Summary:

1. Drug policies should be based on evidence of cost-effective health and social benefits for people who use drugs and for their families and communities: Criminal sanctions only add to any harms caused by the use of drugs, and are an expensive and ineffective option which waste public money and do not reduce harms to people, families or communities.

2. Re-instatement of funding and of central oversight: I have seen cuts to funding locally and nationally caused by reorganisation of drug treatment service commissioning and provision since 2013 which have seen them move in the main outside of the control NHS and into local authorities, without any ring fencing of their budgets. It is a challenge to provide a high quality service where the needs have increased while the funding has fallen for example in Birmingham by 46%. The devolution of commissioning to local authorities has led to a post code lottery for clinical services which need expert central co-ordination.

3. International opinion has now moved to accept that countries should move towards decriminalisation of possession of all drugs for personal use. (see more detail below)

4. Drug Consumption Rooms are accepted as an integral part of effective drug treatment services in areas where they are needed around the world. The UK needs to learn from international evidence of efficacy.

What is the extent of health harms resulting from drug use?

I visit the Birmingham Coroner’s Office every two months, in order to collect information about drug related deaths in order to find ways to prevent future deaths. I have seen drug related deaths rise over the last four years in Birmingham. In 2018, we saw twice as many accidental drug overdose deaths as in 2015. The deaths are disproportionately high among the most vulnerable people who are either sleeping outside or vulnerably housed in hostels, and among those who are not engaged with the drug treatment services.
5. We have seen new cases of HIV in this population in Birmingham in the last two years, and increasing numbers of drug related infections of all kinds.
6. In our local prison we have seen deaths during 2018 (two still awaiting inquest) which the Coroner feels are related to the use of synthetic cannabinoids, as well as considerable morbidity among the vulnerable prisoners who should be in a place of safety.
7. We have seen increasing numbers of deaths associated with cocaine in the city, which is thought to be because of its historically high levels of potency (increased from 30% to over 80% purity) despite all efforts at prohibition.
8. In Scotland we have seen an upsurge in new cases of HIV among the people who use drugs in that city. 133 new cases between 2015 and 2018, around half being part of the local homeless community. It is clear to those involved that a “Safer Drug Consumption Room” (SDCR) should be part of the response to this local problem. The international evidence that this would be likely to reduce HIV and other infections, and reduce drug related harms and community harms associated with drug use was described in the Home Office report in 2014, but despite this our present Home Office continues to say that they will not support a pilots in the UK. I find this astonishingly short sighted, when the clinical need and the business and health and cost effectiveness case has clearly been described in Glasgow.
https://www.gov.uk/government/publications/drugs-international-comparators

9. At the Committee on narcotic Drugs meeting in March 2019, the UK statement included the sentence: “International efforts to reduce HIV transmission have fallen short so we must redouble our efforts here”.
10. I would suggest the UK should look within its own home, and accept that Drug Consumption rooms when needed by communities have been found to be a cost effective part of a properly balanced drug treatment system and as such are now endorsed by the International Drug Control Board as being within the spirit of the International Conventions.

Treatment and harm reduction:

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.

11. Since the Health and Social care act 2012, when drug treatment was moved out of the NHS and into Public Health (where there was initially no experience in commissioning and provision of these services ) there has been a reduction in clinical excellence and in the quality and training of staff. When in 2013, Public Health moved into local authorities, there was initially no expertise at all, and no ring fencing of the drug and alcohol budgets.
12. This resulted in the budget for drug and alcohol services in my city of Birmingham (the largest LA in the country) being cut by 46% since 2015. It has been a challenge to run a safe and effective service for half the money. Inevitably staff are stretched and sometimes overwhelmed by the challenges. The harm reduction services which were in place before 2015, are now being re-invented, but of course funding is less. The Birmingham Coroner has said that “it cannot be unrelated” that drug related deaths have increased.

13. I am the data analyst for the Drug Related Death Local Inquiry Group in the city, and can report that the number of people who have died because of drug overdose has more than doubled in this period of time, from 46 deaths in 2015, to more than 90 people who died in 2018.

14. All local professionals and volunteers in the field are doing their best, but with half the resources.

Is policy is sufficiently geared towards treatment? This includes the extent to which health is prioritised, in the context of the Government’s criminal justice-led approach.

15. Our local West Midlands Police and our Police and Crime Commissioner are united in feeling that people who are affected by use of drugs are best diverted away from the criminal justice system (which they point out is expensive and ineffective) and towards the health and social care they need. They have started to do this, but of course at times they find themselves constrained by the Home Office.

16. The West Midlands Police contributed in a positive way to the organisation of a pilot “pill/powder testing pilot” at a music festival in the City last summer. They analysed the results and found that from a police and health point of view it was a very successful event, showing what can be done when common sense is applied.

17. I took part as a volunteer and it was clear to me that very useful harm reduction conversations were possible with teenagers who had never spoken to a professional about drug harms and drug use before. It was a fascinating experience for myself as an aging GP, and for example I was able to explain that one young man, that the substance he had been sold as ketamine, was in fact Chloroquine (a malaria treatment).

18. These harm reduction schemes can save lives and reduce harm to young people who all over the world are using drugs recreationally with no effective regulation and no contact with professional advice. They need support and I was pleased to see that the Home Office supported a recent pilot in Weston Super mare. However they seem to me to make a mockery of our laws which normally ask the Police to apply criminal sanctions for the possession of drugs controlled by the Act. This is why I believe we should follow the thirty other countries who have decriminalised possession of all drugs for personal use.
This is now accepted as best practice by the UN Chief Executives Board..(see below) including the UN Office of Drugs and Crime.

Best practice:

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

19. Our drug policy is still dictated by the Home Office. I would suggest it should be led by the Department of Health. International opinion confirms that criminal sanctions for the use of drugs are ineffective as well as inhumane, and that drug policies should instead be based instead on Public Health.

20. As you will be aware, this happened in Portugal in 2001. They simultaneously removed criminal sanctions for possession of drugs for personal use, and transferred the money released from the criminal justice system into the health and social care support for people who needed it. You will have seen the results, which include falling rates of HIV, falling rates of drug related death, no increase in the number of people using heroin, and a fall in the number of drug related cases in prisons.

21. The International drug policy conventions are overseen by the United Nations Office on Drugs and Crime, (UNODC) based in Vienna. They meet with all the member nations, at the Commission on Narcotic Drugs each year in Vienna in March. In March this year, just before the annual CND meeting, the United Nations Chief Executives Board, which coordinates the 31 United Nations groups, including the UNODC, launched an unusual document which they signed unanimously, calling on countries to work towards harm reduction and health-based drug policies. In particular they recommended decriminalising the possession of all drugs for personal use.

22. They stated that “punitive drug policies are ineffective in reducing trafficking and in reducing non-medical drug use and supply.” I would suggest that UK drug policy should follow their advice.

23. They suggested that Member States should aim :“To promote alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use”

24. https://www.unodc.org/documents/commissions/CND/2019/Contributions/UN\_Entites/What\_we\_have\_learned\_over\_the\_last\_ten\_years\_-\_14\_March\_2019\_-\_w\_signature.pdf

25. The new “International Guidelines on Human Rights and Drug Policy” was published on March 13th 2019 by the WHO, UNAIDS and UNDP,

27. https://www.humanrights-drugpolicy.org/

28. Section Nine states: “Utilise the available flexibilities in the UN drug control conventions to decriminalise the possession, purchase, or cultivation of controlled substances for personal consumption.”

29. As a member of International Doctors for Healthier Drug Policies (IDHDP). I spent March 14th and 15th 2019 at the United Nations in Vienna, at the annual meeting of the UN Committee of Narcotic Drugs.

30. It seems to me that the UK is lagging behind world opinion on human rights-based drug policy which respects the Sustainable Development Goals (SDGs) launched and signed by the UK in 2015 with 17 powerful and practical aims to change the world by 2030. Since 2015, both countries and international third sector organisations have realised that: “Drug policy reform is a development issue: we cannot achieve the SDGs unless we end the ‘war on drugs’.”

31. From my experience working in the field since the 1980s, I have come to believe that in the UK we have been wasting money by focussing our efforts on expensive criminal justice-based policies which have caused more harm than good to my patients over the years.

32. Even the police are recognising that attempts at prohibition are not only expensive but also in-effective, and increasing numbers of young people are dying decades too early. We need to divert resources into health and social care and away from what does not work (the criminal justice system) in order to save public money, reduce harm and prevent future deaths.