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Equasy – An overlooked addiction with implications for the current debate on drug harms

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The regulation of illicit drugs in the UK is via the 1971 Misuse of Drugs Act [MDAct]. That of legal drugs is via the Medicines Act if they have clinical utility or via trade regulations in the case of tobacco, alcohol, food supplements and vitamins. When a new drug comes along and concerns are expressed about potential harm, its status is reviewed in the UK by the Advisory Council on the Misuse of Drugs [ACMD] which has a statutory duty to advise the UK government on the harms and risks so that appropriate policy can be generated. Typically this leads to a decision to classify it or not under the MDAct.

In recent years, following a systematic review by the ACMD, ketamine (Nutt and Williams, 2004) has been brought under the act into class C whilst khat (Williams and Nutt, 2005) was considered not to require regulation. Recently benzylpiperazine and related stimulant drugs have been reviewed and recommended for a class C status in agreement with the EMCDDA risk analysis (EMCDDA, 2007). Similarly cannabis classification was reviewed in 2002 (ACMD, 2002) and downgraded to class C, a decision subsequently endorsed by two further reviews (Rawlins, *et al*., 2005, 2008). Ecstasy is currently in class A, a position challenged by the House of Commons Select Committee on Science and Technology (2006) which has lead to an ongoing review of its status.

The UK MDAct classifies drugs into three classes, A, B, C on the basis of their harmfulness: *Class A* (the most harmful) includes cocaine, diamorphine (heroin), 3,4-methylenedioxymethamphetamine (MDMA, ecstasy) lysergic acid diethylamide (LSD) and methamphetamine. *Class B* (an intermediate category) includes amphetamine, barbiturates, codeine and methylphenidate. *Class C* (less harmful) includes benzodiazepines, anabolic steroids, gamma-hydroxybutyrate (GHB) and cannabis. This system of classification serves to determine the penalties for the possession and supply of controlled substances. The current maximum penalties are as follows: *Class A drugs*: for possession – 7-year imprisonment and/or an unlimited fine; for supply – life imprisonment and/or fine; *Class B drugs*: for possession – 5-year imprisonment and/or an unlimited fine; for supply – 14-year imprisonment and/or fine; *Class C drugs*: For possession – 2-year imprisonment and/or an unlimited fine; For supply – 14-year imprisonment and/or fine.

How best to assess the classification of a drug is an issue that is and has always been problematic. A potential method for exploring harms has been developed that assesses harms across nine domains; three relate to the personal harms of the drug [acute harms e.g., from overdose, chronic harms and harms due to intravenous use], three relate to its propensity to cause dependence [liking, physical dependence and psychological dependence] and three cover social harms [harms from intoxication, (including anti-social behaviour), harms from supply/dealing, associated acquisitive crime and health care costs]. Each can be scored on a 0–3 scale and a value for each drug derived from which a rank order of harm may be produced (Nutt, *et al*., 2007). In this study, we also assessed alcohol, tobacco and some other misused substances to provide anchor points that would allow non-experts and the general public to better understand the harms of drugs with which they might not have familiarity. This study produced a degree of public debate and considerable media coverage. This taken together with the subsequent coverage of the classification of cannabis (ACMD, 2008) and the ongoing review of 'ecstasy'/MDMA has shown that the arguments about relative drug harms are occurring in an arcane manner, at times taking a quasi-religious character reminiscent of medieval debates about angels and the heads of pins!

The reasons for this are multiple and complex, but one major element is that the drug debate takes place without reference to other causes of harm in society, which tends to give drugs a different, more worrying, status. In this article, I share experience of another harmful addiction I have called equasy to illustrate an approach that might lead to a more rational and broad-based assessment of relative drug harms.

The dangers of equasy were revealed to me as a result of a recent clinical referral of a woman in her early 30's who had suffered permanent brain damage as a result of equasy-induced brain damage. She had undergone severe personality change that made her more irritable and impulsive, with anxiety and

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loss of the ability to experience pleasure. There was also a degree of hypofrontality and behavioural disinhibition that had lead to many bad decisions in relationships with poor choice of partners and an unwanted pregnancy. She is unable to work and is unlikely ever to do so again, so the social costs of her brain damage are also very high.

So what was her addiction – what is equasy? It is an addiction that produces the release of adrenaline and endorphins and which is used by many millions of people in the UK including children and young people. The harmful consequences are well established – about 10 people a year die of it and many more suffer permanent neurological damage as had my patient. It has been estimated that there is a serious adverse event every 350 exposures and these are unpredictable, though more likely in experienced users who take more risks with equasy. It is also associated with over 100 road traffic accidents per year – often with deaths. Equasy leads to gatherings of users that often are associated with these groups engaging in violent conduct. Dependence, as defined by the need to continue to use, has been accepted by the courts in divorce settlements. Based on these harms, it seems likely that the ACMD would recommend control under the MDAct perhaps as a class A drug given it appears more harmful than ecstasy (See Table 1).

Have you worked out what equasy is yet? It stands for ***E***quine ***A***ddiction ***S***yndrome, a condition characterised by gaining pleasure from horses and being prepared to countenance the consequences especially the harms from falling off/under the horse. I suspect most people will be surprised that riding is such a dangerous activity. The data are quite startling – people die and are permanently damaged from falling – with neck and spine fracture leading to permanent spinal injury (Silver and Parry, 1991; Silver 2002). Head injury is four times more common though often less obvious and is the usual cause of death. In the USA, approximately 11,500 cases of traumatic head injury a year are due to riding (Thomas, *et al.*, 2006), and we can presume a proportionate number in the UK. Personality change, reduced motor function and even early onset Parkinson's disease are well recognised especially in rural clinical practices where horse riding is very common. In some shire counties, it has been estimated that riding causes more head injury than road traffic accidents. Violence is historically intimately associated with equasy – especially those who gather together in hunting groups; initially, this was interspecies aggression but latterly has become specific person to person violence between the pro and anti-hunt lobby groups.

Making riding illegal would completely prevent all these harms and would be, in practice, very easy to do – it is hard to use a horse in a clandestine manner or in the privacy of one's own home! I suspect there would be little public or government support for such an option despite the banning of inter-species violence from equasy recently enacted in the Anti-Hunting bill. Indeed why should society want to control harmful sports at all? This attitude raises the critical question of why society tolerates –indeed encourages – certain forms of potentially harmful behaviour but not others, such as drug use. There are many risky activities such as base jumping, climbing, bungee jumping, hang-gliding, motorcycling which have harms and risks equal to or worse than many illicit drugs. Of course, some people engage in so called 'extreme' sports specifically because they are dangerous. Horse riding is not one of these and most of those who engage in it do it for simple pleasure rather than from thrill seeking, almost certainly in complete ignorance of the risks involved. Other similarly dangerous yet fun activities are rugby, quad-biking and boxing. With the exception of boxing, which is outlawed in some European countries, sports are not illegal despite their undoubted harms.

So why are harmful sporting activities allowed, whereas relatively less harmful drugs are not? I believe this reflects a societal approach which does not adequately balance the relative risks of drugs against their harms. It is also a failure to understand the motivations of, particularly younger people, who take drugs and their assessment of the perceived risks compared with other activities. The general public, especially the younger generation, are disillusioned with the lack of balanced political debate about drugs. This lack of rational debate can undermine the trust in government in relation to drug misuse and thereby undermining the government's message in public information campaigns. The media in general seem to have an interest in scare stories about

Table 1 A comparison of ecstasy and equasy using the 9-point scale.

Parameter of harm	Ecstasy	Equasy
Acute harm to person	+1 per 10000 episodes	++1 per 350 episodes
Chronic harm to person	+?	++
Intravenous use	Not applicable	Not applicable
Euphoric effects	++	+/++
Physical withdrawal	−/+	−
Psychological withdrawal	−/+	+?
Harm to society: RTAs etc.	?	+ (methane emissions also)
Dealing harms	+	− (as legal)
Societal costs: NHS etc.	+	+

RTA, Road Traffic Accident; NHS, National Health Service.
− = harm; + = more harm.

illicit drugs, though there are some exceptions (Horizon, 2008). A telling review of 10-year media reporting of drug deaths in Scotland illustrates the distorted media perspective very well (Forsyth, 2001). During this decade, the likelihood of a newspaper reporting a death from paracetamol was in per 250 deaths, for diazepam it was 1 in 50, whereas for amphetamine it was 1 in 3 and for ecstasy **every** associated death was reported.

Is there a lesson from these relative comparisons of harms and risk that regulatory authorities could use to make better drug harm assessments and thus better laws? The example of equasy when compared to the use of drugs highlights the divergence between the activities in terms of levels of risk and social and moral acceptability. Perhaps this illustrates the need to offer a new approach to considering what underlies society's tolerance of potentially harmful activities and how this evolves over time (e.g. fox hunting, cigarette smoking). A debate on the wider issues of how harms are tolerated by society and policy makers can only help to generate a broad based and therefore more relevant harm assessment process that could cut through the current ill-informed debate about the drug harms? The use of rational evidence for the assessment of the harms of drugs will be one step forward to the development of a credible drugs strategy.

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