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FEATURE

WAR ON DRUGS

Doctors, their leaders, and the drug policy debate

Despite the odd shout and whisper for reform, most doctors' professional organisations have little to say about policies such as the criminalisation of people who use drugs. **Richard Hurley** reports

Richard Hurley *features and debates editor, The BMJ*

In June the BMA quietly set policy that moves towards supporting an end to criminal penalties for non-medical drug use. An emergency motion at its Annual Representatives Meeting supported "legislative change so treatment and support are prioritised over criminalisation and punishment of individual drug users."[1]

The motion also called for the Department of Health to take over responsibility for drug policy from the Home Office. Proposed by Iain Kennedy, chair of the BMA's public health medicine committee, it passed with little discussion and received little publicity.

The BMA, which represents some 170 000 UK doctors, had no detail of its plans to share with *The BMJ* but suggested that because of a lack of political appetite in the government the policy was a longer term goal to be achieved through low key lobbying.

Health problem

In 2013 the BMA's Board of Science, led by Averil Mansfield, published *Drugs of Dependence: The Role of Medical Professionals*—a culmination of two years' work to establish impartial evidence around drug taking, treatment, and policy in the UK, to reframe drug use as a health problem, and most of all to prompt debate.[2]

In the foreword Mansfield, a former BMA president, wrote, "The present approach is not satisfactory."

She continued, "The medical profession would never condone drug taking. Individuals who press others into experimenting with the use of drugs may deserve punishment. But those who fall into drug dependence become a medical problem from which we, as a society, cannot escape and they badly need our help."

Mansfield wants to get all doctors talking about drug use. "I'm a surgeon not an expert on drugs," she told *The BMJ*, "but as a caring and compassionate profession this is something that we ought to have much more interest in."

"We need to treat drug misuse as a medical problem rather than necessarily as a criminal one, and doctors should be part of the debate."

Opioid deaths doubled

In 2015 the UK had its highest recorded drug related mortality (fig). Between 2012 and 2015 deaths from opioid misuse doubled in the UK, to 1201.[3] More than 80% of shoplifting and burglary may be to fund drug dependency, costing the country £16bn (€19bn; $20bn) a year.[4] And despite the current policy a quarter of UK 15 year olds are estimated to have ever taken an illegal preparation of unknown quality and potency.[5]

Mansfield is also concerned about the prison sentences and criminal records for non-violent drug offences that ruin lives and make drug users fear asking for help. "Lots of jobs and careers are scuppered. It's tragic," she says.

As for how policy might be reformed, Mansfield is unsure, but she suggests looking to countries such as Portugal, where for 15 years personal drug use has been managed not through criminal processes but through civil ones that prioritise health (box 1).

"I'm not trying to give a cut-and-dried answer to what society should do," she said. "But we need to make some changes so that people have less fear and we can give them the help they require."

Mansfield wanted her report to prompt the BMA to hold a debate, including voices opposed to legal reform. "The BMA has never really wanted to declare its hand on what we're doing wrong and what we could do better," she said. "It should look at the issue openly and not be afraid that the 'red tops' [tabloid newspapers] are going to say that the BMA has gone soft on drugs. None of us are soft on drugs."

Sympathetic coverage

The BBC covered Mansfield's report sympathetically, and the more reactionary media showed surprisingly little interest.

The Royal Society for Public Health (RSPH), which has 6000 members including directors of public health, and the Faculty of Public Health (FPH), which has 4000 members, mostly doctors, also found support among the media when they called

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Box 1: Portugal decriminalised all drug use 15 years ago

"In Portugal there has been a slight increase in drug use but many people will use drugs once or twice and that's it," said Ed Morrow, campaigns manager at the Royal Society for Public Health.

"Decriminalisation is not a silver bullet," he says. "It won't automatically lead to a drop in harm on its own. But it's an enabler: it removes a barrier that makes everything else you need to do easier, in terms of harm reduction, education, and getting people into treatment."

Problematic drug users fell from 7.6 to 6.8 per 1000 population between 2000 and 2005.[6]

"In the 18-24 year old age group use has gone down, and the level of use overall is still below the European average," he says. "It's not had the cataclysmic effect on use people feared."

"Drug related deaths are massively down and so are infection rates: new cases of HIV and hepatitis C infection have fallen through the floor—massive reductions. It's been a huge success. And costs have fallen too."

HIV infections dropped from more than 1000 new diagnoses in 2001 to fewer than 100 in 2013. Drug related deaths fell from more than 70 in 2001 to fewer than 20 in 2012.[7] All Portuguese political parties now support the policy.

for decriminalisation of personal drug use last summer, with their report *Takinga New Line on Drugs*.[8]

This report made the front page of the *Times* and was covered in the *Financial Times*, the *Telegraph*, and the *Economist*. "What was surprising was that the media you'd think were most conservative were interested in the report and positive," said Shirley Cramer, chief executive of the society, whose members include directors of public health.

"The report is pragmatic about helping people to become healthier and that this must be the priority," she explained.

It also calls for the Department of Health to lead on UK drug policy; for closer alignment of drug strategy with those for alcohol and tobacco; and for statutory and evidence based drugs education in schools to encourage prevention.

"Portugal has been so successful," Cramer said (box 1). "It's closest to the model we'd like to see in this country."

Some jurisdictions, now including California, have gone further than decriminalising cannabis use to allow regulated supply. "We found a lot of international evidence for decriminalisation where it has worked well," said Ed Morrow, the RSPH's campaigns manager. "We are interested in the emerging evidence base around regulated supply but it's not yet of sufficient standard or broadness for us to take a position."

Logic of decriminalisation

Despite any formal response from the government to this report, Morrow thinks that the new UK Psychoactive Substances Act, which bans distribution and sale but not possession and use, shows "inherent acceptance of the logic of decriminalisation."

"We want to extend that logic to traditional illegal drugs," he said.

The UK Misuse of Drugs Act says that unauthorised possession of some drugs is illegal, punishable with prison sentences up to seven years and unlimited fines. But several police commissioners support the report, Cramer said, and many already practise de facto decriminalisation in the way they enforce the law. The RSPH plans to keep working with police to encourage these approaches—for example, testing people's drugs at music festivals and lobbying for supervised injection facilities that can reduce overdose and deaths.

John Middleton, chair of the Faculty of Public Health, agreed: "We got a lot of support for the report. We didn't get any negative feedback from the royal colleges. There's a broad degree of acceptance, and they see that the tough on drugs approach is not working, as we're now seeing with the rise in drug related deaths."

No formal stance

The BMJ spoke to several royal colleges (box 2). The surgeons and the physicians had no comment to make on drug policy. The psychiatrists, the general practitioners, and the emergency medicine doctors also have no formal stance on government drug policy but emphasised their commitment to treating individual patients with drug use disorders. They expressed concern about cuts to drug treatment services that have been moved out of the NHS to local authority control and the government's switch from evidence based treatment, including maintenance with opioid substitutes, to approaches that prioritise abstinence.

"Our big priority is acknowledging the failure of our current drugs policy in leading to a staggering rise in preventable deaths," said Simon Wessely, chair of the Royal College of Psychiatrists. "Drug policy should be centred on the health of drug users. But the legal status of drugs is for government to decide, not doctors. We don't think there's much evidence that legal status has much impact on drug use."

Johann Grundlingh, toxicology lead at the Royal College of Emergency Medicine, said "We're not a political organisation. But we don't want people to take drugs and die. And we don't want people who take drugs to feel segregated so they can't get help. The legislation needs to be reviewed. We need open debate to find a better solution."

Clare Gerada, former chair of the Royal College of General Practitioners, was more direct. "Drug policy is a complete disaster," she said, "and it's within doctors' remit when it's killing people," adding that the college didn't discuss drug policy while she was its chair. "I personally support decriminalisation. The BMA and colleges should be calling for sensible drug policies based on evidence of risk and harm."

International action

Three United Nations conventions aim to protect people by banning all non-medical use of some substances, such as heroin, cocaine, and cannabis.[9] Many countries try to fulfil this prohibition by making production, trafficking, sale, and possession of drugs subject to criminal penalties.

"The current UN embargo is not helping and in fact causes harm," said Mansfield. "Drugs are restricted in many parts of the world even for right and proper pain relief," referring to the chilling effect prohibition laws exert over medical access to opioids.

Mansfield is on the board of International Physicians for Healthier Drug Policies, which campaigns for reform. Chris Beyrer, professor of public health and human rights at Johns Hopkins Bloomberg School of Public Health and corresponding author of a substantial review of the international evidence on

Box 2: Who thinks what

BMA—Supports moves towards decriminalisation of drug use, with no current plan to actively advance this aim

Royal Society of Public Health—Vocal support for decriminalisation of drug use

Faculty of Public Health—Vocal support for decriminalisation of drug use

Royal College of General Practitioners—No formal stance

Royal College of Psychiatrists—No formal stance

Royal College of Emergency Medicine—No formal stance

Royal College of Physicians of London—No formal stance

Royal College of Surgeons—No formal stance

the health implications of drug policy earlier this year,[10] is also on the board.

"Mobilising physicians has been a challenge," Beyrer said. "They don't necessarily want to engage with the political but want to stick to our tract—that is, clinical care. That is a challenge when you have policy so clearly harmful to health—for example, the criminalisation of petty use and possession.

"Being tough on crime is popular with politicians. And it's hard for them to back away from those positions."

Morrow concurs: "Policy often lags behind what the public thinks. The conservative parts of government don't want to look soft on crime. But the debate and the zeitgeist have moved forward. The reticent part of government is scared of a voter backlash that doesn't exist in the way it once did."

Some people of course maintain that prohibition enforced through criminalisation of drug users is necessary, but Cramer thinks there are few with such views in the mainstream medical world. "You'll have a lot of trouble finding someone in the public health community who doesn't see the merits in decriminalisation now," she said.

Doctors' duty

Dainius Pūras, UN special rapporteur on health, believes that healthcare professionals should be leading policy reform. Clinicians have an ethical responsibility to champion the health and dignity of their patients, he says, as well as to publicise the harms caused by criminalisation.

"Stigma and fear can distort science and medical ethics, and these views can seep into laws, policies, and the practice of medicine," he said.

Mansfield agrees: "It's part of our job as doctors to try to ensure that society is looked after in a general sense.

"As a profession we could be doing more about drug misuse. The BMA could be doing more. Most of the doctors in the UK belong, and we could easily give them a nudge to think about it at least."

Competing interests: I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

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From the BMA report *Drugs of Dependence: The Role of Medical Professionals*[2]

"We do not have a predetermined medical position on the ways in which policy might be changed, rather a desire to start from a secure baseline of knowledge. As with so many other medical conditions, we believe that there is no 'one size fits all' solution to the problem of drug misuse, and the medical profession's familiarity with the need for advocacy for each individual patient should be at the forefront of this debate.

"We have vast expertise to call upon and compassionate understanding to offer. Our involvement, indeed our leadership, in this debate will ensure that the medical issues become central to the national debate and the criminal justice aspects are put into a more accurate context.

"We have the special opportunity to listen to patients' views and concerns and to guide them, as individuals, through the various treatment options. We owe it to the patients, their families and those around them to get actively involved in the national debate and so to ensure that the medical aspects are at the heart of the discussions."

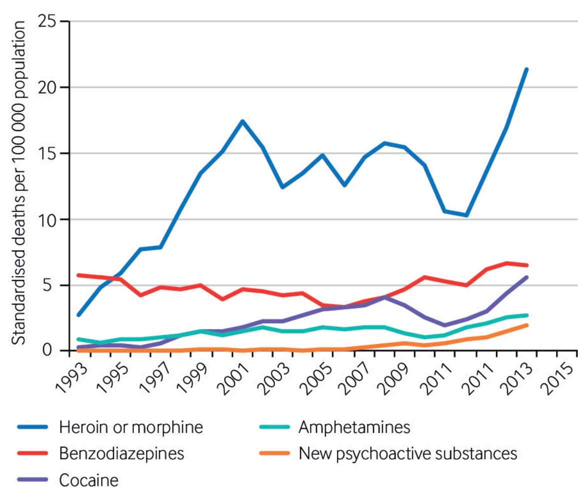
From the RSPH-FPH report Taking a New Line on Drugs[8]

"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. Levels of drug harm, not simply levels of drug use, should be taken into account when considering the success of drugs policy.

"This could include 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.

"Only a quarter of the public believe the current UK drugs strategy is effective in protecting their health and wellbeing. The current legal framework is confusing for the public, and does not correlate with evidence-based assessment of relative drug harm."

Figure



Drug related deaths in England and Wales, 1993-2015[3]

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