ASSESSING THE HARM OF ALL SOCIAL DRUGS

COLIN BLAKEMORE

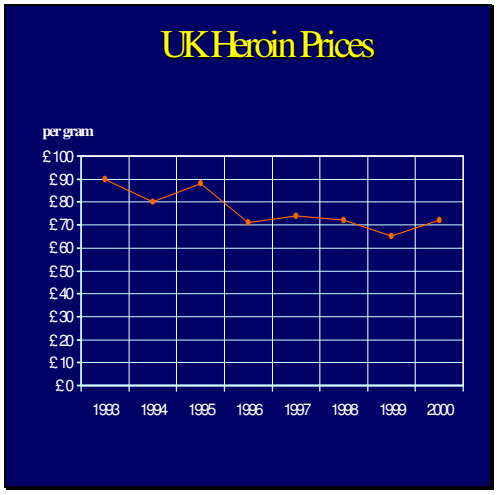
CHIEF EXECUTIVE, MEDICAL RESEARCH COUNCIL, LONDON
WAYNEFLETE PROFESSOR OF PHYSIOLOGY, UNIVERSITY OF OXFORD

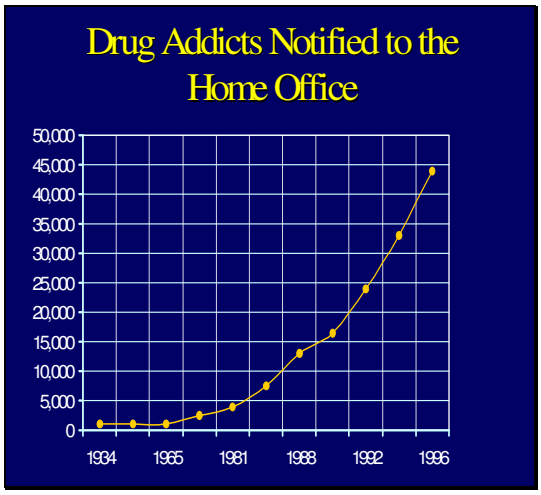
Although we recognise enormous problems in devising schemes for classifying drugs, yet classification is essential to guide sentencing in the law, to determine attitudes to education and social instruction, and to influence the emphasis put on the policing of different drugs. No single classification system can ever be perfect but it is important to devise the most rational one that we can. Are the systems of classification we presently have rationally based, and can they be improved?

In assessing the harm of drugs, science, research and evidence are crucially important. It would be nice to think that we could simply quantify the problems associated with a particular drug and assign a number indicating the harmfulness of that drug. But if we go too far along that track, we run the risk of reaching the same situation that risk assessment as a science did in the 1970s, when the entire system was dominated by numerical risk analysis and probabilities. This failed to take any account of people, and their idiosyncrasies, personal perceptions and prejudices, which we now know play an enormous part in risk assessment. So one has to take those aspects into account in thinking about classification schemes for drugs, as well as rational scientific information about real indicators of harm.

CURRENT SITUATION

The general approach which we have around the world, of tackling drug problems by draconian policing, has not worked. Street drugs have never been more freely available, more widely used, more potent, or lower in cost. If we judge the success of what we have been doing by its impact on the availability, price and use of drugs, it has clearly failed. It is incumbent on those who defend an ever-increasing emphasis on policing and prohibition to state what are their reasons for believing that this approach is ever likely to work.



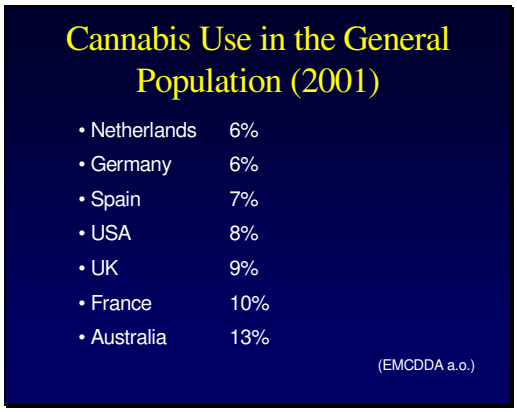


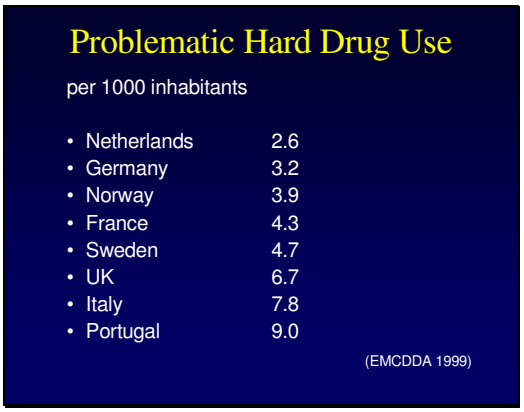
In real terms, UK heroin prices have been falling progressively from the early 1990s, and the number of notified drug addicts has increased. As availability has risen, prices have fallen.

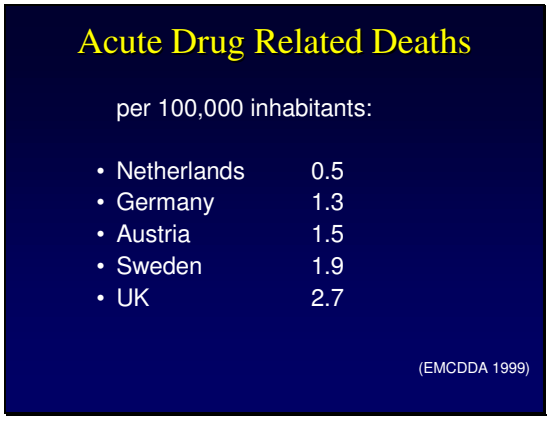
The Runciman Report recognised that one needs to stand back and ask what the objective of public, legal and political attitudes to drugs actually is? If it is the literal eradication of drug use, it is an enterprise bound to fail. "In the course of our enquiry it has become inescapably clear to us that the eradication of drug use is not achievable and is not therefore either a realistic or a sensible goal of public policy." (*Runciman Report 2000*.) If eradication is not the goal, a reasonable goal would be to limit the overall harmful impact of drug use on both society and individuals.

CHANGES IN POLICY

The question then to ask is whether relaxation of control, which will be a drawing back from the draconian policies that have been followed, particularly for less harmful drugs, inevitably leads to an increase in problematic drug use. The question becomes whether people can be trusted with more relaxed attitudes to less harmful substances. The Netherlands experience is widely cited, and there are many reasons to qualify what one says about the output and outcomes of what has happened, not least that the differences in cultural attitudes may mean that the findings are not generalisable. Nevertheless, there are lessons to be learnt from this experiment.







Even for cannabis, the drug for which the Netherlands' approach is most tolerant, there is no evidence that use has increased disproportionately. In fact, cannabis use

in the general population is lower in the Netherlands than in most other European countries, and substantially lower than in the US and the UK. Equally, problem hard drug use and acute drug-related deaths in the Netherlands are among the lowest in Europe, and very substantially lower than in the UK. Although the Netherlands is a single country with a particular culture that may not be representative of what would happen elsewhere, findings certainly do not support the conclusion that relaxing laws restricting less harmful drugs will inevitably lead to a huge abuse of the new freedoms, or to an escalation in the use of other more dangerous drugs.

How are Drugs Presently Classified?

- *Social drugs* – includes both legal and illegal drugs. Illegal drugs are further separated into hard and soft drugs, or Class A, B or C (according to the Misuse of Drugs Act). This system at least purports to be based on rational evidence of harm and impact on society.
- *Medical drugs* - therapeutic, preventive, and other drugs useful in medicine.
- *Enhancing drugs* – growing number of substances used, even if not completely socially sanctioned, for a variety of enhancing effects: cognitive enhancing, memory enhancing, physically enhancing, e.g. Viagra, a drug used to improve sexual function; Modafinil, an arousing drug which increases vigilance.

Difficulties with Classification

The distinctions between the different classes of drugs are becoming increasingly blurred:

- Social attitudes to names of drugs. For example, 'heroin' (illegal, universally condemned and target of most efforts of policing and control), and 'codeine' (painkilling drug of tremendous medical benefit, available over the counter in some forms), both work through a common pathway in the brain. These two drugs are at opposite ends of the scale of acceptability but both work chemically through the production of morphine in the brain, which then activates opiate receptors.
- There are many examples of drugs first introduced for medical purposes leaking into social markets, perhaps altered in their potency by methods of delivery, e.g. the injection of benzodiazepines.
- The acceptability of social drugs varies from culture to culture around the world. so no one scheme is likely to satisfy everybody.
- Some legal drugs are supplied illegally, so the boundaries between legal and illegal distribution methods are blurred: e.g. 30% of cigarettes are supplied illegally.
- Medical drugs spill over into social use, e.g. Modafinil is a drug used to treat narcolepsy, as it prevents sleepiness, but it is also used to maintain vigilance in troops and enhance performance in the workplace, and it elicits a minority interest in the illegal drug market.
- Legal drugs are used to treat drug abuse and addiction, e.g. Methadone is an opiate used to treat the problem of another opiate, heroin. A morally clear view is difficult with substitution therapies, which have similar pharmaceutical effects to illegal street drugs, so it proves difficult to maintain a clear distinction between them.

Crucial Questions to Ask About any Drug

- Does the use of the drug harm individuals other than the user?
- Is its use costly to society in other ways, e.g. placing additional demands on health and social services?
- Is it so patently dangerous to the health or careers of users that society is obliged to protect them from their own wishes? There is a case for intervening and contradicting personal freedoms if the risk to the individual is so great.
- Do users perceive use as a problem? Most abusers of hard drugs recognise the negative impact their drug use has on their lives and do perceive it as a problem, whereas the use of hallucinogens is very rarely viewed that way.
- How regularly do users stop, and how difficult is it for them to abstain?
- How do the risks of any particular drug compare to socially acceptable drugs like alcohol and tobacco? When considering social attitudes to drugs, it is very hard to condemn a street drug that is, by any standards, less dangerous than those drugs we already live with in society.

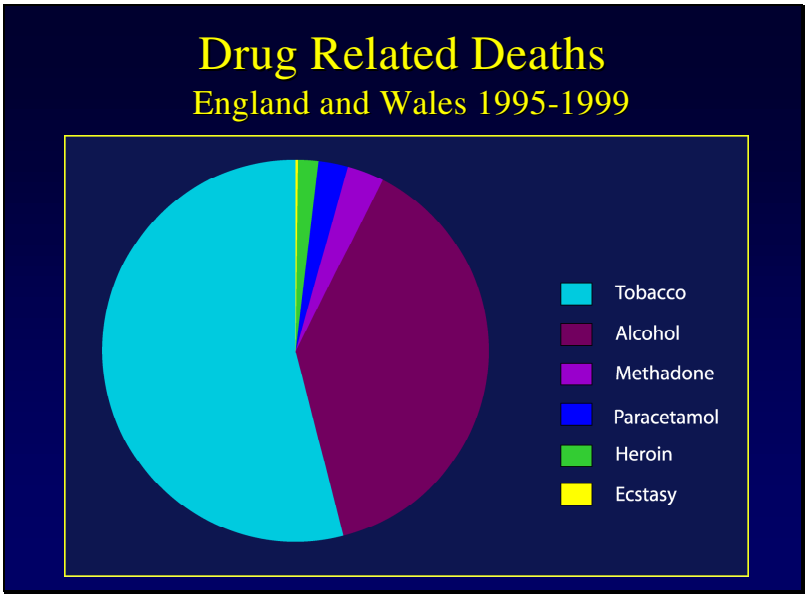
Another conclusion of the *Runciman Report 2000:* "We believe that the present classification of drugs in the MDA should be reviewed to take account of modern developments in medical, scientific and sociological knowledge." This has happened and continues to happen.

How one Might Base a Scale of Harm

This would involve a continuous review of scientific, sociological and economic evidence by a panel of experts, with representation from academia, the police, relevant NGOs and the general public, in order to assess the potential harm of each individual substance. Drugs would be ranked ordinally according to the currently available evidence of harm by a number of criteria. Alcohol and tobacco should be included in this process, even if only to provide calibration for the absolute assessment of harm in other drugs. Finally, sharp classification within the scale contradicts its continuous and shifting nature, so there should not be sharp demarcation such as A, B, C or soft and hard, or other subdivisions one might like to impose.

What Should the Criteria of Assessment be?

Toxicity, mortality and dependency
On this basis, tobacco is at the top of the list because tobacco claims the lives of more than half of its users and every cigarette reduces life by 11 minutes on average. Alcohol follows closely, and then illegal drugs - injected opiates, smoked cocaine, injected amphetamines, barbiturates and paracetamol - coming lower down in the list. On the graph below, the number of deaths related to the use of ecstasy has been exaggerated, as it is not even one pixel wide in reality.



Relation to violent behaviour
Most crimes of violence, particularly domestic violence, are alcohol-related. Crack cocaine also has a strong connection to violent behaviour.

Relation to crime
Crime often occurs to support a habit. One third of the proceeds of acquisitive crime are used to purchase heroin or crack cocaine. 80% of drug addicts have convictions for theft. Alcohol is associated with criminal actions, such as personal injury and violence to others. Smuggling is significant for both illegal and legal drugs, such as cocaine and tobacco.

Cost to the NHS
Tobacco and alcohol are very high in terms of medical costs. Injected opiates have the highest costs of the illegal drugs.

Negative impact on others
Violence, disruption to family life, problems created for helpers and carers are common effects of addictions to all substances, both legal and illegal.

Total economic impact
Costs of the loss of productive working life and costs incurred by the health service.

PROBLEMS WITH THE SCALE OF HARM

We all recognise that the assessment would have to be multi-factorial; there are many components to it, so how should the individual criteria be weighted? Should the main emphasis be on crime, or on the costs to society or the individual? There are significant individual differences in the extent of harm. Some people are able to live productive lives while using drugs, even when addicted. They experience few physiological effects as long as they can maintain a clean supply of the drug. So there are going to be huge differences in the individual extent of harm. Some people with

addictive personalities may succumb completely to substances and to certain behaviours, which other people deal with very readily.

Public perception is also a factor. However rationally one might devise the system, it needs to be acceptable to the public, media and politicians. It is important then to consider how one approaches providing education and information to the general public, not just how one numerically ranks the dangers of drugs. The personal benefits to some people of the drugs that they use should certainly be part of the process of assessment, although that would be difficult to rank because it is always an individual judgement. In particular, personal medicinal use must be respected as well as cultural and religious use.

Although a classification system of this kind might be considered over-simplistic, there are so many faults with the system we have currently that it is important at least to consider alternatives.