Is it possible to reduce population levels of illegal drug use?

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The 2021 UK Drug Strategy, *From Harm to Hope*, presented an ambitious programme of work that sought to address more than a decade of increases in drug-related harm[1]. Strategy priorities were primarily a response to the recommendations of Dame Carol Black's independent report on the UK drugs situation [2], and were accompanied by additional funding of £903m. The National Audit Office's (NAO) recent value for money report identified mixed progress towards Strategy objectives[3], with an increase in the number of drug workers entering the sector, but concerns about local implementation of some actions, the ability of government to evaluate policy impact, and sustainability of Strategy actions beyond 2024/25.

A headline priority of the Strategy is to develop a 'generational shift' in attitudes towards drugs, and reduce overall use across the population to a '30-year low'. Preventing drug use has always been implicit in drug policy, but this is the first time that this has been a key indicator. Overall population prevalence of drug use is already lower than the historic highs of the late 1990s, suggesting the target is acheivable[4]. However, the use of drugs has increased since 2016, including use of cannabis, ketamine and powder cocaine by young people. There has been an accompanying rise in indicators of drug-related harm, including hospitalisations, and deaths from drug poisoning and long-term health conditions. The estimated number of people using illicit opioids and crack has barely changed, and the number of young people entering drug treatment has fallen, suggesting a high level of unmet need[5].

Historically, drug prevention in the UK has been hampered by out-of-date thinking on effective approaches, inadequate funding, and an inability to scale-up programmes[6]. Reflecting the control of drugs under the Misuse of Drugs Act 1971, most prevention activity has been delivered through the criminal justice system, rather than health, social care, or educational systems. Over half of the *Reducing Demand* funding stream of the Strategy (£30m), for example, is allocated to drug testing for suspects in custody

(£16m), whilst only £5m over three years is dedicated to development and delivery of innovations in prevention.

Whilst associated with high societal costs, those who come into contact with the criminal justice system or treatment services are a minority of the estimated three million adults who use drugs in England and Wales each year[4]. Most cases of drug use in the UK are time-limited and infrequent, and most people who use drugs mature out of use in their twenties without requiring any formal intervention, experiencing serious harm, and without coming to the attention of the police[2]. Nevertheless, the NAO notes that the Home Office seeks to toughen sanctions on these people who use drugs 'recreationally' as a way to reduce demand, although international evidence on this type of approach is sparse[7].

Early onset of drug use is associated with escalation to more harmful and longer-term patterns of use, and these may be compounded by experiences of adversity, social isolation, or poor mental health [7, 8]. Even when drug use is infrequent, individual use episodes can be risky, as they result from exposure to illicit products purchased through exploitative criminal markets. Harmful behaviours may arise whilst intoxicated, and periods of drug use can disrupt education, employment and social relationships. Primary prevention or delaying initiation of drug use can therefore have significant public health benefits, including for those experiencing co-occurring challenges [9]. But focusing on prevalence rate targets *per se*, rather than harms associated with risky use episodes may deprioritise those risks of greatest relevance to the majority of people who use drugs

Typically, drug use prevention in the UK has been limited to youth services, or delivered through school-based activities and brief interventions. Taking cues from the tobacco field, a multi-level approach should be adopted with activities expanded beyond traditional providers, and prevention principles embedded across diverse settings, including where people socialise [10-12]. Ideally, all professionals that regularly come into contact with children and young adults should have the skills to recognise substance-related risks, provide brief information and advice, and offer signposting and referrals to more specialist support [13]. Development of prevention 'champion' roles through local coordinating bodies such as Combatting Drugs Partnerships[14] could be used to drive this work.

A strength of the Strategy is the recognition that much useful prevention activity is also 'unlabelled' and operates across policy areas and programmes such as early years and family support, generic youth work, educational engagement, and investment in communities [15]. While difficult to implement, broader initiatives that enhance parenting skills, emotional regulatory strategies, and practices that enhance family and school bonding help protect against drug use[9]. Educational settings (including further and higher education) should not just be seen as places to provide drug education, but as hubs that link with community providers to support students across a range of interacting health and wellbeing issues. The recently announced Early Support Hubs for Mental Health[16], for example, aim to provide easier access to counselling and support for young people, but could feasibly increase protections against early substance use. Coordinating policy activity across government is challenging, and subject to competing priorities and ambitions. It is therefore essential that a diverse range of initiatives are included in understandings of drug policy, and that they are included in advocacy for investment.

Despite some recent media and political backlash[17], harm reduction activities should be considered complementary to an overall preventive approach for young adults, and provide those people who take drugs with age- and setting appropriate advice, including de-escalation and cessation of use. Finally, some Strategy funding (£1m, currently paused) allocated to pilot behaviour change messaging on University campuses, could be usefully used to reduce stigma and improve self-efficacy for help seeking.

Considering natural cycles of drug use prevalence, it is feasible that the government will be able to achieve its ambition of historically low levels of use over the next decade. This should not, however, obscure opportunities for strengthening prevention and harm reduction systems in the UK. Rhetoric around 'tough consequences' for possession offences or achieving 'generational shifts' in demand may hold important political capital, but this should not be at the expense of support for evidence-based interventions.

References

1. H.M.Government. From harm to hope: A 10-year drugs plan to cut crime and save lives. London: H.M.Government; 2021.
2. Black C. Review of drugs part two: prevention, treatment, and recovery. London, UK: Home Office; 2021.
3. National Audit Office. Reducing the harm from illegal drugs. London, UK: National Audit Office; 2023.
4. ONS. Drug misuse in England and Wales: year ending June 2022. London, UK: Office for National Statistics; 2022.
5. Office for Health Improvement and Disparities. Substance misuse treatment for young people: statistics 2021 to 2022. London, UK: OHID; 2023.
6. ACMD. ACMD Drug misuse prevention review. London, UK: Home Office; 2022.
7. Sumnall HR. Encouraging a 'generational shift' in the UKs relationship with drugs. A commentary on the new UK drug strategy. What can be achieved with drug prevention? International Journal of Drug Policy. 2022;109:103841.
8. ACMD. Vulnerabilities and substance use: ACMD report. London, UK: Home Office; 2018.
9. UNODC. International Standards on Drug Use Prevention (2nd ed.). Vienna, AT: UNODC; 2018.
10. Khan J. The Khan Review: Making Smoking Obsolete. London, UK: OHID; 2022.
11. Sloboda Z, Johnson KA, Fishbein DH, Brown CH, Coatsworth JD, Fixsen DL, et al. Normalization of Prevention Principles and Practices to Reduce Substance Use Disorders Through an Integrated Dissemination and Implementation Framework. Prev Sci. 2023;24(6):1078-90.
12. Burkhart G, Tomczyk S, Koning I, Brotherhood A. Environmental Prevention: Why Do We Need It Now and How to Advance It? J Prev (2022). 2022;43(2):149-56.
13. NICE. Drug misuse prevention: targeted interventions. NICE guideline [NG64]. London: NICE; 2017.
14. H.M.Government. Guidance for local delivery partners: From harm to hope. London: H.M.Government; 2022.
15. ACMD. Prevention of drug and alcohol dependence. London: Home Office; 2015.
16. BMJ. Seven days in medicine: 25-31 October 2023. BMJ. 2023;383:p2523.
17. Kennedy D. How ketamine became the UK's hidden campus killer. The Times. 2023 15/5/2023.