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The role and basis of the drug laws

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On 30 October 2009, the home secretary in the UK asked David Nutt to resign from his post as chairman of the government's advisory council on the misuse of drugs. The previous day, the Centre for Crime and Justice Studies at King's College London had published Nutt's paper, 'Estimating drug harms: a risky business?'. This is an edited version of his Eve Saville memorial lecture, delivered at Kings College in July 2009. The paper points out that ecstasy and LSD are less dangerous than alcohol. He had previously clashed with the home office over his editorial, 'Equasy – an overlooked addiction with implications for the current debate on drug harms', published in the Journal of Psychopharmacology *in January 2009. This reflects on the reality that ecstasy is overall less harmful than riding. The home secretary was not amused, and the relationship between academic publication and scientific advice to government was cast into the limelight. David Nutt is now chair of the Independent Scientific Committee on Drugs.*

In the UK, non-medical drug use is controlled by the 1971 Misuse of Drugs Act 1971 (MDAct). The use of alcohol and tobacco products falls under separate taxation and age-of-purchase controls. This separation is not related to any differential pharmacology or relative harms of these drugs (see Figure 1), as recent assessments have demonstrated (Nutt *et al.*, 2007). Rather it reflects a combination of historic accident and economic pressures to preserve the *status quo* of alcohol and tobacco and prevent new drugs entering the market. The justification for the current illegality of many drugs is that they are harmful and hence criminal sanctions are necessary to reduce harms. This assertion is both inaccurate and a smokescreen for other motives, which means that the current UK drug laws are un-scientific and unjust.

The usual justification for making drugs illegal is that this will reduce the dangers from their use. Perhaps the major purpose of the law is to reduce harm in society and no one could seriously disagree that this is a reasonable goal of legislation – if it were to work. However, in the case of many illegal drugs, the evidence for societal harm reduction through their illegal status is not overwhelming. Paradoxically, harms may be increased when drugs are made illegal. Examples include illness from dirty needles, infected supplies of illegal heroin, and exposure to criminal gangs in the purchase of many drugs. Moreover, the illegality of some drugs may encourage the use of more dangerous legal drugs; it could be argued that the rise of binge drinking in the 1990s has been driven by fear of criminalisation for possession of ecstasy. One thing is certain: the costs of imposing criminal sanctions for drug use are not trivial. So, the policy, even if it works, is almost certainly not the most cost-effective way of

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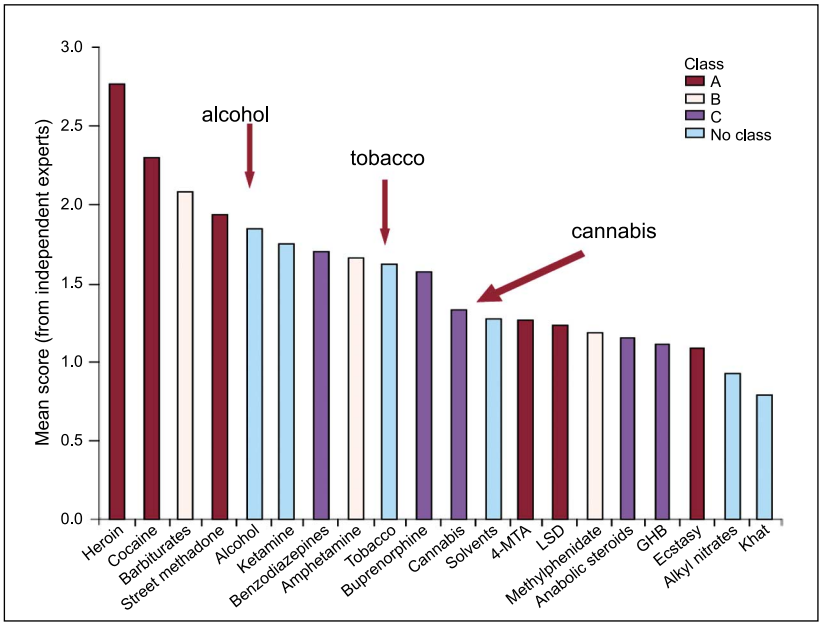

Figure 1: Mean harm scores for 20 substances
The respective classification under the Misuse of DrugsAct, where appropriate, is shown above each bar. Class A drugs are indicated by black bars, B by dark grey, and C by light grey. Unclassified substances are shown as unfilled bars.

Figure 1. Drug harm ranking – little relation to UK MDAct (mean harm scores for 20 substances)

reducing societal harm, and health and treatment measures are almost certainly much better. An assessment of the effect of decriminalisation of personal drug use in Portugal a decade ago shows significant reductions in both harms and societal costs of drug use (Hughes and Stevens, 2010).

Another commonly-used argument is that drugs harm the individual. So, making them illegal is a way to save individuals from self-inflicted damage. Putting aside the moral argument as to whether the state has the right to such interventions (the right to medical cannabis use is currently being determined in the European Courts), is there evidence of a net reduction in harm from this approach? This question was brought to prominence when the last UK government made criminalisation of cannabis users a fundamental part of the argument for raising the classifying of cannabis to class B. It went like this – if you use cannabis and are caught, we will give you a criminal record in order to deter you from using this drug which *may* cause you harm. The effect of this legislation is therefore to criminalise users of cannabis in the spurious hope that this would reduce the use of the drug and hence harms from it. Since cannabis has a low propensity to harm, the majority of people caught in this way will be penalised for doing something that would not seriously affect their wellbeing. However, we know that receiving a criminal record and especially a prison sentence is *very likely* to harm everyone by significantly reducing life chances for employment and so driving people into criminal activity which is likely to relate to more harmful drugs such as heroin and crack. The current penalty for cannabis use is disproportionate to the crime and so unjust. It is also out of touch with public opinion, and makes no economic sense either.

One of the more disappointing aspects of the drug policy debate that surrounded my sacking was the lack of any overt discussion of the moral principles that relate to drug use. Much of the political rhetoric around drugs is driven by a moral position, but most politicians will not own up to this, preferring to hide behind a smokescreen of concerns about drug harm. The last prime minister, Gordon Brown, did at least break cover when he said soon after taking power that cannabis use was unacceptable, though he then tried to qualify this opinion by pointing out that this was because the new form of cannabis – skunk – was lethal (which it is not, in contrast to alcohol, which is). Until we can properly debate the morality of drug taking, we shall not properly engage with the full range of individual concerns about drugs.

There are other arguments and factors that are relevant to the drug law debates. One is that the UK has signed up to international conventions on drug restrictions, especially the UN 1961 Single Convention on Narcotic Drugs. It is often claimed that this means we have to make drugs illegal. This is not true. For the drugs covered under the UN regulations all we have to do is not allow them to be actively marketed; we do not have to penalise users. This is apparent from the fact that the Dutch have been able to sell cannabis in coffee shops without contravening their UN obligations. The Portuguese decriminalisation of the personal use of all drugs is allowed within the conventions. The fact that some of the more vociferous signatories to the conventions, in particular the US, would prefer criminal rather than civil approaches to drug use is no reason for the UK not to follow a more enlightened path.

UK politics itself has, in recent years, been a major block to rational debate about drugs. Perhaps this will change now David Cameron is prime minister as he is the most drug-experienced person to have held this post, having been caught using cannabis as a schoolboy at Eton (for which he was not expelled). As an MP, he served on the home affairs committee and took a progressive and sensible view on drugs, arguing that ecstasy was inappropriately positioned in class A and that cannabis should be in class C. Soon after he became the leader of the Conservative Party he repeated this view, and within hours was dragged before the grandees of the Party and told that this was not the way to win power. The next day he publicly retracted this view. It will be interesting to see what line the new government takes on drugs in general and on school expulsion for possession in particular.

The MDAct was developed in the late 1960s and brought into law in 1971 with the express purpose of taking political machinations out of the decision-making process relating to drug harms and classification. The more recent decision to remove interest rate control from parliament to the Bank of England was made for similar reasons. This latter decision was made by Gordon Brown when chancellor, which makes it especially disappointing that he and his government often breached the MDAct by pre-empting the scientific advice of the advisory council on the misuse of drugs (ACMD). This scientific council was set up under the MDAct to ‘keep the drug situation in the UK under review and to advise Government ministers on the measures to be taken for preventing the misuse of drugs or for dealing with the social problems connected with their misuse’. One of its key remits was to decide on the relative harms of drugs and recommend classification in the three bands – A, B and C.

No government had ever gone against the clear advice of the ACMD. Even the Thatcher government had accepted ACMD advice to set up needle exchange programmes to reduce the spread of HIV, though this cut right across her political philosophy. However, with both the recent ecstasy and cannabis classification debates,

the last government played petty politics in rejecting the ACMD recommendations and denying its evidence. In so doing, they undermined much of the work the ACMD had done over many years in providing the best scientific evidence and advice on minimising drug-related harms. This further reinforced the view of many young people that politicians cannot be trusted to be honest about drugs. It is critical that the new government takes the Lib-Dem approach to drug classification, which is to set up a fully independent committee to assess drug harms. The recent statement by the new science minister, David Willetts, that he regrets the processes that led to my sacking is hopefully a sign of a better approach.

There are other more sinister factors that may influence the decision-making process on drug classification. A major one is the role of the legal drugs industries, especially the alcohol industry, and their involvement in political lobbying. A survey conducted about 15 years ago found that the majority of UK politicians did not believe alcohol to be a drug and a similar proportion received financial benefits of some sort from the drinks industry. The situation is unlikely to be very different today, though it is harder to discern because the drinks industry has become complex and opaque, and its lobbying arms-length. The massive increase in damage from alcohol that we have experienced over the last 20 years is mostly attributable to a doubling of consumption over the same period (Leon and McCambridge, 2006), which has been driven by greater accessibility to alcohol in supermarkets, increased licensing hours and a real price reduction of at least 50% (see Figure 2). The last two of these factors were explicit aims of the last government! The comparison with cannabis is revealing: over the same time, the use of cannabis has increased 20 fold (in terms of people who have ever used it), yet cannabis-related harms have changed little and schizophrenia, which is linked by some to cannabis use, is, if anything, declining.

So, what should determine whether a drug should be criminalised or not, and what should be done to mitigate the damage from legal drugs? Clearly none of the above processes or measures can be sufficient. Criminalisation of users is rarely, if ever, a just or effective approach. This is especially true in two situations:

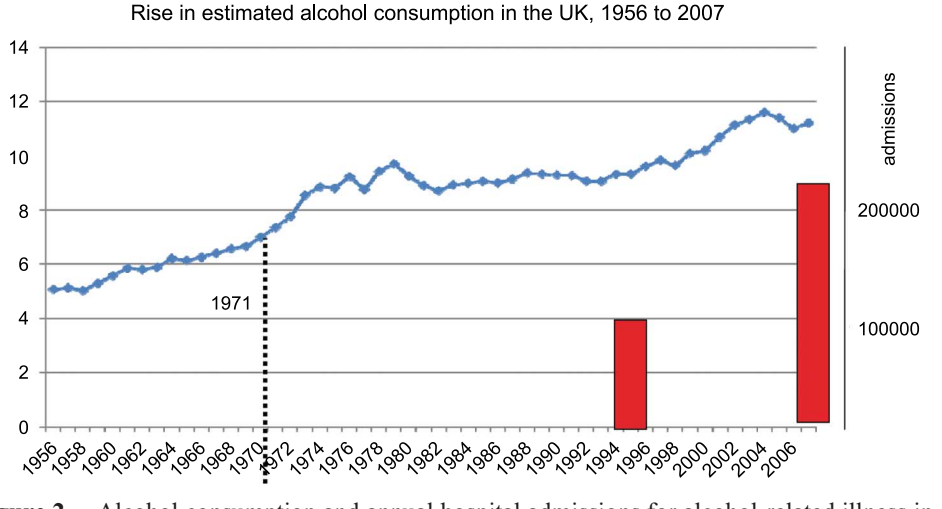

Figure 2. Alcohol consumption and annual hospital admissions for alcohol-related illness in 1995 and 2006

(1) where the societal harms of drugs are less than the harms of criminalisation; and
(2) where drug use is caused by addiction to the drug and therefore hard for users to control (see Nutt, 2010a).

It is hard to argue that criminal sanctions against the use of drugs less harmful than alcohol are just. Alternative approaches to regulating their use (for example, through licensed outlets based on the Dutch coffee shop model) should be seriously considered. One approach to new synthetic drugs would be to control them under a new class, a class D based on the New Zealand model. Sales to minors would be prohibited, the product would be made to a pharmaceutical standard, unit doses would be at a safe level, and manufacturers would be obliged to monitor sales, provide health advice and evaluate health outcomes.

What about alcohol and tobacco? One true paradox of the previous government's attitude to science and evidence has been a diametrically opposed attitude to these two drugs. The last government consistently increased the tax on tobacco to reduce use and harm – and this worked. In contrast, it actively lowered the real price of alcohol – possibly to protect the whisky and beer industries – and increased licensing hours, so promoting the current epidemic of alcohol-related harm and social damage. When the Scottish government tried to instigate a sensible policy of making shops price drinks according to alcohol content (the basis on which alcohol tax is set), the Labour Party in Scotland blocked the measure. Similarly, when the chief medical officer, Liam Donaldson, argued for the same approach in England and Wales, his report was shot down with such ferocity that he decided to resign. Now NICE, the National Institute for Health and Clinical Excellence, has published its own report, coming to the same conclusion (NICE, 2010). The alcohol industry has been trying to discredit this report (see Nutt, 2010b). Alcohol use is price sensitive, especially for non-addicted users, and one of the few proven ways to reduce the population harms of alcohol use that is acceptable in a Western democracy. The others are restrictions on the sales of strong alcoholic drinks in supermarkets and shortening licensing times.

Many factors underpin decision making on drugs. Most are not scientific or evidence based and are often hidden behind a smokescreen of health optimisation, even in the face of evidence that they do the opposite. A more open and transparent public debate about the appropriate ways to minimise the total harms of drugs, including considerations of the damage that their interdiction also incurs, is urgently required.

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