"A systems approach to drugs policy…"

BEING REAL ON DRUGS

Jake Chapman

DEMOS

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Acknowledgements

This pamphlet is the latest outcome from a series of projects that evolved from *System Failure*, which marked my first step in applying systems thinking to 'wicked' issues in the public sector.[1] My appreciation of the complexity of the issues has been advanced by all those whom I have worked with over the years, including members of the Neighbourhood Renewal Unit, the Metropolitan Police and many researchers at Demos. I have learned far more than I have contributed in all these associations.

The first stimulus for this project was *The Wire*, in which David Simon eloquently demonstrated the complexity and irrationality present in the drug use and enforcement system in the USA. My research into the systemic aspects of drugs progressed through two Demos projects, *Connecting the Dots* and *Taking Drugs Seriously*.[2] I am particularly indebted to participants at the systems workshops in the latter project for enabling me to appreciate the drug policy system far more deeply.

I am grateful to my colleagues and associates who were willing to provide me with accounts of their positive experiences with drugs, some of which are included in this report. However, my greatest thanks go to Jonathan Birdwell at Demos who has steered my thinking and writing and provided support and encouragement whenever needed. Thanks also to Claudia Wood, Eric Carlin and Les King for insightful comments on earlier drafts.

Any errors and omissions remaining in the text are entirely my responsibility.

Jake Chapman
April 2012

Executive summary

Drug policy is rarely out of the news. Recently there have been calls for change from retired figures of authority that have captured the headlines, marking both the 40th birthday of the Misuse of Drugs Act 1971 (MDA) in the UK and the 50th birthday of the UN Single Convention on Narcotic Drugs. One of the best publicised reports, from the Global Commission on Drug Policy whose members include a who's who of international statesmen, declared that 'the war on drugs has been lost'. Despite billions of pounds spent, the original aims of both the MDA and Single Convention of reducing drug use and making drugs more expensive remain elusive. Instead, drugs policy has generated a range of harmful unintended consequences across the globe. Many of the objections to current policy stem not from this failure to achieve original objectives, but from the harmful unintended consequences these policies have generated.

Unintended consequences arise whenever policies are based on an inadequate appreciation of how a complex system operates. They also arise when a system evolves and changes and policy fails to evolve in step. This pamphlet argues that both are the case when it comes to drug policy. The dominant narrative concerning drug policy has remained incomplete and one-sided for a number of reasons discussed herein. Moreover, the emergence of 'legal highs', produced in China to simulate the effects of banned substances and sold over the internet, means that drug policy crafted in the 1970s needs revisiting.

Different perspectives

The approach taken in this report is based on systems thinking. There are two core reasons for this. The first is that the issue of

drug policy is inherently complex with a host of interactions between health, crime, different groups of users, issues of mental illness and addiction, and an ever increasing number of drugs. The second is that it is a contested issue with different perspectives based on radically different sets of values and explanations of what is occurring. The combination of complexity and plurality requires a different approach to policy, one that avoids choosing between the different perspectives or presuming that there exists a simple 'solution' to the issue, which is precisely what a systems approach sets out to do. This pamphlet argues that the application of systems theory can help move the debate about drugs policy behind its seemingly intractable impasse into a realm where improvements to policy can become a possibility.

Drugs policy is locked between two fundamentally opposed perspectives: prohibition, on the one hand, which reigns among policy makers (at least while they are in power), and legalisation, on the other, which is thought to reign among liberalisers and others who are 'soft on drugs'. Between these two extremes are those who take a harm reduction approach, some of whom see the issue in terms of health and some of whom favour decriminalisation for use (but not supply). Each perspective is able to assemble evidence and arguments to support its core values and its way of making sense of the world of drug use. Proponents of the perspectives are thereby convinced that they are right, fail to acknowledge or understand the other perspectives at work and force policy makers to choose between the perspectives being promoted.

This report starts from the position that each of the different perspectives is not wrong, but incomplete. Part of the complexity of the 'system' of drugs policy is the existence of these different perspectives; without appreciating them policies will continue to generate unintended consequences. Rather than choose between the different perspectives, this report aims to synthesise them so as to understand better the functioning of the system as a whole.

The report starts by examining why drug policy has been so resistant to change and concludes that there is a self-

reinforcing set of interactions that maintains the dominance of prohibition among politicians who are in power. This effect has a number of contributing causes, and one of them is the perpetuation of an entirely negative view of drug use and drug users by newspapers, media and politicians. This is despite the fact that some of these negative outcomes are themselves a product of prohibition, not necessarily of drug use.

Positive and negative experiences

This report is, for the most part, reflections of an academic and systems thinker who has been studying the drug policy debate for a number of years. It is mainly a think piece, which strongly reflects the author's own personal journey towards understanding the debate and the evidence better. The amount of research into drugs is staggering. It cannot be presented in its entirety in this report. Moreover, because of the illegality of drug use, all research suffers from methodological problems. The author has tried to be balanced in choosing which research to cite – opting for reports from committees and academics that are well respected throughout the field.

The report consists primarily of an evidence review in exploring why drugs policy remains such a difficult and fraught area of policy. However, the author did initiate a small experiment as part of this report and extracts from the findings are reproduced in chapter 5. The author has been struck over the years by the preponderance of negative stories associated with drug use in newspapers and other media. However, as many readers will also note, while they may know a number of people who had negative experiences with drugs – as the author certainly does – they also know a number of friends, business associates and acquaintances from all walks of life who have had positive experiences with drugs. These stories are rarely, if ever heard. One of the most shocking things from the recent biography of Steve Jobs was the revelation that taking LSD was, in his view, one of the most important things he did in his life. For a man who completely revolutionised our world and became incredibly rich and admired, that may come as quite a shock for

many people. But part of the reason for that is that we are so unaccustomed to such pronouncements in public. The only way to counter the overwhelmingly negative stereotypes of drug users is to provide more examples into the public domain of positive experiences. This is not because the author believes that most people have positive experiences, or that these outweigh the many negative experiences that also attend drug taking. It is not claimed that these stories are representative, nor are any conclusions or recommendations based on them. They are offered so the reader can consider some positive experiences associated with drug use – not among the normal stereotypes, but among successful professionals from all walks of life. All the stories collected as part of the project are available at www.BeingRealOnDrugs.com. It is essential that positive experiences with drugs also enter into the public narrative and become part of the consideration for policy makers in deciding drug policy – even if the choice of prohibition is still the favoured outcome. At the very least the policy debate will be more honest and realistic.

The extracts from a selection of these accounts illustrate the ways in which drugs can be used to enhance personal awareness, improve intimate relationships and solve problems. This is consistent with research into therapeutic use of some of the drugs that has recently been restarted following a 40-year ban. However, the author stresses that although it is possible for people to have positive drug experiences there is also the capacity for profoundly negative experiences including addiction, mental illness, criminal activity and even death. The report examines each of these areas with a view to identifying the underlying causes of the negative outcomes and hence how the system could be improved to reduce their occurrence. In many cases these negative results are amplified by some of the unintended consequences of current drug policy based on prohibition.

Groups of drugs and users

Another source of complexity that needs to be addressed in any improved drug policy is that there are different categories of

drugs and of drug users. The report identifies three broad groups of drug types: those that cause the user to be more open (cannabis, ecstasy, hallucinogens); those that act as stimulants (cocaine, amphetamines); and those that suppress awareness (opiates, heroin). While each group of drugs can have severe negative consequences for users, the first group is distinguished by having a number of benefits that are too often ignored because of negative stigma.

The group of drug users that cause the most harm, to themselves and to others, are those addicted to heroin or crack cocaine. Evidence from large scale surveys in the USA indicate that the people who remain addicted for a long time often also have another mental condition (such as depression, obsessive-compulsive disorder or schizophrenia), usually live on the margins of society and are an extremely vulnerable group.

The report starts from the assumption that the group of users requiring most protection are young people. This reflects our approach as a society to protecting young people from potentially harmful substances. It also reflects the disproportionate negative impact that drugs can have on young people because of the developmental stage of their brains. The report argues that, given the high numbers of young people who use drugs regardless of their illegality, the provision of important and trustworthy information about drugs and parental style are the most important protections for young people and drugs.

Routes to improvement

In order to create the opportunity for making improvements to drug policy the first requirement is to refine the image of drug users, since it is the wholly negative stereotypes of drug users that lock the current system in place. This requires politicians to shift their way of thinking and talking about drug users, a shift that should include more honest consideration of the positive benefits of drug use. Some of those benefits – having fun and improving social relationships – are still discounted in policy debates, but are a key feature of fostering a happier electorate and closer communities.

The drugs that enhance individuals' openness could potentially be used in a range of therapeutic contexts. It is suggested that as part of the shift in attitudes towards drugs their use for enhancing people's lives is explored.

The report does not conclude with specific policy recommendations on the grounds that another set of over-simplified policies is not necessary. Instead, what is needed is a different way of thinking and talking about drug policy, one that recognises the reality of drug users and the full spectrum of drug experiences available. It is not a question of being hard or soft on drugs: what is required is to be real on drugs.

Preface

The approach taken in this pamphlet requires a short introduction to make sense of the journey involved. The approach is rooted in systems thinking[3] and has two key features that are set out below.

The first is a holistic approach that keeps the focus on relationships and interactions between factors and aspects of an issue. One reason for this is that when there is a rich interconnectedness then ideas of simple causation are usually incomplete and lead to over-simple conclusions. When interventions or policies are based on an over-simplified account they will generate unintended consequences, some of which can be both embarrassing and harmful. It is normal for the interconnections between aspects of an issue to create feedback loops in which it is impossible to assign any one factor as a primary cause. The behaviour of complex systems is largely determined by these feedback loops, so changing the behaviour of the system requires that these feedback loops are addressed. Part of the journey of this report is uncovering key feedback loops that are determining the behaviour of the 'drug policy system'.

The second feature is that in social issues such as drug policy there are always several different perspectives on what is occurring, why, and what should be done about it. This is not simply a difference in the goals and values of those who disagree; there is also a profound difference in the way that advocates of each perspective understand what is happening and make sense of the whole domain. A systemic approach acknowledges these differences and regards them as part of the complexity that has to be addressed. It does not seek to choose between the perspectives but instead aims to generate a 'bigger picture' of the system that incorporates both the interconnections and the different perspectives. In turn this bigger picture should clarify

the scope for intervening in the system and how to be most effective in doing so. There will still be profound differences about what type of outcome is most desirable. However, with the greater understanding generated, whatever intervention or policy is chosen it is likely to be more effective and generate fewer unintended consequences.

Drug policy in the UK has remained largely unchanged for the last 40 years, so much of the investigation of causation and effectiveness ends up being critical of current policy. This is not because current policy is 'wrong'; it is just that current policy has largely shaped the existing system and if change is required then it is essential to understand where the presumptions of causation are inadequate. It is much harder to be critical of alternative policies or identify the unintended consequences they would generate simply because they have not been implemented, and in some cases not well articulated. As will become clear in the final chapters of this report, this imbalance does not reflect a presumption in favour of any particular policy.

1 Calls for change

There is a growing volume of calls for changes to the laws and policies used for controlling 'illicit drugs'. This report explores both the reasons behind the calls for change and the reasons for resisting those calls. The aim is to examine the arguments and the available evidence and try to draw some conclusions – about why the demand for change has become so vocal and what could be done to address the issues raised.

The most prestigious and widely reported call for change was by the Global Commission on Drugs, an august collection of world figures including Kofi Annan, former Secretary-General to the UN; Jimmy Carter, former US president; Sir Richard Branson, head of Virgin; George Schultz, former US Secretary of State; Paul Vocker, former Chairman of the US Federal reserve; Ruth Dreifuss, former President of Switzerland; along with four former presidents from South American countries. The following quote from their report *War on Drugs* summarises their conclusions.

The global war on drugs has failed, with devastating consequences for individuals and societies around the world… Vast expenditures on criminalization and repressive measures directed at producers, traffickers and consumers of illegal drugs have clearly failed to curtail supply or consumption… Arresting and incarcerating tens of millions of these people in recent decades has filled prisons and destroyed lives and families without reducing the availability of illicit drugs or the power of criminal organisations.[4]

The following is part of a lengthy editorial in the *Observer* prompted by the report:

The taboo shows no sign of being broken by Britain's spineless political class, despite this generation of leaders being the first to have widespread, first-hand experience of illegal drugs. They will undoubtedly have come across cannabis, cocaine and ecstasy throughout their university, social and professional lives. Some of their best friends – and colleagues – will have taken them.[5]

Another call for change that made the headlines was by Baroness Manningham-Buller, ex-head of MI5. At a conference in the House of Lords she called on the government to decriminalise and regulate cannabis.[6] A year earlier Bob Ainsworth, one-time Home Office minister responsible for drugs, had also called for radical change.[7] He was preceded by Sir Ian Gilmour, the retiring resident of the Royal College of Physicians, who called for 'legalising heroin and cocaine to cut crime and improve health',[8] and the Chief Constable of Humberside, Tim Hollis, who at the time was also the chairman of the drugs committee of the Association of Chief Police Officers. Hollis made it clear that he thought it was wrong to criminalise young people for personal possession and use of drugs.[9] Professor David Nutt caused a furore when, while chairman of the Advisory Council on the Misuse of Drugs (ACMD), he asserted that taking ecstasy, a class A drug, was about as dangerous as horse riding.[10] This was not such a radical idea since a decade earlier the Home Affairs Select Committee had called for the reclassification of ecstasy on the grounds of being less harmful than other class A drugs.[11] More recently in its evidence to the Sentencing Council on Guidelines relating to Drugs Offences, the ACMD called for possession of drugs to be effectively decriminalised.[12]

These calls for change are by pillars of the establishment, in many cases by people who had direct responsibility for enforcing the laws that they are calling to be changed – but only when they had retired. To have been so outspoken while in office would have been to risk dismissal, the fate that eventually befell Professor Nutt. Part of the difficulty of challenging a prohibition is that there is always an implicit prohibition of challenge – a taboo on discussing alternatives because merely

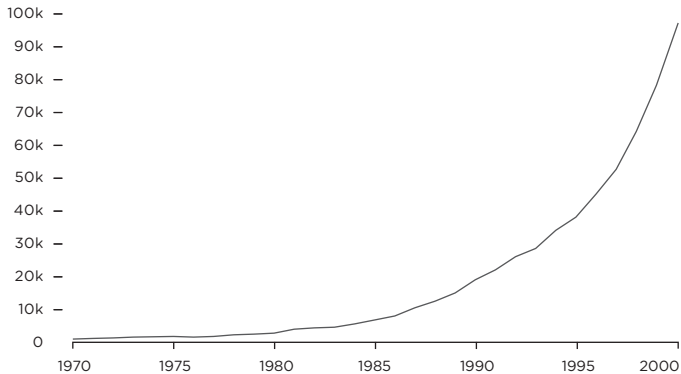
discussing them raises the possibility that the prohibition may not be justifiable.

The Misuse of Drugs Act

The Misuse of Drugs Act 1971 (MDA) is now more than 40 years old and has not been substantially changed in that time, though of course many more substances have been added to the prohibited list. Initially framed to curtail the production, distribution and use of cannabis, LSD, heroin, cocaine and a few other substances, the legislation now covers more than 600 compounds with tens being added each year. It is not hard to find evidence that the MDA failed to achieve its original objectives because the number of drugs and drug users have multiplied while the prices have declined. Figure 1 shows the increase in the number of heroin and cocaine addicts known to the Home Office or in treatment. The numbers are known to have stabilised somewhat since about 2000, although the latest estimate of the total number of opiate and cocaine users in the UK is 306,000.[13]

One of the unintended consequences of making possession of drugs illegal is that there is no reliable source of data on either the numbers of users or the amounts used. The data reproduced here have been obtained from sources that have done their best to verify estimates by using more than one source. However, most of the data are derived from surveys, such as the British Crime Survey (BCS), that require respondents to own up to taking part in an illegal activity, which leads to a level of under-reporting. Such surveys do not include groups known to have a high proportion of drug users, homeless people, travellers and those in detention or prison, so the under-reporting will be even higher. In the USA there have been some checks made on self-reports of drug use by taking biological samples from respondents. One such test used people who had been arrested for an offence; comparing the biological test with the self-reports showed that the self-report rate was 50 per cent of the actual use.[14] In another study, using a school survey, the rate of reported cocaine use was 52 times less than that detected in the

Figure 1 **Number of dependent opiate and cocaine users known to treatment services, 1970–2000**



Source: Cabinet Office[15]

Note: Until 1996 data are for number of addicts notified to the Home Office; since 1997 data are for the number in treatment.

biological samples.[16] These may be extreme cases, but are consistent with common sense: relying on people to self-report an illegal activity will yield under-estimates of activity use.

Numbers of drug users

The data used in figure 1 are more reliable than self-reported survey data because they are based on the numbers of individuals in treatment. Of course, the total population of opiate and cocaine users is significantly larger and less quantified. But nonetheless, figure 1, taken from a Cabinet Office Strategy Unit report, shows that the number of dependent opiate and cocaine users seeking treatment has grown exponentially between 1970 and 2000 despite policy efforts.

Data on the number of drug users more generally are shown in table 1. These data have been derived from the BCS. The breakdown by age indicates that by the age of 30 more than half of all adults in the UK have tried an illicit drug. If young

Table 1 **The proportion of 16–59-year-olds reporting having used drugs in their lifetime by age group, 2005/6, and for all ages, 2009/10**

Age group	16–19 (%)	20–24 (%)	25–29 (%)	30–34 (%)	35–44 (%)	45–54 (%)	55–59 (%)	All ages	2009/10 all ages
Cannabis	35.1	44.4	46.7	40.1	28.5	18.8	11.1	29.8	30.6
Amphetamines	7.5	14.5	23.8	20.5	11.8	5.6	2.8	11.5	11.7
Any cocaine	6.5	14.5	15.2	10.4	6.4	2.4	1.1	7.3	8.8
Ecstasy	5.8	14.4	18.2	14.0	5.7	0.9	0.2	7.2	8.3
Opiates	0.4	1.1	1.9	1.2	0.9	0.5	0.3	0.9	0.9
Any drug	40.4	49.0	51.6	45.8	34.2	23.4	15.4	34.9	36.4

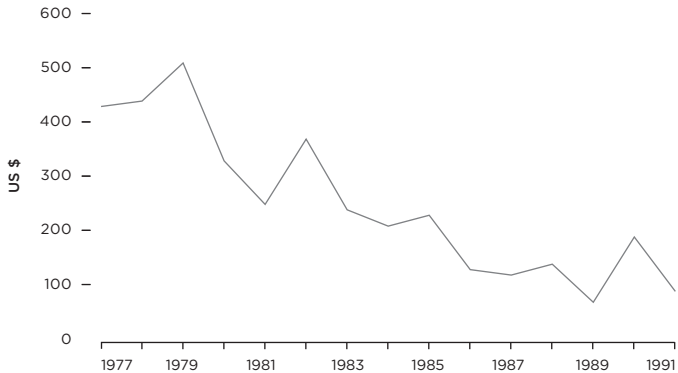
Source: BCS (England and Wales)[17]

people continue to experiment with drugs at the rates shown by recent cohorts, then by the time the current 25–29-year-olds are 60, more than half of all adults in the UK will have used an illegal drug at some point in their lives. Clearly younger people are reporting a higher incidence of experimenting with drugs than older cohorts (though this may partly be the result of older respondents being more circumspect about owning up to an illegal activity). Note that these data also show that opiate users are a relatively small proportion of all drug users; cannabis is the most widely used drug. In 2009/10, 8.6 per cent of the adult population in the UK had used drugs in the last year,[18] corresponding to more than 4 million people. There are not many laws broken by such a large number of people every year, except maybe driving over the speed limit.

Drug prices

Not only has the number of users increased significantly since 1971 when the MDA was enacted, but the price of drugs has steadily declined since then – despite large seizures and attempts to disrupt production overseas. To compare drug prices over time it is necessary to take account of the general change in

Figure 2 **Cocaine prices in New York, 1977–1991, US$/gm for purchase of 1 gram pure cocaine**



Source: Caulkins, *Developing Price Series for Cocaine*[19]

consumer price indices and, often more important, the purity of the drug being sold. Figure 2 shows the declining price of cocaine from 1977 to 1991 with these corrections made.

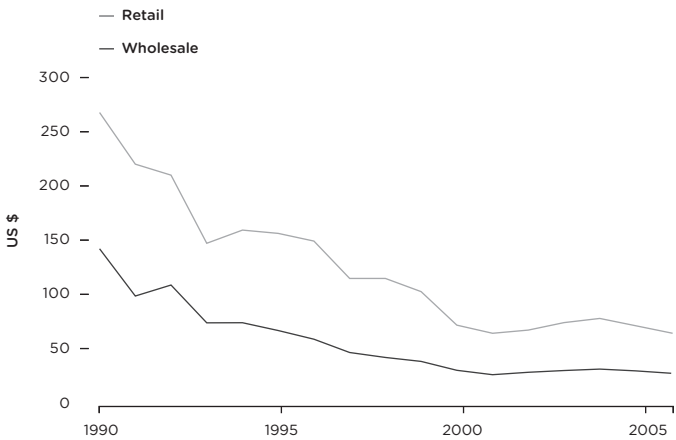
Figure 3 shows a more recent decline in the price of heroin in Europe, though the degree to which the data have been adjusted for inflation and purity is not clear.

Again, it seems clear that the most reliable sources of information suggest that prices for cocaine and heroin have generally declined despite the consistent efforts of police and law enforcers to target suppliers in order to increase the cost and decrease the demand.

Unintended consequences

For many of the critics of the MDA, and 'the war on drugs' more generally, the failure to achieve its objectives is not the main reason for calling for change. The more significant issue, at least in the eyes of the critics, is that the criminalisation of drug use

Figure 3 **Heroin prices in Europe, 1990–2006, US$/gm**



Source: UN Office on Drugs and Crime, *2008 World Drug Report*[20]

and drug users has generated harms that are, in many instances, as great or greater than the drug use itself. The harms generated by prohibiting drug use are *unintended consequences* and have arisen partly as a result of the failure of the MDA to achieve its goals, but more significantly because the world in which the legislation is now operating is radically different from, and far more complex than, the world in 1971. The most obvious unintended consequences are:

- providing a very large source of funds for criminal organisations at international, national and local levels; these funds have been used in producer countries to bribe law officers and judges, thereby undermining civic society; at a more local level the funds provide gangs with money and influence
- making the use of drugs more dangerous and risky because the criminal vendors will 'cut' drugs with unknown substances to an unknown degree; the first change when a 'legal high' is banned is that the purity of what is sold decreases substantially

- criminalising thousands of young people each year for recreational use of drugs; this blights their careers for the rest of their lives

The more subtle unintended consequences include:

- bringing the law into disrepute because complete enforcement is impossible and the number of people breaking the law is so high
- inhibiting research on potentially useful psychoactive compounds
- making it harder to conduct research into drug use and users
- making young people suspicious of any 'official advice' on drugs
- making data on drug use and numbers inherently unreliable

The UN Office on Drugs and Crime acknowledges a number of unintended consequences, which have been recently summarised as:

- increasing the power and reach of organised crime
- stigmatising and marginalising large numbers of citizens
- misdirecting expenditure
- violating human rights[21]

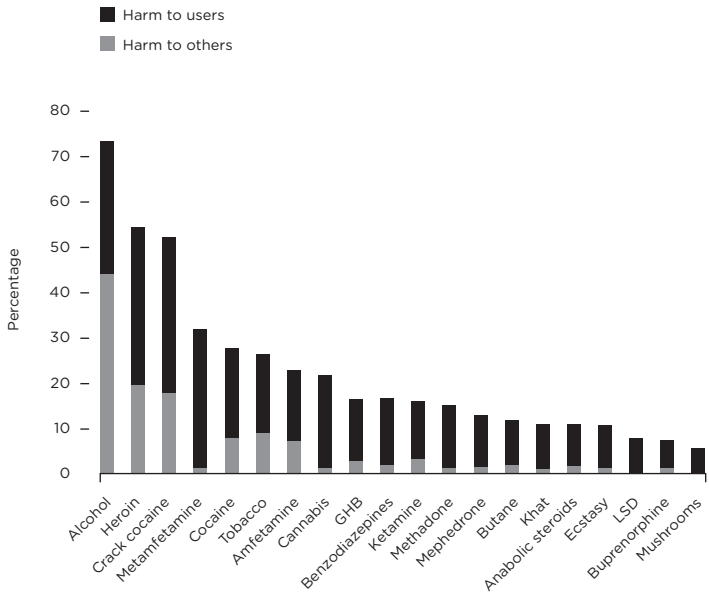
A number of commentators have observed that it should be feasible to introduce a robust regime that regulates drug use and availability without generating such serious unintended consequences.[22] Despite this, there has been no substantive political discussion of options that would be more suited to the world in which drugs are now supplied and used. Again it is hard to think of any policy area where this level of contrary evidence of harmful unintended consequences has gone more or less ignored.

Evidence related to drug policies

In addition to these unintended consequences there is a growing body of academic evidence that many aspects of drug policy lack an evidence base.

One of the critiques of current policy in the UK is the classification of different substances into three categories: classes

Figure 4 **The relative harms of 20 psychoactive substances**

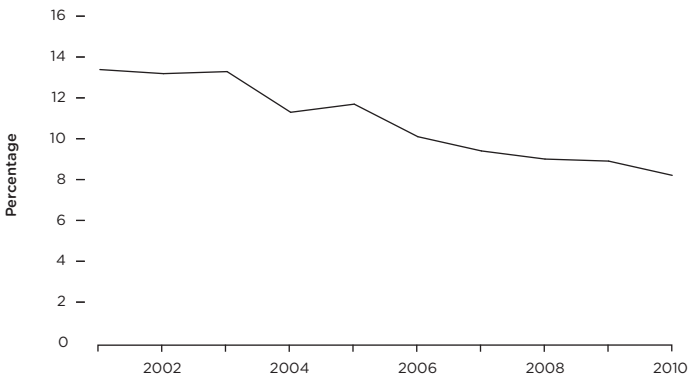


Source: Nutt et al, 'Drug harms in the UK'[23]

A, B and C. The criminal penalties are most severe for class A, implying that their use constitutes the most serious harm to users and society in general. A recent study by Professor Nutt and colleagues at the Independent Scientific Committee on Drugs indicates that the evidence on harm does not support this classification. Figure 4 is based on their publication in the *Lancet*.

The class A substances appear in positions 2, 3, 4, 5, 12, 17, 18 and 20. The substances not controlled by the MDA occur in positions 1 (alcohol), 6 (tobacco) and 15 (khat). It is striking that the most harmful substance – alcohol – is not controlled by the legislation at all, and three of the apparently most harmful class A drugs – LSD, ecstasy and mushrooms – are at the bottom of the harm scale.

Figure 5 **The proportion of school pupils using cannabis in the UK, 2001—10**



Source: Fuller (ed), *Smoking, Drinking and Drug Use Among Young People in England 2010*[24]

In defence of the classification system ministers have claimed that classifying drugs in classes A and B 'sends an important message' that they should not be used and thus acts as a deterrent effect (albeit no longer commensurate with levels of harm). This argument was used when cannabis was reclassified to class B in 2008 amid fears that its downgrade to class C in 2004 had led to greater levels of use. However, research suggests that these classification changes bore no impact on use rates. Figure 5 shows the trend in cannabis use among school pupils. There is a slight blip between 2004 and 2005, but the overall trend was not significantly influenced by either reclassification. This suggests that the notion that classification conveys 'an important message' is probably a myth.

In sum, there have been increasing calls for a rethink of drug policy, particularly from establishment figures who have first-hand knowledge of the situation. There are three broad reasons for these outspoken critics. First, prohibitive drug policy has failed to achieve its objective of making drugs more expensive and less available and hence deterring their use.

Second, the MDA and other prohibitive legalisation have generated a significant number of unintended consequences, some of which may be judged as harmful as, if not more than, the use of drugs themselves. Third, there is a dearth of evidence supporting current drug policies, particularly the classification scheme set out in the MDA. The next chapter tries to make sense of why drug policy remains stuck in this failure.

2 The lack of response

Although there has been a growing intensity in calls for changing drug policy, there is nothing new about the critiques; indeed some were voiced at the time the legislation was first enacted. The critiques have been more vocal in other countries, particularly the USA and Canada, where there are vociferous lobbies advocating legalising and regulating drug use. Here is how a Professor of Medicine in Canada describes the situation:

Imagine an extremely expensive government policy proven to be completely ineffective at achieving its stated objectives. Consider also that whenever this policy is subjected to any kind of impact assessment, the government's own data clearly show that the policy has been ineffective, expensive and fuelled the growth of organized crime. Finally, imagine this remarkable set of circumstances persisting for decades – at great cost to taxpayers and community safety – and yet elected officials say and do nothing to address the status quo.[25]

There have also been calls for radical change in and from the governments of South American countries, where cartels and drug gangs have gained enormous power as a result of the funds they have generated from producing and smuggling drugs. President Calderon has waged the biggest campaign against drug gangs in Mexico's history and in a recent speech in New York said:

We are living in the same building. And our neighbour is the largest consumer of drugs in the world. And everybody wants to sell him drugs through our doors and our windows. If the consumption of drugs cannot be limited the decision makers must seek more solutions – including market alternatives – in order to reduce the astronomical earnings of criminal organisations.[26]

Despite all the discourse, protests and growing evidence of malfunction, if not failure, most governments around the world have done very little to adapt or change drug policy. This chapter explores a number of reasons for this lack of response in the UK.

At the outset it is worth mentioning the potential constraints presented by the United Nations conventions on drugs and drug trafficking. Although the UN Single Convention in 1961 was influential in the framing of the Misuse of Drugs Act 1971 (MDA) some ten years later, the UN conventions have not prevented a number of countries and jurisdictions, for example Australia, Netherlands and Portugal, from adopting different policies. So it is unlikely that this is a genuine constraint if there were a strong enough reason and political will for change.

Reasons for inaction

Importance of language and framing

The first possibility for inaction is associated with the way that drug policy is framed and the language that is used – particularly in the press. Since President Nixon first used the phrase at a press conference in June 1971, the press have referred to drug policy as 'the war on drugs'. It is long forgotten that Nixon was spurred to action by the large numbers of GIs in Vietnam addicted to heroin; the phrase has become the tagline for all drug policy. This type of language poses a problem for anyone who wants to question or change drug policy. For most people there is something total about a war. It is a matter of survival or fighting 'evil', and we have to devote all our resources to winning – losing the war is not an option. There is also an obligation to obedience to the authorities running the war, which means being willing to go along with instructions that in peacetime we might oppose or challenge. All these implicit associations make it hard to challenge 'the war on drugs' and suggest that those advocating change have to start by admitting that 'the war on drugs' has been lost. That admission appears weak – especially if there are voices claiming that more money, tougher laws and tighter border controls will enable the war to be won.

The taboo

The second reason why politicians do not engage with drug policy is because of the taboo on discussing alternatives due to the underlying moral judgement of doing so. The prohibition of drug use is predicated on the assumption that they are immoral and nothing good can come of their use. Even raising the question of whether the current policy is the best challenges this position; so there is a prohibition on challenging the prohibition. This is further reinforced by the 'red-top' press being strongly anti-drugs and the source of a number of negative myths and stereotypes around drug users. Anyone challenging drug policy is damned as 'being soft on drugs', so there is virtually no debate about options and alternatives. In this vacuum both the public and many politicians will fear that any change to current policy is likely to make matters worse, thereby reinforcing the view that it is best to continue with the current approach.

The risk of political suicide

The third reason why politicians do not engage with this issue is quite simple: most of them regard it as a quick route to political suicide. This arises from the fact that polling tends to show that the public do not want drug laws to be changed (though this isn't always clear cut and depends on survey wording)[27] – they tend to want politicians who are 'tough on drugs'. Since drug policy is not a core issue for most politicians they pragmatically choose to stand for what the majority of the voting public want.[28] The result is that drug policy remains stuck despite all the challenges, unintended consequences and evidence that things are not working well. As the former prime minister of Luxembourg, Jean-Claude Juncker, has succinctly put it: 'We know what to do, but we don't know how to get re-elected once we have done it.'[29]

What do the public think?

Given the evidence cited in chapter 1 against current policy, why is public opinion so firmly against change? There are two ways that make sense of this.

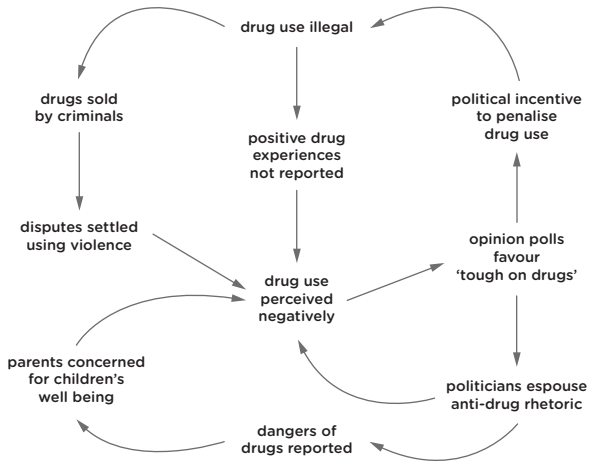
The first is to recognise that there is a self-reinforcing system operating in which the public calls for tough policies against drugs, politicians respond by enacting tough laws and support them with accounts of the damage and horrors caused by drugs, which in turn reinforces the public's view that drugs are a pernicious evil that requires tough action to eliminate them from society.

The second is based on the experience of different groups in relation to drugs, all of which provides evidence to support the feedback system described above. For example parents of teenagers read stories about other children becoming addicts or mentally ill as a result of using drugs; they may even know another parent to whom this has happened. People living on deprived estates see drug dealers and addicts operating and are appalled by the discarded needles, the violence, dishonesty and theft involved. These negative experiences are all too real, and it is irrelevant that they only apply to a small minority of drug users. No one wants their children incapacitated, addicts stealing from their homes or cars, or drug dealers fighting turf wars on their estate.

These negative perceptions are not countered by any positives. Few adults witness their children having profound experiences or ecstatic fun using drugs. The young professionals who use drugs creatively – the clubbers who experience love and empathy dancing in large groups and the people who find drugs enhance their relationships – are all silent, because they have been participating in an illegal activity and owning up would jeopardise their careers. Prohibition serves to suppress the reporting of any positive drug experiences and leaves the general public with an overwhelmingly negative perception.

What compounds this is that in some cases it is the criminalisation of drug use that has either caused or exacerbated the negative outcomes and perceptions. Drug dealers fight violent turf wars because they cannot resolve disputes using a legal process. Drugs purchased from criminals for a good night out are impure, making their use far more risky. The only way for addicts to obtain their next dose is to buy it, which leads many to financial ruin and then stealing. If police succeed in breaking up

Figure 6 **A simplified diagram showing the self-reinforcing system created by prohibition**



Note: To 'read' the diagram interpret each arrow as meaning 'causes' or 'leads to'. For simplicity only a few causes of the negative perception are illustrated.

a gang dealing in drugs their success is likely to provoke a new turf war between rivals seeking to claim the vacated territory.

This interaction between the prohibition of drug use, the negative outcomes that apply in a minority of cases, and the suppression of any positive outcomes because drug use is illegal provides a reasonable account of the negative perception of drugs by the general public, which in turn influences politicians through opinion polls, which in turn fashions government policy and attitudes, which exacerbates and reinforces the negative outcomes. Figure 6 highlights this important feedback system.

This analysis demonstrates that the prohibition of drugs has created a self-reinforcing system, one that is actually immune to whether or not it achieves its declared objectives because the outcomes generated reinforce the perception that prohibition is

the only way to address the issue. In order to make any improvement in this system it is necessary to affect the feedback loops that maintain the system.

The reasons for finding an alternative approach to drug regulation remain compelling:

- not providing £4–6 billion to criminal gangs in the UK each year[30]
- not criminalising thousands of young people each year
- not bringing the law into disrepute and making drug use more dangerous

There are also examples in Portugal, Netherlands and Australia that indicate other approaches are feasible.

In order to extricate ourselves from this self-reinforcing system we must:

- understand exactly where the MDA has succeeded and where it has failed, and as far as possible identify the causes of failure and ways that they could be avoided
- address the issue of the morality of drug use directly, since if this remains in place then no amount of intellectual debate will cause a change
- explore positive drug experiences and their place in overall drug use in order to achieve a more balanced decision-making process
- understand better the links between drug use and addiction and mental illness, and to what degree policies can reduce their occurrence
- appreciate the significant differences between different drugs and drug users so that policies can be developed that address the key issues for each group

These are the topics that are addressed in the next five chapters.

It is obvious from the description of the interactions between perceptions, outcomes, legislation and the actions of politicians, drug users and suppliers that what is being addressed is an extremely complex set of interactions. When confronted

with this sort of complexity it is tempting to seek to simplify the issue by focusing on one cause, or by adopting an ideological position, or to make use of stereotypes that evoke prejudices used in justifying a simplistic 'solution'. It is much harder to maintain a holistic view, one in which there are multiple causes for outcomes, many different perceptions and desires, and where the interactions between the different agents and agencies is to some degree unpredictable and generates ambiguity. One detailed look at the issue concluded: 'Our analysis suggests that reformers' arguments are complex and multi-dimensional, not easily reduced to bumper stickers or advertisements.'[31]

In what follows, the analysis will aim to surface this complexity and explore ways in which it can be addressed by identifying the key interactions and challenging the assumptions made about what is causing what.

3 Success or failure?

One of the issues that requires detailed examination is the degree to which the Misuse of Drugs Act 1971 (MDA) has succeeded or not. Despite the evidence set out in chapter 1 it could be argued that without prohibition the harms from drug use would be a lot worse.[32] There are a number of ways to consider this argument and to suggest that this is not a reasonable speculation.

First, the alternative to the MDA would not have been an unregulated market for drugs. Everything that we ingest, whether food, drink, alcohol, cigarettes or pharmaceuticals, is regulated and a supplier found guilty of breaking those regulations faces criminal prosecution. The difference between these foodstuffs and illicit drugs is that with illicit drugs there is effectively no control over suppliers and their product, and the *user* is also subject to criminal sanctions. So the question now becomes one that considers the impact of criminalising users – not the removal of regulations around the supply of drugs. In passing it should be noted that the prohibition of alcohol in the USA in the 1920s was a prohibition on supply – alcohol users were not criminalised in that version of prohibition.

Second, it is important to try to clarify 'things would have been a lot worse'. For those opposed to any drug use the more that is consumed the worse the state of affairs. But for those concerned with minimising harms to individuals and society the calculus is more complex and would have to include less financing of criminal gangs, lower risks from impure substances, fewer youths criminalised and perhaps greater awareness of how to use drugs responsibly. Against these possible benefits would be potential increases in the number of dependent users, possible increases in mental disorders and accidents while under the influence of drugs, and greater numbers of young people failing to fulfil their potential in school and life because of

psychological damage or poor performance at school. While there are of course many who are able to balance moderate drug use with productive activities, there are also many young people who cannot. And it is certainly possible that regulating cannabis and LSD in the same way as alcohol could increase their cultural acceptance, and thus their use. But nonetheless, this would be balanced against minimising a range of other harms.

Finally, it might be extremely important to determine *which* drug use would have increased, because drugs vary significantly in attributes such as their addictive potential, their association with mental disorders and the degree of impairment caused by intoxication. They also vary significantly in the extent to which their effects are actually desirable among significant numbers of people. One of the themes that will be developed through the rest of this report is that it is a mistake to lump all drugs and all drug users together. Different groups of users have very different motivations and the factors that influence their behaviour are different.

In short, the number of unknowns is so large as to make it impossible to derive any convincing answers about whether things would be worse without prohibition. Nevertheless there are aspects of these issues that can be explored, even if numerical precision is not possible.

Numbers of users

It is common sense that if drug policy were changed in some way that reduced the 'punishment' associated with drug use then more people would be likely to try them; this presumes that making drug use a criminal offence will deter at least some people from trying them. Whether they would like the effect of the drug and continue to use it remains an open question, but surely there would be an increase in those trying it? What is interesting is to try to estimate the magnitude of that increase. It is essential to consider this question for specific drugs or group of drug users, since it is clear that the factors that might influence young people are different from those that might affect clubbers or heroin addicts.

Cannabis use by young people

As a starting point it is worth noting that more than 40 per cent of young people in the UK have tried cannabis by age 24 (see table 1 in chapter 1). This puts an upper bound on the possible impact of removing or reducing criminal sanctions, namely an increase in the number of users by a factor of 2.5. As discussed, changing the classification of cannabis between categories B and C did not have any significant impact on the trend in use among young people.

This is consistent with most of the other evidence that is available. According to Professors Peter Reuter and Alex Stevens:

in most nations throughout the Western world, from Australia to Finland, there was an upturn of about one-half in rates of cannabis use among 18-year-olds between approximately 1992 and 1998 though from very different base rates in the various countries. Some of those nations had become tougher in their marijuana policies in that time (e.g. the US), most made no change and others became more tolerant (e.g. Australia); the policy stance seemed to have no effect. It is hard to identify which underlying cultural values drove these changes simultaneously, but their breadth and consistency make it very likely that the increasingly globalised popular culture has a prominent role. After about 1998, the growth stopped as abruptly as it started; again there is no policy intervention that one can turn to for an explanation.[33]

This conclusion is reinforced by a substantial review of all the evidence available by Babor and colleagues in *Drug Policy and the Public Good*. Here are two excerpts on their exploration of pupils' use of illegal drugs:

The evaluative record seems fairly consistent for cannabis. There is no clear cut case in which a reduction in the form or enforcement of the prohibition on use or possession resulted in a substantial change in consumption of the drug.[34]

A particular drug, or a particular form of a drug, comes into fashion in a particular youth cohort. Often it goes out of style for the next generation of youth, which moves on to something else. Lagging the waves of use are waves of societal reaction to the use. Prohibitions on possession and use are brought in as part of the societal reaction. At least for cannabis it is not clear that

these post hoc reactions have been potent enough to overcome the inherent power of these societal waves in use.[35]

Another study, involving comparing 28 different countries,[36] concluded that the decriminalisation associated with Dutch coffee shops in Amsterdam had little effect on cannabis use. In the USA and Australia, different states have adopted different policies on the criminalisation of cannabis use and enforcement regimes. A study comparing drug use under these different regimes in geographically neighbouring states concluded that there was no significant difference in the trends in cannabis use.[37]

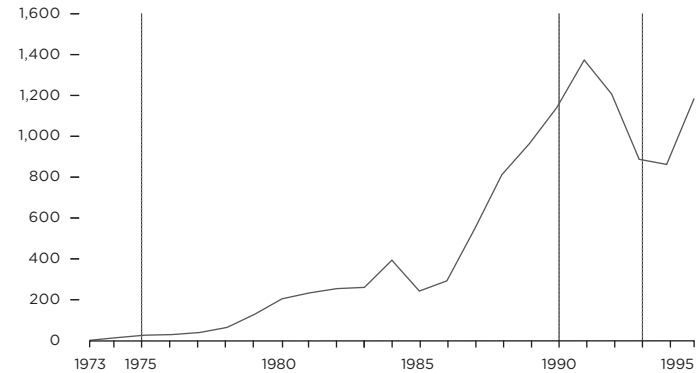
These conclusions from trends in cannabis use are supported by more direct research into the deterrence effect of legislation. In a 1988 survey of high school students in the USA only 4 per cent of respondents said that they would use cannabis if it were legalised.[38] This is supported by a range of other studies that have been summarised as 'perceived severity [of punishment] plays virtually no role in explaining deviant/criminal activity'.[39]

It should be noted that in all the cases cited, cannabis use has not stayed constant but has shown significant variation over time. This indicates something was clearly influencing use; it just did not appear to be drug policy or enforcement regimes.

Number of heroin users

There is less evidence available for the impact of prohibition or/and enforcement on the number of heroin users. Indeed, even obtaining accurate data on the number of users at any time is problematic since many heroin users fall outside the general surveys used to estimate drug use. For example the British Crime Survey (BCS) estimates that 0.1 per cent of the adult population aged between 16 and 59 used heroin in the last year; this is equivalent to about 48,000 users. A more detailed assessment based on data from treatment programmes, criminal justice data and drug intervention programmes estimates the number of heroin users at 306,000.[40]

Figure 7 **Drug deaths in Italy, 1973—1995**

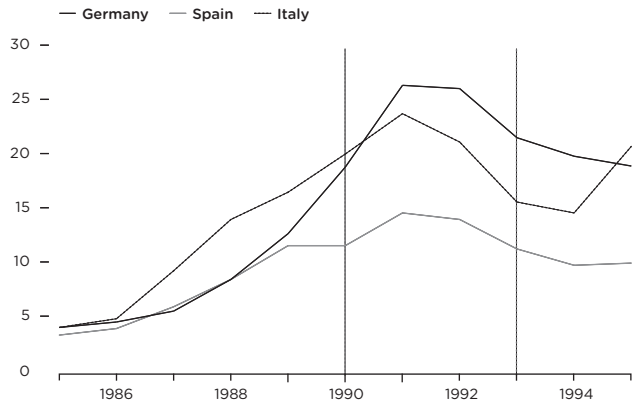


Source: MacCoun and Reuter, *Drug War Heresies*

Italy changed its drug laws significantly between 1967 and 1995 thereby effectively carrying out a useful experiment in the effect of criminalisation.[41] From 1954 to 1975 drug use was penalised. It was depenalised in 1975 and then repenalised in 1990. In 1993 drug use was once again depenalised. Figure 7 shows the recorded number of drug deaths each year in Italy. Since a very large proportion of these total deaths result from heroin use the changes can be used as a reasonable proxy for the number of heroin users.[42] The figure is divided into the four drug policy periods by the vertical lines; the two periods of penalisation are pre-1973 and between 1990 and 1993.

The decrease in the number of drug deaths a year after penalisation in 1990 seems to be good evidence that criminalising drug use had a positive effect, but closer examination of the data makes this conclusion less certain. For example it turns out that the number of drug offences recorded in Italy dropped markedly two years *before* the introduction of penalties in 1990, indicating that the number of users had started to decline before the change in legislation. Moreover, figure 8 shows the deaths per million citizens in Italy, Germany and

Figure 8 **Deaths from drugs in Germany, Spain and Italy, 1984–1995**



Source: MacCoun and Reuter, *Drug War Heresies*

Spain over the period 1985 to 1995, with the changes in Italian drug laws marked by vertical lines. Throughout the entire period Spain had depenalisation policies in place whereas Germany had strict criminal penalties and strong enforcement. Yet in all three countries the changes in deaths from drugs follow broadly similar trends.

The authors of this analysis conclude that 'changes in the consequences of Italian heroin addiction probably have little to do with Italy's ever changing drug laws and most likely reflect broader trends in epidemiology and drug trafficking beyond Italy's borders'.[43]

Portuguese decriminalisation

A more recent example of a change to a decriminalising regime is Portugal, where drug legislation was changed in 2001. Under the new legal framework, all drugs were 'decriminalised' not 'legalised'. Thus, drug possession for personal use and drug

usage itself are still legally prohibited, but violations of those prohibitions are deemed to be exclusively administrative violations and are removed completely from the criminal realm. Drug trafficking continues to be prosecuted as a criminal offence. The precise results from this change are hard to pin down, for many of the reasons noted in the previous comparative exercises, most importantly that there are continuous changes in trends and patterns of drug use irrespective of legislation. One report claimed that the changes were a 'resounding success',[44] another that it was a 'disastrous failure'.[45]

A detailed comparison of the two reports[46] shows that they made use of different data sets and overstated their cases to favour their own agendas. What appears to have happened is that immediately after decriminalisation drug use increased, but that then the rate of ceasing to use drugs increased. At present, the rate of initiation in the important 15–24-year-old group is significantly lower than pre-2001. Table 2, taken from that paper, summarises the current situation in Portugal compared with a number of other countries in 2010, some nine years after decriminalisation. It is clear that Portugal is faring better than most for cannabis and cocaine, but has an average level of heroin use. Comparing Portugal with Spain and Italy, countries with similar geographies and drug problems, the authors concluded in another study that 'contrary to predictions, the Portuguese decriminalization did not lead to major increases in drug use. Indeed, evidence indicates reductions in problematic use, drug-related harms and criminal justice overcrowding.'[47]

In sum, the fear that removing criminal penalties from drug use would result in dramatic increases in the number of users is not supported by evidence, including that from Portugal. This raises questions about the motives of drug users, how important the cultural acceptance of drug use is and the degree to which price and availability determine trends in use, rather than policy approach or penalty. In a review of different drug policies in Portugal, Switzerland and Sweden one researcher concluded that while drug policy was not 'central to what people do in relation to drug use' nevertheless, having broad public support for drug policy was key to success (however it was measured).[48]

Table 2 **Proportion of 15–64-year-olds using drugs in last year**

Country	Cannabis (%)	Cocaine (%)	Opiates (%)
Albania	1.8	0.8	0.45
Estonia	6.0	0.6	1.52
France	8.6	0.6	0.47
Italy	14.6	2.2	0.72
Netherlands	5.4	0.6	0.31
Portugal	3.6	0.6	0.46
Spain	10.1	3.0	0.13
Sweden	2.1	0.6	0.17
England and Wales	7.9	3.0	0.81
Australia	10.6	1.9	0.40
New Zealand	14.6	0.6	1.10
Canada	13.6	1.9	0.50
USA	12.5	2.6	0.58

Source: UN Office on Drugs and Crime, World Drug Report 2010[49]

In all the examples examined, significant changes in the number of drug users over time have been observed, and it is clear that there are a number of factors causing these changes. The uncomfortable truth is that these variations are not well understood, and do not appear to be affected by either drug policies or enforcement regimes.

4 The morality of drug use

When considering the reasons for the lack of change to drug policy in chapter 2, one of the possible reasons raised was that discussion of change was taboo because drug use was regarded as immoral. From this perspective, the unintended consequences and other costs are worth paying because society must maintain its moral standards. The aim of this chapter is to explore the issues associated with this perspective and place them in a larger context.

There is more than one perspective that advocates drug use as being immoral. One group of arguments is based on the harmful direct *consequences* of drug use to others. For example they will point to the fact that addicts lose control of their life, mistreat their families and are willing to lie and steal in order to continue their addiction. As Mill argued more than 150 years ago, 'the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others'.[50] This utilitarian argument forms the basis of many moral judgements against drug use.

Another group of arguments is based on the idea that it is only through constraint that civilised society is able to maintain social cohesion. This was famously argued by Lord Devlin in his critique of the proposal to legalise homosexual activity.[51] He argued that legislators are obliged to prohibit any act that is viewed as morally repugnant by its citizens, primarily to preserve the society's cohesion.

Another version of the argument is that it is legitimate to prohibit certain activities on the grounds that the activity is inherently immoral. For example, Bennett in the introduction to the first US National Drug Strategy argued that 'drug use degrades human character'.[52] From this perspective it is more significant that the drug addict has lost self-control than that he or she causes harm to others.

Although these distinctions between philosophical positions can be drawn, most advocates of the immorality of drug use will base their reasoning and beliefs on all three types of argument.

Harm to others

A number of the arguments presented below challenge the presumption that the harm caused to others by drug use justifies penalising drug users. These arguments should *not* be interpreted as denying or belittling the harms that drug use causes to people who are not themselves drug users. The harms are real; the argument is addressing two related issues. The first is about balancing the harms of drug use with the harms unintentionally generated by prohibition. The second is whether penalising users and prohibiting drug use are the best ways to minimise these harms.

As pointed out in chapter 1, prohibition itself causes a significant level of harm – to both drug users and non-users. Following a strictly utilitarian approach to minimising harms requires a calculus that can weigh costs of the harms arising as a result of drug use against those that arise as a result of prohibition. This involves comparing incomparables, such as bad parenting by addicts (the result of drug use) against gang turf wars (the result of prohibition). Not only is the calculus impossible, it is also not easy to determine on which side of the equation some of the harms should lie because the direction of causation is contested. For example, is mental illness a precursor to drug use or does drug use cause mental illness; or are both true but in different individuals?

There is also a level of harm caused by drug use in the UK and other advanced economies in the 'producer countries' where drug cultivation distorts the economy, causes environmental damage and corrupts civic society. These harms are largely the result of unintended consequences of prohibition and for this reason are not explicitly addressed in the following sections.

The broad areas of harm to others caused by drug users are crime against others; health costs to society, including mental

health; and lack of fulfilling roles such as parents, employees or students adequately. These are potentially enormous areas of enquiry and dispute that can only be briefly summarised here.

Crime and drugs

It is extremely difficult to arrive at any firm conclusions concerning the relationship between drug use and crime, although it is clear the two are often interrelated. A Strategy Unit report on drugs asserted that a very large proportion of all crime was attributable to heroin and crack addicts.[53] However, this conclusion appears to have been based on extrapolations from inadequate samples of arrestee drug-abuse monitoring. Nevertheless, drug strategy was for a time 'crime driven and treatment led'[54] in the belief that by treating heroin addicts crime could be reduced. As professors Reuter and Stevens point out, 'the apparent lack of correlation between British crime rates and the prevalence of class A drug use means that it may be difficult to discern the effect of drug policy on overall crime rates'.[55] It is known that a number of people convicted of crime test positive for drugs, yet research indicates that many users were offenders *before* they took drugs.[56] There is also a link between prostitution and drug use, with many prostitutes known to sell their bodies in order to buy drugs; but again it is not at all clear which came first.

It has been established that many persistent offenders and addictive drug users have severe personal and social impediments as a result of a deprived upbringing[57] – crime and drug use are related by a prior cause. One advocate of prohibition argues that only about 10 per cent of crime is caused by drugs and that this is either by heroin or crack addicts or by gangs fighting turf wars.[58] Other evidence shows there is clearly some link between crime, particularly acquisitive crime, and drug use; for example, addicts in the Swiss Heroin Assisted Treatment (HAT) programme self-reported a reduction of 60 per cent in crime, a statistic supported by arrest records.[59] Moreover, the fact that a treatment programme that makes drugs legally available has such an impact on the recipients' criminal activity

means it is reasonable to ask whether the cause of the harm is prohibition or the drug addiction.

Those arguing for a different system of regulation point out that much of the crime currently associated with drug users is the result of prohibition. The turf wars between gangs only exist because being outside the law the only way they can settle disputes is through violence. Furthermore, a comprehensive review of all peer-reviewed research on the impact of law enforcement on drug market violence concluded that violence and homicide were increased by increases in the intensity of enforcement and disruption of illicit drug markets.[60]

This brief review of evidence has indicated that the relationship between drug use and crime is far more complex than usually appreciated. There is undoubtedly some crime committed by drug addicts and by drug dealers in fighting turf wars. It is clear that there is a high amount of immoral activity that currently accompanies drug use in society. However, the evidence suggests that this is just as much an unintended consequence of prohibition as caused by drug use itself.

Before leaving this topic it should also be pointed out that assumptions made by campaigners that legalising drugs would eliminate much criminal activity is over-simplistic. In at least one case the argument uses a high estimate of drug-related crime in order to demonstrate large savings achievable by scrapping prohibition.[61] It is not possible to be specific about the unintended consequences of policies that have not been implemented, but it is clear that criminals will not cease to use illegal means of securing income simply because drug laws are changed.

Health costs and drugs

It could be argued that drug users – through their selfish behaviour – cause a disproportionate amount of health costs to be borne by society, and therefore their use is immoral because it causes harms to others – albeit in the broadest sense. It could also be argued that drug use is immoral because it causes individuals to inflict health harms on themselves. There are three major health costs associated with drug use:

- impairment of personal health as a direct result of the drug itself
- a deterioration in mental health as a result of drug use
- some health condition, predominantly HIV and hepatitis, contracted as a result of the way in which a drug has been used

There has been a significant education programme in the UK, supported by needle exchange and other facilities, which has substantially reduced the health costs associated with the third category. It has not eliminated the problem, but has certainly curtailed its impact on health services. It is one of the main areas where governments in the UK and elsewhere have adopted an evidence-based harm minimisation policy, and this has led directly to reduced harm associated with drug use.

Many experts argue, supported by evidence, that the impairment of health from drug use itself is exacerbated by the criminalisation of drug use because drugs are mixed with unknown substances to an unknown degree by criminal vendors. For example, it is well known among health professionals and police that a batch of purer than normal heroin arriving on the market can lead to a wave of overdose deaths. As the Swiss HAT programme has demonstrated, people taking regular doses of pure heroin can lead normal productive lives and do not have specific health problems.[62] A stronger point has been made by Measham and Rolles who point out that in a policy environment in which a heroin user was provided with pure heroin and clean equipment,

There is no link to failing drug producer states; no criminality, profiteering or violence involved in any stage of the drug's production, supply or use; no blood-borne disease transmission risk; a near zero risk of overdose death; and no offending to fund use.[63]

The relationship between drug use and the mental health of drug users is not straightforward. Evidence suggests that in many instances drugs do not cause mental health issues, but often drug use is the result of mental health issues. A significant number of people prone to mental illness, particularly depression, become drug users as a strategy for self-medication.[64]

A sample of crack-cocaine users found that as many as 55 per cent had symptoms of moderate to severe depression.[65] Another study found that heroin users who repeatedly relapsed while in treatment were those with an additional psychiatric disorder (depression, anxiety, obsessive-compulsive behaviour, bipolar or mild schizophrenia).[66] It is also known that people already suffering from psychotic illnesses choose to use cannabis.[67] The particular case of mental health problems that drug use may induce in young people is discussed at greater length in chapter 6.

Inadequate role fulfilment

Inevitably, when discussing the harms caused by drugs the debate centres on the users of heroin and crack cocaine. However, it should be emphasised that these are a small, but potent, minority of drug users. Of the roughly 18 million people in the UK who have ever used drugs about 4.3 million used drugs in the last 12 months.[68] Of this 4.3 million about 300,000 were heroin or crack addicts. The remaining 4 million were mostly occasional users who were fully functioning members of society, although some of the 4 million were also excessive users of one or more drugs and were not fulfilling their potential. The exact proportion of these excessive users is not captured in any of the statistics collected, but would certainly include the 10 per cent of the 3.3 million cannabis users who have been described as dependent users,[69] thus another 330,000 people are being incapacitated by their use of drugs.

Some of the greatest harms suffered as a result of drug use are by the children of addicted parents, not least because it becomes a self-perpetuating cycle of suffering imposed by each generation on the next. The issue is not entirely caused by drugs, since most of the parents involved are dual diagnosis – they have a mental ailment as well as an addiction.[70] It is also the case that in many cases the addiction is to alcohol. Nevertheless, this is an area of severe harm to a very vulnerable group and has always been part of addressing the worst aspects of deprivation and its perpetuation through generations of neglect and abuse. The

current initiatives to tackle 'troubled families' is a continuation of this work and is, rightly, separate from drug policy issues.[71]

Maintaining social cohesion

The argument that drug use has to be prohibited to maintain some sense of social cohesion is the weakest argument among those being considered in this chapter because drug use has effectively become normalised. This is evidenced by the fact that more than half of young people have used illegal drugs and by the prevalence of drugs being used in movies, TV programmes and books. There was even a TV series of a single mother making a living as a drug dealer.[72] Drug use is accepted as part of the celebrity culture, so it is no longer surprising when rock stars, models, movie and TV stars as well as the very rich are reported or caught using drugs.

Associated with the social cohesion argument is the reasoning that activities which 'the majority of citizens find immoral' should be prohibited. This argument has been used to resist reforms to the divorce law, the law prohibiting abortion and the law prohibiting homosexuality. Even though legislation was passed more than 50 years ago, both abortion and homosexuality remain moral issues that divide people, so the differences in deep values have not been resolved. In all these cases there is a profound political problem, namely enforcing a contested moral using the law.

Many have argued against this mode of policy making, on the basis that attitudes to what is 'moral' and 'immoral' have been subject to change over time. It is also clear that some previously stigmatised groups are now regarded as human beings with the normal range of feelings, ambitions and fears. The UK Drug Policy Commission (UKDPC) has pointed out that a similar shift in attitudes to drug users, particularly addicts, is required if treatment is to become more effective.[73]

It is worth noting that the association of drugs with fun and pleasure can be regarded as a way in which drugs, including alcohol, can be regarded as a way of *increasing* social cohesion. However, there is a long history of Puritanism and avoidance of

the prurient that has effectively excluded the consideration of fun and pleasure from 'serious' matters such as formulating policy. There has been a significant shift in this regard over the last three or four decades, but the old attitudes persist, as evidenced by the fact that 'having fun' is dismissed as a trivial benefit of using drugs.

Conclusion

Exploring the basis of judging drug use as immoral has thrown several issues into sharp focus. It has become obvious that many of the worse harms are associated with the minority of drug users who are addicted to heroin and crack cocaine. This group is rightly the focus of a wide range of harm reduction and crime reduction policies. The large majority of drug users do not cause significant harm to either themselves or others.

Looking at the moral argument based on 'harm to others' has directed attention to the presumptions of causation. If all the criminals in jail were criminals as a result of their drug use, if all those drug users with mental health problems had their condition created by drugs, then the harms caused would be overwhelming. However, it is extremely likely that in many cases criminality and mental health problems precede drug use and that all three are powerfully influenced by poverty and exclusion. The issue of causation will be discussed further in chapters 6 and 7. It is also the case that some of the harms are exacerbated or caused by the unintended consequences of prohibition itself.

The moral argument based on social cohesion are less compelling since drug use has become effectively normalised, and the pursuit of fun and pleasure is now accepted as part of a normal, healthy life. Discussion around both issues brought into focus the negative perception of drug users that was a key part of the self-reinforcing system described in chapter 2. The next chapter addresses this directly.

5 Positive drug experiences

This chapter attempts to address the overwhelmingly negative perception of drug use and drug users that exists in public discourse and the media. This was central to the self-reinforcing system described at the end of chapter 2, which sustains prohibition despite myriad examples of its ineffectiveness. The negative perception of drug use and users was also seen to underlie some of the moral judgements against drugs in the last chapter. The aim of this chapter is to put these negative perceptions in a broader context and to provide some contrary evidence.

It is generally accepted that some drugs can enhance socialising and cause a degree of fun. Although it is accepted that drug use may provide short-term amusement and fun, it is not regarded as a source of lasting benefit – mainly because what is experienced is presumed to be illusory. The presumption of illusion is contested by advocates of the use of psychedelics for facilitating mystical experiences; they also cite as evidence the universal use of psychoactive substances in traditional cultures to provide guidance and healing. The approach taken here is to examine the evidence available to support the notion that drug experiences can be beneficial.

The Good Friday experiment

One of the best known experiments, known either as the Good Friday experiment or the Marsh Chapel experiment,[74] was conducted at Harvard by Pahnke on 20 divinity students. Half were given a dose of psilocybin,[75] the other half a placebo. All 20 students participated in a Good Friday service in Marsh Chapel. All the subjects wrote a description of their experiences and were interviewed immediately, several days and six months after Good

Friday. This material, together with questionnaires completed by all the subjects, was used to assess the nature of the students' experiences. Almost all the subjects who received psilocybin reported, and were evaluated as, having profound religious experiences. A long-term follow-up more than 20 years later was critical of the original methodology and used more sophisticated tests on the subjects but came to the same conclusion:

All psilocybin subjects participating in the long-term follow-up, but none of the controls, still considered their original experience to have had genuinely mystical elements and to have made a uniquely valuable contribution to their spiritual lives. The positive changes described by the psilocybin subjects at six months, which in some cases involved basic vocational and value choices and spiritual understandings, had persisted over time and in some cases had deepened. The overwhelmingly positive nature of the reports of the psilocybin subjects are even more remarkable because this long-term follow-up took place during a period of time in the United States when drug abuse was becoming the public's number one social concern, with all the attendant social pressure to deny the value of drug-induced experiences.[76]

The experiment was repeated more rigorously in 2008 by researchers at Johns Hopkins with remarkably similar results.

The most striking finding from this 14-month follow-up evaluation of the effects of psilocybin and methylphenidate administered to hallucinogen-naïve volunteers is that a large proportion of volunteers rate their 'psilocybin experience' as among the most personally meaningful and spiritually significant of their lives.[77]

The group at Johns Hopkins has carried out other carefully controlled and evaluated experiments using psilocybin with adult volunteers. The most recent result they have reported is a significant, and apparently permanent, improvement in subject's *openness* as a result of a psilocybin experience.[78] This is an important conclusion because it helps to explain, or make sense of, several other strands of research using psychoactive substances.

Early research

In the 1950s Stanislav Grof, working in a psychiatric hospital in Czechoslovakia, explored the use of LSD as a therapeutic tool with both seriously mentally ill patients and subjects with much milder symptoms. In all he supervised more than 2,500 sessions in which people received carefully controlled doses of LSD. He reported significant improvements in many patients. His observations are consistent with the subjects becoming progressively more open to their innermost sensations, feelings and experiences with successive exposure to LSD.[79]

The ability of psychoactive substances to facilitate people being more open also makes sense of the Shulgins' reports of the use of MDMA (ecstasy) for couples therapy.[80] Whereas psychedelics like LSD and mescaline create a sensory and intellectual openness, ecstasy seems to create an emotional openness that is profoundly useful for couples in difficulties.

One of the strong themes that emerges from the writings of researchers like Grof and Shulgins is that the psychoactive experiences obtained under drugs need to be consciously integrated into life. The lessons they draw from the use of drugs are not dissimilar to those appropriate to meditation retreats or group therapy processes, both of which also foster a level of openness in participants that cannot be sustained. The point is that when a person is more open that normal they can achieve a valid insight, but it is only when they return to their 'normal' state of consciousness that the significance of the experience and the way it can be put to use in the person's life can be assessed.

Positive drug experiences

Experiments such as those by the Shulgins and Grof – as well as those reported proud admissions by Steve Jobs of his use of LSD – may come as a shock to many people. This is because most news reports and discussions about drug use focus on their harms, or a tragic overdose death. We rarely if ever hear about positive experiences of drugs from those who do not fit the stereotype in public discourse. As Professor Peter Reuter has pointed out, this means that the calculus of decision-making regarding drugs will continue to unduly favour the harms of

drugs. Of course, whether the positives outweigh the harms is an incredibly difficult if not impossible question to answer. But it is extremely important that policy decisions are made from a more accurate and realistic basis. If everyone took a survey of their friends, family, acquaintances or business colleagues – and received frank and honest answers protected by anonymity – then the author contends that many people might be surprised by the number of positive drug experiences revealed.

The sample

To test this theory, the author approached approximately 40 people who were friends, acquaintances or business associates – people encountered during the course of the author's careers in academia and business, as a meditation teacher and leadership tutor. He asked those whom he knew well enough to approach to submit a report of any positive experiences with drugs that they felt had a profound or lasting impact and affected their lives for the better. The average age of those who responded was 49 and their median income was between £45,000 and £60,000 a year. Although roughly equal numbers of men and women were asked to contribute, of those who did so two-thirds were men. All those in the sample are successful professional people, many of whom have above average intelligence and more self-awareness than normal.

These attributes may have contributed to them having more positive drug experiences than 'normal'. As an academic, the author is very aware of the potential bias in this sample; consequently this report does not base any significant findings or recommendations on the results. However, it was felt that pulling the veil back on positive experiences of drug use among professionals is an important aspect of shifting the debate about drug policy. Further research should explore this aspect in a more scientific fashion, using a more representative sample. What's presented below, however, is a first step in addressing this misbalance.

Each contributor also completed a simple questionnaire that gave their age band, income band, occupation and a

summary of their experience with a range of 'recreational drugs'. Most of the respondents had tried, at least once, most of the popular drugs. However the stories submitted are based on the use of only five drugs with more than 80 per cent being based on cannabis, ecstasy or ayahuasca (a South American concoction that has DMT as its active ingredient), with the remainder based on LSD and psilocybin. It is striking that there are no positive stories from the stimulant drugs, cocaine and amphetamines; it is less surprising that there are none from heroin, ketamine, opium or barbiturates. These observations are consistent with the notion that it is openness that leads to positive experiences, and that it is the psychedelics, ecstasy and cannabis that provide this. All the accounts collected as part of this project are available on the web at www.BeingRealOnDrugs.com.

Here is a typical example of someone experiencing ecstasy for the first time in a safe setting. It has been submitted by a psychologist aged 45 to 60 earning between £45,000 and £60,000. He is married and the experience described took place about seven years ago:

I have suffered a major setback to my health suffering a chronic and incurable disease. It has brought me frighteningly close to death several times. As a result, domestic life has been virtually taken over by my medical needs – in the space of four years I have had 20 surgeries. I was in a state of grim endurance.

My wife and I arranged to take ecstasy with two close friends. We took a single tablet with water, then one of our friends asked us what intentions, if any, we each had for the session. Mine was 'to lighten up a bit', to get over this feeling of being completely beaten up by life.

Over the next hour nothing much happened except that I found myself talking quite openly and confidently with the others, moving very easily into interesting conversations. This was a little unusual for me as I am normally quite shy and overly self-conscious in social situations. What had happened, I realised, was that my neurotic self-checking filters (the ones that have to inspect and approve everything I say before I say it, several times over) had dropped away, creating a clear passage for my natural self-expression. I began to trust the ecstasy.

I also began to feel very warm, flushed, and a faint sheen of sweat was now appearing on my face. Yet it was a surprisingly nice sensation. Shortly after the one hour point I felt a new kind of energy frothing up inside me, coursing through my body like champagne bubbles. This was wonderful! It felt so good! So this is what they meant by being 'up'!

I also began to move in time to the music. The music! Oh, the music! It demanded movement from my body, and my body yearned to dance. At this point, though, I became aware of a pressing sensation in my bladder so I decided to go upstairs to the toilet. It was great moving up the stairs so lightly, my constant back pain of recent years having totally disappeared. Before returning downstairs I decided to take a look at my face in the bathroom mirror.

Just at that moment there was a new frothing up of energy. It spilled into my head, my face, and found its way to the muscles around my cheeks. And then it made me do something which was, strangely, almost against my will. It was awakening nerve endings that had lain dormant for ages. It almost hurt as some inactive facial muscles stirred back into life, but here it came…

I smiled.

I smiled the biggest smile of my life.

Looking at myself smiling back at myself, I felt like a newborn infant just smiling for the sheer joy of being. The more I smiled, the happier I felt. And the happier I felt, the more I wanted to smile. This was a huge turning point for me, as I had forgotten what it was like to be really, really happy and relaxed, and I had become resigned to spending the rest of my life in some low emotional flatland. Now I realised just how depressed I had been.

When I trotted back downstairs I was beaming from ear to ear – no, make that from temple to temple, my smile was so big! Everyone looked up at me with delight as I walked into the room. 'I'm BACK!' I cried. And I wasn't just meaning back in the room.

I told my wife that I had a heartfelt desire not only for her to see me being in this state, to enjoy me being at my most open, relaxed and happy, but also for me to carry as much as I could from this state back into my normal life. This was another huge turning point, as we returned to our old close contact and had the deepest mutual understanding we had had in years. We spoke some important truths to each other, all lovingly intended and lovingly received.

The uplifted state stayed with me and took a long time to fade – at least a couple of weeks. It had unleashed in me a rush of joy that was still accessible

when I focused on it weeks later. That little tablet helped me contact joy, revamp my relationship, recover my self-esteem, and have key insights into my mental blocks. It enhanced the quality of my life and made me a better person. I would say this degree of happiness, self-contentment and communion with others is something everyone should experience at least once in their life.

All the reported ecstasy experiences that have been influential in people's lives have had this heart-opening quality. Here is how one person described her experience of the clubbing scene.

This has been contributed by a woman, educated to degree level, who works in arts management. She is aged between 36 and 45 and earns up to £30,000 a year:

The thing that I enjoy most about this undeniably powerful substance is that when I take it I sometimes experience a blurring of the distinctions between what is 'myself' and what is 'other' – it is a feeling of deep unity with my surroundings and the people around me. There is no 'me' or 'them', there is only an 'us'. All judgement is suspended. It is like discovering another realm of connectedness that overlays the normal world – it's always there, but most of the time we can't see it. Sometimes when this happens it is so strong it literally knocks me off my feet and all I can do is sit there observing and enjoying what's going on around me. It is huge and peaceful and carries with it the feeling that this unity between all beings is the only thing that truly matters in this life.

Once I'd had this experience, I found it impossible to go back and see the world as I had previously. Ultimately this changed worldview led me onto a path of self-discovery that has been continuing ever since. Ecstasy is the drug of the heart, and it has opened my heart to a level of experience far more profound than anything I could have imagined existed until I tried it for myself.

Improving relationships

The heart opening also facilitates lasting improvement in people's intimate relationships. Here are two accounts that are typical of many reported in this exercise.

This example has been contributed by a married man, aged between 45 and 60 who, as the CEO of an NGO earns between £45,000 and £60,000 a year:

The ecstasy played a crucial role in opening our hearts in such an unambiguous way to each other, and ensured that we entered a place of radical honesty. We were able to speak our truth with an unfamiliar clarity, and to hear each other at a deeper level without the usual judgement or resistance. We saw beyond the need to justify ourselves, but instead had an intense curiosity to understand. This became a common theme for our ecstasy experiences. On this occasion it was as if a big heavy metal door opened that had closed on our relationship, caught up as we had been in the logistics of busy careers and still unfamiliar parenthood. Looking back on it we wondered whether we might easily have slipped gradually out of love with each other had we not had this wake-up call. As it was, we fell in love again that holiday, but this time with another that we knew so well. We felt in touch with a tremendous truth of connection, the energy flowing between us. That feeling stayed with us a long time – for months.

This example has been contributed by a married man who describes himself as a professional musician. He is aged between 45 and 60 and earns between £60,000 and £75,000 a year:

Ecstasy had the effect of making both of us feel connected to our bodies bringing back a warm physical connection that had disappeared very fast when we were furious with each other! Of course when we woke up the next day all the problems that we had in our lives together had not really gone anywhere, but the way we were communicating and relating was genuinely and totally different, and so we were in a much better place to work out what needs to be done. Sorting out problems from a place of love, feeling on the same side, is radically easier than being in fierce opposition. As a tool for working on our relationship ecstasy was powerful and transformative, and I wish more people were open to that possibility. Whether the drug-induced experience is regarded as 'real' or not is irrelevant – if, afterwards, you are in a different state of mind and that is a positive difference, then hallelujah. That difference is unquestioningly real, and in our case had a very positive outcome.

As mentioned earlier the role of ecstasy in facilitating couples counselling has been known since the 1980s.[81] A report on experiences in a clinical setting with 29 subjects concluded:

In general, it is reasonable to conclude that the single best use of MDMA is to facilitate more direct communication between people involved in a significant relationship. Not only is communication enhanced during the session, but afterward as well. Once a therapeutically motivated person has experienced the lack of true risk involved in direct and open communication, it can be practiced without the assistance of MDMA. This ability can not only help resolve existing conflicts but can also prevent future ones from occurring due to unexpressed fears or misunderstandings. Regardless of the mechanism, most subjects expressed a greater ease in relating to their partners, friends, and co-workers for days to months after their sessions.[82]

It is not only ecstasy that can aid relationships. Here is an extract of a much longer report by an older couple who have been using cannabis to improve their relationship.

This was submitted by a retired professional woman aged between 61 and 75 with an income between £30,000 to £45,000:

There were three helpful effects of smoking cannabis that helped us resolve difficult arguments. The first was that it got us to relax and take everything more light-heartedly – and when we were in a nasty row this alone was always helpful. Secondly it improved the contact between us. By that I mean that we listened to each other more carefully and came to understand each other better – not just intellectually but also emotionally. Finally being stoned made us more open, especially more intellectually open, so that we were not quite as fixed in our view of what had been going on. These were the effects that helped us sort out some of our more difficult issues – issues about how to bring up children, who was responsible for chores, whether one of us was being too generous or too mean – the sort of stuff that can drive couples apart.

One of the side-effects that we noticed was that cannabis also enhanced all our sensations. It made music a lot more vivid, good food was amazingly delicious (but bad food was intolerably bad) and being sexual together was taken to new levels of closeness and experience. We both found that the

increase in the intensity of physical sensations more than compensated for our declining libidos. And because we have been working at resolving the difficulties in our relationship the depth of love between us has continued to grow. This has continued for the last 15 years until now, as we approach our 70s, we are having better sex than ever before.

So when we were discussing how we could contribute to this project, we decided that this is what we wanted to share with other people. We are fed up with seeing 60 and 70-year-olds who have given up on their sexuality and their sexual relationship. Yes one's libido does decline dramatically with age, but there are probably many ways to counteract this – cannabis is definitely one way.

Increased self-awareness

Almost all the beneficial experiences reported included an element of increased personal awareness; usually an insight into the way the subject had been interpreting events or other people, sometimes an understanding of a need or fear and other times a radical reappraisal of the subject's life. Here is an experience occurring at an earlier stage in someone's life.

This has been submitted by a married man who works as a teacher. He is aged between 36 and 45 and earns between £60,000 and £75,000:

When I was 20 and at university I took LSD again with two slightly older friends. We joked around and laughed a lot in the early stages of the experience but I noticed as the trip began to peak these friends went off into their own worlds a little more. We then listened to a lot of music and mostly just sat still; occasionally someone would get up and change the record or make a cup of tea and sometimes we would share what we were thinking, but mostly we just gave each other the space to 'be'. This in itself was something of a revelation – I had not grown up in a family or had friends where anybody was just allowed to 'be'. Normally I would be scared by a situation where people were not fighting for space, but this was different. For the first time since I was a young boy I felt completely in the moment. Within my thinking I was then powerfully struck by all manner of thoughts and revelations about my own life as it had been but also how I wanted it to be. I was able to accept that I was the controller of my own life and destiny and realised it was time to

stop feeling a victim so much. After much introspection I also focused outward and became very conscious of the sheer vastness of the world and the universe. I had a limited life experience and a very small world view, the thoughts and experiences on this LSD trip awakened some deep yearning for more – to see more, do more and be more than I had previously dreamed possible.

Sometimes the insights from the drug experience are not appreciated until after the effects have worn off. Here is an example from a man who felt the real impact the next day.

This account has been submitted by a married man, aged between 36 and 45 who earns about £30,000 as a part-time lecturer at a college of further education:

After the ecstasy had taken effect one of the friends said to me: 'I don't really know who you are.'

Even with my inhibitions reduced by ecstasy this was a very direct personal question, which I would have previously skirted around. I decided not to back away from the question and revealed how life was for me and how scared I was of telling other people exactly how I felt. I had an immediate sense of relief at really being 'seen' by someone else, perhaps for the first time. I am sure making this decision has had the most profound effect on my life.

Later the next day, when I was returning to work, I had what can only be described as an epiphany. I realised that I had built myself into a prison of thoughts about how the world was. It was a world in which I had to keep to my own rules and constructs at all costs. Any ideas of others or thoughts of mine that didn't fit in caused me great conflict. It was as startling as waking up. I realised that my thoughts had little to do with how the world actually was. Me being right or wrong was of no importance whatsoever and in fact my insistence on being right was laughably ridiculous.

Sometimes what subjects see about themselves completely changes the direction of their life. One person reported a series of powerful ayahuasca ceremonies held in the Amazon with two shamans during which his pride and inflated sense of himself was made all too obvious to him. This is how he reflects on that experience.

This example has been contributed by a married man, aged between 36 and 45 who describes himself as a meditation teacher. He earns between £45,000 and £60,000 a year:

In the years that have followed the weeks I spent in the Amazon, the memory of these experiences has never left me. If I find myself blowing my own trumpet or putting someone down unfairly, there is always this quiet voice urging me to take a deep breath and remember. The person who knows me best is my wife, who I have been with for 25 years. She tells me how much those experiences changed me. They made me more open to receiving love, more generous and explicitly loving with her and more humble in my work. I became much more available on an emotional level and far more content in myself. I also became much more open in conflicts, able to see my own part more clearly and take responsibility. In short, my experiences in the Amazon made me a much more genuinely loving person.

From the work of Grof it is clear that psychedelics can lower a subject's barriers to their own unconscious. Here is an example of someone who used this to recover memories of his childhood, of which he had no conscious recollection.

This was submitted by a professional man aged 61–75 earning between £75,000 and £100,000 a year; the experiences described occurred more than 30 years earlier:

I set a clear intention for myself. In the beginning my intentions were rather vague, such as understand more about my childhood before age 11. Later on they became very specific – for example to discover what happened in the kitchen the day that I was so scared without knowing why.

As the psilocybin started to work I experienced tingling in my throat, then a swirling feeling – and then fear. It took me a long time to understand what the fear was about – now I know it was just a fear of letting go. At some point the fear would pass. Then the trip would start! I would often experience intense hallucinations. I would usually be caught up in these hallucinations for a while – and then at some point I would start to have a strong emotion – often sadness. As I allowed the emotion to be there I would suddenly find myself in a childhood scene. I wasn't simply remembering the scene – I was reliving it. I experienced what I saw and felt as a child in vivid detail. I noticed that my voice had changed to that of a child,

especially when I was screaming or crying loudly. I found it amazing – and at first unbelievable. But over time I learnt to trust the process and later was able to verify a great deal by talking to my mother and sister.

Most of the scenes I relived were extremely distressing. I discovered why I had chosen not to remember my childhood. It was brutal, lonely and completely devoid of love. I regularly cried myself to sleep wanting to be held; I was beaten, hit and told how bad I was every single day. It was a fairly typical working-class childhood of parents who had been completely traumatised by the War. I relived feeling terrified, feeling powerless to protect my younger sister, feeling I was unlovable, feeling abandoned and lonely. I kept a journal of what I discovered in each trip and I undertook about 40 trips over a six-month period. Each trip uncovered a different aspect of my childhood – I was literally exploring areas of my psyche that I did not know existed up to that time. I was fascinated, appalled and exhilarated – and it marked the beginning of a complete transformation of who I was and how I was in the world.

Here is the account of someone who had been troubled by a fear of losing his father all his life. At the suggestion of his counsellor he took some ecstasy, asked himself what the fear was about and then relaxed. It has been contributed by a married man who describes himself as a senior IT engineer. He is aged between 36 and 45 earning between £45,000 and £60,000 a year:

Suddenly a very strong feeling engulfed me. Tears began to flow uncontrollably as quite unexpectedly a great realisation occurred to me – namely that the fear I had of my father dying was based on the trauma of 'losing' him in my childhood each time I left him to stay with my mother. The inner 'child' in me had decided it simply could not face that feeling ever again – to the point that death would be a blessed release. And this was the feeling I had been carrying with me throughout my life – that I had borne that loss once and was not prepared to do so again.

I did know that my father took care of me as the oldest of the two brothers when my mother was busy looking after my younger brother as a baby, and at that moment I remembered the bond we had formed in that time and how this was so clearly what underpinned this, my darkest most deep rooted fear – the one that could send me over the edge again and was very likely one of

the root causes of my loneliness, self-loathing and general discontent, which led to my alcoholism.

Now given the facts about my childhood, this 'realisation' might seem blithely obvious to anyone with a vague interest in psychotherapy. I do not deny this – but the point was that I had not been able to see this myself. The fear was so deep rooted that I could not see through it or connect to it to any degree. I had discussed this 'logically' with my counsellor but somehow it did not have any kind of impact – I was quite simply incapable of connecting to it emotionally. The ecstasy seemed to have removed all the barriers I had placed in the way to understanding this simple yet ultimately utterly poignant formative aspect of my childhood and the effect it had on me for all those years.

Problem solving

The key suggestion made by the last subject's counsellor was that he specifically asked a question as he took the drug; the question determines the subject's *intention* in using the drug. This is also a feature of the ceremonies using ayahuasca and was a key lesson from the experimenting with psychedelics in the 1960s. People who have learned this trick about using drugs positively have found it possible to use drug experiences to solve problems, often difficult technical problems. Here is an example of a software engineer who had been stuck trying to solve an important problem for several weeks. He was in danger of not being able to produce the software for the client on time when he decided to get stoned one evening.

This contribution is from a man aged between 36 and 45 who earns between £45,000 and £60,000 as a software engineer:

For the first time I had a wish to dedicate this journey to the specific problem that was bothering me. So there I was, just observing my mind go through it all when suddenly I got it! This was very different than the kinds of eureka moments I was used to as part of a typical 'thinking hard about it' session. It wasn't as if I found a solution but I suddenly knew what the solution was 'like' and where it was at. It's hard to explain. Like overhearing an answer to someone else's unrelated question that somehow sheds light on something meaningful to you. I became very excited and got up to sit at my keyboard

and see if I could translate my insight into something tangible straight away. It didn't take long to see that it wasn't going to work out. I couldn't just switch focus and concentration back on, and sober up just because I wanted to. Back to the sofa then with a notebook and a pen, where I took a few minutes to write down my thoughts – nothing organised or clear, just a bunch of ideas and possibilities.

The next morning I discovered there was no need to read the piece of paper. I woke up with more clarity than when I went to bed. It was as if my mind had had the entire night to play with my stoned insights and was waiting proudly to show me the results as soon as I woke up. By the end of that day I had it nailed, and a few weeks after that I was able to finally finish the project. My clients were very happy with the result, my colleagues impressed with the technical prowess and both my professional confidence and cache where buzzing.

Conclusions

These extracts from the accounts of people who had positive drug experiences make it clear that using some drugs can be extremely beneficial for people. The accounts are not unique. There are about 100 accounts of experiences using cannabis available at www.marijuana-uses.com, a site run by a professor of psychiatry at Harvard, and there are more accounts of positive ecstasy stories in 'E is for Ecstasy'.[83] There are also many accounts of positive psychedelic experiences in the Shulgins' books[84] and on the web[85] and accounts of spiritual experiences in Strassman's book on DMT (the active ingredient in ayahuasca).[86] However, it should be noted that all the contributors to this exercise, and most of those contributing to the cannabis uses website, do so anonymously – for the obvious reason that they are admitting to breaking the law. This reinforces the point made in chapter 2: while the use of these drugs is illegal the only reports heard about their effects are going to be negative – reinforcing the view that they need to be, and should be, prohibited. Steve Jobs, the iconic CEO of Apple, is reported as having said that taking LSD 'was one of the two or three most important things' he did in his life.[87] How many more highly successful people would acknowledge the

positive influence of drug experiences on their life if they were not illegal?

While accounts of outstanding experiences provide compelling evidence of the positive use of drugs, one of the contributors to the project had a different perspective.

This account has been submitted by a married man, aged between 45 and 60, earning between £45,000 and £60,000 a year, who describes himself as a 'provider of personal development courses in Europe, USA and Australia':

Whilst I understand the value of giving specific examples of drug experiences that I've had, I think that it is accurate to say that it is the cumulative, underlying, or overriding effect of these experiences upon my life that has been and remains the most valuable to me. More than any particular moments, although there have been many outstanding ones, there is a way of seeing that I have learnt from such experiences that colours my entire outlook on life, ways of relating to others, and deep-seated spiritual beliefs. It is very difficult to convey such things in prosaic words. It's a bit like being asked to describe dining in a fine restaurant to someone who has never experienced eating.

6 Negative drug experiences

Just as there are stories about positive drug experiences so there are many graphic horror stories of negative drug experiences. They are often not single experiences but rather a steady decline into addiction, poverty, homelessness and crime. This chapter considers the three broad categories of 'negative drug experiences': addiction, mental illness and death. Not all drugs contribute equally to these three risk categories. The aim of this chapter is to identify the risks associated with the different types of drugs and to consider what can be done to reduce them.

Addiction

Addiction is one of the greatest fears associated with drug use; indeed a significant proportion of reporting of drug use refers to addicts or junkies, with the implicit assumption that most drug users are addicted. This is not the case, as the data discussed below make clear, but the fear of addiction plays a large part in the negative perception of illegal drugs. Of course, addiction is not restricted to psychoactive compounds. People can, and do, become addicted to all kinds of activities including eating, gambling, sex, shopping and exercise. People become addicted to *experiences* and lose control of their behaviour in attempting to repeat or re-create pleasurable experiences.

There are a large number of different theories about what causes addiction and how it can be treated. In his comprehensive review of theories of addiction Robert West summarises the evidence supporting the spectrum of different theories.[88] One group of theories assumes that addicted people are making a rational choice to continue their behaviour and that it is only when the costs of doing so outweigh the benefits that they will change this behaviour.[89] There is another group of theories

based on the idea that addiction is a disease and needs to be treated as a medical condition; this includes the self-medication theory.[90] These theories are supported by the evidence that there is an inherited propensity to become addicted. Yet another group of theories focus on the importance of conditioning and learning, and point out that addicts effectively train themselves and that breaking out of addiction requires reconditioning and relearning.[91] There are also theories that relate addiction to personality,[92] to the effects of dopamine in the brain[93] and to social learning.[94] Professor West, the editor of the journal *Addiction*, reviews more than 30 different theories and points out the insights and deficiencies in each. He comes to the conclusion that although each theory has something useful to say about an aspect of addiction, they are all partial theories.[95]

West is able to bring the diverse theories together by recognising that what determines our behaviour is a *complex system* involving our emotional states, drives and motives; our evaluations and beliefs; and our impulses and inhibitions. These all interact with our plans and account for our behaviour. Anything that disrupts the healthy functioning of this motivational system can lead to addictive behaviour. West points out that some people are more prone to addiction because their motivational system is already out of balance, or the environment in which they find themselves undermines the normal checks on behaviour. This accounts for the observable genetic component to addiction and why some groups in society seem to be more vulnerable to addiction, particularly those with low self-esteem and a tendency towards impulsive behaviour. He is able to demonstrate that each of the partial theories of addiction is accounting for a particular mode of failure of the motivational system – and any failure leads to the out-of-control behaviour characteristic of addiction.

Although it is relatively easy to identify extreme addiction, in practice it is hard to measure precisely. In a comprehensive analysis of US survey data, Heyman adopted the definition 'substance dependence' in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.[96] This depends on seven observable and measurable signs related to

drug use, such as tolerance, withdrawal, using the substance even after vowing to stop and so on. Anyone reporting three or more of these symptoms in the previous 12 months is deemed to be dependent on the substance involved.[97] Heyman made use of large sample surveys of the US population that were representative according to ethnicity, residence, income, education gender and other demographic measures. The first sample involved 67,000 people, the second 43,000. The results can be summarised as follows:

- about half of all respondents had used an illicit drug
- 45 per cent had used cannabis; 2 per cent had used opiates (heroin etc)
- the number that had ever been addicted in the whole sample was less than 3 per cent

The probability that someone who had ever used a particular drug would become addicted is summarised in table 3. It is striking that the addictive potential for heroin, about 1 in 5 users, is not much worse than that for alcohol, 1 in 7.5 users. For other illicit drugs the addictive potential is much smaller, around 1 in 20 on average. These estimates are lower than those reported in other studies.[98]

Table 3 **Probability of dependence for those who have used a drug**

Substance	Probability of dependence
Any illicit drug	4.0
Cannabis	2.0
Cocaine	5.3
Amphetamines	5.2
Opiates	19.5
Opiates, GIs in Vietnam	46.2
Alcohol	13.1

Source: Heyman, *Addiction, a Disorder of Choice*

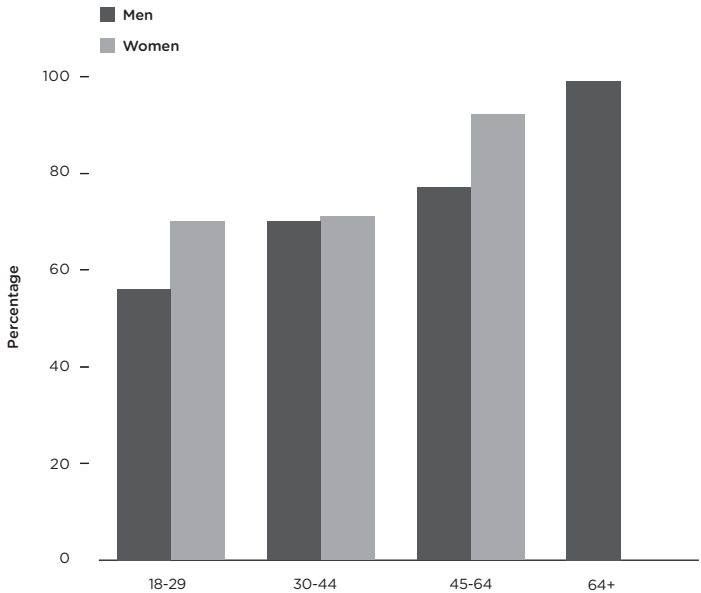
The very high addiction rates for GIs in Vietnam is in part explained by the stress of fighting a war and also by the GIs being in an environment where drug use had become 'normalised'[99] – a point that is included in West's theory of addiction where the environment can significantly contribute to undermining the functioning of the motivational system. It has also been previously reported that most GIs ceased using heroin once they returned to the USA.[100] Incidentally, it was the GI addiction figures that caused President Nixon to announce a 'war on drugs' – it was seriously undermining the war effort in Vietnam at the time.

Recovering from addiction

Heyman derived several other conclusions from his analyses of the large-scale survey data, including a demonstration that growing up in a deprived neighbourhood significantly increased the probability of becoming addicted to any of the psychoactive compounds. However, his most striking results were obtained from other large-scale surveys that explored relapse and remission rates among those addicted. The first survey (1980–84) covered 19,000 subjects; later surveys (in the 1990s and 2001/02) involved 8,100 and 9,300 subjects, respectively. The results are summarised in figure 9 and show that by about age 37 approximately 70 per cent of those who ever met criteria for dependence are no longer reporting any symptoms. This conclusion is supported by the later surveys; indeed they show slightly higher remission rates. Heyman pointed out that this rate of remission is largely independent of any treatment, since only about 16 per cent of those reporting dependence had obtained treatment. His conclusions from these large-scale surveys were in sharp contrast to the conventional wisdom – that drug addiction is a chronic relapsing condition that resists treatment.

In exploring the data Heyman was able to show that *relapse* rates by addicts in treatment are significantly greater than those by addicts not in treatment. This is the opposite to what is expected and the difference is not due to different substances

Figure 9 **Remission rates for illicit drug dependence by age and gender**



Source: Heyman, *Addiction, a Disorder of Choice*

being involved in the two groups, nor is it accounted for by differences in the length of time that they have been addicted. Instead Heyman discovered that the main difference is that addicts in treatment are far more likely also to suffer from an additional psychiatric disorder. He concluded that it is the repeated failure of treatment for these people suffering from mental illness *and* addiction that accounts for the widespread belief that addiction is a chronic relapsing condition that resists treatment. He also provided strong evidence that the key to facilitating recovery in those *not* suffering from an additional mental illness is to provide them with a very strong incentive backed up by regular drug testing. This is consistent with West's theory of addiction.

Both West's theory and Heyman's data analysis cast addiction in a very different light from the conventional stereotype. First, for all drugs other than heroin, the probability of addiction is significantly less than that for alcohol. Second, most people who become dependent on a drug are able to give it up without treatment. Heroin is the most addictive drug and the heroin users who become stuck in addiction are likely to have an additional psychiatric disorder that makes it much harder for them to recover. It should also be noted that the majority of these problematic addicts lead chaotic lifestyles and are usually homeless or living in hostels: they are an extremely vulnerable and excluded group.

Mental illness

A preliminary discussion of the relationship between drugs and mental illness was begun in chapter 4 where it was pointed out that for some people their use of drugs could be regarded as a form of self-medication, so for that group it is mental illness that leads to drug use rather than the other way around. Heyman's work on addiction supports this link for some of those addicted to drugs, particularly those whose addiction continues past middle age. However, in terms of negative drug experiences and drug policy it is the proposed link between young people using strong cannabis and psychotic illness that is regarded as the more significant risk.

This issue has been thoroughly reviewed by the Advisory Council on the Misuse of Drugs (ACMD), but it did not reach any definitive conclusions.[101] It is not in doubt that very large numbers of young people use cannabis; from 1996 to 2004 more than a quarter of 16–24-year-olds had used it in the last year, though this figure has recently fallen to less than 20 per cent. It is also the case that 'skunk' style cannabis is between two and three times stronger than the historically used resin and grass. Skunk also has a particularly *low* concentration of cannabidiol, which is known to act as an *anti-psychotic* agent.[102] It has also been established that the use of cannabis can precipitate a relapse in people who have a history of schizophrenia, indicating

a potential link. Interviews with people suffering a psychotic episode were found to be 18 times more likely to have used skunk than a control group.[103]

However, over the period 1996 to 2005 the prevalence and annual incidence of schizophrenia and psychoses has decreased.[104] A similar result has been observed in an Australian study over a period when there was a dramatic increase in cannabis use but no evidence of an increase in schizophrenia.[105] The ACMD concluded that there may be a causal relationship between use of cannabis at an early stage and the later development of mental illness, but that the relationship is complex and not yet driving any increase on schizophrenia or psychoses. The ACMD also noted that since the majority of young cannabis users do not develop mental illness there must be a predisposing factor in those that do.

There is also a concern that current skunk users may develop mental illnesses in the future. The concern arises as a result of studies that show that tetrahydrocannabinol can affect brain development, which may cause permanent changes in the developing brains of adolescents.[106]

Although scientific evidence of causation is indeterminate it is possible to explore the issue further in order to understand what could be done to better protect young people from the psychological ill-effects of all drugs, not just cannabis. The main reason why young people are particularly at risk is that their brains are still maturing and they have not yet developed a strong sense of self, which makes it harder for them to integrate the material that surfaces under the influence of drugs, particularly hallucinogens. From the work of Grof,[107] and the link to increased openness reported in chapter 5, it appears that drugs enable people to access previously unconscious material. Most psychoanalytic theories presume that material is suppressed and made unconscious because it is too difficult for the individual to assimilate. Once a person has matured and developed a strong sense of self, then surfacing that material can be beneficial (as exemplified in some of the stories recounted in chapter 5). However, young people who resurface such material may experience a new level of distress or breakdown. So

although there may not be scientific or statistical evidence to confirm a direct causation, there is a broad body of psychological theory that makes such a link psychologically understandable, even likely.

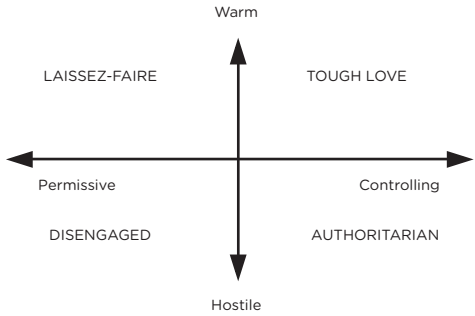
Young people at risk

One implication from this approach is that the young people most at risk are likely to be those who have experienced the most traumatic childhoods, generally those from deprived neighbourhoods, often with a single chaotic parent who may be mentally ill or addicted or both. They can, and often are, identified early in their lives as being at risk not only from drugs but also from alcohol, poor school achievement, irresponsible sex and crime. The particular activity through which they end up in trouble is not the source of their problems; the prime cause is the lack of parenting and deprivation experienced in their early years. At a workshop convened to explore the best ways to protect young people[108] it was noted that the best that could be done for these young people was to help them to manage risk in their lives better – for example through cognitive behavioural techniques that help build 'character' skills such as sticking to a task and the ability to delay gratification.

A more general conclusion about young people at risk can be derived from a recent Demos study into binge drinking.[109] The study explored the effect of parenting style, both in the early years and in the teenage years, on the propensity to binge drink. The study used two axes of parenting style, parental warmth and level of discipline, to identify four parenting styles, as shown in figure 10. Using two sets of longitudinal cohort data they explored the effect of parenting style on drinking behaviour at age 16 and later in life. The main conclusions can be summarised as:

- high levels of parental warmth when the child is under 5 significantly reduces the chances of excessive drinking at age 16
- disengaged parenting at age 10 makes the child twice as likely to drink excessively at age 34

Figure 10 **The four parenting styles used in the study of binge drinking**



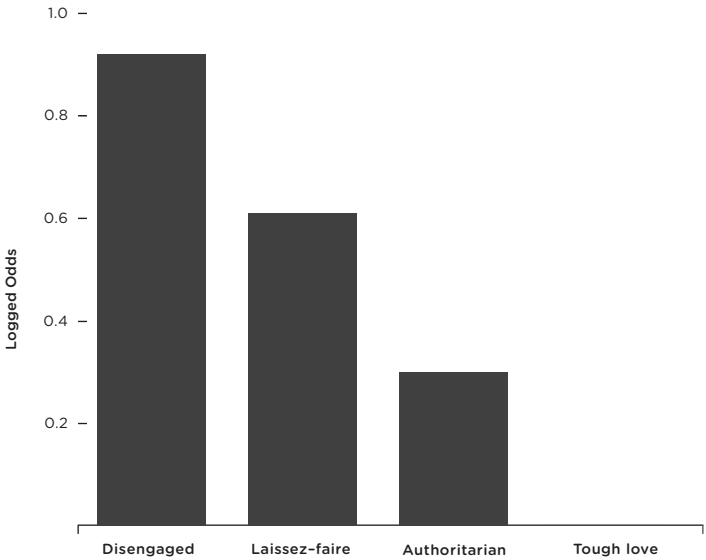
Source: Bartlett et al, *Under the Influence*[110]

- disengaged parenting at age 16 makes the child over eight times more likely to drink excessively at that age; this result is shown graphically in figure 11

It is very likely that the same conclusions will apply to the probability of young people using drugs excessively since the growth in determined drunkenness followed the demise of the ecstasy and dance culture.[111] If this is the case then one of the strongest influences on young people's drug use is the style of parenting, a result that needs to be communicated to parents worried about their children's use of drugs.

At the workshop on 'how best to protect young people' held as part of the Demos project[112] on 'legal highs' those present reported a number of problems with advice being given to young people. The first was that a lot of young people ignored official advice because it ran counter to the experience of their peers. The second, acknowledged by officials present, was that it was extremely hard to give two different messages at the same time, one saying 'don't use drugs' and the other saying 'if you use drugs here is how to do it safely'. To some degree the official website Frank overcomes this by headline messages directed at

Figure 11 **Odds of excessive drinking at age 16 by parenting style when child was 16**



'not using' and providing guides for young people who are already users.[113] The cannabis guide (which is surprisingly hard to find) provides advice on recognising dependence and 'how to stop', but nothing on the warning signs that a user would experience if they were starting to show signs of mental illness.[114] Similarly there is virtually no advice for young people exploring hallucinogens, such as LSD, on how to do so safely or how to help someone having a 'bad trip'.

It is obviously dangerous for young people with immature brains and a maturing sense of self to experiment with powerful psychoactive compounds. However, it is also essential that we acknowledge that half of them are likely to do so before they are 25 and so should provide them with advice on how to minimise their risks and recognise when things are starting to go seriously wrong.

Deaths

One of the strongest furores around drug policy was initiated by Professor David Nutt, then chairman of the ACMD, when he wrote, 'Drug harm can be equal to harms in other parts of life. There is not much difference between horse-riding and ecstasy.'[115] Politicians and some of the press were outraged by the comparison because horse-riding was in the category of acceptable risk-taking pastimes whereas taking ecstasy was regarded as some combination of immoral, dangerous and depraved. The pronouncement eventually cost Professor Nutt his position on the ACMD, which triggered a crisis in the relationship between scientists serving on advisory bodies and the government. So it is clear that this is a sensitive area and one in which prejudices can easily override 'evidence'.

The first observation to make is that ascertaining the *cause* of death is extraordinarily hard, particularly when it is established that the subject had used a drug before death. The Office for National Statistics publishes a table of 'The number of deaths where selected substances were mentioned on the death certificate'.[116] In the caveats applying to the data it is pointed out that:

- about a third of all drug-related deaths also mentioned alcohol use or abuse on the death certificate
- where the death certificate mentions more than one drug it is impossible to attribute a definite cause and the death will be recorded under each drug mentioned (thus multi-counting the death)
- about 7 per cent of drug-related deaths do not specify any particular substance

Table 4 summarises these data for 2009 for England and Wales. For comparison the numbers of deaths attributable to tobacco, alcohol and road traffic accidents are included.

It is clear from table 4 that heroin, morphine and methadone account for the majority of the deaths attributable to illegal drugs. (Heroin and morphine are combined because they cannot be distinguished at autopsy. Methadone is the opiate used as a substitute for heroin in treatment.) Apart from these

Table 4 **Deaths from drugs of all types and other causes, 2009**

Deaths related to drug poisoning	
Heroin and morphine	880
Methadone (opiate substitution treatment)	408
Medicines	
Anti-depressants	405
Sleeping pills (all types)	353
Pain relief	288
Paracetamol	255
Cocaine	202
Amphetamines (excluding ecstasy)	49
Ecstasy	27
Cannabis	22
GHB/GBL	16
Total all deaths from drug poisoning	2,878
Deaths from tobacco[117]	86,150
Deaths from alcohol[118]	6,769
Deaths from road traffic accidents[119]	2,222

Source: ONS, *Statistical Bulletin: Deaths related to drug poisoning in England and Wales* 2010[120]

three drugs the number of deaths from the use of illegal drugs is small in comparison with those from alcohol, tobacco and road accidents, and small even compared with the deaths from medicines (though these include a number of intentional overdoses). As regrettable as any death is, in comparison with other risks people willingly take, most drug use is not high on the list.

It should also be noted that in the list of deaths in table 4 that prescription drugs, listed as medicines, account for almost half of the total. In the USA the number of deaths from prescription drugs has been a rapidly increasing problem for the last two decades and is now greater than the number of deaths from road accidents.[121] Of growing concern in the USA is the number of teenagers using prescription drugs to get high:

'Prescription drug abuse by teens is exceeded only by marijuana, and there are just as many new abusers and older of pain relievers as there are for marijuana.'[122]

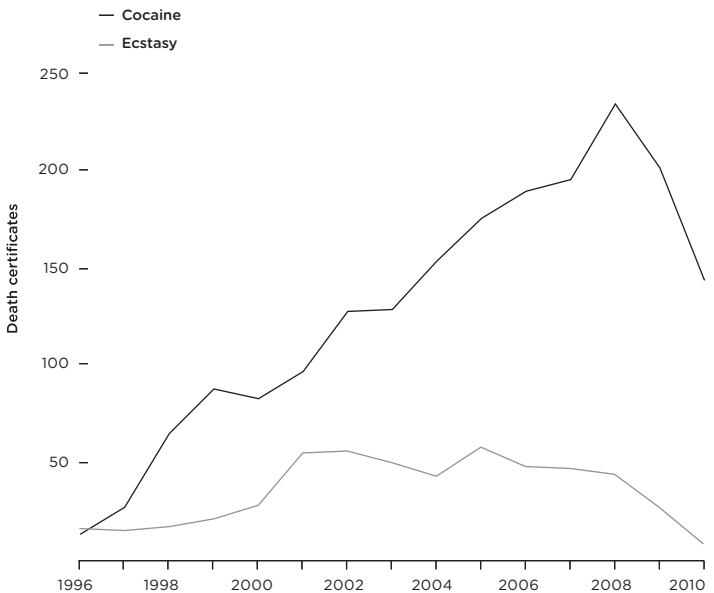
Drug purity

In chapter 1 it was asserted that making drugs illegal increased the risk to drug users because the drugs they purchased from criminals were diluted to an unknown degree with unknown substances. One of the reasons why there is a high incidence of deaths from heroin is that the difference between the dose that will create a 'high' and a lethal dose is about a factor of 2. With drug dealers adulterating their wares it is all too easy to make an error of this magnitude in deciding how much to use.

The data on drug deaths can illuminate another aspect of this effect. Figure 12 shows the trends in cocaine and ecstasy deaths in England and Wales since 1996. There is a significant increase in the number of deaths from 2000 to about 2008 with a significant decrease since then. According to the BCS the number of ecstasy users increased slightly between 1996 and 2001/02 and has steadily declined since then, with the numbers now using the drug about the same as in 1996. For cocaine, the number of users trebled between 1996 and 2000 and has increased by about 25 per cent since then, with a slight decrease since 2008. So the changes in numbers of deaths cannot be explained simply by the number of users.

There is anecdotal evidence and some documentary evidence to suggest that from about 2000 onwards the purity of cocaine and ecstasy declined significantly.[124] As a result users either increased the quantity they used or elected to complement their dose with alcohol or other drugs. This could explain the increase in deaths up to 2008. The explanation that has been proposed for the decline since then is that the then legal high, mephedrone, also known as meow meow, was used as a substitute for the impure cocaine and ecstasy available.[125] The analysis was based on the screening of army personnel, which clearly demonstrated a substitution. This was confirmed by the annual survey of drug use by clubbers carried out by MixMag.[126]

Figure 12 **Number of death certificates that mentioned cocaine and ecstasy in England and Wales, 1996–2010**



Source: Bird, 'Ecstasy's lethality has increased'[123]

The *Statistical Bulletin of Drug Poisoning Deaths* in 2010 included, for the first time, five mentions of mephedrone on death certificates. It also reported that the listing of ecstasy on death certificates had fallen to just 8 from 44 in 2008. The reduction in cocaine reports on death certificates was from 235 in 2008 to 144 in 2010.[127] On the face of it the use of mephedrone yielded a net *reduction* in drug poisoning deaths of about 120 a year. The most significant difference between the drugs was that while mephedrone was legal it was also extremely pure. As soon as it was banned the samples seized were found to be impure[128] and the latest MixMag survey indicates that clubbers are returning to use cocaine and ecstasy.[129]

Conclusions

Addictions, mental illnesses and deaths brought about as a result of taking drugs are devastating on the families of those involved and it is right for the public to be fearful of these potential outcomes. However, as the analyses and arguments presented in this chapter have indicated, they are not inevitable outcomes of drug use and a great deal more could be done to reduce their occurrence. The people who become stuck with heroin addiction are among the most vulnerable in society, many also suffering from a mental illness. Recognising this, perhaps more could be done in assisting them to have functional lives. Young people are at risk when using drugs, because of their physical and psychological immaturity, but current advice on drugs leaves them without advice on warning signs and their parents without advice on how to head off a disaster. In the case of drug deaths there is evidence pointing to the low purity of drugs as a prime cause. In all these instances the unintended consequences of the criminalisation of drugs and drug users is exacerbating the problems, not alleviating them.

7 Taking stock

This chapter has three main aims. The first is to explain the significance of the different perspectives operating in the drug policy domain and how these make it far harder to achieve a consensus on which to build more effective policies. The second is to review the arguments presented in the previous chapters and obtain a 'bigger picture' of what is occurring. The third aim is to extract some principles on which future drug policies could be based.

When there are profound disagreements about a social issue there is a danger that the debate between the different views can become so polarised that each side of the argument 'shouts past each other'. Furthermore the disagreement can be used to dismiss any argument or evidence from 'the other side'. It is very likely that someone committed to the prohibitionist view on drugs would dismiss much of the evidence and argument in the preceding chapters on the grounds that it is clearly 'pro-legalisation'. The label is enough to discredit anything that is said – whether or not the conclusion is pro-legalisation. These symptoms occur in all debates about contentious social issues by people on all sides of the debates – especially where the beliefs and values at stake are regarded as very important by the participants. Obvious examples outside the drug area include abortion, gay marriages and women bishops.

Some aspects of the polarisation have been touched on in chapters 4 and 6, but it is useful to explore the issue further here in order to appreciate the obstacles to achieving any consensus on drug policy. Current policy is based on the prohibitionist perspective, so any critique of current policy is presumed, by those who support it, to be an attack on prohibition. This is regarded as a serious threat because the prohibitionist position is based on values that regard drug use as inherently bad. In

support of that value judgement they will cite drug use as destroying families, generating addiction and mental illness, and fostering criminality. From this perspective the idea that drug use might be regulated differently would be a disaster because it would increase the number of families destroyed, people addicted and estates ruined by criminality. The point to be emphasised here is the presumed direction of causation: it is drug use that causes these negative outcomes.

Presumptions about causation

Many of the data and arguments presented in the previous chapters have been challenging this presumed direction of causation. It is normal for disagreements on social issues to boil down to disagreement about the direction and strength of different causes. Box 1 summarises the differences that emerged in a study of anti-social behaviour on deprived estates in Manchester.[130]

Box 1

Anti-social behaviour

The different views about the causes of anti-social behaviour in Manchester are summarised below. These short descriptions do not do justice to either the strength of feelings involved, or the more subtle aspects of the perspectives involved. However, they are sufficient to demonstrate that each perspective is well articulated and clearly has some evidence to support their view on what is the cause of the problem.

Enforcers

This is the group that wanted to adopt a zero tolerance approach to anti-social behaviour in general and youth nuisance in particular. They wanted to establish very clear boundaries of what is acceptable and to enforce those boundaries with the force of law as necessary. Youths who, in their view, terrorise old women should not be exempt from the use of criminal sanctions. They regarded those who object to

anti-social behaviour orders (ASBOs) and criminal sentences as part of the problem – it is their liberal attitudes and failure to impose boundaries on children that has led to the current problem. They regarded tough sanctions as effective deterrents.

Distracters

According to this group youths have always been mischievous, and probably always will be. The root of the problem is that now they do not have safe ways to let off steam. This group argued that what was needed were supervised activities and channels where the youngsters can channel their energy creatively. They see a large part of the problem stemming from general lack of youth facilities and the early closure of those that do exist. They also regarded demonising and criminalising children as the worst possible response to the problem and likely to foster more bad behaviour.

Parenters

This group maintained that it was wrong to blame or punish the children who cause trouble because the people who are really at fault are the parents. They saw the problems stemming from poor parenting, in particular a failure to impose and enforce normal boundaries of acceptable behaviour. So for this group the way forward was to hold parents more accountable for the behaviour of their children. They supported the use of tenancy agreements and acceptable behaviour contracts, which if breached meant that the entire family was evicted. For this group focusing on the children is letting the real villains get away.

Deprivation

This group point out that the problem of youth nuisance occurs on deprived estates – middle-class suburbs are largely free of the problem. This group maintained that the real problem is families living in poverty. This means that there is often

insufficient space in the home for the children to play or study, and there are not the usual resources of books and games available, so it is not surprising that the children are out on the street causing mischief. All this is aggravated by the poor condition of the deprived estate, the poor quality local school, the widespread use of drugs and incidence of criminality in the impoverished community. This group regarded punishing the children of these impoverished families as inappropriate and as being advocated by people who do not want to see or address the underlying cause – poverty. The solution they proposed was to take measures to address the poverty.

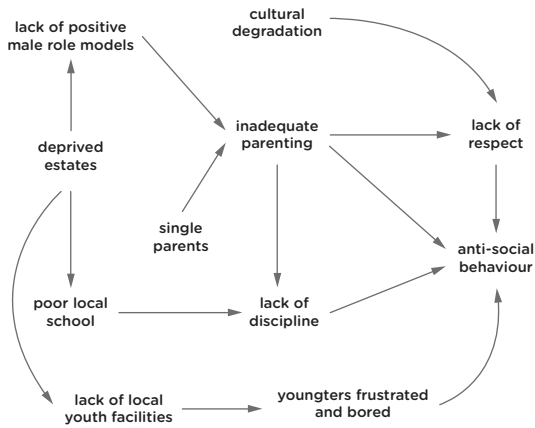
Cultural breakdown

This group regarded youth nuisance and the whole spectrum of anti-social behaviour as symptomatic of the loss of value and respect in modern culture – a trend they see reinforced by the media, TV, computer games, rap songs and celebrities behaving badly. They pointed out that many of the youths involved in nuisance do not have a father at home; the only male role models they see are drug dealers. They do not see how we can expect young children to behave appropriately when their parents fight and divorce, when common courtesies are regarded as antiquated, and crime and violence is glorified. For this group youth nuisance is a symptom of cultural breakdown and therefore a distraction from the core issue – which is finding ways to reinstate traditional values of respect.

In the arguments between the various protagonists in the anti-social behaviour debates everyone presumes that their account of events, their theory of what causes the problem, is the only one that is correct and that all the others are wrong. In fact, it is more productive to start from the presumption that each of the different perspectives is valid but provides only a partial view of what is happening.

The 'bigger picture' of what is occurring is that *all* the proposed causes are operating and taken *together* they explain

Figure 13 **A simplified representation of some of the interacting causes that account for anti-social behaviour**



Note: Each arrow should be read as 'causes' or 'leads to'.

both how anti-social behaviour arises and why it is so difficult to address. It is poverty *and* lack of facilities *and* poor parenting *and* loss of cultural norms *and* cheeky kids out of control that lead to anti-social behaviour. Addressing only one of the causes will not eradicate anti-social behaviour – though it may offer some slight improvement.

What is more, the proposed causes themselves interact and in many cases reinforce each other. Poverty and deprivation is one reason for the lack of facilities and poor local schooling; single parents are generally poorer than average and find it harder to discipline and control their children; and the loss of cultural values is reinforced by the lack of positive male role models on deprived estates. So there is a complex system of interacting causes from which anti-social behaviour emerges. Figure 13 shows a part of this system.

Earlier, in chapter 6, Robert West's account of addiction was able to show how each of the individual theories of addiction illuminated one way in which a person's motivational system could be thrown out of balance – and it was the out-of-balance system that generated addictive behaviour. Here we have each theory of anti-social behaviour illuminating one of the many causes that interact together to produce the undesirable behaviour. In both instances the individual accounts were not wrong, they were just incomplete.

Over-simplification

In the case of drug use there is a complex system of interactions between mental illness, addiction, criminality, youth culture and pleasure seeking that yields a host of different outcomes, some of which are clearly undesirable. In this case the dominant theory used to explain what is occurring is based on a prohibitionist position. Like the individual theories of addiction and anti-social behaviour, it is not wrong, but it is incomplete.

Over-simplification: prohibitors

It is overly simplistic to presume that drug use is the cause of addiction, of mental illness and of criminality among drug users. As the evidence in the earlier chapters has indicated, there are multiple causes at work, some in the opposite direction to that presumed by the prohibitionist position. While it is certain that some users become mentally ill as a result of using drugs it is equally certain that some people with mental illness self-medicate with illicit drugs to alleviate symptoms – and it is often these people who become stuck in long-term addictions. It is also true that some people may become criminalised as a result of their use of drugs, though in this case the most likely sequence of causation is that a conviction for drug use makes it harder to find employment which leads to a life of crime – in this case the undesirable outcome is as a direct, but unintended, consequence of prohibition itself. There is also no doubt that there are causes originating in poverty, deprivation, exclusion and traumatic

childhoods that are contributing to the complex system in which drugs are used and from which negative outcomes emerge.

Over-simplification: legalisers

It is not only the prohibitionist view of drug issues that is over-simplified. Many of those advocating the legalisation of drugs assume that doing so would dramatically reduce street crime[131] and turf wars and eliminate the income that current criminal organisations obtain from drugs.[132] This is naive and falls into the same trap of presuming that there is a single cause for street crime and for turf wars and that once drugs were legalised there would be no black market organised by criminals. It is alarming that people seriously advocating a change in policy are presuming that a change in the law will persuade criminals to give up their criminality!

There is a profound problem at the root of the legalisation argument – pricing. If drugs were regulated and taxed to be cheaper than current black market prices then use would increase, which would increase levels of addiction and accidental deaths and so on. If the price is kept high then the existing black markets would continue with all the problems described earlier in the report. The point is that in highly complex systems all simple solutions will generate unintended consequences, which may dwarf other benefits.

Over-simplification: harm reducers

Even in the harm-reduction approach there can be a presumption of simple causation in the scientific approach to collecting and assessing evidence. As illustrated for anti-social behaviour, there are usually multiple causes for any outcome and in some cases strong feedback loops that invalidate simple statistical correlation techniques. Furthermore, in social policy it is impossible to define in any scientific sense what constitutes harm or how to compare harm perceived by one person as against that perceived by another; these are all contested issues. One of the claimed successes of the harm reduction approach is

the widespread use of methadone treatment for heroin addicts and it 'has stronger evidence of effectiveness that any other intervention for drug use'.[133] However, as a critic of the approach has noted, 'In Edinburgh, for example, where methadone is widely used as a treatment for heroin dependency there are now more deaths associated with methadone than with heroin.'[134] The point is not that the harm reduction approach is wrong, just that where it presumes simple causation it too is over-simplified and can mislead.

Facing up to complexity

The attraction of overly simplistic theories is that they avoid facing the complexity, ambiguity and uncertainty that usually pervades persistent social issues. Facing complexity and ambiguity is uncomfortable. Furthermore, if complexity and ambiguity are acknowledged then it is much harder to be certain of what to do, harder to carry conviction and to present simple convincing arguments. Everyone, including politicians and policy makers, prefers certainty and a clear course of action that will yield the required results.

However, if the complexity in a situation is not taken into account there is a profound consequence, namely that any intervention or policy will generate a host of *unintended consequences*. Each cause or interaction not considered in the formulation of the policy will lead to an unintended outcome. The inverse is also true: a large number of unintended consequences deriving from an intervention or policy is a good indication that the theory on which that policy was based was over-simplified – it either ignored or overlooked a significant number of interactions.

The strong conclusion from this line of argument is that current drug policy is based on an over-simplified theory of how the world of drugs and drug users works. That is why it generates the large number of unintended consequences documented in chapter 1.

Achieving consensus

Drug policy is not unique in having a number of different factions; the polarisation is extreme, but not unusual. There are two core reasons why the polarisation is extreme and achieving consensus so difficult. The first is that each position is based on different values. The prohibitionists regard drug use as immoral and inherently corrupting. The legalisers regard it as a greater sin to remove the right of adults to imbibe intoxicating substances if doing so does not lead to harm to others. The harm-reducers regard the prime role of policy is to minimise the harms caused to self and others by drug use. The differences in values mean that each of the protagonists will attribute different weights to different interventions and outcomes.

The second reason is that each group of protagonists is convinced that they are right. They have evidence to support their view of the way the world works that, in their view, proves the validity of their arguments and defeats the arguments put forward by other groups. Just as in the anti-social behaviour case, each perspective can gather sufficient evidence to make its case compelling – at least to its supporters. And this is because they are not wrong – the evidence they adduce is usually right – but their theories and explanations are incomplete.

It is this combination of having deeply held values and a perspective that has concrete evidence to support it that convinces each group of its own rectitude – and makes it so much harder to achieve any sort of general consensus on drug policy. However, there is a way for a more limited consensus to be achieved.

Finding consensus

An example of a limited consensus occurred in the systems workshops run as part of a previous project on drugs policy.[135] The people attending the workshops represented both the spectrum of views on drug policy and, significantly, different ways of engaging with drug users. So there were people from the police, workers from charities working on the street, academics, policy makers, professionals from the ACMD and so on. In general discussions there was little agreement, but when the

group was asked to address a specific objective, such as how best to protect young people, then the principled differences were set aside and they were willing to pool their experience and evidence in order to work out how best to meet the objective. It was important that the objective did not of itself violate anyone's principles.

In the second workshop in the same project the specific objective addressed by the group was how government should respond to the apparently endless stream of new psychoactive compounds. In this case seeking a new form of regulation did trespass into the values of the prohibitionist member and made group consensus harder to achieve. Nevertheless, everyone was able to contribute to the debate, and their evidence and perspective was incorporated. This is significant since it is only by including all the different perspectives that a policy can integrate all the different interactions and chains of causation. Each perspective pays particular attention to the interactions that support its own conclusions, so by aiming to accommodate all the different perspectives there is a far better chance of developing a policy that takes all the interactions into account, and is therefore less likely to generate unintended consequences.

Addressing the complexity

Employing a process that seeks to include all the different perspectives on an issue is the first step towards addressing the complexity of the situation since it facilitates the inclusion of all the different interactions. However, there is another source of complexity that is regularly overlooked in complex social issues and it involves *differentiating* significant differences between agencies or groups of individuals. This is illustrated in the case of anti-social behaviour in box 2.

Box 2

The disputed role of ASBOs

During a workshop on anti-social behaviour a fierce argument emerged between one group who felt that anti-social behaviour orders (ASBOs) were effective at discouraging future bad

behaviour and another group who asserted that ASBOs were used as tokens that enhanced the reputation of the youths involved. After a few heated exchanges a youth project worker, who ran projects with some of the youths on one of the deprived estates, intervened and drew a key distinction between gang leaders and followers. He asserted that for gang leaders ASBOs were ineffective and did indeed often enhance the leader's reputation, but for the 'followers' the threat of an ASBO was often sufficient to bring the youth under control. This was a significant intervention because it allowed both sides to have their position affirmed without making the other side wrong.[136]

In the case of drug policy it is essential to differentiate between different groups of drug users; imagining that a single policy can cover clubbers, heroin addicts and youngsters trying cannabis is a gross over-simplification and guaranteed to generate unintended consequences. The groups will have different motivations, will respond differently to incentives and sanctions, and are at risk in very different ways. In an ideal world it would be best to devise a policy for each group that recognised the harms and benefits involved, addressed the motivations and vulnerabilities of each group and used the most appropriate regulatory regime to minimise harms and unintended consequences. In practice it will be difficult to devise legislation that targets different groups, but a combination of age and drug(s) used could provide a reasonable basis for addressing the key differences. The key groups against which the impact of drug policy proposals should be evaluated are:

- young people who have not yet used any drugs
- young people who are using drugs, usually cannabis
- clubbers and festival goers, who primarily use cannabis, ecstasy and powder cocaine
- occasional professional users who primarily use powder cocaine and cannabis
- old hippies who use cannabis and psychedelics
- heroin and crack cocaine addicts

Another source of complexity lies in the ever increasing number of psychoactive substances that have been banned: there are more than 600 on the current list.[137] What is more, there are now between 10 and 40 new substances added to the list each year. As explained in the previous study into 'legal highs', the steady supply of new compounds brings the whole process of banning and classifying into disrepute, as evidenced by the furore over mephedrone and the subsequent evidence (presented in chapter 6) that it reduced drug deaths.[138] Many of the conclusions from that study are reinforced by the data and arguments here.

Conclusions

As in other contested areas of policy, the advocates of different positions are able to cite valid evidence to support their position and conclusions. Each perspective is not wrong, but it is incomplete. This means that the separate perspectives are over-simplified compared with the actual situation. Policies based on over-simplified perspectives generate many unintended consequences because they are not taking into account all the interactions and complexity present. The fact that current drug policy generates a significant number of unintended consequences is an indication that it is based on an over-simple approach.

In order to address the complexity that exists in the area of drug use it is essential:

- to recognise the valid arguments and evidence associated with different perspectives and rather than choosing one perspective to aim to create a 'bigger picture' that is a more complete representation of the issue
- to differentiate between different groups of drug users, each with different motivations and responses to policies
- to achieve a consensus by focusing on specific low-level objectives, such as protecting young people

8 Conclusions

In democracies there is an ideal, and a long history, of resolving policy differences by adversarial debate with the winner chosen on the grounds of the most compelling arguments supported by the best evidence. However, as the preceding chapters make clear, this process fails where the issue involved has a high level of complexity – in the sense of a high level of interconnectedness – and different perspectives so their proponents disagree about the nature of the problem, the goals of any improvement and how to achieve them. The rich interconnectedness enables advocates of each perspective to select evidence that appears to support their explanation of what is occurring, and reinforces their view that they, and only they, are right. The adversarial process fails because it is reduced to a choice between these perspectives, each of which is based on a *partial* understanding of the issue. Policies based on such partial understandings generate unintended consequences and do not produce the intended outcomes. In other words, they are a recipe for policy failure, as we have seen.

A more comprehensive understanding of the issue needs to be based on an appreciation of both the rich interconnectedness and the insights within each of the different perspectives – it needs to be a synthesis of the perspectives, not a choice between them. This has been the thrust of all the arguments and evidence assembled in relation to drug policy in the previous chapters.

Moving beyond morality

Not all policy debates are resolved by rational argument; some are resolved by choosing between different moral positions or value systems. Prohibitionist drug policies have their origins in moral arguments about the destructive effect of drugs. A moral

position remains evident in the strong negative perceptions and reporting of drug use, a process reinforced by prohibition as explained in chapter 2. The moral position is reinforced by the presumed negative consequences of drug use that arise as a result of a partial view of the complexity around drugs. A more detailed examination shows that in many cases mental illness and propensities to addiction and crime *precede* drug use. It is clear that a significant number of negative unintended consequences of prohibition also cause harm. So a moral position based on harm becomes less tenable. It is further undermined by the normalisation of drug use among young people, with half of all 30-year-olds having used illegal drugs at least once – which also causes doubt about any moral consensus concerning drugs.[139] The moral aversion to drugs also ignores the fact, evidenced by the accounts in chapter 5, that drug use can have a strongly *positive* effect on the lives of some users. All these factors mean that it is problematic to base a drug policy on a moral judgement.

As argued in detail in chapter 2, the prohibition of drugs and criminalisation of users has created a self-reinforcing system which reinforces its own propaganda. In particular, prohibition has effectively suppressed all debate of alternative ways of reducing the negative effects arising as a result of a large fraction of the population using drugs. Without any well-reasoned alternatives available there is an understandable fear that moving away from the current position could make matters much worse. In part this is also based on a set of presumptions about causation, which are not supported by the evidence available.

Overcoming stereotypes

In order to escape from this self-reinforcing system it is necessary to break the feedback loops that hold it in place. Central to this is rehabilitating the image of drug users. The current stereotype of a heroin user is as 'a half-crazed junkie, neglecting their young children and stealing to feed their habit', but this only fits less than 2 per cent of drug users[140] – those who are addicted to heroin or crack cocaine. For this very vulnerable group current policy amounts to a 'war on drug users' and they are subject to

stigmatisation and exclusion, which severely restricts their ability to recover and reintegrate into society.[141]

The stereotypes of other drug users are for cannabis users as 'lazy and unproductive potheads' and for LSD users as 'loopy and dreadlocked acid heads'. However, the vast majority of such users are regular citizens, with good jobs, most in happy relationships, many with healthy and well-loved children. Almost all these drug users experimented with drugs as teenagers and use them less as they mature and gather responsibilities. By the time they are in their late 30s and early 40s their drug use may have ceased altogether or be reserved for one or two occasions a year. The occasional use of drugs by this group enhances the fun in their lives and may, as exemplified in chapter 5, produce life-enhancing experiences.

A key distinction between these two groups, apart from the sheer numbers, is that the drugs used by the groups are very different. Whereas cannabis and ecstasy enable the user to become more open, heroin and other opiates effectively close the user to external input; they are being used to blank out reality rather than enhance perceptions. All too often the key distinctions between these groups of drugs and groups of users are lost in the political debate and press reporting on drug issues.

It may appear insignificant to be proposing that the starting place for improving drug policy is to change the way that drug users are talked about and perceived, but as has been demonstrated in other instances, such as racism and homophobia, the way issues are discussed does condition how they are thought about – and this powerfully conditions what is done. For the largely excluded group of heroin addicts the key is to engage in a sympathetic way that supports recovery. For recreational drug users the key is recognising that they are otherwise regular citizens.

As well as shifting the image of drug users it is also necessary to have, at least in outline, some alternatives to the current policy so they can be thought about, discussed and even researched. In order to initiate this process the remainder of this chapter will explore three aspects of drug use as examples of alternative approaches. The first is the therapeutic use of

psychoactive drugs and is related to the history and positive drug experiences described in chapter 5. The second is an expansion of the ideas for an alternative method of regulating drugs, which was started in the previous study that looked at the issues around so called 'legal highs'. The third is the protection of young people. This builds on one of the workshops conducted in the previous study and on the relevant research reported earlier, particularly in chapter 6.

Examples of alternative approaches

Therapeutic use of psychoactive drugs

This is a useful example to explore precisely because it casts some of the psychoactive drugs, such as cannabis, ecstasy, LSD and psilocybin, in a completely different, and potentially positive, role. These drugs affect individuals powerfully, and this potential can be harnessed therapeutically if carried out in the right setting. There are no reported benefits from the therapeutic use of the stimulants (cocaine, amphetamines) nor the narcotics (heroin, opiates) other than pain relief, again reinforcing the need to distinguish between drugs in considering policy options.

There is a substantial body of literature establishing the medical uses of cannabis,[142] sufficient to persuade 17 different states in the USA to pass legislation permitting its use.[143] Cannabis is not regarded as a cure for any specific diseases but as a way of ameliorating the symptoms of a wide range of ailments. The symptoms for which it is regarded as most useful are pain relief, loss of appetite and the amelioration of nausea.

Chapter 5 referred to some of the recent research using psilocybin at Johns Hopkins University. Other studies have explored its use for treating obsessive-compulsive behaviour and extremely painful headaches, known as cluster headaches, with some success.[144] These results are similar to those obtained using LSD; one recent review noted:

Recent behavioural and neuroimaging data show that psychedelics modulate neural circuits that have been implicated in mood and affective disorders, and can reduce the clinical symptoms of these disorders. These

findings raise the possibility that research into psychedelics might identify novel therapeutic mechanisms and approaches.[145]

A recent review of LSD therapy for alcoholism has concluded that a single dose of LSD can be effective in treating the condition.[146] For the last 40 years the exploration of these possibilities has been effectively outlawed by prohibitionist drug policies.

One of the striking results from the limited survey of positive drug experiences reported in chapter 5 was the frequency with which ecstasy was the drug that prompted the positive experience. This is consistent with the results reported by the Shulgins[147] and the work of a group of Swiss psychiatrists reported by Holland.[148] The Swiss psychiatrists treated 121 patients over a five-year period. More than 90 per cent of the patients described themselves as improved, with 65 per cent 'significantly improved'. The review concludes that ecstasy aids the therapeutic process in four ways:

- by improving the connection between client and therapist (and in couples' work between the partners)
- by enhanced recall of difficult or traumatic experiences
- by sharpening the faculties and enabling people to make important personal insights
- by helping people accept themselves and those they relate to better

These attributes are all present in the stories used in chapter 5. It is a serious loss to not have this drug available as a therapeutic tool.

Out law or in law

One of the most damaging effects of *out*lawing drugs is precisely that they are moved *out*side the law. It means that all these drugs are produced by criminals, moved around by criminals, sold by criminals, doctored by criminals and used by criminals (since by definition all users are breaking the law). *The state has no effective*

means of control at any stage. For a large part of the population to be subject to a market that is entirely outside state control is neither safe nor sustainable. And the situation simply becomes ever more unsustainable as the trade in drugs becomes global, available on the internet with ever-increasing numbers of new synthetic compounds of unknown toxicity available. *Taking Drugs Seriously* concluded that government should:

consider a radical reform of the measures for the control of psychoactive substances to provide an overall and integrated framework for controlling the supply of all potentially harmful substances – including alcohol, tobacco and solvents – perhaps through a Harmful Substances Control Act.[149]

This conclusion has been reiterated in evidence given to the Home Affairs Committee by leading members of the UKDPC.[150] Dame Runciman and Roger Howard make the point that there is a case for considering control through consumer protection legislation, for example through trading standards or the Medicines and Healthcare Authority. At present, by selling psychoactive substances as 'plant food' internet sites are effectively unregulated, a position that would not be tolerated if the products contained alcohol or nicotine. The point here is that by casting psychoactive substances *outside* consumer legislation, consumers are left less protected.

In a background paper to the Global Commission on Drug Policy, Mike Trace, a former deputy drug czar in the UK, came to a similar conclusion: 'greater control of supply, demand and related problems can be achieved through moving to a regulated system of distribution'.[151] Whatever system of regulation is employed it will be enforced with criminal and civil sanctions, so the change is not 'legalising' all use of these substances; rather it is bringing them under control whereas at present they are entirely out of control. A 2009 report by the charity Transform, entitled *After the War on Drugs: Blueprint for Regulation*, details a number of different regulatory regimes that would include a range of safeguards, including illegal sales to individuals below the age of 20, bans on advertising, zoning restrictions for

proprietors, and legal responsibility among suppliers and distributors for abiding by laws regarding the content and distribution of psychoactive substances.[152]

It is beyond the scope of this project to derive specific recommendations in this domain. However, from the preceding discussions it is clear that the regime needs to distinguish between the major groups of drugs: the 'openers' (cannabis, ecstasy,[153] hallucinogens), the 'stimulants' (cocaine, amphetamines) and the 'close downers' (heroin, other opiates). It would also make sense to include pharmaceutical compounds within the same scheme since the chemicals and issues overlap substantially.

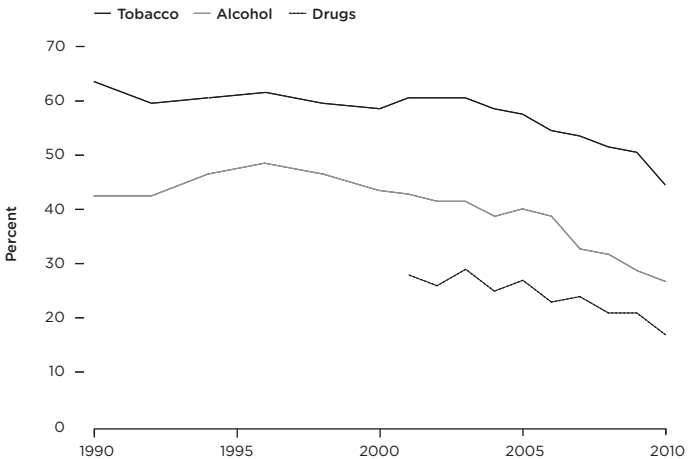
Protecting young people

The first step is to establish what is known about young people and their use of drugs. One of the surprising trends is that since about 2000 the proportion of young people using drugs has steadily declined. There is a similar downward trend in the proportion of young people drinking alcohol and smoking cigarettes. Despite these trends being good news, no one actually knows what is causing them. This is of concern since the trends could just as easily reverse. As pointed out in chapters 1 and 3, the trends in drug use by young people appear to be indifferent to the classification of different drugs and the enforcement regime – at least to the degree that changes do not have any effect on the trends in use (figure 14).

A surprising result has emerged from the longitudinal study of a cohort of children all born in the first week in April in 1970. The cohort has been examined regularly throughout their lives, and recently they were asked about their drug use. It emerged that the pupils most likely to use drugs were those with *the highest IQs*. The results are striking, as evidenced by this extract:

At age 30, about 35% of men and 16% of women said they had smoked marijuana at least once in the previous year; over the same time period, 9% of men and 4% of women said they had taken cocaine. Previous-year drug users tended to have scored higher on IQ tests than non-users.

Figure 14 **Trends in the percentage of pupils using alcohol, tobacco and illegal drugs**



Source: Fuller (ed), Smoking, Drinking and Drug Use Among Young People in England 2010[154]

The IQ effect was larger in women: women in the top third of the IQ range at age 5 were more than twice as likely to have taken marijuana or cocaine by age 30, compared with those scoring in the bottom third. The men with the highest IQs were nearly 50% more likely to have taken amphetamines and 65% more likely to have taken ecstasy, compared to those with lower scores.

And these results held even when researchers controlled for factors like socioeconomic status and psychological distress, which are also correlated with rates of drug use.[155]

Another surprising result is that the vast majority of young people obtain their drugs from friends and family; in another sample questioned only 6 per cent purchased drugs from an unknown seller.[156] This explodes the myth of the 'pusher' at the school gate and emphasises that drug use has become a social activity for many pupils.

Having explored what is known the next step is to look at the potential harms and benefits. Here is an account by one of the respondents in chapter 5 recounting a teenage LSD experience:

During my teenage years I became very withdrawn and disconnected from my family. As a result of this, at a time when many teenagers are building their identity I felt that I was losing what identity I did have. I was very susceptible to outside influences and somewhat lost. I experimented with alcohol and drugs and in amongst this teenage experimentation I took LSD at a party at the age of 17. I was completely blown away by the sheer 'otherness' of the experience – having thoughts and feelings that my 17-year-old self struggled to fully take on board. I felt that the LSD had liberated me from many of the pre-conditioned thought processes and mental traps that I was in and it opened up an enormous sense of possibility. For the first time in my life I saw that life was really something to fully experience and that having many different experiences could be the key to fulfilling something deep within myself.

This account indicates that there may be benefits in addition to the obvious one of socialising and having fun. If the benefits are not recognised then any conclusions will be biased – and discredited in the eyes of young people who hear of the benefits from their peers.

It is known that there are two groups of young people most at risk from taking drugs. The first are those who have a history of mental illness in the family or who display a level of mental frailty. This latter group can include exceptionally gifted children who find it hard to integrate into peer groups because of their abilities. The whole group can be helped by being given clear guidance on self-diagnosis of their risks and the warning signs of deterioration.

The second group at risk are those who have had a traumatic childhood, often as a result of deprivation or/and abuse. This group is known to be at risk from a spectrum of activities, not just drugs, and can be helped best by early intervention to assist individuals to manage their risky behaviour. For this group making an activity illegal is certainly not a deterrent – it may even provide an incentive.

For both groups the negative consequences of drug use do not appear immediately but only as a result of prolonged and regular use. Before triggering a serious mental illness there are warning signs well known to street workers, which include paranoia, a tendency to isolate themselves and to focus on 'blanking out' rather than having fun and socialising.[157] As pointed out in chapter 6, none of the official advice on drugs to young people provides these warning signs. If government was serious about protecting young people it should convey a more complete message along the lines,

If you take drugs you are taking a serious risk with your mental health. If you do decide to risk it here are the warning signs of something starting to go wrong. If you start seeing any of these, then stop using, otherwise you might spend the rest of your life in a really bad state.

There should also be advice on how to use hallucinogens safely and what to do if a friend experiences difficulties with any drugs.

Following the careful evaluation of a number of currently available information-based programmes aimed at young people Babor and colleagues concluded:

An interesting question is why we persist with information based or other ineffective prevention programmes. Part of the answer may be that the most important audience for these programmes is not the young people who are the putative beneficiaries, but concerned adults, especially parents of adolescents, who wish to see something being done that they think is likely to be effective. Hence we end up with programmes that send the messages that parents think most appropriate for their children, rather than programmes that might be of some use to young people.[158]

It is known that adolescence is a time of rebellion, exploring boundaries, developing relationships and risk taking. Most parents find the teenage years troublesome because although the adolescent is starting to behave as an adult, including sexually, they have not yet developed an adult way of being in the world. The teenage years are a period of

developmental transition, and for parents, mentors or teachers to be effective they need to understand what it is that is changing. The transition has been described in detail by Kegan.[159]

A key feature of the transition is that the teenager makes sense of the world *through* their relationships, whereas an adult is someone who *has* relationships. (In a similar way very young children experience the world *through* their emotions and it is only later that they become beings who *have* emotions.) This makes sense of why peer group expectations are the dominant factor in determining adolescent behaviour – and why messages that make sense to parents are ineffective for adolescents. This also goes some way to explaining the success of the 'tough love' approach described in chapter 6 (see figure 11): it maintains the relationship with the teenager through 'warmth' and provides clear boundaries for them to operate within. It is interesting to note that the 'tough love' approach is the one that requires the greatest time and effort from parents; it is often parents too busy with their careers who end up with children in trouble with drugs. Again, none of this advice is provided on government websites or in official publications.

What emerges from this brief review of what is known about young people and drug use is sufficient to give parents advice on the best way to proceed, sufficient to improve the information provided to young people (basically ignoring what parents might want to see said) and sufficient to initiate a research programme to discover how to be even more effective. These are the key research questions:

- Why has drug and alcohol use among young people decreased since 2000?
- Why do young people who do not use drugs choose not to do so?
- Why is it the children with higher IQs are most likely to use drugs?
- What are the features of youth culture that encourage drug use?

There is also scope for developing better self-diagnostic tools for young people and for exploring different styles of early

intervention for the severely at-risk group who have had a traumatic childhood. The outcome will not be drug-free schools, but it might be better protection for those most at risk, parents better equipped to handle teenage drug use and some respect for official advice on drugs for young people. In short, there would be a host of very useful improvements.

It is instructive to note that in this example it was feasible to develop a set of actions and policies that would improve the protection of young people without engaging at all with the debate about prohibition, legalisation or decriminalisation.

Finally

It is conventional for reports of policy projects to conclude with a series of clear policy recommendations for consideration by officials and politicians. The aim of this report has been different: it has been to give an account of the complexity of the system that the drug policy of the last 40 years has created and to demonstrate that simple 'solutions' are simply not available. So there are no simple recommendations to make. The existing system is clearly not working, both in its own terms and in a wider sense of protecting citizens and young people, which is why there is a growing volume of calls for change. However, before politicians can entertain changing policy in this area there needs to be a shift in the way that drugs and drug users are discussed and thought about. It is not a question of being hard or soft on drugs, what is required is to be real on drugs. If this report begins that process then it will have made an important start on a critical process of change.

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It is now 40 years since the introduction of the Misuse of Drugs Act, and in the words of the Global Commission on Drug Policy, 'the war on drugs has been lost'. Despite billions spent, drug use has not been reduced. This pamphlet uses systems theory to examine why, uncovering a debate locked between two fundamentally opposed perspectives: prohibition and legalisation.

Being Real On Drugs starts from the position that these different perspectives are not wrong, but incomplete. Part of the complexity of the 'system' of drugs policy derives from these perspectives; without appreciating them policies will continue to generate unintended consequences. According to systems theory, such consequences arise whenever policies are based on an inadequate appreciation of how a complex system operates, or when a system evolves and policy fails to evolve in step. This pamphlet argues that both are the case when it comes to drug policy.

Rather than choose between the different perspectives, the report aims to synthesise them. This requires politicians to shift their way of thinking and talking about drug users, a shift that should include more honest consideration of the positive benefits of drug use. What is needed is a different way of thinking and talking about drug policy, one that recognises the reality of drug users and the full spectrum of drug experiences available. It is not a question of being hard or soft on drugs; what is required is to be real on drugs.

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