene and safer use. Research has also shown that supervised consumption facilities are associated with self-reported reductions in risky injecting behaviours, reducing the risk of HIV transmission and overdose. 18 A review of supervised consumption facilities found that they do not enhance drug use or drug trafficking. 19

5.6 A review of heroin assisted treatment in Europe and Canada found that it was effective in reducing the use of ‘street’ heroin, improvements in health and reducing crime. 20 Other countries to adopt a harm-reduction approach include the Czech Republic, Norway and the Netherlands.

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