The Regulation-Legalization Debate

The three drug control Conventions constitute a recognition by the international community of a global problem requiring international cooperation and the acceptance of a collective responsibility to deal with it. The aims of the Conventions are to ensure adequate supplies of narcotic and psychotropic drugs for medical and scientific purposes only, to prevent drug abuse and to prevent and suppress illicit manufacture, diversion and trafficking. Their strength derives from the breadth of consensus that inspired them and from their foundation in international law; their weakness stems from their status as a compromise solution for nations of widely diverse historical, cultural and legal traditions, and from their relative difficulty of adaptation to fast-changing conditions.

The guiding principles of the Conventions rest on the control of supply and on that of demand through supply, whereas measures specifically aimed at reducing or eliminating demand have traditionally been regarded as a matter for national legislation. Countries party to the Conventions may be criticized for a lack of commitment to supply reduction strategies, but are rarely held accountable to the international community for inadequate endeavours to prevent and treat drug abuse.

The slant towards supply-side measures has encouraged a relative harmonization in this field and, conversely, has encouraged diversification on the demand side. The policy of disrupting international supply lines from 'producer' to 'consumer' countries was absorbed easily into the logic and rhetoric of the cold war and, in the first few years after 1989, seemed almost to take its place. Yet in recent years there has been increasing criticism that the resources poured into the 'war on drugs' have been badly spent; and that the international drug control regime, instead of contributing to the health and welfare of nations, may have aggravated the situation. Several factors, such as worsening drug abuse problems in developing countries and concern over the transmission of blood-borne infections by injecting drug users, have led to a new focus on the drug consumer, both as a principal source of the problem and as the only medium through which a viable solution can be reached.

There is a new focus on the drug consumer as the principal source of the problem.

Amidst perceptions of an impasse in the drug policy field, numerous pressure groups have emerged, calling for changes to international drug control through the relaxation of prohibition – for example, through modifications to the existing drug control Conventions – and through a new emphasis on measures to reduce the harm associated with illicit drug use. Because these groups are eclectic in background and include academics, politicians, medical scientists, economists and influential opinion leaders, for the most part motivated by serious and well-founded concerns, they represent a serious challenge to the current philosophy of drug control.

The UN's principal drug control agency, the United Nations International Drug Control Programme, (UNDCP), can only act with a mandate from Member States; nonetheless it has a responsibility, through the forum of the Commission on Narcotic Drugs (CND) (see Part 5.3), to examine the criticisms made of the three Conventions and to evaluate alternative proposals. Equally importantly, it has a responsibility to engage all UN Member States in the discussion, in order to take the debate beyond the relatively narrow geographical boundaries within which it has been confined, and to examine the consequences of alternative drug control measures in terms of the economic, health and social effects such changes might cause.

The 'great debate' of today's drug policy, often referred to as 'the legalization debate', is in many respects a misnomer. It should perhaps be renamed the 'regulation debate', since what is at issue is not so much an outright choice between prohibition and legalization, as the degree of regulation to which currently illicit drugs should be subjected. Excessive concentration on these two extremes has diverted attention and energy from the serious questions the discussion raises.

In the first place, neither 'extreme' is quite as radical as its detractors make out: few if any proponents of legalization would have all drugs available to everyone without restrictions, but aim to establish a legal regime of controlled quality and availability. Nor, despite the polemics, do either of the three international drug Conventions insist on the establishment of drug consumption *per se* as a punishable offence. Only the 1988 Convention clearly requires parties to establish as criminal offences under law the possession, purchase or cultivation of controlled drugs for the purpose of non-medical, personal consumption, unless to do so would be contrary to the constitutional principles and basic concepts of their legal systems. None of the Conventions requires a party to convict or punish those who commit such offences, even when they have been established as punishable; alternative measures may always substitute for criminal prosecution. Countries party to the drug Conventions in which natural plant-based drugs such as coca, opium and cannabis were traditionally used, were granted a time period during which use was to be discouraged and gradually phased out. Continued cultivation was permitted for scientific and medical purposes, for the use of raw materials such as poppy straw and hemp and, in the case of coca, for preparing a non-alkaloid flavouring agent for a variety of uses.

"The legalization debate" is in many respects a misnomer.

The range of options concerning personal consumption and possession for such consumption lie along a continuum, which reflects not only the degree of control specified by the law, but also the degree of discretion with which the law is applied. The options include severe repression of possession and use; firm to moderate repression, with exemptions to include maintenance prescribing for dependent persons in treatment; discretional use of the criminal law (non-prosecution of first offenders, treatment as alternative to prison etc.); policies of harm reduction; tolerance; decriminalization; *de facto* legalization and, finally, legalization.

There are many popular misconceptions surrounding what different drug control regimes in the past (or lack of them) have achieved or failed to do. The lack of sustained scientific analysis of past experiences, and the uniqueness of each historical moment, permit diverse interpretations. However, in some cases, examination of a particular experiment or period provides a yardstick against which actual and hypothetical policies can be measured. Several examples are given below.

Legalization – China

China is the only known case of when legalization of a psychoactive drug – opium – was forcibly imposed upon one nation by the will of another. The opium trade between India and China was developed in the 1770s by the then British Governor General of Bengal, Warren Hastings. His concern about the effects of opium on the local inhabitants caused him to stop opium use in Bengal and encourage its export to China. By 1830, one British firm in China was selling 6,000 chests of opium per year domestically, despite the existence of a ban imposed by the Chinese Emperor. The attempts made by the Chinese authorities to enforce the ban led to two Opium Wars and the seizure of Hong Kong by the victorious British. As part of the settlement, China was compelled to accept unlimited imports of opium on payment of a duty. The opium trade became so successful that large areas of agricultural land in China itself were given over to cultivation of the opium poppy, while by 1906, it was estimated that 13.5 million Chinese, or 27% of the adult male population, smoked opium.[1]

Prohibition – USA

The period of national alcohol prohibition in the United States of America, which lasted from 1920 to 1934 is, paradoxically, cited by both opponents and advocates of legalization to support their case. In fact the 18th Amendment did not ban the possession or consumption of alcohol, but the "... manufacture, sale or transportation of intoxicating liquors within, the importation thereof into or the exportation thereof from the United States". During the period alcohol consumption dropped by 30 – 50% and the incidence in men of cirrhosis of the liver, which had been 29.5 per 100,000 in 1911, dropped to 10.7 in 1929.[2] On the other hand, the prohibition years were characterized by a growth in organized crime, corruption and violence, and by a high incidence of death and disease caused by consumption of home-produced 'moonshine' and industrial alcohol. Even without prohibition, other factors such as the temperance movement had a considerable influence in lowering drinking rates; at roughly the same period in the UK, which severely restricted times and outlets for sale of alcohol without imposing an outright ban, the cirrhosis rate dropped by half between 1914 and 1920.[3] The particular circumstances of prohibition – the fact that the ban was of a substance with a long, uninterrupted history of social acceptability, and occurred in a period overshadowed by world war and by economic depression – make it difficult to extrapolate lessons for modern times.

The 'British System'

The 'British system' generally refers to a period lasting from around the 1920s until the mid-1960s when British physicians could prescribe heroin to certain types of addict. Most were middle class who had become dependent on opiate pain killers during hospital treatment. The system fell into disrepute through the over-prescribing practices of a few doctors, and the consequent development of a black market, which in turn was augmented by an influx of cheap, high quality heroin from Iran and South-East Asia. The rapid rise in the number of dependent heroin users (an estimated 30-fold increase in 10 years) and the growth of a youth drug culture caused public alarm and served to politicize the issue. With the availability of non-injectable opiates such as methadone, the willingness – and the right – of doctors to prescribe heroin became severely circumscribed. Twenty years later the HIV/AIDS epidemic caused health priorities to dominate drug policy once more, with the prescription of injectable drugs by specially registered doctors to certain categories of addict. Throughout the UK drug abuse treatment clinics provide condoms, clean syringes and other services to limit the harm from drug injection practices.

US Cannabis Decriminalization

In the 1970s, eleven US States decriminalized personal possession of cannabis and made it a civil offence punishable with a fine. Most states did not record significantly increased rates of consumption over those that did not decriminalize, with the exception of Alaska, where 12 – 17 year-olds were smoking joints at twice the national average by 1988 – cannabis was recriminalized in 1990.[4] In general, an accurate analysis of the precise impact of legislation was hampered by weaknesses in survey techniques and by the general climate of tolerance (presence but non-enforcement of laws) which led to a peak of cannabis use in 1979.

Switzerland

Switzerland has become the testing ground for radical drug policies, particularly at the liberal end of the spectrum. Since the end of the 1970s a number of 'open' drug scenes had existed in the city of Zurich, including the park of Platzspitz, although it was used only for cannabis dealing until 1986, when heroin dealers moved in. The rapid spread in Switzerland of HIV/AIDS through injecting drug use, modified local and city government policies from a repressive-permissive mix to a focus on containment and *Ueberlebenshilfe* (survival assistance). In 1987 more than 20 governmental and non-governmental health and social care groups moved into 'Needle Park' to provide medical help, resuscitation teams, oxygen equipment, condom and syringe dispensing facilities, mobile kitchens, toilets and

showers. The park attracted increasing numbers of users, many of them from outside Switzerland. Despite the services provided, health and social problems increased, as did crime rates in and around the area. The city reacted by providing alternative services such as 'low threshold' methadone programmes and other harm reduction measures (see Part 6.2). In March 1989, 2,150 free syringes were distributed each day; four months later the number had trebled. A total of 234,000 syringes were handed out in the month of June 1990, while the average number of resuscitations had risen over the year from 3.5 to 6.2 per day. Addicts were injecting more, not less. Shootings, stabbings, robbery and theft became more common as Turkish, Lebanese and Yugoslav dealers competed for market shares. In October 1991, the district authorities ordered the city government to close the park. In compensation, medical and social services were made generally available to all addicts, not just those from Zurich. In the short term, criminal activity diminished, illegal drugs became more expensive and less available, while the number of drug-related deaths in Zurich fell.[5] With the closure of Platzspitz the open scene moved to an area round the disused railway station of Letten. Although one aim of the policy had been achieved – the level of HIV infection ceased to rise – a similar pattern of lawlessness and violence developed, and the Letten open scene was also closed down in February 1995.

The failure of Zurich's attempt to contain the city's drug problem geographically, and to deal with it humanely, led to a refocusing of Swiss drug policies. On the one hand, open scenes ceased to be tolerated, with more repressive policies introduced that were aimed at removing the public nuisance factor. On the other, alternative programmes of harm reduction were launched. A major experiment was begun to distribute injectable opiates, under medical supervision, to 1,000 hard core addicts, for whom other forms of treatment had failed. This three-year experiment, which received a special dispensation from the International Narcotics Control Board for the import of heroin, began in January 1994 in the German-speaking cities of Basel, Zurich and Thun; it provides injectable heroin, morphine or injectable methadone to addicts up to three times a day for a small daily fee. The World Health Organization has been invited to make an independent assessment of the expermiment at its conclusion. In the meantime, the Netherlands and Australia were considering embarking on similar trials.

From 1992 Switzerland began to experiment with the use of specially created 'shooting galleries' known as *Fixerräume* or *Gassenzimmer*. Use of these premises for injection purposes was restricted to drug dependent individuals known personally to the staff. Drugs were neither prescribed, distributed nor traded. In August 1992 some 70 – 80 individuals were using the premises daily between the hours of 1800 to 2200.

The Netherlands

For over 20 years Dutch drug policy has been firmly rooted in principles of harm reduction (see below). A distinction is drawn between cannabis derivatives and drugs such as heroin, cocaine and psychotropic drugs deemed to 'present an unacceptable risk', with the aim of separating the consumer market for 'hard' drugs from that of 'soft' drugs. Dealing in 'hard' drugs is not tolerated and trafficking is punishable by lengthy prison sentences. Possession for personal use of almost any drug is tolerated, methadone maintenance is standard practice for opiate dependency, and clean syringes are distributed without charge. Until the end of 1995 the sale or purchase of up to 30 grams of cannabis derivatives was *de facto* decriminalized and tolerated in specified locations. However, complaints from European neighbours at the growth of 'drug tourism', a rise in domestic cannabis consumption, and fears that the cannabis trade was being used as a front by organized crime groups trafficking in more dangerous drugs, caused the Dutch government to implement tighter controls. The number of 'coffee shops' and other retail outlets for cannabis was reduced by 50% while those that were allowed to operate had to adhere to five principles: no advertising; no sale of hard drugs; no nuisance to the neighbourhood; no selling to minors; and no sales of more than five grams.

Germany

German drug policy incorporates elements of both the Dutch and the Swiss approaches. A decision taken in 1994 by the German Federal Constitutional Court held that while the possession, purchase and sale of even small quantities of cannabis derivatives for personal consumption should remain illegal, it was not generally in the public interest to prosecute such offences. The individual *Länder* were required to accept this principle, and to ensure the introduction in due course of a standardized national practice with regard to discontinuation of proceedings on the part of the competent public prosecution offices. In practice, the margins set on personal use of cannabis have varied widely from, for example, six grams in Bavaria up to 30 grams in Schleswig Holstein. A sizeable movement in Germany calls for wider forms of decriminalization and even legalization. Several German towns also provide premises for injecting drug users, known as *Gesundheitsräume* or 'health rooms'.

Harm reduction

The principles of harm reduction, which are sometimes confused with those of legalization, have a different starting point from policies aiming at abstinence or based on intolerance of use. They accept the recourse to illicit drug use as an inevitable, though undesirable, weakness of human nature which has been created at least in part by society's failure to provide adequate opportunities for the relief of stress, boredom, loneliness or for self-realization. Proponents of harm reduction believe that drug policies based on abstinence are bound to fail because they ignore the root causes of the problem – that what is required are policies which help to free individuals from the circumstances which led to the drug taking, enabling them to decide autonomously to quit. The transmission of HIV and other blood-borne infections through sharing drug paraphernalia, the recourse to crime in order to pay for the dependency; the uncertain quality of drugs purchased on the street; and the social marginalization of consumers are all cited as factors which necessitate a better integration of drug users and the provision of assistance to them, including drugs if necessary. It is claimed that by giving such care crime levels will fall, cities will become less violent, dependent drug users will be healthier and more integrated into society and thus more likely to return to a productive life. The ultimate objective is the overall reduction to a minimum of the harm caused by the drugs, and also of the harm perceived as being caused by the illegal status of drugs. These principles were incorporated into the "Frankfurt Resolution", a declaration signed by representatives or city counsellors of nine European cities in Frankfurt in 1990. The signatories proposed that:

The principles of harm reduction are sometimes confused with those of legalization.

(i) The criminal law should only be used to repress drug trafficking;
(ii) Neither the consumption nor the possession of drugs for purely personal use should be prosecuted;
(iii) Help should not be linked only to abstinence – survival assistance should be a first priority;
(iv) There should be a separation in law between cannabis and other illegal drugs;
(v) The use, purchase and possession of cannabis should be decriminalized;
(vi) Trade in cannabis products should be placed under legal control; and,
(vii) Prescription of drugs to addicts under medical supervision should be considered.

While these proposals are not national policy, cities in several East and West European countries implement them to the extent possible. An alternative association, known as European Cities Against Drugs, has been formed to oppose any such relaxation in existing laws.

Many of the arguments put forward on behalf of harm reduction may also be applied through a flexible interpretation of prohibition. Some stricter forms of prohibition forbid syringe exchange schemes

and stigmatize addicts such that they are afraid to come forward for treatment, but this is less a condition of prohibition *per se* than of a particularly severe interpretation of it. The likelihood of transmission of the HIV virus through injecting drug use is one of the strongest arguments for a harm-reduction approach: the World Health Organization estimated that about 40% of recent AIDS cases were caused solely by sharing injecting equipment, compared to about 16% in 1985.[6] In Scotland the seropositivity rate in Edinburgh, where maintenance prescribing and needle exchanges had been opposed, rose to over 50% in the mid 1980s,[7] whereas in Glasgow, less than 50 miles away, where such facilities were available, the level was less than 5%.[8] However, the sharing of injecting equipment depends upon more complex factors than availability – in Italy, the European country with one of the highest HIV positive rates amongst injecting drug users, syringes are available at low cost in any supermarket.

Legalization

Many of the premises underlying the pro-legalization argument resemble those of the harm reduction lobby, but they go considerably further. While most harm reductionists believe in decriminalizing cannabis and making other drugs available to dependent users, few recommend that drugs be made more widely available through the removal of criminal sanctions from the entire trade. The case for legalization is based on a mix of arguments drawn from economic, health/social and philosophical analyses. The principal assumptions are:

Legalizers maintain that prohibition's combined costs to society are not repaid by its doubtful benefits.

(i) The policy of declaring a 'war on drugs' has been a failure – despite the colossal investment made in law enforcement, more drugs are available now than ever before. Courts and prisons in many countries are overburdened by drug possession offences, in particular those relating to cannabis, while many serious crimes go unpunished.
(ii) The adulteration of substances causes more harm than the drugs themselves. Under a legal regime there could be quality control, better knowlege and education about drugs and their effects; taxes could be levied to provide improved health care for problem users.
(iii) Consumption might rise initially, but would level out to 'moderate' levels in most cases.
(iv) The criminal law has no right to interfere with personal behaviour if it causes no harm to others.
(v) The sole beneficiaries of prohibition are criminal profiteers: legalization would remove the profits, cause the cartels to collapse and put an end to much of the violence and crime that are inherent in the illicit market.

The overall conclusion is that the combined costs to society in terms of higher crime and violence, the drain on financial resources and the sacrifice of civil liberties, are not repaid by the doubtful benefits that prohibition can bring.

Policy failure?

Few would argue that prohibition has been unequivocally successful, and many prohibitionists would admit that the attempt to curb the supply of illicit drugs has substantially failed. Despite major law enforcement expenditures, which ranged in the USA from US$4.7 billion in 1988 to US$12.3 billion in 1993, the street price of both cocaine and heroin decreased,[9] indicating an increased availability. Nevertheless, prohibitionists believe that the *absence* of prohibition would have created problems even worse than its presence, perhaps analagous to the health consequences of the abuse of the legal drugs, alcohol and tobacco. It is argued that illegal drugs should be made legal because the number of illicit drug-related deaths – which some estimate to be around 20,000 a year in the USA – is slight compared to the 100,000 alcohol-related mortalities and the 400,000 attributed to tobacco.[10] Yet legalizers who use as an 'argument' that the currently legal drugs are associated with proportionately more harm than the illegal ones, may simply be shooting themselves in the foot. Reuter et al.[11] have suggested that, if

out of 100 million adult consumers of alcohol in the USA, approximately 15% suffer long-term consequences and if, under legalization, only a quarter as many consume heroin as consume alcohol but with a similar percentage of harm as a result, then instead of 750,000 addicts there would be 3,750,000 heroin addicts in the country. They speculate that the 'capture rate' – the proportion of occasional users who become habitual – might in fact be closer to that of cigarettes, that is over 50%.

Kleber[12] also points to problematic use of the legal drugs, and to the existence of 50 million nicotine addicts and 18 million problem drinkers, compared to less than two million cocaine addicts. He suggests that under legalization the numbers of cocaine users might jump to between 20 – 25 million, of whom 4.7 – 15.8 million might become compulsive.

A further argument that could be set against that of policy failure is that, in several western industrialized countries, there are signs that the current drug cycle has begun to stabilize, and in some cases even to decline among the general population.[13] Legalization might serve to re-stimulate a waning interest. The decline must of course be seen in the light of an upsurge in the consumption of synthetic stimulants and, for heroin and cocaine, a higher harm per user level caused by fewer people consuming proportionately greater amounts – in the USA it was estimated in 1994 that 25% of users were taking 75% of the cocaine consumed.[14] But if the cumulative effects of prohibition and increasing public awareness of the negative consequences of long-term drug use have served to erode the user population base in a significant area throughout the world, then its achievements are not negligible.

Prohibitionists believe that the **absence** *of prohibition would have created problems even worse than its presence.*

Developing country impact

A striking aspect of the legalization debate is that it takes place almost exclusively in and about western industrialized nations, and the availability of literature on the subject reflects this. Yet economic and geographic spaces have shrunk, reducing the planet to a single market place. Changes in drug policy, or in trafficking and consumption patterns, have repercussions that extend far beyond the confines of a single country. The existence of rigorous law enforcement in one region displaces trafficking activities to areas of greater tolerance; choice of location for the management of illicit capital is determined by the absence or laxity of money laundering legislation; and regions of the world perceived as 'virgin' consumer markets are carefully targeted by traffickers in search of market expansion. It has been claimed as an argument against prohibition that the outlawing of opium and coca use has actively encouraged trafficking of the lower-bulk, more easily concealable heroin and cocaine in powder forms; and that parallel to this – also as a consequence of illegality – consumers have been compelled to use the most concentrated form of the drug available, often through injection. Heroin injection is becoming an increasing problem in India, Thailand and Myanmar while injection of cocaine and of ampetamine-type stimulants is spreading in Brazil.[15] To what extent prohibition has contributed to this situation must be carefully studied: any association is likely to be complex, and may furnish only part of the answer. Many accessories of modern life, from Coca Cola to Levi jeans and Scotch whisky, perceived as deriving from the affluent West, are adopted in poorer countries as status symbols, indicators of cosmopolitanism and sophistication. The use of cocaine in particular has become a hallmark of success amongst newly affluent groups in societies undergoing a period of particularly rapid economic change. If the pattern follows a course similar to that in the USA in the early 1980s then the use of crack cocaine or ATS may start to have a devastating impact on the poorest economic sectors of fragile developing democracies. Signs of an emerging trend are already showing up (see Part 1, Box 1B).

Legalizers assume that licensing opium poppy and coca farmers for cocaine production would benefit the Asian and Latin American economies. According to Nadelmann[16] the notion that "... we can keep ... millions of peasants unemployed or under-employed and living on a few hundred dollars, at most, around the world pursuing a better standard of living through crop substitition is laughable." Admittedly, crop substitution alone provides no long-term solution, but has long been superseded by the wider concept of alternative development (see Part 6.3). Whether legalization would provide a better overall standard of living is by no means certain. Two main alternatives might emerge: first, that the drug manufacturing cycle would continue to be dominated by past market leaders – the cartels – who would see their fortunes consolidated. As newly 'enfranchised' captains of industry they would doubtless seek to strenghten their position through political election and occupation of crucial financial and economic centres of power. Corruption, as it has functioned in the narcotics world, would no longer be a question of *plomo o plato* (bullet or silver) but would be blatant, overt lobbying. Institutional corruption functions perfectly efficiently without the pressures of drug traffickers, as the fall from grace of numerous European and Asian public figures shows.

The second and possibly more likely option is that the multinational pharmaceutical companies would establish a virtual monopoly over the manufacture and distribution of formerly illicit drugs. Given the long experience of the pharmaceutical industry in regulation and in quality control this would represent a natural development, both for psychotropic drugs and for the plant-based products. Under a legal regime regulated by an international control mechanism, more efficient, streamlined, and cost-effective methods would be introduced, either by synthesis of the traditional plant materials, or else by relocation of some cultivation to geographically more convenient centres where standard quality could be assured. California might become the world centre of cannabis cultivation, for example. In this scenario the peasant farmers would be the prime losers. Next would be the middle men: the jobs of hundreds of thousands of intermediaries between the farmers and the major trafficking groups would vanish, with significant repercussions for local economies. Although the extent to which the illegal drug economy boosts the legal one is unknown (see Part 4) there could in the short term be a sudden fall in dollar revenue, collapse of land prices and a possible migration of farmers looking for new employment in the cities.

The degree to which the governments of poorer countries would be willing or able to deal with the consequences of legalization is not at all certain. Setting aside the economic safety net that might be required to integrate coca and opium poppy farmers into a free market economy, equally important and potentially larger investments would be needed to provide education and health care programmes to prepare for the generalized availability of a wide range of psychoactive substances. For an economically hard-pressed government weighed down with large public debts and an eye on re-election, the value of long-term invisible investment might be neglected in favour of the more tangible benefits derived from short-term financial measures.

Moreover, if the past practices of the pharmaceutical and tobacco companies can be taken as precedents for the way in which a marketing drive for other drugs would be run, then a serious danger exists that targeted advertising might weaken any prevention efforts. A report published in 1993 by the French branch of the organization, Medical Lobby for Appropriate Marketing (MALAM), showed that misleading advertising was being used by pharmaceutical laboratories to market their products in developing countries. Out of 6,170 advertisements published in 23 large circulation medical magazines between July 1987 and June 1988, contra-indications were omitted in half and undesirable side effects in 40%. Another study, commissioned by the US Congress from the Office of Technology Assessment, revealed that about two-thirds of 241 medicinal products sold by American laboratories to four developing countries (Brazil, Kenya, Panama and Thailand) did not carry enough information to enable doctors to prescribe them effectively and safely. As a result of MALAM's lobbying, nine products were

withdrawn from sale or had their formulae changed after 1987, while the advertising of 16 other products was totally or partly stopped.[17]

Samarasinghe[18] points out that there are important differences between drug use in poor countries and in affluent societies. In the industrialized countries drug use is perceived as harmful when evidence of medical complications, dependence or major social or family disruption occurs. In poor countries such as Sri Lanka, the economic impact of apparently non-problematic substance use can constitute a steady drain on family resources. What in the West would be considered 'acceptable' – a daily consumption of four cigarettes and two units of alcohol by one member of a household – amounts to 40% of the earnings of a family in the lowest income quartile of Sri Lanka.

An "acceptable" consumption of cigarettes and alcohol in the West amounts to 40% of the earnings of a poor Sri Lankan family.

It is recognized that the groups most vulnerable to drug abuse are those where social cohesion is weakest, and this is especially true at the end of the 20th century as traditional social and economic patterns in many parts of the world have undergone major upheaval. As discussed in Part 2, these changes may produce a sense of rootlessness which in some cases leads to drug use. Samarasinghe suggests that where there is a wide range of leisure pursuits and avenues for enjoyable social interaction, alcohol use may be an adjunct to generally pleasurable activities. In poorer settings there is less enjoyable stimulation, and the pharmacological effect produced by a drug, whether pleasant or not, serves as the central experience in the drug-taking ritual rather than being simply an accompaniment to activities which are in themselves pleasurable. He points out that the pure effects of drugs of dependence, with the exception of stimulants, are not inherently rewarding when conditioned cues do not operate, and that a social process is required to make users continue using the drug until the effect itself acquires conditioned ability to evoke positive reactions. The process of conditioning, and later of dependence, is hastened by the absence of experiences which are in themselves pleasurable, and thus, he argues, drug users in developing countries tend as a result to develop features of the dependence syndrome at much lower levels of consumption than they do in the developing world. This too must be weighed up when considering the effects of legalization.

The administration of legalization

One of the most controversial areas in the legalization debate surrounds the exact form of regulation that the legalized drugs would have – whether the regime would be operated under government monopoly or private franchise; what form of overall control would be exercised by international or national control bodies to ensure quality and guarantee supplies; how drugs would be dispensed and by whom (doctors, pharmacies, tobacconists or others); under what conditions – whether exceptions would be made for minors and certain special categories; and which drugs would be legalized – cannabis only, or all currently illicit drugs.

If the process were in the hands of private enterprise there would have to be some regulatory body to impose levels of potency, standards and quality control. A choice would have to be made regarding whether the newly legal drugs would be sold as cigarettes are, with a label indicating contents and with a health warning, or according to the current restrictions on legal pharmaceuticals, which go through a prolonged period of scientific controls and tests before being released commercially. At present, a two-fold regime operates – restrictions designed to prevent abuse; and prescribing and dispensing limitations designed to prevent health injuries and to promote compliance with good clinical practice. Without removing public health regulations it would be impossible to ensure the availability of opiates, stimulants and other substances for recreational purposes.[19] Legal liability would be

inconceivable unless full clinical trials were carried out, yet a mere health warning could not possibly cover all the circumstances in which use of a given drug was inadvisable. The whole concept of liability would be altered by the dependence potential of psychoactive drugs.

An effective control apparatus would impose significant costs on the industry which would in turn be passed on to the consumer, and might create space for an unregulated black market. Such costs could be covered by advertising, but this would also require careful supervision – if private enterprises were vying for market shares there would be competition to increase sales and to project the most alluring and benign image of the product concerned. Independent consumer guides would have to guarantee accuracy and impartiality.

The regulation of legalized drug sales would have very different connotations depending upon whether retail outlets were a tobacconist, a pharmacy (over the counter or with a doctor's prescription), or in specialized locations such as the Dutch 'coffee shops' which would also require a system of public licensing. It is not clear what would happen to prescription drugs under legalization – whether one would have an 'automatic' right to heroin but not, for example, to antibiotics. Doctors might resist requests to prescribe psychoactive drugs on demand, on the grounds that their role is to heal the sick, not prescribe for recreation. Ethan Nadelmann[20] suggests that a mail order system could be established whereby any adult could apply for personal supplies of any drug. His proposal would undoubtedly obviate some of the objections to legalization but would require a relatively high-technology, high-cost system with built-in, anti-fraud devices whose operational sophistication and user cost would put it out of reach of most countries.

How would legalized drugs be regulated?

Exempt groups

If an age limit of 16, 18 or even 21 is set (as all legalizers stipulate) then one can assume firstly that a black market would continue, albeit diminished, and secondly that, as occurs with alcohol and tobacco, minors would have more access to legal drugs than they currently do to illegal drugs, partly through parental and older peer access, and partly because the price would be more affordable than at present. In the USA it was reported that 62% of high school seniors had smoked cigarettes, thirty percent of them in the last month.[21] Some 87% of high school seniors admitted drinking alcohol, of whom half had done so in the previous month. There are an estimated 12 million under-age drinkers.[22] Adult precedent sets a strong example for the young; teenagers are alert to hypocrisy in adult behaviour and might resist the warning "it's all right for us but not for you".

To protect the majority of non-consumers from the minority of consumers, new means of drug testing would have to be introduced into a whole range of job categories and activities. It is not clear which categories would be included, but at the very least, they would involve the armed forces, machine operators, drivers, pilots, medical workers, and those working in sensitive industries such as nuclear power. Whether these categories would be under a total or partial drug ban (e.g., weekends permitted) would require careful consideration. The singling out of special categories excluded from the right to consume drugs, and the means for enforcing the exclusion, call into question a whole series of civil liberty issues. The breathalyser test is a relatively low-cost, non-invasive first indicator of alcohol level in the blood which only leads to more thorough testing if the first reading is positive. Introducing comprehensive testing for a wide range of drugs to guarantee an adequate level of protection for the majority of non-consumers would be costly, and might mean a far higher level of invasion of privacy than is currently perceived as tolerable.

The moral question of legislating for drug-taking, pregnant women would have to be faced. It is widely recognized that drug use of any kind – alcohol and tobacco included – may harm the foetus and cause

neo-natal disorders. If such problems rose significantly under legalization, the right to motherhood might be called into question.

Legalize cannabis only?

Most proponents of legalization believe that cannabis should be the first drug to be made legal, but that, given the central aim of depriving the black marketeers of their profits and reducing crime and violence, cannabis legalization alone is not sufficient. Legalizers are often accused, unjustly, of calling cannabis "harmless". It is indisputable that, in certain kinds of individuals and at certain levels of use, cannabis causes problems for physical and mental health such as short-term memory loss, loss of concentration, impaired motor function and bronchial and pulmonary complications. Researchers at the University of California reported in 1988 that one 'toke' of cannabis delivers three times more tar to the mouth and lungs than one puff of a filter-tipped cigarette, and that cannabis deposits four times more tar in the throat and lungs, and increases carbon monoxide levels in the blood by four to five times.[23] Moreover, cannabis tends to be a more potent drug nowadays than it was in the 1960s and 70s, due to cultivation of new strains of the plant which have much higher levels of THC, the drug's principal psychoactive property. Persistent use in adolescence may have serious effects on the maturation process and is thought to contribute to the loss of energy and interest in one's surroundings known as 'amotivational syndrome'.

Cannabis legalization alone is not sufficient to achieve the legalizers' central aims.

On the other hand, consumption does not show the same patterns of long-term habitual or dependent use as does cigarette smoking, and no drug-related mortalities have been directly attributed to the cumulative effects of cannabis. This does not mean that cannabis may not have been implicated indirectly or directly in drug-related deaths such as driving accidents, but merely that, (a) within the range of illicit drugs, it appears the least harmful and (b) for a variety of reasons, perhaps linked to its status as a prohibited drug, the social and health costs resulting from use have been less harmful to date that those of cigarettes or alcohol.

The function of the law in terms of 'symbolic threshold'or 'forbidden fruit' was discussed in Part 2; at least for most young Americans, it seems the law acts more as a deterrent than as an incentive – in separate studies, 60 – 70% of New Jersey and California students reported that fear of getting in trouble was a major reason for not using drugs.[24] On the assumption that the law has a symbolic significance, prohibitionists argue that to legalize, or even to decriminalize cannabis would be to send the 'wrong message' by implicitly removing society's unequivocal disapproval of use. Yet opponents of cannabis prohibition query whether the high social cost in terms of law enforcement, court and prison costs and of social stigma, is justified by the harm the absence of the law would produce. In some countries cannabis offences account for the overwhelming majority of drug law violations that come before the criminal courts. In the UK in 1991, for example, possession of cannabis constituted 94% of cannabis offences, and three-quarters of all illicit drug offences;[25] in Australia 61% of all drug arrests are for cannabis offenders.[26] Of the one million drug arrests made each year in the USA approximately 25% are for the simple possession of cannabis, and constitute the fourth most common cause of arrest.[27]

Many feel that to prohibit a drug which is so widely used is to encourage disrepect for drug laws and for legality in general, and that the harmfulness of the drug has been sensationalized, such that young people feel misled by their elders and no longer believe in the anti-drug messages directed at them. Mark Kleiman, who acknowledges the harm cannabis can do but believes its prohibition produces more costs than benefits, proposes a "new social and legal category of 'grudgingly tolerated vices'" for items

not strictly prohibited, but forbidden to minors and to adults who have demonstrated the inability to consume them responsibly.[28]

Cannabis is often cited as a 'stepping stone' to other drug use on the grounds that it is usually the first drug taken illicitly by dependent heroin users. This affirmation does not prove a causal relationship, and sidesteps the fact that only a tiny proportion of cannabis smokers goes on to take heroin. It also ignores another, possibly valid hypothesis, that the drug user who has already crossed the barrier of legality to experiment with illegal drugs and who has experienced the (comparatively) mild hallucinogenic properties of cannabis, may be more predisposed than a non-user to try drugs with more intense hallucinogenic properties such as LSD.

A study conducted in the 1970s[29] explored the cannabis-heroin link in groups of adolescents in Manhatten. It suggested that cannabis was a gateway to heroin use, less for its pharmacological effects, than for an association with drug sellers which led users to begin selling in order to finance their own habit. The principle of keeping cannabis users from falling into a 'lifestyle of illegality' in its broadest sense has been one of the driving principles of Dutch drug policy since 1976.

The potentially therapeutic use of cannabis in relieving post-chemotherapy nausea, multiple sclerosis, the treatment of glaucoma and in halting the wasting syndrome associated with AIDS is given as a further justification for legalization. In the almost total absence of careful, long-term clinical trials, it would take many years of scientific testing at great cost before cannabis could conceivably enter the official pharmacopoeia. In the short term, for these special categories, decriminalization for personal use would be the only feasible option, and one which would not violate the international drug conventions.

Or legalize all drugs?

The crux of the legalization debate with cannabis, as with other currently illicit drugs, is the likely effect on health and social welfare. The legalizers admit that overall drug consumption would probably rise to begin with, but predict this would drop to a level of moderation. Drugs would be both cheaper – therefore addicts would not have recourse to crime to pay for their habits – and free of the harmful substances currently used to dilute doses for street sale. Addicts would be less likely to inject, and when they did so they would not need to share needles and other 'works'. Even should consumption levels rise, the average harm per user would diminish. Resources saved from law enforcement costs could be diverted to the prevention and treatment of abuse.

The crux of the legalization debate is the likely effect on health and social welfare.

Under legalization, drugs would become cheaper and more available. The number of consumers would be increased by a quota of new users, and existing users would almost certainly celebrate the price reduction by consuming more. That physical availability can and does impact on use has been demonstrated on numerous occasions – in 1973 – 75 a shortage of heroin in New York City interrupted supplies, and with them the recruitment of new users; addiction levels rose again when supplies were re-established.[30] Other examples include the higher rate of opiate abuse among physicians, nurses and pharmacists compared with the general population; the effect of cigarette-vending machines on smoking by minors; the high rate of opiate dependence among American troops in Vietnam compared to the Pacific phase of World War II.[31]

Degree of availability is one aspect which clearly distinguishes legalization from harm reduction. With the latter, the dependent user might be given maintenance doses under medical supervision, usually, though not necessarily, with the long-term aim of quitting. Under legalization the willpower required

to come off drugs altogether might be undermined by the knowledge that the drug of dependence is freely accessible.

The economic availability of drugs, or how price relates to demand, was discussed more fully in Part 4. However research shows that even in dependence-creating drugs there is a considerable elasticity of demand which varies in direct relation to price. Research done on tobacco price elasticities in sub-groups of age and gender showed that the greatest effect on price was on males under the age of 25, with a price elasticity which operated primarily to deter the decision to begin smoking regularly.[32] In Canada, where the average total tax on a pack of 20 cigarettes in 1991 was about seven times the average in the USA, tax increases were thought to have reduced adult cigarette smoking by 35% and adolescent smoking by 62%.[33] The per capita consumption of alcohol in Ontario between 1928 and 1974 varied inversely with the unit price of alcohol in an almost mirror image fashion.[34]

Against these arguments the legalizers would point out that, despite the availability and non-prosecution of cannabis use in Holland, consumption rates are still lower than the USA. The Dutch claim that their low key approach has made cannabis use 'boring'. Nonetheless, there is no majority consensus in Holland, or in any other country that practices decriminalization, to legalize cannabis or any of the other controlled drugs.

Making powerful and relatively untried, mind-altering drugs of dependence widely available would be a high risk venture. In contrast to heroin, which can be substituted by methadone in dependency treatment, there is no such thing as a maintenance dose for cocaine or crack cocaine, nor have substitute substances had proven efficacy in detoxification therapy. The legalizers would say that only a small percentage of consumers ever become addicted, and that social and psychological factors determine addiction more than the properties of the drugs. This may be true in some cases, but whereas heroin addiction can in principle be maintained at a constant level without undue physical deterioration, the same does not hold for stimulants. The administration of cocaine and amphetamines on a regular dosage schedule to normal, healthy human volunteers with no previous psychopathology, without social conditioning influences or the anxiety of being caught and prosecuted, can result in paranoid psychotic behaviour – quite simply, the direct consequence of the drugs' action on the brain.[35]

Making powerful mind-altering drugs widely available would be a high-risk venture.

Economics

Most proponents of legalization envisage a form of harmfulness tax on drugs, to be pitched high enough to serve as a deterrent to use and low enough to prevent the continuation of a black market. Finding this optimum level would call for finely-tuned, economic analysis together with an accurate forecast of likely consumption trends – a hard task even for the most advanced countries. Despite the influx of resources redeployed from law enforcement, the taxes might have to be high to cover the costs. In the USA, drug abuse costs due to lost productivity, damaged health and other costs (excluding law enforcement and crime) were estimated at US$70 billion in 1988.[36] The approximately US$20 billion dollars collected from alcohol taxes in 1995 by Federal and State governments[37] pays for only half the US$40 billion that alcohol abuse costs in direct health care, without counting other costs.[38] Nearly US$13 billion in cigarette taxes[39] is only about a sixth of the US$75 billion spent in direct health care costs directly attributable to tobacco,[40] without counting social security disability payments caused by cancer, heart disease etc.

For the legalizers to claim that increased health costs could be borne by re-allocating resources may be wishful thinking. Moreover, the effects of broader based drug consumption could have far reaching

effects on the social fabric – accidents at work, on the road and in the home would be more common, and suicides and deaths by overdoses would probably rise.

Crime, organized crime and violence

The legalization lobby is convinced that crime, violence and organized crime would be significantly reduced if drugs were legalized. There is no doubt that drug trafficking has permitted the criminal cartels to buy their way into power, political influence and judicial impunity. But, as discussed above, legalization would not remove the profits that have already been earned, merely jeopardize the future earning power of the lower cadres. Those whom legalization dispossessed would not simply give up and start being good law-abiding citizens but would probably look elswhere for a lucrative source of income, be it child pornography, trafficking in counterfeit currency, precious metals or body parts. The progressive integration of drug trafficking with other illegal networks indicates that the world's mafias are not resting on their narcotic laurels. Moreover, even under legalization, there would almost certainly be room for a narcotics black market, expecially if (a) certain categories were excluded, (b) not all drugs were legalized (such as crack or the so-called 'designer drugs'), or (c) if only some countries did so.

While it is true that the profit motive is the principal motor of the illicit drugs industry, it should be remembered that money laundering legislation incorporating measures to trace, freeze and confiscate criminal assets is in its infancy. Only a handful of industrialized western nations had systems in place by the end of the 1980s, and the rest are only slowly catching up. Even now, many outstanding issues remain unresolved - such as the compliance of off-shore centres with the 40 recommendations proposed by the Financial Action Task Force (FATF) (see Part 6.6), the reluctance of some countries to introduce appropriate legislation and relax bank secrecy, and the question of corporate criminal liability. With the marginalization of non-cooperating countries, and with the application of firm political will to implement existing legislation – not always demonstrated when powerful commercial and political interests are at stake – traffickers might have considerable difficulty in finding a safe haven for their ill-gotten gains.

Legalization would not necessarily end the narcotics black market.

Although it seems likely that a proportion of the predatory crimes committed to finance drug use would disappear, the crime/drugs relationship is far from clear. A review of North American studies suggests that a typical crime 'career' is well established prior to the onset of narcotic drug use and intensifies afterwards.[41] A study of New York youngsters who both used drugs and committed non-drug offences, indicated that delinquency was about as likely to begin before, as after the initial use of illicit drugs.[42] Rather than having a cause-and-effect relationship, the two forms of activity often seem to occur as products of similar external factors. Even under legalization, it has been suggested that a significant proportion of user-dealers, deprived of the income currently derived from participation in the black market, would be forced by economic hardship to continue criminal activities in order to survive.[43]

The complex association between drugs and violence is analysed by Paul Goldstein in Part 3, Box 3B. The legalizers believe that 'systemic' violence – which is inherent in a highly profitable illegal trade – would disappear under legalization. That it would be reduced is likely – Goldstein's 1988 analysis of cocaine-related homicides in New York City showed that most violence was the result of 'turf' wars among drug dealers, and that only about 2% could be attributed to direct pharmacological effects.[44] However, he suggests there may be a more complex association whereby individuals with a propensity for violence may be drawn to the drugs trade rather than any other, precisely because of the knowledge that violent instincts will find a sanctioned outlet. If drugs were legalized and violence were no longer a requisite for the trade they might transfer their 'services' elsewhere.

At the user level, proponents of legalization say the violence associated with acquisitive crimes would diminish once the need to rob and steal to buy drugs was removed. This might well be correct, but it would have to be balanced against the possible increase of violence of a pharmacological nature. Stimulant abuse has been associated with increased excitability and aggression which may turn into violence, as have the irritability and depressive state that typically follow a 'binge'.

The right to consume drugs?

The extent to which an individual's right to consume psychoactive drugs conflicts with the collective good was mentioned earlier. The health and social consequences on families, in the workplace and on society of drug abuse have been discussed in Part 3. These are actual, not potential harms, generated by a significant proportion of the drug-using population. The notion that the individual drug taker imposes no harm on society is not sustainable either on economic or on social grounds if the costs of that use are borne by society to the detriment of primary health care and social welfare. In nearly all countries alcoholics and those suffering from pulmonary disease from cigarette smoking have access to public health care, whose costs democratic society accepts as a collective burden. But if, under legalization, the victims of drug abuse of all kinds were to multiply, the tide of compassion might turn. Public health services might reject those who had chosen to act against their own best interests, leaving the rich to pay and the poor to lie in the gutter. Carried to its ultimate conclusion, insistence on the right to take drugs could be interpreted such that the community is absolved of responsibility for those who knowingly damage their own welfare. In many parts of the world the sector of the population over 60 years of age is set to double in the next 30 – 40 years.[45] Adding the costs of drug abuse to those of an aging, non-productive population might prove an intolerable burden. The result could be even greater devastation of many sectors of the world's population.

The regulation debate has been diverted from its proper course by overemphasis on its extremes.

Conclusions

Far from being a discussion of clear-cut policy options the regulation debate is, as Kleiman[46] has observed, more a question of choosing among problems than choosing among solutions. Any attempt to modify human behaviour is a quest for the elusive reconciliation between pragmatism and idealism – trying to legislate for an imperfect world without giving up the struggle for a better one.

The regulation debate has been diverted from its proper course by over-emphasis on its extremes, the 'zero tolerance' lobby on the one hand and the legalizers on the other. The legalizers may well have harmed the case for harm reduction by using it as a Trojan horse to gain recognition in the policy camp prior to launching the more extreme part of their campaign. Harm reduction need not be a stepping stone to legalization and is not necessarily incompatible with the maintenance of prohibition, within which, as rational discussion of the various options shows, there is room for diversity and compassion.

One of the principal risks with legalization is its irreversibility. It took thirty years from the identification of cigarettes with lung cancer to bring about a reversal in smoking habits among adults, and only then in industrialized countries, by means of sustained, costly, public awareness campaigns. Smoking is now increasing rapidly in developing countries, particularly amongst the young.[47] The tobacco experience should teach that even knowledge of harmful consequences does not necessarily prevent their occurrence and that drug habits acquired in youth are particularly difficult to dislodge.

The discussion of regulation has inevitably brought alcohol and tobacco into the heart of the debate and highlighted an apparent inconsistency whereby use of some dependence creating drugs is legal and of others is illegal. The cultural and historical justifications offered for this separation may not be

credible to the principal targets of today's anti-drug messages – the young. If it is accepted that education and prevention are the most effective, long-term strategies against drug abuse, then planning a drug control regime for the next century should tackle this problem and its implications for both the developing and the developed world.

One of the few unequivocal messages to emerge from the debate is the need for consensus. Consensus produced the three international drug Conventions and would be needed for any subsequent modification. International consensus and a broad consistency of approach are also indispensable for the maintenance of a coherent national policy – when one country's drug control regime differs radically from that of its neighbours, the country perceived as more tolerant may experience unwanted consequences in terms of increased trafficking and drug 'tourism'.

Regarding legalization, there seems to be little call so far for such a radical overturn of the current system. Where surveys or opinion polls have been carried out – in the USA and in Italy for example[48] – legalization has been rejected by the overwhelming majority of those questioned. Nonetheless a growing minority does seem to be seeking alternative methods of drug control, and may be willing to take limited risks of experimentation. Laws – and even the international Conventions – are not written in stone; they can be changed when the democratic will of nations so wishes it. But the legalizers must find better answers to the trickier questions before hearts and minds across the world will follow them.

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