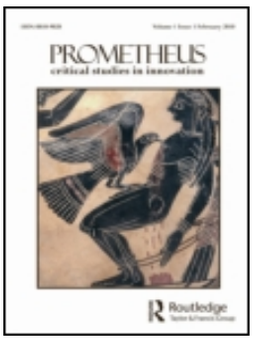

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Prometheus

ISSN: 0810-9028 (Print) 1470-1030 (Online) Journal homepage: https://www.tandfonline.com/loi/cpro20

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To cite this article: Ewan Hoyle (2010) The 'War on Drugs' has failed. It's time for a war on drugs, Prometheus, 28:3, 303-307, DOI: 10.1080/08109028.2010.518055

To link to this article: https://doi.org/10.1080/08109028.2010.518055

Published online: 05 Nov 2010.

Prometheus
Vol. 28, No. 3, September 2010, 303–307

Routledge
Taylor & Francis Group

RESPONSE

The 'War on Drugs' has failed. It's time for a war on drugs

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One of the most pressing issues in the relationship between government drug policy and science is the future of opioid maintenance treatment. Methadone provision is known to reduce street heroin use, enhance health, reduce crime, and generally improve the stability of chaotic lives. Heroin maintenance treatment is yet more successful. There have now been six randomised trials over the past 15 years that have demonstrated that heroin maintenance has substantial benefits over oral methadone for dependent users who have not responded to methadone treatment. Such individuals are more likely to comply with treatment, show greater reductions in criminal activity and in street heroin use, and are generally a smaller burden to society. In short: methadone works, heroin works better.

It would be nice to see the government embracing these results and making every effort to allow communities across the UK to benefit from this new approach. Instead, policy appears to be heading in the opposite direction, with talk of time-limited methadone programmes. Lord McNally (2010), our current Minister of State for Justice: 'Where a substitute treatment is required, most cases of opioid dependence is [sic] most cost-effectively managed via oral methadone programmes which in itself should be a step towards abstinence'. What is not contained in this statement is any explanation of why diamorphine (pharmaceutical heroin) is so prohibitively expensive. Currently, diamorphine maintenance treatment is carried out with the drug provided in ampules at an approximate minimum cost of £89 per gramme. This is despite diamorphine powder currently being provided to hospital pharmacies at a minimum price of £6.80 per gramme for other medical purposes. So we see that diamorphine is not only more effective than methadone in maintenance treatment, but also has the potential to be considerably cheaper. If there were the political will, diamorphine could be the most cost-effective treatment option by quite some distance.

Heroin maintenance treatment trials have so far concentrated on investigating and replicating results with long-term dependent users who have not responded well to methadone maintenance. An evidence-based policy derived from these results would make heroin maintenance treatment available to just such individuals, a group which makes up a relatively small percentage of the heroin-using population. Policy makers have choice in this situation. They can ignore the evidence. They can accept the evidence and modify policy according to the recommendations made by the researchers

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ISSN 0810-9028 print/ISSN 1470-1030 online

DOI: 10.1080/08109028.2010.518055
http://www.informaworld.com

involved. Or they can take a step back, consider the implications of the available evidence, and adopt an ambitious policy that can quickly bring about considerable benefits to society and savings in government expenditure. It is not only methadone non-responders who have entered into heroin maintenance treatment trials. A German trial included users who had not previously received opioid substitution therapy. The results for these patients were the same as for everyone else: heroin was considerably more effective in achieving positive outcomes.

If we make diamorphine cheaper by removing regulatory obstacles, we open up the possibility of diamorphine maintenance treatment as a *first-line* treatment for heroin dependency. Diamorphine should be considerably more attractive to prospective patients to the point where outreach programmes could be tasked with recruiting known street prostitutes, user-dealers and habitual criminals into treatment. There would be substantial costs to setting up programmes (the medically-supervised, clinic-based consumption model with personalised treatment is likely to be the most sensible course of action), but the potential benefits are enormous.

There are two principles important to think about when considering such a plan. The first is early intervention. In the fields of medicine and social work, early intervention is vital in minimising harm. The participants in RIOTT, the British Randomised Injecting Opioid Treatment Trial, had experienced an average of 16 years' heroin use and six spells in prison (Strang *et al.*, 2010). Do we really want to restrict the most effective treatment available to people who have lived such lives? Or would we rather intervene early to prevent a potential life of criminality, street prostitution, violence, unemployment and risk of overdose, HIV and hepatitis? A dependent heroin user brought into treatment *before* funding the habit through burglary or prostitution stands a much better chance of becoming a happy, productive contributor to society.

The second principle is prevention. Any drug policy should seek to minimise the number of entrants into the lifestyle of a dependent drug user. At present, the vast majority of new users will first encounter street heroin through contact with an existing user. There are very few street-level dealers of heroin who do not use the drug themselves and utilise dealing as a means to make money to fund their own drug use. Attracting such individuals into treatment removes an obvious point of entry for others. It is not always dealers who recruit, though. Those who have a friend who uses are less likely to find themselves without access to heroin. A friend who does not use is less useful and less understanding, so users have an incentive to convert them. Some male users will enter into relationships with young women, persuade them to use heroin, and subsequently encourage them to work as prostitutes to fund the drug use of both. All these behaviours become redundant/unnecessary in an environment of widespread heroin maintenance services, so the rate of new entrants into heroin use should be substantially reduced. In Switzerland, where heroin maintenance has been available to a select group of addicts for many years now, there are additional reports of perceptions of heroin use changing. Heroin use is increasingly seen more as a medical condition in need of treatment and is accordingly less attractive to Swiss youth. Their heroin-using population is getting older and smaller as a result.

David Nutt's paper talks much of the overestimation of the harms of illegal drugs and the underestimation of the harms of prohibition and the legal drugs we consume, especially alcohol. He is absolutely right to attack the criminalisation of drug use and the disproportionate harms inflicted by incarceration, but it is important to be very careful not to underestimate the harms that any drug can cause. Of particular concern is the perception of cannabis as being a drug of relative safety. Respected investigators

of the link between cannabis and schizophrenia estimate the proportion of schizophrenia being attributable to cannabis consumption at around 10%, or 25,000 UK individuals. We know that approximately 10% of schizophrenia cases end in suicide, and so Gordon Brown's assertion that skunk is 'lethal' may be essentially accurate. Based on this evidence, around 2500 British citizens will commit suicide because of mental illness caused by their cannabis use. This figure says nothing of the torment experienced by the other victims of cannabis-induced schizophrenia, and the grief and anguish of their families and friends. The argument that because rates of schizophrenia have remained relatively steady cannabis can have little effect on psychosis, is also a poor one. Schizophrenia is a complex condition with multiple identified genetic and environmental risk factors, and no doubt many more that have not been identified. To claim that cannabis has no effect on rates of schizophrenia on the back of this epidemiological evidence is to assert that all other environmental factors have remained constant over time and that fashions of diagnosis have not changed. No such assumptions can be made.

The association between cannabis use and schizophrenia is often explained using the 'correlation not causation' argument. And it may be a valid argument. We can, however, say with some certainty that those who use cannabis are at a greater risk of serious mental health problems. Whether this risk is a consequence of their consumption of cannabis or because people at risk of mental health problems seek out cannabis, the sensible policy response is identical. Indeed, it is identical to the sensible policy for all drugs. We should be doing our very best to ensure that education is delivered on the potential social, health and economic harms of specific drugs before they are used. For drugs, such as cannabis, amphetamines, cocaine and ketamine, that may have serious psychiatric effects, it is desirable for users to be knowledgeable about the early warning signs of psychosis so they can moderate or cease their drug use and seek medical help should such signs become apparent. In the case of cannabis, a user might even be able to switch to a less potent strain of the drug, one with a different effect profile. The best time to deliver such education is surely as near as possible to first use. This might be most effectively achieved through specially-trained professional pharmacists operating in a legal, but strictly regulated, market. The majority of current education on harms is delivered in schools and is very variable in quality. Illegal dealers are not a reliable source of information on drug harms, and the tripartite system mandated by the Misuse of Drugs Act is little better. The classification of ecstasy and magic mushrooms in class A would be laughable were it not so dangerous to give them equivalent status to heroin and cocaine. Also concerning is the apparent underestimation of the propensity for harm of the class C drug, ketamine. A recent online survey carried out by YouthNet found that 77% of the 16–25-year-olds surveyed felt they needed more support and guidance on the subject of drugs. Current education efforts are failing.

The strict government regulation of drugs deprives drugs of many of the ways in which they can cause harm, whether through contaminants, unpredictable purity or through the ignorance of the user. Regulation is an eminently sensible course of action and a great many politicians are fully aware of its potential to yield great benefits for society. But then there is what is called the 'green-room syndrome' in which politicians express complete agreement with drug policy reform sentiments when the microphones are off before becoming shining examples of political orthodoxy when they are switched on. Similarly, persuasive arguments for reform can be cut short because the politician agrees completely, but needs to know how to sell reform to the voters and to the *Daily Mail* in particular.

Professor Nutt likely ascribes too much influence over policy making to the alcohol and tobacco lobby. Politicians have simply built up a perception of public opinion that presents drug policy reform as a no-go area. They genuinely believe that proposing the legalisation of drugs will bring electoral disaster. Phrases like 'soft on drugs' are the stuff of politicians' nightmares. For the cause of this perception we need only look at public opinion polls. Opinion polls on drug policy almost always ask some variant of what is basically the same question: 'Do you think drugs should be legalised?'. And in reply they get a fairly consistent answer: 'No'. Consider the most recent standard British poll conducted by Vision Critical in January 2010. It asked: 'Do you support or oppose the legalisation of each of the following drugs?'. Some 18–19% supported the legalisation of ecstasy, cocaine and heroin; 35% supported the legalisation of cannabis. There is nothing in this poll that gives a politician any encouragement to talk positively about the legalisation of drugs.

The legalisation question is entirely the wrong question to be asking, though. Legalisation implies that drug use will suddenly become allowed or even approved by society, and that drugs will become more readily available and more widely used. All sensible drug policy reform advocacy groups recommend the control and regulation of drugs and it is this proposal that will be presented should any political party be reassured of the issue's non-toxicity.

In the light of this incongruity, Liberal Democrats for Drug Policy Reform commissioned its own poll, asking participants to choose which of light regulation, strict government control and regulation, and prohibition they would find most tolerable for a series of drugs. In order to inform participants, we also provided brief descriptions of the implications of each model, such as where drugs would be sold, what restrictions would be placed on who could purchase a drug, and who would profit from the trade. When asked to consider proposals that might realistically be presented should control and regulation ever become the policy of any party, the poll participants approved legal regulation over prohibition at rates of: 70% to 25% for cannabis, 49% to 40% for amphetamines, 41% to 39% for mephedrone, 39% to 54% for ecstasy, 36% to 59% for cocaine, and 30% to 65% for heroin.

In the light of these poll results a politician might see a cautious, rational approach to the issue as a means of gaining public acclaim, rather than ending a career. The legal sale of heroin may still be a step too far, but the strict government control and regulation of all other drugs (most likely starting with cannabis), combined with widespread provision of diamorphine maintenance treatment, might still bring about such catastrophic effects on the illegal drug trade that the legal sale of heroin would not need to be a part of early reforms.

It is important to attend to the science when formulating drug policy, but not so we can file drugs into subjective categories of harm. Rather, we should accept that all drugs (including alcohol and tobacco) have harms, and that the most pragmatic way to protect people is to use the evidence available to make them fully aware of the nature of these harms. It is also important not to hide behind science when important and potentially controversial decisions have to be made. Denmark has accepted the evidence supporting diamorphine maintenance treatment without conducting a trial of its own. The UK should probably have done the same. It would be disappointing to see more widespread diamorphine maintenance treatment being delayed by scientific and political conservatism.

There will be no conclusive scientific evidence supporting the strict government control and regulation of drugs until a nation state declares that the United Nations

conventions restrict its ability to protect citizens from harm, and takes the decision to experiment. For the sake of all the citizens of the nations touched by the illegal drug trade, that decision (or a UN decision to reform the conventions) cannot come soon enough. It is imperative, however, that the first nation to make this decision takes great care to ensure that reform is as beneficial as it can be to its society, economy and public health. If the first state gets the balance wrong, it will be much more difficult for others to follow.

The negative effect of the 'War on Drugs' has been greatest on the people who take drugs, the communities in which they live, and the societies of producer and transit countries forced to endure horrific violence and corruption. If we are serious about a war on *drugs*, then we have to subject them to regulations and controls that minimise as far as possible their ability to do harm.

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