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TAKING A NEW LINE ON DRUGS

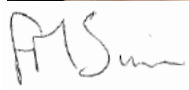


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1 Foreword




Dr Fiona Sim OBE
Chair
Royal Society for Public Health

Drugs policy discourse throughout the 20th century was dominated by the mantra that drug use is a criminal activity, rather than a health issue. However, despite an approach centred around prohibition and law enforcement, this policy has failed to curtail demand or supply, or reduce the harm that drugs cause. We have also tended to view legal and illegal drugs differently, when the

evidence suggests that there is similarity in the harm they cause to health and wellbeing, and that in some cases certain illegal drugs may cause lower levels of harm than some legal substances.

It would therefore be fair to say this approach has failed on many levels. It has criminalised and stigmatised a significant proportion of the population, many of whom are the most vulnerable people in society. It has rendered illegal drugs very much more dangerous than they might be in a regulated market. It has unhelpfully skewed precious law enforcement resources – dictated by the legal status and classification of the drug rather than the harm they may cause. And it has left the public confused about drug harm, which could undermine efforts to encourage individuals to reduce the risks to their health and wellbeing.

This report seeks to explore a different approach to drug policy by setting out how we can move away from viewing drug use through an ideological lens and instead take an evidence-based approach aimed at improving and protecting the public's health and wellbeing. The objective would be to reduce drug-related harm – this would include minimising substance abuse, but this would not be the end in and of itself.

Our approach seeks to focus development of drugs policy on minimising the specific harms drugs can cause to people and society. This would necessarily involve rebalancing our approach to legal and illegal drugs, doing our utmost to prevent drug abuse in the first place, but also ensuring that harm is minimised for those who do use substances, whilst ensuring that those responsible for the harm are brought to account. It is time we considered taking a new line on drugs.




Professor John Middleton
President
Faculty of Public Health

The Faculty of Public Health is pleased to be part of this report. We need a new, people-centred approach to drug policy, rooted in public health and the best available evidence. This report is an important part of a growing, powerful evidence base that sets out what that approach should look like. The time for reframing the

global approach to illicit drugs is long overdue. The imbalance between criminal justice and health approaches to illicit drugs is counterproductive. Criminalisation and incarceration for minor, non-violent offences worsen problems linked to illicit drug use, such as social inequality, violence and infection. Possession and use should be decriminalised and health approaches prioritised.

Drug harm operates across a socio-economic and ethnic gradient. Illicit drug use worsens health inequalities and health-related harms, including the stigma of a criminal record, violence, debt, social breakdown and infection risk. Addressing economic and social disadvantage is essential to addressing the root causes of addiction and addictive behaviours.

A harm-reduction approach is fundamental to tackling these problems. Recovery – reducing chaotic lifestyles and enabling educational, employment and housing opportunities – is also important. However, the dominant concept of recovery as equating to abstinence is limiting.

Drug education in schools – provided through the medium of high quality Personal, Social, Health and Economic (PSHE) education – should be a key part of the curriculum, and taught from an early age. Educational approaches for young people must be evidence-based, interactive and peer-led – 'just say no' just won't cut it.

2 Executive Summary

This report, 'Taking a New Line on Drugs', comes at a timely moment for drugs strategy both in the UK and across the world. The special session of the United Nations General Assembly on the world drug problem, which took place in New York in April 2016, represented a missed opportunity to move on from the 'war on drugs' and take a new approach, despite the pioneering policies focused on public health and harm reduction being pursued by a number of nations. In the UK, the Psychoactive Substances Act came into effect in May 2016, and we await a refreshed Government drugs strategy later in the year.

'Taking a New Line on Drugs' assesses the situation in the UK as regards rising health harm from illegal drugs, with reference to their context within the wider 'drugscape' of legal drugs such as alcohol and tobacco, and sets out a new vision for a holistic public health-led approach to drugs policy at a UK-wide level.



1. 'Drugs' are not just those substances that are currently illegal. They also include socially-embedded legal substances, such as alcohol and tobacco, used by the majority of people in the UK. Drugs strategy must reflect this reality, and not create artificial and unhelpful divisions.
2. All drug use increases the risk of some form of related harm, be it to the individual, those around them, wider society, or all three. However, drug harm cannot be objectively measured on a single scale – it is multi-faceted, including physical, psychological and social harm, both to the user and to others. Every drug has a different harm profile across these categories, and so it is too simplistic to only say 'drug A is more harmful than drug B'.
3. Illegal drug use in the UK rose through the 1960s to 1990s, but has fallen over the course of the past decade. However, this overall fall hides the increase in the use of Class A drugs – those deemed most harmful under the existing classification system – and the take up of new psychoactive substances, the rate of which remains uncertain. More importantly, drug harm is not declining in line with the fall in use, and there have been increases in many types of harm including the number of deaths. Levels of drug harm, not simply levels of drug use, should be taken into account when considering the success of drugs policy.
4. At both individual and population level, alcohol and tobacco cause far greater harm to health and wellbeing than many of their illegal counterparts. Tobacco kills the most people and alcohol is not far behind, with death rates from alcohol misuse on the rise. Alcohol and tobacco use alone costs society more than all Class A drugs combined, and our policy priorities should reflect this.
5. Only a quarter of the public believe the current UK drugs strategy is effective in protecting their health and wellbeing.
6. The current legal framework is confusing for the public, and does not correlate with evidence-based assessment of relative drug harm. This situation is likely to get worse with the recent introduction of the Psychoactive Substances Act.



7. Internationally, increasing numbers of countries, alongside the World Health Organisation, are recognising the failures of prohibition-centric drugs policies. Instead, they are moving towards a public health approach which focuses primarily on reducing the overall level of harm associated with drug use, rather than the level of drug use itself, accepting that a certain level of use will always remain inevitable among those who are unable or unwilling to stop. International pioneers such as the Netherlands, Canada and Portugal have seen encouraging results, with reduced levels of drug harm and without the increases in use feared from decriminalisation.
8. From a public health perspective, the purpose of a good drugs strategy should be to improve and protect the public's health and wellbeing by preventing and reducing the harm linked to substance use, whilst also balancing any potential medicinal benefits. RSPH is calling for the UK to consider exploring, trialling and testing such an approach, rather than one reliant on the criminal justice system. This could include:
 - a. Transferring lead responsibility for UK illegal drugs strategy to the Department of Health, and more closely aligning this with alcohol and tobacco strategies.
 - b. Preventing drug harm through universal Personal, Social, Health and Economic (PSHE) education in UK schools, with evidence-based drugs education as a mandatory, key component.
 - c. Creating evidence-based drug harm profiles to supplant the existing classification system in informing drug strategy, enforcement priorities, and public health messaging.
 - d. Decriminalising personal use and possession of all illegal drugs, and diverting those whose use is problematic into appropriate support and treatment services instead, recognising that criminalising users most often only opens up the risk of further harm to health and wellbeing. Dealers, suppliers and importers of illegal substances would still be actively pursued and prosecuted, while evidence relating to any potential benefits or harm from legal, regulated supply should be kept under review.
 - e. Tapping into the potential of the wider public health workforce to support individuals to reduce and recover from drug harm.



From a public health perspective, the purpose of a good drugs strategy should be to improve and protect the public's health and wellbeing by preventing and reducing the harm linked to substance use, whilst also balancing any potential medicinal benefits.



3 Background

This section sets out what we mean when we talk about ‘drugs’, the harm these drugs can do, and how that harm has been developing over time.



We should recalibrate out understanding to acknowledge that most UK adults use psychoactive drugs.



3.1 What are drugs and why do we use them?

When many people think of ‘drugs’, they tend to think of those substances the use and supply of which is prohibited by the state. The use of alcohol and tobacco has become so socially embedded that we no longer tend to think of them as drugs at all – yet this, in reality, is what they are. A dictionary definition of a drug is as ‘a medicine or other substance which has a physiological effect when ingested or otherwise introduced into the body’¹. Alcohol and tobacco (more specifically, the nicotine it contains) are among those drugs classed as psychoactive, in that they affect the mental processes of the user². It is these psychoactive drugs, as a whole, that form the subject of this report.

In recognition of this we should recalibrate our understanding to acknowledge that most UK adults use psychoactive drugs. Of those that are legally available, eight in 10 drink alcohol³, and around one in five smoke tobacco⁴. There are also significant numbers who take prescribed psychoactive drugs, with one in 11 having used prescribed antidepressants in the past year⁵ and one in 10 regularly taking sleeping pills⁶.

A smaller but significant number use illegal drugs (based on self-report past year use): most common is cannabis (around one in 15), followed by cocaine (almost one in 45) and ecstasy (around one in 60). A much smaller number (one in 1,000) use opiates, including heroin and methadone⁷. Illegal drug use is higher among young people, with one in 10 11-15 years olds reporting having taken an illegal drug in the past year⁸. The prevalence of use of new psychoactive substances (NPS) – substances that mimic the effects of a number of illegal drugs, but with a different molecular structure – remains a relatively unknown quantity, although it is thought to be largely confined to those who also use traditional illegal drugs⁹.

Based on their effects and mode of action in the body, psychoactive drugs can be roughly divided into three classes (although it should be noted that some drugs, such as cannabis, straddle more than one of these categories)¹⁰:

- **depressants**, including alcohol and heroin, which slow normal brain function, provide pain relief and euphoria;
- **stimulants**, including cocaine and nicotine, which elevate mood and alertness;
- **psychedelics/hallucinogens**, including LSD and magic mushrooms, which alter perception of reality.

LEGAL

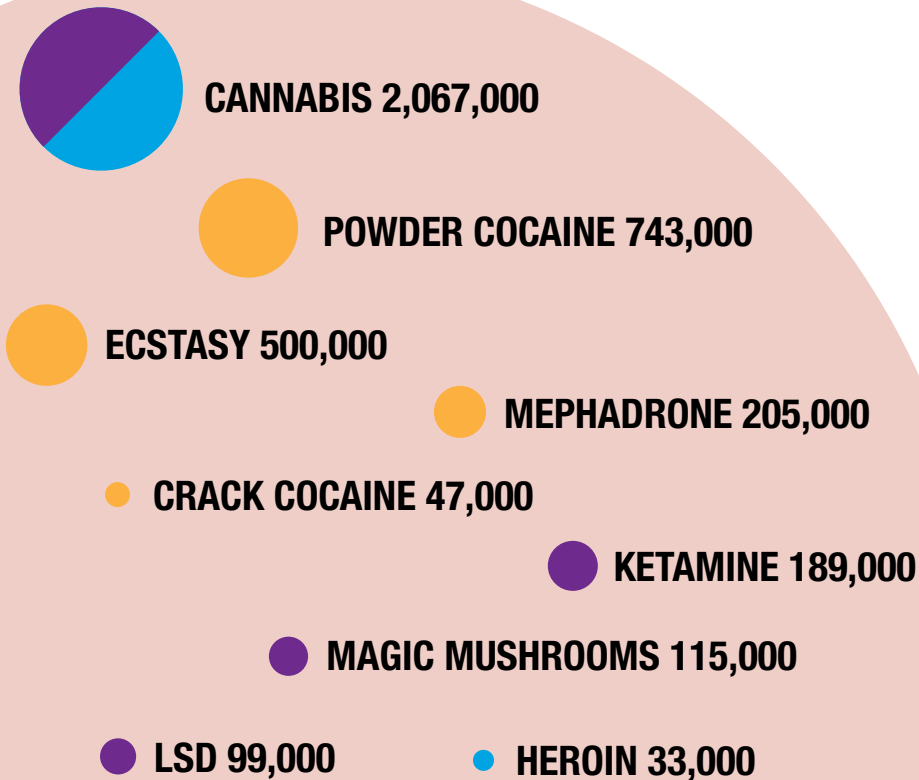
ALCOHOL 38,849,040

TOBACCO 9,344,200

UK drug users by category and legal status

● = Depressants ● = Stimulants ● = Psychedelics/hallucinogens

Source: Home Office¹¹



ILLEGAL

PRESCRIPTION

3 Background

Why people use drugs

2 IN 5
TO RELIEVE
PAIN

2 IN 5
TO BE
SOCIABLE

ALMOST
1 IN 5
TO RELIEVE
DEPRESSION
AND/OR
ANXIETY

1 IN 3
TO FEEL
MORE
RELAXED

And why they don't

ALCOHOL OR TOBACCO

1 IN 4
SAY IT'S TOO
RISKY OR
HARMFUL

1 IN 6
DON'T LIKE
OR DESIRE
THE EFFECTS

1 IN 10
DON'T WANT
TO RISK
ADDICTION

ILLEGAL DRUGS

1 IN 10
DON'T
LIKE OR
DESIRE THE
EFFECTS

1 IN 4
SAY IT'S TOO
RISKY OR
HARMFUL

1 IN 10
DON'T WANT
TO RISK
ADDICTION

People initially experiment with drugs for a variety of reasons: out of curiosity, because of peer pressures or rebelliousness. This initial experimentation typically occurs at a young age – up to half of young people may have experimented with illegal drugs or solvents by the time they are 16¹². They continue to use them, among other reasons, to relax, to become intoxicated, for pleasure, for escapism, to lose inhibitions, to enhance socialising and other activities, to self-medicate and relieve pain, to improve mood or, in some cases, to relieve cravings linked to dependence¹³. This dependence can also result from prolonged use of prescribed medication, such as opiate-based painkillers.

Law enforcement and historical, social and economic forces all help determine who is exposed to which drugs. Poverty, unemployment and social deprivation are particularly significant factors that contribute to more risky patterns of substance use¹⁵.

However, some individuals are more likely to engage in riskier substance use than others¹⁶. Those with pre-existing mental health conditions, including anxiety and depression, are particularly at risk¹⁷. It is estimated that up to half of people with mental health problems also have current alcohol or other drug issues¹⁸.



Source: RSPH public opinion survey¹⁴.

3.2 Drug-related harm

The majority of people who use drugs (broadly defined) do so without experiencing significant health, financial or other harm. However, all drug use increases the risk of some form of related harm, be it to the individual, those around them, wider society, or all three.

The 16 harm criteria agreed on by the Advisory Council on the Misuse of Drugs (ACMD), set out in the table below, express the various ways in which drug use can result in harm¹⁹. These are clustered into five subgroups and represent physical, psychological and social harm, with harm to the individual separated from harm to others. The types of harm include those which are both directly and indirectly health related.

Table 1: types of drug harm. Adapted from Nutt et al. 2010²⁰.

		Types of harm	Examples
To users*	Physical	Drug-specific mortality	Acute alcohol poisoning, heroin overdose
		Drug-related mortality	Fatal road traffic accidents, lung cancers, suicides
		Damage-specific damage	Cirrhosis, seizures, strokes, cardiomyopathy, stomach ulcers
		Damage-related damage	Consequences of unwanted sexual activities, self-harm and blood-borne viruses
	Psychological	Dependence	Alcoholism, heroin addiction
		Drug-specific mental impairment	Ketamine intoxication, drunkenness amphetamine-induced psychosis
		Drug-related mental impairment	Mood disorders, such as depression, related to drug use or lifestyle
To others	Social	Loss of tangibles	Loss of income, housing, employment; imprisonment
		Loss of relationships	Damaged relations with friends or family
	Physical and Psychological	Injury	Domestic violence, road crashes, foetal harm, transmission of blood borne viruses
	Social	Crime	Acquisitive crime
		Environmental damage	Toxic waste from drug production, discarded needles
		Family adversities	Family breakdown, child neglect
		International damage	Deforestation, destabilisation of countries, international crime
		Economic cost	Costs to healthcare, police, prisons, social services; indirect costs e.g. lost productivity
		Community	Decline in social cohesion and community reputation

3 Background



By scoring 20 drugs taken in the UK against the 16 harm criteria, the ACMD illustrated how different drugs vary in their specific combination of physical, psychological and social harm, and facilitated a balanced assessment of overall harm for each drug²¹. Heroin, crack cocaine and methamphetamine were identified as causing the greatest harm to users, whereas alcohol causes the greatest harm to others by a wide margin. Drug-specific mortality substantially contributes to harm from a number of drugs including alcohol and heroin, with economic cost also a high contributor for tobacco, cannabis, alcohol and heroin²².



It is very difficult to assess the scale of the impact of drug use on longer term mental health.



3.2.1 Harm to users

The majority of mortality from illegal drugs is due to accidental poisoning, which accounted for more than three quarters of recorded illegal drug misuse deaths in 2012²³. More than four in five are related to opiate use²⁴.

Acute and chronic physical harm varies greatly depending on the drug used, although many drugs cause damage to the same body regions and organs and may have similar harmful effects²⁵. The severity of physical harm is also highly variable depending on the drug, frequency of use and dosage.

Physical harm related to drug use is not simply a direct result of drug pharmacology but may also result from the method of administration. Hepatitis C, for example, is a blood borne infection spread by the sharing of drug paraphernalia including needles and pipes, and which contributes greatly to drug-related mortality and morbidity. Two in five drug injectors in the UK are infected with hepatitis C²⁶. While HIV transmission among injecting drug users remains a serious problem in many other countries, only 1% of UK users are now infected, largely thanks to the implementation of successful harm reduction programmes²⁷.

Physical harm related to drugs can also include injuries which occur when intoxication causes a loss of coordination or impaired judgement.

People often use drugs for positive psychological effects at the time of use, such as increased sociability, energy, improved mood, euphoria or hallucinations²⁸. Conversely, both during and after use, some drugs can leave users feeling anxious, depressed, irritable, confused and/or paranoid, depending on the substance and manner of use²⁹. Continued use can have further effects on mood, including chronic depression, anxiety and in some cases, psychosis³⁰. Prolonged use of some drugs has also been linked with higher rates of suicide – individuals with a substance abuse disorder are six times more likely than non-drug users to attempt to take their own life³¹.

However, it must be noted that it is very difficult to assess the scale of the impact of drug use on longer term mental health, as the relationship between the two is so complex. While certain drugs can initiate or make existing mental health conditions worse – for example, there is evidence to suggest that cannabis use is a risk factor in developing symptoms of psychosis and that prolonged use may increase the risk of psychotic disorder by impacting on the persistence of symptoms³² – people with pre-existing mental health conditions are also more likely to turn to substance use in the first place³³.

Prolonged use of all substances, including prescribed psychoactive and analgesic medications, can lead to dependence, both psychological and sometimes physical, with a risk of withdrawal syndrome if use is suddenly halted. The severity and symptoms of dependence vary greatly depending on the drug, individual, and usage behaviours. The scale of illegal drug dependency is difficult to define and quantify, but the estimated figure of 371,279 ‘high risk’ drug users in the UK (excluding Northern Ireland) is instructive³⁴.

3.2.2 Harm to others

Drug use can put not just the user but others around them at serious risk of harm. Within intimate relationships where one partner has a problem with alcohol or other drugs, domestic abuse is more likely than not to occur³⁵, and many people with substance misuse problems also have children³⁶ – it is estimated that 2-3% of children under 16 in England and Wales have at least one parent with a serious drug problem³⁷. Drug use can also harm people who are not familiar to the user – one in six road traffic deaths, for instance, involves at least one driver over the legal alcohol limit³⁸.

Drug use (and enforcement) can also have significant consequences at population level, placing strain on health and criminal justice systems and incurring huge social and economic costs. Class A drug misuse (primarily heroin and crack cocaine) in England and Wales alone costs society an estimated £15.4 billion a year – £44,231 per problematic user³⁹. This figure is predominantly accounted for by the social and economic costs associated with drug-related crime – £13.86 billion in 2003/04, with fraud (£4.87 billion) and burglary (£4.07 billion) the costliest criminal acts. Drug arrests alone cost £535 million a year⁴⁰. Of the remainder, £488 million goes on the cost of drug-specific and drug-related mortality and morbidity to the NHS, in providing both acute treatment for the primary effects of drug use, and treatment for secondary effects such as behavioural and mental disorders⁴¹.



“Substance use in the United Kingdom is both diverse and dynamic, with ease of availability and more variety than ever before. It is of paramount importance that we focus on minimising the negative impact on individuals and communities and we ‘future proof’ against emerging substance use issues and the changing profiles of substance users.”

Jim McVeigh
Director
Centre for Public Health
Liverpool John Moores University



3 Background



Trends in use are not all, or the most important part of, the picture – they must be compared with trends in resultant harm, which are not declining in line with use, and are in many cases increasing.



The crude death rate associated with illegal drug misuse has more than doubled in the past 20 years.



3.3 Trends in harm: illegal drugs

In the UK and throughout the Western world, levels of illegal drug use increased dramatically through the 1960s to the early 90s⁴². However, overall illegal drug use in England and Wales has fallen slightly over the course of the past decade, from 12.2% in 2003/04 to 8.6% in 2014/15 (self-reported, last year use, ages 16-59)⁴³. A large proportion of this fall is due to a reduced prevalence of cannabis use, which has fallen from 11% in 2002/03 to 6.7% in 2014/15⁴⁴. This is offset by a slight increase in Class A drug use, which has risen from 2.7% in 1996 to a high of 3.6% in 2008/09 and now sits at 3.2%⁴⁵. Similar trends have been reported in Scotland and Northern Ireland^{46,47}. It is therefore hard to make a case that current drugs policy has been effective in deterring use of those drugs deemed by the current classification system to be 'most harmful'.

However, trends in use are not all, or the most important part of, the picture – they must be compared with trends in resultant harm, which are not declining in line with use, and are in many cases increasing. In England and Wales – which has the most complete and available data – the crude death rate associated with illegal drug misuse has more than doubled in the past 20 years, from 15.7 per one million population in 1993, to 39.9 per million population in 2014⁴⁸. 2014 saw a 17% increase in deaths, following a 21% increase in 2013⁴⁹. Within this, males are more than two and a half times (2.65) more likely to die through drug misuse than females, and those between the ages of 30 and 50 are also more at risk. Both these trends have been on the increase over the past twenty years⁵⁰.

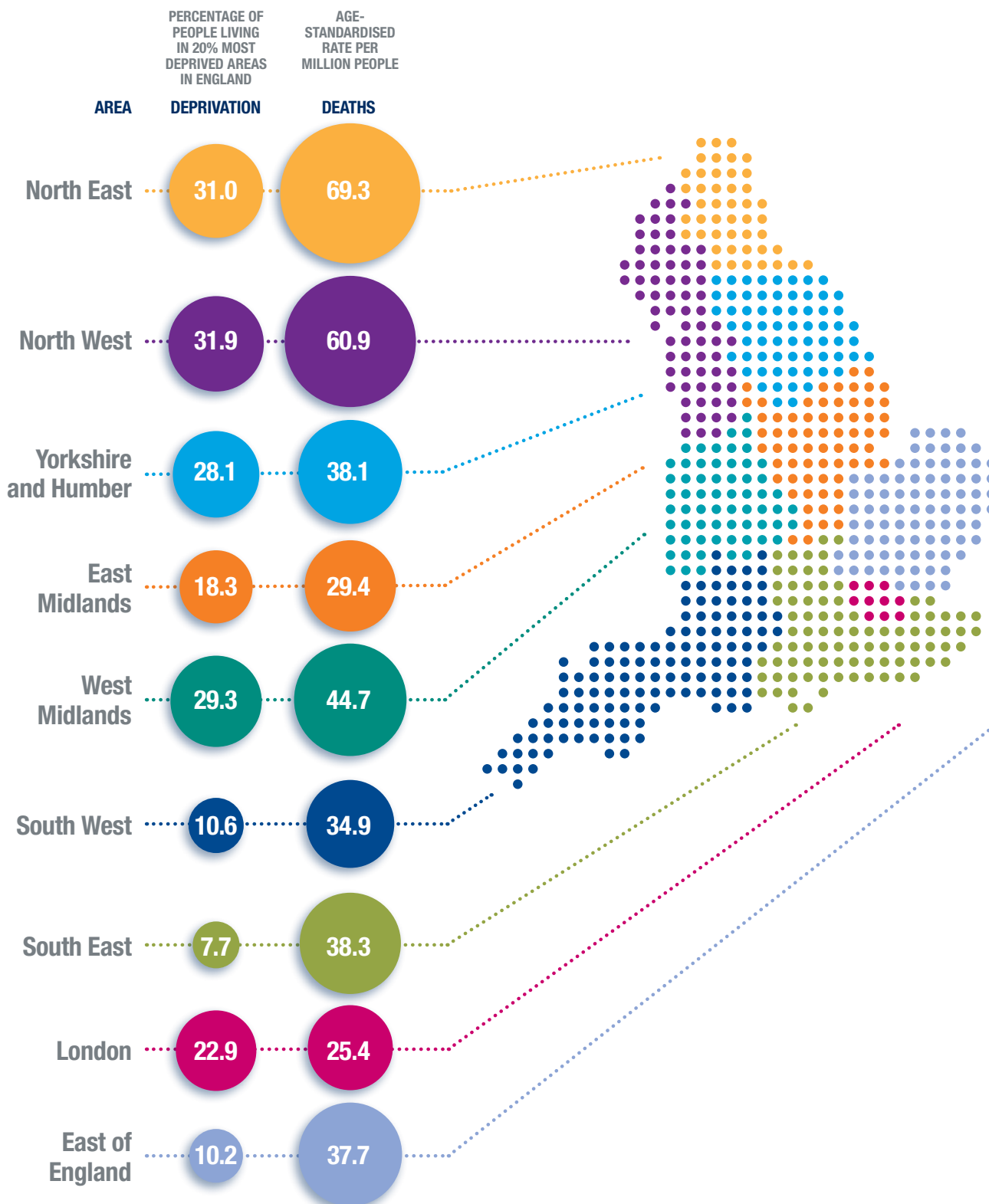
The increase and profile of drug-related mortality can in part be explained by drug-specific mortality trends. Both historically and currently, the use of cocaine and amphetamines, and to a lesser extent benzodiazepines, is associated with significantly lower mortality rates than that of heroin, which has seen a greater increase in deaths in the past 20 years than any other drug⁵¹. Heroin-specific mortality is exacerbated by patterns of high daily usage, often interrupted by prolonged periods of abstinence, treatment and imprisonment, all of which serve to make overdose increasingly likely as users return to use with the same dosage but diminished tolerance for the drug⁵².

In England, there were 7,104 hospital admissions for individuals with drug-related mental and behavioural disorders in 2013/14, down 11% from 2003/04⁵³. However, admissions for drug poisoning have increased by 76.6% over the same period, from 7,876 in 2003/04 to 13,917 in 2013/14⁵⁴.

In terms of harm to others, strain on the criminal justice system is a major consideration. There were 155,832 recorded illegal drug offences in England and Wales in 2015, down from 230,000 in 2013 (note that this figure includes only trafficking and possession offences, not other offences such as theft where drugs were an influencing factor)⁵⁵. This is not necessarily evidence to suggest drug crime is reducing, but may rather be a symptom of a changing police approach. Police forces have increasingly been adopting alternative strategies to cannabis possession, such as on the spot penalties and warnings instead of prosecution, alongside the reform of stop and search policies. Some police forces have already gone so far as to cease actively pursuing cannabis users and small-scale growers⁵⁶. This is recognised by the Office for National Statistics as a reason for the reduction in recorded crime⁵⁷, and by association, cost.

Drug harm is also known to be unevenly distributed towards those from more socio-economically deprived groups. For instance, someone earning less than £10,000 a year is almost five times as likely to be a frequent illegal drug user as someone earning £50,000 or more⁵⁸. It is therefore not surprising to find a correlation between deprivation rates and drug-related mortality rates across the regions of England, as shown here.

Drug mortality versus social deprivation



Source: ONS^{59,60}.



At individual and population level, alcohol and tobacco cause greater health and social harm than many of their illegal counterparts.



3.4 In perspective: harm from legal drugs

The use of alcohol and tobacco – legal drugs – is deeply embedded in our society. Despite increased awareness of significant harm to users, they continue to be used widely by all sections of the population. High levels of harm, both to users and those around them, are prevalent due to the ease of acquisition and social acceptability that accompanies their legal status. At individual and population level, alcohol and tobacco cause greater health and social harm than many of their illegal counterparts⁶¹.

It can be suggested that tobacco has far more dependent users than any other drug in the UK; of the 10 million smokers in the UK, around 6 million may be classed as dependent on the basis that 60% say they would find it hard to go a day without smoking, 63% say they want to quit, and 69% have their first cigarette of the day within an hour of waking⁶². This compares to the 6% of UK adults who show signs of alcohol dependence, equating to about 3.1 million people^{63,64}.

Despite significant declines in use, smoking remains the leading cause of preventable illness and early death in the UK, killing more people each year than the next five causes of preventable death combined⁶⁵. A 50-year study of lifetime smokers has shown that between half and two thirds will be killed by their habit – a higher proportion than from almost any other drug⁶⁶.

Alcohol is the third largest risk factor for preventable disease, responsible for 10% of the UK burden of disease and death, and for a quarter of all deaths among men aged 16-24. The proportion of people dying from a range of alcohol-related causes remains significantly greater than it was 20 years ago in all four UK nations, with a 19% increase in alcohol-related deaths in England from 2001 to 2012⁶⁷. Scotland is the only nation to have seen significant falls over the past decade, but still has the highest mortality rates⁶⁸.

While the impact of passive smoking has been lessened by restrictions on indoor smoking and smoking in cars with children present, alcohol remains a significant risk factor for injury to others – for instance, more than half of all violent crime in 2015 was alcohol-related⁶⁹. Harm to children remains significant, with over half of child protection cases involving alcohol or misuse of another substance⁷⁰. Diagnosed cases of foetal alcohol syndrome have also tripled in England over the past 16 years⁷¹.

High and frequent societal use of alcohol and tobacco puts intense strain on public services in the UK. Alcohol misuse costs England alone around £21 billion per year in healthcare, crime and lost productivity⁷². The cost of smoking to society in England is estimated to be £13.9 billion a year, which includes the £2 billion a year spent by the NHS on treating smoking-related disease⁷³. The joint figure of almost £34 billion a year for these two legal drugs is more than twice the £15.4 billion associated with all Class A drug use combined.

4 The current approach

This section examines how the UK has attempted to deal with illegal drugs to date, contrasts this with developments in other countries, and suggests why the UK needs to think again about drugs strategy.

4.1 Current UK strategy

Despite the profound health consequences related to drug misuse, responsibility for developing drugs strategy for the UK lies primarily with the Home Office, rather than the Department of Health. The UK Government has responsibility for setting the overall strategic direction of drug policy, although the manner of its delivery outside of England is largely a responsibility of the devolved national governments, with Scotland, Wales and Northern Ireland also having their own drugs and alcohol strategies.

The current UK drugs strategy states its overall objectives as follows:

- **Reducing demand**, particularly among vulnerable young people, families and those involved in the criminal justice system.
- **Restricting supply** by tackling the criminal organisations importing and supplying drugs.
- **Building recovery** in communities through the new 'locally-led' system and a greater focus on the wider determinants of drug-use⁷⁴.

In terms of delivering on these objectives, the UK public is currently unconvinced – only a quarter believe current UK drugs and alcohol policy is effective at preventing harm to the public's health and wellbeing⁷⁵.

ONLY 1 IN 4
members of the
public believe
current UK drugs
and alcohol
policy is effective
at preventing
harm to health
and wellbeing

Source: RSPH public opinion survey⁷⁶.



4 The current approach

4.2 The legal framework

At the time of writing, the legal framework for drugs policy in the UK is in a state of some confusion. Spurred by increasing concern about NPS, the Psychoactive Substances Act (PSA) finally came into effect on 26 May 2016, having been delayed while attempts were made to address concerns over enforceability.

Under the PSA, it is now a crime to produce, supply or import any drug that ‘acts on the central nervous system to change mental functioning or emotional state’, a definition meant to encompass all current and future NPS, and which abandons any attempt at evidence-based assessment of relative harm – any psychoactive effect is assumed to be inherently harmful. The Act provides exceptions for food, medicinal products, healthcare activities and research, as well as for alcohol and tobacco⁷⁷. It does not change the status of drugs that are already illegal.

However, it is not a criminal offence to possess substances covered by the PSA. This may create a confusing situation for law enforcement when an individual is found in possession of a given substance – possession is a criminal offence only if it is an illegal drug under the Misuse of Drugs Act and not a psychoactive substance covered by the PSA, but the two may be virtually indistinguishable at the time.

The pre-existing legal framework for illegal drugs is based on the Misuse of Drugs Act 1971, introduced to prevent the non-medical use of potentially harmful drugs. The Act divides illegal drugs into three classes, A, B and C, as determined ‘according to their accepted dangers and harmfulness in the light of current knowledge’, with Class A regarded as the most harmful⁷⁸. The ACMD advises the government on this, although classifications do not always wholly reflect this advice. These classes have been used by subsequent governments to set enforcement priorities and penalties, and inform public health messaging⁷⁹.

The Misuse of Drugs Act is complemented by the Misuse of Drugs Regulations 2001, which authorises certain individuals to supply and possess certain controlled substances – for instance, doctors who can prescribe them for medical reasons. This is done under a system of five ‘schedules’ ranging from drugs that have no accepted use (schedule 1), through prescription-only drugs, to low-strength preparations that require only minimal controls (schedule 5). Unauthorised production, supply, import or possession of these controlled substances is an offence⁸⁰.

Illegal drugs therefore belong to both a legal class and a medicinal schedule. While the function of scheduling to protect the public, while also permitting access to drugs with legitimate therapeutic value, is clear (albeit inconsistent in application), the purpose of the classification system is becoming increasingly less so. Reports from both the House of Commons Science and Technology Committee and the RSA Commission have found this system ‘not fit for purpose’⁸¹. Analysis has suggested there is almost no correlation between overall associated harm and the class of drugs (including legal drugs) in the UK⁸².



There is almost no correlation between overall associated harm and the class of drugs in the UK.



4.2.1 Enforcement and deterrence

In reality, enforcement practice has been evolving independently from drug classification. This is most notable in the case of cannabis, for which the National Police Chief's Council (NPCC) (formerly the Association of Chief Police Officers) has issued specific guidance acknowledging that priorities are divorced from the classification system⁸³.

It is not evident that a drug's legal classification has any effect on its level of availability or use, and the impact of classification changes is not monitored by the Government. The rationale of the current classification system is that more harmful drugs should carry greater penalties, thereby more strongly deterring use and supply. However, in practice:

- Maximum penalties for both use and supply are very poorly correlated with the level of harm associated with illegal drugs⁸⁴.
- Harsher penalties for illegal drug use do not appear to deter use, a point supported by evidence from international comparisons⁸⁵. **Only one in 10 UK adults say that a drug's legal classification has any influence on how likely they are to use it**⁸⁶.
- Penalising use is too blunt a tool to address the nuanced harm associated with substance misuse, and causes further harm to those who are criminalised, a point explored further in section 5.3 of this report.



It is not evident that a drug's legal classification has any effect on its level of availability or use.



With enforcement resources scarce, Durham Constabulary have ceased actively pursuing and prosecuting cannabis users and small-scale growers. Drug enforcement priorities are instead being focused on street gangs, dealers and the large profits resulting from the illegal drug trade.

"I believe that vulnerable people should be supported to change their lifestyles and break their habits rather than face criminal prosecution, at great expense to themselves and to society.

"The scant resources of the police and the courts are better used tackling the causes of the greatest harm – like the organised crime gangs that keep drugs on our streets and cause misery to thousands of people – rather than giving priority to arresting low-level users."



Ron Hogg
Police and Crime Commissioner
Durham Constabulary

4 The current approach



Classification, when done badly, can undermine both trust in the information provided and the public's ability to make informed choices.



4.2.2 Public confusion

Given the poor correlation between drug harm and classification, the current system risks sending misleading signals to the public about relative harm, and this may be contributing to avoidable risk. This is particularly the case for the two in five people who state that a drug's classification influences how harmful they think it is compared to other substances⁸⁷. This disconnect may be behind a number of popular misperceptions, such as most people rating mephedrone as less harmful than LSD, despite research suggesting it has the potential to pose greater risks⁸⁸.

Classification, when done badly, can undermine both trust in the information provided and the public's ability to make informed choices. Public consultation has found that the majority find the current system 'confused, inconsistent and arbitrary'⁸⁹.

The classification system also gives rise to a misleading linear perception of harm by failing to separate out different types of harm. GHB, for example, is a Class C drug, which ranks somewhere between cocaine (Class A) and ketamine (Class B) in terms of overall harm to users. Its lethal overdose potential is extremely high compared to many other drugs⁹⁰, including higher classification drugs such as cannabis (Class B), and yet this vital subtlety is not conveyed by its Class C classification.

Furthermore, the current classification system gives the public no way of comparing the severity of harm from illegal drugs with that from legal drugs. This may contribute to the popular belief that alcohol and tobacco are less harmful, despite overwhelming evidence to the contrary^{91,92}. In the context of NPS, it has also made it difficult to adequately convey risk and dispel the misconception that they are safer than traditional illegal drugs.

Under the PSA, the supply of all NPS is now illegal by default, with penalties decided outside of the existing classification system. This leaves a confusing legal environment that treats NPS, Class A, B, C, and legal drugs in a variety of ways that do not accurately reflect harm or easily evolve in line with emerging evidence.



4.3 International context

The modern-day prohibitionist approach to drugs policy has its legal foundation in the 1961, 1971 and 1988 United Nations drug treaties, ratified and incorporated into the domestic laws of more than 150 countries. This international legal framework mandates criminal sanctions for the production and supply of a range of psychoactive substances, and at least some form of sanction (which may not be criminal) for their possession or use. This has led to high incarceration rates worldwide⁹³. In the US, for instance, it is not uncommon for individuals to be given a custodial sentence, sometimes for life, for cannabis related offences⁹⁴.

However, in recent years there has been a notable shift from policy makers and political leaders across the globe in their approach to drugs, drug users and associated harm and penalties. In 2012, the United Nations Office on Drugs and Crime (UNODC) acknowledged the “growing recognition that treatment and rehabilitation of illicit drug users are more effective than punishment”⁹⁵. The World Health Organisation now advocates a ‘rebalancing’ of global and national drugs policies towards public health and harm reduction, criticising an over-focus on punitive enforcement for hampering the effectiveness of evidence-based harm reduction interventions, stating that this bias has led to “...policies and enforcement practices that entrench discrimination, propagate human rights violations, contribute to violence related to criminal networks and deny people access to the interventions they need to improve their health”⁹⁶.

4.3.1 Moves towards harm reduction

Harm reduction is an approach to drugs policy that focuses primarily on reducing the overall level of harm associated with drug use, rather than the level of drug use itself, accepting that a certain level of use will always remain inevitable among those who are unable or unwilling to stop⁹⁷.

In recent years, more than 90 countries – including the Netherlands, Canada, Switzerland, Uruguay, Spain, Australia and some US States – have adopted an approach to drugs policy that specifically includes a focus on harm reduction⁹⁸. Countries that have long subscribed to heavily enforced supply-side policies and punishment for those caught using drugs are beginning to reconcile elements of harm reduction within their frameworks, or pioneering totally new frameworks, with encouraging results. The following table sets out a number of these.



“
... policies and enforcement practices that entrench discrimination, propagate human rights violations, contribute to violence related to criminal networks and *deny people access to the interventions they need to improve their health.*

World Health Organization, 2016



4 The current approach

NETHERLANDS

APPROACH

- Effectively decriminalises cannabis, tolerates sale from licensed 'coffee shops'
- Aims to dissuade use of riskier drugs
- Aims to reduce harm to users
- Aims to diminish nuisance by drug users
- Aims to combat production and trafficking of drugs by separating cannabis and hard drugs markets

RESULT

- Levels of problem drug use below those of the UK (both general and cannabis specific)
- Treatment programmes associated with reduction in crime
- Separation of cannabis trade from hard drugs trade leads to low prevalence of hard drug use
- 'Coffee shops' generate around £300m in tax annually - used to fund public health and social inclusion

CANADA

APPROACH

- Federal government adopts harm reduction approach, including legalisation and regulation of cannabis
- Improves interdepartmental cooperation and coordination to address public health and public order
- Focuses on prevention, treatment, harm reduction and enforcement priorities

RESULT

- Supervised injecting facilities deemed 'life-preserving' by Supreme Court of Canada
- City that pioneered supervised injecting (Vancouver) sees HIV and chronic Hepatitis C rates plummet

SWITZERLAND

APPROACH

- Expands harm reduction approach for people who inject heroin
- Introduces pioneering heroin-assisted therapy (HAT) programmes and safe consumption facilities
- Prioritises public health and cost-saving above punitive enforcement

RESULT

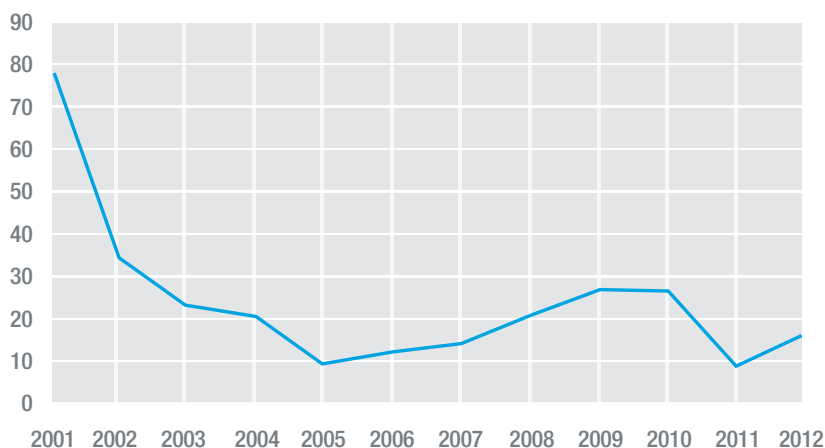
- Health outcomes for heroin addicts on HAT programmes greatly improve
- Criminal activity of HAT participants drops, more than covering cost of treatment
- HAT provision reduces importation of illicit heroin, and new cases of heroin use fall

4.3.2 Portugal and the case for decriminalisation

In 2001, Portugal took the decision to remove criminal sanctions for the personal possession and use of all illegal drugs and instead focus on harm-reduction and health promotion. It had become clear that the country's previous approach of strong prohibition, enforcement and prosecution had failed: by 1999, Portugal had reached crisis point, with almost 100,000 heroin addicts and the highest rate of drug-related AIDS deaths in Europe¹⁰⁹. In the years since decriminalisation and reorientation of resources to health promotion and harm reduction:

- New cases of HIV among those who inject drugs have declined dramatically, from 1,016 in 2001 to 56 in 2012.
- Problem drug use has declined in 15-24 year olds.
- Deaths due to drug use have fallen significantly, from 80 in 2001 to 16 in 2012.
- Cases of hepatitis C and B have both fallen in the drug using population.
- Overall levels of drug use are now below the European average¹¹⁰.
- Social costs, including both indirect health costs and direct costs associated with the legal system, have fallen by 18%¹¹¹.

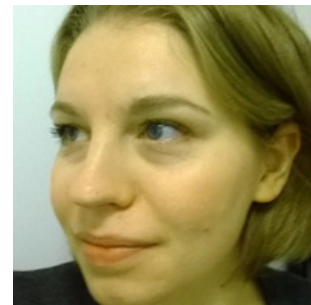
Drug-induced deaths



Newly diagnosed cases of HIV and AIDS among people who use drugs



Source: adapted from Transform 2014¹¹².



When Portugal adopted a health-led approach to drugs in 2001 it did so because it wanted a humane, mature, evidence based strategy to reduce drug harms. In the UK, the government's most recent legislation, the Psychoactive Substances Act, appears to be unworkable and couldn't be more in contrast to these ambitions.



Helen Mills
Research Associate
Centre for Crime
and Justice Studies

4 The current approach



Resources should be re-focused on creating an environment that minimizes drug-related harm as far as possible, and on building a comprehensive system that supports people to avoid, reduce and recover from drug-related harm.



4.4 The need for a new approach

From a public health perspective, the purpose of a good drugs strategy should be to improve and protect the public's health and wellbeing by preventing and reducing the harm linked to substance use, whilst also facilitating any potential medicinal benefits. The current approach is failing to do this in a number of ways:

- Health harm related to drug use is rising;
- Harm remains concentrated among specific and often vulnerable groups;
- Additional and unnecessary harm is being caused to people who use drugs by stigmatization, criminalisation, and illicit drug markets;
- Opportunities to reduce harm are being missed because the public are confused about the relative risk of harm from different drugs, including legal ones;
- Finite resources are not being effectively targeted at reducing harm.

To address these failings, resources should be re-focused on creating an environment that minimises drug-related harm as far as possible, and on building a comprehensive system that supports people to avoid, reduce and recover from drug-related harm. This approach should include reducing use, where this is the most practical and effective route, while also recognising reasons for use. Specific aspects of the approach RSPH would like to see are set out in section 5.



5 A public health approach to drugs strategy

This section sets out an alternative potential approach to drugs policy which places emphasis on supporting the public's health, reducing harm from drugs and moving away from criminalising users.

5.1 Closely aligned, health-led strategies

As we have seen in section 3 of this report, the personal and societal harm associated with legal drugs such as alcohol and tobacco is just as great, if not greater, than the harm associated with many illegal drugs. The misuse of legal and illegal drugs often occurs together, which can multiply their respective harm¹¹³—illegal drugs were combined with alcohol in more than a third (36%) of drug misuse deaths in 2012, a proportion that has remained similar in recent years¹¹⁴.

However, the current UK approach consists of separate strategies for alcohol, tobacco and illegal drugs, with the drugs strategy led by the Home Office rather than the Department of Health. Resources are focused on enforcement relating to drugs that are currently illegal but which are in many ways less harmful than alcohol or tobacco. Every year, the UK spends upwards of £4 billion on enforcement, courts, probation and prison related to illegal drugs¹¹⁵. Some of this resource could potentially be re-focused on illegal activities related to legal drugs. For example, 10-15% of licensed premises in the UK persistently sell alcohol to underage buyers, yet only 0.5% are called up for review¹¹⁶. The strong enforcement of the minimum purchase age for alcohol has been found to be very effective at limiting harm, and given its broad reach, the public health impact can be very high¹¹⁷.

This over-focus on illegal drugs is out of step with the balance of public opinion: 80% of the general public agree that the more harmful a drug is to health, the more tightly controlled it should be. In theory, this could place alcohol and tobacco under tighter controls than a number of currently illegal drugs. This is clearly unrealistic as these are deeply socially-embedded substances, and the criminal markets that could emerge would likely cause more harm than good. While alcohol, tobacco and illegal drugs still require tailored approaches and dedicated resources, it is important to recognise legal and illegal drugs as two sides of the same coin, which cause comparable and often interlinked harm.

This should be reflected at a strategic level, with illegal drugs strategy sitting alongside alcohol and tobacco strategies under the lead of the Department of Health – with ring-fenced funding transferred accordingly. These strategies should not be siloed but closely interlinked and guided by a set of common principles. This would create greater opportunities to share learning and best practice and develop interventions that address cross-cutting issues of addiction and substance misuse.

Transfer lead responsibility for UK illegal drugs strategy to the Department of Health, and more closely align with alcohol and tobacco strategies



Illegal drugs were combined with alcohol in more than a third of drug misuse deaths in 2012.



5 A public health approach to drugs strategy



It would help de-stigmatise illegal drug users and de-normalise alcohol abusers, with positive implications for take-up of treatment for each.



Bringing strategies for alcohol, tobacco and other drugs closer together in this way would help fundamentally reframe the way we perceive and address substance misuse in terms of relative harm, and allow resources to be targeted where they can have the greatest impact. It would help de-stigmatise illegal drug users and de-normalise alcohol abusers, with positive implications for take-up of treatment for each.

Wales has already adopted this approach, going so far as to adopt a unified substance misuse strategy encompassing both alcohol and illegal drugs. When developing the 10 year (2008-18) strategy, 'Working Together to Reduce Harm', policy makers made no distinction between harm caused by illegal drugs and that caused by alcohol, which accounted for 467 deaths in 2013¹¹⁸. Since the implementation of the strategy, Wales has seen deaths from drug misuse decrease by 30%¹¹⁹, and alcohol consumption has fallen on all three measures: drinking above guidelines, heavy (binge) drinking, and very heavy drinking¹²⁰.



5.2 Prevention through universal education

A vitally important aspect of any drugs strategy is giving young people, who are among those most at risk, the tools and understanding they need to make informed choices about drug use (legal and illegal) and avoid or minimise harm. As has already been seen earlier in this report, the current legal classification system is woefully inadequate for this purpose, and must be reformed and supported by a comprehensive education strategy, of which the user-level drug harm profiles outlined in section 5.3 could form a part.

However, current drugs education provision in the UK is inconsistent¹²¹. Drugs and addiction do not feature in the mandatory curriculum. Instead, drugs education is at the discretion of individual head teachers who can decide whether or not it is covered in Personal, Social, Health and Economic (PSHE) education.

Of those educational activities that are provided, the vast majority have not been evaluated, and a number that have been evaluated have been shown to be ineffective, or even counterproductive¹²². To be effective in preventing substance misuse, drugs education must be interactive and take an approach that focuses more broadly on developing resilience, self-efficacy, impulse control and life skills in relation to risk taking behaviour¹²³.

There is a clear and pressing need then, for the provision of drugs education that is both universally available to all young people, and in line with prevention best practice. The Alcohol and Drug Education and Prevention Information Service (ADEPIS), run by the charity Mentor and funded by the Department for Education, has been established to issue guidance on effective drugs education in schools, and advises that proper PSHE education is crucial in helping young people develop the necessary values and skills to avoid drug harm¹²⁴.

RSPH strongly advocates that PSHE education be made a statutory requirement in schools at all key stages. Statutory PSHE education, supported by access to evidence-based resilience programmes, is an important component in addressing not just drug harm but the whole spectrum of young people's health and wellbeing issues, from sexual and mental health to childhood obesity.

Population-wide education through universal PSHE education must also be complemented by specific interventions targeted at those young people who are at particularly high risk of drug misuse, for instance those who have at least one parent with a substance misuse issue.

Introduce statutory, comprehensive, Personal, Social, Health and Economic (PSHE) education in schools, with evidence-based drugs education as a mandatory component



There is a clear and pressing need for the provision of drugs education that is both universally available to all young people, and in line with prevention best practice.



5 A public health approach to drugs strategy

Inform strategies and enforcement priorities using holistic, evidence-based drug harm profiles and rankings and use these for public health messaging, rather than the current 'A, B, C' legal classification



The introduction of evidence-based drug harm profiles would enable people to better understand the risks of harm associated with different substances, particularly new psychoactive substances which many people think are safe due to them regularly being referred to as 'legal highs'. Talking about all drugs in a holistic, health-focused way may also help reduce the stigma around drug use and encourage more people to seek support for substance misuse.

Hattie Moyes
Research and
Development Manager
Rehabilitation for Addicted
Prisoners Trust



5.3 Beyond legal classification: evidence-based drug harm profiles

The closer alignment of substance misuse strategies would require priorities to be informed not by the existing legal classification system, but by a coherent set of evidence-based rankings and comparative harm profiles for both legal and illegal drugs.

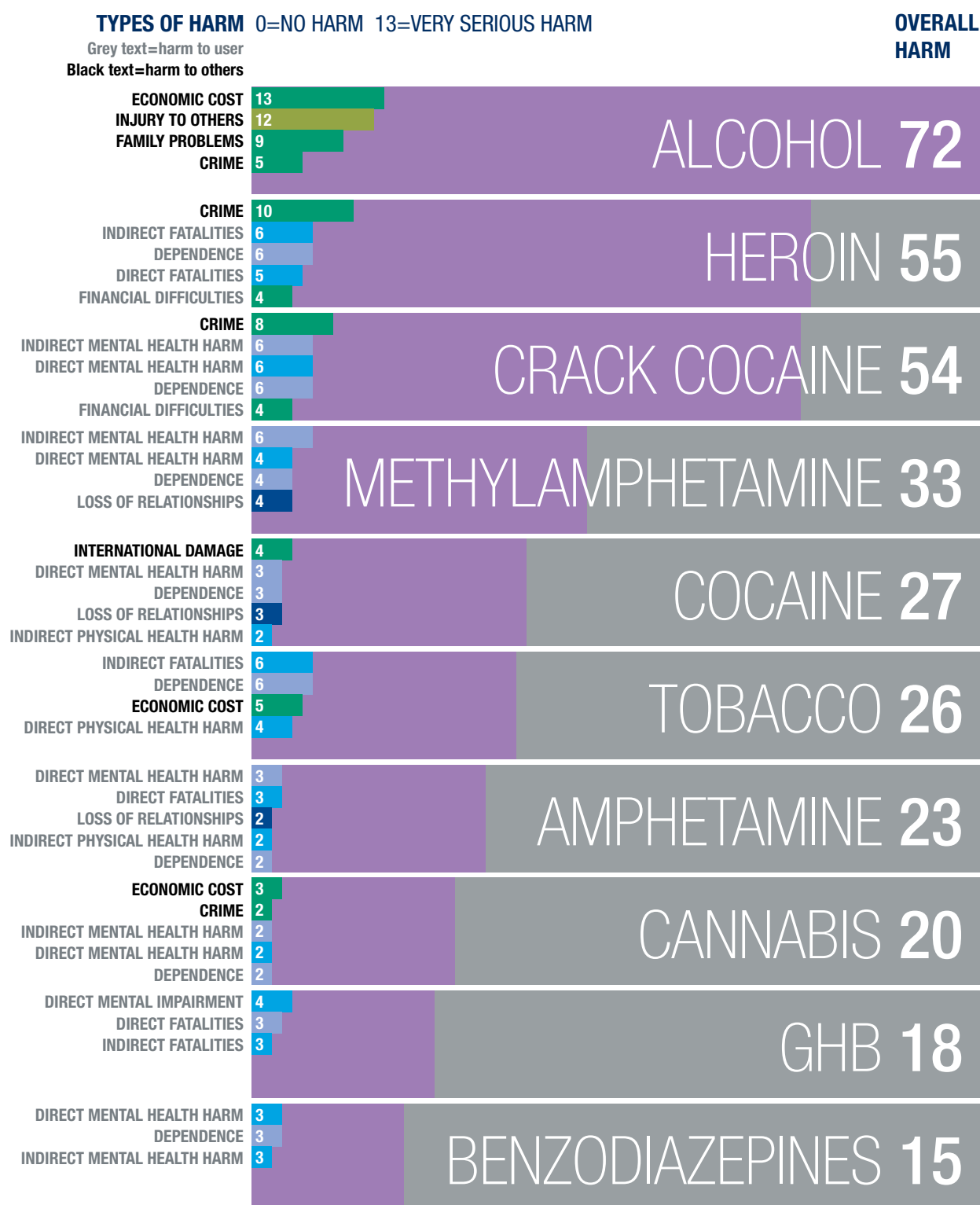
The Independent Scientific Committee on Drugs has provided a basis on which this could be done. Using a process of multi-criteria decision analysis, they arrived at weighted scores, for a range of legal and illegal drugs, for each of the 16 types of harm agreed upon by the ACMD and set out in section 3 of this report. These scores were then added to provide an overall harm score and ranking for each drug¹²⁶. The top 10 most harmful drugs according to this method, and the types of harm that contribute most to their overall score, are illustrated on the next page.

1 IN 10
people say
a drug's class
influences
how likely
they are
to use it
compared to
other illegal
drugs.

2 IN 5
say a
drug's class
influences
how harmful
they think
it is
compared
to other
substances.

3 IN 5
agree the
drugs
classification
system should
be replaced
by some-thing
that better
reflects health
risks.

The top 10 most harmful drugs and the harms that account for at least 50% of their overall harm:



Based on the model reported in Nutt, D. J., King, L. A., Phillips, L. D., & on behalf of the Independent Scientific Committee on Drugs. (2010). Drug harms in the UK: a multicriteria decision analysis. *The Lancet*, 376(1558-65).

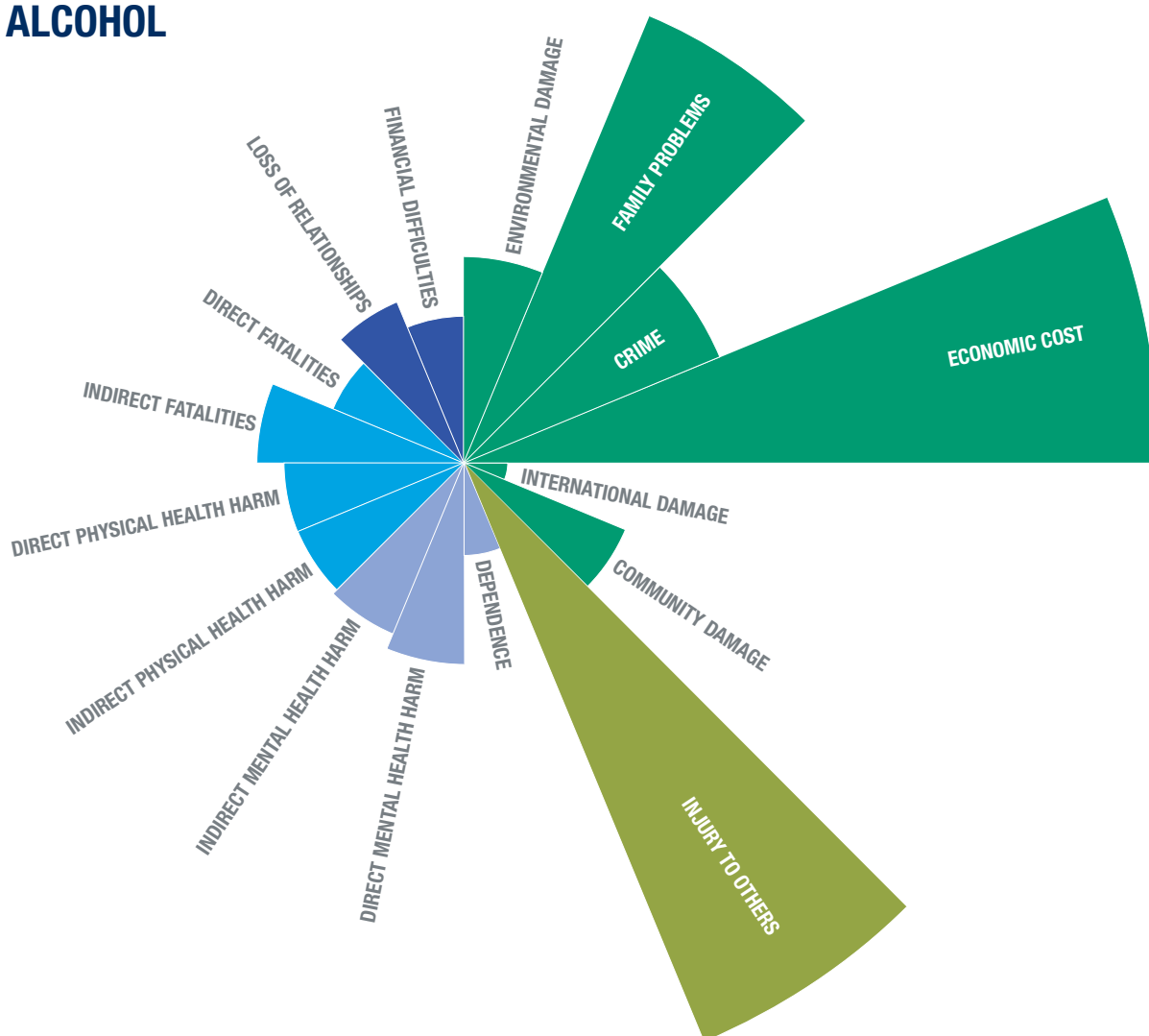
5 A public health approach to drugs strategy

As well as being used to inform drug strategy and enforcement, these rankings could be used to provide the public with easily accessible information on the specific, relative risks of harm associated with different drugs, including legal ones. They could be used to produce user-level drug harm profiles, disseminated through public health messaging and education in schools and other community settings, and targeted particularly at high-risk groups. This would help promote a holistic understanding of drug harm, rather than a simplistic and misleading sense that every type of harm correlates with legal classification. The drug harm profiles provided here are an example of how this could be done, and would require a robust process of piloting and refinement before any wider implementation.

Drug harm profile key:

- = Social harms to users
- = Social harms to others
- = Physical harms to users
- = Psychological harms to users
- = Physical and psychological harms to others

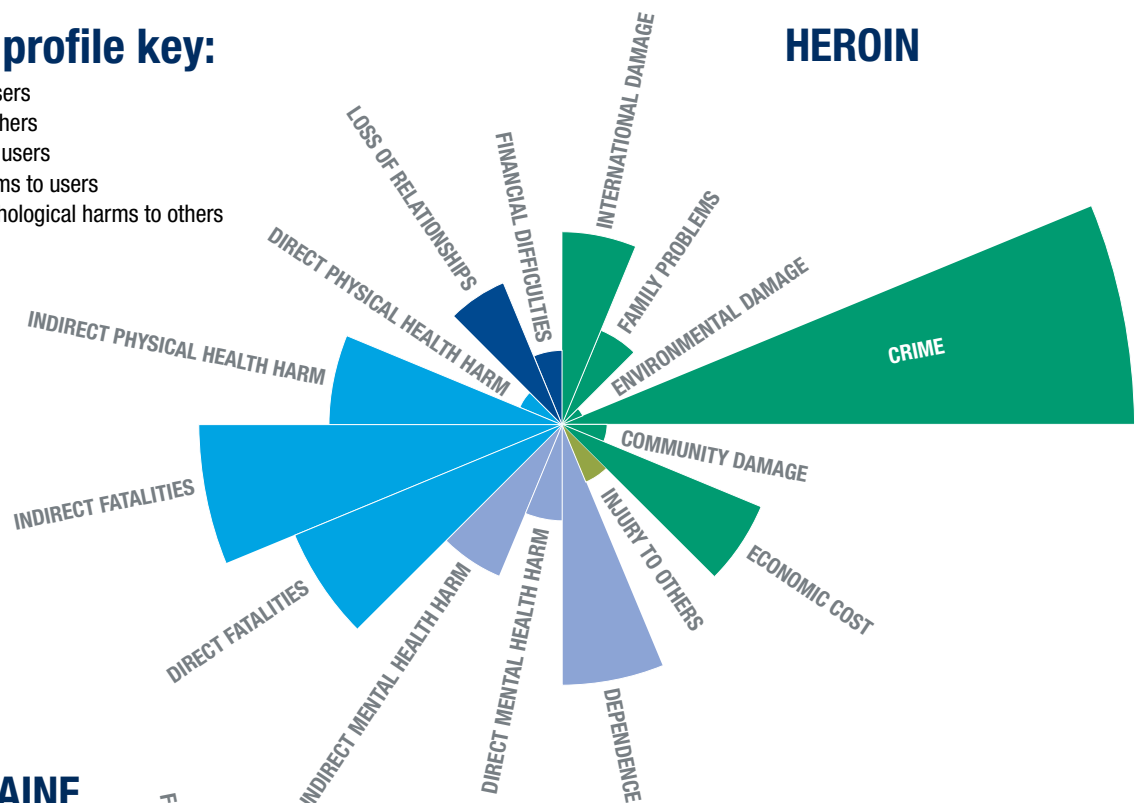
ALCOHOL



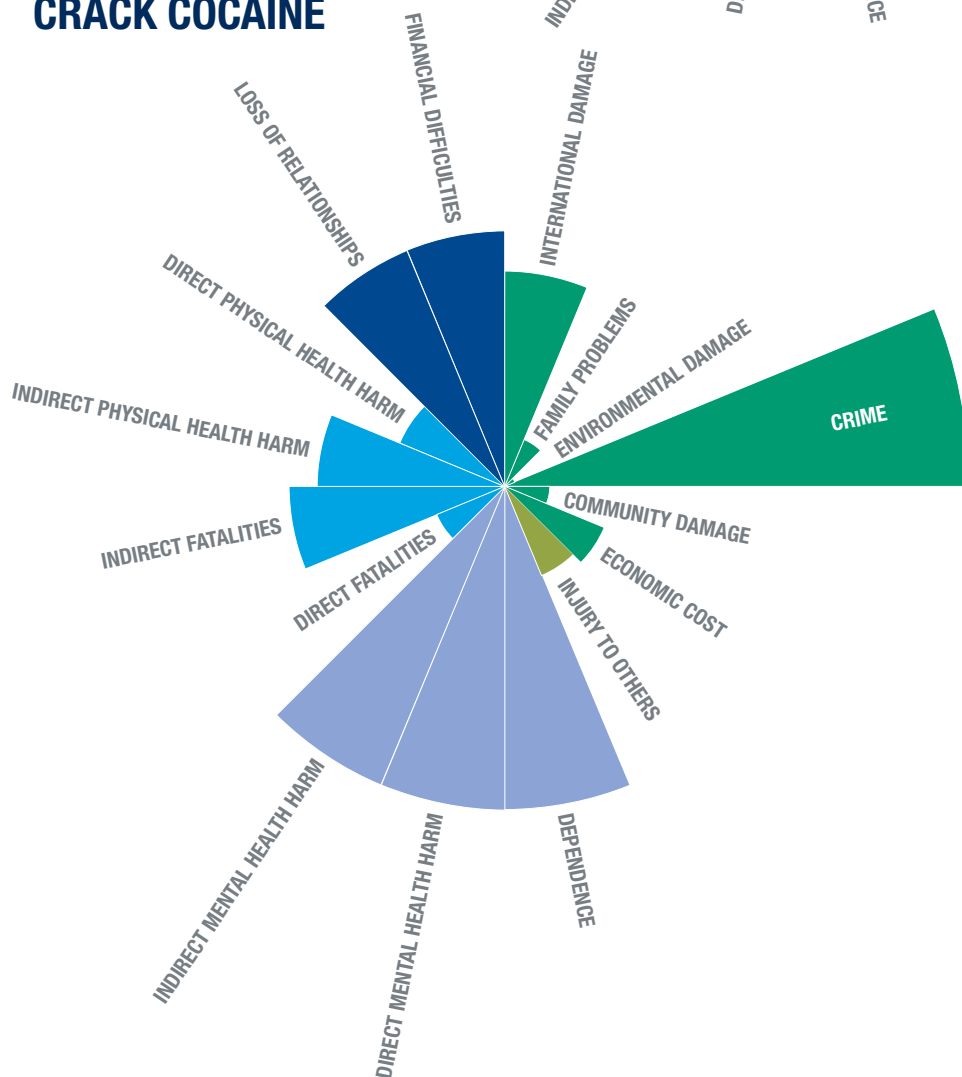
Drug harm profile key:

- = Social harms to users
- = Social harms to others
- = Physical harms to users
- = Psychological harms to users
- = Physical and psychological harms to others

HEROIN



CRACK COCAINE

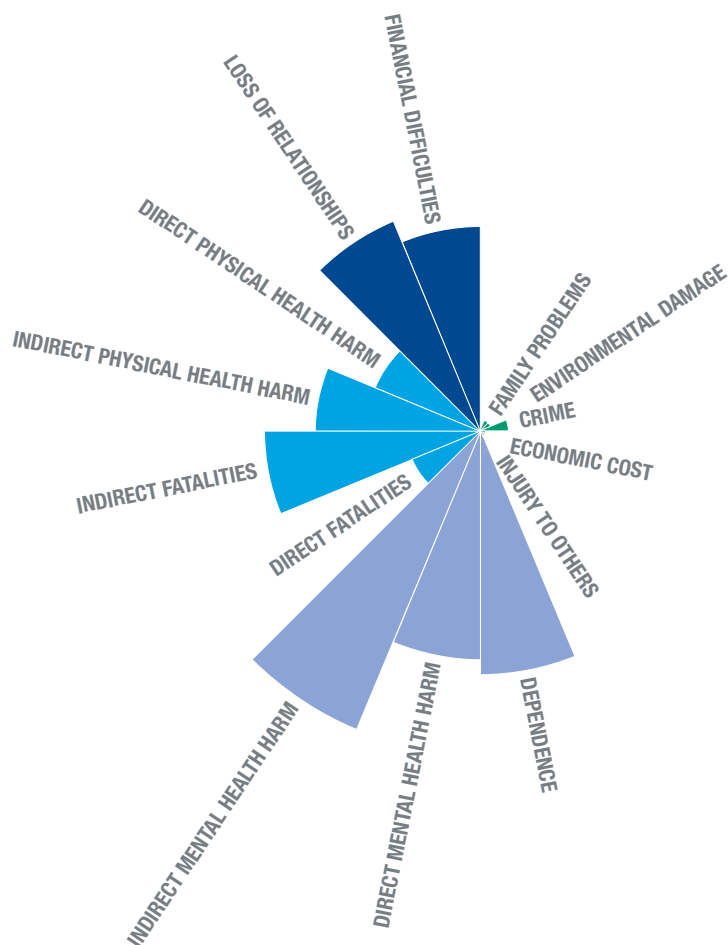


5 A public health approach to drugs strategy

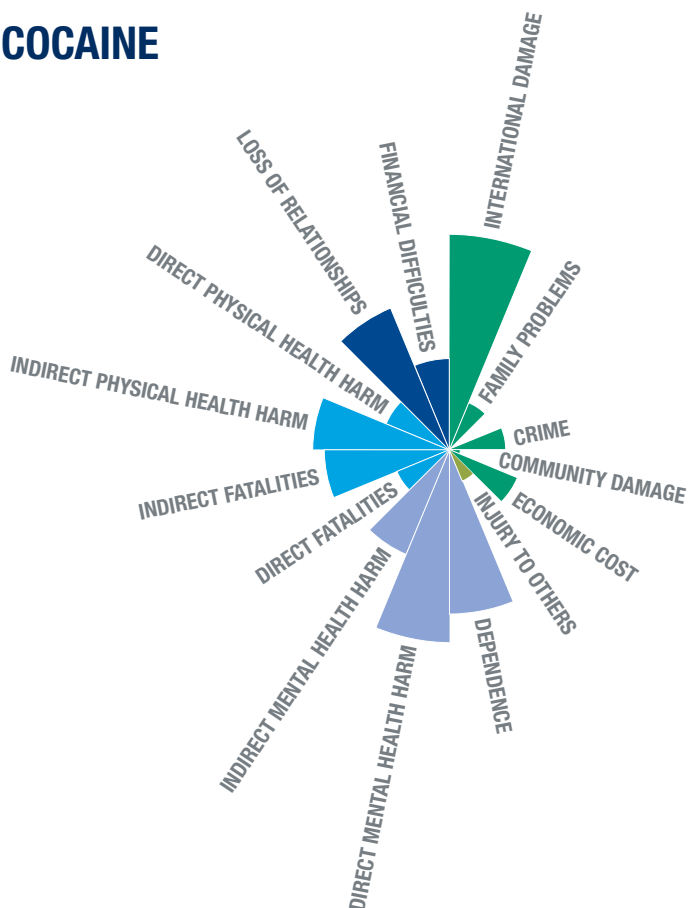
Drug harm profile key:

- = Social harms to users
- = Social harms to others
- = Physical harms to users
- = Psychological harms to users
- = Physical and psychological harms to others

METHYLAMPHETAMINE



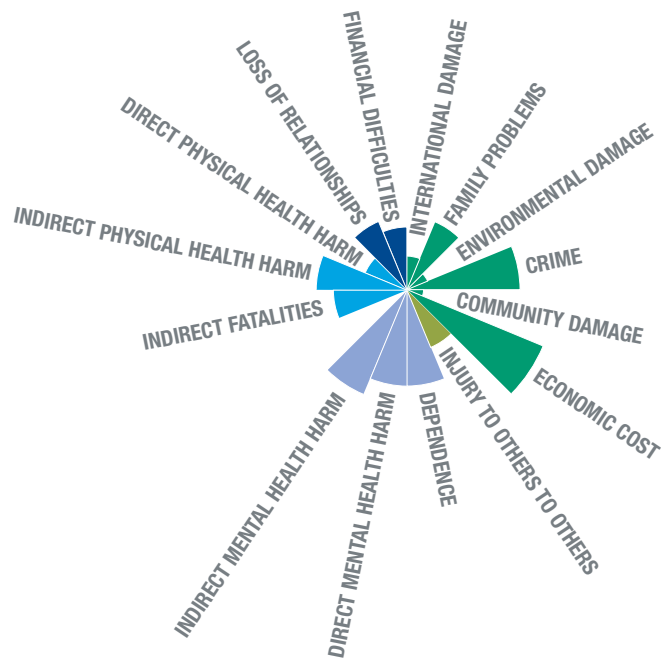
COCAINE



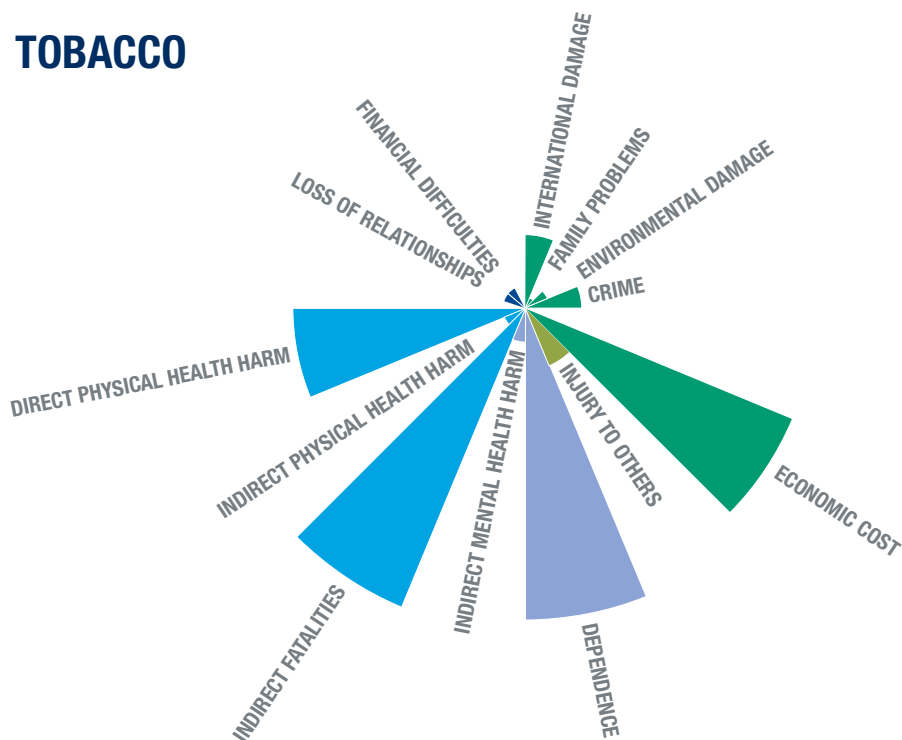
Drug harm profile key:

- = Social harms to users
- = Social harms to others
- = Physical harms to users
- = Psychological harms to users
- = Physical and psychological harms to others

CANNABIS



TOBACCO

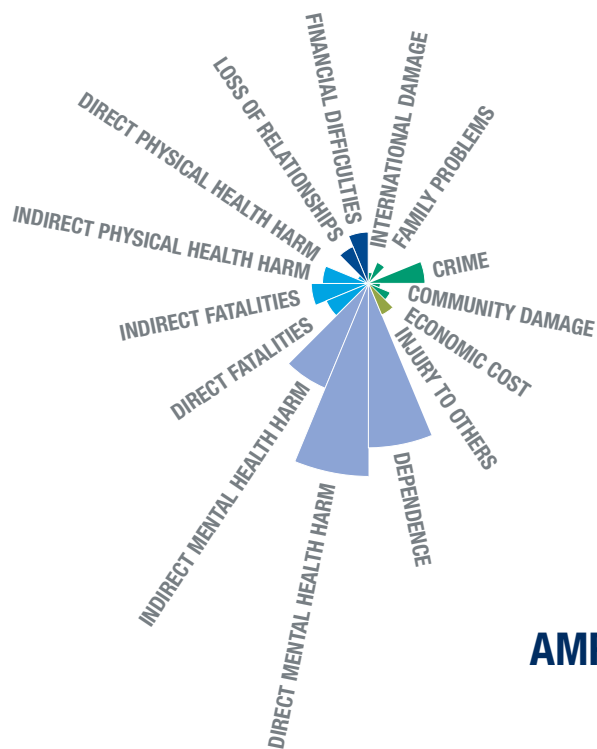


5 A public health approach to drugs strategy

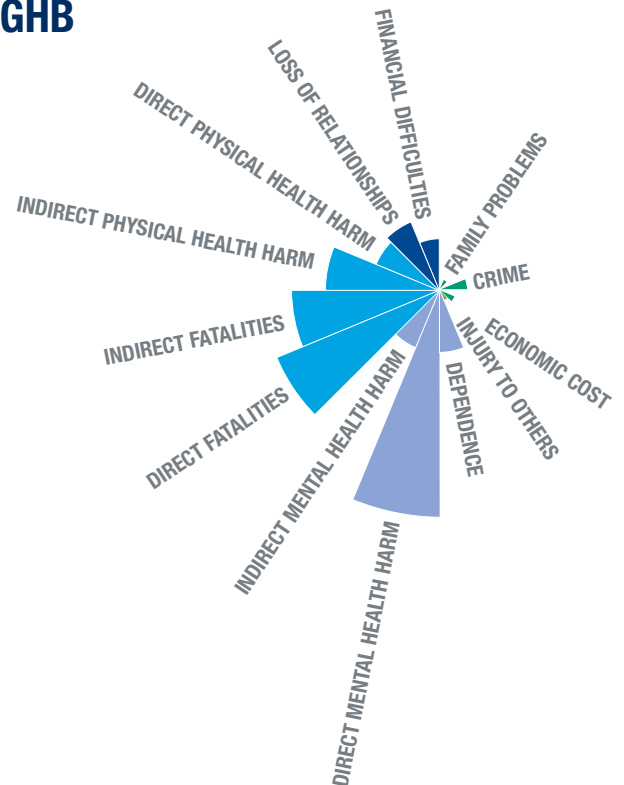
Drug harm profile key:

- = Social harms to users
- = Social harms to others
- = Physical harms to users
- = Psychological harms to users
- = Physical and psychological harms to others

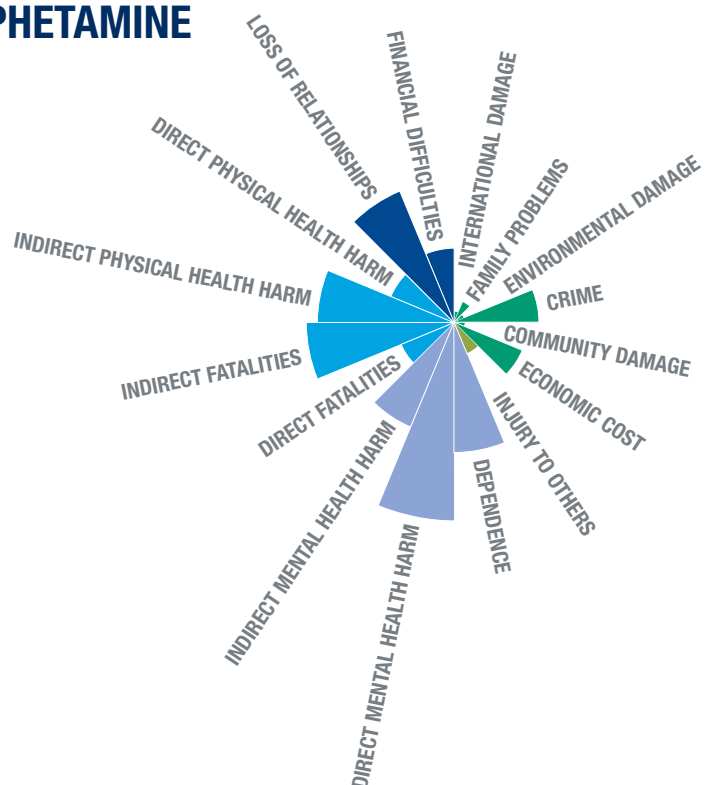
BENZODIAZEPINES



GHB



AMPHETAMINE



5.4 Decriminalising drug users

Criminal penalties for drug possession, ranging from a discharge to imprisonment for several years, are currently employed in an attempt to create an environment that strongly deters illegal drug use, and thereby protects individuals and others around them from associated harm. However, there is an emerging body of evidence that criminal sanctions are not effective in these aims, including a review of international drug policies commissioned by the Home Office that concluded there is no evidence tougher sanctions deter use¹²⁸.

There is no evidence that the small reductions in overall illegal drug use in the UK since the late 1990s have been related to criminal penalties for personal possession, which have stayed broadly similar, if not weakened. In cases where penalties have been reduced, for instance when cannabis cautions became available as an alternative to criminal sanctions, the use of cannabis continued to decline¹²⁹.

There is good reason to suggest that moving away from criminalising drug users could reduce key forms of health-related harm, by removing those forms of harm that are caused or exacerbated by criminalisation itself:

- **Criminalising drug users can undermine chances for good health and wellbeing**, both in the short and long term. Even for people who receive non-custodial sentences, including formal cautions, gaining or adding to a criminal record can cause serious damage to life chances. They may lose their current job, and face numerous barriers to moving on including access to colleges and universities, training, employment, housing, personal finance and travel¹³⁰.
- For the more than 1,000 people imprisoned for personal drug use in England and Wales each year¹³¹, the impact can be far more serious, especially for the young, among whom rates of illicit drug use are highest. The recent Harris Review concluded that imprisonment for 18-25 year olds interrupts development, severs ties with the family and community, and brings trauma and exposure to gang violence in prisons¹³². Although recovery and rehabilitation programmes exist within prisons, access to drugs is widespread, with a particular acute emerging challenge relating to NPS¹³³. The stressful and disorientating period after release can be traumatic, and, for people with a history of opiate misuse, fatal – the risk of overdose is hugely increased among prisoners on recent release¹³⁴.
- **Criminalisation exacerbates health and wellbeing inequalities**, since its effects are more likely to be felt among certain ethnic and socio-economically disadvantaged groups. Illegal drug use is lower among black and minority ethnic (BAME) groups than the white population¹³⁵, and yet black people are six times more likely to be stopped and searched for drugs. In London, black people are charged five times more often for possession of cannabis than white people¹³⁶.
- **The criminal status of drug use may deter people from coming forward for treatment**. An RSPH survey found one in five young people would be put off seeking help due to the stigma of having illegal drugs on their record, and almost one in four by the legal status of the drug. Only one in 20 felt confident they would receive the help they would need for illegal drug use, without judgement or stigma¹³⁷.

Decriminalise the personal possession and use of illegal substances and where helpful, divert users into the health system. The evidence relating to any potential health benefits or harm from legal, regulated supply should be kept under review

**Almost
1 IN 4
young
people
would
be put
off
seeking
help for
drug
use
by its
illegal
status.**

**Only
1 IN 20
young
people are
confident
they would
receive the
help they
would
need for
illegal
drug use,
without
judgement
or stigma.**

Source: RSPH public opinion survey¹²⁷.

5 A public health approach to drugs strategy



We welcome the Society's call for the end of criminal sanctions for drug possession offences; criminalisation has no deterrent effect and the evidence from other countries shows that decriminalisation can have better health and social outcomes.

Niamh Eastwood
Executive Director
RELEASE



Given that criminalisation has not proved as effective as could be desired in reducing use of the most harmful illegal drugs, and is responsible for a large degree of additional long-term harm to health and wellbeing, distributed unequally across socio-economic groups, a sea change in approach is required. Personal possession and use of illegal drugs should therefore be decriminalised, and the UK should move towards a harm-reduction approach similar to that of Portugal, where drug possession for personal use is now a civil matter, not a criminal one.

Under such a system, users are referred to dissuasion panels – focussed on tailored treatment and support to quit, not punishment – and can be sanctioned for non-attendance. 60% of the public support trialling this approach in UK cities¹³⁸. Some police forces have also expressed support for such an approach^{139,140}, as it would free up finite police resources to focus on more serious drug offences – dealers, suppliers and importers would continue to be pursued and prosecuted.

International evidence from countries such as Portugal and the Czech Republic suggests that decriminalisation does not lead to a significant increase in illegal drug use¹⁴¹.

A body of international evidence is also beginning to emerge as to the potential benefits and harms of taking supply of certain drugs out of the hands of organised crime by establishing legal, regulated markets¹⁴². The Government should keep this evidence under review.



Drugs policy should completely be considered a health issue. The involvement of law enforcement and any kind of punitive reaction to drugs in our society damages the health of individuals and the fabric of communities.

Neil Woods Chairman and Former
Undercover Drugs Detective Sergeant
Law Enforcement Against Prohibition UK



5.5 Supporting individuals to reduce and recover from drug harm

A humane, health-led approach to drugs strategy must ensure that individuals who do suffer drug-related harm are efficiently signposted to appropriate support and treatment to reduce and recover from that harm, rather than being criminalised.

However, there remain significant barriers to treatment for many users, despite significant progress in recent years in getting some of the most high risk individuals into services¹⁴³. There are still large numbers of people experiencing problems with substance misuse who are not getting the help they need for a number of reasons including social stigma¹⁴⁴, mental health problems, and attitudes to treatment¹⁴⁵.

With local authorities facing ongoing cuts to their public health budgets, from which drug treatment services are funded, this situation may get worse. However, there are significant opportunities for members of the 15 million-strong wider public health workforce to help mitigate this gap in service provision, if they are provided with the right training and support. Professionals such as health trainers, who are trained from within communities to support people to improve health behaviours, can be key assets for individuals who may lack the knowledge, motivation or confidence to effectively navigate services.

Those who work with vulnerable young people, in particular, including foster carers and staff in residential homes, need training to be better able to deal with substance misuse issues.



Exploit the potential of the wider public health workforce to support and direct drug users into treatment services

**Almost
1 IN 2**
people would not know where to get help if they were concerned about their substance use.

**More than
2 IN 3**
would not know where to get help if they were concerned about their use of illegal drugs.

**Only
1 IN 5**
feel confident they would receive the help they'd need without judgement or stigma for problem alcohol or tobacco use.

**Only
1 IN 10**
feel confident they would receive the help they'd need without judgement or stigma for illegal drug use.

Source: RSPH public opinion survey¹⁴⁶.

6 The new lines: summary of recommendations

This section summarises the five key pillars of RSPH's public health approach to drugs strategy. These recommendations are fully explored in section 5.

Closely aligned, health-led strategies

1. Transfer lead responsibility for UK illegal drugs strategy to the Department of Health, and more closely align with alcohol and tobacco strategies.

Prevention through universal education

2. Introduce comprehensive, statutory PSHE in schools, with evidence-based drugs education as a mandatory component.

Beyond legal classification: evidence-based drug harm profiles

3. Inform strategies and enforcement priorities using holistic, evidence-based drug harm profiles and rankings and use these for public health messaging, rather than the current 'A, B, C' legal classification.

Decriminalising drug users

4. Decriminalise the personal possession and use of illegal substances and where helpful, divert users into the health system. The evidence relating to any potential health benefits or harm from legal, regulated supply should be kept under review.

Supporting individuals to reduce and recover from harm

5. Exploit the potential of the wider public health workforce to support and direct drug users into treatment services.

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The report of the Royal Society for Public Health is very much welcomed. It argues that the valuable work of health professionals in dealing with the health and social consequences of the harm caused by drugs is impeded rather than assisted by a muddled prohibitionist framework that criminalises some users of psychoactive drugs whilst very harmful psychoactive drugs including alcohol and tobacco remain legal. It calls for a rational, evidence-based approach to address the harm from all psychoactive substances, led by the Department of Health, focussing resources on a health approach to drug harm based on the decriminalisation of the personal possession of drugs. The resources released should be used to enhance the role of the wider public health workforce to assist in the harm reduction and recovery of problematic drug users and the support to communities damaged by the illicit drug trade.

On behalf of the APPG for Drug Policy Reform



Molly Meacher

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