# Written evidence from DrugScience

## 1. Executive summary

- The extent of health harm resulting from drug use is enormous, as estimated in a wide range of studies.

- Rates of drug-related overdose death in the UK continue to be among the highest in Europe.

- Other health harms include infections, secondary infections, as well as indirect health impacts.

- Drug misuse is linked to personal (micro) and social (macro) origins, covering a broad range of issues from social deprivation to adverse childhood effects.

- There is a strong case for early intervention and education strategies to address drug misuse and reduce drug harms.

- The effectiveness of efficiently delivered, evidence-based policies and treatments for drug misuse is well established.

- Yet in the current criminal justice-led approach to drug policy health is not prioritised.

- Evidence points to a state-control model of drug policy being the most effective at managing health (and other) harms.

- Portugal offers an excellent evidenced-based example of a drug policy revision that has led to significantly better individual, social and economic outcomes.

- In line with the UN Chief Executive Board (March 2019), DrugScience recommends the decriminalisation of people who use drugs.

## 2. The role of DrugScience
DrugScience wants to see a world where drug control is rational and evidence-based; where drug use is better informed and drug users are understood; and where drugs are used to heal, not harm. By delivering, reviewing and investigating scientific evidence relating to psychoactive drugs we provide an evidence base free from political or commercial influence, creating the foundation for sensible and effective drug laws.

We submit evidence in order to continue to contribute to the current scientific, political and ethical discussions regarding drug harms, including the importance of drug education, prevention, harm reduction and treatment. DrugScience is keen to be involved in the development of an evidence-based policy framework, in which drug use is no longer regarded as a crime but as a health issue, to be efficiently addressed and compassionately treated.

3. Health and harms

The extent of health harm resulting from drug use is enormous, as estimated in a wide range of studies, all of which are well known and available. For the purpose of brevity, we only highlight some of these studies, and present further references for many others. In all cases of drug harm, it is vital to distinguish between the action of the substance, the relationship between dose and harm, and the harms caused by a lack of quality assurance.

3.1. Drug related morbidity and mortality

Rates of drug-related overdose death in the UK continue to be among the highest in Europe, despite (or arguably because of) the comparatively harsh penalties for drug users (ONS, 2017). While there has been a slight decrease in drug deaths between 2016 and 2017, the numbers of deaths remain historically high (GOV 2018). Fentanyl analogue deaths as well as cocaine deaths have been steadily increasing since 2010.

People in drug treatment or in prisons who have used opioids are six time more likely to die prematurely than people form the general population (Pierce et al, 2015), and opioid users who have never been in treatment are at the greatest risk of drug-related death (PHE, 2016).

3.2. Infections

The extent of infections among people who inject drugs (PWID) is described in detail by PHE (2016)\(^1\). PWID are the group most affected by hepatitis C in the UK, prevalence remains high with at least a quarter currently living with hepatitis C, and many unaware that they are infected, raising the risk of further transmission.

There is also the risk of increased sexually transmitted infections due to vulnerability and coercion from drug use. While most PWID have been diagnosed and are accessing HIV care, their HIV is often diagnosed at a late stage (PHE, 2016).

Around half of all PWID have a recent symptom of a bacterial infection. Incidents of MRSA and MSSA have increased (PHE, 2016).

In the prison population, rates for blood-borne viruses (BBV) and tuberculosis are far higher compared to community primary care and the general population (PHE, 2016).

3.3. **Secondary consequences of infection**

There are a range of secondary consequences of these infections, including but not limited to: liver cirrhosis, liver failure, AIDS, heart failure due to bacterial endocarditis, mobility loss due to bone infections and amputations, chronic ulcers due to skin infections, and brain injury due to abscess and other post infectious brain damage. Other organ damage might occur due to organ infection abscesses e.g. bacterial endocarditis.

Further, neuronal loss and secondary brain function loss can occur, leading to dementias and brain syndromes due to drug or alcohol use. Reduced consciousness might result from trauma, and respiratory depression can cause anoxic brain and other tissue injury.

3.4. **Indirect negative health impacts**

The impacts of drug [including alcohol] use on health are wide ranging, going much further than health harms of the individual user (Nutt et al, 2010). Rather, they tend to have a ripple effect on the environment. For instance, there are various indirect negative health impacts on the therapeutic use of drugs due to prohibition and stigma. It is well recognized that prohibition or intense legal control of drugs with therapeutic value, generally pain killers, reduces access to them. This results in poor pain control in the most vulnerable, in particular during end of life palliative care and in low and middle income countries\(^2\) \(^3\).

As such, a sole focus on individual health harms is insufficient as drug use is associated with a broad range of further harms that need to be incorporated in policy making. Drug use often places an enormous strain on the families of users, especially the children involved, potentially causing serious harms to children of any age. Parental drug misuse can have a serious long-term impacts on the health and well-being on family members (Clinical Guidelines on Drug Misuse and Dependency Update, 2017), and be severely detrimental to children’s development (Keen and Alison, 2001).


\(^3\) [https://catalyst.nejm.org/quandary-opioids-chronic-pain-addiction/](https://catalyst.nejm.org/quandary-opioids-chronic-pain-addiction/)
4. Prevention and early intervention

Drug use is linked to personal (micro) and social (macro) origins, covering a broad range of issues.

On a macro level, underlying social drivers include inequality, poverty and deprivation. It is vital to understand how the environment affects the choices that an individual can and does make. Unemployment, poverty, crime, housing decay and drug misuse are often seen in the same distinct areas (ACMD, 1998).

Although harmful drug use exists in all areas, it is most pronounced in areas of social deprivation, which is associated with poorer health generally (Clinical Guidelines on Drug Misuse and Dependency Update, 2017). The highest rates of drug related problems are nearly always found in the poorest urban areas and there is a strong statistical association between deprivation and drug misuse (ACMD, 1998). Indeed, in the UK, deprivation is likely to make a significant, causal contribution to the cause, complications and intractability of drug misuse (ACMD, 1998).

Furthermore, homelessness is associated with drug misuse, highlighting that measures are needed to better address the root causes of homelessness, so that it can be prevented (Aldridge et al, 2018).

On a micro level, the key influences associated with both the initial as well as the continued, sustained use of drugs are family and friends, as well as the wider environment as drug choices are often informed by current fashion and trends (ACMD, 1998).

Adverse childhood events (4 or more) predispose the brain to find drugs more rewarding and thus are a risk factor for future drug dependence. These include for example whether a family is conflict ridden, or whether there is absence of affection (ACMD, 1998) or abuse of varying kinds. Additionally, genetic risk factors and poor mental health can be contributing factors to drug misuse. This complexity of factors between drug use and personal and social factors needs to be fully understood and incorporated in policy making.

4.1. The need for early intervention to address drug misuse

For successful early intervention, there is a need to focus on drug education and communication, rather than prevention per se. This is emphasised by a range of current and past programmes, such as Mentor UK⁴, Personal, Social, Health and Economic (PSHE) education⁵ and Drugwise⁶.

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⁴https://mentoruk.org.uk/alcohol-and-drug-education/
⁶https://www.drugwise.org.uk/does-drug-education-stop-drug-use/
While drug prevention aims to prevent substance use, drug education informs people about facts and explores attitudes and contexts, behaviours and consequences. The key aim of drug education is to enable children to make healthy informed choices. Even if someone chooses to continue using substances, they may do so less dangerously and will have the tools to make an informed and effective decision should they decide to change. It can also delay first use and in this way can be seen as having a harm-reduction outcome. Some drugs have the potential to cure cancer; they may also be lethal if misused. We do not seek to “prevent” their use but educate about it. Neither do we aim to “prevent” alcohol in our culture, much of which revolves around its consumption, we seek to reduce the harm which can result from its use (Hargreaves, 2016). It also has the important role of allowing children to understand and cope with problems to them stemming from alcohol and drug use in their parents.

**Drug education should:**
Include all drugs including medication, volatile substances, alcohol and tobacco.

Be evidence based. Drugs education must be based on robust theory, research and evaluation, its content informed by needs analysis, focusing on use that is most likely.

Be a process that involves all of its' stakeholders - teachers, parents and students.

Be started before young people start to use drugs and establish patterns of behaviour.

Utilise interactive teaching techniques and group activities that engage all learners.

Be delivered by teachers who are confident and trained in its delivery.

Include normative education. Evidence shows that students overestimate drug use amongst their peers and so come to think of the behaviour as the 'norm'.

Include general social skills training to increase the ability to consider risk and implement responsible decisions.

Be part of a ‘spiraling curriculum’, ongoing and revisited throughout a young person’s education.

Be delivered within PSHE, a planned programme of learning that helps young people grow and develop as individuals and as members of families and social and economic communities (Hargreaves, 2016).

Be part of a ‘spiraling curriculum’, ongoing and revisited throughout a young person’s education.

Drugs education should not:
 Simply provide information about alcohol and other drugs without addressing the socio-cultural contexts.

 Be based on scare tactics. These fear based approaches can in fact increase drug use, exaggeration breeding contempt for the overall health message.

 Always be delivered by ‘external experts’ to a school. These ‘experts’ often teach from personal experience that leaves them with opinionated approaches not informed by evidence. In the worst cases they may have hidden and pernicious agendas.

 Be a box ticking exercise. Schools should be committed to delivering drugs education for their students, not for OfSTED (Hargreaves, 2016).

As all pupils are to be taught about mental and physical wellbeing in school from 2020⁷, this urgently needs to include drugs and alcohol. Good quality drug education can impact on changes in specific drug using patterns and reduce the use of drugs and associated problems for young people. As such, it can contribute towards decreased harm and increased safety for young people, their families and communities.

4.2. How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use?

The evidence-base for drug-misuse treatment has improved considerably the past decade (Clinical Guidelines on Drug Misuse and Dependency Update, 2017). Specifically, systems based around motivational interviewing, contingency management and other psychotherapies (such as CBT) have very good evidence bases.

Today, the effectiveness of efficiently delivered, evidence-based treatment for drug misuse is well established, consistently showing that drug treatment impacts positively on levels of drug use, offending, drug-related crime, overdose risk and the spread of blood-borne viruses (Clinical Guidelines on Drug Misuse and Dependency Update, 2017; Hickmann et al, 2018). Drug treatment can result in long-term sustained abstinence for a notable proportion of those entering treatment- this applies to different types of drug problems and different treatment interventions and settings (Clinical Guidelines on Drug Misuse and Dependency Update, 2017).

Moreover, drug treatment can also improve the quality of life for families and carers indirectly affected by drug misuse (Clinical Guidelines on Drug Misuse and Dependency Update, 2017). Thus there is the need for early intervention, especially in cases where children grow up in a detrimental environment (ACMD, 1998).

⁷https://www.wired-gov.net/wg/news.nsf/articles/DNWA-B9RF6Q
Yet while there is significant evidence for the effectiveness of early intervention and prevention strategies, there is also a clear need for further research.

5. **Treatment and harm reduction**

5.1. *How effective and evidence-based is treatment provision?*

Deaths involving heroin and/or morphine have more than doubled since addiction services were transferred from NHS control to local authorities in 2012, and are now at the highest level on record (Drummond, 2017).

Drug and alcohol services have been badly cut back in the UK over the last few years due to sustained funding cuts when drug and alcohol services were moved out of ring-fenced NHS budgets and into local authority budgets which have been repeatedly cut.

This has led to an inequality in health provision for those with drug and alcohol dependence compared with other physical and mental health disorders. This change in funding has created a division between drug treatment and other health treatments which has created less joined-up care pathways. For example, people with dual diagnosis, that is mental health problems and drug dependency, who have poorer prognosis for each condition, now have a more disjointed service due to service been funded and run through different treatment systems. Good evidence-based interventions are available but are now not delivered effectively due to this fracture in treatment and funding. A further detriment has been created by cuts to social care provision which is an essential part of recovery from drug dependence. In some areas, e.g. Glasgow, where this linkage has been recognised, it has been demonstrated that providing easy and quick access to secure housing has improved outcomes for people recovering from drug dependence.

5.2. *Is policy sufficiently geared towards treatment?*

Unfortunately, current policy is not at all geared towards treatment. Health is not prioritised in the current criminal justice-led approach to drug policy. Rather, the punitive approach which focuses on crackdowns and law enforcement, has led to the increasing criminalisation of people who use drugs. Prohibition and the unregulated supply of drugs has not solved any drug-related issues, but rather increased health harms from the illegal drug trade. This is particularly obvious in prisons where the explosion of use of synthetic cannabinoids after urine testing for cannabis has led to an epidemic of harms and many deaths.

6. **Best practice**

6.1. *What would a high-quality, evidence-based response to drugs look like?*

Evidence points to a state-control model of drug policy being the most effective at managing health harms. This is more effective than a free market or a prohibition approach.
6.2. What responses to drugs internationally stand out as particularly innovative and/or relevant, and what evidence is there of impact in these cases?

There are an increasing number of countries decriminalising successfully, especially from a public health perspective. This is in line with developments in the scientific literature that consider decriminalisation as a better policy than criminalisation, a valid alternative to it or at least conclude that there is the urgent need to reconsider current restrictive policies (e.g. Edwards and Galla, 2014; Heinze and Armas-Castaneda, 2015; Husak, 2003). Importantly, in March 2019, the UN Chief Executive Board also unanimously endorsed decriminalization of people who use drugs.

The Portuguese policy of decriminalisation of the ‘consumption, acquisition and the possession for personal use of narcotic drugs and psychotropic substances’ is known as one of the most successful policies of its kind (Cabral, 2017). Hereby, the drug user is not a criminal who needs to be punished but a citizen who suffers from an illness and must be helped.

Previous to the introduction of the current drug policy, Portugal had a very high prevalence of problematic drug use (together with e.g. particularly high rates of HIV infections due to intravenous drug use).

Since the implementation of decriminalisation, the number of HIV and AIDS in drug users has decreased, and the number of deaths by drug overdose has stabilised, now being one of the lowest in Europe (EMCDDA, 2016). Drug consumption of young adults is also low (Santos and Duarte, 2014). Further, the number of drug users seeking medical treatment has increased. The removal of the fear of facing prison sentence might have helped some users in their decision to seek medical treatment (Martins, 2013). Also, the social costs of drug consumption has decreased since the adoption of the policy, resulting in notable economic savings (Goncalves et al, 2015).

Today, after nearly 17 years of implementation of a policy of drug decriminalisation, Portugal offers an excellent evidenced-based example of linking drug policy to significantly better individual, social and economic outcomes.

7. Recommendations

DrugScience recommends:

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- to return evidence-based public health and harm reduction outcomes to the heart of policy making.

- to increase investment in research into new approaches to treatment particularly for opioid dependence – treatments that do not require the use of other addictive opioids such as buprenorphine or methadone.

- to recognise the importance of deprivation as a cause of problematic drug use and to address longer term social inequality and deprivation in policy making.

- to include measures to better address the root causes of homelessness, often associated with drug use.

- to reverse cuts to public health and drug services and to improve drug treatment services. Many drug misusers have a wide range of health and social problems, which require interventions from a variety of providers, and improved communications between providers.

- to involve drug users as active partners in their drug treatment and recovery.

- to further develop various harm reduction strategies. For example, local authority commissioners may need to maintain and expand the provision of effective harm reduction interventions to reduce risk, and prevent and treat infections, such as needle and syringe programmes (NSP), and opioid substitution treatment (OST).

- to offer vaccinations and diagnostic tests to people who inject or have injected drugs before to combat infections. If tests are positive for one of the infections, drug services need effective care pathways and provide access to treatment.

- to improve harm reduction through better communications about drug risks. These also need to include licit drugs, such as alcohol and tobacco which are often problematic.

- to train first responders on how to deal with novel potent opioids (such as fentanyl derivatives) as outlined by PHE (2017)

- to end criminalisation of people who use drugs as agreed by the UN Chief Executive Board in March 2019 and to further explore progressive regulation options, as for example in Portugal.

While policy decisions today have often moved from abstinence to harm reduction practices, our recommendations strongly highlight the need for further progressive practices.
8. BIBLIOGRAPHY


Keen, J. and Alison, L. (2017). Drug misusing parents: Key points for health professionals. Archives of Disease in Childhood, 85, 296-299.


**Further online information:**


