

# A personal account

*For decades Britain's most respected drugs official, in retirement 'Bing' Spear became a powerful critic of current medical and government policy. This is his last public statement, made on his behalf shortly before his death on 9 July. It reveals his concern over the contraction of prescribing options and dismisses current political thinking as skin-deep posturing*

WHAT FOLLOWS ARE some thoughts which are the product of 34 years' close contact with the United Kingdom's 'drug problem'. Over these years I experienced a number of conversions, some of which I would like to discuss with you this morning. My main theme is that it is high time for a fundamental review of the whole question of 'substance use'. This does not mean I have gone 'soft' on drugs or joined the growing numbers advocating legalisation or decriminalisation. For me, all the television debates and erudite articles about legalisation are, at the moment, irrelevant and premature.

### **Time to rethink the war**

Why do I think it is time for a rethink? Quite simply, we appear to have lost our way and to be uncertain about the nature of the 'drug problem' or the 'challenge' we are facing. Are we concerned over the growing numbers of mainly young people resorting to substances which society has proscribed, or deemed unacceptable, but whose effects they nevertheless find pleasurable? Or over the harm which this use is doing to individuals or to the wider society?

If it is over youth drug use, we should not forget that people have been using various substances responsibly since the beginning of civilisation and will no doubt be still doing so when the world ends. If it is over harm, we should put this harm – and any harm which can be said to result from our current control policies – into perspective. Most people who use drugs come to no harm and most of the serious consequences are the result of illegality – an argument frequently put forward by would-be legalisers, but one which cannot lightly be dismissed. I am still in contact with a number of addicts who have been taking heroin for over 20 years while leading, by their standards,

The post-1968 'treatment era' was an unmitigated disaster

*from*  
**Bing Spear**

*Formerly Chief Inspector of  
the Home Office Drugs  
Inspectorate*

This paper is edited from one presented in June at the Summer University in Dinard, Brittany. The meeting was organised by T3E, a pan-European exchange, training and research network for professionals in the drugs field (UK contact Kazim Khan, 0171 477 8536), which will publish the paper in full along with others from the meeting. We are grateful for their permission to reprint extracts here.

**PAGE 2: a tribute to 'Bing'**

reasonably normal lives.

Is there not a strong element of hypocrisy in our prevailing attitude to drugs? We are quite content to talk about encouraging responsible drinking, and safer sex to counter the spread of HIV, but any use of drugs is seen as a misuse which must be stamped out.

Given the political will, and the resources, much can be done to alleviate such harm to individuals as does occur through improvements in education, treatment and social support. Far more worrying, and the other main reason why I feel a fundamental review is called for, is the threat to society posed by the immense and inexorably growing power of the criminal syndicates which control the international drug traffic.

That threat was neatly summed up recently by the head of one of our major provincial drug squads. Pointing out that the drug barons were now very powerful, and had the cash to buy public popularity by providing housing, football fields, etc, he added the chilling prediction that "soon they'll be elected and untouchable".

### **Locked in history**

Much has changed since the first attempts were made nearly a century ago, mainly on moral grounds and on the initiative of the USA, to control a few substances which had been used since the early days of civilisation, for the most part with little serious consequences. We need to go back to first principles and, in the light of late 20th century knowledge and attitudes, examine carefully the rationale for these international control policies on which most national responses to drug use are still based. If we are fighting a war against drugs, and if, as the relentless increase in drugtaking globally would seem to confirm, we are manifestly not winning that war, perhaps it is time for another

look at the rules of engagement.

Instead, despite immense public concern and fear of drugs, all we get from our current political masters is rhetoric. Few UK politicians seem prepared to dip more than a tentative toe in the debate about legalisation or decriminalisation, far less engage in a fundamental rethink. They are content to hide behind glossy government publications, which, by proposing more "vigorous law enforcement, accessible treatment and a new emphasis on education and prevention" are primarily designed to reassure a concerned public that the fight against the drug menace is being energetically pursued. What they are usually light on is ensuring service purchasers and providers respond positively to these proposals.

We hear much about the need to educate our children, very little about the need to improve the understanding of those in authority, who did not have to contend with drugs during their formative years. There is a generation gap in information which needs to be closed if rhetoric is to be replaced by constructive, rational debate, to which our political masters can respond.

I make these points not to suggest that drugtaking is safe or that it should be encouraged, merely that there are a number of inconsistencies and double standards in our attitudes and responses to substance use, which might profitably be examined.

### **Treatment era initiated**

The UK's drug controls have their foundation in the 1913 Hague Convention, aimed at restricting the production and availability of certain drugs to "legitimate and scientific needs". From the outset it was accepted that these new controls should interfere as little as possible with normal medical practice and preserve the tradition of complete clinical freedom, which British doctors have long enjoyed.

This fundamental respect for principle that the state should not interfere in medical practice meant that from 1920 until 1968 British doctors had total freedom under the law to treat any patient, including addicts, with any controlled drug, such as morphine, heroin or cocaine, in any quantity or form the doctor considered appropriate. No official body – the Department of Health, the Home Office or the medical profession's own governing body, the General Medical Council – could tell a doctor how he should treat his patients.

That principle still stands, but in 1968 it became necessary to make some

changes in respect of the prescribing of heroin and cocaine to addicts. This was because of increasing addiction to these drugs among a comparatively small group of young people in London, and the irresponsible prescribing of one lady doctor which could not effectively be dealt with under the law as it then stood. Recommendations made by a committee of doctors led to the prescribing of heroin and cocaine for the treatment of addiction being restricted to doctors working at specially established "treatment centres". There was no change in the doctors' right or ability to use heroin and cocaine for other therapeutic purposes, for instance, in cases of painful terminal illness.

The idea behind the treatment centres was that heroin addicts would now be treated by experts, in more suitable settings, as a result of which there would be little or no over prescribing to fuel the

All we get from our political masters is rhetoric and glossy publications

black market. Hopefully, addicts would form a therapeutic relationship with clinic staff and in due course be persuaded to discontinue their drugtaking.

Addicts could not be compelled to go to the new clinics – initially set up in London, where the problem was centred – and prescribing restrictions applied only to heroin and cocaine. This meant that an addict could still attend any other doctor of his choice, but could not be prescribed heroin or cocaine.

### **'Unmitigated disaster'**

With the benefit of hindsight there is no doubt that the 'treatment era' ushered in after 1968 was an unmitigated disaster, not because the basic idea was wrong, but because of the way that idea was developed. The moral high ground was seized by a small group within the medical establishment, in psychiatry in particular, who imposed their own ethical and judgmental values on treatment policy. As a consequence there is now very little prescribing of heroin or any injectable drug to addicts.

This does not mean the 'British system' has failed or been abandoned. The basic principle, that a person addicted to drugs should be able to seek help which may, or may not, include the provision of a regular supply of drugs, remains intact,

despite the intrusion of medico-political prejudices.

Such prejudices mean that today, if there is any prescribing, the favoured drug is oral methadone. This is the drug recommended in official, but not legally binding, treatment 'guidelines', over which the clinic psychiatrists had considerable influence. None of these damaging changes, in which the pervasive US influence is only too apparent, resulted from properly conducted evaluations of the overall effect of clinic prescribing practices since 1968. The first evaluation is about to happen, almost 30 years after the clinics were set up.

I say changes in prescribing policy were 'damaging' because of the very obvious effect they had on drug use beyond the clinics' doors – never something to concern the clinic psychiatrists, whose consistent refusal to acknowledge many of the realities of the wider addict world has been mainly responsible for the increasing irrelevance of the 1968 responses. For a psychiatrist keen to change human nature, these realities include the unpalatable fact that a dwindling proportion of today's drug users are really candidates for psychiatric help and that social and economic, rather than medical factors, lie behind the global increase in addiction. Prescribing will not solve the drug problem, as is sometimes argued, but for the drug user it offers treatment options which merit serious consideration.

So what can be done in the short term about the clearly worsening overall problem? From whatever standpoint, the immediate future looks depressing. The control/enforcement approach of the past 80 years has failed and, as our Royal College of Psychiatrists has noted, "drug problems will not be beaten out of society by yet harsher laws, lectured out of society by yet more hours of health education, or treated out of society by yet more drug experts".

Yet these strategies, with a few variants, appear to be the limits of current international thinking, which is still dominated by the unrealistic prohibitionist attitudes prevalent on the other side of the Atlantic. Until that dominance is successfully challenged, and there is a general acceptance that drug use is here to stay, there will be little improvement.

But there is an answer. As a young freelance journalist friend has written: "Drugs must ultimately be controlled by culture, by customs and conventions behind which the law waits as a recourse of last resort". The problem is – how do we achieve this?