# An alternative to the war on drugs

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**Stephen Rolles** argues that we need to end the criminalisation of drugs and instead set up regulatory models that will control drug markets and reduce the health and social harms caused by current policy

Epidemiologist Elizabeth Pisani and other leading commentators describe which countries are leading the way in tackling HIV infection among injecting drugs users in this 10 minute BMJ video.]. *Click arrow to view video*

Consensus is growing within the drugs field and beyond that the prohibition on production, supply, and use of certain drugs has not only failed to deliver its intended goals but has been counterproductive. Evidence is mounting that this policy has not only exacerbated many public health problems, such as adulterated drugs[1] and the spread of HIV and hepatitis B and C infection among injecting drug users, but has created a much larger set of secondary harms associated with the criminal market. These now include vast networks of organised crime, endemic violence related to the drug market,[2] corruption of law enforcement and governments, militarised crop eradication programmes (environmental damage, food insecurity, and human displacement), and funding for terrorism and insurgency.[3] [4]

These conclusions have been reached by a succession of committees and reports including, in the United Kingdom alone, the Police Foundation,[5] the Home Affairs Select Committee,[6] The prime minister's Strategy Unit,[7] the Royal Society of Arts,[8] and the UK Drug Policy Consortium.[9] The United Nations Office of Drugs and Crime has also acknowledged the many "unintended negative consequences" of drug enforcement,[10] increasingly shifting its public rhetoric away from its former aspirational goals of a "drug free world," towards "containment" of the problem at current levels.

## Problems of prohibition

Despite this emerging consensus on the nature of the problem, the debate about how policy can evolve to respond to it remains driven more by populist politics and tabloid headlines than by rational analysis or public health principles.

The criminalisation of drugs has, historically, been presented as an emergency response to an imminent threat rather than an evidence based health or social policy intervention.[11] Prohibitionist rhetoric frames drugs as menacing not just to health but also to our children,

national security, and the moral fabric of society itself. The prohibition model is positioned as a response to such threats,[12] [13] and is often misappropriated into populist political narratives such as "crackdowns" on crime, immigration, and, more recently, the war on terror.

This conceptualisation has resulted in the punitive enforcement of drug policy becoming largely immune from meaningful scrutiny.[14] A curiously self justifying logic now prevails in which the harms of prohibition—such as drug related organised crime and deaths from contaminated heroin—are conflated with the harms of drug use. These policy related harms then bolster the apparent menace of drugs and justify the continuation, or intensification, of prohibition. This has helped create a high level policy environment that routinely ignores or actively suppresses critical scientific engagement and is uniquely divorced from most public health and social policy norms, such as evaluation of interventions using established indicators of health and wellbeing.

# Emerging change

Despite this hostile ideological environment, two distinct policy trends have emerged in recent decades: harm reduction[15] and decriminalisation of personal possession and use. Although both are nominally permitted within existing international legal frameworks, they pose serious practical and intellectual challenges to the overarching status quo. Both have been driven by pragmatic necessity: harm reduction emerging in the mid-1980s in response to the epidemic of HIV among injecting drug users, and decriminalisation in response to resource pressures on overburdened criminal justice systems (and, to a lesser extent, concerns over the rights of users). Both policies have proved their effectiveness. Harm reduction is now used in policy or practice in 93 countries,[16] and several countries in mainland Europe,[17] [18] and central and Latin America have decriminalised all drugs, with others, including states in Australia and the United States, decriminalising cannabis.[19]

Decriminalisation has shown that less punitive approaches do not necessarily lead to increased use. In Portugal, for example, use among school age young people has fallen since all drugs were decriminalised in 2001.[20] More broadly, an extensive World Health Organization study concluded: "Globally, drug use is not distributed evenly and is not simply related to drug policy, since countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones."[21]

Similarly US states that have decriminalised cannabis do not have higher levels of use than those without. More importantly, the Netherlands, where cannabis is available from licensed premises, does not have significantly different levels of use from its prohibitionist neighbours.[19]

# New approach

Although these emerging policy trends are important, they can be seen primarily as symptomatic responses to mitigate the harms created by the prohibitionist policy environment. Neither directly tackles the public health or wider social harms created or exacerbated by the illegal production and supply of drugs.

The logic of both, however, ultimately leads us to confront the inevitable choice: non-medical drug markets can remain in the hands of unregulated criminal profiteers or they can be controlled and regulated by appropriate government authorities. There is no third option under which drugs do not exist. The choice needs to be based on an evaluation of which option will deliver the best outcomes in terms of minimising the harms, both domestic and international, associated with drug production, supply, and use. This does not preclude reducing demand as a legitimate long term policy goal, rather it accepts that policy must also deal with the reality of current high levels of demand.

A historical stumbling block in this debate has been that the eloquent and detailed critiques of the drug war have not been matched by a vision for its replacement. Unless a credible public health led model of drug market regulation is proposed, myths and misrepresentations will inevitably fill the void. So what would such a model look like?

Transform's blueprint for regulation[22] attempts to answer this question by offering different options for controls over products (dose, preparation, price, and packaging), vendors (licensing, vetting and training requirements, marketing and promotions), outlets (location, outlet density, appearance), who has access (age controls, licensed buyers, club membership schemes), and where and when drugs can be consumed. It then explores options for different drugs in different populations and suggests the regulatory models that may deliver the best outcomes (box). Lessons are drawn from successes and failings with alcohol and tobacco regulation in the UK and beyond, as well as controls over medicinal drugs and other risky products and activities that are regulated by government.

**Five basic models for regulating drug availability[22]**

- *Medical prescription model or supervised venues*—For highest risk drugs (injected drugs including heroin and more potent stimulants such as methamphetamine) and problematic users
- *Specialist pharmacist retail model*—combined with named/licensed user access and rationing of volume of sales for moderate risk drugs such as amphetamine, powder cocaine, and methylenedioxymethamphetamine (ecstasy)
- *Licensed retailing*—including tiers of regulation appropriate to product risk and local needs. Used for lower risk drugs and preparations such as lower strength stimulant based drinks
- *Licensed premises for sale and consumption*—similar to licensed alcohol venues and Dutch cannabis "coffee shops," potentially also for smoking opium or poppy tea
- *Unlicensed sales*—minimal regulation for the least risky products, such as caffeine drinks and coca tea.

Such a risk guided regulatory approach is the norm for almost all other arenas of public policy, and in this respect it is prohibition, not regulation, that can be viewed as the anomalous and radical policy option.

Moves towards legal regulation of drug markets depend on negotiating the substantial institutional and political obstacles presented by the international drug control system (the UN

drug conventions). They would also need to be phased in cautiously over several years, with close evaluation and monitoring of effects and any unintended negative consequences.

Rather than a universal model, a flexible range of regulatory tools would be available with the more restrictive controls used for more risky products and less restrictive controls for lower risk products. Such differential application of regulatory controls could additionally help create a risk-availability gradient. This holds the potential to not only reduce harms associated with illicit supply and current patterns of consumption but, in the longer term, to progressively encourage use of safer products, behaviours, and environments. Understanding of such processes is emerging from "route transition" interventions aimed at encouraging injecting users to move to lower risk non-injecting modes of administration by, for example, providing foil for smoking.[23] This process is the opposite of what has happened under prohibition, where a profit driven dynamic has tended to tilt the market towards ever more potent (but profitable) drugs and drug preparations, as well as encouraging riskier behaviours in high risk environments.

The oversight and enforcement of new regulations would largely fall within the remit of existing public health, regulatory, and enforcement agencies. Activities that take place outside the regulatory framework would naturally remain prohibited and subject to civil or criminal sanctions.

Regulation is no silver bullet. In the short term it can only seek to reduce the problems that stem from prohibition and the illicit trade it has created. It cannot tackle the underlying drivers of problematic drug use such as inequality and social deprivation. But by promoting a more pragmatic public health model and freeing up resources for evidence based social policy and public health based interventions it would create a more conducive environment for doing so. The costs of developing and implementing a new regulatory infrastructure would represent only a fraction of the ever increasing resources currently directed into efforts to control supply. There would also be potential for translating a proportion of existing criminal profits into legitimate tax revenue.

Different social environments will require different approaches in response to the specific challenges they face. Transform's blueprint does not seek to provide all the answers but to move the debate beyond whether we should end the war on drugs to what the world could look like after the war on drugs. It is a debate that the medical and public health sectors have failed to engage with for far too long.

# Notes

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# Footnotes

- Contributors and sources: SR is the author of *After the War on Drugs: Blueprint for Regulation.* The book is published by Transform Drug Policy Foundation, which actively campaigns for drug policy and law reform, and is available free online (www.tdpf.org.uk/Transform_Drugs_Blueprint.pdf).

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