Written evidence from Honorary Professor Susanne MacGregor

16 May 2019

Thank you for your letter of 8 May 2019, inviting me to provide any further information that the Committee should consider, following my oral evidence session on 7 May.

I am aware that you have received 64 written submissions and have been given detailed briefings by advisors and civil servants so I do not want to add too much to the vast volume of material you need to review.

However, there are a few further comments I would like to make arising from the Session in which I participated.

1. Mr Ben Bradshaw asked ‘Does prohibition and a criminal justice approach to drugs help or hinder harm reduction?’

The discussion that followed focused on the failure of prohibition (as interpreted over the past century) to prevent the use of controlled drugs – indeed prevalence of use of an increasing variety of drugs has increased in general. It is fair to note that supporters of prohibition and a ‘war on drugs’ approach would argue that things might have been worse and their policies have ‘contained’ the problem.

The arguments against prohibition point to its ‘policy harms’, some of which we did discuss:

- the production and distribution of more dangerous, more potent, adulterated and unknown substances
- the system’s ineffectiveness in controlling an increasing volume and range of psychoactive substances – such as the new ‘synthetic’ drugs
- the costs of the criminal justice system itself
- yet its inability to respond adequately to the needs of the high proportions of prisoners and ex-prisoners who use drugs and alcohol and have associated mental illnesses and/or learning difficulties
- and the marginalisation of drug users and the harms they encounter through criminalisation.

We could also have mentioned:

- the expanding criminal market and growth of serious organised crime
- geographical displacement – as control in one area is effective, production and distribution simply move elsewhere
I should also have taken the opportunity here to raise the question ‘what might be the alternative to prohibition?’

The answer currently offered in many international and UK forums is ‘a public health approach’. However, understandings of this term vary from narrowly ‘disease prevention’ to more broadly ‘health promotion’. There are also differences in emphasis on the causes of ill health or disease – from individual choices and behaviours to social determinants.

The committee might usefully focus some attention on the question ‘what would a public health approach to drugs policy look like?’

There are several interpretations of ‘a public health approach’:

- The public health profession in practice today focuses much of its work on encouraging partnership or multi-agency cooperation at local level, aiming at encouraging more healthy local populations and focusing on those conditions which impact most at population level – such as smoking, obesity and alcohol use as well as air pollution.

- Differentiated regulation of different substances depending on evidence of their harms (to both individuals and society). Regulatory frameworks might range from at one end commercial marketing of cannabis (or ecstasy or even cocaine) to at the other end restricted availability for medical purposes only of more dangerous substances e.g. heroin. There would still be problems of leakage or illegal markets which would require controls. This approach would encourage the development of different forms of regulation for different substances. Gradual moves in that direction can now be seen beginning with policies on cannabis/marijuana internationally (Canada, Uruguay).

- As developed currently in Scotland and discussed in relation to knife crime – an epidemiological approach as advocated by Slutkin: this is a form of community action, led by doctors with attention to social and community work. The focus is on an individual in a social network, with responses such as crisis intervention involving data sharing and identification of hot spots or clusters of risk factors. (There have been some criticisms made by civil liberties groups around the construction of data bases).

- Some equate the public health approach with harm reduction policies (tending to focus on the most problematic users and substances but not always). These involve a package of technical interventions such as NSE (needle and syringe exchanges), OST (opiate substitution treatment) and SIF (safe injecting facilities or drug consumption rooms) plus other interventions such as drug testing at places where illegal drugs are available (e.g. festivals or clubs). The focus of policy is on the harms linked to drug use, with often a fairly relaxed stance on general drug use – perhaps a more libertarian viewpoint but usually just turning a blind eye to issues of supply.
• Public health in general emphasises the role of the environment, including physical, social and cultural environments (and policy environments). Because of this, there is in my view a tendency in public health to favour state intervention and control rather than very liberal policies. These might range from controls on, for example, how alcohol or drugs are to be marketed and priced, and advocating limitations on advertising and availability (outlet density and licensing). This approach would tend to control psychoactive substances/ today’s illicit drugs in the same way as tobacco and alcohol. What we have seen with tobacco of course is an increasing tendency to favour more prohibitionist-like policies / stricter controls and there are a number who now advocate similar curbs on the availability of alcohol. So a public health approach would involve different forms of control not an absence of control.

• Some advocates of a public health approach argue that the policy lead should be taken by health departments rather than home affairs or criminal justice departments. The focus of attention should be on demand not supply (though supply will continue to be controlled to some extent). However others question what would happen in practice if the Department of Health and Social Care were put in charge of drug policy, worrying that drugs would not be a priority as most attention would continue to be on hospital-based treatment rather than social or community care and there would be a neglect of education, prevention and public health. Chronic and unpopular illnesses would continue to be neglected. Some think this would also give too much power to psychiatrists (although as we heard the problem currently in UK is the decline of addiction psychiatry).

2. There was some discussion of the causes of drug use and problematic drug use. We touched on the link to mental illness. I could have said more to draw attention to the issue of underlying trauma – from child sexual exploitation especially but from other adverse experiences. These call for sensitive responses including psychotherapy.

3. Dr Sarah Wollaston asked about the availability of opiates and comparisons between the USA and UK. We mentioned that the health system background in the USA is different so over prescribing by doctors is not likely to occur here to the same extent.

However, I would add that the current situation there, as I understand it, is that controls on prescribing by doctors have been implemented but this then had the effect of diverting dependent users to the illicit heroin market.

In the USA there were high levels of prescriptions in deprived areas (rust belt areas) linked to levels of disability, ageing and the reality of pain. These have been identified by Angus Deaton and Anne Case as ‘diseases of despair’ and will be the focus of the current Deaton/IFS enquiry into inequality in UK. Their studies have linked declining life expectancy in certain socio-economic groups (white, middle aged, males especially) to deprivation and poverty, using statistics on suicide, and deaths linked to alcohol and drugs.
In looking at drug overdoses, the appearance of illicit fentanyl needs to be monitored. John Corkery at the University of Hertfordshire is the leading expert on overdose deaths in UK.

4. I spoke of the Central Drugs Coordination Unit at the Home Office - I should have referred to this as the Central Drugs Prevention Unit.