

## Commonsense Drug Policy

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Ethan Nadelmann argues that current drug policy is misguided. He criticizes supply reduction strategies and notes that consumption rates would likely continue even if we were able to reduce or eliminate the supply of drugs from other countries. Harm-reduction strategies that have been implemented in various European countries are described, in contrast to strategies used in the United States. For example, methadone maintenance is available in the United States, but its use is more strictly controlled than in other countries. Nadelmann also describes the results from Swiss and other European studies that have examined the effects of prescribing heroin for addicted individuals. Those results and other harm-reduction strategies implemented elsewhere show great promise and should be used to guide and modify U.S. drug policy.

### First, Reduce Harm

In 1988 Congress passed a resolution proclaiming its goal of "a drug-free America by 1995." U.S. drug policy has failed persistently over the decades because it has preferred such rhetoric to reality and moralism to pragmatism. Politicians confess their youthful indiscretions, then call for tougher drug laws. Drug control officials make assertions with no basis in fact or science. Police officers, generals, politicians, and guardians of public morals qualify

as drug czars—but not, to date, a single doctor or public health figure. Independent commissions are appointed to evaluate drug policies, only to see their recommendations ignored as politically risky. And drug policies are designed, implemented, and enforced with virtually no input from the millions of Americans they affect most: drug users. Drug abuse is a serious problem, both for individual citizens and society at large, but the "war on drugs" has made matters worse, not better.

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Drug warriors often point to the 1980s as a time in which the drug war really worked. Illicit drug use by teenagers peaked around 1980, then fell more than 50 percent over the next 12 years. During the 1996 presidential campaign, Republican challenger Bob Dole made much of the recent rise in teenagers' use of illicit drugs, contrasting it with the sharp drop during the Reagan and Bush administrations. President Clinton's response was tepid, in part because he accepted the notion that teen drug use is the principal measure of a drug policy's success or failure; at best, he could point out that the level was still barely half what it had been in 1980.

In 1980, however, no one had ever heard of the cheap, smokeable form of cocaine called crack, or drug-related HIV infection or AIDS. By the 1990s, both had reached epidemic proportions in American cities, largely driven by prohibitionist economics and morals indifferent to the human consequences of the drug war. In 1980, the federal budget for drug control was about \$1 billion, and state and local budgets were perhaps two or three times that. By 1997, the federal drug control budget had ballooned to \$16 billion, two-thirds of it for law enforcement agencies, and state and local funding to at least that. On any day in 1980, approximately 50,000 people were behind bars for violating a drug law. By 1997, the number had increased eightfold, to about 400,000. These are the results of a drug policy over reliant on criminal justice "solutions," ideologically wedded to abstinence-only treatment, and insulated from cost-benefit analysis.

Imagine instead a policy that starts by acknowledging that drugs are here to stay, and that we have no choice but to learn how to live with them so that they cause the least possible harm. Imagine a policy that focuses on reducing not illicit drug use per se but the crime and misery caused by both drug abuse and prohibitionist policies. And imagine a drug policy based not on the fear, prejudice, and ignorance that drive America's current approach but rather on common sense, science, public health concerns, and human rights. Such a policy is possible in the United States, especially if Americans

are willing to learn from the experiences of other countries where such policies are emerging.

### Attitudes Abroad

Americans are not averse to looking abroad for solutions to the nation's drug problems. Unfortunately, they have been looking in the wrong places: Asia and Latin America, where much of the world's heroin and cocaine originates. Decades of U.S. efforts to keep drugs from being produced abroad and exported to American markets have failed. Illicit drug production is bigger business than ever before. The opium poppy, source of morphine and heroin, and *cannabis sativa*, from which marijuana and hashish are prepared, grow readily around the world; the coca plant, from whose leaves cocaine is extracted, can be cultivated far from its native environment in the Andes. Crop substitution programs designed to persuade Third World peasants to grow legal crops cannot compete with the profits that drug prohibition makes inevitable. Crop eradication campaigns occasionally reduce production in one country, but new suppliers pop up elsewhere. International law enforcement efforts can disrupt drug trafficking organizations and routes, but they rarely have much impact on U.S. drug markets.

### Drug policy should reduce the damage to users and the society around them.

Even if foreign supplies could be cut off, the drug abuse problem in the United States would scarcely abate. Most of America's drug-related problems are associated with domestically produced alcohol and tobacco. Much if not most of the marijuana, amphetamine, hallucinogens, and illicitly diverted pharmaceutical drugs consumed in the country are made in the United States. The same is true of the glue, gasoline, and other solvents used by kids too young or too poor to obtain other psychoactive substances. No doubt such drugs, as well as new products, would quickly substitute for imported heroin and cocaine if the flow from abroad dried up.

While looking to Latin America and Asia for supply-reduction solutions to America's drug

problems is futile, the harm-reduction approaches spreading throughout Europe and Australia and even into corners of North America show promise. These approaches start by acknowledging that supply-reduction initiatives are inherently limited, that criminal justice responses can be costly and counterproductive, and that single-minded pursuit of a "drug-free society" is dangerously quixotic. Demand-reduction efforts to prevent drug abuse among children and adults are important, but so are harm-reduction efforts to lessen the damage to those unable or unwilling to stop using drugs immediately, and to those around them.

Most proponents of harm reduction do not favor legalization. They recognize that prohibition has failed to curtail drug abuse, that it is responsible for much of the crime, corruption, disease, and death associated with drugs, and that its costs mount every year. But they also see legalization as politically unwise and as risking increased drug use. The challenge is thus making drug prohibition work better, but with a focus on reducing the negative consequences of both drug use and prohibitionist policies.

Countries that have turned to harm-reduction strategies for help in alleviating their drug woes are not so different from the United States. Drugs, crime, and race problems, and other socioeconomic problems, are inextricably linked. As in America, criminal justice authorities still prosecute and imprison major drug traffickers as well as petty dealers who create public nuisances. Parents worry that their children might get involved with drugs. Politicians remain fond of war rhetoric. But by contrast with U.S. drug policy, public health goals have priority and public health authorities have substantial influence. Doctors have far more latitude in treating addiction and associated problems. Police view the sale and use of illicit drugs as similar to prostitution—vice activities that cannot be stamped out but can be effectively regulated. Moralists focus less on any inherent evils of drugs than on the need to deal with drug use and addiction pragmatically and humanely. And more politicians dare to speak out in favor of alternatives to punitive prohibitionist policies.

Harm-reduction innovations include efforts to stem the spread of HIV by making sterile syringes readily available and collecting used syringes; allowing doctors to prescribe oral methadone for heroin addiction treatment, as well as heroin and other drugs for addicts who would otherwise buy them on the black market; establishing "safe injection rooms" so addicts do not congregate in public places or dangerous "shooting galleries"; employing drug analysis units at the large dance parties called raves to test the quality and potency of MDMA, known as Ecstasy, and other drugs that patrons buy and consume there; decriminalizing (but not legalizing) possession and retail sale of cannabis and in some cases, possession of small amounts of "hard" drugs; and integrating harm-reduction policies and principles into community policing strategies. Some of these measures are under way or under consideration in parts of the United States, but rarely to the extent found in growing numbers of foreign countries.

### **Stopping HIV with Sterile Syringes**

The spread of HIV, the virus that causes AIDS, among people who inject drugs illegally was what prompted governments in Europe and Australia to experiment with harm-reduction policies. During the early 1980s public health officials realized that infected users were spreading HIV by sharing needles. Having already experienced a hepatitis epidemic attributed to the same mode of transmission, the Dutch were the first to tell drug users about the risks of needle sharing and to make sterile syringes available and collect dirty needles through pharmacies, needle exchange and methadone programs, and public health services. Governments elsewhere in Europe and in Australia soon followed suit. The few countries in which a prescription was necessary to obtain a syringe dropped the requirement. Local authorities in Germany, Switzerland, and other European countries authorized needle exchange machines to ensure 24-hour access. In some European cities, addicts can exchange used syringes for clean ones at local police stations without fear of prosecution or harassment. Prisons are

instituting similar policies to help discourage the spread of HIV among inmates, recognizing that illegal drug injecting cannot be eliminated even behind bars.

These initiatives were not adopted without controversy. Conservative politicians argued that needle-exchange programs condoned illicit and immoral behavior and that government policies should focus on punishing drug users or making them drug-free. But by the late 1980s, the consensus in most of Western Europe, Oceania, and Canada was that while drug abuse was a serious problem, AIDS was worse. Slowing the spread of a fatal disease for which no cure exists was the greater moral imperative. There was also a fiscal imperative. Needle-exchange programs' costs are minuscule compared with those of treating people who would otherwise become infected with HIV. Only in the United States has this logic not prevailed, even though AIDS was the leading killer of Americans ages 25 to 44 for most of the 1990s and is now Number Two. The Centers for Disease Control (CDC) estimates that half of new HIV infections in the country stem from injection drug use. Yet both the White House and Congress block allocation of AIDS or drug-abuse prevention funds for needle exchange, and virtually all state governments retain drug paraphernalia laws, pharmacy regulations, and other restrictions on access to sterile syringes. During the 1980s, AIDS activists engaging in civil disobedience set up more syringe exchange programs than state and local governments. There are now more than 100 such programs in 28 states, Washington, D.C., and Puerto Rico, but they reach only an estimated 10 percent of injection drug users.

**Prejudice and political cowardice are poor excuses for allowing AIDS to spread.**

Governments at all levels in the United States refuse to fund needle exchange for political reasons, even though dozens of scientific studies, domestic and foreign, have found that needle exchange and other distribution programs reduce needle sharing, bring hard-to-reach drug

users into contact with health care systems, and inform addicts about treatment programs, yet do not increase illegal drug use. In 1991 the National AIDS Commission appointed by President George Bush called the lack of federal support for such programs "bewildering and tragic." In 1993 a CDC-sponsored review of research on needle exchange recommended federal funding, but top officials in the Clinton administration suppressed a favorable evaluation of the report within the Department of Health and Human Services. In July 1996 President Clinton's Advisory Council on HIV/AIDS criticized the administration for its failure to heed the National Academy of Sciences' recommendation that it authorize the use of federal money to support needle-exchange programs. An independent panel convened by the National Institute of Health reached the same conclusion in February 1997. Last summer, the American Medical Association, the American Bar Association, and even the politicized U.S. Conference of Mayors endorsed the concept of needle exchange. In the fall, an endorsement followed from the World Bank.

To date, America's failure in this regard is conservatively estimated to have resulted in the infection of up to 10,000 people with HIV. Mounting scientific evidence and the stark reality of the continuing AIDS crisis have convinced the public, if not politicians, that needle exchange saves lives; polls consistently find that a majority of Americans support needle exchange, with approval highest among those most familiar with the notion. Prejudice and political cowardice are poor excuses for allowing more citizens to suffer from and die of AIDS, especially when effective interventions are cheap, safe, and easy.

**Methadone and Other Alternatives**

The United States pioneered the use of the synthetic opiate methadone to treat heroin addiction in the 1960s and 1970s, but now lags behind much of Europe and Australia in making methadone accessible and effective. Methadone is the best available treatment in terms of reducing illicit heroin use and associated crime, disease, and death. In the early

1990s the National Academy of Sciences' Institute of Medicine stated that of all forms of drug treatment, "methadone maintenance has been the most rigorously studied modality and has yielded the most incontrovertibly positive results.... Consumption of all illicit drugs, especially heroin, declines. Crime is reduced, fewer individuals become HIV positive, and individual functioning is improved." However, the institute went on to declare, "Current policy... puts too much emphasis on protecting society from methadone, and not enough on protecting society from the epidemics of addiction, violence, and infectious diseases that methadone can help reduce."

Methadone is to street heroin what nicotine skin patches and chewing gum are to cigarettes—with the added benefit of legality. Taken orally, methadone has little of injected heroin's effect on mood or cognition. It can be consumed for decades with few if any negative health consequences, and its purity and concentration, unlike street heroin's, are assured. Like other opiates, it can create physical dependence if taken regularly, but the "addiction" is more like a diabetic's "addiction" to insulin than a heroin addict's to product bought on the street. Methadone patients can and do drive safely, hold good jobs, and care for their children. When prescribed adequate doses, they can be indistinguishable from people who have never used heroin or methadone.

Popular misconceptions and prejudice, however, have all but prevented any expansion of methadone treatment in the United States. The 115,000 Americans receiving methadone today represent only a small increase over the number 20 years ago. For every ten heroin addicts, there are only one or two methadone treatment slots. Methadone is the most tightly controlled drug in the pharmacopoeia, subject to unique federal and state restrictions. Doctors cannot prescribe it for addiction treatment outside designated programs. Regulations dictate not only security, documentation, and staffing requirements but maximum doses, admission criteria, time spent in the program, and a host of other specifics, none of which has much to do with

quality of treatment. Moreover, the regulations do not prevent poor treatment; many clinics provide insufficient doses, prematurely detoxify clients, expel clients for offensive behavior, and engage in other practices that would be regarded as unethical in any other field of medicine. Attempts to open new clinics tend to be blocked by residents who don't want addicts in their neighborhood.

In much of Europe and Australia, methadone treatment was at first even more controversial than in the United States; some countries, including Germany, France, and Greece, prohibited it well into the 1980s and 1990s. But where methadone has been accepted, doctors have substantial latitude in deciding how and when to prescribe it so as to maximize its efficacy. There are methadone treatment programs for addicts looking for rehabilitation and programs for those simply trying to reduce their heroin consumption. Doctors in regular medical practice can prescribe the drug, and patients fill their prescriptions at local pharmacies. Thousands of general practitioners throughout Europe, Australia, New Zealand, and Canada (notably in Ontario and British Columbia) are now involved in methadone maintenance. In Belgium, Germany, and Australia this is the principal means of distribution. Integrating methadone with mainstream medicine makes treatment more accessible, improves its quality, and allocates ancillary services more efficiently. It also helps reduce the stigma of methadone programs and community resistance to them.

Many factors prevent American doctors from experimenting with the more flexible treatment programs of their European counterparts. The Drug Enforcement Administration contends that looser regulations would fuel the illicit market in diverted methadone. But the black market, in which virtually all buyers are heroin addicts who cannot or will not enroll in methadone programs, is primarily a product of the inadequate legal availability of methadone. Some conventional providers do not want to cede their near-monopoly over methadone treatment and are reluctant to take on addicts who can't or won't commit to quitting

heroin. And all efforts to make methadone more available in the United States run up against the many Americans who dismiss methadone treatment as substituting one addictive drug for another and are wary of any treatment that does not leave the patient "drug free."

Oral methadone works best for hundreds of thousands of heroin addicts, but some fare better with other opiate substitutes. In England, doctors prescribe injectable methadone for about 10 percent of recovering patients, who may like the modest "rush" upon injection or the ritual of injecting. Doctors in Austria, Switzerland, and Australia are experimenting with prescribing oral morphine to determine whether it works better than oral methadone for some users. Several treatment programs in the Netherlands have conducted trials with oral morphine and platinum. In Germany, where methadone treatment was initially shunned, thousands of addicts have been maintained on codeine, which many doctors and patients still prefer to methadone. The same is true of buprenorphine in France.

In England, doctors have broad discretion to prescribe whatever drugs help addicted patients manage their lives and stay away from illegal drugs and their dealers. Beginning in the 1920s, thousands of English addicts were maintained on legal prescriptions of heroin, morphine, amphetamine, cocaine, and other pharmaceutical drugs. This tradition flourished until the 1960s, and has reemerged in response to AIDS and to growing disappointment with the Americanization of British prescribing practices during the 1970s and 1980s, when illicit heroin use in Britain increased almost tenfold. Doctors in other European countries and Australia are also trying heroin prescription.

The Swiss government began a nationwide trial in 1994 to determine whether prescribing heroin, morphine, or injectable methadone could reduce crime, disease, and other drug-related ills. Some 1,000 volunteers—only heroin addicts with at least two unsuccessful experiences in methadone or other conventional treatment programs were considered—took part in the experiment. The

trial quickly determined that virtually all participants preferred heroin, and doctors subsequently prescribed it for them. Last July the government reported the results so far: Criminal offenses and the number of criminal offenders dropped 60 percent, the percentage of income from illegal and semilegal activities fell from 69 to 10 percent, illegal heroin and cocaine use declined dramatically (although use of alcohol, cannabis, and tranquilizers like Valium remained fairly constant), stable employment increased from 14 to 32 percent, physical health improved enormously, and most participants greatly reduced their contact with the drug scene. There were no deaths from overdoses, and no prescribed drugs were diverted to the black market. More than half those who dropped out of the study switched to another form of drug treatment, including 83 who began abstinence therapy. A cost-benefit analysis of the program found a net economic benefit of \$30 per patient per day, mostly because of reduced criminal justice and health care costs.

The Swiss study has undermined several myths about heroin and its habitual users. The results to date demonstrate that, given relatively unlimited availability, heroin users will voluntarily stabilize or reduce their dosage, and some will even choose abstinence; that long-addicted users can lead relatively normal, stable lives if provided legal access to their drug of choice; and that ordinary citizens will support such initiatives. In recent referendums in Zurich, Basel, and Zug, substantial majorities voted to continue funding local arms of the experiment. And last September, a nationwide referendum to end the government's heroin maintenance and other harm-reduction initiatives was rejected by 71 percent of Swiss voters, including majorities in all 26 cantons.

The Netherlands plans its own heroin prescription study in 1998, and similar trials are under consideration elsewhere in Europe, including Luxembourg and Spain, as well as Canada. In Germany, the federal government has opposed heroin prescription trials and other harm-reduction innovations, but the League of Cities has petitioned

it for permission to undertake them; a survey early last year found that police chiefs in 10 of the country's 12 largest cities favored letting states implement controlled heroin distribution programs. In Australia last summer, a majority of state health ministers approved a heroin prescription trial, but Prime Minister John Howard blocked it. And in Denmark, a September 1996 poll found that 66 percent of voters supported an experiment that would provide registered addicts with free heroin to be consumed in centers set up for the purpose.

Switzerland, attempting to reduce overdoses, dangerous injecting practices, and shooting up in public places, has also taken the lead in establishing "safe injection rooms," where users can inject their drugs under secure, sanitary conditions. There are now about a dozen such rooms in the country, and initial evaluations are positive. In Germany, Frankfurt has set up three, and there are also officially sanctioned facilities in Hamburg and Saarbrücken. Cities elsewhere in Europe and in Australia are expected to open safe injection rooms soon.

### Reefer Sanity

Cannabis, in the form of marijuana and hashish, is by far the most popular illicit drug in the United States. More than a quarter of Americans admit to having tried it. Marijuana's popularity peaked in 1980, dropped steadily until the early 1990s, and is now on the rise again. Although it is not entirely safe, especially when consumed by children, smoked heavily, or used when driving, it is clearly among the least dangerous psychoactive drugs in common use. In 1988 the administrative law judge for the Drug Enforcement Administration, Francis Young, reviewed the evidence and concluded that "marihuana, in its natural form, is one of the safest therapeutically active substances known to man."

As with needle exchange and methadone treatment, American politicians have ignored or spurned the findings of government commissions and scientific organizations concerning marijuana policy. In 1972 the National Commission on Marihuana and Drug Abuse—created by President

Nixon and chaired by a former Republican governor, Raymond Shafer—recommended that possession of up to one ounce of marijuana be decriminalized. Nixon rejected the recommendation. In 1982 a panel appointed by the National Academy of Sciences reached the same conclusion as the Shafer Commission.

Between 1973 and 1978, with attitudes changing, 11 states approved decriminalization statutes that reclassified marijuana possession as a misdemeanor, petty offense, or civil violation punishable by no more than a \$100 fine. Consumption trends in those states and in states that retained stricter sanctions were indistinguishable. A 1988 scholarly evaluation of the Moscone Act, California's 1976 decriminalization law, estimated that the state had saved half a billion dollars in arrest costs since the law's passage. Nonetheless, public opinion began to shift in 1978. No other states decriminalized marijuana, and some eventually recriminalized it.

Between 1973 and 1989, annual arrests on marijuana charges by state and local police ranged between 360,000 and 460,000. The annual total fell to 283,700 in 1991, but has since more than doubled. In 1996, 641,642 people were arrested for marijuana, 85 percent of them for possession, not sale, of the drug. Prompted by concern over rising marijuana use among adolescents and fears of being labeled soft on drugs, the Clinton administration launched its own anti-marijuana campaign in 1995. But the administration's claims to have identified new risks of marijuana consumption—including a purported link between marijuana and violent behavior—have not withstood scrutiny.<sup>1</sup> Neither Congress nor the White House seems likely to put the issue of marijuana policy before a truly independent advisory commission, given the consistency with which such commissions have reached politically unacceptable conclusions.

In contrast, governments in Europe and Australia, notably in the Netherlands, have reconsidered their cannabis policies. In 1976 the Baan Commission in the Netherlands recommended, and the Dutch government adopted, a policy of

separating the "soft" and "hard" drug markets. Criminal penalties for and police efforts against heroin trafficking were increased, while those against cannabis were relaxed. Marijuana and hashish can now be bought in hundreds of "coffee shops" throughout the country. Advertising, open displays, and sales to minors are prohibited. Police quickly close coffee shops caught selling hard drugs. Almost no one is arrested or even fined for cannabis possession, and the government collects taxes on the gray market sales.

In the Netherlands today, cannabis consumption for most age groups is similar to that in the United States. Young Dutch teenagers, however, are less likely to sample marijuana than their American peers; from 1992 to 1994, only 7.2 percent of Dutch youths between the ages of 12 and 15 reported having tried marijuana, compared to 13.5 percent of Americans in that age bracket. Far fewer Dutch youths, moreover, experiment with cocaine, buttressing officials' claims of success in separating the markets for hard and soft drugs. Most Dutch parents regard the "reefer madness" anti-marijuana campaigns of the United States as silly.

Dutch coffee shops have not been problem free. Many citizens have complained about the proliferation of coffee shops, as well as nuisances created by foreign youth flocking to party in Dutch border cities. Organized crime involvement in the growing domestic cannabis industry is of increasing concern. The Dutch government's efforts to address the problem by more openly and systematically regulating supplies to coffee shops, along with some of its other drug policy initiatives, have run up against pressure from abroad, notably from Paris, Stockholm, Bonn, and Washington. In late 1995 French President Jacques Chirac began publicly berating The Hague for its drug policies, even threatening to suspend implementation of the Schengen Agreement allowing the free movement of people across borders of European Union (EU) countries. Some of Chirac's political allies called the Netherlands a narco-state. Dutch officials responded with evidence of the relative success of their policies, while pointing out that most

cannabis seized in France originates in Morocco (which Chirac has refrained from criticizing because of his government's close relations with King Hassan). The Hague, however, did announce reductions in the number of coffee shops and the amount of cannabis customers can buy there. But it still sanctions the coffee shops, and a few municipalities actually operate them.

Notwithstanding the attacks, in the 1990s the trend toward decriminalization of cannabis has accelerated in Europe. Across much of Western Europe, possession and even minor sales of the drug are effectively decriminalized. Spain decriminalized private use of cannabis in 1983. In Germany, the Federal Constitutional Court effectively sanctioned a cautious liberalization of cannabis policy in a widely publicized 1994 decision. German states vary considerably in their attitude; some, like Bavaria, persist in a highly punitive policy, but most now favor the Dutch approach. So far the Kohl administration has refused to approve state proposals to legalize and regulate cannabis sales, but it appears aware of the rising support in the country for Dutch and Swiss approaches to local drug problems.

In June 1996 Luxembourg's parliament voted to decriminalize cannabis and push for standardization of drug laws in the Benelux countries. The Belgian government is now considering a more modest decriminalization of cannabis combined with tougher measures against organized crime and heroin traffickers. In Australia, cannabis has been decriminalized in South Australia, the Australian Capital Territory (Canberra), and the Northern Territory, and other states are considering the step. Even in France, Chirac's outburst followed recommendations of cannabis decriminalization by three distinguished national commissions. Chirac must now contend with a new prime minister, Lionel Jospin, who declared himself in favor of decriminalization before his Socialist Party won the 1997 parliamentary elections. Public opinion is clearly shifting. A recent poll found that 51 percent of Canadians favor decriminalizing marijuana.

## Will It Work?

Both at home and abroad, the U.S. government has attempted to block resolutions supporting harm reduction, suppress scientific studies that reached politically inconvenient conclusions, and silence critics of official drug policy. In May 1994 the State Department forced the last-minute cancellation of a World Bank conference on drug trafficking to which critics of U.S. drug policy had been invited. That December the U.S. delegation to an international meeting of the U.N. Drug Control Program refused to sign any statement incorporating the phrase "harm reduction." In early 1995 the State Department successfully pressured the World Health Organization to scuttle the release of a report it had commissioned from a panel that included many of the world's leading experts on cocaine because it included the scientifically incontrovertible observations that traditional use of coca leaf in the Andes causes little harm to users and that most consumers of cocaine use the drug in moderation with few detrimental effects. Hundreds of congressional hearings have addressed multitudinous aspects of the drug problem, but few have inquired into the European harm-reduction policies described [earlier]. When former Secretary of State George Shultz, then-Surgeon General M. Joycelyn Elders, and Baltimore Mayor Kurt Schmoke pointed to the failure of current policies and called for new approaches, they were mocked, fired, and ignored, respectively—and thereafter mischaracterized as advocating the outright legalization of drugs.

In Europe, in contrast, informed, public debate about drug policy is increasingly common in government, even at the EU level. In June 1995 the European Parliament issued a report acknowledging that "there will always be a demand for drugs in our societies... the policies followed so far have not been able to prevent the illegal drug trade from flourishing." The EU called for serious consideration of the Frankfurt Resolution, a statement of harm-reduction principles supported by a transnational coalition of 31 cities and regions. In October 1996 Emma Bonino, the European commissioner

for consumer policy, advocated decriminalizing soft drugs and initiating a broad prescription program for hard drugs. Greece's minister for European affairs, George Papandreou, seconded her. Last February the monarch of Liechtenstein, Prince Hans Adam, spoke out in favor of controlled drug legalization. Even Raymond Kendall, secretary general of Interpol, was quoted in the August 20, 1994, *Guardian* as saying, "The prosecution of thousands of otherwise law-abiding citizens every year is both hypocritical and an affront to individual, civil and human rights... Drug use should no longer be a criminal offense. I am totally against legalization, but in favor of decriminalization for the user."

One can, of course, exaggerate the differences between attitudes in the United States and those in Europe and Australia. Many European leaders still echo Chirac's U.S. style antidrug pronouncements. Most capital cities endorse the Stockholm Resolution, a statement backing punitive prohibitionist policies that was drafted in response to the Frankfurt Resolution. And the Dutch have had to struggle against French and other efforts to standardize more punitive drug laws and policies within the EU.

Conversely, support for harm-reduction approaches is growing in the United States, notably and vocally among public health professionals but also, more discreetly, among urban politicians and police officials. Some of the world's most innovative needle exchange and other harm-reduction programs can be found in America. The 1996 victories at the polls for California's Proposition 215, which legalizes the medicinal use of marijuana, and Arizona's Proposition 200, which allows doctors to prescribe any drug they deem appropriate and mandates treatment rather than jail for those arrested for possession, suggest that Americans are more receptive to drug policy reform than politicians acknowledge.

But Europe and Australia are generally ahead of the United States in their willingness to discuss openly and experiment pragmatically with alternative policies that might reduce the harm to both

addicts and society. Public health officials in many European cities work closely with police, politicians, private physicians, and others to coordinate efforts. Community policing treats drug dealers and users as elements of the community that need not be expelled but can be made less troublesome. Such efforts, including crackdowns on open drug scenes in Zurich, Bern, and Frankfurt, are devised and implemented in tandem with initiatives to address health and housing problems. In the United States, in contrast, politicians presented with new approaches do not ask, "Will they work?" but only, "Are they tough enough?" Many legislators are reluctant to support drug treatment programs that are not punitive, coercive, and prison-based, and many criminal justice officials still view prison as a quick and easy solution for drug problems.

Lessons from Europe and Australia are compelling. Drug control policies should focus on reducing drug-related crime, disease, and death, not the number of casual drug users. Stopping the

spread of HIV by and among drug users by making sterile syringes and methadone readily available must be the first priority. American politicians need to explore, not ignore or automatically condemn, promising policy options such as cannabis decriminalization, heroin prescription, and the integration of harm-reduction principles into community policing strategies. Central governments must back, or at least not hinder, the efforts of municipal officials and citizens to devise pragmatic approaches to local drug problems. Like citizens in Europe, the American public has supported such innovations when they are adequately explained and allowed to prove themselves. As the evidence comes in, what works is increasingly apparent. All that remains is mustering the political courage.

#### Note

1. Lynn Zimmer and John P. Morgan (1997) *Marijuana Myths, Marijuana Facts: A Review of the Scientific Evidence*. New York: Lindesmith Center.