Prevention and early intervention

- What are the reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high-risk use to the normalisation of recreational use.
- How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.

The HM Government 2017 Drug Strategy stated that the Government “have no intention of decriminalising drugs.” This overly simplistic statement presents a problematic starting point for development of evidence-based policy on prevention and early intervention. The “no decriminalisation” policy overlooks the vast array of psychoactive substances with differing potential for harm and addiction, including drugs controlled under the Misuse of Drugs Act (MDA) 1971 and new psychoactive substances under the Psychoactive Substances Act 2016, as well as legally available drugs (notably alcohol) and diverted prescription medicines that are an increasing UK societal problem (e.g. opiate painkillers).

The UK Government policy statement of 2017 is clearly out of step with international opinion and progressive policy development, and UK strategies are neither particularly effective nor evidence-based in my opinion. A new 2019 position statement on drug policy from the United Nations Chief Executives Board calls on member states to “promote alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use,” pointing the way to more effective and humane drug policies. [1] Within the EU, the case of Portugal is a well-publicised and salutary case. Portugal decriminalised the use of all drugs in 2001; since that time HIV infections and drug-related deaths have decreased to well below the European average [2].

We have long known that simply banning the use of psychoactive drugs does not impact on the scale of problematic drug use. Rather drug scheduling perversely changes the nature of the drug supply chain towards illicit but highly profitable routes of access, fuelling criminal activity and risky behaviour on the part of the consumer. The case of cocaine, scheduled over recent decades as a Class A drug under the 1971 MDA, illustrates this problem. Cocaine deaths have recently reached their highest numbers since records
began (432 deaths in 2017), with an estimated 875,000 using the drug in England and Wales (a 15% year-on-year hike) [3].

I would like to highlight two other problematic areas where the lack of an evidence-based approach to drug policy is causing additional harm to substance users and wider society:

**Problem 1:** The unregulated illicit drugs market, particularly in new psychoactive substances, means that users are exposed to additional harm through drug mislabelling, consumption of substance mixtures and new substances with unpredictable short- and long-term toxicities.

The Welsh Government funded WEDINOS (Welsh Emerging Drugs and Identification of Novel Substances) project, administered through Public Health Wales, is a pioneering harm reduction initiative to collect, test and inform on drug samples from a range of stakeholders across Wales (individual users, drug services, police, ambulance service, night-time economy, prison service, festivals etc.).

Rigorous analytical chemistry characterisation of samples submitted has revealed frequent mislabelling and fairly random drug sample mixing [4], meaning that the end user is exposed to unnecessary harm due to the lack of a robust and regulated supply chain (unlike that for conventional medicines). A further serious problem is the lack of quality control with respect to drug dose, something we have observed for example in the 10-fold dose range of MDMA (Ecstasy) from festival samples. In this circumstance, the consumer is completely unaware of the risks to their health and wellbeing, a consequence of the unregulated supply chains characteristic to illicit drug substances. In contrast, a legal drug such as alcohol or nicotine is at least regulated with respect to dose, meaning the consumer knows more clearly the risks associated with consumption.

**Potential solution 1:** In the absence of moves towards decriminalisation, we advocate expansion of the harm reduction approach of drug testing throughout the UK, and further cooperation and collaboration with European agencies such as the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction).

**Problem 2:** Banning psychoactive substances prevents UK-based research on their potential therapeutic/medicinal properties.

Within the UK, we are arguably in the grip of a mental health crisis that requires our urgent collective attention and resource. It is noteworthy that many psychoactive substances used in the unregulated recreational market have their origins in mental health drug discovery programmes of pharmaceutical companies. We have recently highlighted international developments into promising clinical studies on psychotherapy using the illicit psychoactive substances MDMA (Ecstasy) and psilocybin for the treatment of post-traumatic stress disorder (PTSA) and depression respectively [5].

The provisions of the MDA 1971 and Psychoactive Substances Act 2016 severely curtail the ability to study the potential therapeutic opportunities afforded by known psychoactive substances in the UK, or the ability to carry out new research into treatments for neurological disease that are so desperately needed.
Potential solution 2: If we are to realise the opportunity to use psychoactive substances for the benefit of patients, we need to find creative solutions to allow research and development efforts to flourish unimpeded in the UK.

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Sources of reference