

Key Concepts in
Substance Misuse



..... Part 1

..... Drugs, Democracy

..... and Society

Aaron Pycroft

What the aims and purposes of drugs policy should be and who decides lies at the heart of debates about drug use. These debates continue to be extremely polarised between arguments for continued prohibition and those who favour legalisation. It is argued by some that the ‘war on drugs’ has failed (see Transform Drugs Policy Foundation at www.tdpf.org.uk/) and that a new approach is needed. Those in favour of continued prohibition (such as the United Nations and many governments) argue that drug use creates significant problems that we have a duty to control and eradicate. However despite the dominant prohibitionist paradigm there are significant global events and processes which are challenging the nature of this debate. Levine (2003) argued that global drug prohibition was facing a number of crises including harm reduction policies, the growing opposition to punitive drug policies, and the widespread use of cannabis around the world. To this we can now add that some countries and jurisdictions are adopting policies of decriminalisation or legalisation either with respect to all drugs or to cannabis.

Despite drugs causing an indisputable range of harms within societies it would seem that people of all kinds enjoy using a range of psychoactive substances and often do so without experiencing any significant harm. The debate about drug use as a legitimate activity is then inextricably bound up with notions of morality, free choice and liberal democracy. It is important to note that the idea of liberalism is founded on the idea of individual human rights and freedoms, whereas democracy is concerned with the idea of the collective will; so within a liberal democracy any individual rights that I enjoy are always circumscribed by the democratic process, and invariably there are tensions between the two.

drugs, democracy
and society



One of the challenges of drug use (and addiction in particular) is that it seems to impair our capacity to choose, and that drug-related deaths are not due to a self-inflicted, freely chosen lifestyle. Illicit drug use imposes substantial costs on societies, and rates of illicit drug use and deaths have increased in the developed world since the 1960s and developing world since the 1990s. We can identify several other factors (see Darke et al., 2007) that highlight the importance of having good and robust drug policies:

- As drug use/dependence usually starts in adolescence it is important that we protect young people from the potential harms of drugs use. However drug use can be a normal part of adolescence so as a society would we want to criminalise this behaviour; should for example we treat cannabis or ecstasy use in the same way as alcohol and tobacco use?
- Importantly not all drug users remain drug users with most people moving away from drug use; does the use of criminal sanctions increase the possibility of people becoming locked into services and identity-based behaviours that do not allow them to move away from that use? (See section on addiction as a complex adaptive system.)
- In diagnostic criteria (see section on dependence syndromes), clinical distinctions are made between substance use, misuse and dependence with the numbers declining between categories. Not everyone who uses drugs will experience problems with those drugs, or become dependent, therefore approaches need to be dimensional and differentiated, rather than 'one size fits all.'
- However we know that an increased risk to experiencing harms and dependence is linked to particular social characteristics: being male, young, unemployed, lower educational achievement, being unmarried, having a lower socio-economic status; environmental factors such as family conflict, parental attitudes and individual, family and community disadvantage. Arguments have been made about the ways in which the alleviation of poverty and inequality are the most important factors in addressing drug problems with, for example, research carried out by Stevens (2011) demonstrating that the countries that have the lowest levels of drug-related harms are those that have the best welfare policies and not those who are most effective in criminalising drug use.
- Also there are genetic factors influencing addiction (see section on the evolutionary context), which are triggered by environmental effects and which raise important questions about rational actor models favoured by governments which focus on personal responsibility.

So clearly it is important to have drug policies that address the issues of individual and social harms, but this then begs the question of how we should decide the best ways to balance what would appear to be an ethical dilemma. This dilemma is between an individual's right to choose to use drugs and the need to protect people from the potential harms of that drug use. There is, however, the added dilemma of what to do when people engage in potentially harmful behaviour despite the best efforts of state and society to persuade them not to do so. We can look, for example, at a range of potentially risky behaviours such as skydiving, mountain climbing and having unprotected sex and ask whether these activities present any more risks to individuals and society than using drugs? If, objectively, this is not the case then why in practise do we deal with them so differently by, for example, criminalising drug use?

Case Study

A number of years ago I was walking through town on a very cold winter morning (the temperature was below zero) and I came across a man that I knew lying by the side of the road who appeared to be unconscious. I had worked with the man before and knew him to be alcohol dependent. I tried to rouse him; he was clearly very intoxicated and only able to mumble a few words. My primary concern was the risk of hypothermia and I rang for an ambulance and explained the situation. They refused to come out because the man was intoxicated.

How or why would this situation be different to a person who has injured themselves on a mountain due to their failure to follow proper procedure, or someone adrift at sea having fallen asleep on a lilo? Do you think that under these circumstances the emergency services would refuse to attend?

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1 Ethical Evaluations of Drug Use and Drug Policy

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How we decide on the legitimacy of individual or collective actions and the limits of those actions falls within the realm of normative ethics. Normative ethics is concerned with an understanding of how we should act under certain circumstances and there are three main paradigms as follows:

1. Deontology – duty and principle (associated with Immanuel Kant, 1724–1804)
2. Utilitarianism – considering the consequences (associated with Jeremy Bentham, 1748–1832 and John Stuart Mill, 1806–1873)
3. Virtue ethics – the importance of character (associated with Aristotle, 384–322 BC)

For each of the evaluations I have adapted the work of Banks (2004) which provides an excellent introduction to the subject matter and useful frameworks to analyse ethical dilemmas.

DEONTOLOGY

Immanuel Kant ([1785] 1993: 30) established the principle known as the categorical imperative stating that we should ‘Act only according to the maxim by which you can at the same time will that it should become a *universal law*.’ For Kant this categorical imperative binds human beings as rational agents precisely because they are rational, and reason demands that we demonstrate respect for all persons. This respect is absolute, becoming a universal law applicable in all situations and circumstances and does not allow us to treat another person as a means to an end (see Utilitarianism). In evaluating ethical dilemmas deontology argues the following:

Practical Evaluation

1. *The focus is on the act; therefore one must identify the act to be evaluated.* Is drug taking *per se* an area of ethical conflict, and why?
2. *What is the intention underlying the act?* Is the intention to use drugs in itself harmful, is it selfish, and am I able to make rational choices about drug use? Likewise if I am a policy maker what is my intention in prohibiting, legalising or decriminalising drug use? Interestingly when we make absolute rules then invariably we have to make exceptions to those rules; a good example is the growth of harm reduction measures and its sponsorship by the UN despite official prohibition. There is an acceptance that despite the best efforts to prevent drug use some people need help due to their drug use.
3. *What duties are involved in this situation and to whom or what?* Who are my duties directed towards, is it to an individual's rights or to some notion of the common good?
4. *Do the duties conflict?* Is it possible to balance both individual rights and the common good, and are the two actually in conflict? Is it appropriate to use criminal justice sanctions for people who use drugs even though those drugs may well have been supplied by another person? Will criminal justice or non-criminal justice sanctions help or make the situation worse?
5. *Will this act show respect for the human dignity of everyone involved?* Does the right to use drugs enhance human dignity at all levels of state and society, and likewise do drug enforcement laws and actions do the same?
6. *Will it use any person as a means to an end?* Is it appropriate for example to use criminal justice legislation and harsh penalties to deter other people from using drugs? In this case the state punishes me but also uses my sentence as a means to deter others; is this just?
7. *Given that the act must follow the categorical imperative and therefore must be applied universally, can I will this act onto everyone?* Would I want the right to use any drug to be a universal law, for all people under all circumstances, and depending upon my answer to this question, can this be maintained without exception?

Exercise

See if you can think of something that in your view should become a universal law; present your universal law to a group and see if it is possible to maintain a rational commitment to that law that does not permit any exceptions under any circumstances.

UTILITARIANISM

The principle of utility or the Greatest Happiness Principle argues that an action is right in so far as it tends to produce the greatest happiness for everyone affected, or the best overall consequences. Utilitarians (also known as consequentialists) argue that there is nothing absolutely or inherently right or wrong, only actions that can be agreed to be beneficial to the greatest number. This approach is fundamental to notions of democracy and also human rights. Whereas Kant would argue that human rights are absolute, Bentham and Mill argued that rights are whatever society agrees them to be, and which produce the greatest happiness. A problem with the latter approach is the tyranny of the majority whereby minorities or minority interests in society do not have access to power and influence.

Practical Evaluation

1. *Identify all the options.* Is drug use acceptable or not, or are there some drugs which are of benefit to individuals and others that are not?
2. *Identify all those affected by the decision.* Who is affected by drug use, do the harms outweigh the benefits, and likewise for any actions taken to ameliorate drug harms?
3. *Describe the harms and benefits for all those affected under option 1, then option 2 and so on.* It is important to clearly identify the whole range of harms and benefits in a clear and rational way.
4. *Choose the option that produces the most benefits for all those affected by the decision after calculating the differences between the good and the bad effects.* A decisional calculus is made to arrive at a decision about the right thing to do, which is in effect a majority decision. On this basis is it appropriate for example to give more people the right to use Class A drugs without fear of punishment if the majority of people desire it?

Exercise

After reading the sections on legislation (Chapter 2), prohibition (Chapter 4) and decriminalisation (Chapter 4) of drugs, weigh up as many of the pros and cons of these approaches as possible and reach a decision about the approach that has the most utility; but who would gain the most and who would lose the most based on your decision?

VIRTUE ETHICS

Virtue ethics offers a differing perspective on moral agency from these other codes and has seen a growing literature in social work (see Van Den Bersselaar, 2005; Pullen-Sansfacon, 2010) and social psychology (see Annas, 2003). This approach does not ask the deontological question of what are the rules that are right to follow from a sense of duty because God or the state or someone in authority tells me to do so, and neither does it take the utilitarian approach of decisional calculus based on the greatest happiness or pleasure; virtue ethics are concerned with character and the kind of person that I need to become to live the good (ethical) life (in ancient Greek *eudaimonia*). Virtues are personal qualities or traits of character demonstrated through habitual action that make persons of excellence and the development of a virtuous character.

There is considerable debate about what constitutes a virtue, and what virtues are essential for eudaimonism. For example Macintyre (2007) argues that Aristotle, Paul of Damascus, Benjamin Franklyn, Jane Austin and Karl Marx all have very different understandings and lists of virtue. Aristotle's list of virtues includes: Benevolence, Civility, Compassion, Conscientiousness, Cooperativeness, Courage, Courteousness, Dependability, Fairness, Friendliness, Generosity, Honesty, Industriousness, Justice, Loyalty, Moderation, Reasonableness, Self-confidence, Self-control, Self-discipline, Self-reliance, Tactfulness, Thoughtfulness and Tolerance.

Inherent within virtue ethics is the concept of *entelecheia* which refers to the importance of potential in all people to achieve different possibilities, and that despite difficulties it is possible to develop a stable attitude to life that allows an orientation of the will towards the good life (Van den Bersselaar, 2005). In the helping relationship this is just as important for the helper as it is for those who are helped and in practice Pullen-Sansfacon (2010) argues that this can be achieved through reflective practice and practical reasoning to develop virtues (for a good example of disagreements about what constitutes a virtue watch the film *Gladiator* and the scene where the Roman Emperor Marcus Aurelias is murdered by his son Commodus after he tells him that he will not succeed him as Emporer and Commodus compares their list of virtues).

Interestingly, within abstinence based approaches to alcohol and drug use such as Alcoholics Anonymous and Narcotics Anonymous, 'sobriety' is seen as a virtue which is very much linked to protestant and evangelical notions of purity and self-discipline. Research on temperance cultures (see, for example, Levine, 1993) shows that there are differing perspectives on these virtues in the Catholic wine drinking regions of Southern Europe and the Protestant North.

Practical Evaluation

In addressing moral dilemmas as a person with a moral character, I must assess the knowledge I have or will need to reach my full potential and become a virtuous person.

1. *Regardless of the dilemma, I must first ask what kind of person I should become to be the best person I can be.* Is drug use virtuous? In what ways might it impact upon my character? Might I be concerned about how drug use affects other people's characters and lives? Does drug use enable me to live a good life?
2. *I must then ask which virtues will allow me to become the best person that I can become. I will identify which virtues I must practise in this situation and explain to myself why they are relevant to my goals of becoming virtuous and developing good moral character.* Are abstinence and temperance virtues that I would want to have, and to see in other people, and how might I consider the relationship between drug use and self-control?
3. *Once I have decided what kind of person I will need to become to be a virtuous person and which virtues I will need to practise I must ask myself which option in the dilemma allows me to practise these virtues, and explain to myself how this option allows me to practise these virtues and why the other options would not.* For example this could be related to the use of punishment and deterrence in dealing with drug issues. As a probation officer or a police officer is my use of coercion fair and appropriate? As a substance misuse worker do I view qualities such as empathy, openness and trust as necessary virtues that I need to acquire in order to be effective in my work?
4. *I will then practise these virtues until they become habit and part of my character so that when ethical dilemmas present themselves to me in the future I will know what to do and will no longer face a dilemma of this kind.* Am I consistent and just in my approach that is visible to the people that I work with and those that I serve?

Exercise

Make a list of the virtues that you consider important for people with drug and alcohol problems to acquire in helping them to overcome their problems. Then compose a list of the virtues that you think are essential in pursuing excellence in your professional role in helping people with drug and alcohol problems. Compare the two lists and identify any key differences and discuss in a group setting.

Having outlined the main paradigms of normative ethics it is useful to use them as a tool of analysis to interrogate the following approaches to drug policy and drug users.

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2 The International and National Legislative Framework

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Through the World Health Organization, the United Nations defines illicit drug use through the use of four levels of analysis (see unodc.org):

1. Any chemical entity or mixture of entities, the administration of which alters the biological function of the living organism;
2. The use to which the substance is put (this excludes legitimate medical use for the alleviation of disease);
3. A restriction to psychoactive drugs that alter mood, cognition and behaviour; and
4. Drugs which are self-administered and impair health or social functioning.

The aim of this definition as enshrined within the conventions is to ensure that psychoactive substances are only cultivated and developed for proper medical and scientific use, and to ensure that they are not diverted into illicit channels.

THE UNITED NATIONS CONVENTIONS ON ILLICIT DRUGS

The Single Convention on Narcotic Drugs 1961

The adoption of this Convention is regarded as a milestone in the history of international drug control. The Single Convention codified all existing multilateral treaties on drug control and extended the existing control systems to include the cultivation of plants that were grown as the raw material of narcotic drugs. The principal objectives of the Convention are to limit the possession, use, trade in, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes and to address drug trafficking through international cooperation to deter and discourage drug traffickers. The Convention also established the International Narcotics Control Board, merging the Permanent Central Board and the Drug Supervisory Board. (See www.incb.org/incb/convention_1961.html.)

Convention on Psychotropic Substances 1971

This Convention establishes an international control system for psychotropic substances. It responded to the diversification and expansion of the spectrum of drugs of abuse and introduced controls over a number of synthetic drugs according to their abuse potential on the one hand and their therapeutic value on the other. (See www.incb.org/incb/convention_1971.html.)

United Nations Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988

This Convention provides comprehensive measures against drug trafficking, including provisions against money laundering and the diversion of precursor chemicals. It provides for international cooperation through, for example, extradition of drug traffickers, controlled deliveries and transfer of proceedings. (See www.incb.org/incb/convention_1988.html.)

The UK is a signatory to all of these conventions and is required to uphold the aims and objectives of each convention in its domestic law making. It is possible for signatories to these conventions to introduce

stricter domestic legislation than that which is demanded by the conventions, but they cannot introduce more lenient approaches (Fazey, 2003). The Select Committee on Home Affairs (2002) notes that although this restricts unilateral action on the part of the UK when legislating on drug issues, there is possibly more room for manoeuvre than is usually acknowledged. The committee argues that this is because 'the treaties do not lay down specific control mechanisms within the basic premise of criminality of drug possession and supply' (paragraph 266).

The Misuse of Drugs Act 1971

Following on from these internationally agreed definitions, the British Government introduced the Misuse of Drugs Act (1971) which since its inception has remained the cornerstone of UK policy. The legislation is only concerned with drugs that are banned or only permissible for use in scientific and medical efforts and therefore for instance does not cover the use of alcohol or nicotine.

The purposes of the 1971 Act are to provide means for controlling all drugs and to divide these drugs into three classes in descending degree of danger (A, B and C) and to grade the penalties for misusing drugs in each class accordingly; the Act distinguishes between unlawful possession and trafficking and creates new trafficking offences with severe punishments; it continues to require the notification of drug addicts to the Home Office (this was a continued requirement of the Dangerous Drugs Act 1967) and restricts the prescription of drugs of dependence to them; the Act allows for the provision of special treatment centres; and gives the Home Secretary powers to act quickly in the case of overprescribing by general practitioners; the Act brings new substances under control and makes necessary regulations for the control of production, supply and possession of those substances; and the Act allows for the demand of information from pharmacists or practitioners supplying drugs in areas where a particular drug problem arises. The legislation established an advisory council (the ACMD) to assist the Home Secretary in the preparation of controls and counter measures and aims to promote research and education in relation to the dangers of drug misuse (Stark et al., 1999).

Drugs, which are controlled by this legislation and are divided into three classes – A, B and C – are listed in Schedule 2 of the Act. Crucially each drug is judged according to its 'relative harmfulness' and classified accordingly. However the 1971 Act is not explicit in deciding how and why some drugs are more harmful than others. The Act uses the following criteria – firstly whether the drug is being misused, secondly whether it is

likely to be misused and thirdly whether its effects are likely to constitute a social problem. Although this raises problems in terms of explicitly determining which category a particular drug should go into, from the perspective of an enforcement agenda it is used to determine the criminal sanctions that are applied to the misuse of a particular drug (see Runciman, 1999) and seeks to deter people from drug use via criminal sanctions (House of Commons Science and Technology Committee, 2005/6).

CLASSIFICATION UNDER THE MISUSE OF DRUGS ACT 1971

Class A Drugs

Includes: Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms (if prepared for use), amphetamines (if prepared for injection).

Penalties for possession: Up to seven years in prison or an unlimited fine, or both.

Penalties for dealing: Up to life in prison or an unlimited fine, or both.

Class B Drugs

Includes: Cannabis, Amphetamines, Methylphenidate (Ritalin), Pholcodine.

Penalties for possession: Up to five years in prison or an unlimited fine, or both.

Penalties for dealing: Up to 14 years in prison or an unlimited fine, or both.

Class C Drugs

Includes: tranquilisers, some painkillers, GHB (Gamma hydroxybutyrate), ketamine.

Penalties for possession: Up to two years in prison or an unlimited fine, or both.

Penalties for dealing: Up to 14 years in prison or an unlimited fine, or both.

Offences under the Act

- Possession of a controlled substance unlawfully
- Possession of a controlled substance with intent to supply it
- Supplying or offering to supply a controlled drug (even where no charge is made for the drug)
- Allowing premises you occupy or manage to be used unlawfully for the purpose of producing or supplying controlled drugs

Drug trafficking (supply) attracts serious punishment including life imprisonment for Class A offences. To enforce this law the police have special powers to stop, detain and search people on 'reasonable suspicion' that they are in possession of a controlled drug (see <http://drugs.homeoffice.gov.uk/drugs-laws/misuse-of-drugs-act/>).

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..... 3 The Relationship between Politics and Scientific Knowledge in Formulating Drug Policy

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The sanction and controls related to drug use are enforced through criminal law, civil law and governance. It is important that these should be based upon the best evidence that can be provided to government so as to ensure democratic legitimacy for any legislative response

(Stokes et al., 2001). However it is argued by Strang and colleagues (2012) that much of the public debate concerning drug policy is not informed by scientific evidence and is driven by values and political processes. This of course raises an important question about whether 'scientific' evidence is value free, or whether ultimately we have to decide the impacts of actions by the ethical paradigms outlined above.

Even if science is value free and objective how is this to be implemented in human society and utilised to inform policy? In particular what is the relationship between this knowledge and the democratic process? These problems are encapsulated within the Misuse of Drugs Act 1971 and the role of the ACMD in advising on the relative harms of particular drugs, and the political decisions that the Home Secretary makes based on that advice.

These decisions become very important when making decisions about which drugs should be controlled under the Misuse of Drugs Act 1971 and whether temporary or permanent especially in relation to New Psychoactive Substances (see Bartholomew, Chapter 11, this volume). In considering the concept of relative harm and the evidence for the validity of decisions then alcohol (which is not controlled under the Act) provides a clear case of contradiction. It is interesting to make a comparison with cannabis as they are similar drugs.

Firstly, both lead to psychomotor impairment of balance and movement with an increased risk of accidents. Secondly, both cause lengthened reaction times which are dose related and so can cause problems such as road traffic accidents. Thirdly, this is linked to an impairment of judgement, and increased risk taking, and for alcohol increased aggressiveness. Fourthly, both drugs cause emotional changes and a decreased reaction to social expectations, with alcohol causing a significant risk of violence towards self and others. Alcohol is linked with a wide range of physical and mental health problems, whereas although treatment may be required for cannabis use, the health problems are similar to those for smoking tobacco (see Roffman and Stephens, 2006).

Although it can be seen that there are many similarities between these two drugs, alcohol is particularly problematic because it is associated with such a wide range of medical, psychological and social issues and has the propensity to cause aggressive and violent behaviour. The costs from alcohol use includes 1.2 million violent incidents, 360,000 incidents of domestic violence, increased anti-social behaviour and fear of crime, expenditure on alcohol treatment, over 30,000 hospital admissions for Alcohol Dependence Syndrome (ADS), up to 22,000 premature deaths per annum, up to 1,000 suicides, up to 17 million

working days lost through alcohol related absence, up to 1.3 million children affected by parental alcohol problems and with marriages twice as likely to end in divorce (Home Office, 2004).

If we take the notion of relative harm and apply this to alcohol in terms of its toxicity, prevalence of misuse and harm to society, then clearly within the context of the Misuse of Drugs Act this is a dangerous drug; however, rather than seeking to control and disrupt supply, and curtail use, the Licensing Act 2003 effectively does the opposite by liberalising supply and availability. The work of Edwards and colleagues (1994) and Babor and colleagues (2003) clearly demonstrates that there is a correlation between the total amount of alcohol consumed within a population and the level of a wide range of alcohol-related problems in that population. So by increasing supply and availability government is actively creating more alcohol-related problems.

In trying to assess the range of harms caused to self and to others, research by Nutt and colleagues (2010) found that heroin, crack cocaine and metamfetamine were the most harmful drugs to individuals, whereas alcohol, crack cocaine and heroin were the most harmful to others; overall alcohol was the most harmful drug.

We can see that as cannabis use has become more widespread then concerns about its effects have become more prevalent, for example, in relation to mental health problems and addiction. However, as compared with alcohol 'the acute toxicity of cannabinoids are very low: they are very safe drugs and no deaths have been directly attributed to their recreational or therapeutic use' (British Medical Association evidence in Runciman, 1999) whereas 'social customs and economic interests should not blind us to the fact that alcohol is a toxic substance ... no other commodity sold for ingestion, not even tobacco, has such wide ranging adverse physical effects' (Babor et al., 2003: 4).

DRUG LINKS WITH MENTAL HEALTH PROBLEMS

(See also Chapter 16.)

One of the main reasons for reclassifying cannabis back to Class B under the Misuse of Drugs Act 1971 was the perceived link with mental health problems, particularly in relation to the use of the more potent Sinsemilla (also known as Skunk). There is a clear relationship between alcohol and mental health problems (Meltzer, 1995), with between 22% and 44% of adult psychiatric inpatients experiencing problems with alcohol and drugs and the most severely dependent drinkers reporting the greatest number of mental and physical health problems (Gossop et al., 2003).

Gossop (2000) argues that there is no convincing evidence that cannabis causes mental health problems and that, given that the prevalence of psychosis in the general population is about 1%, it is obvious that some cannabis users will develop psychosis. He also makes the point that cannabis use may exacerbate existing problems; however, it is also the case that cannabis may form a part of poly drug use which may exacerbate the risks of developing mental health problems.

THE GATEWAY THEORY

The Gateway Theory has been one of the major arguments against the legalisation or decriminalisation of cannabis. The hypothesis is that cannabis use leads to the use of harder drugs. This theory is based upon the observation that hard drug users have a history of cannabis use. This theory was reviewed by Runciman (1999) who argued that this is partly linked to the drug markets in which dealers encourage people to try other drugs and that the earlier the initiation into cannabis then the more likely people are to progress to other drugs. However, any sustainable theory has to show the strong probability of progression and not just that a heroin user has also used cannabis. It is evident from the statistics that the vast majority of cannabis users do not progress, otherwise there would be far greater numbers of 'hard' drug users than there actually are.

One of the key challenges for state and society is to determine what is an acceptable level of use and availability of particular psychoactive substances. In addition, can we be serious about reducing tobacco usage, through banning smoking in public places, but at the same time liberalise the use of cannabis? These are difficult questions that go to the heart of citizenship and freedoms within society but are nonetheless important to address. Both student and practitioner need to ask smart questions; for example, when talking about cannabis or alcohol what are we talking about, given the differing strengths and types of each, and different patterns of use? Government has a duty to protect people from harm, and drugs cause an inordinate amount of human suffering, and so at the very least a reasonable and rational approach to classifying harm is required.

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4 Alternatives to Prohibition

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DEFINITIONS

Decriminalisation takes away the status of criminal law from those acts to which it is applied. This means that certain acts no longer constitute criminal offences. With regard to drugs, it is usually used to refer to demand; acts of acquisition, possession and consumption. Following decriminalisation, it

still is illegal to use, possess, acquire or in certain cases import drugs, but those acts are no longer criminal offences. However, administrative sanctions can still be applied; these can be a fine, suspension of the driving or firearms licence, or just a warning. (See <http://eldd.emcdda.org/>.)

Legalisation is the process of bringing within the control of the law a specified activity that was previously illegal and prohibited or strictly regulated. Related to drugs, the term is most commonly applied to acts of supply; production, manufacture or sale for non-medical use. Legalisation would mean that such activities, and use and possession, would be regulated by states' norms, in the same way that it is legal to use alcohol and tobacco. There can still exist some administrative controls and regulations, which might even be supported by criminal sanctions (e.g., when juveniles or road traffic are concerned). From a legal point of view, any form of legalisation would be contrary to the current UN conventions. (See <http://eldd.emcdda.org/>)

Medicalisation

The medicalization model, by encompassing in the medical domain some phenomenon or problem, allows medical considerations to be decisive in the interpretation of that problem and in the choice of measures to resolve the situation. With respect to drug use, medicalization can have a broad range of meanings and consequences. When it means providing normal, good quality medical care to drug addicts, including the prescription of illicit drugs, it should be applauded as a positive development. However, medicalization also may define regular, frequent drug use as a mental disorder; designate abstinence as the only acceptable treatment outcome; and/or recommend compulsory treatment for all users of illegal drugs, be they dependent or casual users. The latter three versions of medicalization demonstrate that, while the medicalization approach for drug policy seems more humane than repression of drug use, it risks becoming a form of repression itself. (Polak, 2000: 351)

The aim of the United Nations Conventions had been to try and seek a convergence and consistency of drug policy across the world. However over time a number of different countries and jurisdictions within countries have taken differing approaches such as decriminalisation, legalisation and medicalisation. The latter, particularly with respect to harm reduction (see Shea and also Leighton, Chapters 17 and 18, this volume)

Table 4.1 Differing paradigms of drug control and treatment

Sweden	Portugal	Switzerland
<p>Narcotic Drugs Punishment Act 1968.</p> <p>Commitment to drug free society.</p> <p>In 2006 the UN applauded Sweden's approach as an exemplary model.</p> <p>Levels of drug use have been historically low in Sweden. Whether this low level of drug use is due to the policy or other factors such as homogeneous culture, 87% Lutheran, with a strong temperance movement, is open to debate.</p> <p>This approach is based upon a collective approach that values an individual's need for security and safety.</p> <p>Drug user seen as a fundamental problem and out of control.</p> <p>Therefore illicit drug use is explicitly criminalised.</p> <p>Abstinence in treatment is enforced.</p>	<p>Law 30/2000 in 2001 decriminalised use, possession and acquisition of all illicit substances for personal use (up to 10 days' supply is allowed).</p> <p>This is not legalisation as possession, growers, dealers and traffickers are prosecuted.</p> <p>Ended penal sanctions and introduced a system of referrals to Commissions for the Dissuasion of Drug Addiction (CDT) made up of social workers, legal staff and medics.</p> <p>In 2000 drug use and related problems were high particularly with injected heroin use and HIV infections. Cannabis use was relatively low.</p>	<p>Federal Drug Law 1975 saw an increase in arrests and registration of illicit drug users. The law rejected needle exchange and imposed onerous restrictions on substitute prescribing.</p> <p>The 1980s saw large gatherings of injecting drug users in public places and the spread of HIV was a major problem.</p> <p>To try and reduce crime and health problems in 1987 the Zurich authorities allowed a needle park used by up to 1k people per day.</p> <p>In the mid 1980s after a 'revolt of the medics' needle exchange was allowed.</p> <p>At Platzspitz harm reduction approaches were taken dealing with overdose needle exchange, hepatitis vaccination, condoms and other harm reduction approaches.</p>

Sweden	Portugal	Switzerland
<p>The levels of crime associated with drug use cover the spectrum of minor, ordinary and serious.</p> <p>Alternatives to prison exist but cases classed as serious have mandatory prison or treatment.</p> <p>There is compulsory drug testing for all offenders.</p> <p>Compulsory treatment also used for alcohol but overall rarely used.</p> <p>Therapeutic Communities have been popular but expensive treatment models; so increasing use of 12-step programmes.</p>	<p>Police refer to CDT and the person is seen within 72 hours. Can impose fines, community service and aims to dissuade new drug users.</p> <p>They assess status as being occasional and dependent users, with the latter receiving treatment.</p> <p>Overall there has been an increased use of cannabis, decreased use of heroin, increased uptake of treatment, reduction in drug-related deaths.</p>	<p>This approach saw large numbers of people causing disruption to local residents and was closed in 1992.</p> <p>In 1994 the Swiss Government established a policy based on the four Pillars of prevention, therapy, harm reduction and law enforcement.</p> <p>Heroin assisted therapy was central to this approach (HAT) providing injected heroin for a subset of people living with dependency but not having good outcomes from other interventions. Also low threshold methadone prescribing was introduced.</p> <p>Overall heroin use has declined and not increased as feared.</p>

Source: Beckley Foundation and Open Society Foundation

has been controversial, but the former two approaches have been seen to be contrary to the UN Conventions. The debate about drug use has really been defined by addressing the widespread use of cannabis at the lower end of the harm spectrum, and the need to address problems of opiate use at the other end. In looking at differing examples of drug policy then Sweden has a strict prohibitionist stance, Portugal has decriminalised all drug use, and Switzerland has focused on medicalisation for opiate users. Table 4.1 shows some of the key features of these approaches.

Exercise

1. To what extent do you think that prohibitionist policies actually work in preventing the use of drugs? Is it possible to have a one-size-fits-all model as demonstrated in the UN Conventions and to what extent should cultural variations be allowed for within this framework?
2. Is it ethical to demand abstinence from drug use and to use criminal justice sanctions to enforce this?
3. With respect to decriminalisation is it acceptable to trade off harms, so for example it would be preferable to see a decrease in heroin use but an increase in cannabis use?
4. Is it preferable to use civil sanctions as opposed to criminal justice sanctions and how might these work in the UK?
5. Should harm reduction services be as open access and as low threshold as possible?
6. In your opinion would it be more preferable to provide heroin on prescription rather than a substitute such as methadone?

USEFUL RESOURCES

The United Nations Office on Drugs and Crime: www.unodc.org/

The European Monitoring Centre on Drugs and Drug Addiction: www.emcdda.europa.eu/

The Transform Drug Policy Foundation: www.tdpf.org.uk/

DrugScience: www.drugscience.org.uk/

The Beckley Foundation provides an interactive Cannabis map indicating the legislative status of cannabis for all countries: <http://reformdrugpolicy.com/cannabis-map/map/>

The Open Society Foundation: www.opensocietyfoundations.org/
For information about countries that have legalised cannabis and what this means in practice see www.newhealthguide.org/Where-Is-Marijuana-Legal.html

REFERENCES

Polak (2000) 'Thinking about drug law reform: some political dynamics of medicalization', *Fordham Urban Law Journal*, 28(1): 351–361.