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Illegal drugs in the UK: Is it time for considered legalisation to improve public health?

Phil Dalgarno[1], Steve O'Rawe[2] and Richard Hammersley[3]

Abstract

This paper investigates options available to policy makers responding to the challenges of drug use in modern society, focussing on the UK. It investigates the failings of prohibition policy that has driven historic reactions to drugs, drug use and drug users globally, nationally and locally. This policy paradigm has been largely destructive and counter-productive and has led to a whole host of health and social problems. The authors have approached their investigation from a public health perspective, free from moral biases that have driven many policy initiatives until now. Many countries and regions of the world are rejecting prohibition as they move towards public health models in opposition to criminal justice responses, and this trend is continuing. Four policy models are examined; prohibition as the status quo; extension of prohibition to include alcohol and other drugs; decriminalisation; legalisation and regulation of all drugs. Each of these policy options are contested; none have universal support. However, given careful consideration, this paper proposes that our only way out of the public health and criminal justice crises that have been driven by drug policy globally is to adopt the more contentious option of legalisation and regulation of all drugs commonly used non medically.

Keywords

decriminalisation, drugs, drug policy, legalisation, prohibition, regulation

Introduction

Since 1961 when the UN Single Convention on Narcotic Drugs was published, there has been a proliferation in the use of illegal drugs to levels previously unimagined, although the convention and subsequent supply reduction activity were supposed to curtail and contain use. Before 1961 in the UK, the use of controlled drugs occurred mainly amongst a small bohemian milieu, including jazz musicians and some immigrant groups (Courtwright, 2002; Kohn, 2003). Almost sixty years on, lifetime prevalence of cannabis use amongst adults is above 20% in many European countries (EMCDDA, 2018a, 2018b), with Uruguay, Canada and several states in the USA introducing legislation to legalise the production, distribution and sale of the drug, Mexico and Jamaica expected to follow suit and many other countries relaxing prohibitive measures (Global Commission on Drug Policy (GCDP), 2018).

The prevalence of other drugs has also risen, including some drugs, such as MDMA, not used at all in 1961. New drugs, such as mephedrone, are being sold and consumed and the market for new psychoactive substances is growing (Miliano et al., 2018).

Background

Supply reduction has not contained or reduced prevalence, despite huge investment and extreme police and military activity (Harm Reduction International, 2017). Instead it has created a highly profitable criminal black market, resulting in violence and corruption, locally, nationally and globally (McCoy, 2003). Some drug entrepôt countries are on the verge of collapse as effective states (McCoy, 2003; Shirk, 2011) and global networks initially used for drugs are now used also for weapons, illicit donor organs, people smuggling and,

[1]Glasgow Caledonian University, Scotland
[2]University of the West of Scotland, Scotland
[3]University of Hull, England

Corresponding author:
Phil Dalgarno, Department of Psychology, George Moore Building, City Campus, Cowcaddens Road, Glasgow G4 0BA, Scotland.
Email: P.Dalgarno@gcu.ac.uk

indeed, any in-demand illegal commodity (Lichtenwald et al., 2009).

There is a substantial and undiminishing demand for illicit drugs that is currently being met by an entirely illegal, untaxed and unregulated industry, run by international criminal networks, which is one of the largest industries in the world (United Nations Office on Drugs and Crime (UNODC), 2018). For example, the total global cannabis retail market in 2005 was estimated as between £35 billion and £105 billion ($57 billion and $170 billion) (Reuter and Trautmann, 2009). The total global value of the illicit drugs trade may be £236bn (Godlee, 2018), all of it controlled by those criminal networks to fund their activities and denying governments any revenue through taxation. Yet, in each of six USA states that have legalised the sale of cannabis (Alaska, California, Colorado, Nevada and Oregon), over $1bn has been collected in tax revenue.

> Remarkably, all six states collect more revenue from their excise taxes on cannabis than from their excise taxes on beer and wine. Two states, Colorado and Nevada, collect more from their cannabis excise taxes than from their excise taxes on all alcohol, including liquor, wine, and beer. And in Washington State, cannabis excise taxes are nearly on par with excise tax revenue from all forms of alcohol. (Davis et al., 2019: 21)

The economic argument for regulated sales of cannabis seems attractive, but it is opposed by a drug prohibitionist policy stance. These tensions will be further borne out as more States in the USA continue to adopt new drug policies.

The primary concern of this paper is public health. The fact that many psychoactive substances are illegal has not prevented people from using them. At minimum, a large minority of users take them in harmful ways with substantial personal and social costs. From a public health perspective, this is barely different from the problems of alcohol and tobacco use, except that the industry generates no tax revenue, which can support treatment and rehabilitation for those who develop problems, and is beyond regulation. The paper will not discuss the economics of drugs policy because the relevant figures are enormous, involve estimates of the costs of intangibles such as harm to families, and involve estimates of the activities of a secretive industry.

Despite intensive resistance by the tobacco industry, cigarette smoking has been tackled by obtaining unequivocal research evidence that smoking is harmful, regulating the sale and marketing of cigarettes and changing social norms about smoking, including developing the widespread perception that smoking is not worth the health risks. In about forty years, smoking prevalence in the UK has dropped to about a quarter of its peak. Since 1974, smoking in the UK has fallen from just below 50% of the adult population to just below 20% (ONS, 2018). The ban of smoking in public places has been a major public health benefit also (Anyanwu et al., 2018). The industry, however, has increasingly diverted its sales efforts to less regulated markets in the developing world (Drope et al., 2018). While the costs of smoking are high and the dangers well documented, few would call for outright prohibition. Due largely to the known dangers of the unintended consequences of such action that led to the repeal of alcohol prohibition in the US, but still persists with other, less harmful, psychoactive drugs.

Alcohol also harms public health and its sale and marketing can be regulated, by various means including pricing and taxation, voluntary industry cooperation and by changes in social norms. Over the past forty years, gross UK alcohol intake, and consequent harms, has increased. Cheaper alcohol may be one reason for this, perhaps partially solvable by minimum pricing (Ludbrook et al., 2012). Although the alcohol industry is not public health's 'friend' (Wallack, 1992), the industry does, for example, under pressure, regulate to some extent the marketing of its products (see portmangroup.org.uk). It also resists pressure from public health, for example continuing to sponsor sport and music events. For example, the Scotch Whisky Association (SWA) has, for over four years, actively opposed minimum unit pricing (MUP) of alcohol in Scotland – a cross-party, widely supported initiative (Alcohol Focus Scotland, 2016). Despite their efforts to stymie the Act, MUP is now operational in Scotland, and one year on from its introduction has received positive evaluation and has shown to decrease the volume of total alcohol consumption (Mooney and Carlin, 2019). Social norms about alcohol that have also changed for the better include intolerance of alcohol-related violence, including domestic violence (Livingston, 2011), and reduced drunk-driving (Alcohol Concern, 2009).

No such options are available for illegal drugs. Repeated commission reports and public discussions about appropriate norms tend to get buried or dismissed as sending the "wrong message" (Smith, 2009). Apparently, the only politically acceptable option is to document the harms caused by illegal drugs and use these as rationalisations for their generally unsuccessful suppression. Yet, for many drugs the harms are less than for alcohol or tobacco (Nutt et al., 2010). Moreover, although drugs can be potent determinants of health and disease, in primary care settings, drug users have obvious motives for being discreet about these behaviours, including concerns about

being stigmatised as drug users, which can have a knock-on detrimental effect on their individual recoveries (McPhee et al., 2013). These dampen efforts to practice preventative medicine and minimise harm.

Recent changes to regulate cannabis instead of banning it may be encouraging, but it is unclear that cannabis is a special case, any more than alcohol or tobacco. Drug harms are more to do with the mindset of users and the settings of use, including the extent to which products are quality controlled, fairly priced and can be obtained safely (Shewan and Dalgarno, 2005).

The arguments

There are four options open to us: (1) Leave things as they are; (2) Extend laws to ban alcohol and tobacco; (3) Decriminalise or depenalise some or all currently illegal drugs; (4) Legalise and regulate some or all currently illegal drugs.

Let us consider some implications of each of these options in turn.

Option 1: Leave our drug laws – national and international – as they are and continue as we have done for the past half a century.

Current drug laws effectively criminalise millions of otherwise law-abiding citizens and perpetuate a vast illegal and unregulated industry. Unregulated, the industry can sell adulterated products, products that are in particularly dangerous formulations, and products that are bogus. These can be sold by anyone, to anyone, with no requirement for responsible marketing, or packaging that explains how to minimise risk, or offers informed choice between different products, or provides any rules or norms about appropriate use.

The unpredictable content of 'drugs' makes what is already a risky pastime considerably more so. Taking heroin as an example, the illegality of the trade together with an unreliable supply can have the effect of making the end product questionable in terms of both content and strength. Even minor fluctuations in potency can result in deaths. Leaving things as they are, abdicates health and safety controls to a criminalised industry and the folklore of drug users. In recent years, deaths from overdose in the USA, for example, have risen sharply, much of it related to the increase in fentanyl-laced street heroin (Ciccarone, 2017). The appeal of fentanyl for the black market is largely that it is very potent, making it easy to smuggle in small quantities containing many doses.

Yet, UK governments have generally focussed on supply reduction rather than regulation and treatment rather prevention. There are complex reasons for favouring the status quo, including unknown pressures from powerful lobbies such as the alcohol, tobacco and pharmaceutical industries and concerns regarding media opprobrium (see Hammersley, 2018; Hammersley and Reid, 2002).

Option 2: We can *extend* the existing laws to include currently legal substances known to be harmful; this would mean that alcohol and tobacco would come within the domain of the various national and international laws and their amendments.

The extension of existing drug laws to encompass currently legal substances with *proven* and *irrefutable* links to personal and social harms, specifically alcohol and tobacco (Nutt et al., 2010) may, on the face of it, be attractive to many. This would be a logical move in that it would categorize two of the more harmful and most widely available substances where they should properly be. However, one particular flaw with this is that alcohol in particular is culturally integrated, enormously popular, and its use associated with celebrations and festivals. Moderate imbibers (of whom there are many) would be penalised for the transgressions of the immoderate. We already have a plethora of legislation to regulate the product, as well as the adverse social problems associated, from weights and measures to drink driving.

A more concrete problem would be the almost instant creation of a further black market for criminal cartels. Alcohol prohibition was famously tested in America in the 1920's and resulted in some health improvements, but coupled with considerable public health and safety problems (Levine and Reinarman, 2004) and the proliferation of highly organised criminal gangs (McCoy, 2003). The repeal of prohibition in 1933 saw these same criminal organisations move seamlessly into the supply and distribution of other intoxicants, heroin in particular (McCoy, 2003; Musto, 1999). During Covid-19 lockdowns, alcohol bans in Sri Lanka and South Africa began causing public health problems and losing government revenue almost immediately.

Making illegal something that people enjoy – and plainly, this is the principal motivation for intoxicant use with most people – does not stop them from wanting it, and it does not stop the drugs industries from meeting those desires. Illegality pushes up prices, and places many useful public health controls beyond the law. Also, the arguments against option 1 apply even more so to the possibility of all major intoxicants being illegal.

A more effective approach might be to make alcohol socially unacceptable, as is being achieved to an extent with drunk driving and violence whilst intoxicated. Conversely, when a widely used drug is illegal, then both the law and medical advice can seem biased and hypocritical to users, who may largely disregard official warnings as lacking credibility. Current blanket bans on any illegal drug, anytime, anywhere are increasingly

detached from reality in a society where, for example, the current Prime Minister has admitted to adolescent cannabis and cocaine use (Dawar, 2008).

The prohibition of alcohol would have enormous implications for public health. On the face of it, such a move should theoretically lead to improvements, but in reality, the situation would be almost identical to that of the illicit drugs market, which is to say that while consumption would continue, we would see a corresponding drop in purity/quality, an increase in adulterants as individuals (or organisations) attempt to produce their own, and an inevitable increase in negative health outcomes. Prohibition of alcohol would also result in a sharp and very steep rise in cost, affording even greater financial rewards to criminals. In the end, it seems a much more preferable option to have better regulation of cost, availability and training for staff in order to reduce alcohol related harm (Babor et al., 2010).

Option 3: We can introduce the *decriminalisation or depenalisation* of some/all drugs, as the Scottish National Party has adopted as a future policy for the Scottish Government (Chiara, 2019) and as has been adopted in Portugal where all drug offences are now civil not criminal offences.

In Portugal, and most other places, it does not seem to have made much difference (Hughes and Stevens, 2010). For example, public health in Portugal remains frustrated that harm reduction and treatment facilities remain limited and drug injectors continue to live and inject in squalid conditions. While drug supply itself remains illegal the industry cannot be taxed or regulated. There can be positive public health gains, such as reduction in blood borne virus infection and drug injecting (Cabral, 2017; Greenwald, 2009) but there is a danger of conflating recreational use with problem use, with increased referral to 'treatment' for those who deem it unnecessary. This approach risks contributing to the widely-held, but mistaken belief, that drug users, of any description, 'need' to be 'treated'.

Decriminalisation is an imperfect compromise; it looks good in theory but the reality is that it is unworkable without a number of different authorities and official bodies being prepared to "turn a blind eye". A decriminalised drug is not legal, nor strictly illegal, depending on certain circumstances, nor is it necessarily of any better quality as it comes from the same sources as any other illegal drug. To use the Netherlands as an example: cannabis is decriminalised and can be sold in licensed coffeeshops to consumers over the age of 18 in amounts up to 5 grams. However, this process has many problems. For one, coffeeshops are not legally permitted to hold more than 500 grams of cannabis for sale at any one time. Further, growing cannabis on the premises, and the transportation of cannabis from A (the producer) to B (the retail outlet) is forbidden by law. And yet, all three of these problems are circumvented by simply ignoring the laws. This state of affairs can only really exist with the goodwill of the law enforcement services, something that can, hypothetically at least, disappear at any time. This is an ad hoc relationship, meaning that there is considerable leverage for corruption and continues to afford ample opportunities for organised crime.

Option 4: We consider the *legalisation* and strictly enforced *regulation* of all common types of drug for personal, non-medical use.

This is the thorny subject that needs to be debated. It is fraught with difficulty, being laden with emotion and with media-driven preconceptions and misconceptions, but as we have stated earlier, there are now many countries, states and regions that are fully legalising and regulating cannabis (GDPC, 2018). We are not proposing a "free for all", and a range of legally binding and strictly observed caveats would be in place concerning, in particular, the *regulation*, specifically applied to the supply and distribution of currently illegal substances.

When drugs are regulated, then it is also possible to develop mature policies and practices about where and how they should be consumed. For example, which forms of opiate or opioid would be available and at what potencies? The popularity of alcohol does not extend to selling 100% ethanol in convenience stores, or drinking whilst working. The ban on smoking in public premises became popular even with smokers. It would also be possible to discuss pricing and the appropriate forms of different substances that should be sold, with a view to reducing the social and financial costs of illegal drug problems.

Given the reluctance of the tobacco and alcohol industries to self-regulate, the primary imperative in any move towards the legalisation of drugs would be the *exclusion of private enterprise* from the process beyond the production of specific substances not available via producer countries. Uruguay has nationalised cannabis production, distribution and sale, which adds further revenue to the national coffers (Walsh and Ramsay, 2016). Matters such as supply, distribution and quality would, as a necessity, require state control (similar perhaps to models for the control of alcohol used in Canada and some Scandinavian countries) with scrupulous and ongoing monitoring. There are differing models emerging. The states in the US seem to have a less regulated system for cannabis, while Uruguay and Canada prefer much more state involvement and greater control of the regulatory process (Government of Canada, 2019; Walsh and Ramsay, 2016). Although a lesson learned from Canada is that the state needs to

be able to deliver, or users will continue to purchase illegally.

We would like to discuss some possible implications of legalisation on cannabis – among the most widely used illicit psychoactive substances, and the second most widely used psychoactive after alcohol (UNODC, 2018).

The shift in patterns of cannabis use and manufacture are making it extremely difficult to gauge, or estimate, use globally. However, on the available data, cannabis is consumed by some 75 per cent of reported users of illicit drugs— an estimated 183 million people reporting use in the last year (UNODC, 2017: 13). Cannabis accounts for more than one half (53%) of all illicit drug seizures worldwide (UNODC, 2017: 40). This, a drug which is now fully legal and available in two UN member countries (Canada and Uruguay), fully legal in 11 US states and available for medical use in a further 33 (Business Insider, 2020), and not taking into account the number of countries where its use is decriminalised, such as Portugal and the Czech Republic. There are numerous accounts of the economic benefits the legalisation of cannabis (Wodak et al., 2002; Rolles et al., 2012; Room, 2014); and yet, under the UN Single Convention (1961) we persist in attaching ourselves to a diktat that has completely failed in just about all that it set out to do.

Cannabis is consumed and grown in almost every country, and the overall amounts produced are reportedly far larger than the total production of other illicit drugs. Cultivation is widely dispersed and relatively little is known about the extent of cannabis production. 135 countries, covering 92% of the world's population have some sort of cannabis cultivation going on within their borders (UNODC, 2017: 39). What these figures from the UN tell us is that cannabis use is embedded into most societies despite international prohibition policies (with the exception of those mentioned above), with reported use increasing, particularly in the developing world.

The UNODC was established in 1997 as the Office for Drug Control and Crime Prevention by combining the United Nations International Drug Control Program (UNDCP) and the Crime Prevention and Criminal Justice Division in the United Nations Office at Vienna. It is a member of the United Nations Development Group and was renamed the UNODC in 2002. In 2018 it had an estimated annual budget of US$326 million. This will be a fraction of the total worldwide law enforcement budget aimed at preventing cannabis production. Consider the potential savings made by halting the interdiction of cannabis and legalising and regulating it instead. Consider also, why we have a situation where, in one country (Canada) where HRH Elizabeth II is head of state, a commodity is legal and available, while in another (UK), possession, supply and cultivation are criminal offences punishable by loss of liberty.

The use of cannabis is not only widespread in North America, Latin America and Europe, but is extremely common on the African continent too. Indeed, the West Africa Commission on Drugs (WADC), set up by former Secretary General of the UN, Kofi Annan, reported in June 2014 that the region must embark on a radical rethink of support for drug prohibition policies. Olusegun Obasanjo, the commission chairman and former president of Nigeria, reported that,

> We call on West African governments to reform drug laws and policies and decriminalise low-level and non-violent drug offences. (WADC, 2014: 1)

While the report later states,

> Decriminalising drug use is one of the most effective ways to reduce problematic drug use as it is likely to facilitate access to treatment for those who need it. (WADC, 2014: 54)

There is little evidence to suggest that drug prohibition policies, whether domestically or internationally, are reducing the use, sale or supply of controlled drugs predicted by the UN in 1961 (Bewley-Taylor, 2001; GCDP, 2018; Lines, 2010; Rolles et al., 2012; Rosmarin and Eastwood, 2012; Stevens, 2011; Trace, 2011).

McKeganey (2011) does argue, however, that Sweden's zero tolerance approach to drug use has shown that tough approaches to interpreting the UN Single Convention can succeed. His argument stresses that a tough and consistent approach to drugs can produce results desired by the UN when he writes:

> It may be necessary to adopt tougher enforcement policies, abstinence-focused treatment and widespread prevention. (McKeganey, 2011: 145)

In isolating cannabis, McKeganey (2011) seems to have a point, with Sweden's cannabis using population among the lowest in Europe. However, when we look at Murkin (2014), what can also be seen is that Sweden's cannabis using population is *almost* the same as Portugal's, which decriminalised cannabis use in 2001 (Greenwald, 2009). In effect, the levels of cannabis use in what are two polar policies between Sweden and Portugal have little impact on reported consumption prevalence. Of course, cultural and environmental differences between these two countries can be assumed to be a factor in decisions to use.

Despite this, it can clearly be seen that Portugal's cannabis use is comparatively very low.

Although there is nothing particularly new about countries deciding to shape their own drug policy (as is stated in Article 4 of the UN Single Convention (1961), all countries have to develop their own bespoke prohibition policy) to suit the conditions and policies within domestic borders, it is estimated that there are now somewhere in the region of 21 countries around the world with some kind of formalised decriminalisation policies that challenge the global consensus created by the 1961 UN Convention (Rosmarin and Eastwood, 2012). The Netherlands, which has the longest tradition of employing decriminalisation policies in Europe, also has the lowest per capita number of people who inject heroin compared with all other EU countries. Reporting a fall in heroin users from 30,000 in 2001 to 18,000 in 2008 (Trance, 2012: 7).

This highlights the complexity, and even the contradictions, inherent in international drug prohibition policy. How can international treaties be observed when so many countries, are searching for a new way of interpreting existing global legal proscriptions on certain commodities? When even the USA, the biggest backer of this policy has its own domestic pressure to 'soften' its approach through the recent votes to legalise marijuana, there is a suggestion that the Single Convention in its present form may be dismantled completely at some point in the future. What may be beginning to occur is the formation of blocs within the UN that are calling for change. Many of the Latin American countries are examples of what may be referred to as 'like-minded states', getting together to attempt to drive the debate to higher levels (Lines, 2010).

Unintended effects of prohibition

Synthetic cannabinoid receptor agonists (SCRAs) were originally developed by the pharmaceutical industry to:

> have potential therapeutic uses as appetite suppressants and as agents that improve memory. (Reggio, 2009: vi)

However, these substances emerged onto the drugs scene in the early to mid-2000s as 'legal highs' or 'new psychoactive substances' and marketed as 'legal alternatives' to cannabis. What the industry thought would be an alternative to cannabis (a plant, which cannot be patented) to treat ailments already associated with therapies containing THC and CBD (Reggio, 2009), soon turned out to be a particularly volatile substance with many health and social adverse consequences.

These products, commonly known as 'Spice' (among other branded names such as 'K2' and 'Black Mamba'), quickly attracted the attention of the media in the UK and elsewhere, with various 'zombie' headlines (e.g. The Mirror, 2019) due to the extreme debilitating effects of the drug on its users. While this is a fairly toxic and potent 'version' of cannabis, its attraction was initially due to its 'legal' nature, meaning users would not be subject to prosecution under the UKMDA (1971). The popularity of these products has since declined though, with the introduction of the Psychoactive Substances Act (2016), which effectively criminalised SCRAs to similar extents as their real counterpart – cannabis.

Indeed, use of SCRAs has been reduced to those on the margins of society – targets of redtop newspapers – often homeless with complex mental health needs. Closely followed by those in prison, largely due to the smoking ban and the ease with which the substance can enter jails (Public Health England, 2015). Some media attention has highlighted that these drugs have managed to get a foothold in vulnerable and marginal communities with occasional attempts from broadsheets in offering 'understanding' of the situation (The Guardian, 2019).

If ever there was an argument for the legalisation of cannabis, surely this is it. Very few would countenance the use of noxious substances if there was a legal, less harmful one available as illustrated by Grace et al.'s (2020) study of released prisoners in England rejecting 'Spice' in favour of cannabis. SCRAs are rarely used where cannabis is either legal or decriminalised.

Conclusion

The purpose of this piece is not to provide definitive answers to what has become a serious and chronic public health and criminal justice problem, so much as to open the area for rational debate. The debate surrounding drug policy has historically been shrouded in fear of speaking out against those purporting to represent the moral majority. Morals have been used unashamedly over time as a way of portraying drug users as 'the other' (Berridge, 2013). From Anslinger's 'Assassin of Youth' (Anslinger, 1937) to the character assassination of Prof David Nutt for campaigning for drug law reform (Luger, 2011) morals have shaped the policy agenda. With the global policy landscape moving toward forms of legalisation, regulation and decriminalisation (GDPC, 2018), the option of nullifying debate on the issue is becoming increasingly indefensible.

For many people, neither legalisation nor even decriminalisation of some/all drugs will be a solution they are prepared to countenance, but in some respects this is beside the point, as they would not use drugs any more than they use other things they eschew but others

enjoy. There is considerable evidence to indicate that the drug laws (national and international) are unfit for purpose and may exacerbate the situation. We can either re-evaluate the situation rationally and pragmatically or face the prospect of fifty more years of failure.

On top of this, we are now experiencing a global pandemic in the form of the Covid-19 virus, which will have had numerous, as yet undocumented, negative effects on the harms experienced by many drug users worldwide. Availability and price will no-doubt have reduced and increased with their symbiotic relationship that will have affected patterns of use, and even moved many from their drug of choice to more volatile replacements. The argument for regulation of all drugs is more relevant now than ever.

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