

CLOSING DISCUSSION

PROF. COLIN BLAKEMORE AND DR. CHARLES SCHUSTER

PROFESSOR COLIN BLAKEMORE IS THE CHIEF EXECUTIVE OF THE MEDICAL RESEARCH COUNCIL, UK

DR CHARLES SCHUSTER OF THE WAYNE STATE SCHOOL OF MEDICINE, IS THE EX-DIRECTOR OF THE NATIONAL INSTITUTE ON DRUG ABUSE (NIDA), US.

Prof Blakemore said that the meeting had opened up taboo subjects in a valuable way. The drug control regimes of the past 30-40 years had not been successful and it is now time to reassess them.

He identified a group of key issues:

- Many strongly-held opinions in this area are not based on evidence and better evidence is needed on the risks of recreational drugs.
- A new flexible system for drug classification should be based on the need for public protection.
- The blurred boundary between therapeutic and off-label drug use raises new problems.
- The boundary between medicinal, illegal and cognition enhancing drugs is also ill-defined.

Dr Charles Schuster expressed his interest in returning to review the impact of Foresight on UK Governmental policy in years to come. He noted that in the 1980s, when he took up directorship of NIDA, the US public's greatest concern was drug abuse, which was reflected in subsequent funding for research. In particular, crack cocaine and the intravenous spread of HIV infection spurred such concerns. At that time, policy was being made by various agencies that only considered supply reduction as appropriate, and ignored harm reduction, especially surrounding HIV at a time when heterosexual transmission was denied. Schuster found that the debate over drugs was dependent on the way in which the problem was conceptualised. For example, an exclusively moral view of drug use suggested zero tolerance initiatives, which precluded the concept of needle exchange and other harm reduction initiatives. This led to contradictory policies and a tension between those who espoused supply reduction, demand reduction and harm reduction. Furthermore, harm reduction strategies were put in the paradoxical position of having to prove their effectiveness before they could be implemented. Evidence now suggests that different initiatives are appropriate for different stages of a drug abuse epidemic.

Dr Schuster pointed out that he shared, probably with many members of the audience, a history of having imbibed a variety of different psychoactive drugs, both legal and non-legal. He thought it important for people to be honest about this type of thing, particularly people in similar positions as his, as ex-director of NIDA.

Among issues he highlighted were:

- Cannabis for medical use. The anecdotal evidence is very strong and justifies controlled clinical trials. However, the concern among the administration is that if evidence suggests cannabis is sufficiently safe for medical use, it is thus safe for recreational use.
- The same applies to psychedelics for people with mental health disorders or terminal illness. In addition, psychedelics can be spiritually beneficial but it is essential to have the right set and setting for a psychedelic experience to be potentially beneficial and not harmful.
- Psychedelics can also enhance creativity by changing the way in which an individual perceives themselves and the world. There is a necessity to look at the potential long-term beneficial effects of drugs such as LSD.
- The difference between those drugs that humans and animals abuse and psychedelics, is that psychedelics are not self-administered by animals and are not addictive.
- Terminology: the term *illicit drugs* has salacious and moralistic overtones whereas the term *illegal drugs* is more neutral and necessary if we are to move away from a moralistic concept towards a public health concept of drug abuse. Drugs used for treating drug addicts should also be referred to as *medications*.
- The issue of personal liberty, not only for drug taking, but for infringement upon personal liberty by those who treat drug abusers. E.g., new long-acting opiate formulations raise issues of whether drug addicts would have a genuine choice to use such agents or whether their use could be coercive.

Schuster stressed that harms associated with obsessive drug-seeking and taking are just as great as harms due to physical toxicity. While vulnerability to drug misuse can be associated with genetic inheritance, early environmental influences or psychiatric problems, there are also many constraints on drug use such as personal values or religion. Fundamentally, reward circuitry in the brain has been developed by evolution to ensure engagement with certain activities, such as eating, and these circuits are co-opted by addictive drug use. This biological predisposition is thus going to be expressed by a small but significant minority. It is therefore important to consider the least intrusive constraints to offer children to prevent development of dependency and addiction. Ultimately, parental engagement with children and the provision of alternative activities to drug use might be more effective than regulation at governmental level. A respondent pointed out that despite the “war on drugs”, it is still easier for a US teenager to buy cocaine than beer.

KEY POINTS

Better evidence of recreational drug use harm is needed to inform a more flexible drug regulation and classification system.

Drug supply reduction policies can work more harmoniously with demand reduction and supply reduction policies by recognising the different stages of a drug abuse epidemic.

Research into the therapeutic potential of cannabis and psychedelics should be welcomed if policy is to move away from a moralistic conception towards a more evidence-based public health conception of drug abuse.

There are both genetic and environmental factors in the genesis of drug abuse but ultimately parental engagement with children and the provision of alternative activities to drug abuse may be more effective than governmental regulation.