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Changing Perspectives on Problematic Drug Use¹

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What is Drugs Policy?

Drugs policy can be said to comprise the various ways that governments and societies try to deal with substances that many people consume for pleasure or medicinal purposes but which can also have negative consequences for users, their families, or wider society. The difficulty with this view of drugs policy is that it includes so much – not only laws regulating the substances but also programmes for dealing with those who fall foul of the laws or who develop problems with substance use, and also programmes for prevention of use, or safer use. All these require efforts across a large number of sectors including policing and law enforcement, health, education, customs, ‘homeland security’, and community organizations. This is a very large canvas, and this chapter will look at only a part of it – primarily the overarching government policies that various countries have adopted, how these have changed over time, and challenges to these policy directions.

History

Societies have used, and attempted to control, intoxicating or psychoactive substances as far back as records go. In Western societies, alcohol was the substance mainly used, and correspondingly controlled, for most of recorded history. Although other substances were occasionally used

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(usually hallucinogens such as ‘magic mushrooms’), this was relatively rare and it was not until a range of different intoxicants became more available that use increased, and society felt the need to control that use. Although policy responses have varied, there are some main ways that large-scale societies and governments have conceptualized the issues, and these have determined the policies applied.

Conceptualizations of Drug Use

Societies and governments have variously taken the view that issues surrounding drug use are:

- economic: some substances ought to be freely traded;
- moral: people are weak and so substance use needs to be prohibited, and users need to be reformed and/or punished;
- health: some substances cause addiction and dependency, so use needs to be prevented or users need to be treated;
- criminal justice: many behaviours, including drug use, need to be controlled, forbidden or punished.

Countries usually utilize different or overlapping responses, depending on factors such as the status of the majority of the users, and whether or not use is associated with social disruption.

The United Kingdom

The experience of the United Kingdom is an interesting example. Up until the middle to late 19th century, because drugs other than alcohol were not seen as a problem, there were no drug policies, no laws, and no regulations. Instead, the government’s approach was centred on an economic concept: drugs were commodities that could be traded in and with other countries, with resulting economic benefits to the United Kingdom. As Babor et al. (2010) state:

... psychoactive substances were an obvious choice; once the demand for them has been created, it becomes self-sustaining. Thus psychoactive substances became a favourite commodity from which to extract revenues for the state ... The most notorious of such cases were the Opium Wars that Britain fought with China in the 1840s and 1850s to force the opening of the Chinese market for Indian opium. (p. 203)

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As a result of this aggressive marketing, smoking opium became very common in 19th-century China, and a great deal of money was made by the British. However, while this economic model was applied abroad, the position taken with regard to the 'home market' was somewhat different. Many sailors, traders, employees of the East India Company, and others associated with the opium trade, returned to the United Kingdom, and a market for opium started to develop across Europe. At first this was relatively unproblematic but, around the same time as the opium wars, the active ingredient within opium, morphine, began to be produced on a large scale within Europe and became the basis of many popular patent medicines, including laudanum. As very many people purchased these products without understanding the potential for overdose, calls arose for legislative control. This led in Britain to the Pharmacy Act of 1868, which is highly important for two reasons.

First, it established the policy of limiting availability of dangerous drugs, a policy then followed by other European nations. Second, it placed central responsibility on a health-related profession, the Pharmaceutical Society established in 1841, to oversee the Act's provisions. Thus as well as aiding public health by having dangerous drugs sold or dispensed by individuals knowledgeable about their qualities, the Act also provided a significant boost to the status (and profitability) of a health profession. This created the conditions for a very long-standing approach (which became known as the British System) of placing health professionals at the heart of the governmental and policy responses to the control of drugs.

The impact of the Pharmacy Act was that the vast majority of people who used opiates did not become dependent on them (as opposed to in China, where the British trade in opium meant that over a quarter of the male population were regular consumers by 1905). In fact, recreational or addictive use in nations where opium was not so aggressively marketed remained rare until the early 20th century, with very many recordings of high praise for the drug. Nevertheless, some people did become dependent, especially once the more potent form of morphine, heroin, was developed in 1874 (and marketed from 1897 as a nonaddictive morphine substitute and cough medicine for children). However, the large bulk of those dependent were either members of health-related professions (who had ready access to morphine and heroin), or people who had become dependent following initial use of a heroin- or morphine-based medicine.

When the problem of what to do about these people became sufficiently pressing, the government set up the Rolleston Committee, which

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reported in 1926. This laid down a policy framework, which remained largely unchanged for the next 40 years, the central position of which was maintenance-prescribing for dependent users of heroin (MacGregor & Ettorre, 1987; Velleman & Rigby, 1990). This Committee laid down guidelines for appropriate maintenance prescribing:

Persons for whom, after every effort has been made for the cure of the addiction, the drug cannot be completely withdrawn, either because (i) complete withdrawal produces serious symptoms which cannot be satisfactorily treated under the ordinary conditions of private practice; or (ii) the patient, while capable of leading a useful and fairly normal life so long as he takes a certain non-progressive quantity, usually small, of the drug of addiction, ceases to be able to do so when the regular allowance is withdrawn. (Rolleston Committee, 1926)

These guidelines gave control over prescribing to general practitioners, who could use their discretion on the treatment/maintenance of dependent individuals. This centrality of prescribing, and the discretionary powers of doctors, confirmed the primary orientation for dealing with heroin use as within the health sphere. Prescribing was of course not the only plank of government policy, enforcement has always been included in the system of controlling drug use in the United Kingdom, but it was the primary focus. This system was the practice until the 1960s (Velleman & Rigby, 1990) and then followed by another health-oriented approach focused more on short-term prescribing of reducing amounts of opiates, leading to abstinence. It was not until the 1980s that the long-standing health orientation shifted towards a more confrontational, crime and enforcement approach, swayed by an increasingly USA-influenced United Nations and international 'war on drugs'.

The United States

While the main conceptual basis of British drugs policy was originally economic, followed by health, drug policy within the United States developed very differently. First, both medicine and pharmacy remained essentially unorganized in the United States until the First World War. Although the American Medical Association was founded in 1847, and the American Pharmaceutical Association in 1851, both remained small and nationally unrepresentative groups for the next 60–70 years; and

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crucially, both lacked the authority to license practitioners. As Musto (n.d.) states:

Licensing of pharmacists and physicians, which was the central governments' responsibility in European nations was, in the United States, a power reserved to each individual state any form of licensing that appeared to give a monopoly to the educated was attacked as a contradiction of American democratic ideals. (para. 5)

Thus within the United States, with respect to drugs policy, there was

- no practical control over the health professions;
- no control on the labelling, composition, or advertising of compounds that might contain opiates or cocaine;
- no representative national health organization to aid the government in drafting regulations, and
- no national system of developing laws or regulations relating to drugs (because the form of government adopted in the United States, a federation of partly independent states, was a conscious attempt to prevent the establishment of an all-powerful central government characteristic of Europe).

The result, unsurprisingly, was no drug policy at all with most states making little attempt to control addictive substances until quite late in the 19th century. Opiates were used in abundance for almost every ailment, with hypodermic syringes even advertised to consumers in the Sears Roebuck catalogue (Musto, 1973).

The second difference between the United Kingdom and the United States related to who became addicted. In the United States there was a large population of Chinese immigrants, especially on the West Coast, many of whom were already dependent on opium. United States' policy then, fragmented and with no lead from the health lobby, began with the stigmatization of Chinese immigrants and opium dens across California, leading rapidly from town ordinances in the 1870s to the formation of the (United States'-focused and led) International Opium Commission in 1909. During this period, the portrayal of opium in literature was squalid and violent, and purified morphine and heroin became widely available for injection (Brown, 2002).

The US approach towards illicit drugs was also greatly influenced by the temperance movement's approach to alcohol. This movement helped establish the attitude that there could be no compromise with the 'forces

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of evil' and that 'moderation' was a false concept when applied to alcohol: prohibition was the only logical or moral policy when dealing with this great national problem. As Musto (n.d.) argues, the significance for the control of 'narcotics' (in the United States this term covers most illicit drugs, including marijuana) is that 'The moral question of how to deal with a dangerous substance was being fought out over alcohol, but the case would be stronger even with narcotics when that issue was brought to national deliberation.'

As a result of these three factors – no strong health professional lobby, a stigmatized group being visibly addicted, and a strong Puritan prohibitory approach, the dominant conceptualization adopted was a moral and a criminal justice one: laws regulated use, and those breaching those laws were to be punished. Further, the strong moral approach, coupled with a belief that most of the drugs they were seeking to outlaw came from other countries, also meant that the United States felt a duty to ensure that other countries took a similar line. Accordingly, the United States pursued a twin approach from the start of the 20th century: strict controls at home, and an international approach to dealing with supply. The Harrison Narcotics Act of 1914 basically outlawed opiates. Providing maintenance prescriptions was unlawful, and the federal government could take action nationwide to arrest and convict health professionals who practiced this. In 1920 a prohibition policy was also adopted for alcohol. However, while alcohol prohibition laws were repealed in 1933, anti-drugs laws became increasingly draconian, and by the 1950s, punishment for violations included the death penalty (Musto, 1973; n.d.). Nevertheless, with regard to marijuana, there has been a recent shift in policy at state level in the United States, discussed below.

International Drug Policy

The United States' international approach to drug control started with an international meeting at Shanghai in 1909 to consider opium traffic among nations. The United States wished to join with China in its own efforts to eradicate the serious opium problem that British trade had left it with. This meeting resolved with almost unanimous agreement that opium for nonmedicinal uses should be prohibited or 'carefully regulated', and that all nations should 're-examine' their laws. Subsequently, the Hague Opium Conference, 1911, and Opium Convention of 1912, placed the burden on domestic legislation in each nation to control the preparation and distribution of medicinal opium, morphine,

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heroin, cocaine, and any new derivative with similar properties (Taylor, 1969). The Hague Convention was then incorporated into the Versailles treaty, which ended the First World War. Britain, therefore, passed the Dangerous Drugs Act of 1920, not because of any serious problems with addiction but because, by ratifying the Versailles treaty, it had committed to comprehensive domestic legislation (Berridge & Edwards, 1981).

Further international treaties followed, which continued the policy, started by the United States, of seeking to control and criminalize a wide range of drugs – mainly opiates and cocaine, but also marijuana. Although the United States' international influence on drug control waned during the 1920s due to an increasingly isolationist stance, by the outbreak of the Second World War it was again participating in international antidrug activities (Musto, 1973). The United States exercised drug control primarily via law enforcement and moral outrage both within its borders, by criminalizing possession and demonizing all drug use, and increasingly across the entire world by ensuring that the main organizations it underwrote financially and politically, such as the United Nations and the WHO, adopted similar terminologies and approaches.

In the 1970s the term 'war on drugs' was coined in the United States, and the power of this prohibitory, criminal justice approach, and the efforts put into ensuring international engagement, cannot be minimized. The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances made it mandatory for the signatory countries to 'adopt such measures as may be necessary to establish as criminal offences under its domestic law' (UN, 1988, p. 3) all the activities related to the production, sale, transport, distribution, etc., of a range of restricted substances. Criminalization also applies to the 'cultivation of opium poppy, coca bush or cannabis plants for the purpose of the production of narcotic drugs', an element that the United States had tried unsuccessfully to introduce internationally in 1925.

Convergence of Policies

More recently there has been a move away from the 'war on drugs' ideology, and the US has started to accept the necessity of not only using a crime and punishment model, and begun to provide substitute medication (e.g. methadone) and sterile injecting equipment. The most recent US *National Drug Control Strategy* (2010) was presented as a new direction in drug policy, where drug use is seen mainly as a public health issue,

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and where the enormous demand is recognized as the prime cause of drug problems. The strategy emphasizes prevention, treatment and recovery from addiction, and calls for the integration of addiction treatment into mainstream medicine, as with other chronic disorders. Indeed, President Obama stated that while he was not in favour of legalization, he believed drugs ought to be treated as ‘more of a public health problem . . . we’ve been so focused on arrests, incarceration, interdiction, that we don’t spend as much time thinking about how do we shrink demand’ (Reuters, 2011). A special situation has developed with regard to marijuana, and this is discussed below.

Although UK policy was influenced by the ‘war on drugs’, it still retained a primarily health and social care approach, with drug treatment being commissioned and performance managed via the National Treatment Agency for Substance Misuse (NTA), part of the National Health Service (NHS). This ‘health’ approach has been reinforced by the recent emphasis on ‘recovery’ (UKDPC, 2008). While earlier policies were primarily aimed at increasing the number of people accessing treatment, notably with provision of opioid substitute drugs, Britain has attempted to integrate all aspects of its drugs strategy, with successive policies focusing on treatment outcomes and social reintegration of users (Home Office, 2008) and on making recovery a key policy element (Home Office, 2010; Scottish Government, 2008), as well as on reducing the supply.

Other European countries also have made serious attempts to move away from a ‘war on drugs’ to rebalance drug policy objectives between reducing harms and promoting recovery. National drug strategies and action plans now exist in almost all of the 30 countries monitored by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Portugal’s current drug policy is more than ten years old, but it has gained increased attention in recent years, first from drug-policy analysts and advocacy groups, but now also from governments in Europe and beyond. Central to the Portuguese policy is the decriminalization of drug use, discussed below.

Outside the European Union, a number of national or regional strategies have been published recently, notably by Australia, Russia, the United States and the Organization of American States (OAS). These documents reveal similar characteristics to the European approach. Hence the OAS’s Hemispheric Drug Strategy describes drug addiction as a chronic relapsing disease that should be treated as such. The first Russian drug strategy (2010–2020) builds on a recognition of the scale of the drugs problem and its contribution to the spread of infectious diseases. The Australian drug strategy (2010–2015) has the broadest scope,

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with minimizing harm as the overarching approach to all psychoactive substances capable of causing addiction and health problems, including alcohol, tobacco, illicit and other drugs.

Decriminalization or Legalization

The picture presented above is of an increasing convergence in drug policies across the world, still with an emphasis on a ‘war on drugs’ and on prohibition and criminalization; but with a clear view that prevention, treatment, and harm reduction are important components as well.

A rather different approach is that of the drug liberalization movement, and its two component parts, legalization and decriminalization. There have always been strong voices arguing for a more libertarian view of drug policy, and since the early 2000s these voices have started to gain some political capital. Commentators have called attention to numerous factors that suggest that an antidrug policy may not be sensible, helpful or deliverable, including:

- most illicit drugs are less harmful than either alcohol or tobacco, which are legal in the vast majority of countries;
- the libertarian view, that as long as someone is doing no harm to others, they should be allowed to consume whatever they wish;
- the ‘war on drugs’ seems demonstrably not to be working, as very large amounts of drugs are still available, and (certainly until recently) the numbers of drug users worldwide has continued to increase;
- prohibition turns large numbers of citizens into criminals, and if significant numbers of people ignore a law, it suggests the law needs changing;
- prohibition increases price, which increases acquisitive crime and organized crime, with resulting rises in violence and corruption. Gamboa (2012) estimates that over 10,000 deaths a year in the United States are caused by the criminalization of drugs, and nearly 13,000 people died in drug-related violence in Mexico in the first 9 months of 2011 (BBC, 2012)
- prohibition also reduces quality, adulterated drugs are frequently sold, and negative health consequences, and deaths, rise.

Because of these factors, there have been increasing calls for either decriminalization, or legalization (or relegalization, reflecting the fact that drugs which are currently illicit used to be legal).

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Decriminalization

Proponents of drug decriminalization call for reduced control and reduced penalties. Some support these ideas as a ‘halfway house’ towards legalization, and propose that illegal drug users be fined instead of imprisoned, or given other punishments that would not appear on their permanent criminal record. In many ways, decriminalization is a form of harm reduction. On the other hand, because decriminalization is in some ways an intermediate between prohibition and legalization, it has been criticized as being ‘the worst of both worlds’ in that drug *sales* would still be illegal, thus perpetuating the problems associated with organized crime while also failing to discourage illegal drug use by removing the criminal penalties that might otherwise cause some people to choose not to use drugs. Counter arguments include that decriminalization of possession of drugs would refocus law enforcement onto arresting dealers and big-time criminals, thus making it more effective.

Engaging with these arguments, in recent years 15 European countries have made changes to their penalties for possession of small amounts of drugs. Three broad types of penalty changes can be identified since the early 2000s: changing the legal status of the offence (criminal or non-criminal); changing categories of drugs, when the category determines the penalty; and changing the maximum penalty available. Most of the countries that have altered their penalties have used a combination of these types of change, complicating any concise analysis.

Changing the legal status of the offence is perhaps the most significant step. In 2001 Portugal became the first country to decriminalize personal possession of all drugs, reducing the *maximum* punishment from 3 months’ imprisonment (already far smaller than in many other countries) to an administrative fine given by the new ‘commissions for dissuasion of drug abuse’, which prioritize health solutions over punitive sanctions. These changes have been extensively evaluated, and demonstrated positive results (Domoslawski, 2011; Greenwald, 2009; Hughes & Stevens, 2010). In Luxembourg, since 2001, personal possession of cannabis incurs only a fine for the first offence, and maximum penalty for personal possession of all other drugs was reduced from 3 years in prison to 6 months. A similar change took place in 2003 in Belgium, and moves towards decriminalization were also made in Estonia and Slovenia.

Without changing the legal status, other countries (Romania, Bulgaria, Czech Republic, Italy, and the United Kingdom) changed the categorization of different drugs, with the category determining the penalty. The United Kingdom has been especially changeable, in 2004 reclassifying

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cannabis from Class B to Class C, lowering the maximum imprisonment for personal possession from 5 to 2 years; and national police guidelines were issued not to arrest, but to give an informal warning, if there were no aggravating circumstances. Then in January 2009, cannabis was reclassified to Class B, raising maximum penalties to 5 years' imprisonment again. Revised national police guidelines continued to advise an informal warning for a first offence, with a criminal fine for a second offence. A third group of countries, Finland, Greece, Denmark and France, reduced their penalties for personal possession, without addressing legal status or categories and, in 2005, Slovakia widened the definition of 'possession for personal use' from 1 to 3 doses of any illicit substance, while leaving the maximum punishment unchanged.

The situation in Holland has also given rise to a great deal of discussion. The possession of small quantities of drugs for personal use is accorded a much lower priority in Holland: anyone with less than 0.5 g of Schedule I drugs (e.g. heroin, cocaine) will generally not be prosecuted, and for cannabis a maximum of 5 g will not lead to investigation or prosecution. The Netherlands is the only country in Europe with a national system for the regulated supply of cannabis. When the principle of 'separating the markets' between dangerous drugs and cannabis was codified in 1976, *coffeeshops* emerged as a semi-legal sales channel for cannabis, albeit under strict conditions, including not serving alcohol. A *coffeeshop* is not to be confused with a *koffiehuis* (coffee house) or a *café* (the equivalent of a bar). *Coffeeshops* are tolerated as an attempt to keep young people away from other more dangerous drugs. Nevertheless, around three-quarters of Dutch municipalities do not allow *coffeeshops*; the total number has declined, and two new criteria were introduced in 2012 to tighten controls on these venues. The 'closed club criterion' limited *coffeeshop* access to registered members (maximum 2000), and the 'residence criterion' limited accessibility only to adults resident in the Netherlands. The rationale behind these developments was to reduce public nuisance and return *coffeeshops* to their original purpose: small-scale points of sale of cannabis for local users. However, the mayors of major Dutch cities have said that restricting access to *coffeeshops* will simply lead to an increase in street dealing and criminality. At the time of writing a new government has come into office, and there is ongoing debate as to whether these new laws will be enforced.

In the United States, in 2013, 19 states allow possession of small amounts of marijuana with a medical prescription. Two states, Colorado and Washington have just legalized possession of small amounts of marijuana for recreational use, bringing them into direct conflict with US

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federal laws and the 1988 UN Convention, which the US strongly supported. How this will play out is yet to be seen.

Thus, although laws vary across different countries, there are signs of a converging trend towards decriminalization or a reduction in penalties for personal possession of drugs, and no Western country has introduced new criminal penalties or increased prison sentences over the last ten years.

Relegalization

Drug relegalization calls for the end of government-enforced prohibition of the distribution or sale and personal use of specified (or all) currently banned drugs. Not all proponents of drug relegalization necessarily share a common ethical framework, and proposed ideas (e.g. Transform, 2009) range from full legalization, completely removing all government prohibition or control, to various forms of regulated legalization, which might mean:

- mandated labels with dosage and medical warnings;
- restrictions on advertising;
- age limitations;
- restrictions on amount purchased at one time;
- requirements on the form in which certain drugs would be supplied;
- ban on sale to intoxicated persons;
- special user licences to purchase particular drugs.

Any regulated legalization would probably have a range of restrictions for different drugs, depending on perceived risk, with some being sold over the counter in pharmacies or other licensed establishments, while those with greater risks of harm might only be available on licensed premises where use could be monitored and emergency medical care made available. Full legalization is often proposed by libertarians who object to drug laws on moral grounds, while regulated legalization is suggested by groups such as Transform (<http://www.tdpf.org.uk/>), and Law Enforcement Against Prohibition (LEAP, <http://www.leap.cc/>) who object to the drug laws on the grounds that they fail to achieve their stated aims and instead greatly worsen the problems associated with use of prohibited drugs. An important distinction that is often lost is that favouring drug relegalization does not imply approval of drug use.

*Changing Perspectives on Problematic Drug Use***New Drugs**

The policy responses discussed so far in this chapter are all attempts to deal with a growing but relatively predictable set of substances: opiates (primarily heroin), stimulants (primarily amphetamine and cocaine), hallucinogens (primarily LSD), and marijuana. A major new phenomenon appeared in the 1980s: the rise of synthetic substances, designed to not fall within the remit of existing laws but to be very attractive to potential users. These new psychoactive substances have been referred to colloquially as ‘designer drugs’ or ‘legal highs’. Drugs legislation generally covers specific substances, as opposed to whole classes of chemicals. Accordingly, each new drug synthesized is not covered by existing legislation, and needs to be added to the list of illegal substances, as evidence accrues of dangerousness (or as media-induced ‘moral panics’ create situations where politicians feel they need to declare a substance illegal, long before there is sufficient evidence as to whether or not the substance is dangerous, and if so, at what level). In the United Kingdom, the Chair of the Advisory Council on the Misuse of Drugs (ACMD, set up to advise the government), Professor David Nutt, suggested a more rational policy towards declaring drugs illegal, based on the level of harm the drug had the potential to cause (Nutt, King, Saulsbury, & Blakemore, 2007). Professor Nutt’s championing of this idea was so politically unacceptable that senior politicians attempted to force him to resign; when he refused, he was sacked (Guardian, 2009).

Ecstasy (MDMA)

The first synthetic drug was Ecstasy (MDMA), which combined some of the properties of two classes of drug (stimulants and hallucinogens). Although first synthesized in 1912, it was largely forgotten over the next 65 years, until it began to be used recreationally in the late 1970s and rose to prominence via dances and ‘raves’ across the Western world. Ecstasy was made illegal in the United Kingdom in 1977 and in the United States in 1985. However, MDMA proved to be the proverbial ‘tip of the iceberg’.

Other New Drugs

The new drugs market is distinguished by the rapidity by which suppliers respond to control measures by offering new alternatives to restricted

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products. This has led the European Monitoring Centre for Drugs and Drug Addiction to set up an ‘early warning system’ and a speedy risk assessment for any new drug that appears problematic, so that European governments can be ready to take action. A range of information sources and leading-edge indicators, including Internet monitoring and wastewater analysis (see below) are all used to help obtain a better picture of emerging drug trends in Europe. Between 1997 and 2010, more than 150 new psychoactive substances were formally notified through this early warning system, and all are now being monitored by the EMCDDA. The rate at which new substances appear on the market has increased, with 24 in 2009, 41 in 2010, and 49 in 2011. Many of these new substances have been detected through test-purchases of products sold on the Internet and in specialist shops (e.g. ‘smart’ shops, ‘head’ shops, ‘legal high’ shops). The number of online sources offering at least one psychoactive substance rose from 314 in 2011 to 690 in 2012 (European Monitoring Centre for Drugs and Drug Addiction, 2011a, 2012a).

Increasing Amphetamine Use

An emerging issue is the increased capacity and sophistication in the illicit amphetamine market (European Monitoring Centre for Drugs and Drug Addiction, 2011b) with changing patterns and trends in the production and trafficking of this widely used synthetic stimulant, as well as the chemicals for its manufacture. In many ways, amphetamine can be termed a ‘European drug’, with data suggesting Europe to be both the world’s number one producer of the substance and a major consumer market. While, globally, methamphetamine is more widely used, amphetamine has stabilized as the second most widely consumed stimulant drug in Europe today (after cocaine). And in many countries, especially in the north and east of Europe, it is the second most widely used illicit drug after cannabis. This suggests that, although amphetamine attracts much less attention in media and policy circles than cannabis, cocaine or heroin, it should not be treated as a ‘secondary issue’. Research published in 2011 showed that around 12.5 million Europeans had used amphetamines in their lifetime, some 2 million in the previous year. European amphetamine markets are therefore highly profitable ‘business opportunities’ for organized crime (European Monitoring Centre for Drugs and Drug Addiction, 2011b). There are distinct production and trafficking areas (‘criminal hubs’), with large-scale production and organized crime involvement being found mainly in northern Europe,

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centred on the Netherlands and to a lesser extent Belgium. Significant production and trafficking of the drug also occurs in the north-east, notably in Poland, where production is reported to be on the rise.

Emerging Initiatives in Policy and Practice

The rapid spread of new substances is pushing governments around the world to rethink their standard responses to the drug problem, with policymakers demanding new, faster and effective ways of drug control to protect public health and deter suppliers from circumventing controls (European Monitoring Centre for Drugs and Drug Addiction, 2011a, 2012a). But there are both practical and legal obstacles facing countries when responding to such new substances. New drugs may pose health and other risks to individuals and the general public, yet hard data on these may initially be lacking. Testing products can be time consuming and expensive, which can hinder rapid, targeted responses by legislators. Legislative procedures to bring a substance under the control of the drug law can take over a year in some countries, and controlling a substance may have unintended consequences, such as the emergence of a more harmful, noncontrolled replacement. Faster processes have been introduced in some countries, including emergency systems that enable a substance to be placed under temporary controls, or fast-track systems placing substances under permanent control by shortening the consultation periods in the law-making process. But striking the right balance between swiftness of response to new substances on the one hand, and sufficient scientific evidence and legislative supervision on the other, is an important policy goal.

Wastewater Analysis

Wastewater analysis or sewage epidemiology is a rapidly developing scientific discipline with the potential for monitoring population-level trends in illicit drug consumption (European Monitoring Centre for Drugs and Drug Addiction, 2008). Advances in analytical chemistry have made it possible to identify urinary excretion of illicit drugs and their main metabolites at very low concentrations. This is comparable to taking a much-diluted urine sample from an entire community. With certain assumptions, it is possible to back-calculate from the amount of metabolite in the wastewater to an estimate of the amount of a drug consumed

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in a community. While early research focused on identifying cocaine and its metabolites, recent studies have produced estimates on levels of cannabis, amphetamine, methamphetamine, heroin, and methadone. The identification of less commonly used drugs, such as ketamine and new psychoactive substances, looks promising. This area of work is developing in a multidisciplinary fashion, with important contributions from a number of disciplines including analytical chemistry, physiology, biochemistry, sewage engineering, and conventional drug epidemiology. At least 18 research groups in 13 European countries are working in this area (European Monitoring Centre for Drugs and Drug Addiction, 2011b). At the top of the current research agenda is development of consensus on sampling methods and tools, as well as the establishment of a code of good practice for the field.

In January 2012 the EMCDDA launched a multicity demonstration project, and by the end of that year the project had generated comparable data from 26 European cities, thanks to a specifically designed and agreed common sampling approach (European Monitoring Centre for Drugs and Drug Addiction, 2012b). This demonstration project will provide comparable information in real time on weekly patterns of use, trends and changing consumption habits in the participating cities. Wastewater analysis is an emerging science. While its methods do not provide the detailed consumption data currently yielded by drug surveys, its ability to provide timely estimates of illicit drug consumption in a given population make it a useful complement to existing methods for studying drug use trends in Europe.

Heroin Assisted Treatment

In the treatment of opiate addiction, both gradual reduction and methadone maintenance have long had their advocates. Indeed, the prescription of substitution drugs (e.g. methadone, buprenorphine) has become a mainstream, first-line treatment for opioid dependence, with around 700,000 of Europe's 1.3 million problem opioid users receiving substitution treatment today (Strang, Groshkova, and Metrebian, 2012). But there has always been a small minority of entrenched opioid users who have repeatedly failed to respond to interventions to either reduce use or substitute a different drug, and they used to be thought of as 'untreatable'.

Since the early 2000s there has been increasing interest in utilizing medicinal heroin as a substitute drug (Metrebian, Carnwath, Stimson &

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Soltz, 2002; Strang et al., 2010; Uchtenhagen, 2010). Supervised injectable heroin (SIH) treatment was first introduced in Switzerland in the mid-1990s in the face of a growing national heroin problem. The new approach was a step on from prescribing heroin to addicts without supervision, practised in the United Kingdom throughout the 20th century – the British System referred to earlier in this chapter. By 2011, some 2,500 clients across the European Union and Switzerland were enrolled in SIH treatment, under direct medical supervision to ensure safety and to prevent diversion of diacetylmorphine (medicinal heroin) to the illicit market.

Strang et al. (2012) report that the research trials conducted since the mid-1990s provide strong evidence that, for this specific group of long-term heroin users, SIH treatment can be more effective than oral methadone maintenance treatment (MMT). Less positively, the risk of adverse events (e.g. fatal overdoses) was higher in SIH than MMT, underlining the need for clinical precautions. The cost of SIH treatment for this problematic target group was also considerably higher than that of MMT. But, according to the report, if analysis takes into account all relevant parameters, especially related to criminal behaviour, SIH treatment saves money. The very fact that SIH has been trialled in this way is a major policy and practice initiative; we will need to wait to see if it will be taken into the mainstream.

Opioid Maintenance in European Prisons

A recent systematic review and editorial published in *Addiction* (Hedrich et al., 2012; Hedrich & Farrell, 2012) describe opioid maintenance treatment (OMT) as an ‘effective option for opioid-dependent prisoners’, offering benefits similar to those reported in community settings. According to the findings of the systematic review, prison-based OMT offers important benefits, such as continued treatment for inmates in OMT before incarceration, and recruitment into treatment of problem opioid users previously untreated. For both groups, it reduces illicit opioid use, injecting and associated risks while in prison, and potentially minimises the likelihood of overdose on release. The papers also find prison-based OMT to be cost-effective, offering ‘potential for important gains in public health and subsequent cost savings’. Of the 30 countries monitored by the EMCDDA, 24 now sanction prison OMT.

Although this implies that encouraging progress is being made in several European countries towards closing the treatment gap between

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community and prison, in most countries such equivalence of care is an aspiration rather than a reality. One major conclusion is that, in order to promote equivalence and continuity of treatment, it is important to challenge negative perceptions of prison-based opioid maintenance treatment among policymakers and prison administrators and to develop appropriate training programmes for prison staff and professionals.

Hepatitis C

Hepatitis C virus (HCV) infection is highly prevalent in injecting drug users (IDUs) across Europe, with national samples of IDUs showing between 22% and 83% infected. A large proportion of IDUs are now over 40, most of whom will have been living with HCV for 15–25 years. The natural history of chronic HCV (cirrhosis risk escalates after 15–20 years) and the ageing cohort effect in this population, mean that a large burden of advanced liver disease can be anticipated over the next decade. In spite of this burden and the recent improved treatment outcomes for HCV patients, available data show treatment uptake to be very low in this group (1–9%). Considerable improvements in HCV antiviral therapy have been reported in recent years and there is a growing recognition of the importance of providing HCV infection treatment to IDUs. Data show that this group can now be treated as successfully as non- or ex-injectors and that low rates of reinfection are recorded after successful treatment.

Conclusions

Babor et al. (2010) make a number of helpful points about where we are at present, and where we should be going with international drugs policy. Several of these are especially relevant to this chapter:

1. *There is no single drug problem within or across societies; neither is there a magic bullet that will solve ‘the’ problem.* There are marked differences between and within societies in the types of drugs used at a particular time, how they are used, the problems caused by the drugs, and how a society responds.
2. *The drug policy debate is often dominated by false dichotomies that can mislead about legitimate options and expected impacts.* Law enforcement and health service approaches each contribute, as when, for example, police warn users of dangerously high-potency batches;

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and health services treatment leads to fewer crimes. In addition, targeting drug use *per se* as well as targeting the drug-related harm is not inconsistent because harm-reduction approaches can lead to abstinence while abstinence can result in reduced harm.

3. *Perverse impacts of drug policy are prevalent.* Drug policies should be judged not only on intended effects but also on unintended consequences, using cost-benefit analysis.
4. *In terms of prevention, many policies that affect drug problems are not considered drug policy, and many specific drug policies have effects outside the drug domain.* Similar factors can predict problematic drug use and other problem behaviours, and policies in one domain can impact on others.
5. *Similarly, there is modest support for school, family and community prevention programmes,* especially those that focus upon improving overall behaviour and social skills, and not specifically on drug use.
6. *In terms of control, efforts by wealthy countries to curtail cultivation of drug-producing plants in poor countries have not reduced aggregate drug supply or drug use, and probably never will.* Significant expansion in cultivation curtailment, as in defoliation and alternative development programmes, has not produced desired results. One reason is that production can be simply moved to another area, or another country.
7. *Once drugs are made illegal, there is a point beyond which increased enforcement and incarceration yield little added benefit.* Increasing enforcement against drug dealers does not result in price increases beyond what would occur with routine enforcement.
8. *The legal pharmaceutical system can affect a country's prescription drug problem and drug policy options.* Because of increasing rates of misuse of psycho-pharmaceuticals, more efficient distribution and dispensing of medicinal products could be a first step towards an effective policy addressing misuse of prescription medications.
9. *There is virtually no scientific research to guide improvement of supply control and law enforcement efforts.* The lack of careful study of enforcement, interdiction, incarceration, and related measures poses a major barrier to effective application.
10. *Substantial investment in evidence-based services for opiate-dependent individuals usually reduces drug-related problems.* Injecting drug use poses a high risk of overdose and death, and has resulted in an epidemic of HIV/AIDS in many societies. Expansion of effective services for opiate dependent individuals will benefit not just drug users but society at large.

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In conclusion, drugs policy has grown up piecemeal over many years, often strongly influenced, either overtly or covertly, by ideological positions. It is certainly rarely evidence based and, although available scientific evidence is neither perfect nor sufficient, it is equally certain that what is available is rarely used to best effect. It would be a move in the right direction if more leaders and policymakers were to apply the available evidence to create more effective drug policy.

Note

1. A longer and more detailed version of this chapter is available on the author's website: <http://www.bath.ac.uk/psychology/staff/richard-velleman/> (accessed March 4, 2013).

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