The health consequences of illicit drugs policy:

Royal Society for Public Health submission to the inquiry of the Health and Social Care Select Committee.

1 The Royal Society for Public Health (RSPH) is an independent health education charity, dedicated to protecting and promoting the public's health and wellbeing. We are the world's longest-established public health body with over 6,500 members drawn from the public health community both in the UK and internationally. Since the publication of our landmark drug policy report, *Taking a New Line on Drugs,* in June 2016,[1] RSPH has played a proactive role in advocating for a public health-based approach to drug policy in the UK.

2 For the purposes of this inquiry, we have responded only to the terms of reference most relevant to our work to date on this issue.

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

3 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.

4 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 2012[2]. More than four in five are related to opiate use[3]. Since 2012, the total number of deaths due to drug misuse has risen yearly (with the exception of a slight reduction in 2017).[4]

5 Although overall illegal drug use in England and Wales has fallen slightly over the course of the past decade, 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 the crude death rate associated with illegal drug misuse has more than doubled in the past 24 years, from 15.8 per one million population in 1993, to 42.7 per million population in 2017[5]. In Wales the figures went from 10.8 per million to 64.5 per million over the same time period. Within this, males are more than two and a half times (2.58) more likely to die through drug misuse than females, and those between the ages of 30 and 50 are also more at risk.

6 There is a complex interplay between drug use and mental health. People often use drugs for positive psychological effects at the time of use, such as increased sociability, energy, improved mood, euphoria or hallucinations[6]. 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 use[7]. Continued use can have further effects on mood, including chronic depression, anxiety and in some cases, psychosis[8]. 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 life[9].

7 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 symptoms[10] – people with pre-existing mental health conditions are also more likely to turn to substance use in the first place[11].

8 Although it is widely acknowledged that there is indeed harm from illicit drug use, it does not follow that criminalisation is the most effective way of reducing these harms. Different policy approaches can have very different impacts on the degree of societal and user harm from illicit drug use, as discussed below.

9 Furthermore, 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 more[12]. There is therefore a correlation between deprivation rates and drug-related mortality rates across the regions of England.

10 Finally, it is important to place health harms from illicit drugs in perspective against the harm from legal drugs such as alcohol and tobacco – both of which are 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 counterparts[13].

What are the reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high-risk use to the normalisation of recreational use.

11 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 16[14]. 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 dependence[15]. This dependence can also result from prolonged use of prescribed medication, such as opiate-based painkillers.

12 It should also be noted that there is a wider environmental context in which certain groups are more likely to initiate drug use than others. On top of individual predispositions, 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 use[16].

13 Some individuals are more likely to engage in riskier substance use than others[17]. Those with pre-existing mental health conditions, including anxiety and depression, are particularly at risk[18]. It is estimated that up to half of people with mental health problems also have current alcohol or other drug issues[19].

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

14 RSPH believes that the current system, with drugs strategy led by the Home Office rather than the Department of Health and Social Care (DHSC), is detrimental to the aim of reducing harm from illicit drugs.

15 Illegal drugs strategy should sit under the lead of DHSC – with ring-fenced funding transferred from the Home Office to DHSC accordingly. There should be close alignment with alcohol and tobacco strategies, 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. This would enable a greater priority to be set on health outcomes, through evidence-based harm reduction interventions.

16 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, with positive implications for take-up of treatment services.

17 RSPH believes criminalising drug users can undermine chances for good health and wellbeing, both in the short and long term. Criminalisation also exacerbates health and wellbeing inequalities, since its effects are more likely to be felt among certain ethnic and socio-economically disadvantaged groups. RSPH has called for the decriminalisation of personal possession and use of illegal substances, and for users instead to be diverted into the health system where possible.

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

18 RSPH recommends a public health approach to drugs strategy that moves away from criminal sanctions. The five key pillars of this framework are:

i. **Closely aligned, health-led strategies:** transferring lead responsibility for UK illegal drugs strategy to DHSC, and more closely aligning it with alcohol and tobacco strategies.

ii. **Prevention through universal education:** Introducing comprehensive, statutory PSHE in schools, with evidence-based drugs education as a mandatory component.

iii. **Beyond legal classification: evidence-based drug harm profiles:** Informing strategies and enforcement priorities using holistic, evidence-based drug harm profiles and rankings and using these for public health messaging, rather than the current 'A, B, C' legal classification.

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

v. **Supporting individuals to reduce and recover from harm:** Exploiting the potential of the wider public health workforce to support and direct drug users into treatment services.

For a more detailed description of RSPH's recommended approach to drugs policy, see *Taking a New Line on Drugs*[20].

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

19 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 Europe[21]. In the years since decriminalisation and reorientation of resources to health promotion and harm reduction:

a. New cases of HIV among those who inject drugs have declined dramatically, from 1,016 in 2001 to 56 in 2012.

b. Problem drug use has declined in 15-24 year olds.

c. Deaths due to drug use have fallen significantly, from 80 in 2001 to 16 in 2012.

d. Cases of hepatitis C and B have both fallen in the drug using population.

e. Overall levels of drug use are now below the European average[22].

f. Social costs, including both indirect health costs and direct costs associated with the legal system, have fallen by 18%[23].

20 Countries such as the Netherlands, Canada, and Switzerland have all moved towards harm reduction approaches, including steps such as decriminalising use, introducing safe consumption facilities, and reprioritising with a focus on prevention and treatment. In each case the results have been positive, with reductions in problem drug use and improvements in health outcomes. For a summary of the specific programmes and outcomes in these countries, see our report *Taking a New Line on Drugs*[24].

References

[1] Taking a New Line On Drugs https://www.rsph.org.uk/our-work/campaigns/taking-a-new-line-on-drugs.html (accessed 18.03.19)

[2] Public Health England. 2016. *Trends in drug misuse deaths in England, 1999 to 2014*. http://www.nta.nhs.uk/uploads/trendsdrugmisusedeaths1999to2014.pdf (accessed 18.03.19)

[3] Public Health England. 2016. *Trends in drug misuse deaths in England, 1999 to 2014*. http://www.nta.nhs.uk/uploads/trendsdrugmisusedeaths1999to2014.pdf (accessed 18.03.19)

[4] Dr Sarah Barber, Nikki Sutherland, Rachael Harker; House of Commons Library Debate Pack – Drugs Policy, 23 October 2018.

[5] Deaths related to drug poisoning, England and Wales, 2018, ONS. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsrelatedtodrugpoisoningenglandandwalesreferencetable (accessed 18.03.19)

[6] Mind. 2004. *Understanding the psychological effects of street drugs*. http://www.mentalhealthintheuk.co.uk/Understandingstreetdrugs.pdf (accessed 18.03.19)

[7] Mind. 2004. *Understanding the psychological effects of street drugs*. http://www.mentalhealthintheuk.co.uk/Understandingstreetdrugs.pdf (accessed 18.03.19)

[8] Moore, T. et al. 2007. *Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review.* http://www.sciencedirect.com/science/article/pii/S0140673607611623 (accessed 18.03.19)

[9] Ilgen, M. & Kleinberg, F. 2011. *The link between violence, substance abuse and suicide.* http://www.psychiatrictimes.com/substance-use-disorder/link-between-substance-abuse-violence-and-suicide (accessed 18.03.19)

[10] Kuepper, R. et al. 2011. *Continued cannabis use and risk of incidence and persistence of psychotic symptoms: 10-year follow-up cohort study.* http://www.ncbi.nlm.nih.gov/pubmed/21363868 (accessed 18.03.19).

[11] Saffer, H. & Dhaval, D. 2002. *Mental illness and the demand for alcohol, cocaine and cigarettes*. NBER Working Paper 8699. http://www.nber.org/papers/w8699.pdf (accessed 18.03.19).

[12] Home Office. 2014. *Drug misuse: findings from the 2013/14 crime survey for England and Wales.* https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2013-to-2014-csew/drug-misuse-findings-from-the-201314-crime-survey-for-england-and-wales (accessed 18.03.19).

[13] Advisory Council on the Misuse of Drugs. 2015. *Prevention of alcohol and drug dependence.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406926/ACMD_RC_Prevention_briefing_250215.pdf (accessed 18.03.19).

[14] Mind. 2004. *Understanding the psychological effects of street drugs*. http://www.mentalhealthintheuk.co.uk/Understandingstreetdrugs.pdf (accessed 18.03.19).

[15] Boys, A, et al. 2001. *Understanding reasons for drug use amongst young people: a functional perspective*. Health Education Research 16(4) 457-469.

[16] Galea S, & Vlahov D. 2002. *Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration*. Public Health Reports 117(supplement 1): S135 –S145.

[17] Gell, L, et al. 2016. *What determines harm from addictive substances and behaviours?* Oxford: Oxford University Press.

[18] Advisory Council on the Misuse of Drugs. 2015. *Prevention of alcohol and drug dependence.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406926/ACMD_RC_Prevention_briefing_250215.pdf (accessed 18.03.19).

[19] Weaver, T et al. 2003. *Comorbidity of substance misuse and mental illness in community mental health and substance misuse services*. The British Journal of Psychiatry 183(4) 304-313.

[20] Taking a New Line On Drugs https://www.rsph.org.uk/our-work/campaigns/taking-a-new-line-on-drugs.html (accessed 18.03.19)

[21] Specter, M. 2011. *Getting a fix: Portugal decriminalised all drugs a decade ago. What have we learned?* http://www.newyorker.com/magazine/2011/10/17/getting-a-fix (accessed 18.03.19).

[22] Murkin, G. 2014. *Drug decriminalisation in Portugal: setting the record straight.* http://www.tdpf.org.uk/blog/drug-decriminalisation-portugal-setting-record-straight (accessed 18.03.19).

[23] Release. 2016. *A quiet revolution: drug decriminalisation across the globe*. https://www.release.org.uk/publications/drug-decriminalisation-2016 (accessed 18.03.19).

[24] Taking a New Line On Drugs https://www.rsph.org.uk/our-work/campaigns/taking-a-new-line-on-drugs.html (accessed 18.03.19)