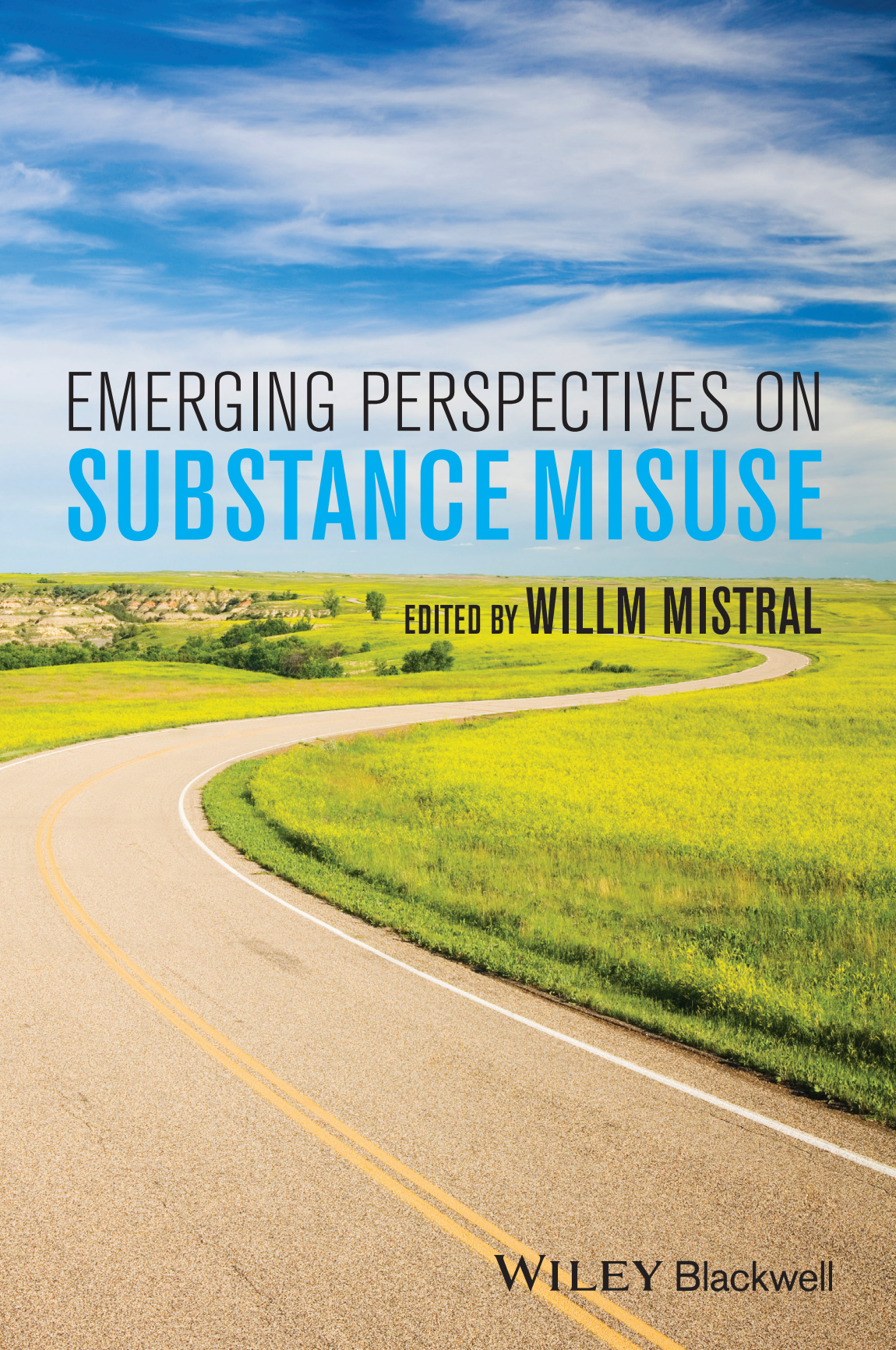
EMERGING PERSPECTIVES ON
SUBSTANCE MISUSE
EDITED BY WILLM MISTRAL
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Contributors

Professor Amanda Baker, Centre for Translational Neuroscience and Mental Health, University of Newcastle, Australia. Email: amanda.baker@newcastle.edu.au

Rebecca Brown, PhD candidate, Department of Gender and Cultural Studies SOPHI, University of Sydney, Australia. Email: rbro9702@uni.sydney.edu.au

Professor Robin Davidson, Consultant Clinical Psychologist, Northern Ireland. Email: robindavidson@hotmail.co.uk

Sarah Hiles, PhD Candidate, Centre for Translational Neuroscience and Mental Health, University of Newcastle, Australia. Email: Sarah.Hiles@newcastle.edu.au

Dr Louise Hill, Policy Implementation Officer, CELCIS, University of Strathclyde, Scotland. Email: louise.hill@strath.ac.uk

Dr Frances Kay-Lambkin, Senior Research Fellow, National Drug and Alcohol Research Centre, University of New South Wales, Australia. Email: f.kaylambkin@unsw.edu.au

Dr Peter Kelly, Senior Lecturer Clinical Psychology, School of Psychology, University of Wollongong, Australia. Email: pkelly@uow.edu.au

Tim Leighton, Director, Centre for Addiction Treatment Studies, Action on Addiction, England. Email: tim.leighton@actiononaddiction.org.uk

Professor Fiona Measham, School of Applied Social Sciences, Durham University, England. Email: f.measham@durham.ac.uk

Dr Willm Mistral, Honorary Senior Research Fellow University of Bath; for 18 years managed the Mental Health Research & Development Unit, Avon & Wiltshire Mental Health Trust and University of Bath, England. Email: w.mistral@bath.ac.uk

Dr Karenza Moore, Lecturer in Criminology, Department of Applied Social Science, Lancaster University, UK. Email: karenza.moore@lancaster.ac.uk

Professor David Nutt, Director Neuropsychopharmacology Unit, Division of Brain Sciences, Imperial College London, England. Email: d.nutt@imperial.ac.uk

Amanda Searl, Clinical Psychologist, Centre for Translational Neuroscience and Mental Health, University of Newcastle, Australia. Email: reception@greenhillspsychology.com.au

Dr Lesley Smith, Principal Lecturer Quantitative Research Methods, Department of Psychology, Social Work and Public Health, Oxford Brookes University, England. Email: p0073992@brookes.ac.uk

Lorna Templeton, Independent Research Consultant, Member of the Board of Trustees of Adfam, and Alcohol Research UK Grants Advisory Panel, England. Email: ltempleton72@googlemail.com

Dr Louise Thornton, Research Officer, Centre for Translational Neuroscience and Mental Health, University of Newcastle, Australia. Email: Louise.Thornton@newcastle.edu.au

Richard Velleman, Emeritus Professor of Mental Health Research, University of Bath, England. Email: r.d.b.velleman@bath.ac.uk

Stephen Wilkinson, Chartered Clinical Psychologist, Visiting Research Fellow, University of Bath, England. Email: steve.wilk@hotmail.co.uk

About the Editor

Dr Willm Mistral has a long research career related to alcohol, drug, and mental health problems. He is an Honorary Senior Research Fellow at the University of Bath. For over 18 years he managed a team of researchers in the Mental Health Research and Development Unit, a joint enterprise of the Avon and Wiltshire Mental Health Partnership Trust and the University of Bath. To date he has been involved in over 75 research projects, and has more than 50 publications in books and journals.

Preface

The Topic

Excessive consumption of drugs and alcohol is associated with widespread social problems, and policymakers as well as practitioners in the field are seeking effective means to reduce the impact on individuals, families, and wider society. A vast amount of research has been undertaken into the underlying and maintaining causes of substance misuse, and there is considerable evidence to support promising interventions for related social and psychological problems. However, much national policy and practice remains entrenched in the past, often for the want of a clear exposition, or application, of research findings.

Importantly, this book addresses theoretical, practice and policy issues with regard to problematic use of both alcohol and illicit drugs, and presents a wide range of emerging evidence-based perspectives. As well as professionals charged with devising and delivering policies and interventions to reduce alcohol- and drug-related harm, it will also interest an academic audience as problematic consumption and addictive behaviours are increasingly being studied within universities.

The Authors

The contributing authors represent expertise from a range of different specialisms and perspectives in the substance-misuse field. As such, different authors may use differing terminology, as does this preface, referring at times to substance use or misuse, problematic drug or alcohol use, excessive consumption, or addiction. No attempt has been

made to homogenize these terms as the differences represent the way this complex, and sometimes divisive, subject is approached in the real world.

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I am most grateful to all the contributors to this volume. They are busy people, and I feel both privileged and proud that they have made the time and effort to give of their particular knowledge, experience, and understanding of this important subject.

1

Changing Perspectives on Problematic Drug Use[1]

Richard Velleman

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)

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

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

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

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,

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,

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,

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).

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 (Domoslawsk, 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