RHD0008

Written evidence submitted by Drug Science

1.0 Introduction

This response has been collated by Drug Science, a charity founded in 2010 by Prof David Nutt. Drug Science is an independent, science-led drugs charity, bringing together leading experts in science, academia, and policy from a wide range of specialisms to carry out research into drug harms, effects, and potential medical uses. This response is informed by chapters from "Drug Science and British Drug Policy," Critical Analysis of the Misuse of Drugs Act (MDA) 1971 Edited by Ilana Crome, David Nutt and Alex Stevens. We would be delighted to offer copies of this book to those involved in the inquiry, as it provides a deep and comprehensive understanding of reducing harm from illegal drugs.

2.0 Pitfalls of the Misuse of Drugs Act 1971

It has now been over 50 years since the Misuse of Drugs Bill became an Act of Parliament. As stated by the Transform Drug Policy Foundation, 'The Misuse of Drugs Act 1971 is not fit for purpose. For 50 years, it has failed to reduce drug consumption, increasing harm, damaging public health, and exacerbating social inequalities. Change cannot be delayed any longer. We need reform and new legislation to ensure that future drug policy protects human rights, promotes public health, and ensures social justice.' We need drug policies that prioritise public health, human rights, and social justice, ultimately working to reduce the harm caused by drugs. Portugal provides an example of a successful model with a focus on harm reduction and comprehensive treatment.

The MDA 1971 aims, by prohibiting supply, possession and associated activities for specified psychoactive drugs, to discourage those activities for fear of criminal sanction and thereby to reduce associated physical and social harm. However, a House of Commons Select Committee on Science and Technology review (2006: 52) concludes that they 'found no solid evidence to support the existence of a deterrent effect, despite the fact that it appears to underpin the Government's policy on classification.' Despite successive governments' efforts to reduce drug supply and its impact, drug-related deaths (DRDs) have increased by 80% between 2011 and 2021. We draw your attention to the Drug Science research (Lancet 2010, Nutt et al) that showed there was no relation between the harms of recreational drugs and their legal status. This finding has been since confirmed by independent research from expert groups commissioned by the EU DG Justice (van Amsterdam et al 2015) and an Australian charity (Bonomo et al 2019). Taken together they call into question the basis of the current laws and the morality of the current disparity in penalties that do not reflect harms.

The Misuse of Drugs Act 1971 also plays a significant role in the ethnic disproportionality of policing in England and Wales, particularly in London. Stop and search powers are disproportionately applied to ethnic minority groups, especially young people and those identifying as black. In 2019, black people were stopped at a rate nine times higher than

their white counterparts, with similar disparities among Asian and mixed heritage populations.

In the sections below we discuss key points to cover the four areas of the inquiry requiring input.

3.0 Disrupting Drug Supply

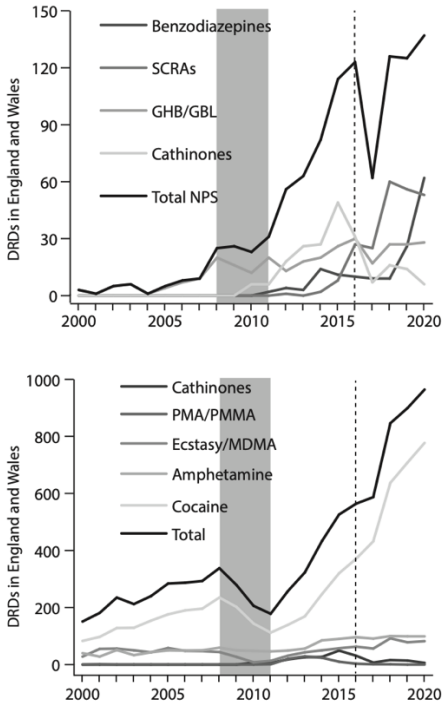
3.1 Novel Psychoactive Substances (NPS)

The rapid influx of NPS, including synthetic cathinones and synthetic cannabis receptor agonists (SCRAs), in the UK since 2008 revealed deficiencies in the Misuse of Drugs Act 1971 to control such substances. The Psychoactive Substances Act 2016 (PSA 2016) was introduced as an attempt to control NPS. However, this legislation had limitations and unintended consequences, including increased use in custodial institutions, and the development of more potent, and hence more dangerous, compounds.

3.2 Drug-Related Deaths and NPS

Before the PSA 2016, DRDs for NPS were rising across England and Wales. Major drug groups implicated in these deaths included cathinones (primarily mephedrone), SCRAs and benzodiazepine analogues. NPS-related deaths decreased substantially in 2017, likely reflecting their reduced access, availability and use. But alongside this change there occurred renewed popularity of established street drugs with increased deaths, as when all drugs are equally illegal users tend to gravitate back to their traditional favourites and the purity of these increased. Since the 2010 generic ban on synthetic cathinones, stimulant DRDs have increased five-fold, primarily driven by increased deaths involving cocaine and MDMA, in line with their increased purity (Figure 1). Today stimulant NPS deaths are outnumbered by established drugs like cocaine and MDMA.

Figure 1: Drug-related deaths in England and Wales relating to NPS (first graph) and stimulants (second graph) from 2000–2020. 2008–11 period of peak cathinone availability highlighted in grey. The Psychoactive Substances Act came into force in 2016 (dashed lines). (Based on ONS, 2021).



(Figure 1 from Drug Science and British Drug Policy," Critical Analysis of the Misuse of Drugs Act 1971 Edited by Ilana Crome, David Nutt and Alex Stevens)

3.3 NPS in Custodial Institutions

NPS use in prisons has grown faster than in the general population. Use of very potent so easily hidden SCRAs (such as 'spice' and 'black mamba') is particularly widespread, placing an additional burden on emergency responders. Rather than addressing root causes, the UK Government framed NPS use in prisons as a disciplinary issue instead of developing policies to support prisoners and reduce demand.

4.0 Reducing Long-Term Demand:

4.1 Decriminalization for personal possession

Instead of focusing on reducing long-term demand, we must consider a shift towards a model of decriminalization for personal possession and a framework for legal regulation of drugs in the UK. There is international support for decriminalization, including recommendations from public bodies like the United Nations Chief Executives Board and the World Health Organization. In the UK, organizations such as the Royal Society of Public Health and Social Care Committee (2019) House of Commons committees. Criminalisation has not effectively deterred drug use (and through deprivation of working opportunities may even encourage drug dealing) and has not reduced drug-related harms. We propose removing the offence of possession by repealing sub-sections 5(1) and 5(2) of the MDA 1971. If these were repealed, but sub-section 5(3) was not, it would no longer be an offence to possess substances that are controlled under the MDA 1971, unless there was also intent

to supply. The relevant part of Schedule 4 would also be repealed to remove the stated punishment for the offence.

This proposal is modest and pragmatic because it doesn't require the creation of a new legal framework. Instead, it builds upon existing legislation and doesn't extend to the legal regulation of drug production and sale. Police would retain the power to search and confiscate substances in cases of reasonable suspicion of importation, production, supply, or intent to supply. This would help reduce the harms of criminalisation associated with drug possession, including stop and search, arrest, criminal records, and the impact on individuals and communities, particularly those in over-policed areas. Critically, there is little evidence to suggest that decriminalisation increases drug use, instead the proposal would improve the relationship between law enforcement and people who use drugs.

4.2 Legal regulation

Legal regulation of drug supply should be considered as a separate step beyond decriminalization. Transform Drug Policy Foundation have proposed several models of legal regulation. Legal regulation involves the formal establishment of a legal market for drugs subject to various controls, similar to how alcohol and pharmaceuticals are regulated. This would be risk-based models of control, where the level of regulation for a specific drug or substance is determined by its inherent risks and the social context. There would be different types of regulation for drug supply, including medical prescription, specialist pharmacy sales, licensed sale for consumption on the premises, licensed sales for consumption off the premises, and unlicensed sales. It is critical to support communities that have been disproportionately impacted by drug prohibition, with social equity measures in drug regulation and expungement of historical convictions related to drug offenses. Legal regulation of drugs can support a reduction in prohibition-related harms and provide a more rational and evidence-based policy-making environment.

5.0 Barriers to Accessing Treatment and Recovery Support:

Addiction is as a complex, multifaceted condition influenced by various behavioural, psychological, social, and biological factors. While there are medications available to assist with addiction treatment, the success rate remains relatively low. Funding needs to be provided, prioritised and coordinated for the key areas discussed below otherwise these remain major barriers which are not recognised.

5.1 Provision of sufficient and high quality services

Currently there is a lack of comprehensive services for patients. There needs to be provision not only of medical treatments for mental and physical illness, but coordinated, collaborative psychological interventions, and provision for education, training, housing and recreational activities. Services need to be developed and commissioned to provide quality provision to reduce the risks for drug and alcohol use that emanate from inequalities, lack of family support, homelessness, mental health conditions, contact with the criminal justice system, and domestic abuse. There needs to be supported and recovery housing provisions to support people across different stages of recovery, for example those offered by Phoenix Futures.

Synthetic opioids are entering the drugs supply chain in the UK, resulting in rising overdose deaths and presenting an urgent need to expand harm reduction measures. The risk of synthetic opioids was discussed in The House of Commons, Home Affairs Committee, Drugs, Third Report of Session 2022–23 by Prof David Nutt (Edmond J. Safra Professor of Neuropsychopharmacology and director of the Neuropsychopharmacology Unit in the Division of Brain Sciences at Imperial College London, and Founder and Chief Scientific Officer at Drug Science). Although the Government Response to the Committee's Third Report states the UK Government and devolved Governments are engaged on the issue of synthetic drugs, we believe more needs to be done. Ensuring accessible drug treatment is crucial, with a need for diverse substitute medications like methadone, diamorphine, and extending prescribing options to include benzodiazepines. Barriers to substitute prescribing, such as assessing motivation, must be eliminated. While a drug consumption facility is set to open in Glasgow, it's imperative to establish more facilities nationwide, especially in high-need areas. Additionally, we must also have functioning drug surveillance and warning systems in place in healthcare and in border agencies, to make sure that safety information is widely available to professionals and to people who use drugs.

The pioneering Middlesbrough Diamorphine-Assisted Treatment programme provided invaluable health benefits to participants, demonstrated high engagement, and reduced offending and criminal justice costs significantly. Despite the success, funding was withdrawn, which prompted a motion by 21 MPs expressing their dismay at the closing of the programme.

5.2 Marginalised groups

Certain marginalized groups, such as those with comorbidities, refugees, rough sleepers, prison leavers, sex workers, disadvantaged individuals, specific minority ethnic groups, LGBTQIA+, older people, and young people, face challenges and barriers to treatment. It is essential for local commissioners and services to collaborate with representatives from these groups to assess local needs for alcohol and other drug treatment. Strategies should be developed to target and enhance access for each under-represented group, tailoring services to meet the diverse needs of the local population. These factors significantly impact service access and the effective utilization of services, including recovery support. Engaging individuals from various communities is crucial, and service plans should be co-produced with them in a culturally sensitive manner.

5.3 Education of professionals and the public

The importance of optimising training provision for substance use professionals in the UK was highlighted in the 2021 report led by Professor Dame Carol Black and by the publication of the UK Government's Drug Strategy in 2021. They recommend that the Academy of Medical Royal Colleges should develop a training centre for the NHS and third-sector workforces.

Education of professionals plays a critical role in ensuring patients are thoroughly assessed and treated. A key example of this is healthcare professionals who don't feel confident treating patients with medical cannabis due to a perceived lack of scientific evidence and a lack of experience prescribing medical cannabis, especially due to the prescribing route for unlicensed 'special' medicinal products. This highlights the need for systematic training of

prescribers, pharmacists (especially at Clinical Commissioning Group level) and medical prescribing advisors.

There are multiple barriers in the training of third-sector substance use professionals. Barriers to training included financial and organisational factors, the impact of which could often be diminished by using online training methods. There are training needs in therapeutic techniques and in building therapeutic relationships, such as group work, motivational interviewing, and recovery.

We also need better education for the public on the harms associated with drugs and the treatment services available. This education needs to be accessible and inclusive of marginalised groups. National drug education should start in school and harm reduction programmes need to be in place at universities such as the Staying Safe initiative.

5.4 Rescheduling of psychedelics and cannabis specifically for research and treatment
There is renewed interest in using psychedelic drugs and medicinal cannabis as potential treatments for addiction and mental illnesses. Research indicates that these psychedelics may be beneficial in combination with psychotherapy. However, the Misuse of Drugs Act (2001) places psychedelics in Schedule I. This means these drugs cannot be stored, prescribed or researched without possession of a controlled drugs (CD) licence from the UK Home Office, which acts as a serious barrier to legitimate psychedelic scientific research by making it more difficult, time-consuming and costly to study. We recommend rescheduling psychedelics from Schedule 1 to Schedule 2 of the Misuse of Drugs Regulations (2001), reducing unnecessary barriers to scientific research.

Prof David Nutt and Prof Jo Neill (Professor of Psychopharmacology at the University of Manchester and chair of the Medical Psychedelics Working Group at Drug Science) provided evidence to The House of Commons, Home Affairs Committee, Drugs, Third Report of Session 2022–23 on the barriers to researching controlled drugs under Schedule 1. The Government's response the Committees report was published on 14th November 2023. The response states it is awaiting the Advisory Council on the Misuse of Drugs (ACMD) advice and the potential options available to extend Schedule 2 status for research purposes. We consider that the need for a decision is urgent.

Access to medicinal cannabis on the NHS is severely restricted by its Schedule 2 status, despite growing real world evidence for its safety and effectiveness from Drug Science's observational study (Project T21). This has for example demonstrated medical cannabis use reduces opioid analgesic use (also see specific case study here). Prescribing is currently restricted to a doctor on the General Medical Council (GMC) specialist register (although a GP can continue prescribing after treatment has been started) where the cannabis-based medicinal product is an unlicensed 'special' medicinal product for use by a specific patient. Removing the requirement of a specialist to initiate prescribing and providing sufficient training to GPs would help to reduce this barrier to medical cannabis.

The Government's response the Committees report states the Government 'remains committed to taking an evidence-based approach to unlicensed cannabis-based medicines' and that 'clinical guidelines from the NICE demonstrate a clear need for more evidence to

support routine prescribing and funding decisions'. We argue the evidence base is already documented and is growing through the real-world evidence collected in Drug Science's observational study (Project T21) which currently has over 4,000 patients registered. We have discussed in detail the role of real-world evidence and would like to highlight that Sir Michael Rawlins, the former head of the MHRA and NICE, pointed out in 2008 that Randomised Controlled Trials are not the apex of evidence. We would like to draw your attention to the briefing document containing evidence for cannabis-based medicinal products for treating chronic pain which Drug Science has created.

5.5 Investing in new treatments

There have been no real breakthroughs in medication treatment for addiction this century. Now studies with psychedelics such as psilocybin and ketamine are showing a great deal of promise. However, the Schedule 1 and Schedule 2 status of these limits research [see 5.4] so repealing these would facilitate research. But as these compounds can't be patented there is little likelihood of commercial pharmaceutical companies developing them. This means that the UK government must provide earmarked funding through the MRC and NIHR otherwise this potential will not be realised.

6.0 Certainty of Government Funding

We need adequate and sustained funding available for drug harm reduction programs and support services to help long term recovery. This must also include funding for effective education and training of healthcare professionals. We also need more government funding for research into cannabis and psychedelic research for the treatment of addiction and other comorbid mental health conditions.

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