

**Report of the Legal Frameworks Group
to the King County Bar Association Board of Trustees:**

**International Trends in Drug Policy:
Lessons Learned from Abroad**

**King County Bar Association
Drug Policy Project**

1200 Fifth Avenue, Suite 600
Seattle, Washington 98101
206/267-7001

www.kcba.org

Introduction

This report is the product of the Legal Frameworks Group of the King County Bar Association Drug Policy Project, which included the participation of more than two dozen attorneys and other professionals, as well as scholars, public health experts, state and local legislative staff, current and former law enforcement agents and current and former elected officials. The Legal Frameworks Group was established as an outgrowth of the work of the Task Force on the Use of Criminal Sanctions, which published its own report in 2001 examining the effectiveness and appropriateness of the use of criminal sanctions related to psychoactive drug use.

The Criminal Sanctions Task Force report found that the continued arrest, prosecution and incarceration of persons violating the drug laws has failed to reduce the chronic societal problem of drug abuse and its attendant public and economic costs. Further, the Task Force found that toughening drug-related penalties has not resulted in enhanced public safety nor has it deterred drug-related crime nor reduced recidivism by removing drug offenders from the community. The Task Force also chronicled the numerous “collateral” effects of current drug policy, including the erosion of public health, compromises in civil rights, clogging of the courts, disproportionately adverse effects of drug law enforcement on poor and minority communities, corruption of public officials and loss of respect for the law. Based on those findings, the Task Force concluded that the use of criminal sanctions is an ineffective means to discourage drug use or to address the problems arising from drug abuse, and it is extremely costly in both financial and human terms, unduly burdening the taxpayer and causing more harm to people than the use of drugs themselves.

The Legal Frameworks Group, building on the work of the Criminal Sanctions Task Force, moved beyond the mere criticism of the current drug control regime and set out to lay the foundation for the development of a new, state-level regulatory system to control psychoactive substances that are currently produced and distributed exclusively in illegal markets. The purposes of such a system would be to render the illegal markets in psychoactive substances unprofitable, to improve restrictions on access by young persons to psychoactive substances and to expand dramatically the opportunities for substance abuse treatment in the community. Those purposes conform to the primary objectives of drug policy reform identified by the King County Bar Association in 2001: to reduce crime and public disorder; to enhance public health; to protect children better; and to use scarce public resources more wisely.

This report is the second of five major research initiatives supporting a resolution by the King County Bar Association seeking legislative authorization for a state-sponsored study of the feasibility of establishing a regulatory system for psychoactive substances. This report surveys innovative developments around the world in approaches to the problems of drug abuse and drug-related crime, searching for appropriate models to replicate or adapt in the United States.

INTERNATIONAL TRENDS IN DRUG POLICY: LESSONS LEARNED FROM ABROAD

Nations across the world face the continual challenge of drug abuse and drug-related crime within their own borders and, like the United States, they struggle with the costly ineffectiveness of their current drug policies. Just as many American states are beginning to depart from the harshly punitive approach through innovations such as drug courts, several nations, particularly in Europe, have devised methods under the rubric of “harm reduction” that have been shown to address the problem of drug addiction more effectively than strict criminal law enforcement. Meanwhile, in other regions of the world, particularly in Asia, states have been turning to ever harsher measures, including summary executions, but with no success in reducing drug use or its attendant harms. The following survey of the most recent international trends in drug policy should provide useful guidance in the effort to improve drug policies in the United States:

INTERNATIONAL LEGAL FRAMEWORK

The current drug control regime is global in scope, under a series of international conventions adopted by United Nations member nations.¹ Most nations are signatories to those treaties, which prohibit the use and sale of the same drugs that are prohibited in the United States.² The U.N. conventions are part of the large body of international law that is not “enforceable” in the traditional sense, but signatories to the drug control treaties are subject to enormous diplomatic pressure, particularly from the United States, not to enact national laws that depart from the prohibition framework.³ The International Narcotics

¹ U.N. ECON. & SOC. COUNCIL, SINGLE CONVENTION ON NARCOTIC DRUGS, 1961, U.N. Doc. UNE/CN.7/GP/1, U.N. Sales No. 62.XI.1 (1961); U.N. ECON. & SOC. COUNCIL, CONVENTION ON PSYCHOTROPIC SUBSTANCES, 1971, U.N. Sales No. E.78.XI.3 (1977); and U.N., CONVENTION AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES, 1988 (1988).

² Robert J. MacCoun and Peter Reuter (2001), *Drug War Heresies*, Cambridge University Press, p. 206.

³ Peter Andreas from Harvard University’s Center for International Affairs describes the political pressure on nations not to withdraw from global drug prohibition: “Open defection from the drug prohibition regime would...have severe consequences, placing the defecting country in the category of a pariah “narcostate,” generating material repercussions in the form of economic sanctions and aid cutoffs and damaging the country’s moral standing in the international community.” Richard Friman and Peter Andreas, eds. (1999), *The Global Economy and State Power*, New York: Roman and Littlefield, pp. 127-8. Dutch scholar Peter Cohen expresses it more dramatically: “The international drug treaties are among the holiest texts of the Drug Prohibition Church. At the Church’s meetings, wherever they are held, you will find people kneeling in ridiculous postures before them, because for them the texts contain the sacred words of the Divine. A reformist perspective on the Treaties or a refusal to kneel before the texts, are very dangerous actions now for countries, as the growing hegemony of the U.S. has consequences that push towards extremism and orthodoxy. The more the U.S. Caesars exploit their hegemony, the more the U.N. Drug Conventions symbolize their desire to define and control Humankind, the same way as their gulag state, armies and armada of aircraft carriers are its material expression.” Peter Cohen (2003), “The drug prohibition church and the adventure of reformation,” *International Journal of Drug Policy*, V.14, no.2, April 2003, pp. 213-215. See also Harry G. Levine (2002), “The Secret of Worldwide Drug Prohibition,” *The Independent Review*, v.VII, no.2, pp. 165-180; and Hans-Jorg Albrecht, “The International System of Drug Control: Developments and Trends,” in Jurg Gerber and Eric L. Jensen, eds. (2001), *Drug War, American Style: The Internationalization of Failed Policy*, New York: Garland, p. 49.

Control Board (INCB), an independent body within the United Nations, serves more as a panel to monitor adherence to the U.N. conventions rather than as an enforcement agency, but it often voices support for or objection to drug policy developments around the world, consistent with prevailing U.S. domestic and foreign drug policy interests.⁴

Within the framework of international drug prohibition, a number of countries, especially in Europe, now employ less punitive measures to address drug use and dependence without endangering their international legal or diplomatic standing – despite occasional public scolding from the United Nations.⁵ Within the European Union, however, fundamental opposition to prohibitionist drug policies has begun to surface among parliamentarians. In 2003 a group of 108 members of European parliaments from seven political groups and 13 European Union member states recommended reform of the United Nations drug control conventions, denouncing prohibitionist policy as the cause of harm “because it is an obstacle to prevention, only leads to blind repression and causes rising profits to organized crime.”⁶ Among European leaders there is certainly no consensus about the wisest approach to drug policy, but there is a desire to reconcile differing views on the matter. Greek Prime Minister George Papandreou, the European Union President in 2003, called for an open and frank discussion of international drug laws to deal with the disparate nature of its members' treatment of the subject.⁷

STRICT PROHIBITION MODEL

The strict prohibition model of drug control is reflected in the current policy of the United States, codified under the federal Controlled Substances Act and complementary executive policies and state and local laws. Under the paradigm of strict prohibition, proscribed drugs and their use are subject to control by the criminal justice system and only complete abstinence is permissible under the law. The primary objective of the strict prohibition model is “use reduction” or “prevalence reduction,” with the eventual goal of eliminating all illegal drug use.⁸ The possession of “soft” drugs, such as marijuana, is either a criminal or a serious civil offense and possession of “hard” drugs,

⁴ For example, the INCB recently warned of “threats to middle-class Americans” by drug traffickers of a new, inhalable form of heroin coming from Colombia. Karl Peter Kirk, “U.N.: Drug Producers Target Middle Class,” *Associated Press*, March 2, 2004. More recently, the U.N. had to back down on its program of providing clean needles to heroin users as part of a campaign to reduce AIDS infection because of U.S. opposition to any program deemed to appear to condone drug use and not to require strict abstinence. “U.S. cash threats to Aids war,” *The Observer* (UK), February 6, 2005.

⁵ The INCB has strenuously warned Canada and other nations that are straying too far from the strict prohibition model of dire international legal consequences. See, e.g., Chad Skelton, “U.N. Needles City Over Injection Site,” *Vancouver Sun*, March 3, 2004, page B1.

⁶ In their joint appeal, the European parliamentarians maintained, *inter alia*, that “the drug prohibition policy stemming from the UN Conventions of 1961, 1971 and 1988 is the actual cause of the increasing damage which the production, trafficking, sale and consumption of illegal substances inflict on entire sections of society, the economy as well as public institutions, thus undermining health, freedom and individuals' lives.” See http://www.radicalparty.org/lia_paa_appeal/.

⁷ “Greek Foreign Minister says international debate necessary to tackle problems with illicit drugs,” *Athens News Agency*, October 6, 2003.

⁸ Robert J. MacCoun (1998), “Toward a Psychology of Harm Reduction,” *American Psychologist*, v.53, pp.1199-1208.

such as heroin or cocaine, is always a criminal offense.⁹ Distribution and manufacturing are always punished even more severely.

American drug control interests extend worldwide, particularly to the countries supplying the drugs that meet U.S. demand. Most of the “source” countries are economically vulnerable and comply with U.S. policies and practices, often employing drug-related punishments more harsh than in the U.S. Southeast Asia is the latest region of the world to be inundated by illegal drugs and the associated criminal enterprises and states such as Thailand have imposed severe, military measures in response, not only inviting criticism from human rights groups, but also failing to abate continued drug abuse problems.¹⁰ Besides drug trafficking, many countries still punish simple drug possession harshly, not only in Asia but even in Bulgaria, which has re-criminalized the possession of small amounts of drugs, punishable by three to fifteen years in prison.¹¹

“Source Control”

The United States remains committed to a vigorous interdiction effort, arguably the most militaristic aspect of the “War on Drugs,” despite decades of failing to stem the plentiful supply of illegal drugs across the border.¹² In the months before the terrorist attacks of September 11, 2001, the top priority for American intelligence agencies was illegal drug interdiction and twice as many agents were assigned to drug enforcement than to counterterrorism.¹³ Despite that effort, the street prices of heroin and cocaine are at a 20-year low.¹⁴ Currently, the U.S. military remains deeply involved in drug interdiction efforts, particularly at the Mexican border and in South America.

⁹ Although the drug control schemes on the federal and state levels predominantly impose criminal sanctions related to illegal drugs, a closer look at some U.S. states and cities reveals a tolerant approach to the possession of small amounts of marijuana. At least twelve of the United States have loosened penalties in recent years. Donna Leinwand, “Canada's plan to allow pot possession causes U.S. rift,” *USAToday.com*, May 8, 2003, at http://www.usatoday.com/news/world/2003-05-07-canadapot-usat_x.htm. In Seattle the recently-enacted Initiative 75 instructs police effectively to turn a blind eye to possession or use of small amounts of marijuana by adults. Beth Kaiman, “Seattle voters favor measure on marijuana,” *The Seattle Times*, September 17, 2003, page A4.

¹⁰ U.S. Department of State (2003), *Human Rights Report*, <http://www.state.gov/g/drl/rls/hrrpt/2003/>; Human Rights Watch (2004), “Timeline of Thailand’s War on Drugs,” August 17, 2004.

¹¹ Brian Bernbaum, “Bulgarian lawmakers get marijuana letters,” *CBS News Online*, April 29, 2004. The passing of the law was met with protests in Bulgaria, including journalists of a trendy Bulgarian magazine placing small amounts of marijuana in legislators’ mailboxes.

¹² While 10-15% of heroin and 30% of cocaine is intercepted internationally, it is estimated that 75% would have to be intercepted to substantially reduce the profitability of drug trafficking. “U.N. Estimates Drug Business Equal to 8 Percent of World Trade,” *Associated Press*, June 26, 1997. Efforts to intercept drugs at the source are also not cost effective. To achieve a one percent reduction in U.S. cocaine consumption, the United States could spend an additional \$34 million on drug treatment programs, or 23 times as much -- \$783 million -- on efforts to eradicate the supply at the source. C. P. Rydell and Susan S. Everingham (1994), *Controlling Cocaine*, Santa Monica: RAND Corporation.

¹³ National Commission on Terrorist Attacks Upon the United States (2004), *The 9/11 Commission Report: Final Report of the National Commission on Terrorist Attacks Upon the United States*, W.W. Norton & Co., pp. 74, 76 and 77.

¹⁴ According to the Office of National Drug Control Policy (ONDCP), cocaine at the wholesale level has continually declined in price from an average of \$125.43 per gram in 1981 to \$38.00 per gram in 1989 and down to \$26.03 per gram in 2000. Office of National Drug Control Policy (2001), *The Price of Illicit Drugs: 1981 through the Second Quarter of 2000*, ONDCP Office of Programs, Budget, Research and

In 2000 the U.S. Congress, with Clinton administration support, provided a \$1.3 billion package for Colombia to combat the illegal drug trade and rebel forces.¹⁵ The failure of “Plan Colombia” was evident early, as the area of Colombia planted with coca actually increased by over 25 percent during the first two years of the military operation and Colombia continued to supply over 80 percent of the cocaine shipped into the U.S.¹⁶ Domestic opposition to “Plan Colombia” continued to mount, and two weeks before the terrorist attacks on the U.S. in 2001, a bipartisan group of legislative leaders in Colombia introduced bills to decriminalize and legalize the drug trade, as former President Ernesto Samper commented: “The problem is that the law of the marketplace is overtaking the law of the state. We have to ask, is legalization a way out of this?”¹⁷

Since September 11, 2001, however the Colombian government has resumed a hard-line stance and has cooperated extensively with the Bush Administration, which has continued to seek increases in the number of military troops and advisors and civilian contractors participating in “Plan Colombia.”¹⁸ After almost four years and \$4 billion invested, even the Director of the White House Office of National Drug Control Policy, John Walters, admitted that the U.S.-sponsored South American anti-drug campaign has failed to dent the flow of Latin American cocaine onto American streets, acknowledging that “we have not yet seen in all these efforts what we're hoping for on the supply side, which is a reduction in availability.”¹⁹

Although the U.S. government points to a decrease in coca cultivation in Colombia as a success, the market is nevertheless robust, as the amount being produced more than satisfies U.S. demand for cocaine, and the trade has adapted by developing new markets outside of the U.S.²⁰ In addition, drug traffickers have produced a genetically engineered strain of “super coca” that is resistant to the defoliating chemicals being sprayed on the coca fields. The potent plant can grow more than twelve feet tall, compared to the regular plant which grows only five feet, and yields four times more cocaine than existing plants, allowing growers to plant smaller fields.²¹

Evaluations, Prepared by: Abt Associates, Inc., October 2001. Table 1, pp. 28-30. A recent update of price and purity reveals a continuation of the same trends. Office of National Drug Control Policy (2004), *The Price and Purity of Illicit Drugs: 1981 Through the Second Quarter of 2003*, Washington, D.C.: Executive Office of the President (Publication Number NCJ 207768), November 2004.

¹⁵ “U.S. drug czar to meet Colombia's president, review aid program,” *CNN.com*, August 9, 2000, at <http://www.cnn.com/2000/WORLD/americas/08/09/colombia.mccaffrey/>.

¹⁶ “Colombia’s Coca Up, U.S. Says,” *The New York Times*, March 9, 2002, p.A5.

¹⁷ Colombians consider decriminalizing drug trade,” *Dallas Morning News*, September 10, 2001, p. A3.

¹⁸ “Bush: Add troops in Colombia,” Bloomberg Newswire, *New York Daily News*, March 23, 2004.

¹⁹ “US Anti-Drug Campaign ‘Failing,’” *BBC News*, Aug. 6, 2004, at: <http://news.bbc.co.uk/2/hi/americas/3540686.stm>. Curiously, a few days later Mr. Walters seemed to contradict his previous statements, touting American-backed efforts as having brought about a 30 percent decline in the production of coca and a sharp reduction in the flow of cocaine into the U.S. “‘Big Decline’ in Colombian Cocaine,” *BBC News*, Aug. 11, 2004, at <http://news.bbc.co.uk/2/hi/americas/3556464.stm>.

²⁰ Juan Forero, “Hide-and-Seek Among the Coca Leaves,” *The New York Times*, June 9, 2004, page A4.

²¹ Jeremy McDermott, “New super strain of coca plant stuns anti-drug officials,” *The Scotsman* (Scotland), August 27, 2004.

Latin American farmers growing coca have organized resistance to the American-led drug eradication efforts, destabilizing their own governments in the process.²² In Bolivia, coca-growing peasants were instrumental in bringing down the presidency of Gonzalo Sanchez de Lozada, who resigned after weeks of violent protests that virtually paralyzed the nation, and Bolivia subsequently softened its stance in support of coca crop eradication efforts.²³

Elsewhere in Latin America, the Brazilian government has authorized the military to shoot down any planes it believes is involved in drug trafficking.²⁴ This type of interdiction strategy has not been popular since a plane carrying innocent civilians was shot down in 2001 by the Peruvian military in conjunction with U.S. intelligence. Colombia resumed their shoot-down program in 2003 and had shot down almost a dozen planes in the first half of 2004 with the backing of the United States.²⁵ Since the election of President Vicente Fox, Mexico has been a strong partner with the United States in the “War on Drugs,” but the lure of profit in the drug trade still corrupts police forces across Mexico. All the detectives on one of Mexico’s state police forces were suspended recently after two top officers were arrested on federal drug trafficking charges.²⁶ Furthermore, despite the Mexican government’s fumigation efforts, opium poppy production increased 78% in 2003 after a 70% increase in 2002.²⁷

In Central Asia, the United States has not been able to stop the growth of opium poppies despite its military presence in Afghanistan, which produced 89 percent of the world’s opium at the end of 2004.²⁸ Almost two million poppy farmers, or seven percent of Afghanistan’s population, are attracted to the high profits. The price of opium has dropped with so many farmers producing poppies, while the price of cucumbers, okra and tomatoes has soared with the shortage of vegetable crops.²⁹ Opium traffickers and their supporters are even among officials in the Afghan government.³⁰ The opium and heroin leaving Afghanistan travels mainly through Iran, which has led to an increase in heroin use in Iran, angering officials who are frustrated at the United States’ failure to take

²² In Peru, the National Confederation of Coca Growers of Peru (CONPACCP) marched to Lima in 2004 demanding the end of eradication of coca crops, shutting down the Peruvian drug agency and recognizing coca as a traditional crop. Hugo Cabieses, “Peru’s cocalers on the march,” *Report on the Americas*, North American Congress on Latin America, v.38, no.1, July/August 2004.

²³ “Bolivia’s president resigns, U.S. troops to assess situation after month of violent clashes,” *CNN.com*, October 17, 2003, at <http://www.cnn.com/2003/WORLD/americas/10/17/bolivia.president/>.

²⁴ “Critics take aim at Brazil’s drug plane law,” *CNN.com, AP*, July 20, 2004, at <http://www.cnn.com/2004/WORLD/americas/07/20/brazil.planes.ap/>.

²⁵ “Brazil to Shoot Down Drug Planes,” *BBC News*, June 23, 2004, at <http://news.bbc.co.uk/2/hi/americas/3833695.stm>.

²⁶ “Mexican State Sacks Entire Police,” *BBC News*, April 13, 2004, at <http://news.bbc.co.uk/2/hi/americas/3621073.stm>.

²⁷ James Blears, “Mexico Produces Bumper Crop of Opium Poppies,” *Voice of America News*, April 16, 2004, at <http://www.voanews.com/article.cfm?ObjectID=56D7E481-1B90-4D36-A58FAFFBA0A6F2EA&Title=Mexico%20Produces%20Bumper%20Crop%20of%20Opium%20Poppies&db=voa>.

²⁸ Nat Ives, “Karzai Plans to Destroy Poppy Fields in 2 Years,” *The New York Times*, December 13, 2004, p. A12.

²⁹ David Rohde, *The New York Times*, Thursday, July 1, 2004, page A13.

³⁰ “Kabul government concedes officials assist drug trafficking,” *The Washington Times*, May 14, 2004.

responsibility for fighting drugs in Afghanistan.³¹ As of 2002, there were an estimated 2 million drug addicts in Iran, giving it one of the highest addiction rates in the world.³² On the other hand, just as the U.S. military began direct operations against the opium producers, Afghan President Hamid Karzai protested, not wanting to antagonize the regional warlords during the period before the first national election.³³ Nevertheless, only six months later, suspicions of U.S. aerial spraying of poppy crops began to arise.³⁴

Illegal drug markets flourish elsewhere in the world, even in the South Pacific, where interdiction efforts have been just as unsuccessful as in Latin America and Asia. Australian and Fijian police have been attempting to intercept the large amounts of methamphetamine that is being produced in Fiji for distribution in the United States, Europe, Australia and New Zealand. Countries in the South Pacific are considered vulnerable to exploitation by drug traffickers and manufacturers.³⁵

Death Penalties and Death Squads

The strictest enforcement practices of the drug prohibition model are found in East Asia and Southeast Asia and on the Arabian Peninsula and have attracted attention from human rights monitors. In one example, Thailand's Prime Minister Thaksin Shinawatra declared victory in the country's "war on drugs" in late 2003, purportedly fulfilling King Bhumibol Adulyadej's 2002 birthday wish that he hoped the country would be free of drugs by his next birthday. During 2003 thousands of suspected drug dealers were allegedly murdered by Thai police in order to carry out that goal.³⁶ Another side-effect of Thailand's drug war has been an increase in alcoholism and homeless children; the number of alcoholics seeking treatment has risen 30% since the major offensive began in early 2003 as former amphetamine users take up alcohol as a replacement.³⁷

In the Philippines, death squads popularly linked to police, businessmen and local officials have been operating with impunity since the late 1990s in Davao City and the surrounding region, slaying dozens of people. No death squad member has been arrested despite years of killings. Those killed are almost always on lists of persons "wanted" by

³¹ "What the Taliban Banned: With the Taliban toppled, Afghan opium is flooding Iran," *The Economist*, March 14, 2002, p. 68.

³² Jim Muir, "Iran's Battle With Heroin," *BBC News*, June 7, 2004, at http://news.bbc.co.uk/1/hi/world/middle_east/2031624.stm

³³ Rowan Scarborough, "DEA official to monitor Afghan anti-drug plan," *The Washington Times*, August 18, 2004.

³⁴ Carlotta Gall, "Afghans Accuse U.S. of Secret Spraying to Kill Poppies," *The New York Times*, February 27, 2005, p. 3.

³⁵ "Fiji: Record drug haul," Reuters, *The New York Times*, June 10, 2004, p. A8.

³⁶ "Thaksin hails death of 'bad people'," Associated Press Bangkok, *Taipei Times*, December 4, 2003, p. 5. Thailand's National Human Rights Commission and Amnesty International have been looking into the situation, reporting that more than 90,000 people have been arrested on drug charges and another 329,000 have been blacklisted. Napanisa Kaewmorakot, "Compensate families of those killed, says NHRC," *The Nation* (Thailand), December 15, 2003.

³⁷ "War on drugs increases the number of alcoholics," *Pattaya Mail* (Thailand), Vol. XII No. 27, Friday July 2 - 8, 2004. With thousands of people arrested, their children are left homeless and, with no adults to care for them, many of the children start sniffing glue and are recruited by drug dealers to deliver drugs. "Drug trade flourishes in Klong Toei," *The Nation* (Thailand), April 12, 2004.

the Philippines Drug Enforcement Agency (PDEA). Davao City Mayor Rodrigo Duterte has warned drug dealers to "start swimming" as far as Indonesia if they want to survive and has called critics of the death squads "reactive idiots." The killings have support, especially among law enforcement and the business community, who feel more confident to operate "free from criminals, drug syndicates and terrorists."³⁸

Many drug-related offenses are subject to the death penalty in Vietnam, Singapore, Malaysia, China, Iran and Saudi Arabia, as hundreds, if not thousands of drug law violators are executed each year. In Singapore the law imposes a mandatory death sentence for at least 20 different drug-related crimes.³⁹ For instance, anyone caught with slightly more than a pound of marijuana or more than a half ounce of heroin is considered a drug trafficker, where the only penalty is death by hanging.⁴⁰ In 2004 the interim president of Iraq, Ayad Allawi, announced that Iraq was also to resume the death penalty for drug traffickers.⁴¹

On June 26, 2004, to mark the United Nations' International Day Against Drug Abuse and Illicit Trafficking, China tried, sentenced and executed dozens of people convicted of drug trafficking. Twenty-eight people were executed in China on that day alone and at least 50 others were executed in the week leading up to Anti-Drugs Day.⁴² Despite the public executions, levels of drug use and abuse and drug-related crime in China are rising.⁴³ While China has 1.05 million registered drug addicts, 75% of whom are under age 35, experts believe the actual number of addicts is over 4 million.⁴⁴

Citizenship Revocation and Deportation

In addition to summary executions and the incarceration of large numbers of people, Thailand is also considering stripping the citizenship of those people whom it believes are involved in trafficking. The new edict also would strip the citizenship of that person's family members.⁴⁵ In The United States, in the wake of the September 11 attacks, federal immigration authorities have taken a hard-line approach by deporting non-citizens convicted of even minor drug offenses, irrespective of how long they have lived away from their country of origin or whether it is currently safe for them to return to their country of origin.⁴⁶

³⁸ Anthony S. Allada, "Swim no, drug peddlers told," *Mindanao Times*, August 13, 2004.

³⁹ Amnesty International (2004), *Singapore: High Execution Rate Shrouded in Secrecy*, available at <http://www.amnestyusa.org/countries/singapore/document.do?id=80256DD400782B8480256E1A005B789>

⁴⁰ Singapore Central Narcotics Bureau (2004), *Laws Against Drug Abuse*, available at <http://www.cnb.gov.sg/enforcement/index.asp?page=9>.

⁴¹ "The going gets tough and so does Allawi," *The Daily Telegraph* (UK), August 10, 2004, p. 19.

⁴² Amnesty International (2004), *China: Annual execution spree looms on UN anti-drugs day*, available at <http://www.amnestyusa.org/countries/china/document.do?id=80256DD400782B8480256EB30057A2DA>.

⁴³ *Id.*

⁴⁴ "Rising drug addiction costing China billions," *Associated Press*, February 12, 2004.

⁴⁵ "Human Rights: Drug kin to lose citizenship", *The Nation* (Thailand), September 5, 2003.

⁴⁶ One man from Ohio, adopted from Brazil when he was eight years old, was sent back to Brazil at age 22 after a small marijuana sale when he was eighteen. While there, living in poverty as an English teacher, he was shot to death four years later. Marilyn Miller and Gina Mace along with Knight Ridder correspondent Kevin Hall, "Deported Man Shot to Death in Brazil," *Akron Beacon Journal*, July 27, 2004, p. A1.

Mass Incarceration

The strict prohibition model of drug control has strained the limits of the criminal justice system. By the end of 2003, the incarceration rate in the United States was at an all-time high, with over two million people behind bars. Nearly seven million people, or one of every 32 adults, were under some form of correctional supervision.⁴⁷ According to the U.S. Justice Department, drug offenders “represent the largest source of jail population growth,” as the number of people in jail for drug crimes increased 37% from 1996 to 2002 and thirteen percent of those jailed for drug crimes were there for their first offense.⁴⁸ With 1.4 million people in federal and state prisons, the numbers are likely to increase, with relatively long mandatory minimum sentences, and even life sentences for drug offenses.⁴⁹ Along with the high incarceration rates is the deterioration of prisons across the country, including in California, the largest state prison system, which was called “dysfunctional” in a recent report commissioned by Governor Schwarzenegger.⁵⁰

Prisons in East Asia are also filling up with drug offenders. The Philippines has launched a campaign to rid the islands of drugs by 2010, resulting in crammed jails and a paralyzed justice system.⁵¹ As of 2004, the country had 3.4 million drug users.⁵² Although Vietnam sentences people to death or life in prison if caught possessing or trafficking 600 grams of heroin or 20 kilograms of opium, the country reported having 169,000 drug addicts in late 2003, up 22,000 from the previous year.⁵³

INNOVATIONS WITHIN THE PROHIBITION MODEL

Despite the global reach of drug prohibition, many countries are finding room to apply different means to address the problems of drug addiction and drug-related crime. In Canada, Australia, New Zealand and Western Europe, and in some corners of the United States, the law treats the offenses of drug possession and use very differently from offenses involving the distribution or manufacturing of drugs, reflecting an understanding of the counterproductive effect of punishing drug users who possess small amounts of drugs for their personal use. Even the former chief of Interpol, Raymond Kendall, has admitted that drug prohibition has failed and has actually worsened conditions, and that

⁴⁷ “Probation and Parole in the United States, 2003,” <http://www.ojp.usdoj.gov/bjs/abstract/ppus03.htm>.

⁴⁸ “Profile of Jail Inmates, 2002,” available at <http://www.ojp.usdoj.gov/bjs/abstract/pji02.htm>.

⁴⁹ See, e.g., John Sharp, “Man Gets Life Sentence for Producing Meth,” *Peoria Journal Star*, May 14, 2004. Proposed federal legislation would increase penalties to ten years to life for some marijuana sales. See “Defending America’s Most Vulnerable: Safe Access to Drug Treatment and Child Protection Act of 2004” (H.R. 4547).

⁵⁰ “Reforming California’s Youth and Adult Correctional System,” California Performance Review, Corrections Independent Review Panel, available at <http://www.report.cpr.ca.gov/indrpt/corr/index.htm> (August 18, 2004); Jim Wasserman, “Schwarzenegger panel suggests reforms for troubled California prison system,” *North County Times* (CA), July 1, 2004.

⁵¹ Non Alquitran and Christina Mendez, “A Banner Year in War on Drugs,” *Philippine Star*, December 25, 2003.

⁵² “Philippine drug users numbered at 3.4 million,” *Xinhua News Agency* (China), September 15, 2004, at http://news.xinhuanet.com/english/2004-09/15/content_1986360.htm.

⁵³ “Three Vietnamese drug traffickers receive death sentences,” *Xinhua News Agency* (China), July 27, 2004.

the only effective solution is harm reduction, suggesting that drugs be medicalized rather than criminalized.⁵⁴

Across Europe there is significant variety in national drug control policies.⁵⁵ In Scandinavia, for example, Sweden and Norway favor the American-style approach and base their drug policies on moral grounds, applying harsh sanctions for drug use and eschewing measures to reduce the harm from illegal drugs.⁵⁶ By contrast, other European nations are more pragmatic in their approach, including Switzerland, the Netherlands, Italy, Spain and Portugal, which have largely decriminalized or “depenalized” personal drug possession and use and have sought to employ measures to reduce the harm from drug use rather than merely attempting to reduce drug use *per se*. Expressing this pragmatic view, the president of the Swiss Confederation recently acknowledged the permanence of drug use in modern life, stating that Switzerland is facing up to “social reality.”⁵⁷

Harm Reduction – A Guiding Principle

The principal objective of the strict prohibition model is “use reduction” but an alternative core concept driving drug policy reforms in Europe and in other wealthy countries is “harm reduction.”⁵⁸ The harm reduction concept has already been embraced in other policy domains, including mandated safety standards for motor vehicles, toys, sports equipment, food and pharmaceuticals, the distribution of condoms in schools, social welfare supports for the homeless and the unemployed and the promotion of the “designated driver” in situations where alcohol consumption raises the risk of traffic-related injury or death.⁵⁹ The practice of harm reduction acknowledges drug use as part of the human world, for better or worse, and measures the quality of individual and community life and well-being rather than drug use *per se*. The principles guiding the practice of harm reduction dictate a non-judgmental and non-coercive approach, rendering services to assist drug users in reducing the attendant harm from drug use and often in reducing drug use itself.⁶⁰

⁵⁴ Raymond Kendall, “Drogues: guerre perdue, nouveaux combats (Drugs: lost war, new combat),” *Le Monde* (France), Oct. 26, 2004, p. 22.

⁵⁵ For an exhaustive and comprehensive survey of legislative approaches to illicit drug use in Europe, see European Monitoring Centre for Drugs and Drug Addiction (2005), *Illicit Drug Use in the EU: Legislative Approaches*, EMCDDA Thematic Paper, Lisbon, available at <http://www.emcdda.eu.int/?nnodeid=7079>.

⁵⁶ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, p. 209.

⁵⁷ Andrew Osborn, “Spliffs in the park and a shop selling hemp,” *The Guardian*, August 3, 2001, page 4. Similarly, the city of Zurich, having seen its harm reduction strategy begin to bear fruit, now expresses its drug policy objectives differently, treating addicts the same regardless if their drug is legal or illegal. In the past the officials focused on the open drug scene to the neglect of other aspects of addiction. “Zurich revises its drugs strategy,” *Swissinfo*, August 12, 2004.

⁵⁸ The seminal work on harm reduction is credited to University of Washington scholar G. Alan Marlatt. See G. Alan Marlatt (1998), *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*, Guilford Press, New York; see also G. Alan Marlatt (1999), *Using Harm Reduction in Treating Addictive Behaviors*, University of Washington.

⁵⁹ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, pp. 388-89.

⁶⁰ “Principles of Harm Reduction,” Harm Reduction Coalition, New York (2001). According to the Harm Reduction Coalition’s Principles of Harm Reduction, harm reduction:

- accepts, for better or for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them;

Critics of the harm reduction approach – defenders of the strict prohibition model – assert that any tolerance of drug use “sends the wrong message” and is tantamount to an endorsement of drug use, leading to greater use and greater harm. However, a service provider practicing harm reduction would likely deliver the following message:

We view drug use as harmful, we discourage drug use and we are eager to help you stop using drugs. If you will not stop using drugs, however, we can help you reduce the harm from your drug use.

Rather than an “endorsement” of drug use, the social message of harm reduction is that certain acts are socially unacceptable but the actor can still repair the damage.⁶¹

It is important to note that harm reduction is not necessarily antithetical to drug prohibition, illustrated by the recent proliferation of harm reduction programs in Europe. Just as harm reduction measures seek to reduce the harmful effects of drug use, they also seek to reduce the harshness of the punitive drug prohibition regime without necessarily challenging the regime itself.⁶²

In North America, the city of Vancouver, British Columbia, is boldly establishing harm reduction as one the “four-pillars” of its drug policy, along with prevention, treatment and law enforcement.⁶³ The harm reduction pillar is described as:

a pragmatic approach that focuses on decreasing the negative consequences of drug use for communities and individuals. It recognizes that abstinence-based approaches are limited in dealing with a street-entrenched open drug scene and that the protection of communities and individuals is the primary goal of programs to tackle substance misuse.⁶⁴

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- understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others;
 - establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies;
 - calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm;
 - ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them;
 - affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use;
 - recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm;
 - does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

⁶¹ Robert J. MacCoun and Peter Reuter, *op. cit.*, pp. 391-92, citing J. Braithwaite, *Crime, Shame and Reintegration*, Cambridge (UK): Cambridge University Press, 1989.

⁶² Harry G. Levine (2002), *op. cit.*, p. 173.

⁶³ Donald MacPherson (2001), *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*, City of Vancouver, Four Pillars Drug Strategy, April 24, 2001, available at http://www.city.vancouver.bc.ca/fourpillars/pdf/Framework_REVISED.pdf.

Vancouver's harm reduction programs currently include a supervised safe injection site, needle exchanges and community health services.⁶⁵ Elsewhere in Canada, the city of Winnipeg has begun distributing crack smoking kits filled with glass-tube pipes, matches and lip balm, hoping to reduce harms to crack users and develop relationships between the users and outreach workers.⁶⁶

Scotland has started providing clean needles, with no questions asked, in its prisons in order to combat the spread of deadly diseases such as Hepatitis C and HIV/AIDS, acknowledging the reality of drug use within the prisons.⁶⁷

Harm reduction principles in Europe support policies that segregate illegal drug markets, whereby distinctions in the treatment of "hard" and "soft" drug markets reduce the likelihood that people acquiring soft drugs will be exposed to dealers trafficking in hard drugs. Profit margins for hard drugs are much higher, giving a seller of hard drugs an incentive to try to sell hard drugs to someone who is only interested in a soft drug like marijuana. Cannabis "normalization" is thus another part of an overall harm reduction strategy.⁶⁸

Diversions and Drug Treatment

Some nations, and currently some states and local governments in the United States, have chosen to divert drug law violators from prison or jail into compulsory treatment. In California, Proposition 36, a ballot initiative enacted in 2000, gives non-violent drug possession offenders the right to receive drug treatment instead of incarceration.⁶⁹ In the first two years of the law's enactment, 66,000 arrestees were diverted.⁷⁰ Across the United States, court-supervised drug treatment programs, most often federally-supported "drug courts," are proliferating rapidly, offering defendants alternatives to incarceration and offering local jurisdictions the opportunity to save court and detention costs.⁷¹ The diversion of drug offenders into treatment, although it is considered an "innovation" in drug policy, still falls squarely into the strict prohibition

⁶⁴ *Id.* at 4.

⁶⁵ City of Vancouver, Four Pillars Drug Strategy, Harm Reduction Fact Sheet, last updated July 1, 2004, available at http://www.city.vancouver.bc.ca/fourpillars/pdf/Factsheet_harmreduction.pdf.

⁶⁶ "Clean pipes for crack addicts," *Edmonton Journal*, August 27, 2004, p. A8.

⁶⁷ Kate Foster, "Heroin kits on demand for Scots prisoners," *The Scotsman*, October 17, 2004.

⁶⁸ Czech Deputy Prime Minister Petr Mares has stated that "what [we're] trying to do is to build a barrier between those who are experimenting with marijuana and those who are offering hard drugs. I don't like our kids to get in contact with drug dealers and I believe that, well...let them have an opportunity to raise two or three marijuana plants and smoke them. It's better than to try to buy it on the streets." Brian Whitmore, "With a velvet approach, Czechs look to revamp vice laws," *Boston Globe*, July 6, 2003, p. A5.

⁶⁹ The Substance Abuse and Crime Prevention Act of 2000, <http://www.prop36.org/about.html>.

⁷⁰ Douglas Longshore, Ph.D., Darren Urada, Ph.D., Elizabeth Evans, M.A., Yih-Ing Hser, Ph.D., Michael Prendergast, Ph.D., Angela Hawken, Ph.D., Travis Bunch, and Susan Ettner, Ph.D. (2004), *Evaluation of the Substance Abuse and Crime Prevention Act: 2003 Report*, Department of Alcohol and Drug Programs, California Health and Human Services Agency, September 23, 2004.

⁷¹ The latest survey of U.S. drug courts is found in C. West Huddleston, III, Karen Freeman-Wilson and Donna L. Boone (2004), *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States*, Alexandria: National Drug Court Institute.

model, whereby individuals are subject to the control of the criminal justice system and total abstinence from drug use is the only permissible outcome.

A number of European nations also divert minor drug law violators into compulsory treatment, including France, Germany, Switzerland, Norway and Italy.⁷² Sweden maintains the most intrusive and paternalistic policy in this regard, allowing local authorities to impose compulsory treatment on any individual suspected of being a drug abuser, *even without any arrest or conviction*.⁷³ In Western Australia, people caught with a personal amount of drugs, besides marijuana, can choose to enter counseling as long as they are first-time offenders, admit to the crime and are only charged with the drug crime.⁷⁴ In the state of Victoria, first time offenders are cautioned and referred to a drug education service.⁷⁵

In a few nations beyond Europe and America, drug addiction is regarded as a health problem rather than as a criminal problem. In Nigeria, for instance, the National Drug Law Enforcement Agency (NDLEA) describes drug addicts as “victims” rather than as “offenders” and those arrested for drug possession are given counseling and released, unless the addiction is deemed to be so damaging to the individual that it requires treatment and rehabilitation with a plan for reintegration into society.⁷⁶ Even on the Arabian Peninsula, the United Arab Emirates is likewise considering shifting its drug policy toward treating drug users like patients instead of criminals, as “victims” that should be treated and reintegrated into society.⁷⁷

Decriminalization

Many nations have pushed the bounds of the strict prohibition model by decriminalizing the possession of small amounts of drugs for personal use. Spanish law has not imposed criminal sanctions for possession of small amounts of drugs since 1983; Italy decriminalized drug possession from 1975 to 1990, re-criminalized drug possession again from 1990 to 1993 and then returned once again to decriminalization.⁷⁸ More recently, the Belgian Parliament modified its drug laws to establish a new scheme that increases criminal sanctions for illegal drug production, continues to criminalize possession and cultivation of drugs, but separates cannabis from all other drugs, allowing for civil fines for possession or cultivation of cannabis for personal use for the first and second offense. Individuals can be sent to treatment in any phase of the legal process if there is evidence of problematic use.⁷⁹

⁷² Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, p. 209.

⁷³ *Id.* at 298.

⁷⁴ Wendy Pryer, “Secret Soft Turn on Hard Drugs,” *The West Australian*, July 26, 2004.

⁷⁵ Australian Institute of Criminology (2004), *Illicit Drugs and Alcohol*, available at: <http://www.aic.gov.au/research/drugs/types/cannabis.html>.

⁷⁶ Okey Ndiribe, “Lagos and the Hard Drugs Menace,” *The Vanguard* (Nigeria), August 11, 2004.

⁷⁷ Muawia E. Ibrahim, “Drug Abusers to be Treated as Patients,” *Khaleej Times* (UAE), June 28, 2004.

⁷⁸ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, pp. 213, 235.

⁷⁹ “Belgium: New package of drug laws enter into force,” European Legal Database on Drugs, February 6, 2003, available at http://eldd.emcdda.eu.int/databases/eldd_news_detail.cfm?id=02/06/2003BELGIUM:%20New%20package%20of%20drug%20laws%20enter%20into%20force.

In Portugal, a new law took effect in July 2001 that eliminated all criminal penalties for possession or use of small amounts of any illegal drug. Instead of arrest, anyone caught using or possessing small amounts of illegal drugs is reported to a special commission set up by local authorities to ensure that users seek treatment. Although sale and trafficking of drugs are still criminally punished, the sale of drugs to support one's own drug habit is considered a mitigating circumstance. As Portuguese drug policy has turned away from the punitive approach, individuals with drug problems have been voluntarily appearing at government offices and asking for treatment, no longer fearing punishment by the state.⁸⁰

Russian President Vladimir Putin signed a bill into law in early 2004 allowing persons to escape criminal liability for possession of small amounts of drugs. The amendment to the Criminal Code stipulated that possession of no more than ten times the amount of a single dose is considered an administrative infraction rather than a criminal offense.⁸¹ This is considered a much-needed positive step in a country with an outdated drug policy scheme that is fueling Russia's HIV-infection rate to epidemic proportions.⁸²

The Dutch government has instituted *de facto* decriminalization even for some drug trafficking activities, having quietly stopped prosecuting the smuggling of small amounts of cocaine coming into Amsterdam's international airport. The policy may soon be expanded to other "hard" drugs.⁸³

In Latin America, domestic social concerns and increasing annoyance with U.S. interference in local politics has led some countries to reform their punitive drug laws, or at least to attempt such reform, while at the same time often retaining harsh laws for drug trafficking. The Venezuelan government proposed decriminalizing possession of up to a ten-day supply of drugs and increased penalties for trafficking.⁸⁴ In Ecuador, people caught with a small amount of drugs who are deemed to have an addiction can be released.⁸⁵ Existing law in Colombia allows the possession of "personal dosages" of cocaine, hashish and marijuana and some Colombian legislators would like to halt the

⁸⁰ Giles Tremlett, "Lisbon takes drug use off the charge sheet," *The Guardian* (UK), July 20, 2001, p. 20.

⁸¹ "No More Jail Terms for Drug Possession," *The Moscow Times*, May 14, 2004.

⁸² Although an estimated 80% of the HIV-AIDS cases in Russia are drug related, the treatment budget is too small to serve the country's four million or so intravenous drug users. With Soviet-era curbs on nearly all controlled substances including methadone, a common treatment for heroin addicts in the U.S., it is hard to give addicts substitution therapy, and nearly 20% of the AIDS cases are in the prison population, making the disease hard to treat and further fueling its spread. Bill Nichols, "Russian AIDS workers wage battle on edge of epidemic," *USA Today*, April 20, 2004, p. A13.

⁸³ In 2003 Dutch customs officers arrested 2,176 smugglers from the Caribbean, an average of more than five per day; now the Dutch government has decided that prosecuting them is a waste of resources. A Dutch Justice Ministry spokesman stated, "Locking up thousands of smugglers doesn't solve the problem - there will always be more of them. We've been honest enough to admit that we only manage to stop fifteen percent of the drugs coming in, so we are trying something new." Justice Sparks, "Dutch law could unleash cocaine flood in Britain," *The Sunday Times* (UK), Feb. 2004, p. 24.

⁸⁴ Irma Alvarez, "Penas hasta de 20 años y multas contra tráfico de drogas (Up to 20 years and fines for drug trafficking)" *El Universal* (Venezuela), January 13, 2004, available at: http://www.eluniversal.com/2004/01/13/pol_art_13105A.shtml.

⁸⁵ Sandra G. Edwards (2003), "Illicit Drug Control Policies and Prisons: The Human Cost," Special Update: Ecuador, Washington Office on Latin America, November 2003, available at: http://www.wola.org/publications/ddhr_ecuador_memo4.pdf.

prosecution of peasants who cultivate less than seven acres of coca or opium plants.⁸⁶ A proposal in the National Congress of Brazil would subject drug users and addicts to educational measures instead of prison terms. Treatment would not be compulsory but freely available to those who elect it. At the same time, minimum penalties for drug traffickers would be raised.⁸⁷ In the Caribbean, Jamaica's National Commission on Ganja, established by the government to consider the issue, recommended decriminalizing the possession of marijuana for personal use.⁸⁸

Decriminalization of cannabis has even reached Sri Lanka, where the government is considering legalizing cannabis as an herbal medicine for ayurvedic practitioners.⁸⁹

Cannabis Normalization

The Netherlands has long been a pioneer in implementing pragmatic and innovative drug policies. A key tenet of Dutch drug policy is "normalization," fostering the integration of drug users and drug addicts into the community rather than their marginalization, which helps to discourage antisocial behavior and facilitates treatment and rehabilitation.⁹⁰ The policy of "normalization" applies most readily to cannabis, or marijuana.

In the late 1960s and early 1970s, the Dutch established two national commissions to review what was perceived as the growing problem of cannabis use by Dutch youth.⁹¹ The first commission, known as the Hulsman Commission, acknowledged the limits of criminal law enforcement in the attempt to control illegal drug markets and drug use:

Police forces will have to be constantly enlarged to keep pace with the never ending escalation. If we opt for criminal law as the central means for opposing drug use, this option is inadequate and therefore also extremely dangerous. Time after time it will show that the means will fall short, upon which those who favor punishment will plead for increase of law enforcement, until it will be amplified a hundred fold from the present situation... This will boost polarization between different

⁸⁶ "Colombians consider decriminalizing drug trade," *Dallas Morning News*, September 10, 2001, p. A3.

⁸⁷ General Paulo Roberto Yog de Miranda Uchôa, National Antidrug Secretary, Federative Republic of Brazil, "The Brazilian National Drug Policy Legislation," Speech at the Senlis Council 2004 Vienna International Symposium, (March 16, 2004), available at: http://www.senliscouncil.net/modules/events/vienna_2004/uchoa_speech.

⁸⁸ "Ministry studying ganja commission proposals," *The Jamaica Gleaner*, August 23, 2001, p. A9.

⁸⁹ Kaminie Jayanthi Liyanage, "Cannabis cultivation: Relaxing the strong arm of the law," *Sunday Observer* (Sri Lanka), May 23, 2004, at: <http://www.sundayobserver.lk/2004/05/23/fea11.html>

⁹⁰ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, p. 239.

⁹¹ The Hulsman Commission, established by the National Federation of Mental Health Organizations, set out to "clarify factors that are associated with the use of drugs, to give insight into the phenomenon as a whole, and to suggest proposals for a rational policy." Louk Hulsman (1971), 'Ruimte in het drugbeleid.' *Boom Meppel*, p. 5. The Baan Commission, chaired by Pieter Bann, Chief of Mental Health, was asked to "investigate causes of increasing drug use, how to confront irresponsible use of drugs, and to propose a treatment system for those who developed dependence on these drugs." "Achtergronden en risico's van druggebruik (Backgrounds and Risks of Drug Use)," Staatsuitgeverij Den Haag, 1972, p. vii.

parts of our society and can result in increased violence.⁹²

The second commission, known as the Baan Commission, issued a landmark report in 1976 evaluating the risks associated with the use of drugs, including tobacco and alcohol, dividing those risks into physical damage, psychological damage and social damage. The report described the social aspects of drug use and small drug trade in the Netherlands, revealing the special characteristics of a youth culture and sub-culture that were important determinants of the functions of drug use. The Baan report concluded that stigmatizing “deviant” behavior, such as drug use, through the use of punitive measures would likely increase the probability that such behavior would intensify, initiating a downward spiral that would impede the return of the stigmatized drug user to a socially accepted life style. Further, the Baan report countered hypotheses that drug use stemmed primarily from social misery or pathology.⁹³

Examining the epidemiology of drug use in the Netherlands and the demographic characteristic of drug users, the Baan report found that most drug use is short-lasting experimentation by young persons and also that cannabis use does not lead directly to other drug use. However, the report concluded that laws declaring cannabis illegal promote contacts between cannabis users and those who use “harder” psychoactive substances, increasing the likelihood of multiple drug use. Like the Hulsman report before it, the Baan report embraced this social scientific perspective and proposed separating the drug-using subcultures.⁹⁴

The legal and policy reforms coming out of the Dutch commission reports evolved into the current Dutch approach, which officially separates the market for cannabis from the market for other drugs. In 1976, the Dutch adopted a written policy of non-enforcement for violations involving possession or sale of up to 30 grams of cannabis, a threshold that was reduced to five grams in 1995. The written policy regulates the technically illicit sale of such small amounts in commercial establishments called “coffee shops,” of which there are up to 1,500 nationwide. The regulations are strictly enforced and prohibit advertising, hard drug sales, transactions over the small quantity threshold and public disturbances. In the meanwhile, Dutch law enforcement agencies move aggressively against any large-scale cannabis growers or distributors.⁹⁵

Because drug use and other consensual activities have been “normalized” in the Netherlands, central Amsterdam may impress the uninformed or moralistic observer as rife with vice. A closer look at the prevalence of psychoactive drug use in the Netherlands reveals, however, that heroin use has not risen in the more than 25 years since the adoption of the two-market strategy, as addicts have grown older and fewer young people have initiated heroin use. Cannabis and heroin use in general is lower in

⁹² Louk Hulsman (1971), *op. cit.*, pp. 49, 51.

⁹³ Peter Cohen (1994), *The case of the two Dutch drug policy commissions. An exercise in harm reduction 1968-1976*. Paper presented at the 5th International Conference on the Reduction of Drug Related Harm, 7-11 March, 1994, Toronto: Addiction Research Foundation, Revised in 1996, pp. 26, 27.

⁹⁴ *Id.* at 4-6.

⁹⁵ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, pp. 240-41, citing Ministry of Foreign Affairs *et al.* (1995), *Drugs Policy in the Netherlands: Continuity and Change*, Rijswijk, The Netherlands.

the Netherlands than in the United States⁹⁶ and cannabis use among Dutch teens remains less than half the rate in the United States and much lower than in Britain.⁹⁷ A recent study comparing marijuana use in the United States and the Netherlands found no evidence that decriminalization of cannabis leads to increased drug use, putting in to question the notion that strict penalties are the way to inhibit use. There was also no proof that having a regulated legal cannabis market provides a “gateway” to other illicit drug use, when cannabis users in the U.S. were far more likely to have used other illicit drugs.⁹⁸

In Switzerland, the Public Health Commission of the State Council favors the legalization of cannabis, but the Swiss Parliament narrowly defeated a bill in 2003 that would have decriminalized cannabis. The Swiss are likely to continue efforts to normalize cannabis use.⁹⁹ Elsewhere in Europe, a movement is afoot to decriminalize cannabis possession in the Czech Republic, where possession of small amounts for personal use has been tolerated since 1999.¹⁰⁰ The law is not specific as to the definition of “small amount,” but police and judges have a great deal of discretion, routinely throwing cases out of court. A recent Czech government study concluded that cannabis is no more of a health risk than alcohol or tobacco. Police officials oppose a move toward decriminalization, however, fearing an increase in crime and the use of hard drugs.¹⁰¹

The British public and public officials have warmed to the notion of cannabis normalization as the British Parliament took a first step in 2003 by reclassifying and downgrading cannabis from a Class B drug to a Class C drug, reducing fines and possible jail time. This classification puts cannabis on a par with steroids and anti-depressants.¹⁰² The reclassification did not legalize or even decriminalize cannabis, but police now have wide discretion to deal with the individual offense. Aggravating factors are now needed to justify arrest, such as using cannabis in front of young people. As for trafficking in

⁹⁶ For U.S. figures see U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse: Volume I. Summary of National Findings (Washington, DC: HHS, August 2002), p. 109, Table H.1; for figures from the Netherlands see Trimbos Institute (2002), *Report to the EMCDDA by the Reitox National Focal Point, The Netherlands Drug Situation 2002*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction, Nov. 2002, p. 28, Table 2.1.

⁹⁷ The most recent study of Dutch school children showed that 20 percent of 15-to-16 year-olds had tried cannabis and five percent smoked it regularly, compared with a lifetime use rate of about 35 to 40 percent in the U.S. and in Britain. In addition, only one of every 1,000 Dutch teens have tried heroin, compared with one of every 100 in the U.S. and one of every 50 in Britain. David Rose (2002), “The Dutch Lesson,” *The Observer* (UK), February 24, 2002, p. 10.

⁹⁸ Craig Reinerman, Peter D. A. Cohen and Hendrien L. Kaal (2004), “The Limited Relevance of Drug Policy: Cannabis in Amsterdam and in San Francisco,” *American Journal of Public Health*, v.94, no.5, May 2004, pp. 836-842.

⁹⁹ Gordana Mijuk, “Swiss parliament blocks moves to decriminalize cannabis,” Associated Press, AP Worldstream, September 25, 2003.

¹⁰⁰ Prevalence of cannabis use in the Czech Republic is relatively high; recent surveys estimate that 60 to 80 percent of 18-year olds have used cannabis. See Brian Whitmore, “With a velvet approach, Czechs look to revamp vice laws,” *Boston Globe*, July 6, 2003, p. A5, *supra*.

¹⁰¹ *Id.*

¹⁰² Warren Hoge, “Britain to Stop Arresting Most Private Users of Marijuana,” *The New York Times*, July 11, 2002, p. A3.

cannabis, however, the maximum penalty for trafficking in cannabis was increased, to 14 years.¹⁰³

Elsewhere in the English-speaking world cannabis laws are being relaxed, including parts of Australia, where minor possession and growing of cannabis is decriminalized and brings only a fine.¹⁰⁴ The most far-reaching proposal has come from Canada, where former Prime Minister Jean Chretien and current Prime Minister Paul Martin have supported the Canadian Parliament's intention to decriminalize, and eventually legalize cannabis. Even the Royal Canadian Mounted Police Commissioner endorsed legislation to decriminalize small amounts of cannabis for personal use.¹⁰⁵ In 2002 Canada's Senate Special Committee on Illegal Drugs released a 600-page report detailing the results of a two-year study on cannabis and its use, recommending legalization with criminal sanctions applying only to "behaviour causing demonstrable harm to others," including illegal trafficking, selling to minors (16 and under) and driving while intoxicated.¹⁰⁶ The fundamental premise underlying the report:

In a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy insofar as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equivalence of others.¹⁰⁷

In its report the committee identified guiding principles for the roles of the state, criminal law, science and ethics in developing public policy on cannabis, concluding that:

Public policy on illegal drugs, specifically cannabis, ought to be based on an ethic of reciprocal autonomy and a resolve to foster human action. It ought to defer to criminal law only where the behaviour involved poses a significant direct danger to others. It ought to promote the development of knowledge conducive to guiding and fostering reflection and action.¹⁰⁸

Canada's move toward relaxing its cannabis laws has infuriated the United States government. The director of the White House drug control office, John Walters, has gone on a campaign claiming that the United States is being inundated with high potency cannabis from British Columbia, even insinuating that it is responsible for sending

¹⁰³ Q&A: Cannabis Guidelines," BBC News, January 22, 2004, at <http://news.bbc.co.uk/1/hi/uk/3103416.stm>

¹⁰⁴ See note 73, *supra* ("Illicit Drugs and Alcohol," Australian Institute of Criminology, at <http://www.aic.gov.au/research/drugs/types/cannabis.html>).

¹⁰⁵ Lisa Schmidt, "Majority of MPs support decriminalizing marijuana, says Keith Martin," *Canadian Press*, November 8, 2001, at http://www.canoe.ca/Health0111/08_martin-cp.html.

¹⁰⁶ The Special Senate Committee on Illegal Drugs (2002), Senate Committee Recommends Legalization of Cannabis, news release, Ottawa, September 4, 2002.

¹⁰⁷ *Id.* at 3-4.

¹⁰⁸ *Id.* at 49.

increasing numbers of Americans to the emergency room.¹⁰⁹ However, according to a recent U.S. Department of Justice report, the vast majority of imported cannabis found in the U.S. comes from Mexico, and the number of cannabis “mentions” in emergency rooms was less than 10% of all drug mentions. Despite 98% of state and local law enforcement agencies describing cannabis availability as high or moderate, only 13% of those agencies identified cannabis as their greatest drug threat.¹¹⁰

Safe Administration of “Hard” Drugs

The trend toward cannabis normalization is pushing the global drug prohibition model to its limit, leading the United Nations International Narcotics Control Board (INCB) to warn of the “undermining” of the international drug control scheme.¹¹¹ Even more controversial, however, is the development of government-sanctioned locations for the safe administration of “hard” drugs, mostly for the safe injection of heroin, but also for the use of stimulants such as crack cocaine. In Europe there are currently almost 50 of these medically-supervised facilities that are available to drug users for administering their own drugs in a safer and non-public space, with the possibility of referrals to social and health services.¹¹²

The INCB issued a report in 2003 harshly criticizing safe injection facilities as “violating the provisions of the international drug control conventions.”¹¹³ However, the treaties provide exceptions for the use of controlled substances if it is for a “medical or scientific purpose.”¹¹⁴ One week after the INCB’s report, the European Union’s drug monitoring agency, the European Monitoring Center for Drugs and Drug Addiction, released a report concluding that such sites are largely achieving their intended objectives, including:

- helping to establish contact with hard-to-reach drug-using populations;
- providing a safe and hygienic environment for drug consumption;
- reducing mortality and morbidity associated with drug use resulting from overdose, transmission of HIV and hepatitis and bacterial infections;
- promoting access to social, health and drug treatment services; and
- reducing public drug use and its associated nuisance.¹¹⁵

¹⁰⁹ Colin McDonald, “U.S. Drug Czar Warns of Potent Pot Here,” *The Seattle Post-Intelligencer*, July 20, 2004, p. B2.

¹¹⁰ “National Drug Threat Assessment 2004,” U.S. Department of Justice, National Drug Intelligence Center, 2004-Q0317-002, April 2004.

¹¹¹ International Narcotics Control Board (2004), *Report of the INCB for 2003*, United Nations, available at http://www.incb.org/e/ind_ar.htm.

¹¹² “Vancouver’s Heroin Users Get Safe -Injection Site,” *CBC News*, Sept. 15, 2003, http://www.cbc.ca/stories/2003/09/15/safe_injection030915.

¹¹³ International Narcotics Control Board (2004), *op. cit.*, p. 37.

¹¹⁴ See note 5, *supra* (Chad Skelton, “U.N. Needles City Over Injection Site,” *Vancouver Sun*, March 3, 2004, p. B1.).

¹¹⁵ Dagmar Hedrich (2004), *European Report on Drug Consumption Rooms*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), February 2004, p. 83. Report available at <http://www.emcdda.eu.int/?nnodeid=1327>. The report’s conclusion was that “safe consumption rooms” reach a population of long-term problem drug users with various health and social problems and they provide a hygienic environment for drug use and, for regular users, decreased exposure to risks of

In Germany, the Consumption and Injecting Room (CIR) in Munster reported the following findings for the year 2002:

The CIR has reached the target group of drug users from the visible public drug scene. Feared effects like congregation of drug users and dealers in front of the facility, nuisance of the public, drug dealing in the CIR or honey pot effects were avoided because of the professional work of our staff and density of control In the CIR, the pre-obtained drugs can be used under relatively safe and hygienic conditions, the likelihood of rescue in cases of overdoses increases, infection-prophylaxis can be provided and concentration of problems in the public, including visible drug use and dealing, inappropriately discarded injecting equipment and congregation of a drug scene, is considerably reduced.¹¹⁶

Such consumption rooms are also available in Frankfurt and Hamburg, where they are integrated in a drug help center with other services such as counseling, medical help and a shelter.¹¹⁷ The German government attributes its steady decrease in drug deaths to its harm reduction policies.¹¹⁸

The Netherlands also has a network of facilities for the safe injecting and smoking of prohibited drugs. Registered users can also get a shower, hot food and a “respite from the rigors of the street.”¹¹⁹ The facilities provide access to rehabilitation programs and job training, allowing social services and police to establish constructive relationships with drug addicts, which helps to reduce public disorder related to drug use. The most common crimes committed by drug addicts, including burglary, robbery, shoplifting and theft from cars, are considerably less prevalent in the Netherlands than in Britain, for

infectious diseases and increased access for hard-to-reach target populations of drug users to health, welfare and drug treatment services. The report found that safe injection facilities provide immediate emergency help in case of overdose and can make a contribution to the reduction of overdose deaths at community level, given sufficient capacity and coverage in terms of location and opening hours, as well as consultation with residents and police, consumption rooms can reduce the level of drug use in public places and help to reduce public nuisance.... There is no evidence that consumption rooms encourage increased drug use or initiate new users. There is little evidence that by providing better conditions for drug consumption they perpetuate drug use in clients who would otherwise discontinue consuming drugs such as heroin or cocaine, nor that they undermine treatment goals. When managed in consultation with local authorities and police, they do not increase public order problems by increasing local drug scenes or attracting drug users and dealers from other areas.

¹¹⁶ Ralf Gerlach and Wolfgang Schneider, *Annual Report 2002 of the Consumption and Injecting Room (CIR) at INDRO, Munster, Germany*.

¹¹⁷ C. Haasen & M. Prinzleve (2001), *Support Needs for Cocaine and Crack Users in Europe*, (COCINEU) Centre for Interdisciplinary Addiction Research, University of Hamburg, Contract number: QLG4-CT-2001-02301, Deliverable N° 2: Evaluation of research situation in Europe.

¹¹⁸ “Drug-related deaths have fallen again,” *Die Bundesregierung* (Federal Government), April 30, 2003, available at <http://www.bundesregierung.de/en/artikel-,10001.482122/Drug-related-deaths-have-falle.htm>
See also “Weiterer Rückgang bei den Drogentodesfällen im 1. Halbjahr 2004 (Further decrease in drug deaths in the first half of 2004),” news release, German Ministry of Health and Social Security, September 2, 2004, available at http://www.bmgs.bund.de/deu/gra/aktuelles/pm/d04/BMGS_104_5864.cfm

¹¹⁹ David Rose (2002), *op. cit.*

example.¹²⁰ The Dutch have also opened a retirement home for addicts and are planning more.¹²¹

Harm reduction measures are also being applied in the Americas. The government of Brazilian President Lula da Silva took steps toward the end of 2004 to redefine its national drug policy as a public health problem rather than a criminal problem. While Brazil will still combat drug trafficking, it is moving toward harm reduction for drug users, placing the problem of drug use under the jurisdiction of the Health Ministry. The goal is to create 250 “drug use centers” around the country in 2005 and expand the network of treatment for drug users.¹²²

The Canadian government approved a three-year trial of supervised injection for intravenous drug users, beginning in Vancouver in 2004.¹²³ At “safe injection” sites, addicts are to be given clean needles, tourniquets, water and cotton balls, nurses supervise the activity and referrals are given for detox centers and homeless shelters. Authorities also hope to increase contact between the state's health agencies and drug addicts. The Canadian government is requiring scientific research to determine the effectiveness of such sites, assessing whether supervised injection reduces the harm associated with intravenous drug use.¹²⁴ A study conducted one year after the safe injection site first opened reported that the clinic saves lives, helps heroin addicts improve their lives, and refers two to four clients per day to addiction treatment programs.¹²⁵ There is also evidence of an improvement in public order in the community surrounding the clinic.¹²⁶ The mayor of Vancouver is interested in adding an “inhalation” room to the safe injection site so that people who smoke drugs such as crack and heroin can benefit from the services provided at the site.¹²⁷ Another site is being considered for Victoria, British Columbia.¹²⁸

¹²⁰ *Id.*, citing the 2000 International Crime Victims Survey.

¹²¹ Seniorenpannd, located in Rotterdam, allows its residents to use drugs they buy off the street while encouraging the residents to consume less. The main goal is to help addicts live their final years in comfort and dignity. According to the home's manager, some people's addiction is irreversible, and the home allows those people to have some stability and quality of life at the end of their lives. Carl Honore, “Home where the old folk snort heroin,” *The Scotsman* (UK), Dec. 20, 2004.

¹²² Luciano Constantino and Iuri Dantas, “Policy proposal considers drug consumption as a public health problem, and no longer one for the police,” *Folha de São Paulo* (Brazil), Nov. 15, 2004.

¹²³ A few “safe injection” sites have already been operating illegally in Vancouver, but the operation of the sites is tolerated by local law enforcement, which supports the activity. The Canadian government must grant special exemptions to such sites, allowing them to have illegal narcotics on their premises. Joel Baglole, “Vancouver's Heroin ‘Fix,’” *The Wall Street Journal*, April 1, 2003, p. D8.

¹²⁴ *Id.*

¹²⁵ “Safe injection site saving lives: report,” *CBC News British Columbia*, September 23, 2004, available at http://vancouver.cbc.ca/regional/servlet/View?filename=bc_sis_study20040923. See also British Columbia Centre for Excellence in HIV/AIDS (2004), *Evaluation of Supervised Injection Site: Year One Summary*, Vancouver Coastal Health Authority, available at http://www.vch.ca/sis/Docs/esis_year_one_sept16_042.pdf.

¹²⁶ British Columbia Centre for Excellence in HIV/AIDS (2004), “Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users,” Vancouver Coastal Health Authority, available at <http://www.cmaj.ca/cgi/content/abstract/171/7/731>.

¹²⁷ Larry Campbell, “A different way to help drug users,” opinion, *National Post*, October 5, 2004, p. A17.

¹²⁸ “Victoria needs safe injection site, says mayor,” *CBC News British Columbia*, March 19, 2004, at http://vancouver.cbc.ca/regional/servlet/View?filename=bc_sis20040319.

Drug Prescription

Supervised injection facilities do not fit comfortably within the strict prohibition model, but an even more controversial development is the medical prescription of prohibited drugs to drug users, currently being tried with heroin in a number of European countries and in Australia and Canada. Closely supervised provision of injectable, pharmaceutical-grade heroin or other, short-acting opiates, has been shown to be more effective than the use of opiate substitutes such as methadone in recruiting, retaining and benefiting chronic, opiate-dependent, injection drug users who are resistant to current standard treatment options.

The longest-running heroin prescription programs are underway across Switzerland, where chronic heroin addicts receive controlled, daily doses of soluble heroin (diamorphine) under supervised care, along with psychosocial treatment, at injection centers across the country. Oral doses (long-acting or short-acting) are also available. Stabilized patients who have been in the program for several months may eventually take home oral doses of either heroin or methadone to counter withdrawal symptoms.¹²⁹

Participants in the Swiss heroin maintenance programs have experienced marked improvement in their physical and mental health, longer stays in treatment, reduction, and sometimes elimination of their drug use, improved social functioning and an enormous reduction in criminal behavior, particularly property-related crimes committed to support the high cost of drug dependency.¹³⁰ The favorable outcomes from the limited trials in the mid-1990s led the Swiss Government to enact the Ordinance Concerning the Medical Prescription of Heroin in 1999, enabling high-quality, standardized treatment to be

¹²⁹ Individual heroin prescription centers in Switzerland have significant autonomy but must comply with national legal guidelines. The 1999 Ordinance states that the objectives for the patient are: 1) sustained commitment to treatment; 2) improvement in physical and mental health status; 3) improvement in social integration (fitness for work, reduced contact with the drug scene, decrease in criminal behavior); and 4) permanent abstinence from opiate consumption as a long-term goal. Swiss Federal Office of Public Health, *Heroin-assisted Treatment (HAT)*, August 28, 2001.

¹³⁰ A six-year study of the Swiss heroin prescription program found “a significant decrease in the use of illegal substances, illegal income and most other variables concerning social conditions.” Franziska Güttinger, Patrick Gschwend, Bernd Schulte, Jürgen Rehm and Ambros Uchtenhagen (2003), *Evaluating Long-Term Effects of Heroin-Assisted Treatment: The Results of a 6-Year Follow-Up*, Zurich: Addiction Research Institute. Other research and published studies related to the Swiss opiate prescription experiment include: Cornelia Brehmer, Peter X. Iten (2001), “Medical prescription of heroin to chronic heroin addicts in Switzerland—a review,” *Forensic Science International*, v.121, pp. 23-26; Jürgen Rehm, Patrick Gschwend, Thomas Steffen, *et al.* (2001), “Feasibility, safety and efficacy of injectable heroin prescription for refractory opioid addicts: a follow-up study,” *The Lancet*, v.358, October 27, 2001; Robert B. Haemmig, “Koda 1 in Bern: Medical Aspects,” in Gabrielle Bammer, ed. (1999), *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*; Martin Killias and Juan Rabasa (1997), “Less Crime in the Cities Through Heroin Prescription? Preliminary Results from the Evaluation of the Swiss Heroin Prescription Projects,” *The Howard Journal*, v.35, no.4, November 1997; and A. Uchtenhagen, “Summary of the Synthesis Report,” in A. Uchtenhagen, F. Gutzwiller and A. Dobler-Mikola, eds. (1997), *Programme for a Medical Prescription of Narcotics: Final Report of the Research Representatives*, Zurich: Institute for Social and Preventative Medicine, University of Zurich.

provided throughout Switzerland. By 2003, there were 1,232 recognized addicts who received daily treatment in 21 outpatient treatment centers and two prisons.¹³¹

Swiss health insurers must pay 75 percent of the cost of heroin prescriptions, or about \$10 million annually. The patients pay the remaining cost, unless they are indigent, in which case the local government subsidizes the amount. Both outpatient and residential treatment, along with counseling and services, are available in centers located in rural areas and in mid-size and large towns. Abstinence is the eventual goal for all patients but short-term goals are emphasized, which is consistent with the principles of harm reduction.¹³²

A growing number of European countries are following the Swiss lead, instituting heroin prescription trials of their own.¹³³ In the Netherlands, a successful pilot program providing free heroin to 300 participants has been expanded to treat thousands of heroin users. According to the Dutch agency managing the heroin prescription trial, all participants in the pilot program had better mental and physical health after one year in the program, while the number of days addicts engaged in crime to "score" heroin dropped from 14 to two per month.¹³⁴ The changing political climate in the Netherlands has cast uncertainty over the future of heroin prescription, however. In 2002 heroin was to be submitted for registration as a medicine in the Netherlands, but since the election of the present center-right coalition government there has been opposition to heroin-assisted treatment and the plans for further expansion of the program and for the registration of heroin as a medicine were rejected by Parliament, leaving only the projects already underway to be continued.¹³⁵

Germany launched a three-year, clinical trial in 2002 for 1,120 opiate addicts, with half being prescribed heroin and the other half methadone. Comparable to the Swiss approach, the German project is designed to benefit dependent drug users who have fallen through the net of existing support programs. The clinical evaluation of the trial is

¹³¹ Franziska Güttinger *et al.* (2003), *op. cit.*

¹³² Samantha Tonkin, "Health insurers to foot bill for heroin," *Swissinfo*, June 12, 2002, at <http://www.swissinfo.org/sen/Swissinfo.html?siteSect=111&sid=1188746>.

¹³³ Research on heroin-assisted treatment has already begun or scientific trials will be starting shortly in several European countries and Australia. In **Spain**, the regions of Catalonia and Andalusia are initiating heroin-assisted treatment trials. The Andalusian project involving injectable heroin has been approved by the Spanish Medicines Agency for about 250 subjects. The Catalanian trial will involve the prescription of oral heroin exclusively. In **Luxembourg**, the adoption of the revised Narcotics Law in March 2001 created the legal basis for heroin prescription and the Health Ministry has scheduled a trial to begin in 2004. **Belgium** is developing a protocol for heroin-assisted treatment research and a study is to be conducted in the cities of Liège, Brussels and Antwerp. In **France**, the Health Ministry announced in 2001 that it supported in principle the initiation of a research project on heroin prescription and it established a working party to prepare for trials. A victory for Gaullists in the June 2002 elections caused a shift in the French government's priorities and a heroin prescription trial is not expected to begin in the near future. Swiss Federal Office of Public Health 2000 (2001), *Heroin-assisted treatment in 2000* (abridged version), available at <http://www.suchtund aids.bag.admin.ch/imperia/md/content/drogen/hegebe/22.pdf>.

¹³⁴ "Experiment heroïne in meer steden (Experimenting heroin in more cities)", *de Volkskrant* (NL), March 5, 2004; see report by the Central Committee on the Treatment of Heroin Addicts (2002), *Medical Co-Prescription of Heroin, Two Randomized Controlled Trials*, Presented to the Minister of Health, Welfare and Sports, the Netherlands, February 2002.

¹³⁵ Swiss Federal Office of Public Health 2000 (2001), *op. cit.*

comparing the heroin treatment group with the methadone treatment group, measuring health improvements and reductions in drug-related crime and addiction.¹³⁶ Supported by the Federal Health Ministry and numerous German states, and overseen by the German Medical Association, opiate prescription centers are currently located in Hamburg, Hanover, Cologne, Frankfurt, Karlsruhe, Munich and Bonn. According to reports published in the press, the initial experience with heroin prescription in Germany has been positive.¹³⁷

Spain has also had success with its clinical trials of heroin prescriptions. Compared to the control group prescribed with only methadone, those who received maintenance doses of heroin markedly improved their physical and mental, they were four times less likely to contract HIV, and the likelihood of their engaging in criminal activity was reduced by double.¹³⁸

In Britain, heroin has long been recognized as a medicine, but the British experience with heroin prescription has been controversial. Heroin maintenance programs were used by general practitioners throughout the early 1900s, supported by the Dangerous Drugs Regulations of 1921, which authorized "any duly qualified medical practitioner ... so far as is necessary for the practice of his profession or employment in such capacity to be in possession of and supply the drugs."¹³⁹ There were less than 100 known heroin addicts from the 1930s through 1960s taking advantage of the treatment through general practitioners.¹⁴⁰ Heroin use in Britain sharply increased in the 1960s, however, attributed to both Canadian and American addicts moving to London and an "American-style" response by Britain to the modest rise in the number of addicts.¹⁴¹ In response to the increase in addicts, the ability of doctors to prescribe heroin was curtailed with the 1971 Misuse of Drugs Act, after which a dramatic increase in heroin addiction ensued as the unregulated "black market" provided an ample supply. The number of

¹³⁶ European Legal Database on Drugs (2004), Germany, available at http://eldd.emcdda.eu.int/databases/eldd_country_profiles.cfm?country=DE.

¹³⁷ Swiss Federal Office of Public Health 2000 (2001), *op cit*.

¹³⁸ Manuel Altozano, "El primer ensayo español con heroína culmina con éxito y supera a la metadona (The first Spanish test with heroin culminates successfully and surpasses methadone)," *el Pais* (Spain), Dec. 9, 2004. See also Rafael Méndez, "Los adictos del ensayo de heroína mejoran su salud cuatro veces más que con metadona (Study reports addicts given heroin improve their health four times more than with methadone)," *el Pais* (Spain), March 17, 2004, p. 56.

¹³⁹ According to H.B. Spear, former Chief Inspector of the Home Office Drugs Branch, the "cardinal" belief of the British medical profession is that "even if only a few doctors are convinced of the therapeutic benefits of a particular drug, that drug should be available for their use." It is this belief system, otherwise known as the "British system," that has led to the continued opposition by the British medical profession to the U.S. attempts to prohibit all legitimate manufacture and use of heroin. H.B. Spear (1997), "Heroin and the 'British System,'" *International Perspectives on the Prescription of Heroin to Dependent Users: A collection of papers from the United Kingdom, Switzerland, the Netherlands and Australia*, Feasibility Research into the Controlled Availability of Opioids Stage 2 Working Paper Number 14 NCEPH Working Paper 52, Gabriele Bammer (ed.) National Centre for Epidemiology and Population Health, The Australian National University, Australian Institute of Criminology, January 1997, pp. 12-13.

¹⁴⁰ *Id.* Philip M Fleming, "Prescription Heroin as Treatment for Dependence – Current UK Situation."

¹⁴¹ Edward M. Brecher and the editors of Consumer Reports (1972), *Licit and Illicit Drugs. The Consumers Union Report on Narcotics, Stimulants, Depressants, Inhalants, Hallucinogens, and Marijuana -- including Caffeine, Nicotine, and Alcohol*, Boston; Little, Brown and Co.

heroin users in Britain increased from less than 2,000 in 1971 to over 300,000 today.¹⁴² Faced with such a high prevalence of heroin use, and observing the positive outcomes from heroin prescription programs in Switzerland and elsewhere, the British government has once again shown interest in expanding the allowance of doctors who can prescribe heroin. Approximately 450 opiate-dependent patients were being prescribed heroin in 2003, and the British Home Office declared its support for the expansion of heroin prescription.¹⁴³

A recent study of British heroin addicts found that injectable opiate treatment allows patients to receive a safe supply of the drug, improve family relationships and avoid contact with the police. Even if quitting is not the main goal of the participant, the program was still considered a viable option, leading to reduced criminality and reduced health risks.¹⁴⁴ Otherwise, the high cost of a heroin habit drives many addicts into welfare fraud, selling small amounts of drugs, frequent thefts and prostitution.¹⁴⁵ Britain's recent drug policy shift reflects the willingness to find more effective means to address the unreasonable public and economic costs of drug addiction, health care, criminal justice and lost productivity.

Heroin prescription has also come to North America, as the Canadian government has approved pilot projects in Vancouver, Toronto and Montreal, involving 470 subjects with one-third in each trial site. The participants will be randomly assigned to three different groups: the control group who will receive strictly methadone maintenance treatment; the group who will receive prescription heroin in addition to methadone maintenance therapy; and a small subgroup who will receive hydromorphone (also known as laudanum), which is a medically available opioid.¹⁴⁶ Addiction medicine physician specialists will monitor individual prescriptions and social workers will assist with access to community resources, including addiction treatment, housing and job training. Clinic staff will guide all those ready towards treatments which get them off drugs altogether. After 12 months, participants will be aided through a transition period, and then monitored by the research team for up to two years to determine the study's longer-term outcomes.¹⁴⁷ The North American Opiate Medication Initiative (NAOMI) began recruitment of heroin users in February 2005. The recruitment period is expected to take six to nine months.¹⁴⁸

¹⁴² Michael White, "Legalise heroin, says former police chief," *The Guardian* (UK), November 7, 2001, p.2.

¹⁴³ "Doubts over heroin prescriptions," *BBC News*, September 12, 2003, at <http://news.bbc.co.uk/1/hi/health/3094750.stm>.

¹⁴⁴ Louise Sell and Deborah Zador (2004), "Patients prescribed injectable heroin or methadone – their opinions and experiences of treatment," *Addiction*, v.99, no.4, p. 442, April 2004.

¹⁴⁵ Self-reporting data estimates a habit can add up to \$100-200 per day. Benedikt Fischer, Jurgen Rehm, Maritt Kirst, Miguel Casas, Wayne Hall, Michael Krausz, Nicky Metrebian, Jean Reggers, Ambros Uchtenhagen, Wim Van Den Brink and Jan M. Van Ree (2002), "Heroin Assisted Treatment as a Response to the Public Health Problem of Opiate Dependence," *European Journal of Public Health*, v.12, no.3, pp. 228-234, citing A. Bretteville-Jensen and M. Sutton (1996), "The income-generating behavior of injecting drug-users in Oslo," *Addiction*, v.91, no.1, pp. 63-79.

¹⁴⁶ "Free Heroin Project Wins Federal OK," *Victoria Times Colonist*, August 19, 2004.

¹⁴⁷ North American Opiate Medication Initiative, *Project Backgrounder*, August 24, 2004.

¹⁴⁸ "North America's first clinical trial of prescribed heroin begins today," *Canadian Institutes of Health Research*, press release, February 9, 2005.

Given the previous reactions of the United States and the United Nations to Canada's approval of cannabis decriminalization and of supervised drug injection facilities,¹⁴⁹ the advent of heroin prescription to North America could further chill Canadian-American relations.

Legalization and Regulation

As outlined above, many industrialized nations have developed pragmatic policies that challenge the bounds of drug prohibition, from the official non-enforcement of cannabis laws to state-sanctioned supervised injection facilities and heroin prescription programs. Nowhere in the world, however, has any state dared to defy the global prohibition regime at its core by asserting regulatory control over the production and distribution of currently prohibited drugs as a means of eliminating the "black" market and its attendant social harms.

To a very limited extent, a few countries have established regulated supplies of cannabis for medical purposes. The Netherlands already provides government-contracted supplies of cannabis to pharmacies to ensure that a safe, controlled and reliable source of the plant is available.¹⁵⁰ Pilot programs for medical cannabis availability in pharmacies have also begun in Canada¹⁵¹ and in Spain.¹⁵² In addition, the Israeli government is trying an experimental program that administers cannabis to Israeli soldiers, traumatized by war with the Palestinians, to treat post-traumatic stress disorder.¹⁵³ Even the heroin prescription programs in Europe and Canada, however, are made possible through specific, carefully circumscribed *exemptions* from the prohibition-based legal framework and not through any fundamental change of that framework.

¹⁴⁹ Joel Baglole (2003), *op. cit.*

¹⁵⁰ Keith B. Richburg, "For Dutch in Pain, Drugstores Offer Pot by Prescription," *The Washington Post*, February 11, 2004. p. A22. See Amendment to Opium Act, 2 October 2002, No. 02.004519, Opium Act, as after enforcement of the Act of 13 July, 2002, to amend the Opium Act (Staatsblad [Bulletin of Acts and Decrees] 2002, 520), and the Decree to actualise the Lists I and II of the Opium Act (Staatsblad 2002, 623), which Decree will be enacted simultaneously with the aforementioned Act Law of 12 May 1928, containing regulations concerning opium and other narcotic substances (Opium Act), available at <http://www.cannabisbureau.nl/eng/index.html>.

¹⁵¹ Deany Beeby, "Federal Pot Pooh-poohed," *The Globe and Mail* (Canada), July 12, 2004.

¹⁵² "La efectividad terapéutica del cannabis exige la estabilidad de su principio activo (The therapeutic effectiveness of cannabis demands the stability of its active principle)," *Diario Medico*, April 1, 2004, available at <http://www.diariomedico.com/edicion/noticia/0,2458,465993,00.html>.

¹⁵³ Corinne Heller, "Israel to soothe trauma with marijuana," *Reuters UK*, October 3, 2004, available at <http://www.reuters.co.uk/newsPackageArticle.jhtml?type=worldNews&storyID=595451§ion=news>.

LESSONS LEARNED: THE LIMITS OF THE PROHIBITION MODEL

The global scope of the drug prohibition regime, secured in international law and “enforced” through the political process, has inhibited innovation, but rising political pressure brought on by the cost of unabated social and economic problems related to prohibited drugs has inspired pragmatic policy shifts. A survey of recent international trends in drug policy yields the following general conclusions that may offer instructive guidance for improving drug policies in the United States:

1) The operation of the **strict prohibition model** of drug control, which seeks to reduce and eventually eliminate of all drug use, has required the primacy of the criminal justice system to enforce laws that require total abstinence and has featured:

a) “**Source control**” strategies to interrupt drug production in countries such as Colombia and Afghanistan, a tactic that has not only completely failed to limit adequate supply of cocaine and heroin to meet U.S. and world demand but has also destabilized foreign governments, poisoned the subsistence crops of peasant farmers and stimulated innovation by the criminal enterprises, such as the production of a new, inhalable form of heroin coming from Colombia and the development of a potent, resilient “super coca” plant;

b) **Death penalties** and **death squads**, particularly in East Asia, where executions, some with due process and some without, have failed to stem the growing use of and addiction to hard drugs in China, Vietnam, the Philippines and Thailand, among other countries; and

c) **Incarceration** of drug users as well as drug sellers, resulting in overcrowded prisons, which is happening in the United States to the greatest degree, with the highest number of its citizens behind bars than any other nation – without having achieved any meaningful reductions in drug use or drug-related crime.

2) The principle of “**harm reduction**” guides the policies of a number of countries that have reformed their drug laws further than the United States. Harm reduction measures aim to reduce the harm from drug use rather than attempting to reduce drug use *per se* and the harm reduction approach is non-judgmental and non-coercive, assisting drug users in reducing the attendant harm from drug use and usually in reducing drug use itself.

Harm reduction measures are unable to address the fundamental problem of the “black” market and the attendant ready access of illegal drugs to young people. So it is important to understand that **harm reduction is not a new paradigm of drug control**, but only an innovative approach within the prohibition model, whereby certain measures are employed to reduce the harmful effects of drug use as well as the harshness of the punitive global drug prohibition regime. The most prominent examples of the harm reduction approach in drug policy include:

a) **Diversion** of drug offenders into treatment, the first step in the shift toward a public health approach, is beginning to take hold in the United States, reducing recidivism and illegal drug use among participants. Such treatment programs are

“abstinence-only,” however, unable to help reduce the harm to drug users who are unwilling to quit;

b) **Decriminalization** of drug use is common in Europe, from Russia to Italy to Belgium to Portugal, where anyone caught with small amounts of illegal drugs are reported to local commissions to ensure that users seek treatment. Individuals with drug problems in Portugal have been voluntarily appearing at government offices and asking for treatment, no longer fearing criminal punishment by the state.

c) **Depenalization** of certain drugs is a step further than decriminalization, particularly the Dutch policy of cannabis normalization, where the market for “hard” drugs has been separated from cannabis, for which there is an official “non-enforcement” policy. The rate of cannabis use in the Netherlands remains less than half of the U.S. rate and since the “hard” and “soft” drug markets were separated there has been no increase in the number of heroin addicts in the Netherlands, with youth initiation of the drug having been suppressed.

d) Numerous countries, including Germany and Canada, have started to provide supervised locations for the **safe administration** of illegal drugs, a practice that has resulted in reductions in the transmission of disease, accidental deaths and public disorder. This approach is testing the limits of the strict prohibition regime and has come under sharp criticism, despite its effectiveness.

3) **Medicalization** of drug addiction is once again becoming a viable option in Europe, as Switzerland, Germany, the Netherlands and Britain, and recently Canada, have instituted opiate prescription programs in which hard-core drug addicts are brought indoors into medically-supervised facilities and stabilized with controlled doses that are free of charge. These programs have brought about very promising outcomes, including:

- reductions in overdose deaths;
- reductions in the transmission of disease;
- reductions in economic crimes related to addiction;
- reductions in levels of public disorder;
- reductions in the quantity of drugs used;
- elimination of drug habits altogether for 20% of participants;
- stabilization of the health of participants;
- increased employment rates of participants;
- law enforcement support; and
- a changed culture where addictive drugs like heroin lose their cachet and are considered more like medication for sick people, resulting in declining rates of first-time use of such drugs.

The opiate prescription programs in Europe and Canada are made possible only through specific, carefully circumscribed *exemptions* from the prohibition-based legal framework and not through any fundamental change of that framework.

4) **Other policies** in Europe have helped to reduce the harm associated with drug use, including alcohol, especially in connection with motor vehicle operation. Numerous countries maintain a zero-tolerance policy for driving with *any* amount of alcohol in the bloodstream and those countries are tough on impaired driving in general. For the protection of young people, most European countries have delayed the driving age to 18 or above, while setting the drinking age at 16 or even below (such as Denmark).

Despite having challenged the bounds of the strict prohibition model with seemingly “bold” policy developments on the international front, no nation has yet defied the global prohibition regime at its core by asserting full regulatory control over the production and distribution of currently prohibited drugs as a means of eliminating the “black” market and its attendant social harms.