Drug Use and Policy

Introduction

The United Nations (UN) estimates that 250,000,000 people or 5% of the adult global population used an illegal drug at least once in 2015 and, as this figure fails to include legal drugs such as tobacco and alcohol, we can be sure that drug-use is widespread in society and its impacts can be seen on a local, national and global scale.[1]

It is widely accepted that the so-called 'War on Drugs' has failed, yet governments and policy makers continue to adopt punitive and enforcement-led strategies on drug use, with the aim of achieving a 'a drug-free world'. This approach has not only failed to achieve its goal of reducing drug production and consumption but has contributed to an increase in the physical, economic and social harms of use. There are alternatives to this current approach. Rather than an enforcement-led strategy we can adopt a public-health led strategy; instead of criminalisation, we can treat users in clinics and we can show respect and dignity in place of stigmatisation and marginalisation.[2]

This policy statement aims to present the harms of current policies towards global drug use and, in response, outline the alternatives. It will argue that the only way to move forward is to promote policies that are evidence-based, pragmatic and compassionate.

Discussion

The Harms of Drug Use

It cannot be denied that drug use can be harmful, depending on the context of use. The harms can be physical, psychological and social, and affect the individual, their family, friends and the wider community.[4] Only by understanding the current risks of drug use can we effectively develop policies to reduce this risk to both users and society.

A drug is defined as "any substance that…causes a physiological change in the body" and, as mentioned previously, this includes both illegal and legal substances such as tobacco, alcohol and even caffeine.[3] Despite widespread use, only an estimated 10% of drug users globally are considered to have a 'drug use disorder', defined as drug dependence and drug abuse or harmful use. [2,4] This suggests that the majority of drug consumption occurs without significant harm to the individual. However, there are an estimated 190,000 premature deaths from illegal drugs, mainly attributed to the use of opioids such as heroin and fentanyl.[1] Although when considering disability-adjusted life years (DALYs), it has been shown that the global burden of alcohol and tobacco is 4% of DALYs and only 0.8% is attributable to illegal drugs.[6] This shows that the legality of a drug does not always confer to its safety and highlights that a considerable global burden of harm is avoidable.

Legalities aside, opioids are frequently cited as the most harmful drug for users.[1,5] This is mostly due to the risks of overdose and the practice of unsafe injection.[1] Fatal overdose is frequently indicated as cause of mortality in opioid users and is, unfortunately, increasing. While treatments such as naloxone are available, their distribution and access within the community is variable. In conjunction, due to the illegality of opioids, users have no control over the purity of the drugs they use, meaning that it is impossible to estimate the strength and therefore an effective dose of that drug, further increasing the risk of overdose.[7] The risk of acquiring an infectious disease from unsafe injection is also considerable, with the use sharing of needles or the use of unsterilised syringes leading to 222,000 and 60,000 deaths from Hepatitis C and HIV respectively.[1]

What must also be acknowledged is the disproportionate harm that some marginalised groups face due to drug use, notably women, ethnic minorities and prison populations.[1] Women are twice as likely as men to suffer from a drug use disorder, face greater barriers in access treatment and are more likely to be imprisoned for drug offences that any other crime.[1,2] The effect on ethnic minorities is also grave, with the most well known example being black population in the United States where they account for 33.6% of drug arrests yet comprise 13% of the population.[2] A group that is often forgotten in the discourse of drug harms is the prison population. Their use of drugs is higher, with recurrent drug use estimated at 20% (note that drug use within the population is 5%) and they face greater harms due to further unsafe infection practices and risk of infection, especially tuberculosis.[1]

We can therefore conclude that any drug can have associated harms but the prohibition of drugs leaves users unable to access appropriate support, whether it be clean needles or treatment for a drug use disorder, leading to increases in the potential harms. However, as is frequently the case, these harms are more acutely felt within minority groups. Steps can be taken to reduce these harms and alternatives do exist, as will be outlined below.

<u>The Harms of Drug Classification</u>

While it can be accepted that that all drugs have varying degrees of risk, the evidence as to why one drug is legal while another is illegal is lacking.[4]

The UN schedules drugs under the United Nations 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances.[4] The United Kingdom (UK), uses an A-C class classification under the Misuse of Drugs Act to stratify the illegality of drugs. Class A includes drugs such as cocaine, ecstasy and LSD and carry a sentence of up to seven years in prison for possession whereas Class C includes drugs such as khat and GHB and can lead to up to two years in prison for possession. Note that while alcohol and tobacco are legal there are considerable regulations and restrictions on their sale and use.[8] While these laws are specific to the UK, similar laws and classifications are seen in countries throughout the world.[2]

When assessing the risks of drug use in a physical, psychological and social context, a disparity in UK law between the legal classification of drugs and their relative harm can be seen. Heroin and cocaine are considered the most harmful and are, rightly, both Class A drugs, however ecstasy is also a Class A drug yet is considered the third least harmful in an analysis of twenty recreational substances. Interestingly, alcohol and tobacco are shown to be more harmful than illegal drugs such as cannabis, LSD and nitrates - alcohol and tobacco together account for roughly 90% of all drug-related deaths in the UK.[4]

When such disparities exist between the evidence and the law, unnecessary harm is inevitable. While often forgotten, the aim of such classifications is not only to provide a framework for law enforcement but is also to provide the public with a guide as to the dangers of various drugs. When the public is aware that there is no evidence behind this advice the opportunity to provide an educational and meaningful public health message is lost.

The Strategies to Reduce Harm

When considering the current harms of drug use and the failure of enforcement-led strategies to tackle these harms it is important to consider what future evidenced-based and pragmatic policies could entail. These policies would aim to promote harm reduction, prevention, education and treatment measures while ensuring equal access to essential medicines, ending the criminalisation of drug use and considering the regulation of drug markets.[2]

Portugal is an example of a country that broke from 'conventional wisdom' and took steps to reform its drug policy. In 2001, due to increasingly problematic drug use, especially heroin, and increasing social concern, the government decided to decriminalise all drugs. This action was coupled with a systemic change focusing on harm reduction, improved treatment for drug users and interventions to support drug users in a social context. Despite initial concerns, both locally and globally, the results have been exceptionally positive. Drug use is estimated to have remained the same but the harms such as the rate of drug users contracting HIV and drug-related arrests have decreased.[9] It is important to note that a coordinated effort was used, with input from all relevant sectors involved including doctors, lawyers and users, and it is likely that an isolated measure would have been insufficient.[2]

While Portugal is just one example, many approaches exist that that do not rely upon incarceration and criminalisation. Switzerland and Uruguay are both recent examples. It does appear though that appropriate education to encourage responsible decision making, needle exchange and syringe programmes, supervised drug consumption facilities, overdose prevention and leading drug users away from courts and into clinics are all effective interventions.[2] Alternatives to the criminalisation of drug use or

possession should be also sought and law enforcement should be redirected to tackle drug trafficking and organised crime.[1]

The legal regulation of drug markets should also be considered and can take many forms. One example is already in common use: the regulation of alcohol and tobacco. Other examples of regulation include medical prescription models, specialist pharmacy models and licensed retail models. These models are varied and each has its own advantages and disadvantages, however there is not a "one size fits all" approach and ideally drugs of varying risks and harms would be matched to the appropriate model and cultural context.[2]

Conclusion

This policy focussed on the overreaching harms of drug use and strategies to reduce this harm. However, there could be further discussion on the production and trafficking of drugs and how this disproportionately affects LMICs, the difficulty for many countries in obtaining essential medicines for pain management due to ardent and unnecessary regulations or the rise of cryptomarkets and their lack of accountability. It is also evident that nearly all evidence for drug policy reform is based on high income countries and that more research is required in LMICs to develop an appropriate global response to drug use and production.

By outlining the current harms of drug use it is clear that the 'War on Drugs' has failed and that punitive approaches to drug policy have only exacerbated issues. Many of the harms outlined above would be reduced if drug policy was public-health led and treated users as patients not criminals. Strategies from harm reduction measures to the legal regulation of drug markets have all been tried and the research to measure their effectiveness should be prioritised.

Moving forward, countries and policy makers should reflect upon their own drug policies and how they impact users. They need only refer to the Sustainable Development Goal 3.5 on strengthening the prevention and treatment of substance abuse to see that it is both a global and important issue. [10]

Calls to Action

1. The Students for Global Health network should:
    a. Affirm that current global drug policies are often harmful, cost lives, damage communities and are ultimately avoidable.
    b. Advocate for an evidence-based and public health approach, by supporting local, national and international campaigns which target policy makers and governments.
    c. Identify other organisations that are advocating on this issue and consider collaboration.
2. Health Professionals should:

   a. Ensure that drug users are treated with dignity and respect when accessing services.
   b. Ensure that their services are accessible to all groups requiring treatment for drug use disorders or related illness.
   c. Support research in LMICs to ensure a coordinated global response to the production and trafficking of drugs.
3. Governments should:
   a. Review their own policies and ensure that they are grounded in evidence, free from political influence, including the classification of drugs.
   b. Consider implementing strategies to reduce the harms and risks of drug use, including needle exchanges, supervised drug consumption rooms and the regulation of certain substances.
   c. Call upon the World Health Organisation and United Nations to continue to monitor global drug production and consumption, and to assess initiatives to reduce their harm.

References

1. United Nations Office on Drugs and Crime. World Drug Report 2017, Executive Summary. Available from: https://www.unodc.org/documents/scientific/Booklet_1_Executive_Summary_conclusions_and_policy_implications.pdf [Accessed Aug 2017]
2. Global Commission on Drug Policy. Taking Control: Pathways To Drug Policies That Work. Available from: http://www.globalcommissionondrugs.org/wp-content/uploads/2016/03/GCDP_2014_taking-control_EN.pdf [Accessed Aug 2017]
3. Oxford English Dictionary. “drug”. Available from: http://www.oed.com/view/Entry/57982?rskey=XQOHoh&result=1&isAdvanced=false#eid [Accessed Aug 2017]
4. Rehm J, Room R, Brinkt W, et al. Problematic drug use and drug use disorders in EU countries and Norway: An overview of the epidemiology. European Neuropsychopharmacology. 2005; 15 (4): 389-397
5. Nutt D, King L, Saulsbury W, et al. Development of a rational scale to assess the harm of drugs of potential misuse. Lancet. 2007; 369: 1047-53
6. Rehm J, Taylor B and Room R. Global burden of disease from alcohol, illicit drugs and tobacco. Drug and Alcohol Review. 2006; 25: 503-513
7. Walley A, Xuan Z, Hackman H. et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013; 346:174
8. GOV.UK. ‘Drug Penalties’. Available from: https://www.gov.uk/penalties-drug-possession-dealing [Accessed Aug 2017]
9. Artur Domoslawski, Global Drug Policy Program. Drug Policy in Portugal: The Benefits of Decriminalizing Drug Use. Available from: https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf [Accessed Aug 2017]

10. SDG Indicator 3.5.1. United Nations Office on Drugs and Crime (UNODC). Available from: http://unstats.un.org/sdgs/files/meetings/iaeg-sdgs-meeting-03/3rd-IAEG-SDGs-presentation-UNODC--3.5.1.pdf [Accessed Sep 2017]