EDITORIAL

Drug policy reform – the opportunity presented by 'legal highs'

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Summary Current UK policy on drugs does little to reduce the potential harms to young people using drugs and in some ways can exacerbate them. The dramatic increase in the number of new psychoactive substances available in the UK carries the risk of increasing those harms and demands a new approach to drug regulation. The All-Party Parliamentary Group for Drug Policy Reform calls for an independent drugs classification body, the introduction of a new category for psychoactive substances whereby their supply can be regulated and a review of the government lead for drugs to ensure a health focus. The Group's proposal and supporting evidence are set out in full.

Declaration of interest None.

Britain's young people face considerable risks as a direct result of the UK's drug policies. We have to accept that a substantial minority of young people will use drugs whether they are legal or not. Indeed, some will be attracted to a particular drug because it is illegal. At present, cannabis, ecstasy as well as heroin and cocaine are in the hands of the same illegal drug dealers who have every incentive to encourage their young, unsuspecting clients to take the more 'exciting' (more expensive and more dangerous) drugs than the cannabis or ecstasy the young people are generally seeking. Those same dealers have an incentive to mix their drugs with cheaper, and sometimes very dangerous, contaminants. The use of rat poison and paint stripper to dilute cannabis or cocaine is the worst example. In 2009, some ecstasy tablets were found to contain none of the basic ecstasy ingredient, 3,4-methylenedioxy-*N*-methylamphetamine (MDMA), at all![1]

For 50 years drug policy throughout the world has been controlled by the United Nations (UN) conventions on drugs of 1961, 1971 and 1988. These conventions have ensured that the possession, use, production and sale of a long list of drugs are criminal offences, with all the undesirable consequences alluded to above. The UK policy followed the 1961 UN Convention with the passing of the 1971 Misuse of Drugs Act, which provided for the criminalising of users as well as dealers in drugs. The policy of the 1960s and 1970s was informed by a moral position that drug-taking is undesirable and therefore should be punished. I would agree that drug-taking is undesirable. The problem is that we all do it. How many of us can honestly say that we never take alcohol, smoke a cigarette or take coffee or tea? We take these things not primarily for their taste, but for their mind-altering properties.

The aim must surely be to reduce as far as possible problem drug use (addiction), whether problem use of an illegal or legal drug. Alcohol addiction is more harmful than addiction to almost any illegal drug.[2] We need to devise policies which will lead to the least harm from drug-taking. If a policy change could lead to a widespread switch from more dangerous to less harmful drugs, we would welcome that. Little or no evidence existed in the 1960s and 1970s to indicate whether or not the policies adopted would actually achieve the desired objectives. Instead of reducing drug use, the implementation of the UN conventions has coincided with catastrophic increases in drug use. In England alone, the number of dependent heroin users increased from about 5000 in 1975 to 281 000 in 2007.[3] And if we look at the international picture, drug use has risen faster under prohibition than at any time in human history.[4] We now have a global illegal drugs market worth more than US$350 billion to the terrorists and criminal drug gangs involved.[5]

Having said that, there is no easy solution to the drug problem. Some illicit drugs are extremely harmful and can be life-threatening, as indeed are legal drugs such as alcohol and tobacco. I would certainly not wish to advocate a policy which could lead to increased problem drug use or increased harm to the public. It is therefore very important to consider such evidence as exists across the world about alternative drug policies. And, of course, there is limited evidence because of the strong control of the UN conventions and the International Narcotics Control Board (INCB) which monitors the implementation of the conventions. Any country exploring more liberal drug policies has suffered the opprobrium of the INCB.[6]

In the following paragraphs I will consider:

(a) cannabis as a special case because of its particular association with psychosis; I include this section because any policies must cater for cannabis, the most widely used drug;

(b) the risks and opportunities presented by the influx of new psychoactive substances which I shall refer to by their popular name, 'legal highs'; and

(c) the policies proposed by the All-Party Parliamentary Group for Drug Policy Reform following an inquiry into 'legal highs'.

These proposals represent a practical way forward towards a safer drug policy.

Cannabis

Although cannabis is considerably less harmful than alcohol, it is more harmful than ecstasy, for example.[2] On the international scale of harms initially developed by the Independent Scientific Committee on Drugs, David Nutt is clear – cannabis scores high on drug-related damage and drug-related impairment of mental functioning, mostly because of the harms associated with smoking cannabis with tobacco and the drug's links with depression and psychotic symptoms.[2] Having read a great deal of the research evidence on the association between cannabis use and mental health, I believe that Professor Nutt's analysis is balanced and as reliable as it can be with the present state of knowledge on the subject.

Nutt concludes that probably the biggest effect of cannabis on people's lives is a general sense of demotivation and a lack of enjoyment of activities when not intoxicated. If cannabis is used regularly, it can affect performance. The big question is whether or to what extent cannabis can cause psychosis. The answer is not straightforward because cannabis does, while the person is intoxicated, create psychotic types of experience. Researchers need to be very clear whether they are measuring the acute short-term effects of cannabis use or the development of a psychotic illness. A confounding factor is that many young people in the early stages of the development of a psychotic illness may be attracted to cannabis because it does seem to relieve some of the negative symptoms of a psychotic illness[2] (which will tend to predominate in the early stages). Parents understandably assume that it has been the taking of cannabis that caused the psychotic illness, whereas the causal relationship may, at least in some cases, be the other way round.

The second confounding factor is that the incidence of schizophrenia seems to be reducing in the general population[2] and yet cannabis use has increased twentyfold over the past 40 years,[2] and skunk (a potent form of cannabis with high levels of tetrahydrocannabinol (THC)) has been available for 10 years. If there were a causal relationship, you would expect the incidence of psychosis to have increased quite substantially.

Many patients with psychosis do like to take cannabis because, although it may exacerbate the voices they hear, the drug helps with tension and anxiety and helps them to think more clearly.[2] I understand that cannabis can upset the medication regime. Would it be better for patients to be able to be completely open about their cannabis-taking, so that this can be factored into the medication plan?

What does all this mean for policy? We should, in my view, have a serious debate about whether the regulation of cannabis, with clear labelling of risks and side-effects; a lower age limit for consumers; and controls over the THC content of the regulated substance would reduce rather than increase the risks to users. When any young person can find as much cannabis as they want and people are prepared to take it despite its status as an illegal drug, perhaps the situation cannot get worse.

Risks and opportunities presented by the influx of new psychoactive substances ('legal highs')

New substances are emerging on to the market at an extraordinary rate. The European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) early warning system logged 24 entirely new substances in 2009, 41 in 2010 and 57 by November 2012.[7] The number of 'head shops' increased fourfold across Europe in just 2 years.[8] The majority (two-thirds) of the 'legal highs' detected are synthetic cannabinoids and synthetic cathinones, with synthetic cannabinoids representing the largest single group.[2] Although cannabis remains the most used illicit drug in the UK, levels of use have been declining moderately from a very high level since the mid 1990s as the use of legal highs (many of which do not appear in the British Crime Survey) has increased markedly.[9] A pan-European study showed that 10% of young people in the UK had taken a legal high in the previous year (the figure for the rest of Europe was 5%).[10]

The majority of synthetic substances are produced in China, although some come from India.[11] They usually come in the form of 1 kg packets of white powder.

The research evidence presented to the inquiry undertaken by the All-Party Parliamentary Group for Drug Policy Reform suggests that young people turn to new psychoactive substances when drugs such as ecstasy and street cocaine become too contaminated.[12] The greatest risk posed by the new drugs is that as one psychoactive substance is banned, another springs up, then another and another. Ivory Wave, for example, had in it three different psychoactive substances over an 18-month period.[11] Each new substance may be more harmful than the one it replaces. But more than anything, young people are taking substances whose content and strength are unknown to them. The risks of harm, particularly overdose, must be greater than for tried and tested substances.

The name on a package tells the user nothing about its content. Bubble, for example, is widely used in the north-west. Its contents vary from week to week,[13] although young people assume that Bubble is a single drug. If one week the strength of the substance is twice the strength of the previous week, the risks to the user are obvious. A particular concern relates to synthetic cannabinoids which bind to some of the same receptors in the brain more strongly than cultivated cannabis. It is less clear how long the synthetic cannabinoids remain active and even less clear how they may influence the relapse rate of serious mental illnesses.

The risks for young people presented by legal highs are very real. But our inquiry panel regard these substances as also presenting an opportunity to explore and extend evidence-based drug policies. The government introduced temporary class drug orders in November 2011. These orders, which last for 1 year, prohibit the supply of a legal high in the UK but do not affect the possession or use of such a substance – at a stroke, the government have

introduced the policy of decriminalising the possession and use of substances, the supply of which is illicit. Whereas decriminalising possession and use of the well-known drugs (e.g. ecstasy), although eminently sensible on the basis of the evidence of risk, would be regarded as a big problem by politicians, the same policy applied to synthetic versions of such drugs seems to be acceptable. If it can be shown that such a policy does not have adverse consequences, it may pave the way for similar policies to be applied to other drugs. Of course, we know from the Portuguese decriminalisation of drugs for more than a decade that, taking account of the level of drug use in neighbouring countries which still criminalise the possession and use of drugs, Portugal's drug use does not appear to have increased as a result of their policies.[14] Nevertheless, to have experience and evidence of the decriminalisation policy here in the UK would be helpful.

Policy proposals of the All-Party Parliamentary Group for Drug Policy Reform following the inquiry into 'legal highs'

After 40 years of unsuccessful drug policy driven by the 1971 Misuse of Drugs Act, a raft of reports were published within a month of each other in December 2012 and January 2013: the report of the Home Affairs Select Committee which recommended a Royal Commission on Drug Policy;[15] the report of the British Medical Association (BMA) which recommended that drug addiction should be regarded as a medical problem rather than as a crime;[16] the report of the UK Drug Policy Commission which recommended a review of drug policy;[17] and the All-Party Parliamentary Group for Drug Policy Reform report *Towards a Safer Drug Policy*,[11] which recommended changes that have been widely regarded as sensible and feasible, and for which we argue that the evidence already exists.

Our first recommendation is that temporary class drug orders should be of indefinite duration and renamed accordingly. When a full risk assessment of a new substance can take many years to complete, there is no rationale for 1-year orders. Extending the decriminalisation of possession and use of legal highs also makes eminent sense.

Reform of the Advisory Council on the Misuse of Drugs (ACMD) is necessary if we are to achieve rational decision-making likely to result in reduced harms to the users of drugs. At present, the scientists on the ACMD analyse the risks associated with any drug and make recommendations to the politicians about the appropriate classification of the drug. Politicians then decide the classification. The result has been a classification table which bears no relation to the relative harms of different drugs and which is therefore ignored by young people. A paper by three eminent scientists and widely quoted[18] included a table of substances based on their overall harms to users and others. Ecstasy is very near the bottom of the table and yet it is a Class A drug. Alcohol, at the top of the table, is legal, whereas cannabis (less harmful than tobacco) is Class B. We have to find a way out of this mess.

We have two excellent precedents for the establishment of independent decision-making bodies to make decisions which are deemed too politically sensitive to be left in the hands of politicians. The first is the National Institute for Health and Care Excellence which decides which treatments shall be funded by the National Health Service, on the basis of scientific analysis of the costs and benefits of each treatment. The other example is the Monetary Policy Committee which decides the level of interest rates each month, again based only on the analysis of the experts.

Of course, politicians would still be responsible for the overall framework of drug policy. However, in the context of an independent decision-making body responsible for the classification of drugs, sensible decisions could be made about which drugs should be controlled in different ways. For example, a Class D could be introduced for those drugs which would be appropriately controlled through regulations. It would then be for the independent body to decide which drugs would best be controlled in that way. New Zealand is introducing such a class.[19] Suppliers in New Zealand will be responsible for proving that the substance they wish to sell is of limited harm to users. They will also have responsibilities to package and label the substance, providing all the necessary information needed to protect users. Consumers will not be criminalised. If cannabis and ecstasy substitutes were initially placed in a Class D and it could be shown that the harms of these drugs to users were very much lower than the harms of illegal cannabis and ecstasy which would continue to be purchased from drug dealers (with all the risks this entails), then the policy could be extended to more traditional drugs.

Finally, in line with the thinking of the BMA,[16] the All-Party Parliamentary Group for Drug Policy Reform is calling for the lead department for drug policy to be reconsidered. If drug addiction is a health problem – and it is – then it cannot make sense for the Home Office to drive policy to deal with it.

A cross-party agreement should be possible on all the proposals discussed here.

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