Drug Policy and the Public Good

Sponsored by:

The Society for the Study of Addiction (UK)

The Pan American Health Organization

Other SSA books:

Alcohol Policy and the Public Good (1994)

Alcohol: No Ordinary Commodity (2003, 2010)

Declarations (personal & institutional)

- DH, NTA, Home Office, NACD, EMCDDA, WHO, UNODC
- Reckitt-Benkiser, Schering-Plough, Genus-Britannia, GW, Diamo, Napp, Titan, Martindale, Catalent, Auralis, Lundbeck, Astra-Zeneca, Alkermes, Fidelity, Rusan, Mundipharma Europe, Lightlake & others
- NHS provider (community & in-patient), Phoenix House, Lifeline, Clouds House, KCA (Kent Council on Addictions)
- UKDPC (UK Drug Policy Commission), SSA (Society for the Study of Addiction); and two Masters degrees (taught MSc and IPAS)
- Work also with several charities including Action on Addiction, and also with J Paul Getty Charitable Trust (JPGT) and the Pilgrim Trust

DRUG POLICY AND THE PUBLIC GOOD

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The Drugs and Public Policy Group

(our 'invisible college')

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- Purpose/objectives
- Methods/tools
- Measures/evaluation
- Process

‘Treatment works’
(Sorry, You can’t borrow efficacy)

- Surgery works
- Some conditions with no special Rx
- Variability in quality

‘I already know what works’

- Dangerous arrogance
- much of Rx (almost certainly) padding
- disproportionate influence of advertising
- obscures clear support for effective ..
- concentrate on proved quality marks

‘We can’t afford to do research’

- Research for research’s sake
- Research for science’s sake
- Research for treatment’s sake

Quality of evidence

I. Evidence obtained from at least one properly designed randomised controlled trial.

II. - 1… well-designed controlled trials (not RCT).

II. - 2… cohort or case-controlled analytical studies (pref. >1 centre/group).

II. - 3… multiple time series with/without intervention.

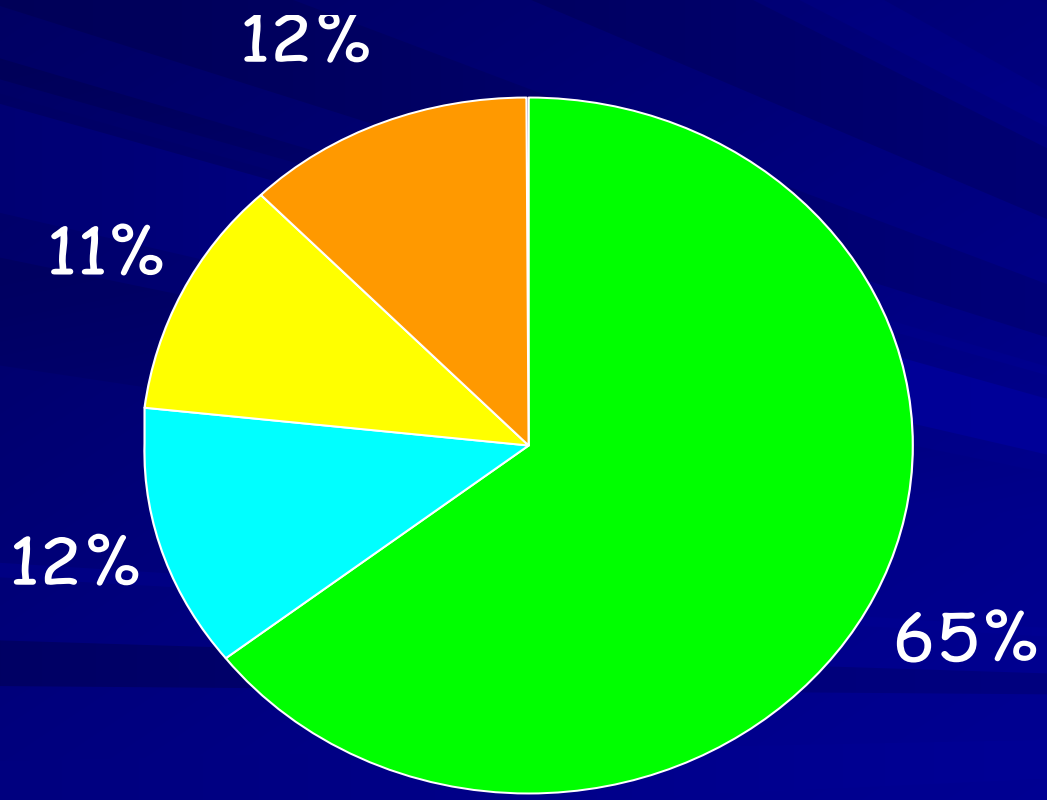
III. Opinions of respected authorities, based on clinical experience/descriptive studies, or reports of expert committees.

Types of Evidence

- Randomized clinical trials
- Descriptive epidemiology
- Quasi-experimental/correlational studies
- Natural experiments
- Qualitative research
- Health services research
- Historical research

What proportion of the pie? UK

Government Expenditure:
Estimated £1.4 billion per annum (2000)



- Law enforcement
- Customs/ Interdiction
- Education/ Prevention
- Treatment/ rehabilitation

Table 7.1 Categorization of strategies and interventions by policy area and broader policy goals

	Policy area	Broad policy goals
Prevention	Drug prevention programmes Mass media campaigns Reducing access for youth through policing	Change attitudes, improve health literacy, and prevent drug use
Services for drug users	Methadone maintenance Counselling, therapeutic communities Coerced abstinence through probation/parole supervision Needle exchange programmes	Reduce use, improve health, reduce crime and overdose deaths, prevent spread of blood-borne viruses, treat psychiatric disorders
Supply control	Arrest traffickers/dealers Force suppliers to operate in inefficient ways	Keeping prices high and reducing availability
Prescription regimes	Regulate pharmaceutical companies, pharmacists, and physicians	Allow psychoactive substances to be consumed for approved purposes, prevent use for non-approved purposes
Criminal sanctions	Increase penalties for drug possession and use Decrease penalties for some types of drug use (e.g. cannabis)	Deter drug use; prevent normalization and contagious spread of drug use. Prevent negative effects of criminalizing less harmful forms of drug use

Table 9.1 Selected studies of opiate substitution therapy

Study	Participants per group	Intervention	Outcome
Maintenance versus detox (Newman and Whitehill 1979)	$n = 50$ patients with heroin addiction	Methadone maintenance (100 mg) versus methadone dose reduction (decreased by 1 mg/day from 60 mg start)	After 32 weeks, 72% of maintenance patients were still receiving services versus only 10% of the dose-reducing group. Only the maintenance group showed reductions in heroin use.
Maintenance versus detox (Sees *et al.* 2000)	$n = 88$–91 patients with opioid dependence	Ongoing psychosocial services with methadone as a maintenance versus detoxification treatment	Methadone maintenance patients were retained longer (438 days versus 174 days) and showed double the opioid abstinence rate (42% versus 20%) relative to medically managed withdrawal patients ($P < 0.01$).
Dose (Ling *et al.* 1976)	$n = 142$–146 VA patients with opioid dependence	LAAM (80 mg) versus low (50 mg) versus high (100 mg) dose methadone	High dose methadone patients had the best rate of retention. Both LAAM and high dose methadone groups had better global drug use outcomes than the low dose methadone group ($P < 0.005$).
Dose (Strain *et al.* 1999)	$n = 95$–97 patients with opioid dependence	Moderate (4–50 mg) versus high (80–100 mg) dose methadone	Both groups decreased illicit opioid use; high dose had significantly greater reductions in opioid use ($p = 0.01$)
Psychosocial services (Woody *et al.* 1995)	$n = 6231$ patients receiving methadone for opiate dependence	Drug counselling versus drug counselling + psychotherapy with comparable contact hours	Opiate use comparable at 6 months, but cocaine-positive urines less frequent in therapy condition (22% of weeks versus 36%, $P < 0.02$).
Psychosocial services (McLellan *et al.* 1993)	$n = 32$–35 patients with opioid dependence	Methadone prescription only vs. with standard psychosocial services vs. with enhanced psychosocial services	All interventions decreased illicit drug use. Increases in services led to a greater percentage of patients showing heroin abstinence ($P < 0.01$). The enhanced service group had better employment, alcohol use, and legal outcomes ($P < 0.05$).
Cost-effectiveness (Barnett 1999)	N/A	Cost-effectiveness analysis to compare methadone maintenance treatmentwith standard care	Methadone maintenance has an incremental cost-effectiveness ratio of <US$6000/quality-adjusted life year. This is substantially more cost-effective than the usual standard of US$50, 000/quality adjusted life year for health care interventions.

Intervention	Effectiveness[a]	Amount of research support and cross-national testing[b]	Comments
Chapter 8: school, family, and community programmes			*Target group*: non-users of dr parents, and the general publ
Family/parenting programmes	Some studies show effectiveness in reducing the onset of drug use.	A few studies conducted in the USA only.	Positive findings for the univer Families Programmeme for 10 including longer term follow-u tiveness analysis. Replication s Other family/parenting progra been evaluated as positively.
Environmental/classroom management programmes	Some evidence supporting the Good Behavior Game.	A few studies conducted in the USA only.	In one study the Good Behavi lifetime drug abuse by up to 5 years after exposure to the pr even stronger effects with boy 6 as highly aggressive and dis study did not find the same le of impacts over the longer ter research has not provided stro
Social or life skills	Most evaluations have not examined effectiveness beyond immediate and short-term follow-up, where the evidence is equivocal. Some evidence of positive impact over the medium to longer term.	Several high quality studies conducted in USA only.	A small number of evaluations positive intervention effects fr prevention programmes for ca also for use of other drugs.

Chapter 9: Services to change behaviour

Intervention	Effectiveness	Amount of research support and cross-national testing
Methadone Maintenance	Good evidence for reduced heroin use, other drug use, crime, HIV infection, and hepatitis.	Numerous studies in high income countries, some in LAMI countries.
Buprenorphine Maintenance	Good evidence for reducing heroin use, other drug use, crime, HIV infection, and hepatitis.	Tested in several countries but not in LAMI countries.
Heroin Substitution	Limited effectiveness as a way to reduce crime and infection among chronic recidivists	Recent programs evaluated in Switzerland, the Netherlands, Germany, Canada, and the United Kingdom.
Opiate Antagonists (e.g., naltrexone, naloxone)	Some evidence for reduced opiate use but medication compliance is major limitation.	Few studies outside of the USA

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Chapter 9: Services to change behaviour

Needle Exchange (NEP)	May reduce drug-related HIV infections and facilitate treatment engagement.	Research in Canada, the United Kingdom, Australia, and the USA
Psychosocial Treatment	Good evidence for reducing drug use, drug-related problems, and criminal activity.	Numerous studies in many countries, including LAMI countries.
Peer Self-help Organizations	Good evidence for reducing drug use, crime, and infections.	Evidence available from several countries including the United States, the United Kingdom, and China.
Naloxone Distribution	Some programmes have shown successful resuscitation.	Only a few studies in the United States and the United Kingdom.
Brief interventions in general medical settings	Good evidence for reducing drug use by at-risk drug users	Evidence from the United Kingdom, the United States, India, Australia, and Brazil.

Three service system changes that made a difference

1. Introduction of large scale opiate substitution services in France and Switzerland.

2. Creation of the drug court system in the United States.

3. Promotion of clinical practice guidelines for opiate substitution in the United Kingdom.

Treatment and Harm Minimization

- Services for opiate dependent individuals have the strongest supporting evidence; and they are also effective ways to reduce drug-related crime and the spread of HIV infection.

- Some harm reduction programs, such as needle exchange programs, reduce high risk injection practices and engage IDUs in treatment and health services.

Where services are sited in different countries

- Specialized drug and alcohol services
- Psychiatric care
- The general medical care system, including primary health care, general hospitals and teaching hospitals.
- The criminal justice/prison system.
- The social welfare system/youth services system.
- The voluntary sector.

Key qualities of service systems for drug users

- **Accessibility**: How easy/difficult is it to enter the service system?; and are necessary services provided following admission?

- **Coordination**: Are services provided in a concerted? Or in haphazard fashion? Do different programs in the system work synergistically?

- **Economy:** Are services cost-effective (i.e., given the same total costs, could one achieve better outcomes with a different system?).

- **Coerciveness:** What degree of coercion or pressure placed on drug users to seek services? n.b. highest in the criminal justice system but often present in subtle ways (e.g., family pressure) elsewhere.

- **Stigma:** Are services viewed as low-status, shameful, and of no value, irrespective of their objective characteristics?

Section III

The evidence base for drug policy: research on strategies and interventions

Section V

Synthesis and conclusions

utine government administration (e.g. how to purify water or build a sturdy
e), social problems have to be 'solved' again and again by each generation
son 1978). Policy can minimize the damage drugs cause and influence what sort
ug problems exist, but it does not allow a society to choose to be completely free
ug problems (Kleiman 1992).

Scientifically grounded conclusions about drug policy

ugh science is unable to forecast confidently the precise effects of many potential
changes (e.g. legalization of all drugs), it can pronounce more authoritatively
her drug policy options. The authors have come to consensus that the evidence
ved in this book supports the following 10 conclusions.

16.3.1 There is no single drug problem within or across societies; neither is there a magic bullet that will solve 'the' drug problem

Various sections of this book (Chapters 3, 4, and 14) revealed that societies differ substantially in the specific drugs that are problematic, the patterns in which drugs are used, the damage associated with drug distribution and use, and the ways in which various substances are controlled, among myriad other factors. There are significant variations as well within societies, for example between the sexes, across races and age groups, and at different stages of a drug epidemic. There is, as a result, no single, globally homogenous 'drug problem'.

For every complex problem,
there is an answer ……

H.L. Mencken

For every complex problem, there is an answer that is clear and simple ……

H.L. Mencken

For every complex problem, there is an answer that is clear and simple and wrong

H.L. Mencken

However, to quote H.L. Mencken, '[f]or every complex question there is an an
that is clear, simple and wrong'. We offer this caution about the search for a si
solution to a complex drug problem, including the assumption that the same
policy will have the same impact in different societies.

16.3.2 Many policies that affect drug problems are not considered drug policy, and many specific drug policies have large effects outside the drug domain

Chapters 2, 3, and 4 have established that drug problems are often intermixed
other social, psychological, and behavioural problems, and that the predicto
young people developing future drug problems are similar to the predictors of d
oping many other difficulties. As a result, policymakers would be ill advised to ass
that only specific 'drug policies' influence drug problems. Economic policies
example, will almost certainly have spillover effects into drug problems because ch
es in a society's economic situation typically impact a range of health behaviours
outcomes (Kiernan *et al.* 1989; Ruhm 2000). The social welfare net a society prov
will also influence its drug problems, for example by determining how long

method to pursue this goal would be to expand OST for opiate-dependent individuals. Yet many policy planning groups convened to reduce street crime include not a single expert in services for drug users. Although more widely appreciated in most societies, the same point holds for efforts to reduce child abuse or a society's prevalence of infectious diseases, all of which may be substantially enhanced by coordination with existing drug policies.

16.3.3 Efforts by wealthy countries to curtail cultivation of drug-producing plants in poor countries have not reduced aggregate drug supply or use in downstream markets, and probably never will

Several wealthy countries, most notably the USA, have invested billions of dollars in efforts to reduce cultivation of drug-producing plants in poor countries. One such approach described earlier in Chapter 10 is called alternative development, which encourages substitution of drug-producing plants with legal crops. A Congressional inquiry into US efforts of this sort in Afghanistan showed not only that agricultural development

16.3.4 Once drugs are made illegal, there is a point beyond which increases in enforcement and incarceration yield little added benefit

Drug prohibition is regarded by many policymakers and much of the public as essential. It increases the price of drugs, stigmatizes drug use, and prevents large-scale corporate entities from promoting drug sales through modern marketing techniques. After these 'structural consequences of illegality' are attained and maintained through routine levels of enforcement, increasing enforcement against drug dealers produces diminishing returns. That is, even if very large numbers of people are incarcerated, drug prices do not rise and availability does not decline much beyond what could be

diminishing returns. That is, even if very large numbers of people are incarcerated, drug prices do not rise and availability does not decline much beyond what could be expected from routine enforcement of drug laws. Further, there may be perverse effects if law enforcement resources are diverted to arresting and incarcerating drug dealers when other crimes that would otherwise claim police attention are neglected (Kleiman 1992; Rasmussen and Benson 1994).

16.3.5 Substantial investments in evidence-based services for opiate-dependent individuals usually reduce drug-related problems

Chapter 9 reviewed a number of health and social services that are intended to reduce drug use and related problems (e.g. crime, transmission of infectious disease). Yet, as shown in Chapter 15, most societies invest in these services at a low level, resulting in limited access and inadequate quality. If a society is committed to 'doing something' about its drug problem, a substantial expansion of such services, particularly for people dependent on opiates, is likely to produce the broadest range of benefits. If the

drugs most heavily and with the most severe consequences. We would emphasize also that the scientific evidence strongly supports the proposition that such services benefit both the drug user and the broader society. Families whose houses might be robbed have as much interest in expanded services for drug users as do the opiate users who commit burglaries to support their drug habits.

16.3.6 School, family, and community prevention programmes have a collectively modest impact, the value of which will be appraised differently by different stakeholders

There are only a small number of high quality studies from the USA that support particular family-based or classroom management programmes in terms of preventing drug use. Interestingly, these programmes do not focus exclusively or specifically on drug use but rather on improving behaviour and social skills more generally, within a family or a classroom environment, and they also show evidence of wider effect beyond drug use and misuse. Prevention programmes that are delivered to younger people before they initiate drug use, that are based on social, psychological, and developmental theories, and that target a broad set of mental, emotional, and behavioural disorders

tion programmes are cost-effective even when they are only modestly effective
gesting that the proverbial ounce of prevention is worth a pound of cure. Whethe
argument is compelling will be likely to depend on the time horizon a policymak
society uses to assess the return on investment in a prevention programmne.

16.3.7 The drug policy debate is dominated in many countries by four false dichotomies that can mislead policymakers about the range of legitimate options and their expected impacts

Under conditions of conflict and high emotion, human beings are prone to per
sharper distinctions than are empirically accurate (Weick 1984). This is true in
drug policy debates, and it creates at least four false choices. First, as this book n
clear, the allegedly distinct approaches of law enforcement and health services (s
times shorthanded as 'cops versus docs') each make significant contributions t

The 4 false dichotomies

- Law enforcement ‘versus’ treatment
  - (‘cops versus docs’)
- Abstinence ‘versus’ harm reduction
  - Mistakenly presented as either/or
- ‘legal’ ‘versus’ ‘illegal’ drugs
  - (‘good drugs’ versus ‘bad drugs’)
- ‘drug users’ ‘versus’ ‘mainstream society’
  - (overlapping; and health and social and c.j. gain for all)

g use derives from medications diverted from the legal market. And as noted
pter 2, tobacco, a largely legal substance, causes far more health damage tha
y of the illegal substances.

ourthly, the putative trade-off between the interests of heavy drug users and thos
he rest of society are also often overstated. To take one example mentioned earli
he book, service systems established for the benefit of drug-dependent people
ayer expense may prevent more HIV infections among non-users than they d
ng drug users.

3.8 Perverse impacts of drug policy are prevalent

iron law of unintended consequences is a commonly cited principle in politic
nce and public discourse. Perhaps all policy analysts in all fields would make th
e observation, but in the drug policy field this law seems unusually apt. The exam
mentioned in the book include heroin and morphine prescription regimes th
to diversion and overdose in the UK, US decertification threats that lead to brut
ernment actions in low and middle income countries, and stigma-promoting pr
ion programmes that discourage drug-dependent individuals from admitting th

improve matters substantially. Given the law of unintended effects, that policymaker would be wise to survey current policies in light of the historical record and make a full appraisal of whether any of them have unintended negative effects in excess of whatever positive benefits they are likely to produce. In many countries, a policymaker's goals might be better served by repealing existing policies or abolishing certain programmes and agencies, rather than attempting new approaches.

16.3.9 The legal pharmaceutical system can affect the shape of a country's drug problem and its range of available drug policy options

As noted in Chapters 3 and 6, the misuse of psychopharmaceuticals has been growing rapidly and is likely to accelerate. In our review of various societies and their drug problems and services, a recurrent theme is the influence of the pharmacy system. When a country has no pharmacy system, or a weak one, policymakers often face sharp trade-offs because admitting a drug for medicinal purposes immediately allows its widespread misuse. The alternative, a law enforcement approach in which the drug

adequate pain control for cancer). Even in societies with well-managed pharmacy systems, diversion of prescription drugs is a serious problem that has been increasing in its dimensions. Nonetheless, the existence of strong pharmacy systems creates other policy options, such as implementing widespread buprenorphine maintenance or asking prescribers to replace dependence-producing medications with less dangerous alternatives. Building up the legal pharmacy system in countries where it is lacking could be the first foothold in developing an effective policy for illicit drugs.

16.3.10 There is virtually no scientific research to guide the improvement of supply control and law enforcement efforts

The lack of research into strategies for enforcement, interdiction, incarceration, and related measures represents a major failure. Independent of how strongly a policymaker values law enforcement and supply control as policy tools, it is difficult to understand why policymakers would not want their policies to be based on good quality evidence. The lack of careful study thus continues to pose a major barrier to applying these policies effectively.

16.4 **Conclusion**

The conclusions above are fewer in number and less confident in tone than some policymakers and many political activists would prefer. This situation reflects the fact that drug policy research has a modest, if growing, evidence base and that we are hewing closely to that evidence base, striving not to advance our personal opinions about how societies should make democratic and cultural decisions regarding drugs. Yet even within the limits of present science, there is no doubt that many drug policies that are known to be ineffective continue to exist, and many that are known to be effective suffer from disuse.

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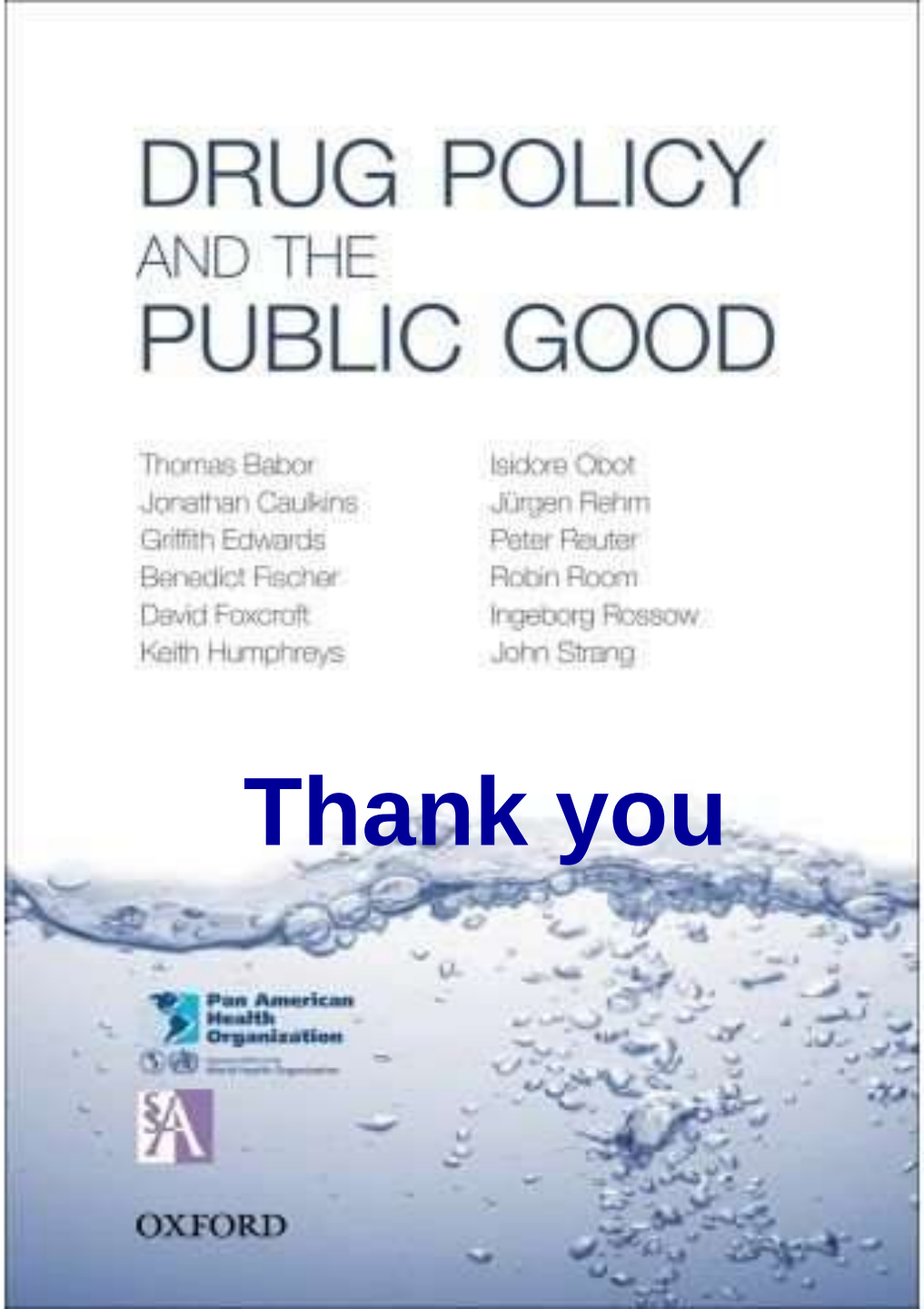
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Thank you
Pan American Health Organization
OXFORD