



# What can be done about:

# Drugs

Price  
40p

## What is a 'recreational' drug?

The brain maintains basic functions such as breathing mostly without conscious thought. It organises appropriate reactions to stimuli reaching it via the senses, for example touching a hot surface or hearing a request. It initiates action such as seeking food. We would be dull personalities however if this was all. Happily the brain can dream, imagine and feel emotion such as excitement and euphoria. Sometimes we feel 'alive' or 'over the moon'. Recreational drugs can enhance performance, remove anxiety and cause euphoria - *chemically*. They override the brain's normal perception of the world.

## What is the drug 'problem'?

Drug use is increasing. 29% of 16-59 year olds have used cannabis at some time but 44% of 16-29 year olds have done so. 1% of this younger group has already used heroin and 5% cocaine, the most dangerous drugs. The health, criminal justice and 'social' costs of most users is small, about £40m/yr, but the costs of dealing with 'problem drug users' was put at £15.4 bn in 2003/04 of which 90% was for drug-related crime. A heroin or crack cocaine addict is estimated to need £10-20,000/year to feed the habit. The drugs 'market' is believed to involve some 300 importers, 3000 'wholesalers' and 70,000 street dealers (pushers) and estimated to be worth

£5.3 bn, 41% of the market for alcohol. Over £1 bn is spent on each of heroin, crack cocaine and cannabis: near £1 bn on powder cocaine.

## What drugs are in use?

The main recreational drugs are listed in Table 1 and described in more detail below. When considering the drug problem it is

common to lump all illegal drug taking together but closer analysis shows very wide differences.

For example the probability of addiction varies and so do the health risks. Many drugs have therapeutic as well as recreational uses. Some legal drugs appear to be more hazardous than illegal ones (see Table 1) and it is not certain the illegal drugs are



*Opium poppies growing legally in Tasmania*

classified in logical order (points made forcefully in a July 2006 House of Commons Select Committee report).

A further dilemma is that many people can take even the most dangerous drugs without becoming addicted or causing harm to others or much harm to themselves. Criminalising such activity is illogical, wasteful of criminal justice resources, and risks charges of 'killjoy' and 'Nanny State'. The following paragraphs look at individual drugs in more detail. It draws heavily on work by Professor Iverson<sup>1</sup> of Kings College, London

## Heroin

The dried seeds of the **opium** poppy were smoked or taken in alcohol as **laudanum** and widely used to relieve pain in the 19th century and earlier. **Morphine**, an extract of opium, is still a pain relieving drug of first choice though both it and opium are now known to be addictive. In 1898 Bayer produced an extract from morphine which was believed to be safer and called this 'heroic' drug **heroin** (slang, **smack**). It can be smoked on tin foil and inhaled (a mode called 'chasing the dragon'), snorted or, most commonly, injected into a vein by needle. It gives an intense pleasurable euphoria and total relief from anxiety but withdrawal leads to a craving for the

Drug	Addiction Risk	Deaths 1996	Effect	Class
Heroin/methadone	High	187/357	Eu	A
Cocaine	High	15	Eu	A
Amphetamines (injected)	High	29 (part)	Eu	A
LSD	Low	0	Eu	A
Nicotine	High	120,000	St	
Alcohol	Medium	4,235	Eu	
Solvents	Medium	>70	Eu	
Amphetamines	Low	29 (part)	St	B
Ecstasy	Low	12	St	A
Temazepan	Low	95	Sed	C
Cannabis	Low	4	Eu	C
Caffeine	Low	0	St	

*Table 1 - Recreational drugs in rough order of hazard*

*Eu = Euphoriant St = Stimulant Sed = Sedative*

*Notes: Figures for deaths are the best available but only approximate. Deaths from, say, nicotine take years but ecstasy only hours.*

*Drugs are classified under the Misuse of Drugs Act 1971, Class A being the most dangerous*

■ Illegal ■ Legal

## An ALDES Briefing Note

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This briefing note has been written by Richard Balmer. It should be technically accurate, but the views are his alone. If you see errors or have comments, please contact him at 79, Links Drive, Solihull, B91 2DJ, or richard\_balmer@blueyonder.co.uk

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next dose. Addiction is appalling. Costs of all drugs are falling but heroin can still cost over £50/day. Addicts need escalating doses, but high doses depress respiration and can lead to death. The use of contaminated needles can cause infections such as HIV. **Methadone** is heroin taken by mouth. The drug is absorbed via the stomach and consequently acts more slowly giving a lower 'high', but it staves off the craving and, under medical supervision, can help wean some users off heroin itself. Naltrexone counters some of the signals triggered by heroin and has also had some success as a treatment.

### Cocaine

For centuries peasants in Columbia (the current main source of supply) and elsewhere in the Andes found chewing coca leaves induced a feeling of well being, reduced hunger and increased endurance. Coca leaves were actually used in the original Coca Cola. The active chemical, **cocaine**, is snorted into the nose in powder form giving a 20-30 minute intensely pleasurable 'high'. '**Crack**' cocaine is smoked and the high is more intense lasting 2 minutes, with a 20 minute 'buzz'. A hit costs £12-20. The highs are followed by deep depression and a single-minded need for another, relieving, dose. It is thought 10-15% become addicted after just one 'snort'.

### LSD

Lysergic acid diethylamide (slang, **acid**) is one of several hallucinogenic drugs and is more potent than **magic mushrooms** or **ecstasy**. It is not addictive but a bad 'trip' can be frightening. There is a risk too that under its influence a user might, for example, believe they could fly from a high window. LSD costs £1-5 per 'hit'.

### Amphetamines:

Amphetamines are basically stimulants - one reason, no doubt, why they are attractive to the livelier, rock, bands. They were originally used as nasal decongestants (eg Benzedrine) and later used (as Dexedrine) to keep World War II pilots alert. Amphetamines are easy to make and the ability to vary formulas led to the production of 'designer' drugs such as meth-amphetamine (slang, **Speed, Crank**) and a concentrated version called crystal meth (slang, **Ice** or **Base**) recently elevated from a Class B to a Class A drug. Drinamyl tablets called **Purple Hearts** are amphetamines mixed with barbiturates. Methylene-dioxy-methamphetamine (MDMA) is known as **Ecstasy** or **E**.

**Ecstasy** is therefore a stimulant and also a euphoriant with mild hallucinogenic properties. One can rave all night and still feel good. Ecstasy raises body temperature. It was thought this increased the risk of dehydration, causing death, but more recently it has been suggested death comes from the reaction of drinking too much water. Past figures showed that deaths rose six-fold from 1996 to 72 in 2001/2. In that time the cost of pills halved from £16.50 to about £8 and later as low as £3. Deaths have now fallen again to about 30 a year as the adverse effects have been recognised. Drug experts have suggested it be down-rated from Class A to B but Government has brushed off this idea.

Heavy use of some amphetamines risks a form a schizophrenic madness but this appears to be reversible. The long term health effects of amphetamines are not known and it was thought the risks of addiction were low. More recently concern has focussed on **Crystal Meth** (methamphetamine)

following problems in America. The real danger comes when amphetamines are prepared in a form which can be injected into the vein as this greatly increases the intensity of the pleasure and hence craving.

### Sleeping Pills and Sedatives

**Barbiturates** and similar drugs slow down the nervous control system, removing anxiety. They can be supplied legally on prescription but must be used with great care because the control dose is not much lower than the lethal one. They are addictive. Benzodiazepine compounds such as **Valium** and **Temazepam** have been commonly used with the latter being safer and preferred.

### Nicotine

The nicotine in tobacco brings alertness, the ability to think more clearly, and eases anxiety. As with all drugs taken into the lungs it is fast acting and it is also highly addictive: 2 packets will often be sufficient to cause dependence. Withdrawal gives rise to agitation, nervousness, bad temper and a craving for nicotine, but this can be overcome with willpower. The health risks come less from the nicotine itself than the carcinogens and carbon monoxide produced in the burning. These cause bronchitic problems and many cancers besides lung cancer. Smoking in pregnancy deprives the foetus of oxygen, slowing growth and leading to lower birth weights and intelligence. The risks of illness and premature death increase substantially with the *duration* of smoking. The risk from 30 compared to 15 years of smoking is not just double but 20 times as great. Giving up increases life expectancy: the sooner the better. **Snuff** is powdered tobacco, snorted.

### Alcohol

Alcohol produces excitement, intoxication and then sedation. It releases normal inhibitions and can promote reckless and violent behaviour in the street, the home, anywhere. It weakens control of motor functions required for example for walking and driving leading to accidents and death. Some 5-10% of users become addicted. Moderate use may reduce the risk of heart disease and stroke and particular claims are made for red wine. Heavy use can lead to heart attacks and stroke, and steady damage to body organs such as the liver. In excess alcohol is a poison.

### Solvents

A number of organic solvents are used as lighter fuel or propellants, for example, for hairspray. They have similar effects to alcohol.

### Cannabis

When the leaves and flowering heads of the Cannabis plant are dried one has material variously called **marijuana**, **hashish**, **dope**, **weed**, **grass**, **spliff** etc, which can be smoked. Cannabis relieves anxiety and distorts the sense of time. In high doses it may cause hallucination and loss of coherence. It intoxicates and eventually causes sleep like alcohol but does not provoke the same aggressive behaviour. Like alcohol it has a detrimental effect on activities such as driving and work. As with smoking tobacco there are health risks from carcinogens etc in the smoke. It is thought one third of regular users are addicted but there is not the same intensity of craving as with heroin. It is the most widely used of all recreational drugs. One third of the population aged 15-

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50 have tried cannabis and 10% of that group are regular users. In the last few years claims that cannabis has pain relieving efficacy have grown bolder and it is probable that it has a range of medical uses. On the other hand a recent study at Kings College London has suggested that 1 in 4 people have a variant of the so called COMT gene where cannabis use carries a 5 times greater risk of triggering schizophrenia. Cannabis can vary in strength. That known as **skunk** contained 14% of the active chemical tetrahydrocannabinol in 2005 compared to 7% 10 years earlier. Recently a herbal mixture from China, sold as 'Spice Gold' and advertised as giving a 'herbal high', has been found to mimic cannabis though its make up is not known.

### Caffeine

About 70 mg of caffeine is present in a cup of coffee, 35 mg in a cup of tea and about 50 mg in a cola drink. Caffeine relieves tiredness and maintains mental alertness. It is only mildly addictive. Withdrawal can lead to fatigue, headaches and loss of performance.

### The arguments for and against prohibition

The classical liberal position is to allow any activity that causes no harm to *others*. One may climb mountains, box, race cars and so on, despite the risk to life and limb. One may drink alcohol but not in circumstances that might impair one's ability to drive and so risk harm to others. The classical liberal advises that individuals should be treated as 'grown ups' taking responsibility for their actions.

No other person is *automatically* harmed by an individual choosing to take a drug. Harm arises from taking it irresponsibly and the law could be framed this way. It does so with respect to alcohol (and nicotine). It is legal to supply and consume alcohol but illegal to be 'drunk and disorderly'.

This absolutist approach can be tempered by the community accepting a general duty of care, for example by protecting minors; providing accurate information; and picking up any pieces afterwards. All this is done already, though not to the extent many consider necessary.

The counter view, held at present by the Government and, it has to be said, the majority of the national press, is that because some drug taking undoubtedly causes harm to both individuals and society it should be denied to all, as occurred with alcohol in the USA during prohibition. Clearly not all adults act at all times in a responsible manner. Many don't care. Others enjoy taking risks: indeed risk taking, experimenting, can be said to enhance life. Challenging 'authority' is part of youth's rite of passage. Some will not receive, others will not appreciate and yet others will reject the educational messages. Use of the *legal* drug alcohol leads to widespread social disturbance, and smoking to widespread personal harm. Individuals will fecklessly, recklessly, harm themselves and in many cases their families and others. Much crime is drug-related. It is plausible to claim that reducing drug use will reduce crime. In any case the argument goes, the state has a *responsibility* to care for its citizens *even if the individuals themselves don't care*. It should take a precautionary approach and keep harmful drugs from citizens.

At present the debate is focussed on cannabis. In the last year cannabis has reverting back to a class B drug which would carry harsher penalties for *possession* (up to 5 years instead of 2 and higher fines) though not *supply* (up to 14 years for both

class C and B) to signal the greater danger of at least some variants. One side argues that cannabis is merely the first step towards taking more serious drugs and there is some evidence that having 'got away with' smoking cannabis some go on to harder drugs. Their opponents claim that demonising cannabis, which is arguably less harmful than smoking or drinking alcohol, undermines the credibility of the law. If society claims smoking cannabis is harmful, they say, it risks 'crying wolf'. More accurate claims will not be believed.

What receives less attention is why people take drugs in the first place. There seem to be 4 separate reasons: as a dare; for pleasure; for stimulation; to escape. Ultimately there is a 5th reason: because they are addicted. The risk of addiction is higher with some drugs than others; appears to increase with usage, and appears to affect some people more than others possibly due to particular genetic traits. One day a test may be developed to provide guidance on genetic susceptibility but this is not yet available.

Of the 4 initial reasons, the one of most concern is the last: the need to escape. Some individuals have always sought escape. In the 19th century and even today it was through the 'demon' drink, though the well meaning temperance movement has given up on that one. Drugs now provide an alternative route. The reasons to escape are many but include poverty, perceived failure, and social inadequacy. It seems logical to tackle the drug problem from that end, not a ban.

The other concern is the risk of addiction. It is very clear from the table that the top 3 drugs, heroin, cocaine and injected amphetamines pose by far and away the greatest threat. It would be a great deal more credible to defend a ban on these 3 drugs than the present assorted bag-full.

### Decriminalisation in practice.

Decriminalisation would mean that drugs such as cannabis, ecstasy and amphetamine tablets would be on public sale. A pragmatic policy would be to sell them at chemists with controls on age and quantity which exist for legal drugs now. As with tobacco, advertising would not be permitted and warnings would be required on packets. There would be problems preventing under age use as with tobacco and alcohol and of trading drugs across international borders. The policy might attract large numbers of users from other countries though Holland seems able to cope.

Decriminalisation would be a step into the unknown. Other countries have different policies but different cultures. It would be electorally brave and there are no guarantees. The use of drugs could increase due to increased availability and perhaps reduced cost, or could as easily decrease due to loss of 'kudos'. 'Pushers' would be removed from the 'soft' market but there is no guarantee it would reduce the numbers experimenting with harder drugs. There should be savings of police, criminal justice and prison costs. If so the money could be re-invested in more treatment centres.

In truth, drug policy should be decided by 'what works'. If the present policy, with all its recent initiatives, was having success there would be no need to change. It is not. There is a good case for trying something new.

*Ref 1. Professor Leslie Iverson, Wolfson Centre for Age Related Diseases, Kings College, London.  
Information taken from Chap 4 of his book: Drugs: A Very Short Introduction, published by Oxford Univ Press, 2001*

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