A turning point for UK drug policy: opportunity or stasis

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The coincidence in 2016 of the UNGASS year and the absence of a revised UK national drugs strategy prompts an attempt to draw conclusions about recent drug policy activity and assess the events of 2016 and early 2017: how far have international strategies responded to actual needs and situations? How is the UK government contributing to and implementing policy reform? Much international activity in 2016 was the result of governments and agencies taking time to re-think previous policy and practice in the light of evidence and example, and to respond to local situations and needs. This has included an increased willingness to challenge the international conventions. Examples and evidence had some impact at the April 2016 UNGASS: although the final statement did not abandon the prohibition frame-work, it has led to comment that there is now recognition that governments and jurisdictions can practise 'policy pluralism'. While the accumulation of evidence and example of progressive and effective drug policy is increasingly convincing and informative to those willing to learn, there remain administrations and bureaucracies which continue to resist meaningful strategic reform – including some which, de facto, permit or tolerate some positive practices. (United Nations Office on Drugs and Crime, 2016.)

In a field where change is constant but progress chimerical, the passing of time does not invariably lead to policy and practice reform, even though knowledge and evidence have accumulated and, in some quarters, understanding has grown. Movement is seldom linear. While there are many examples of practice moving forward, it needs to be recognised that 'forward' is a subjective and contested term in this field and is strongly rebuffed by some commentators on drugs, health and social policy. The desire to see drug policy moving in a more human rights and public health direction remains unsatisfied in the UK (and elsewhere), most recently indicated (February 7 2017) in the House of Lords when the government confirmed in answer to a parliamentary question that 'there are no plans to transfer' responsibility for the drugs strategy from the Home Office to the Department of Health.

But there remains a gap between what we know and what we – or, more specifically, governments and administrations – do. Preference, habit, prejudice, denial and indifference – hear no evil, see no evil, speak no evil – continue, in too many countries, to determine what is

and what isn't done, what is and isn't recognised, what is and isn't discussed and acknowledged and even what is and isn't allowed in thinking, debate and documentation. So evidence and ideology are frequently odds at – harm reduction in the UK, research into medicinal use of illegal drugs and illicit drugs (including cannabis and ketamine) in the UK and the US, human rights in the Russian Federation and the Philippines, the role of ketamine as an anaesthetic in China. Too many governments dither and deny, refuse and oppress, while people continue to die or be killed as a result of prohibition, notably when governments and law-enforcement agencies, legitimate and quasi, interpret drug control policies as a licence to kill.

So while the UK government continues to collude with the prohibition approach still required by international conventions, it also makes or tolerates small, under-reported moves in a more humane direction – the acceptance of foil distribution by treatment agencies as a harm-reduction measure; the publication of the 2014 International Comparators report (Home Office, 2014) which demonstrated the lack of correlation between criminalisation and levels of consumption; the de-facto decriminalisation of cannabis use by some English police forces; drug testing at events and venues - 'policy pluralism' in quietly pragmatic ways. Optimists would see this as an example of localism, others as an inevitable filling of the strategy vacuum. The present UK strategy stasis is being used by some treatment agencies to quietly change practices to ameliorate some of the negative impacts of the current strategy and legal frameworks (HMG, 2010). That recognised, it's sobering to note that the report recommending the distribution of foil was three years in negotiation between ACMD recommendation and Home Secretary decision and approval; the conclusions of the 2014 international comparators report have not brought about any change in national strategy; and the present commissioning and funding climates make it increasingly difficult for treatment agencies to introduce new, creative, realistic, evidence- and need- informed approaches to services, or to maintain service provision at existing levels. Here is another result of austerity and the collision of rhetoric with reality, and an illustration of the limits of localism.

Correspondence with the Home Office [1], the government department which currently takes the lead on UK drug policy, prompted by its international comparators report, restated government claims that the UK drug strategy works and is successful. There is a sense in which this complacency is honestly held, possibly fed by the realisation that after forty years of continuously rising drug use the predictions of societal collapse that shaped the underlying rationale of prohibition have failed to materialise. Society functions well on drugs, in spite of government incompetence in regulating access to consumers, recreational or medical.

More of concern is the manner in which the definitions by which the 'success' of national policy is measured shift and change – the goal posts are in a constant state of movement. The number of drug related deaths, for long the most important indicator of 'success', no longer seem to be a major concern. The fact that UK drug related deaths have increased markedly (BMJ 2016, Office for National Statistics, 2016) in three successive years does not appear to have resulted in any sense of urgency on the part of government, although the December 2016 ACMD report (ACMD, 2016) adopts a very different stance, drawing trenchant conclusions and making evidence-based recommendations which indicate both an awareness of the current domestic situation and ways in which it might be realistically responded to. (The term 'realistically' is used here to refer to practices which have international evidence behind them. It does not refer to the political climate.) Parliamentary questions in the House of Commons in January and February

[1] Personal correspondence January – July 2015.

2017 about strategy development and content have met with an effective non-response from government. Government 'answers' to parliamentary questions emphasis the role of the public health functions of local authorities. What the answers do not include is any acknowledgement that the funding available to local authorities to implement their public health (and all other) responsibilities has been reduced over the past seven years of austerity and reductions of government expenditure; and is set to continue to do so. It might be added that one public health activity which could operate as an effective, slightly up-stream, prevention measure, the provision of a universal youth service, has similarly had funding and resources withdrawn.

Arguments for the 'success' of the UK's policy include references to the numbers of users in treatment, the continued fall in the numbers of reported drug users (a fall replicated in most other western European nations) and the low rates of HIV in the UK drug using population, that is, drug-related morbidity. This selective argument ignores the extent of Hepatitis C infections (Public Health England, 2016b) and the failure to make widely available the new and highly effective pharma-therapies to combat it. The government's position seems to be that it is the trend in reporting of use statistics over several years rather than a focus on the numbers of people using in each particular year which matters. While the numbers reporting regular drug use have been falling, the figure remains at a level little changed from ten years ago, and the number of people who have ever used an illegal or illicit drug continues to rise (HSCIC, 2016). Another goal-post moved.

The rise in drug related deaths is explained in terms of 'the 1980s', a reference to injecting drug users whose using careers began then. This is demographically relevant to current treatment and morbidity and mortality figures, but does not examine some of the more deep-rooted socio-economic origins of drug dependence and the implications these have for macro-economic policy. Although government has responded forcefully, but ineffectively, to novel psychoactive substances by introducing the Psychoactive Substances Act (2016), there seems less willingness or ability to acknowledge the growth in the illicit use of pharmaceutical products, a growth reflected in other parts of the English-speaking world. Meanwhile, the availability of illegal drugs continues undiminished and the quality and purity of those substances improves.

What is equally deftly ignored is the clear connection between drug prohibition, the stimulus of demand from dynamic drug markets in the US, and the endemic violence and instability, regional and national, along transit routes and production areas in South and Central America. As a major consumer and importer of cocaine, and an exporter of prohibitionist policies, here is an example of parochialism which is a cover for the failure of the UK to acknowledge and accept its responsibilities for events outside its own borders. This domestic and parochial vision is enshrined in the Operational Recommendations for the United Kingdom prepared in September 2015 (HM Government 2015) for the 2016 UNGASS. Here, surely, was the opportunity and setting for consideration of the international dimensions and impacts of existing drugs policy and conventions. The sole reference to an international dimension in the Operational Recommendations is the reiteration that the UK is opposed to the use of the death penalty.

It's therefore difficult to meaningfully describe current UK policy as a strategy. The current strategy (HM Government, 2010) is shaped by and conforms with the international prohibition approach. It focuses on reducing demand, restricting supply and building recovery, that is abstinence, all three of which have been shown to have failed; it does not countenance more nuanced reference to the range of origins of and responses to substance use, including problematic use of illegal drugs. There is an emphasis on the social harms of drug use, paying

little heed to the complexity of its origins and effects on the individual user. The sole mention of harm reduction in the 2010 strategy is in a footnote reference - to an alcohol publication. Word has it that the 2016 national strategy, finalised in March 2016, promised for the summer but not yet (March 2017) published, similarly and consistently avoids mention of harm reduction. [2]

Parliamentary questions about the delay in publications of a 'new' drug strategy tabled in February 2017 were told that the strategy 'will be published soon' and that those consulted in its development will include the Advisory Council on the Misuse of Drugs. The absence of harm reduction from the strategy might be seen in practice in the continuing obstacles or delays to making naloxone available across the country; and the dithering – on cost grounds? another result of austerity? – about making the new Hepatitis C pharma-therapies available. (In Sweden, now retreating from its previous zero-tolerance approach to illegal drugs, these treatments are widely available in the south-western region of Skåne [3]). Questions in the House of Lords on February 7 2017 about the delayed publication of a revised national drugs strategy elicited a reply which included the claim that the revised strategy would be informed by advice from sources including the ACMD. Optimists may see this as an indication that the government will accept some of the recommendation in the ACMD's December 2016 report on drug related deaths. Sceptics will see this as a cover for the inexplicable delay, with a hint of shifting responsibility away from ministerial indecisiveness.

It is notable that the UK has not followed the evidenced examples of other jurisdictions by introducing drug consumption rooms. The possibility of a Glasgow DCR (NHS Greater Glasgow and Clyde, 2016) opening shortly and the discussions in South Wales may buck this trend, but may also be an example of devolved power being used to meet local needs which can be explained away or belittled by the 'English' government: as recently as February 2015 the Home Office described consumption rooms as a 'solution to a problem which has only a limited impact in the UK' and as 'costly to run'. [4] It might be inferred from statements of this nature that drug users, along with other socially marginalised groups, do not merit consideration from the public purse. It will be interesting to see what regard government pays to the December 2016 ACMD recommendation that drug consumption rooms be amongst the approaches considered in responding to the recent sustained increase in drug related deaths. Government answers to parliamentary questions say that the response to the ACMD report will be within a three-month time-table.

The 'English' government continues to maintain that the currently illegal drugs, those 'controlled' or scheduled by the 1971 Misuse of Drugs Act, are so because of their dangerousness and harm, to users and to society. The Scottish parliament has adopted more nuanced and realistic analyses and responses, often at variance with the UK strategy (Scottish Government, 2008, 2010). The coverage of these two strategy documents gives rise to considerable potential for debate, confusion and flexibility about which strategy applies to which part of the United Kingdom. Describing illegal drugs as having no medicinal benefits or uses again ignores the growing research evidence of the medicinal use of 'illegal' drugs being established internationally, and increasingly acted on by local and national legislators. The summer 2016 report compiled for the All Parliamentary Group on Drugs stated: "We have found good evidence for one or more of the cannabis products or "natural" cannabis in the

[2] Personal conversations.

[3] Personal correspondence with Mikael Johansson, Skånes Brukarförening.

[4] Personal correspondence January – July 2015.

management of chronic pain. Including neuropathic pain; spasticity; nausea and vomiting, particularly in the context of chemotherapy; and in the management of anxiety" (Barnes and Barnes, 2016). An unexpected recognition of the medical potential of cannabis came with the decision of the Medicines Health and Regulatory Authority (2016) to treat cannabidiol-containing products as medicines – and requiring all suppliers to obtain marketing associations.

Current UK policy inhibits such research being carried out here. It might be inferred that this is a conscious refusal to permit research that might demonstrate the medicinal and therapeutic benefits of some illegal drugs in order to prevent the emergence of evidence which undermines the government's current position. This from a government which frequently extolls the importance of research and has been known to refer to evidence-based policy.

The present refusal by the UK government to consider changes in drugs policy has several origins. There remains an awkward confusion around pleasure and prohibition. Recent government statements arguing against minimum unit pricing for alcohol have argued that MUP would penalise 'responsible drinkers' - not to mention the interests of the alcohol industry. This has to be considered alongside the blanket description of illegal drugs as dangerous and harmful when there is growing evidence that such drugs can also be curative and enjoyable; and are used 'responsibly' by the majority of users. As for 'dangerousness', there are over one hundred deaths annually from paracetamol poisoning, and (so far) none from cannabis poisoning. Pharmaceutical products are associated with a range of adverse health conditions and side-effects, including dependency. The well-established negative impact of tobacco and alcohol on users and society continue to be far greater than those of illegal drugs.

There is an absence of dialogue with drug users, and practitioners other than those from law enforcement. While service user involvement is promoted, only recovering problem users are heard while the voices of functioning users are resolutely ignored. Service users are expected to provide feed-back on their treatment and the agencies they attend; drug users could provide insight into the bigger picture of illegal drug use. Failure to consider changes in drugs policy shields government from the strident criticism and moralising, the demonising attitudes and stigmatising language used by much of the media - usage to which government and some ministers contribute in many of their pronouncements. There may also be a new pragmatic but unacknowledged lack of awareness and willingness to consider such areas of social policy because of the time and resource demands - 500 civil servants 'left' the Department of Health in January 2017- arising from Brexit. Brexit could affect membership of and engagement with the EMCDDA, the European Centre for Disease Control and Prevention and Europol. No UK data are included in the 2015 European School Survey Project on Alcohol and other Drugs, published in September 2016. Here as elsewhere there appears to be no strategy or plan for the continuation of such collaboration and information and data collection. Indeed, data-collection may be a victim of the dual demands of a reduction in red tape (also known as accountability) and austerity. The Office for National Statistics pre-emptively approached government departments in 2013 with details of potential closure of data collection programmes which it claimed would be required of it as a result of austerity-led budget reductions. (DrugLink, 2013.) Although not (yet) implemented, the ONS letter can be seen as an indication of the future. And all this before the wider socio-economic origins of drug use are considered.

More of the same seems to be in prospect for the next few years: the brief for the strategy writing group might well have been 'the same procedure as last year? – the same procedure as every year'. This stasis is reinforced by the continued non-appearance of the 2016, as was

originally promised, national strategy, leaving those responsible for implementation and treatment unsure of their own futures, direction and practice, not to mention funding: the driving force seems to be inertia. Responding to evidence and need has, so far, had little impact on UK governments' thinking and practice. While the content of the International Comparators report was welcome, the report's impact has been negligible. The history of small changes to policy and practice is due for replacement by broader thinking and evidence, which could be based on the findings and lessons of social epidemiologists.

With a government clearly at a loss on how to proceed there is both a serious risk to well established practices in treatment, harm reduction and decriminalisation, but also an opportunity for dramatic change. The post Brexit disentanglement from some international obligations creates a potentially fertile environment for policy experimentation. Several US states, Israel and Canada have already made strides in developing a commercial cannabis industry. The UK has taken a rather dated approach, fostering a national champion in GW Pharmaceuticals. A pro-business government could embrace the stimulating dynamic of the market and allow the creativity of thousands of small producers to unfold. A new phalanx of producers of medicinal and recreational cannabis product could turn the UK into an offshore centre for a new, green economy, building on competitive advantage (advanced pharmaceutical industry, large domestic drugs market, a thriving arts & culture sector) and a unique entrepreneurial culture. In the aftermath of the paradigm shifting trinity of events, UNGASS, Brexit and Trump, little is clear about the direction of drug policy. For reformers this is also an opportunity, but as so often the outcome will be determined by the framing of the issue: scourge of the young or new era bio-technology?

While criticisms and analysis of UK government drug policy are in many ways easy to make, it is less straightforward to see how thinking and emphasis might change. The evidence is there, though not yet accepted or followed in all cases, and representations are being made, within and outside parliament. Whether the government will adopt a more evidence-based approach in its revised national strategy will be shown in its response to the December 2016 ACMD report, a response which will both indicate governmental attitudes to research and evidence; and set the scene for the next five years or so of illegal drug policy in the UK, domestic and international. The down-stream activities which remain the focus of most commentary and statistical scrutiny should not be seen in isolation from wider macro-economic direction, which shape the life conditions which lie behind substance misuse and other social dis-ease.

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