International drug policy – health before politics

Chris Ford and Sebastian Saville

Abstract

Purpose – *The purpose of this paper is to explain how international drug policy continues to have a hugely damaging effect on population health, human rights and wellbeing, not only on individuals who consume and/or sell drugs but also on societies as a whole. And to review whether anything has changed after United Nations General Assembly Special Session.*

Design/methodology/approach – *UNGASS had been seen as a real opportunity for scientific evidence to become the driver of future drug policy. This paper looks at any changes that have since taken place that might support such an aspiration.*

Findings – *The authors found the criminalisation and incarceration of people who use drugs, mainly from the most marginalised sections of society, remains the primary response in almost every member state of the UN and there are at least 33 countries that retain the death penalty for drug offences. The impact on the health of people who inject drugs (PWIDs) living with HIV is devastating and overdose and AIDS related mortality are the leading causes of death. Hepatitis C infections among PWIDs are increasing at epidemic levels even though this now a curable disease.*

Practical implications – *Changes in drug policy urgently needed.*

Originality/value – *This paper is an important review of the health implications of bad drug policy.*

Keywords *HIV, Drug policy, HCV, Discrimination of people who use drugs, Health in prisons, Health of people who use drugs*

Paper type *General review*

Chris Ford is a Clinical Director at the International Doctors for Healthier Drug Policies (IDHDP), London, UK. Sebastian Saville is based in London, UK.

Introduction: the picture

Worldwide the use of drugs is not uncommon, with about 1 in 20 aged between 15 and 64 having used at least one drug in 2014. Of these 250 million people over 29 million develop problems related directly or indirectly to their drug use. In total, 12 million are people who inject drugs (PWIDs) with 14 per cent of them are living with HIV (UNODC, 2016).

Without doubt drug use causes serious problems for some people. However, International Doctors for Healthier Drug Policies (IDHDP) believes the bigger problem is how drugs, and more importantly drug policy, disproportionately affect the poorest members of society as well as people of colour (Global Commission on Drug Policies, 2011).

International drug policy continues to have a hugely damaging effect on population health, human rights and wellbeing, not only on individuals who consume and/or sell drugs but also on societies as a whole (Csete *et al.*, 2016). The criminalisation and incarceration of people who use drugs (PUDs), mainly from the most marginalised sections of society, remains the primary response in almost every member state of the UN (Global Commission on Drug Policy's Report, 2012). There are at least 33 countries that retain the death penalty for drug offences, even for the sale of relatively small amounts of drugs and in ten countries it is a mandatory sanction for certain drugs offences. In 2013, it appears that around 549 people were executed for drugs (The Death Penalty for Drug Offences: Global Overview, 2015).

The impact on the health of PWIDs living with HIV is devastating (UNODC, 2016) and overdose and AIDS related mortality are the leading causes of death in PWIDs (Mathers *et al.*, 2010).

Received 18 January 2017
Revised 20 March 2017
Accepted 23 March 2017

Hepatitis C infections among PWIDs are increasing at epidemic levels even though Hepatitis C is now a curable disease.

The evidence is undisputed worldwide that HIV in PWIDs is a preventable disease. However, Russia has recently recorded its one millionth HIV infection among PWIDs (Osborn, 2016). Increases are also occurring in much of Eastern Europe and Central Asia (The Death Penalty for Drug Offences: Global Overview, 2015). Other recent outbreaks have occurred in Scotland, Ireland, Luxembourg and in Greece where the emergence of the HIV outbreak coincided with the economic downturn particularly budgetary cuts in the health system, the deteriorating socio-economic environment of the Athens city centre, and changes this brought about in injecting behaviours among PWIDs (HIV Outbreak Among Injecting Drug Users in Greece, 2012).

Drug-related deaths have risen in most areas, particularly in the last two years. North America continues to have the highest drug-related mortality rate in the world, contributing to an estimated 25 per cent of drug-related deaths globally (UNODC, 2016). Overdose deaths contribute to between a third and a half of all drug-related deaths, which are attributable, in most cases, to opioids (UNODC, 2016).

Despite moves in some countries towards decriminalisation over the last 15 years, the global response to drugs remains predominantly punitive (Eastwood *et al.*, 2016).

According to studies conducted in a large number of countries, between 56 and 90 per cent of PWIDs have been imprisoned at some stage in their lives (Osborn, 2016; UNAIDS, 2014; World Health Organisation, 1994; Beyrer *et al*., 2003). The prevalence of HIV, HCV and TB is substantially higher inside prisons (Dolan *et al.*, 2016) with the provision of harm reduction services in prison settings continuing to be inadequate and far behind that of the wider community (The Global State of Harm Reduction, 2016).

The politics

April 2016 saw the first United Nations General Assembly Special Session (UNGASS) on the "world drug problem" for almost 20 years. Member states were represented at ministerial level, as well as donors, UN agencies, civil society stakeholders and other interested parties.

There was much preparatory work and co-operation amongst NGOs and other UN departments prior to the UNGASS meeting, largely to help representatives of the member states properly understand the magnitude of the existing problems and of the real opportunity that existed to move towards a system underpinned by evidence and health. It ended up as what could best be described as a rubber-stamping exercise for the document that had already been prepared by the Vienna-dominated 59th Commission on Narcotic Drugs (CND) UNGASS preparatory process. With only 53 member states represented at the annual CND the process does not lend itself to a situation where major changes can be made at the one major meeting (UNGASS) where all states are represented. Despite talk of an open, far-reaching discussion with real change as a possibility the process was as opaque as ever. Any discussion that questioned the existing architecture of the UN drug control system was swiftly suppressed.

On a more optimistic note – the pressure that came from some member states and civil society working together led to "access to controlled medications for medical use" being added to the consensus document for the first time (United Nations, 2016). This is a welcome addition and includes controlled medicines for pain relief and use in drug treatment.

Access to controlled medicines

Currently over 75 per cent of the world's population has no access to controlled medicines, in particular opioids, especially morphine, when suffering severe pain (Human Rights Watch, 2011). This situation leads to a large proportion of the world's population being allowed to die from painful conditions such as cancer or end-stage AIDS while being denied access to this effective and relatively cheap medicine. Each year, an estimated 40 million people are in need of palliative care, 78 per cent of

them people live in low and middle-income countries (World Health Organisation Palliative Care, 2015; World Health Organization, Worldwide Palliative Care Alliance, 2014). Worldwide only about 14 per cent of people who need palliative care currently receive it (Human Rights Watch, 2011).

Overly restrictive regulations for morphine and other essential controlled palliative medicines deny access to adequate pain relief and palliative care and the lack of training and awareness of palliative care among health professionals is a major barrier to improving access (Human Rights Watch, 2011).

Conversely the richest 20-25 per cent of the world's population assume that these controlled medicines are readily available in such circumstances. In fact 92 per cent of the world's supply of morphine is consumed by just 17 per cent of the global population. It has nothing to do with cost or scarcity of supplies but all to do with the failing international drug control systems. While trying to stop the misuse of drugs like heroin, access to these essential medicines is unavailable to so many people, causing unimaginable suffering on a global scale (The Negative Impact of Drug Control on Public Health).

Many pain and palliative care organisations have campaigned for this change for many years and we hope that the IDHDP campaign "Striving for equity in the treatment of pain" contributed in some small way to ensure its inclusion at UNGASS.

Access to controlled medicines for treatment of pain

Access to controlled medicines for the treatment of drug dependence also received a boost by this inclusion. Drug dependence should be seen as having a health problem and treated in the same manner as individuals experiencing any other medical condition. As stated previously, for the first time "access to controlled medications for medical use" was added to the consensus document and officials were seen publicly endorsing this new and important addition. However, there remains a tremendous amount of work to be done to ensure that what was lauded in the UN building in New York becomes reality in the poorest streets of the world.

Currently only 80 countries out of 158 that report injecting drug use provide OST, with only three new countries adopting its use in the last two years (The Global State of Harm Reduction, 2016).

In certain countries, such as the Russian Federation, OST is illegal. Doctors are not allowed to prescribe methadone or buprenorphine by law and the only treatment is detoxification, often forced. This was highlighted when Crimea was annexed from Ukraine in 2014. Until then there were about 8,700 PWIDs on OST in Ukraine, about 800 in Crimea. Very quickly after annexing all programmes were shut down in Crimea and within a year at least 80 (10 per cent) of the 800 were dead (www.theguardian.com/world/2015/jan/20/ukrainian-drug-addicts-dying-due-to-treatment-ban-says-un).

IDHDP is launching the second phase of its Striving for Equity Campaign in early 2017 to help ensure that OST becomes more readily available and accessible to those who need it.

Harmful and nonmedical use of pharmaceutical opioids

Harmful and nonmedical use of pharmaceutical opioids has increased enormously in the USA and some other countries in recent years. The evidence of why this has happened is often forgotten and media driven opinion drives the responses (Scholten and Henningfield, 2016). Added to this is the pharmaceutical companies investment in promoting these opioids as the needed help for people in pain while claiming they are non-addictive. The US Centres for Disease Control (CDC) decided the increasing opioid use was caused by doctors over-prescribing to pain patients therefore bringing in very restrictive guidelines on opioids for chronic pain (Dowell *et al.*, 2016). The evidence does not support this view. A recent large study confirmed that less than 2 per cent of patients with prescriptions for opioid pain medication become long-term opioid users (http://journals.lww.com/pain/Fulltext/2017/01000/Incident_and_long_term_opioid_therapy_among.18.aspx).

Stephen A. Martin, Ruth A. Potee and Andrew Lazris argue that the CDC has taken available data and come up with analysis, which is "neat, plausible, and wrong" (Martin *et al.*). The CDC frames the recommendations as being for primary care clinicians and their individual patients, with a liberal blaming of pain patients thrown in (Scholten and Henningfield, 2016). The real problem seems to

come largely from diverted opioids made by pharmaceutical companies, which the CDC does not mention at all. Only a very small amount results from long-term use with a prescriber in a clinical relationship (Scholten and Henningfield, 2016). This guidance is also hindering the rest of the world getting adequate pain relief. There needs to be comprehensive drug control policies implemented in ways, which reduce harmful use and diversion problems while scientifically balancing the public health benefits against the potential risks of opioid medications. Implementation of the World Health Organization (WHO) policy can contribute measurably to the prevention of diversion of opioids made by pharmaceutical companies while ensuring patient access to the most appropriate medicines. Measures to reduce the risks of nonmedical use of opioid medicines should be based to the greatest extent possible on accurate evaluation of the mechanisms leading to such use, including diversion activities (The Negative Impact of Drug Control on Public Health).

Drug-related deaths

It is now time for policies that radically reduce the numbers of drug-related deaths to be re-considered and introduced. Most overdose deaths are avoidable yet they are increasing at the shocking rate described above.

North America continues to have the highest drug- related mortality rate in the world, contributing to an estimated 25 per cent of drug-related deaths globally (UNODC, 2016). The rate of fatal drug overdose has also increased by 137 per cent since 2000, with more people dying from drug overdoses in 2014 than during any previous year on record, 61 per cent of which were opioid-related (Rudd *et al.*, 2016).

In Canada, the increase in drug overdose deaths is even greater and has jumped an enormous 327 per cent since 2008 (Britten, 2015).

In Western Europe, overdose continues to be a major cause of deaths in PUDs, with more than 6,000 deaths each year, many involving opioids (EMCDDA, 2015). In the UK, there has been a 64 per cent increase in drug-related deaths linked to heroin and morphine in the last two years, now the highest since records began (Office for National Statistics, 2016). The UK now has the highest proportion (38 per cent) of the European total (European Drug Report, 2016).

Some of these deaths are due to new cohorts of drug using populations, stronger drugs such as fentanyl, particularly in Canada, but also older people who live in poverty. For example, in England the Advisory Committee of Misuse of Drugs (ACMD) agreed that many of the deaths are in an older group of people who have used drugs for a long time, have complex needs, including mental and physical health problems of socio-economic deprivation since the financial crisis of 2008 (Advisory Council on the Misuse of Drugs, 2016). Most live in poverty and most are not currently in treatment. The ACMD also welcomed the expansion of OST since the mid-1990s and re-iterated the evidence that being in good-quality treatment of the right duration and correct dose protects PWIDs from overdose and helps to reduce drug-related deaths (Advisory Council on the Misuse of Drugs, 2016). Changes to drug treatment and commissioning practices, with more commercialisation, a greater emphasis on abstinence and payment to providers by "successful completions", along with lack of access to mainstream mental and physical health services for this ageing cohort have made treatment less accessible. Treatment, especially maintenance prescribing, is protective.

At UNGASS the inclusion of naloxone was progress but we know that its availability and distribution is very piecemeal around the world and that its use is only one element of "harm reduction", two words that, remarkably, never feature together in the final UNGASS documents. We have seen a global slow-down of other aspects of harm reduction that are known to be so effective in saving lives, improving the health of individuals and reducing the transmission of HIV, such as Needle Syringe Programmes (NSP), and Drug Consumption Rooms (DCRs). Harm reduction was absent from the 2010 England National Drug Strategy and seems to be absent from the draft 2016 strategy, which is still not published (Drug Strategy, 2010).

HIV infections

HIV in PWIDs is a preventable disease but without health based drug policies this is much less likely. Countries such as UK, Switzerland, Germany and Australia that implemented health based

drug policies, harm reduction and public health strategies early have experienced consistently low rates of HIV (less than 4 per cent) transmission among PWIDs. Other countries such as USA, Portugal, Malaysia and France that responded to increasing HIV prevalence among PWIDs by introducing harm reduction programmes have been successful in containing and reversing the further spread of HIV (rates between 11 and 16 per cent). But many countries that have relied on repression and criminalisation as a response to increasing rates of drug-related HIV transmission are experiencing the highest rates of HIV among drug using populations (Mathers *et al.*, 2008; UNAIDS, 2010; Global Commission on Drug Policy, 2011).

Both at UNGASS and at the World AIDS Conference in South Africa in July 2016, little was said about PWIDs, leaving them still marginalised and forgotten (Shelly, 2016).

The UN pledged in their Sustainable Development Goals to end AIDS by 2030 (www.un.org/sustainabledevelopment/sustainable-development-goals/). But evidence shows that PUDs, a population at particular risk of HIV transmission, are in fact being left further and further behind. The best way to limit the transmission of HIV, along with hepatitis C, among PWIDs is having a wider pragmatic, evidence-based approach to drugs, including all elements of harm reduction, such as DCRs, needle and syringe programmes, OST and overdose prevention and treatment.

For the last ten years, Harm Reduction International (HRI) has monitored global levels of harm reduction, which until this year's report have shown a slow but steady increase in the number of countries providing it. For the first time, this year's HRI report shows no increase at all in the number of countries with at least one needle and syringe programme (The Global State of Harm Reduction, 2016). Simultaneously there has been an increase in rates of stimulant injecting in almost every part of the world. Of 158 countries with reported injecting drug use, more than a third have no needle and syringe programmes at all, and over half do not offer OST.

It is then unsurprising that the UN's 2011 target to halve HIV transmission amongst PWIDs by 2015 was missed by more than 80 per cent. How are we going to end AIDS by 2030? To achieve this aim, PWIDs must be included but with only 3.3 per cent of HIV prevention being directed to PWIDs and overall donor funding for HIV in decline (Prevention Gap Report, 2016; In the Fight against AIDS, 2016) this will not be possible.

HCV infections

Approximately 80 million people are living with hepatitis C worldwide, of which 60-80 per cent of people develop a chronic infection and many die each year. About two-thirds of these are in PWIDs (WHO, 2016).

The global response to viral hepatitis B and C has been poor. For PWIDs, HBV and HCV are the blood-borne viruses most commonly transmitted by sharing contaminated injecting equipment. Despite the recommendation to implement needle and syringe programmes as a key public health measure, as we have seen many countries do not provide new injecting equipment (WHO, 2012; Nelson *et al.*, 2011).

With new treatments and proper investment it is now a real possibility to eradicate HCV. Prior to the development of direct-acting antivirals (DAAs) treatment was difficult and cure rates were less than 50 per cent. With the arrival of DAAs the cure rates have leapt to over 90 per cent and are much easier to take (WHO, 2016). The price becomes an enormous barrier with some pharmaceutical companies charging what they feel that country can afford, resulting in vastly differing prices for a course between countries (The Global State of Harm Reduction, 2016). Governments and pharmaceutical companies must get together and work out a way for these new drugs to be made available to all.

There is widespread stigma and discrimination towards PWIDs and many misconceptions amongst specialists who assume poor adherence, although the evidence does not support this, presenting another barrier to treatment (www.euro.who.int/__data/assets/pdf_file/0011/183980/Presentation-HEP-C-and-treatment-for-PWID.pdf). Clinical trials tailored to PWIDs have good results with high adherence and retention rates (Luhmann *et al.*, 2015). WHO in October 2016 stated that special efforts must be made to ensure treatment is accessible to PWIDs (WHO, 2012).

In September 2016 in England, NICE decided "that the development of a hepatitis C clinical guideline should continue to be paused until there is stability in the availability of treatments and the cost to the NHS of the drugs" (www.nice.org.uk/guidance/indevelopment/gid-cgwave0666). Would this occur for a drug that cured any other disease, such as diabetes?

WHO's first global health sector strategy on viral hepatitis was launched in 2016, which contributes to the achievement of the 2030 Agenda for Sustainable Development (Global Health Sector Strategy on Viral Hepatitis, 2016/2021). The strategy describes the contribution of the health sector to combating viral hepatitis, contributing to its elimination as a public health threat, and promotes synergies between viral hepatitis and other health issues. It positions the response to viral hepatitis within the context of universal health coverage – an overarching health target of the 2030 Agenda for Sustainable Development (www.un.org/sustainabledevelopment/sustainable-development-goals/). The strategy provides a vision of a world where viral hepatitis transmission is halted and everyone living with viral hepatitis has access to safe, affordable and effective care and treatment, and a goal of eliminating viral hepatitis as a major public health threat by 2030.

Achieving these targets will require a radical change in the hepatitis response, and will mean that hepatitis is elevated to a higher priority in public health responses. Unless there is dramatic change, the call for eradication of HCV by 2030 seems another unlikely dream. This is why phase 3 of IDHDP's Striving for Equity campaign will be geared towards addressing this issue.

Prisons

Prisons all over the world are filled way over capacity with people whose only crime is that they are dependent on drugs and as such get caught up in the criminal justice system when they should be getting help from health services.

In 2010 in UK at least 70 per cent of people in prison had used drugs before entering prison, 24 per cent of prisoners reported that it was easy or very easy to get hold of drugs in their prison, 29 per cent of prisoners said they had a drug problem when they arrived and a further 6 per cent said they had developed a problem since arriving (www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2011-12.pdf#page=36). With over-populated prisons and the rise of NPS use this situation has only got worse since this report (McBride, 2016).

Despite much rhetoric about decriminalisation, the criminalisation and incarceration of PUDs remains the primary response in almost every member state of the UN (Global Commission on Drug Policy's Report, 2012). Currently one in every five prisoners worldwide is being held on drug-related charges (UNODC, 2016). UNAIDS estimates that 56-90 per cent of PWIDs will be incarcerated at some stage (UNAIDS, 2014).

Use, initiation and injecting drug use amongst male and female prisoners continues to be consistently documented in prisons around the world and the prevalence of HIV, HCV and TB remain substantially higher inside than outside of prisons (UNODC, 2016; Dolan *et al.*, 2016). This recent comprehensive review of the global disease burden in prisoners found that of the approximately 10.2 million people incarcerated at any given time, an estimated 3.8 per cent are living with HIV, 15.1 per cent with HCV and 2.8 per cent with active TB (Dolan *et al.*, 2016).

Findings from this year's Global State reveal that the provision of harm reduction services in prison settings continues to be inadequate and far behind that of the wider community (The Global State of Harm Reduction, 2016). Few prisons have NSP and OAT is only provided in prisons in 52 countries and most programmes have serious barriers. Prisoners also face an increased risk of overdose following their release, which remains a very serious but almost universally neglected issue (Zlodre and Fazel, 2012).

In 2016, it appears that only England, Scotland, Wales, Estonia, Norway, Spain, some parts of Canada and the USA provide varying degrees of overdose prevention training and naloxone to prisoners on or prior to their release. Harm reduction in prisons is either absent or inconsistent and uncertain. The provision of good-quality and accessible harm reduction, both inside and

outside of prisons, is not a policy option but a legally binding human rights obligation (United Nations Human Rights Office of the High Commissioner, 2015).

Harm reduction initiatives in prisons must be urgently prioritised – and resourced – both by political leaders and prison authorities. National, regional and international prison monitoring mechanisms should systematically examine issues relating to harm reduction during their prison visits.

Ketamine

Schedule I of the 1971 Convention on Psychotropic Substances requires the strictest of controls to be placed on substances listed within it, and is reserved for substances for which there is claimed to be little to no medical or therapeutic value. At CND 2016 before UNGASS there was yet again more talk of attempts of trying to place ketamine in this schedule.

In 2015 the Chinese government had lead a campaign to schedule ketamine because of a national problem of recreational ketamine use. Fortunately, this was not passed due to the global uproar, mainly from the medical and veterinary community, who use ketamine as an indispensable medicine for anaesthesia and pain relief in many developing countries (Joshi and Onajin-Obembe, 2016). If restrictive international controls were introduced, ketamine would be largely unavailable (Joshi and Onajin-Obembe, 2016; Dong *et al.*, 2015).

In many parts of the world, ketamine is the only safe and effective anaesthetic for a wide range of surgical operations allowing patients to breathe spontaneously while receiving a general anaesthetic without the need for endotracheal intubation. Reducing access to ketamine would be disastrous for access to safe surgery. It is on the WHO list of essential medicines: WHO have rightly warned that moving ketamine to a more restrictive schedule would create a public health crisis in countries where no affordable alternatives exist (World Health Organisation, 2015).

The challenges to ketamine are not over and IDHDP remains part of the international campaign lead by World Federation of Anaesthesiologists to be ready when the next attempt at rescheduling takes place (WFSA Fact Sheet Ketamine). Please World Federation of Anaestheiologists now (www.wfsahq.org/the-campaign) (World Federation of Anaestheiologists, 2015). The scheduling proposal has not been withdrawn, it has simply been deferred for two consecutive years, and is likely to re-emerge at subsequent sessions of the Commission on Narcotic Drugs (CND).

UNGASS miscellaneous

While the outcome document in the main supports the status quo, and fails to refer explicitly to harm reduction, decriminalisation or the abolition of the death penalty for drug offences, there were definitely some positive references in relation to health-oriented interventions and proportional sentencing.

In spite of the recent adoption by the UN of the 2030 Agenda for Sustainable Development, unfortunately the UNGASS outcome document did much to sustain a “siloes” approach to the drug issue. There is a clear and obvious need to align international drug policies with the overarching 2030 Agenda and the Sustainable Development Goals, embedding the drugs issue comprehensively and explicitly within the UN’s three pillars: development, human rights, peace and security (www.un.org/sustainabledevelopment/sustainable-development-goals/).

And now the BMJ

The recent collection of articles in the BMJ feature clearly identifies the huge role for doctors – they must lead the way to a place where drug policies have the health of the individual and society front and foremost. Health should be at the centre of this debate and so, therefore, should healthcare professionals. Doctors are trusted and influential and can bring a rational and humane dimension to ideology and populist rhetoric about being tough on crime (Godlee and Hurley, 2016).

As Fiona Godlee, editor in chief BMJ and Richard Hurley features and debates editor BMJ, put so well in their editorial "Evidence and ethics should inform policies that promote health and respect dignity" (Godlee and Hurley, 2016).

Despite this need for doctors to be involved in the drug policy debate, most doctors' professional organisations have little to say about policies such as the criminalisation of PUDs (Hurley, 2016).

Summary

The global war on drugs has failed and has had devastating consequences for individuals and communities around the world, particularly the poorest and most vulnerable. Until very recently these consequences were referred to as "unintended" but it is now undisputable that existing policies have impeded progress on public health measures to reduce HIV and hepatitis C, limited OST, prevented other harm reduction measures being available to all who need them, allowed the mass incarceration of some of the most marginalised members of society and in the most extreme circumstances led to the state sanctioned slaughter of thousands of people simply for using drugs.

More and more doctors from all over the world are questioning these current policies and joining IDHDP. Increasing numbers of obstetricians, paediatricians, cardiologists, surgeons and other specialists are joining the more obvious candidates of HIV/AIDS and addiction specialists in calling for change.

Work of organisations fighting poverty, supporting human rights and providing medical care to the most needy is impeded by current drug policy. An opportunity now exits for a coming together of international agencies and NGOs, which have up to now remained silent on the issue of drug policy. We should all join together in lobbying for change.

Good policies lead to improvement in the health and wellbeing of everybody. All policies should be subject to regular review and evaluation and where shown to be failing, changed.

Change must come soon, and doctors need to be in there leading this change. Please join IDHDP now and be part of that change.

Dr Chris Ford Clinical Director and Sebastian Saville Executive Director IDHDP

IDHDP is an international network of medical doctors, currently about 1,400 from over 100 countries. Having understood the importance of drug policy on practice, all members have signed up to the idea of health becoming the cornerstone of all future drug policies (www.idhdp.com).

Coming from completely different backgrounds, the authors have conceived and managed a number of innovative services in the fields of drug treatment and drug policy.

Chris Ford worked in General Practice for 30 years. During this time she developed a special interest in working with PUDs and/or alcohol many with HIV and/or hepatitis. Increasingly concerned about the gap between practice and policy, Chris and others founded a UK network (SMMGP) for supporting all health professionals working with people who have drug problems. In 2009 Chris set up IDHDP to be a bridge between practice and policy and to increase the international participation of medical doctors in drug policy and continues as Clinical Director.

Starting as a volunteer in a needle exchange in 1992, Sebastian Saville started the Junction Project in Harlesden where together with Chris they built the first non-statutory prescribing service to exclusively serve a large London borough. Sebastian later went on to rebuild the iconic Release legal service where he spent nine years. In 2013 he again joined forces with Chris to help rebuild IDHDP.

They are both well known in the field for having strong views on the need to provide more equitable services for PUDs and for the change of policy to make this possible.

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Corresponding author

Chris Ford can be contacted at: chris.ford@idhdp.com