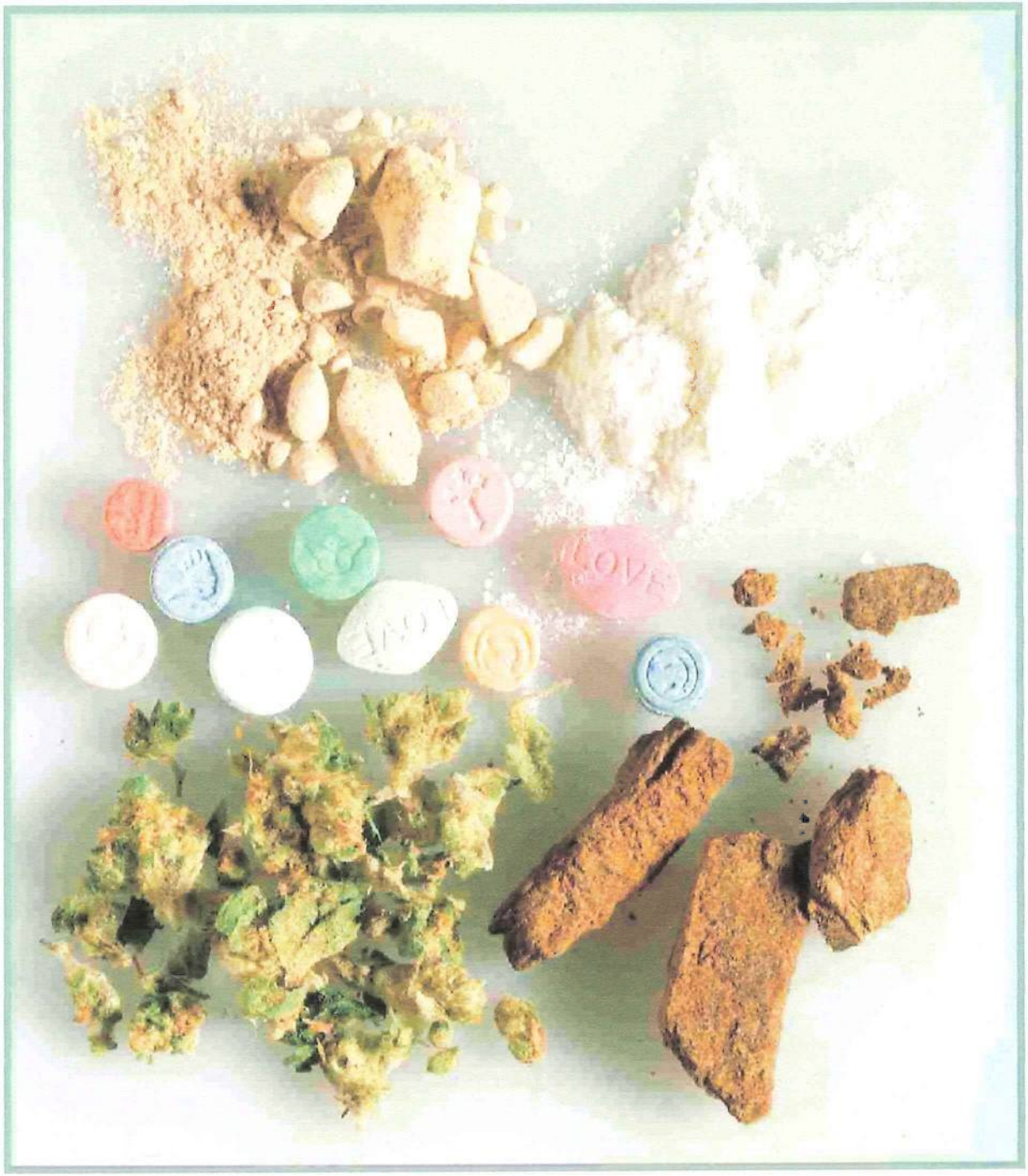

"Hard" vs "Smart"?

A Comparison between American and European Approaches to Drug Policy

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LIST OF ABBREVIATIONS

AIC	Australian Institute of Criminology
AIDS	Acquired Immune Deficiency Syndrome
CDC	Center for Disease Control and Prevention
CND	Commission on Narcotic Drugs
EEC	European Economic Community
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IHRA	International Harm Reduction Association
INCB	International Narcotics Control Board
IWG	Independent Working Group
NIDA	National Institute of Drug Abuse
NSDUH	National Survery on Drug Use and Health
NSP	Needle Syringe Program
OST	Opiod Substitution Therapy
RAND	Research ANd Development Corporation
SAMHSA	Substance Abuse and Mental Health Services Administration
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assemby Special Session
UNODC	United Nations Office on Drugs and Crime
US/USA	United States of America
WHO	World Health Organization

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Introduction

The contrast between European and American drug policy is one aspect out of many others where political approaches are shaped by a long history of societal developments, not just in the structures of policy and legislation, but also in terms of morality and community ethics. The prohibitionist strategy embodied by the American "War on Drugs" has resulted in many incarcerations and high monetary and social costs, but also boasts the signet of moral persistence and "zero tolerance" on drug abuse, without much differentiation between levels of harmfulness among various drug types. Substance abuse is approached primarily as a moral and legal issue in the United States, whereas Europe tends to treat it more like an illness and thus a public health problem. Besides controlling the supply of drugs, Europe has a strong focus on care for the affected addicts, in order to help them back on their feet and to keep them as healthy as possible during their addiction. This approach entails more willingness to engage in harm reduction, which occasionally implicates to put up with the necessary evil of tolerating drug addiction for the higher purpose of minimizing its harmful consequences. After all, the negative impacts from drug consumption not only affect the drug using individual but society in general, with regard to drug-related disease and deaths, crime and prosecution, as well as health care and social welfare costs.

There is a lot of debate on benefits and disadvantages of either approach. With the United States, the solution is sometimes deemed more costly than the problem, since law enforcement and imprisonment consume a lot of taxpayers' money. The "hard" policy of relatively strong penalties for minor offenses such as cannabis possession has been criticized as too rigorous to address the social complexity that is involved with the consumption of different types of drugs. The "soft" approach many European countries pursue has their critics as well, since the concept of harm reduction has often and misleadingly been associated with the negligence of reduction in actual drug use. Additionally, many harm reduction methods are opposed because of their controversial nature: many observers perceive that supplying needles and syringes to injecting drug users or prescribing heroin to addicts does not only send the wrong message to potential future users, but also signals defeat in the struggle for a drug-free world. These moral and ideological implications have inspired a lot of discussion on the fundamental objectives of drug policy, not just in Europe or the US, but also in a wider international context.

Though often criticized and intensely debated, the current global trends in harm reduction are backed up by scientific evidence and a growing group of advocates. Changes in the dynamics of drug policy are underway, both in Europe and the United States. Enough reasons to ask questions about how these different drug policy strategies evolved in their respective social contexts and to review the various aspects that characterize them. Is the impression of "hard" versus "smart" justified?

This paper will first give a brief overview of the historical developments with regard to drug policy in the United States and summarize the most important international drug control agreements. A look at the background and the recent trends of convergence in European drug policy will help to get down to the brass tacks of the multinational European approach, with special focus on the European Union. The second chapter explores a variety of problematic aspects related to prohibitionist drug policy, from inherent limits of effectiveness to unintended global consequences. The third chapter will examine the concept of harm reduction, giving attention to the ideological controversy as well as an update on the scientific evidence. The nature and extent of the current American and European drug problem will be described in chapter number four, with statistical data on drug use and related phenomena like disease and mortality. A separate section on the implementation of harm reduction methods will demonstrate the practical implications of drug strategies in Europe and the US. Finally, the last chapter is dedicated to sociological considerations about different mechanisms in the process of American and European civilization, which might help to answer the question why the "War on Drugs" was waged first and foremost in the United States rather than Europe.

I. Historical drug policy overview

This first chapter will provide an overview of how the modern drug problem evolved and what legal responses were created to fight it. Both Europe and the United States have a long history of drug use, which is a universal cultural phenomenon dating back to the origins of human civilization (Goode, 2008). This review will summarize the development of drug policy in the USA, starting with the 19th century, when policy and legislation became increasingly important instruments for handling drug use, creating the concept of illicit substances. Complementing the national history of American drug policy, the second section is dedicated to the formation of an international drug control system during the 20th century and the state of global regulations today. The final part takes a closer look at the drug policy situation in Europe, with special regard to the development of multilateral European agreements on drug policy and the complex role of a "European approach to drug policy", both with regard to the global context and the political diversity among European countries.

1.1 Drug policy in the USA

The first few sections will illustrate the historical development of federal American drug legislation with regard to the main classes of early illicit drugs: opiates, cocaine and amphetamines, and cannabis. It will be discussed how the addictive qualities of these substances were identified as potentially harmful influences on American society and which measures were taken to impede their negative effects. Subsequently, there will be an overview of the more recent legal instruments that have been shaping US drug policy until today, followed by a brief explanation of the complex legal situation concerning the multitude of conflicts between federal and state laws on drugs.

Opiates

Little known is the fact that opium was once grown within the US, that morphine (which came into common use during the Civil War) was not only legally manufactured but also readily available, as was heroin by the end of the 19th century. Pharmacological research was still in its early stages, and there was not much variety in effective medications intended to treat particular diseases. Opiates were used as a very popular remedy for any kind of pain or other common ailments like cough, diarrhea and a host of other conditions. They were prescribed by physicians, sold over the counter in pharmacies or in general stores, and often

mixed into so-called patent medicines (marketed under melodic names like "Mrs Winslow's Soothing Syrup"). Readily prescribed for "female problems", it is estimated that about two thirds of regular opiate users were women – probably also because alcohol consumption was considered inappropriate for them, whereas the tranquilizing effects of morphine were tolerated. So, as concluded by the famous Consumers Union Report on Licit and Illicit Drugs (Brecher, 1972), 19th century America truly was a dope fiend's paradise.

Opium was also smoked for recreational purposes, which was the starting point of American drug legislation: in 1875, opium smoking in so-called opium dens was prohibited in San Francisco (Harrison, Backenheimer & Inciardi, 1995). The primary rationale was that opium smoking had been ruining young people from respectable families (Terry & Pellens, 1928), but more recent analyzes suggest both a moral and a racist motivation, since opium smoking was common among Chinese immigrants and other (predominantly white) modes of ingestion were not affected (Brecher, 1986). Similar laws followed in various American states, all sharing equally little success, which lead to a change in strategy and a new focus on the supply side: opium for smoking had to be prepared from "weak" opium that contained only a small amount of morphine (less than 9%). In a first attempt, Congress raised the tariff for opium prepared for smoking from 6 to 10 dollars a pound (1883), followed by a ban to importation of opium by the Chinese (1887), and finally prohibiting any importation at all in 1909 (Terry & Pellens, 1928). Remarkably, the amount of legally imported smoking opium in the time period between 1860 and 1909 steadily increased from 21.176 pounds in the first decade to 148.168 pounds in the last (Kolb & Du Mez, 1924). The Pure Food and Drug Act of 1906 is important to mention as well, although not targeted specifically at opiate drugs. In order to protect consumers from any adulterated substances of unknown composition, new quality standards and requirements for the labeling of ingredients were established. This led to a demise of patent medicines, many of which were using opiates (Harrison, Backenheimer & Inciardi, 1995).

Although preceded by similar laws in many individual states, the Harrison Act in 1914 is seen as one of the most influential legal components of American drug policy. Based on the governmental rights to raise revenue with regard to the importing, manufacturing, selling and dispensing of narcotic drugs, it was essentially an attempt to gain more control over the position of narcotics[1] in society and ultimately criminalized the non-medical use of cocaine and opiates. What started out as a bundle of regulations was constantly extended with additional clauses, court rulings and amendments, and became the basis of drug regulation for the next

[1] The Harrison Act started the common practice of including cocaine, which is actually a stimulant of the central nervous system, in the term "narcotics".

50 years. Included with this act was the criminalization of medically prescribed maintenance supplies for addicts, even with the intention of curing the dependence. Although this particular regulation was reversed in 1925, an illicit drug economy had already been established. Early attempts to curb the illicit use of narcotics involved punitive laws comprising of fines and prison sentences for unlawful importation, although the subsequent development shows that they only resulted in higher prizes on the black market (Brecher, 1972).

Cocaine and amphetamines

Cocaine is an alkaloid whose isolation earned Albert Niemann a PhD in chemistry in 1860. The industrial manufacturing of cocaine was increased dramatically after a widely circulated paper about its many beneficial properties written by Sigmund Freud in 1884, who had himself experimented with the drug. Shortly thereafter, it was discovered that cocaine could also be used as an effective anaesthetic, further increasing medical demand. The negative effects of cocaine became more apparent at the turn of the century, when the US was hit by their first cocaine "epidemic". Estimates suggest that about 0.5% of the total population aged 15 and above were addicted to morphine and cocaine (UNODC, 2008).

However, the cocaine market in the US was comparably small when it was constricted by the Harrison Act in 1914. Although cocaine was almost constantly present on the illicit drug market, there was little importation from the 1940s to the end of the 1960s, all due to the cheaper and easier availability of amphetamines. First synthesized in 1887, medical uses for amphetamines were noted from 1927 on. Their stimulant effects were advertized for example in the treatment of narcolepsy, and it was used on both sides in Second World War to increase stamina and improve mood levels during combat. Several advantages made it preferable over cocaine, including its longer duration of effectiveness and the fact that it could be taken orally (Brecher, 1972). After the war, amphetamines were still subject to legal sale but also available at the black market, since they were cheap in production, and the occasional law enforcement drives did nothing to curb its popularity. Still, it appears that there was not much of an abuse problem in the US as late as 1963, probably due to the fact that recreational use of amphetamines was not very widespread. They were predominantly used by specific groups like intercontinental truck drivers, students, athletes and businessmen who valued their stimulant effects (JAMA, 1963).

In 1965, additions to the federal drug law brought about strict rules for record keeping in the legal production of amphetamines, barbiturates and other psychoactive drugs, which impeded

the diversion of legally produced substances to the black market. As a result, illegal manufacturers had less competition and were able to drastically raise their prizes (Brecher, 1972).

Cannabis

Cannabis or "extract of hemp" as it was known to the medical community during the second half of the 19th century was widely used as a recognized medicine recommended for various conditions from rheumatism and headache to hysteria (Brecher, 1972). At first, there was little mention of recreational use, but cannabis started to play a more important role from the 1920s onwards. Especially the bigger cities developed small cannabis markets, with the increased popularity most likely related to the prohibition of alcohol (Harrison, Backenheimer & Inciardi, 1995). The early 1930s saw a dramatic anti-cannabis campaign in the popular press, which was initiated by Henry Anslinger, a Federal Narcotics Commissioner. He established unfounded connections between cannabis use and insanity or even violence, and supplied the media with corresponding stories. As a result, most American states adopted prohibitive laws against cannabis, followed by the Marijuana Tax Act on federal level in 1937. This revenue act regulated cannabis production and distribution in much the same way as the Harrison Act did for narcotics, thus placing cannabis in the same league as cocaine and heroin (Harrison, Backenheimer & Inciardi, 1995), but still fully acknowledging the useful medical properties of cannabis. As predicted by the American Medical Association, the legal ramifications did not help to decrease cannabis use (Brecher, 1986). Since then, restrictive laws and sanction for cannabis sale and possession increased in number and severity (similar to the legislation concerning narcotics).

The "War on Drugs" and current trends

In 1971, the US Congress passed the Controlled Substances Act, which repealed earlier legislation like the Harrison Act and the Marijuana Tax Act and still serves as a consolidated drug law up to this day. Drugs are classified in schedules that regulate their control: Schedule I substances are considerd to have no medical qualities but high risk of abuse, and personal possession is prohibited except for officially approved research purposes. This category includes heroin and LSD as well as cannabis. Schedule II drugs are deemed to have medical properties and lower potential for abuse, like cocaine, opium, morphine and codeine, but are still under rigid control (Dolin, 2001). Although president Richard Nixon was the first to use the term "War on Drugs" in 1970 and declared drug abuse the "public enemy number 1" (Jelsma, 2011), the federal budget for the fight against drugs was still balanced with regard to

investments in both supply and demand reduction. During the presidency of Gerald Ford, the emphasis shifted to law enforcement, and drug-related incarcerations began to increase (Goode, 2008).

The 1980s saw several additional legislative acts during the Reagan administration. The Comprehensive Crime Control Act of 1984, the Anti-Drug Abuse Act in 1986 and the Anti-Drug Abuse Amendment Act in 1988 excerbated penalties for most drug-related offenses, cannabis possession among them (Dolin, 2001). The federal spending on the drug problem was now one-fifth treatment, four-fifth law enforcement (Goode, 2008). The next Crime Control Act in 1990 under president Bush sen. doubled federal appropriations for drug law enforcements, whereas drug policy was more of a low profile political issue under Bill Clinton (Harrison, Backenheimer & Inciardi, 1995).

Now, under the administration of Barack Obama, there are some signs of de-escalation in the prohibitionist approach to drug policy. In 2009, the newly appointed Director of the Office of National Drug Control Policy, Gil Kerlikowske, publicly announced that the phrase "War on Drugs" would no longer be used, because the war analogy was considered counterproductive in dealing with the country's drug problem. He also told the press that the role of treatment would grow relative to incarceration (Fields, 2009). By the end of 2009, president Obama signed a bill that lifted the ban on federal funding for needle syringe programs, a controversial method of harm reduction which was denied federal support in 1988 at the height of the HIV epidemic in the US (New York Times, 2009).

Differences in federal and state drug laws

Federal drug policy in the US is predominantly characterized by a prohibitionist approach with strong emphasis on law enforcement and incarceration. However, the execution of federal laws on state level varies dramatically among the individual American states, and not just with regard to the severity of sentencing. The most significant example is cannabis, which is subject to the widest variety of legal drug regulation in the US. Although prohibited by the Controlled Substances Act that classified cannabis as a Schedule I drug without any medical properties, eleven states[2] downgraded the legal status of cannabis and depenalized personal possession during the 1970s, making it a civil rather than a criminal offense (Room et al, 2008). The depenalization in some states contrasts with harsh legislation in others, which followed the "zero tolerance" strategy in the 1980s and increased penalties. As a result, the same amount of cannabis in personal possession can have very different consequences across the

[2] Alaska, California, Colorado, Maine, Minnesota, Mississippi, Nebraska, New York, North Carolina, Ohio, and Oregon.

country, but so far scientific research indicates no apparent differences in the levels of cannabis consumption (Harrison, Backenheimer & Inciardi, 1995; Room et al, 2008).
Today, there are 16 states[3] that legalized the medical use of cannabis, exempting patients with appropriate documentation from criminal prosecution (Beckley Foundation, 2011). However, because of the prohibitive federal law, medical cannabis cannot be sold in pharmacies, and eligible patients are therefore supplied by special distribution centers (Dolin, 2001). These so-called "buyers' clubs" were repeatedly targeted by federal law enforcement drives, leading to several legal disputes. It was not until 2009 that the Obama administration announced that medical cannabis dispensaries would no longer be subject to federal police raids (Fields, 2009).

1.2 Global drug resolutions

We are looking back on roughly 100 years of international cooperation on drug policy, an impressively long period compared to other issues subject to international agreements. The following brief historical overview will illustrate how these collective efforts first aimed at controling the licit drug trade for medical purposes and were then slowly expanded to restrict all drug production and finally illicit drug trafficking. The scope of control was also gradually extended from opiates and cocaine (1912) to cannabis (1925), synthetic opiates (1948), psychotropic substances (1971) and drug precursor chemicals (1988), in order to accommodate changes in the nature of the drug problem (UNODC, 2008).
These treaties shaped both European and American drug policy, and vice versa, especially in case of the US: "Since the beginning of the twentieth century the United States has sought, with considerable success, to internationalize the principles behind its national response to curb illicit drug use." (Bewley-Taylor, 1999: 1). They not only initiated international conferences on the subject of drug control but also pushed for a prohibition-based international policy system (Sinha, 2001), and often the US would use their policital power to achieve compliance with international drug resolutions among states that were in some way dependent on American foreign aid or international loans. Some observers have remarked that the mere terminology of a "War" on drugs indicates a replacement for the lack of a common American cause after the end of the Cold War and before the War on Terrorism (Jelsma, 2011).

[3] Alaska, Arizona, California, Colorado, Delaware, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington and the territory of Washington, DC.

However, only a small number of countries signed the treaty; the US were not among them, because they considered it to be not rigorous enough (UNODC, 2008).

A renewed global effort and the spread of prohibition

After World War II, international relations had changed dramatically and multilateralism was affected by the Cold War. The United Nations succeeded the League of Nations as the main international security organization, and thus assumed its functions for drug control. At the end of the 1950s, several international treaties on narcotics were in effect, with many countries having signed and ratified only some of them. After many years and negotiations, the Single Convention on Narcotic Drugs was adopted as the new framework for global drug legislation. Also called the "cornerstone of the international control system" (Bewley-Taylor, 1999: 7), it replaced all earlier treaties and protocols but also contained new provisions. The result was a stricter, streamlined control machinery with a stronger emphasis on prohibition, in order to increase the efficiency of multilateral efforts to combat the drug problem: "The Single Convention was established as a universal system for limiting the cultivation, production, distribution, trade, use and possession of narcotic substances strictly to medical and scientific purposes, with special attention on substances derived from plants: opium/heroin, coca/cocaine and cannabis." (Jelsma, 2011: 4). In summary, the non-medical supply and use of drugs was criminalized. Also included was a classification for over 100 substances, assigning them to different levels of control. In order to support the implementation of the convention standards and to monitor their enforcement in the signatory states, the International Narcotics Control Board (INCB) was established. Additionally, medical treatment and rehabilitation of drug users is briefly mentioned for the first time as an obligation that is to be given "special attention" (UNODC, 2008: 62).

The 1971 Convention on Psychotropic Substances was essentially an extension to the Single Convention. As a response to a diversification of drugs and new social developments in recreational drug use, synthetic and non-plant based substances were added to the regulation, most notably amphetamines, benzodiazepines, barbiturates and psychedelics. Due to pressure from the pharmaceutical industry, different and less stringent mechanisms of control were established here (Jelsma, 2011). Similarly, the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances can be seen as a reaction to the constantly growing black market that supplied the still rising demand for drugs. It comprises of additional legal regulations specifically targeted at reducing the illegal cultivation, production and trafficking of illicit substances, since the diversion of drugs from legal pharmaceutical sources was basi-

cally eliminated through the control mechanisms of the first two treaties. Once again, the 1988 Convention emphasizes the need to adopt legal measures turning all activities involved with the non-medical production and distribution of classified substances into a criminal offense (Bewley-Taylor, 1999).

Although some success was noted with regard to the dismantling of globally operating drug networks, drug trafficking still continued and a short downward trend in drug use was followed by significant increases in user rates. In response, a UN General Assembly Special Session (UNGASS) on the world drug problem in 1998 led to new declarations and action plans, and the first time reference to human rights regarding the treatment of drug users. Another novelty was the extension of demand reduction policies to include the effort of reducing adverse consequences of drug abuse, more commonly referred to as harm reduction. This innovation was subject to intensive debate, because several member states (among them the USA) wanted to give priority to classical means of drug use prevention, whereas other nations (among them most European countries) supported harm reduction policies (UNODC, 2008). However, the UNGASS resolution to greatly reduce drug production as well as consumption within the next ten years could not be realized. Although the worldwide demand for drugs appears to have stabilized and supply has become even more concentrated in a few countries (Reuter, 2009), an EU report "found no evidence that the global drug problem was reduced during the UNGASS period from 1998 to 2007." (European Commission, 2009).

1.3 Drug policy in Europe

Due to the high number of European countries and their complex history, it is not possible to illustrate the individual development of national drug legislation within the scope of this paper. Fortunately, this is not essential to reveal the underlying trends that shape the impression of a "European approach on drugs." We will thus focus on the emergence of this concept as an integral and explicit component of the current EU drugs strategy, by looking at the influence from global drug resolutions and the European countries' response – a distinct interpretation of drug policy and the role of harm reduction methods.

Historical background of European drug policy

As has been mentioned, the early international treaties on drug supply control were mostly driven by the United States, and even though European colonial powers largely cooperated, their interests and motivations differed. Especially France, Great Britain, Portugal and the

Netherlands shared in lucrative drug trading monopolies in their overseas possessions, and were reluctant to accept restrictions. In addition to the Asian opium market, they also supplied raw drug products to the pharmaceutical industry in Europe and America, a market which drastically expanded during World War I. Especially cocaine, which was used as a local anaesthetic and was thus important for wartime medical care, was on high demand and one of the most profitable products of that period (Jelsma, 2011).

Drug restrictions however have a long history in Europe. In what is considered the first drug prohibition of the modern era, Napoleon forbid his occupying troops in Egypt to consume cannabis in 1800, with questionable success[5] (Abel, 1982). From the beginning of the 20th century on, European countries showed a lot of diversity with regard to their individual drug problems, their economic interests in drug trade and production as well as their legislative approaches. The early restrictive and later prohibitive legal acts were mostly created to comply with the international treaties, and many European countries took their time before they ratified them and designed national laws in accordance with them. For example, although Germany signed the treaty of the First International Opium Conference in The Hague in 1912, they only passed their first restrictive opium law[6] after defeat in World War I forced them to comply with the treaty of Versailles. The United Kingdom however was quick to follow the US in regulating the possession and distribution of cocaine and opiates in 1916 with the Passage of the Defense of the Realm Act, which started as an emergency wartime law but was to be retained afterwards, setting the stage for drug matters to become criminal issues and be considered as a threat to national security (UNODC, 2008). Although Norway and Finland also saw periods of alcohol prohibition similar to the US in the 1920s, the general European perspective on drug use was much less stern, especially when cultural traditions of consumption were concerned (Jelsma, 2011).

Development of European agencies for drug control

After World War II, the political scenery in Europe changed drastically, which also had an impact on the collective efforts to control the drug problem. The European Economic Community (EEC) was established in 1957, but had no specific political program with regard to illicit drugs. In 1969, the French president Georges Pompidou was the first to point out the need for a coordinated European collaboration on issues of drug policy, and reactions of the then six member states were positive. However, the planning and debates about what govern-

[5] French soldiers are said to have taken some cannabis to Europe.

[6] „Verordnung über den Verkehr mit Opium und anderen Betäubungsmitteln", July 20, 1920 and „Erstes Deutsches Opiumgesetz", December 30, 1920.

ing bodies should be involved and which countries should be participating took years. Eventually, several working groups examined possible options of European cooperation in the fight against drug trafficking and organized crime, the most important probably being the Trevi Group established in 1989. Their efforts were paving the way for the founding of the European Police Office (Europol), originally named the European Drugs Unit, which was agreed upon in the Maastricht treaty (effective in 1993), the same that created the European Union. Europol effectively serves as a supernational police organization, enabling cooperation between the member states by collecting relevant information to fight organized crime and reduce drug trafficking (Elvins, 2003). Another important institution established in 1993 was the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Its principal purpose is to gather, analyze and disseminate information on drug use to policy makers of individual member states and to increase consistency between national and EU drug strategies. Although it does not propose any specific policy, the EMCDDA keeps track of national drug legislation, collects data on drug use prevalence and reviews scientific evidence on drug-related interventions (EMCDDA, 2010b).

However, the EU has little formal authority with regard to drug policy. There is no specific European classification of drugs, and the UN conventions are the only binding international treaties. Legal regulations and penalties for drug offenses are the sole responsibility of the member states (EMCDDA, 2005). In an attempt to level the differences between national drug legislation, the Amsterdam Treaty of 1997 declared the intention of even closer cooperation to establish "minimum rules relating to the constituent elements of criminal acts and to penalties in the fields of organised crime, terrorism and illicit drug trafficking." The EU also declared a commitment to complement each member state's efforts in "reducing drug-related health damage, including information and prevention." (European Union, 1997: 14, 39). The most recent relevant agreement is the Treaty of Lisbon in 2007, which also stresses the EU competence of approximating the legal definitions of drug trafficking and related sanctions (EMCDDA, 2010b).

The "European approach on drugs"

Since the 1990s, the EU has developed a common political perspective that has been deliberately called a "European approach on drugs", which manifests itself in the EU drug strategies and action plans (EMCDDA, 2010b). This approach consists of a simultaneous focus on both demand and supply reduction, and is guided by "respect for fundamental rights, protection of public health, well-being, social cohesion and security." (EMCDDA, 2010b: 4). Especially

following the UNGASS meeting in 1998, many EU countries have adopted an understanding of drug trafficking as a crime, but tend to view the individual user as a sick person in need of treatment (MacGregor & Whiting, 2010). As a result, there has been a shift in attention from law enforcement to public health improvement, earning Europe the reputation of being at the "forefront of the harm reduction response." (IHRA, 2010a: 31). On several occasions, European representatives have in fact questioned the effectiveness of global drug control legislation. In December 2002, a committee of the European Parliament suggested to repeal the 1988 UN Convention because the massive deployment of police and law enforcement in the fight against drugs was considered ineffective. The prohibitive policy based on the three UN Conventions was identified to be "the true cause of the increasing damage that the production of, trafficking in, and sale and use of illegal substances are inflicting on whole sectors of society, on the economy and on public institutions, eroding the health, freedom and life of individuals." (European Parliament, 2002).

The promotion of harm reduction methods as an appropriate response to society's drug problem is one consequence of the stronger focus on public health issues. Under the heading of overall demand reduction, the current EU drugs action plan (2009-2012), a coordinating tool to facilitate the implementation of general EU drug strategies, specifically requires member states to ensure access to harm reduction services to reduce negative health outcomes and mortality among drug users (MacGregor & Whiting, 2010). The official evaluation of the last EU drugs action plan (2005-2008) already notes major progress regarding the establishment of interventions to reduce drug-related harms, although there is still a long way to go and the most important conclusion refers to the lack of reliable and consistent information to assess the effectiveness of political strategies and individual intervention programs (EU Commission, 2008). Harm reduction in this respect is understood as "a sophisticated evidence-based approach to drug policy, programmes and interventions" (MacGregor & Whiting, 2010: 106), which includes controversial methods like provision of sterile needle and syringe for injecting drug users or opiod substitution therapy for treatment of drug dependence[7].

However, the EU is currently composed of 27 member states, with considerable variety in their national drug laws. For example, Portugal became the first European country to decriminalize personal possession of all illicit drugs in 2001 (Hughes & Stevens, 2007), the Netherlands have established a de facto decriminalization of cannabis use by distinguishing between "hard" and "soft" drugs and many other countries have also lowered penalties for personal drug possession (EMCDDA, 2005).

[7] For more information on the concept of harm reduction and related interventions see chapter 4.1 and 4.2.

On the other hand, Sweden still supports a "zero tolerance" drug policy and embraces the ultimate goal of eliminating all recreational drug use, which naturally causes frictions within the EU community (Chatwin, 2003). Although recent reviews also suggest that legislative differences between European countries are not as substantial anymore, there are a lot individual developments among EU member states, with some moving more towards harm reduction and others away from it, sometimes depending on changes in government or influences from public opinion (MacGregor & Whiting, 2010). Still, the annual reports of the EMCDDA also suggest that drug policies across Europe increasingly share formal features like the focus on method monitoring and evaluation, data collection and national action plans to facilitate comparability and enable contribution to a general knowledge base.

There are also indicators that the European approach on drugs has started to exert influence on the global stage of drug policy. "The European Union is now mainly a single voice at international meetings with a strong and explicit harm reduction tone" (Reuter, 2009: 512). At the negotiations on the new Political Declaration on Drugs at the Commission on Narcotics (CND) in 2009, European countries spoke with a unified voice for more emphasis on demand reduction and the explicit inclusion of the term harm reduction. When it was struck from the final text of the UN statement, the majority of Western European delegations signed an additional agreement to document their intention of interpreting "related support services", the phrase that was ultimately used for the declaration, as including harm reduction methods (IHRA, 2010a).

When comparing the current European convergence on drug policy with the situation a few decades ago, it is quite obvious that things have changed in the direction of closer cooperation and a shared approach to drug policy. The EU drug strategy combines the dominant law enforcement tradition with an increasing focus on harm reduction, clearly stating that "the prevention and reduction of drug-related harm is a public health objective in all Member States and in the EU drugs strategy." (EMCDDA, 2010a: 32). Thus, a certain contrast to the prohibitionist approach of the US is apparent.

II. Problematic aspects of prohibition

After carefully reviewing the history of drug legislation in both Europe and the United States, some problematic aspects of the dominant prohibitive approach to drug policy deserve a more in-depth analysis. In order to understand the fundamental controversies that fuel the debate on drug law reform, we will analyse the problems with prohibition on three levels: one, inconsistencies between concerns leading to prohibition and how they are reflected in the legal situation regarding drug use. Two, why prohibition is a tricky legal instrument and how hard it is to evaluate its effectiveness, and three, what unintended negative effects it has had that we can be pretty certain about. So, starting off with a look at the social concerns that gave rise to drug control systems in the first place, we will address how different levels of harm from drug consumption are reflected in current drug policy. The association between drug use and violent crime is not only an intensely debated public concern, but also one of the driving forces for drug use to become a legal issue, which is why this aspect will be explored in more detail. The second part of this chapter is dedicated to the illustration of some peculiarities of prohibition to understand the limits of its effectiveness and how difficult it can be to assess it. The third section will give an overview of another range of problematic aspects about prohibition besides its highly contested effectiveness: unintended negative consequences directly related to the history of global drug policy.

2.1 Social concerns influencing prohibitive drug legislation

The criminalization of drug use was considered a necessary measure to curb addiction and its undesired effects: irresponsible social behaviour, lack of dependability in the workplace, criminal acts to sustain a steady drug supply, devastating and possibly fatal physical symptoms. However, as has been implied in the historical review, the negative consequences of personal addiction were by far not the only concerns, and not even the most important ones. Cultural, economic as well as political factors played a huge role in the labeling process when different drugs came to be associated with various levels of potential danger. Research shows that the results of this development do not reflect the scientific assessment of a drug's inherent risks – in other words, there are discrepancies between the actual harmfulness of different drugs and the level of legislative control they receive (Global Commission, 2011). When comparing the UN drug classification in Single Convention from 1961 (which has influenced both European and American drug legislation) with the assessment of independent experts

(see figure 2.1), there is agreement with regard to heroine and cocaine which top both lists, but significant differences prevail for cannabis and barbiturates (Nutt et al, 2007). Inconsistencies like these have led to various criticism, with the common denominator that drug policies suffer froma a lack of credibility if they do not reflect the actual levels of harm caused by illicit substances. This was also acknowledged by the former executive director of the UNODC, stating that cannabis "is the most vulnerable point in the whole multilateral edifice." (Costa, 2008: 15). According to the Single Convention of 1961, cannabis should receive the same strict legal control as cocaine or opiates. This is hardly the case in practice, where cannabis remains the most openly consumed illicit drug and a popular subject of recurring debates about decriminalization, supported by scientific evidence which indicates a comparably lower level of harm (Room et al, 2008).

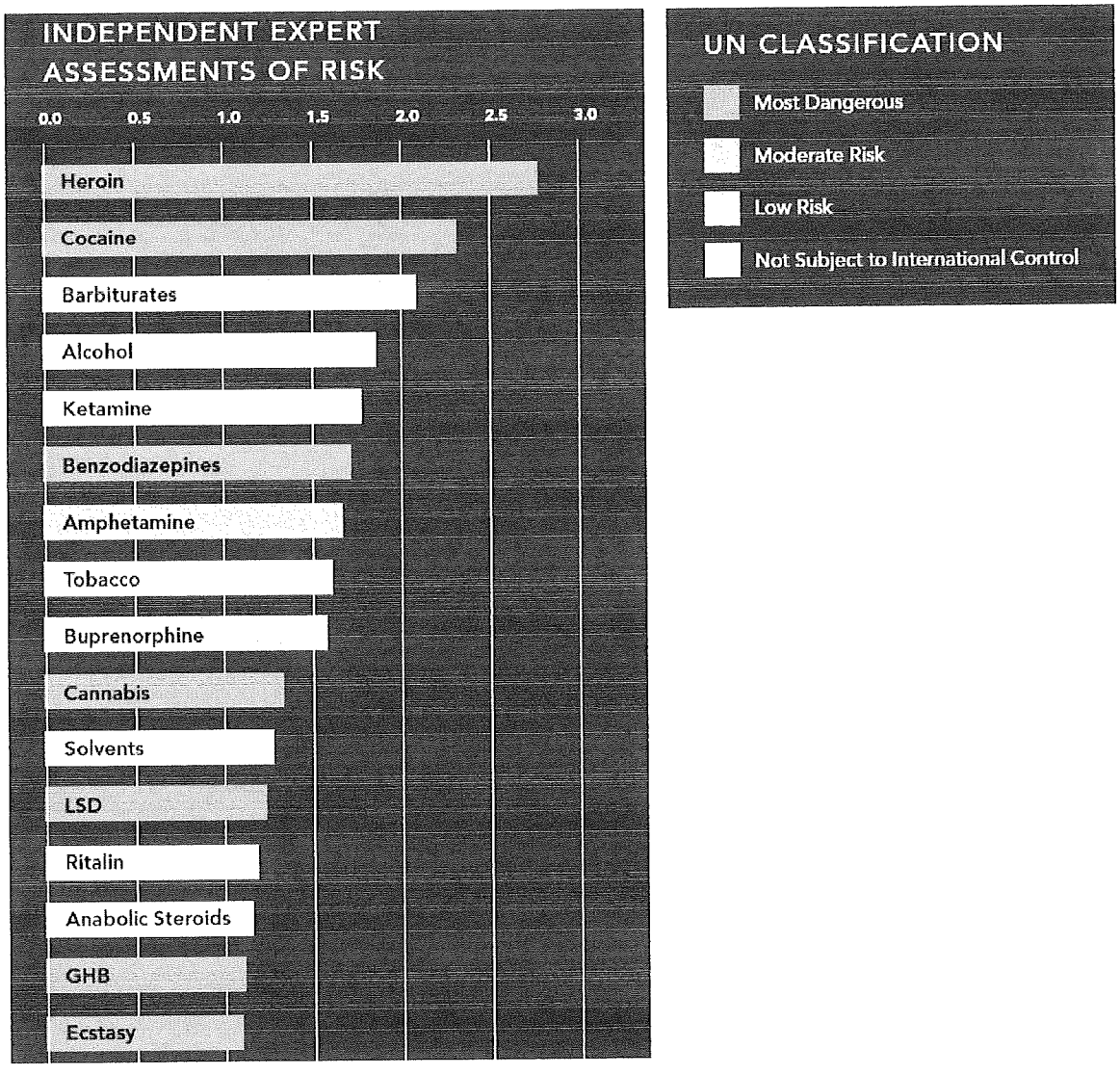

Figure 2.1: Mean scores for the potential risk of drugs as assessed by independent experts, colors indicate UN drug classification (Global Commission, 2011: 12).

The social acceptability of some drugs has deep cultural roots in Western society, the most prominent examples being alcohol[8] and tobacco. While this acceptability does not necessarily reflect lower risk levels of addiction, it does pertain to a culturally adapted set of norms and standards regarding the "acceptable" use of this drug, which also enables the members of society to detect and react to cases of abuse[9]. Cultures where opium smoking is socially accepted (and to some degree regulated) observe addiction problems similar to those caused by alcohol in Western civilizations (Nyswander cited in Goodman & Gilman, 1965). However, the evolution of such normal frameworks takes time, and the lack of a cultural background for newly introduced highly addictive substances naturally weakens the influence of social structures to control their abuse, which makes it seem a rational option to prohibit them altogether.

One of the most important social concerns about drug consumption, which is also closely linked to legal regulation, is the basic assumption that drug use is associated with violent crime. The exact nature of this connection varies based on who is making the assumptions; a general classification by Goldstein (1985) distinguishes between three types: a) the pharmacological effects of the drug or respective withdrawal symptoms make the user commit crimes he would not normally attempt, b) the user commits crimes in order to ensure the continuation of his drug consumption and c) violent crimes associated with the production and distribution of drugs, or related to the actual enforcement of drug laws. Since only the first two types provide a potential rationale for prohibitive drug legislation, we will concentrate on crime associated with the pharmacological and the economic compulsory model.

Research suggests that it is plausible to assume a connection of increased violent behavior with some drugs, notably alcohol, cocaine and amphetamines. Statistical evidence however does not support a strong direct relationship between drug consumption and increased criminal actions, since there is a host of interacting factors of which many seem to be more useful in predicting crime (Boles & Miotto, 2003). Hence, consumption of some substances does seem to contribute to violent behavior, but could not be identified as a main leading cause. Additionally, the causal chain of influence is complex: convicts explained to have intentionally consumed drugs in order to prepare for acts of crime, trying to decrease anxiety and stimulate courage (Goldstein et al, 1992).

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[8] Which was the subject of several attempts on prohibition during the 1920s in the United States and at the beginning of the 20th century in European countries like Finland, Norway and Iceland.

[9] Which is not to say that these standards are sufficient in preventing and encountering addiction, but this is a different debate, which will not be further explored here.

It appears that even though drug use and crime are statistically correlated in many situations (for example, neighborhoods with high levels of drug use also display elevated crime rates), the causal link between the two is comparably weak. As the Australian Institute of Criminology has stated, drug use and crime do not so much share a direct relationship, but appear to have similar causes which influence both phenomena: "Factors such as poor social support systems, difficulty in school, membership of deviant peer groups, early contact with government services and a lack of access to economic support systems are common in the backgrounds of both drug users and criminals." (AIC, 2004). Several other institutions have come to a similar conclusion, among them the National Institute on Drug Abuse who states that "there is virtually no evidence that the pharmacological effects of drugs (alcohol excepted) account for a substantial proportion of drug-related violence" (NIDA, 1990: 266).

The situation looks different for the economic compulsory model, since there is considerable evidence of a strong connection between drug use and criminal actions to obtain the means for drug consumption. Especially the use of expensive and highly addictive drug such as heroin and cocaine has been shown to feature engagement in criminal activities in order to fund drug consumption (Johnson et al, 1985). The most typical offense in this regard is robbery, with or without actual violence, because it enables the user to obtain cash fairly quickly and turn it into drugs without any intermediate steps (NIDA, 1990). Research suggests however that non-violent crimes prevail and that perpetrators prefer these alternatives if available (Gould, 1974). Among the reasons are a fear of harsher prison sentences in the case of apprehension and a lack of a "basic orientation toward violent behavior" as Goldstein (1985: 5) concluded. Still, even the more frequent non-violent crimes (for example shoplifting, prostitution and theft) contribute to the record of criminal offenses, and thus testify to a specific relationship between drug use and crime (Bennett & Holloway, 2009). There is, however, practically no evidence that prohibition actually decreases these kinds of crime, since the offenders mostly act out of compulsion to continue their drug use, regardless of how threatening the perceive the legal situation to be (Global Commission, 2011). Instead, the establishment of a criminal black market for illicit drugs has drastically increased their prices since prohibitive sanctions were put in place (Costa, 2008).

The third type of association between drugs and crime, referred to as systemic violence, is almost consistently demonstrated to be the most extensive one. There is now little doubt over the fact that systemic violence accounts for the lion's share of crime associated with drug use

(Goldstein, 1985; NIDA, 1990; UNODC, 2010). A substantial amount of literature and recurring media coverage deals with the subject of violent crime that occurs within nearly all sectors of the illicit drug market. The most common issues causing death and bloodshed are related to organized crime in general, disputes over territory between rival drug distributing groups, enforcing hiearchies within the distribution chain, and general violent settlements of conflicts in illegal settings (Goldstein, 1995). A recent scientific review evaluated the impact of drug law enforcement on drug-related violence, and the results suggest that an increased investment in law enforcement is not going to reduce violent crimes (Werb et al, 2010). The criminal black market for illicit drugs is a complex phenomenon, which interacts with various social, economic and political factors, posing a real challenge not just to scientific research, but to any attempt of decreasing its scope and harms. Considering that this massive global problem is a direct consequence of the prohibitive approach to drug legislation, it is one of the most frequently cited reasons for drug law reform.

As a concluding remark, research on homicide rates in the US and their relation to drug policy (including the period of prohibition of alcohol) has shown that there is a positive relationship (an increase in legal sanctions for drug use equals an increase in murders) and concludes that the homicide rate is currently 25-75% higher than it would be without prohibition (Miron, 1999). Although analyzes like this one always remain somewhat speculative (because confounding statistical factors can never be fully excluded as possible reason for a correlation), it nonetheless reveals a concerningly strong relationship.

2.2 Limits of effectiveness

One reason why prohibitive laws show little effectiveness with regard to drug use as such is the uncompromising nature of the criminal act itself. Drug use offenses are so-called "crimes without a victim" (or perhaps more accurately "crimes without a complainant"), because they consist of private routines and agreements between two consenting subjects (buyer and seller) with a similar interest in a successful transaction (Brecher, 1972). Law regulations generally have a low impact on criminal acts of this kind, which can also be seen with restrictions for gambling and consensual homosexual acts. It has often been suggested that the prohibition of drugs acts as an additional incentive for their consumption, especially in groups of young people where a disrespect for the law may serve as a way to distinguish oneself. This is not exactly a modern insight:

> "All laws which can be violated without doing any one an injury are laughed at. Nay, so far are they from doing anything to control the desires and passions of men that, on the contrary, they direct and incite men's thoughts the more toward those wry objects; for we always strive toward what is forbidden and desire the things we are not allowed to have. And men of leisure are never deficient in the ingenuity needed to enable them to outwit laws framed to regulate things which cannot be entirely forbidden... He who tries to determine everything by law will foment crime rather than lessen it." (Spinoza cited in Blum & Associates, 1968: 205).

The most important rationale behind the development of the legal framework for drug use containment was the hope to discourage drug use by employing stringent laws, and punitive sanctions were equated with a stronger deterrent effect. Therefore, when the amount of consumed drugs did not decline accordingly, the most frequent conclusion was not that the legislative approach as such had failed. Rather, it was reasoned that the punishments had not been severe enough (DuPont, 2011). Scientific research however points in a different direction – the most important factors influencing the initiation of drug use were found to be peer pressure, fashion as well as the social and economic context of the potential user (Lalander & Salasuo, 2005). A drug's legal status, the risk of detection and legal sentences as well as government prevention messages turned out to play only a minor role.

Aside from failing to deter new drug users, it also seems that prohibitive drug laws do not prevent or interupt problematic drug use, since "it is not possible to frighten or punish someone out of drug dependence" (Global Commission, 2011: 14). Instead, problematic drug dependence is strongly predicted by factors such as childhood trauma or neglect, structural disadvantages, limited opportunities and emotional problems (Buchanan, 2004).

As a summary, it appears that drug policy has less impact on the extent of drug use than is commonly assumed. A recent study comparing cannabis consumption in San Francisco, California (where its use is criminalized) and Amsterdam in the Netherlands (de facto decriminalized use) found that many parameters such as age at onset, maximum and regular use, frequency and quantity as well as use of other drugs were similar in both cities, thus concluding that criminalization does not decrease use, just as decriminalization does not increase it (Reinarman et al, 2004; Room et al, 2008).

Of course, any law that fails to fully achieve its goals should not automatically be subject to repeal. Except, that is, if there is sufficient evidence to suggest that it is actually causing more harm than good. A respective evaluation with regard to drug legislation is hard to conduct: „The intended consequences, lower rates of use and harm, are almost by definition difficult to observe; they are events that did not occur." (RAND, 2009: 1). The prohibitive approach is a

dominant global effort and lacks a similar policy case for comparison. Also, we can only speculate what the drug problem would look like in a world without the current set of international regulations, a scenario which can hardly serve as a legitimate base to compare the particular benefits and shortcomings of the drug policy in place today. When assuming that a lack of drug regulation would have resulted in consumption rates of illicit drugs that are similarly high as for legal substances like alcohol and tobacco, a containment of illegal drug use to 5% of the world adult population could indeed be considered a success[10], especially since the UN identifies only 1% of the world adult population as so-called hardcore problem drug users (UNODC, 2008). However, as it was already mentioned, there is some evidence available suggesting that rates of drug use are not heavily influenced by the nature of drug legislation (Global Commission, 2011), which makes it less convincing to credit the current policy apparatus for this containment of drug consumption rates.

Often named as the true beneficial aspect in the struggle for drug control over the last century is the development of a functioning multilateral system, leaving little room for national digression from the combined effort to work against drug production and traffic (Costa, 2008). As a matter of fact, there are very few legal instruments that share a similarly strong adherence as the legislative standards in the UN drug conventions. Around 95% of all nations worldwide are State Parties to the three most important UN drug treaties from 1961, 1971 and 1988 (UNODC, 2008)[11].

There is, however, a far longer list of problematic aspects: several scientific assessments indicate a broad spectrum of negative developments likely to be caused or negatively influenced by the international system of drug control (Brecher, 1972).

2.3 Unintended consequences of global drug legislation

The evaluation of global drug policy reveals several alarming developments that are directly related to the legal control system of illicit substances. A recent study commissioned by the European Commission as part of the EU Strategy on Drugs 2005-2012 tried to give an objective overview of the general extent of the drug problem and the effects of political actions designed to reduce its scope (RAND, 2009). In addition to measuring outcomes based on the

[10] In comparison, tobacco use among the world adult population is as high as 30%, alcohol use reaches even higher proportions (Costa, 2008).

[11] The Single Convention on Narcotic Drugs in 1961, the 1971 Convention on Psychotropic Substances and the 1988 Convention Against Illicit Trafic in Narcotic Drugs and Psychotropic Substances, for details see chapter 1.2 on global drug resolutions.

initially intended goals, studies like this one also report on unintended and mostly unexpected consequences. The consideration of these negative consequences are of critical importance especially when evidence for the achievement of intended effects is weak and heavily contested.

The major problems caused by the international efforts to control drugs based on the UN conventions have also been summarized by the former Executive Director of the UNODC, Antonio Costa. He identifies several unintended negative consequences, which are illustrated below in more detail: The establishment of a criminal black market for illicit drugs, the policy dominance of law enforcement at the cost of public health expenses, geographical displacement patters of the drug problem, substance displacement as a result of supply shortfalls due to legal regulations and the way in which drug users are perceived and treated by society (Costa, 2008). Additionally, two other aspects deserve attention, especially when considering the current trend to raise awareness for public health interests with regard to drug use: the adulteration of illicit substances and increased risk of infection with HIV and other blood-borne diseases due to prohibitive laws.

The criminal black market

Fueled by enormous profits to be made from supplying the international demand, a whole black market economy has evolved to control production, distribution and sales of illicit drugs. The enormous increase in prices along this line are escalated by the risks involved in bypassing the law, and the profits remain entirely in criminal hands. According to UN estimations, the illicit drug economy is valued in the hundreds of billions of dollars, which in many regions of the world far exceeds the volume of the legitimate trade. The cocaine market alone was estimated to be worth some US$ 85 billion for 2009, the heroine market valued at 68 billion US$ (UNODC, 2011). Large amounts of money from the drug business enable political influence and corruption. Many countries, especially in the developing world, observe violent conflicts between militarized groups that are involved in drug production and trafficking, resulting in deaths, social turmoil, and instability. Aside from these obvious negative consequences, illicit drug economies also impede global development efforts in the affected areas. (Graubner, 2007).

Policy displacement

Even though mentioned as an important aspect of drug control in the UN Conventions, public health interventions were drained of funds for the benefit of law enforcement and security.

Since the latter is often and incorrectly perceived as the more effective way to tackle a society's drug problems, public opinion tends to influence political decision-making into an unbalanced approach. As a result, there is little financial support for the public health domain, and the political commitments refering to it appear to be lip service rather than actual engagement, with drastic consequences to the availability of treatment services (Costa, 2008).

Geographical displacement

When regulations and law enforcements are tightened in one geographical region, the affected sector in drug production and distribution usually moves to a different place. Also called the "balloon effect" (squeezing a balloon in one place causes it to swell in another), this phenonemon has been documented for the trade in both narcotics (for example with shifts in opium production from China to Myanmar to Afghanistan) and cocaine (when supplies from Peru and Bolivia decreased in the 1990s, the main production moved to Colombia; Costa, 2008).

Substance displacement

Drug users tend to switch to other illicit substances with similar psychoactive effects when their initial drug of choice becomes difficult to obtain due to more stringent supply control. Sometimes the new drug is even more addictive or riskier in other ways (for example because the user community has less experience with regard to dosage and interactions with other substances), a tendency which has been observed since the early rise of prohibitive sanctions: addicted opium smokers turned to morphine after importation bans began to decrease opium availability, and ultimately ended up using the immensly more potent heroin[12] (Kolb, 1925) either in a misguided attempt to treat their morphine addiction or while trying to sustain it in the most efficient way by getting the biggest "bang for the buck". Today, heroin is seen as a desirable drug product by both sellers and consumers, since it is compact and thus easier to conceal, and the administration is time-efficient and relatively uncomplicated (RAND, 2009). However, heroin consumption is associated with much higher risks than opium smoking, including the spread of disease through needle sharing, the risk of overdosing and a higher potential for addiction, making it a classical example of substance displacement to a more dangerous drug.

[12] When „weak" opium is smoked, it would take 300-400 grains to get a dose equivalent to an intravenous, one grain heroin shot, which is absorbed immediately in contrast to the much slower intake of opium smoke over a considerable time span.

The way we perceive and deal with the users of illicit drugs

The criminalization of drug use influenced people to view addicts as criminals lacking self-control and determination to overcome their addiction. A historical review shows that the perception of drug dependence as a moral shortcoming rather than an illness was indeed strengthened by the prohibitive legislation against drug use: when consumption of narcotics and cocaine were still legal during the 19th century, drug addiction and their recreational use was certainly not considered socially acceptable (similar to alcohol abuse), but far away from the harsh moral sanctions in place today (Brecher, 1972). Drug laws forced the addict community to go underground, away from mainstream society, which resulted in deviant addict subcultures and social exclusion characterized by homelessness, irregular employment and delinquency (March et al, 2006). Stigmatization followed, and general assumptions about behavior and character of drug users often lead to fear among ordinary citizens, who tend to associate drug use with crime, prostitution and blood-borne diseases (Global Commission, 2011). Once in place, these two simultaneously evolving phenomena – the marginalization of drug users and their social stigmatization – mutually enforce each other, which not only makes it difficult to break stereotypes. It also impedes the provision of funding and the establishment of treatment options, even for addicts motivated to chance their drug habits (not to mention the difficulty in recruiting support for those users who do not display this willingness).

Adulteration of illicit drugs

There is evidence suggesting that illicit drugs are often adulterated or "cut" with other substances before being sold at the street level. Although stories about unorthodox ingredients like powdered glass, household cleaning products or brick dust are not supported by research findings (Coomber, 1997), a recent evidence-based overview of adulterants (Cole et al, 2010) concluded that illicit drugs are often mixed with benign substances (such as sugars), cheaper substances that mimic or support the effect of the drugs (such as quinine in heroin) or substances that will facilitate the drug's administration (for example caffeine to facilitate the smoking of cocaine and heroin). Sometimes these substances are added on purpose to bulk, dilute or enhance the effect of the drugs, sometimes these adulterants result from manufacturing or storing processes (as is it the case with microorganisms and alkaloids).

Since all aspects of production, distribution and (most of time) administration of illicit drugs are illegal, there is no way to ensure product quality and sterility (Reuter & Caulkins, 2004).

Increased health risks for drug users

Prohibitive law regulation also created a disadvantageous environment to react to serious health risks involved with drug use. The biggest threat in this regard is HIV/AIDS, which evolved as an epidemic among injecting drug users from the 1980s on, at a time when international drug policy was quite firmly established (after the 1961 and 1971 UN conventions). Injection as a highly efficient way to administer drug is one of the biggest risk factors for HIV infection, based on the common habit or necessity to share injecting equipment like needles and syringes. Thus, once established in a drug using community, HIV can spread rapidly, with disastrous consequences. Usually not quite as fatally, but nonetheless dangerous, are Hepatitis C or tuberculosis, which are transmitted similarly effective through sharing needles (Elliott et al, 2005). Local outbreaks of anthrax among drug using communities have also been noted (EMCDDA, 2010a).

Prohibitive drug laws continue to affect the global HIV pandemic in a negative way, because they often prevent the implementation of strategies proven to be effective in the reduction of HIV transmission[13]. For example, the legal barriers to needle and syringe programs facilitate the spread of HIV (Bluthenthal et al, 1999) and have exacerbated the HIV epidemic among injecting drug users in the US (Lurie & Drucker, 1997) and many other regions. Statistics show that drug users are also less likely to receive antiretroviral therapy as medical treatment for HIV/AIDS (WHO, 2009b). In addition to negative health consequences for the drug users themselves, there is always the risk that a concentrated HIV epidemic in drug using communities can spread to the general population through modes of sexual transmission, as it has been observed in some regions of Eastern Europe and Asia (Des Jarlais et al, 2009a).

However, HIV and other infectious diseases are not the only reasons for bad health outcomes and higher mortality in drug users. It is a general phenomenon that prohibition prevents drug users from seeking medical care for many drug-related health problems: "a prohibitionist paradigm engenders policies and practices that inhibit drug users' access to care, treatment, and support, be it for HIV disease, addiction, overdose, or other health concerns." (Elliott et al, 2005)

[13] See chapter 4.2 for evidence on various harm reduction strategies.

III. Harm reduction: controversy and evidence

„It would probably take some type of harm reduction movement internationally with definite markers of success to persuade the U.S. to rethink its current policy." (Harrison, Backenheimer & Inciardi, 1995: 275). This pragmatic statement was made 16 years ago and implicitly tells us about the American scepticism towards harm reduction, which in some ways is still in place today. However, the harm reduction movement has gained momentum and at least "in Europe today, that controversy has to a large extent been replaced by consensus." (EMCDDA, 2010b: 7). The interpretations of the harm reduction concept and the surrounding controversy will be discussed in section two, followed by a short review of the evidence on popular harm reduction methods such as needle syringe programs, opioid substitution therapy and drug consumption rooms.

3.1 The harm reduction controversy

The term harm reduction can be understood as both a specific approach to drug policy, based on certain principles, and a set of social interventions for the treatment of drug users which do not require the discontinuation of the drug habit. Or, as the International Harm Reduction Association (IHRA) states it "the defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs." (IHRA, 2010b: 1). Among the most important principles of harm reduction strategies is the commitment to build policies on scientific evidence, practicality and cost-effectiveness, with a strong emphasis on human rights and public health.

The inherent risks of drug use are numerous and can cause considerable harm not just to the individual users, but also to their families, communities and society as a whole. Health-related risks include the possibly fatal consequences of overdosing, the spread of blood-borne disease through shared drug injection equipment, like HIV, hepatitis B and C, tuberculosis and bacterial infections, as well as other physical and mental health problems associated with drug use in general. Other kinds of harm are involved with the different types of drug-related crime[1], and dangerous offenses like driving under the influence of drugs. Economic factors like increased social welfare costs or loss of productivity on the side of the drug users can also be deemed damaging to society, just like the public nuisance caused by drug using communities (Hunt, 2003).

[1] See chapter 2.1 for more details.

The term harm reduction came into perspective after the realization that shared injection equipment among drug users is one of the main drivers in the global HIV epidemic (Leshner, 2008). By providing drug addicts with sterile needles and syringes in exchange for their used ones, the spread of infectious diseases can be effectively contained, but interventions like this also attract a lot of criticism. Harm reduction in the sense of minimizing adverse consequences without actively requiring the individual to discontinue their drug use is much more than a scientific or a political subject – it has become a moral and ideological issue.

There are several potentially negative implications of harm reduction strategies that opponents are worried about. Perhaps the most prominent one is the notion that programs like needle exchanges or opioid substitute therapies encourage drug use in a way that ultimately leads to more frequent consumption or a higher number of users. Although these concerns are not supported by the currently available evidence (which will be discussed in more detail below), the recognition that a substantial proportion of drug users is unwilling or unable to stop their drug habit is clearly conflicting with the fundamental moral paradigm of prohibitionism, that of "zero tolerance" for drug use. Many critics argue that this apparent collision of principles ruins the credibility of the whole drug policy system, thus undermining prevention efforts and weakening the deterrent effect of stringent laws. Again, no evidence was found to substantiate these fears (Watters et al, 1994; Normand et al, 1995), and research findings suggest that this factor has little influence in the complex process that determines people's decisions whether to use drugs or not.

There are also concerns that harm reduction appraoches do not meet the real needs of drug users when it comes to enabling them to concquer their addiction. For example, the provision of substitute therapies to dependent drug users is perceived to prevent them from "hitting rock bottom", which for some could be exactly the experience they need to make in order to gain the determination for quitting drugs. Although there is evidence to dispute this view (methadone maintenance therapy has been shown to keep people in treatment longer than abstinence-based programs, with lower rates of supplemental heroin use), it touches upon the low success rate in "curing" drug users from their addiction. This is, however, a common phenomenon among all drug addiction treatments, since opiate dependence is a long drawn condition, which is difficult to overcome (O'Brien, 2008).

The mere term "harm reduction" is also central to the discussion of the fundamental direction of drug policy, because it has often and misleadingly been associated with the decriminaliza-

tion of drug use (Caulkins & Reuter, 1997). As a result, supporters of the prohibitionist approach have denounced harm reduction strategies as a "trojan horse" of the legalization movement, which coincides with the fact that many harm reduction advocates do indeed call for a drug law reform and the reconsideration of prohibtionist principles. It is also true that needle exchange programs and safe drug consumption rooms are conflicting with some prohibitive legal regulations (for example the ban of personal possession of hypodermic needles and syringes which are still in place in many countries; Hunt, 2003).

There is a tendency to view harm reduction as synonymous for an alternative priority in drug policy, encompassing a choice between two separate goals: harm reduction and use reduction. Although there has been a lot of reasoning that these targets are in no way mutually exclusive (Caulkins & Reuter, 1997) and that harm reduction "complements approaches that seek to prevent or reduce the overall level of drug consumption" (IHRA, 2010b: 1), the term remains subject to a controversial debate in international policy. In fact, the negative connotation of harm reduction is such a powerful factor in public policy that some US communities have experienced difficulties when trying to implement harm reduction strategies, just because their labeling evokes so many negative moral implications (Leshner, 2008).
Harm reduction has become an emotional-laden concept, causing an unhelpful polarization among the scientific, political and social actors who are involved in the process of drug policy development, which hinders a constructive dialogue on how to address the various problematic aspects of drug use. A few critical voices even suggested to abandon the term harm reduction altogether (Beirness, 2008), because "it makes sense that any words that raise ideological intensity without serving especially useful purposes should be taken out of the lexicon." (Leshner, 2008: 514). In fact, although WHO and UNAIDS guidelines on best practice drug treatment methods include needle and syringes programs as well as opiate substitute therapies, the phrase harm reduction is generally avoided in official resolutions of international agreements, and instead the respective methods are described with vague terms such as "comprehensive" services for drug users (Hunt, 2003).
Some scientists repeatedly argue that harm reduction is not to be viewed as a fundamental new philosophy or an "all-or-nothing-approach" to drug policy, but rather as one piece in the whole puzzle of drug-related services, among prevention, education and conservative treatments. The idea is that instead of debating terminology and getting stuck in ideological conflicts, we should focus on scientific evidence about benefits and limitations of any intervention strategies (Beirness, 2008).

3.2 Evidence on the most popular harm reduction methods

Most countries implement a broad range of available interventions for drug users, many of which have been monitored and scientifically evaluated. There are psychosocial treatments and counseling, drug courts as a specialized legal institution for cases of non-violent substance abuse that put drug users in touch with rehabilitation services (King & Pasquarella, 2009), and health-related interventions like HIV testing and drug-specific medical care. The primary objective of most programs is the reduction of drug use, since this is the most obvious influence factor on drug-related harm to individuals and society. However, there are many other criteria that have been considered in the assessment of intervention effectiveness, like reducing crime, promoting health and well-being among drug users and decreasing the overall financial costs to society. Generally, there is a strong scientific consensus on the fact that the investment in evidence-based drug treatment is an efficient way of addressing drug problems (Godfrey, Stewart & Gossop, 2004; Holloway et al, 2005). "Every £1 invested in drug treatment saves two-and-half times that in crime and health costs" (National Treatment Agency for Substance Misuse, 2009: 7).

There is no clear distinction between interventions that are only intended to reduce drug use and those targeted at reducing drug-related harms. Many psychosocial programs are designed to discourage drug use, but also educate users about safe injecting behavior (Copenhaver et al, 2006) and even the most prominent harm reduction methods are usually implemented in a way that encourages further contact between drug user and treatment system. The most controversial interventions which principally focus on harm reduction are needle syringe programs, opioid substitution therapy and safe drug consumptions rooms, and their implementation is generally seen as an indicator for a country's dedication to the prevention and reduction of drug-related harms.

Needle syringe programs

Needle syringe programs (NSP) are perhaps the most well-known harm reduction intervention, and for good reason. The first NSP was established in Amsterdam in 1983, when a local organization supporting injecting drug users asked the municipal health authorities to provide sterile injection equipment after a recent outbreak of hepatitis B. Although the request was initially turned down, the decision was soon reversed and started the global spread of similar programs, which became even more popular after the emergence of HIV/AIDS among drug using communities (WHO, 2004). These programs usually provide organized distribution of

sterile needles and syringes that can be used for injecting drugs, sometimes upon the condition that they are exchanged for used ones. The fundamental target is to prevent the sharing of injecting equipment and thus the risk of transmission for HIV and other blood-borne viral infections. In 2010, there were 82 countries around the world that implemented this idea through community or peer outreach programs, pharmacy-based schemes, specialist NSPs and vending machines (IHRA, 2010a). Additional services like psychological counseling, HIV prevention education or referrals to treatment opportunities are sometimes provided as well, but the extent and quality of these vary widely across contexts (Hunt, 2003). Most of the time, NSPs operate legally, but they still remain illegal or semi-legal in many developing and developed countries, which is a major obstacle to comprehensive HIV prevention efforts recommended by the WHO (2004).

There is substantial evidence that the availability and utilization of sterile needles and syringes effectively reduces HIV infection, with no convincing evidence of severe, unintended negative consequences like increased drug consumption (Gibson et al, 2001; Ksobiech, 2003; Wodak & Cooney, 2005). It was also concluded that NSPs are cost-effective and feasible, an important aspect in comparison with other prevention methods. Still, it is necessary to emphasize the fact that NSPs are not the only necessary intervention effort to control HIV infection rates among injecting drug users: they need to be embedded in a range of other complementary measures (WHO, 2004). It is also essential to ensure sufficient coverage of NSPs in order for them to have a positive impact on drug using behavior, and more research is needed to determine adequate quantities (Palmateer et al, 2010). However, it has been noted that for most countries with little or no appropriate implementation of NSPs, the problem is often not a lack of resources, but the orientation of political attitudes (Des Jarlais & Friedman, 1998).

Opioid substitution therapy

Opioid substitution therapy (OST) is a treatment form for drug users who have been diagnosed with opioid substance dependence, and it usually means that a user will be prescriped replacements such as methadone, buprenorphine, codeine, slow-release morphine or pharmaceutical heroin (IHRA, 2010a). The goal is to reduce or prevent the use of illicit opioids, and to improve the physical and psychological health of the addicted person.

The most commonly used substitution is methadone, a synthetic opioid that prevents withdrawal symptoms but does not produce the euphoric effects of heroin. It is administered orally at a daily dose, and makes opioid addiction much more manageable, with the result that users can often be restored to normal social functioning (Hunt, 2003). Buprenorphine is not quite as

effective as methadone, but it is longer-acting and thus only needs to be taken once every two days (Mattick et al, 2008). The prescription of heroin is the most controversial of all OSTs. After a first study in Switzerland showed positive results in 1994, several countries adopted heroin-assisted programs, and subsequent studies demonstrated high feasibility and effectiveness (Fischer et al, 2007; Lintzeris, 2009). Especially highly problematic users who are not sufficiently interested in methadone treatment are seen as a potential target group for heroin-assisted treatment. Because substitute opioids can cause death in overdose, they are only dispensed under medical supervision and with regard to relatively strict rules.

A systematic review of several studies suggested that methadone maintenance therapy reduces heroin consumption and keeps people in treatment longer than drug-free programs (Mattick et al, 2009). By reducing risky drug using behavior like injecting, OST also acts as an HIV prevention method (Metzger et al, 1998; Drucker et al, 1998). It has also been shown that methadone treatment decreases criminal involvement of drug addicts because the economic pressure to finance the drug addiction is reduced (Gossop et al, 2000). The reductions in illicit drug use, HIV infection and criminal activities are the main factors in making OST a cost-effective intervention from a general point of view, and it yields better results than alternative drug dependence treatments (Zaric et al, 2000; Gossop, 2005).

There are various objections to OSTs, mostly because they only appear to trade one drug addiction with another, and many argue that the ultimate goal of treatment should be complete abstinence from any addicting substance. "It is discouraging that some professionals hold this view even in the face of extensive scientific literature on the effectiveness of such medications in restoring an individual to functionality in the family, at work, and in the broader community." (Leshner, 2008: 514). These criticisms have been intensely debated (Ward, Mattick & Hall, 1998), and the beneficial effects of OST are generally considered to outweigh any potential moral harm.

Drug consumption rooms

Drug consumption rooms are profesionally superivised health care facilities where drug users can bring their preobtained drugs and can use them in safe, hygienic conditions. They are intended to reduce the immediate health risks involved with drug consumption, to provide education and health promotion advice, and to increase access and utilization of medical care among drug users (Hunt, 2003). Although unofficially tolerated drug use at some addiction counseling centers in the Netherlands has been reported since the 1970s, the first supervised consumption room was established in Switzerland in 1986. The legal assessment of the situa-

tion resulted in the acceptance of consumption rooms as medical institutions, which were exempt from drug law enforcement. In 2010, sixty cities reported at least one safe consumption room, and all but two of them (one in Australia, one in Canada) were located in Europe (IHRA, 2010a).

The most extensive review on the subject of safe consumption rooms was conducted by the European Monitoring Centre for Drugs and Drug Addiction, and while the conclusion implied that there is still need for more detailed research, the evidence indicates that consumption rooms essentially serve the intended purpose (EMCDDA, 2004). They are predominantly frequented by long-term drug users at high risk for health and social problems, a so-called "hard-to-reach" target population. In a survey of all German consumption rooms, a third of users reported that these rooms had been their first contact with the drug treatment system (Poschadel et al, 2003). In addition to providing emergency care and thus decreasing the risk of death from overdose and other adverse health consequences, they also contribute to the reduction of fatal overdoses at community level (MSIC Evaluation Committee, 2003). There is no evidence that safe consumption rooms lead to more drug use or attract new users, and when managed in close cooperation with local political authorities and police departments, they do not appear to increase public nuisance by expanding drug scenes (Wolf et al, 2003).

IV. Drug problem and harm reduction in transatlantic comparison

This chapter will compare the current situation of the drug problem and the implementation of harm reduction methods in Europe and the US. Based on recent statistical data, the first section will give an overview on illicit drug use prevalence for the most common drug classes. With a general focus on public health effects, the scope of drug-related health problems will be discussed as well, like increased mortality among drug users and other health risks, most importantly HIV infection. The second section contains information on the extent of harm reduction implementation in Europe and the US, using recent data on the three previously discussed methods (needle syringe programs, opioid substitution therapy and drug consumption rooms) as indicators.

4.1 Selected parameters for the state of the drug problem

Measuring prevalence rates for drug use is difficult and the respective methods differ across countries, impeding comparisons on an international level. Hence, a definite answer to the question of how many people are using drugs is hard to come by, even within a single country as large as the USA, where data on drug use is treated differently by the individual states. The main sources of information are the World Drug Report 2011, compiled by the UNODC[2], the 2010 Annual report on the state of the drugs problem in Europe, published by the EMCDDA[3], and the results from the 2009 National Survey on Drug Use and Health (NSDUH), conducted by the Substance Abuse and Mental Health Administration (SAMHSA).

Prevalence of drug use

By far the most commonly used illicit drug in Europe as well as the US is cannabis. Among the total adult population (aged 15-64 years) in 2009, 10.7% of Americans have used cannabis in the last year, which is a slight increase compared to 10.1% in 2007[4] (UNODC, 2011). This is higher than the European account of 6.8% (EMCDDA, 2010a). Although European canna-

[2] EMCDDA data are preferred to the World Drug Report because the UNODC definition of Europe includes a far wider array of countries, including not only the 27 member states of the EU, but also Albania, Andorra, Belarus, Bosnia and Herzegovina, Croatia, Former Yugoslav Republic of Macedonia, Iceland, Kosovo, Liechtenstein, Monaco, Montenegro, Norway, Republic of Moldova, Russian Federation, San Marino, Serbia, Switzerland, Turkey and Ukraine (UNODC, 2011).

[3] The report is based on information from all EU member states, Norway, and where available from the candidate countries Croatia and Turkey (EMCDDA, 2010a).

[4] Especially since the 2007 percentage is based on the whole population aged 12 and above (SAMHSA, 2010).

bis use is stable or declining, there are large regional differences, with national variation between 0.4% (Romania) and 15.2% (Czech Republic).

The second most prevalent drug is cocaine: The region of North America is the biggest market, and US annual prevalence is estimated to be 1.9% among all people aged 12 and above, which marks a decline from 2.5% in 2006 (SAMHSA, 2010). European figures are not only lower on average with 1.3% of cocaine users among the population aged 15-64 years, but even the highest prevalence rates in Ireland with 1.7% are below US numbers (EMCDDA, 2010a). There is, however, a typical West-East-slope of cocaine use in Europe, with higher rates reported in West and Central Europe (about 1.25%) than in East and South-East Europe (around 0.2%). The general consumption trends appear to have stabilized (UNODC, 2011).

The European and American differences are less pronounced with regard to ecstasy, with 1.1% of annual prevalence in the US (UNODC, 2011) and 0.8% in Europe (EMCDDA, 2010a). The situation is different for amphetamine-type stimulants, where the US report higher rates with 1.5% of the population aged 15-64 years (UNODC, 2011) and Europe 0.6%. The substance causing most of the problems in this category is methamphetamine, which is far more popular in the US than it is in Europe, where the use is primarily limited to the Czech Republic and Slovakia (EMCDDA, 2010a).

Heroin use appears to be about equally prevalent in Europe and the US, with respective estimates of 0.6% and 0.5% of annual users (UNODC, 2011), but again there is a lot of variation among European countries, with the UK and Estonia reporting the highest rates of injecting drug use (EMCDDA, 2010a). The use of illicit opiates also has another problematic dimension in the US: the non-medical use of prescription drugs, which so far is not considered a major concern in Europe.

Drug-related deaths

The comparison of statistics with regard to drug-related deaths is complicated, because definitions, measurements and reporting requirements vary widely. Generally, we are talking about all deaths that were directly or indirectly caused by the use of illicit drugs. This includes "deaths from drug overdoses (drug-induced deaths), HIV/AIDS, traffic accidents – in particular when combined with alcohol – violence, suicide and chronic health problems caused by repeated use of drugs" (EMCDDA, 2010a: 84). There can only be speculative estimations about the overall drug-related mortality. Drug-induced deaths like overdoses are somewhat easier to quantify, but even here large insecurities remain.

The US have one of the highest drug-related mortality rates of 182 deaths per 1 million inhabitants aged 15-64 years, an estimated 38.400 cases a year. Similar calculations for the European region as defined by the UNODC[5] estimate 25.000 to 27.000 drug-related deaths, a mortality rate of 46-48 people per million population (UNODC, 2011). The single most frequent cause of mortality is fatal overdose, predominantly caused by heroin use. The EU member states and Norway reported about 7.300 deaths in 2008, in what is considered a conservative estimate, with Germany and the UK accounting for almost half of these cases. This is a slight increase compared to around 7.000 in 2007 (EMCDDA, 2010a) but still within an overall decreasing trend with regard to the 8.000 overdose deaths in 2000 (UNODC, 2011). In the US, overdose mortality rates have never been higher, with an estimated 27.000 deaths in 2007. This is roughly a five-fold increase since the 1990s, which is mostly attributed to the aforementioned increase in the abuse of prescription opioids (CDC, 2010).

Drug-related infectious diseases

The most important concern with regard to drug-related infectious disease is HIV as well as hepatitis B and C, which is usually transmitted through shared equipment among injecting drug users. Data on newly diagnosed HIV patients in Europe suggests a declining trend following a peak in 2001/02, which was mostly due to dramatic outbreaks in Estonia, Lithuania and Latvia. The EU average in 2008 was 2.6 new HIV cases per million inhabitants, a significant decrease compared with 3.7 cases in 2007 (EMCDDA, 2010a). Research suggests that this is at least partly attributable to the increased availability of prevention services that are specifically targeted at drug users, like needle and syringe programs and opioid substitution therapy (Wiessing et al, 2009).

The general prevalence of HIV in injecting drug users varies drastically across Europe, with Estonia reporting a staggering 72%, followed by Spain with 39%. At the other end of the scale, countries like Bulgaria, Cyprus, Czech Republic, Greece, Finland, Hungary, Slovakia and Slovenia only see HIV in less than 1% of drug users (Mathers et al, 2008). Based on these data, which were compiled by the UN Reference Group on HIV and Injecting Drug Use, the average for all EU member states[6] can be calculated with 8.3%, which compares favorably to the (less precise) global estimate of 18.9%. In Western Europe, 89 out of 100 drug users liv-

[5] The UNODC definition of Europe includes a far wider array of countries, including not only the 27 member states of the EU, but also Albania, Andorra, Belarus, Bosnia and Herzegovina, Croatia, Former Yugoslav Republic of Macedonia, Iceland, Kosovo, Liechtenstein, Monaco, Montenegro, Norway, Republic of Moldova, Russian Federation, San Marino, Serbia, Switzerland, Turkey and Ukraine (UNODC, 2011).

[6] Except Malta, for which no data was available (although HIV prevalence can be assumed to be close to 0% and would thus lower the EU average).

ing with HIV receive antiretrovirals for treatment, whereas this rate is much lower and harder to estimate for Eastern Europe (Mathers, 2010). In case of the US, about 15.6% of all injecting drug users are HIV positive, almost double the European average. The latest update on the global coverage of HIV prevention and treatment services did not include any data on antiretroviral access for American drug users (Mathers, 2010).
With regard to the hepatitis C virus (HCV), the antibody levels among injecting drug users in Europe vary from 12% to 85% according to EMCDDA (2010a), whereas the World Drug Report states the lowest rate with 1% in Finland and allows for the calculation of an average EU rate[7] of 44% (UNODC, 2011). This appears to be a higher prevalence than in the US, where a recent Collaborative Injection Drug User Study analysed HCV rates among injecting drug users in four big American cities (Baltimore, Chicago, Los Angeles and New York City) and found an average of 34% in the year 2004 (Amon et al, 2008).

4.2 Harm reduction implementation in Europe and the USA

Measuring and comparing the extent to which harm reduction methods are put into practice can be challenging, because not all important parameters are reported. The number of sites that provide needles and syringes or OST is one indicator, but that does not tell us much about how often they are frequented and how many drug users are reached by them. Also, the mere existence of an NSP site does not say anything about quality, availability and other included services. The average number of needle-syringes distributed per injecting drug user per year is a better measure of the actual extent of harm reduction practice, although we still cannot determine if this means that a high proportion of users received a relatively balanced number of needles or a small proportion received a high number, and whether the users who benefited from the service are really those most at risk. However, since it is a commonly calculated measure, it will provide a reasonably good overview of coverage.

In Eastern Europe, NSP coverage is generally pretty low, with the notable exceptions of Estonia and the Czech Repulic, which both distribute an average of 151 needle-syringes per user per year. The rest of EU member states in the East lag behind due to insufficient funding, technical assistance or political commitment, with Slovakia distributing only 27 and Lithuania only 37 needle-syringes (Mathers, 2010). It has to be noted that sometimes (as with Slovakia and Hungary) low NSP coverage corresponds with low HIV rates among injecting drug users,

[7] For all EU member states except Cyprus, Denmark, Estonia, Ireland, Spain and Sweden.

although this is in no way a legitimate reason for stalling the scale up of prevention methods. The case study of Estonia shows that low HIV prevalence can quickly turn into a full-blown epidemic when there are no means of containing the spread among drug users. During the 1990s, Estonia saw less than 20 new HIV infections a year, which dramatically increased to more than 1.400 cases in 2000, leading to one of the highest HIV prevalence rates among drug users in the world (WHO, 2009a).

Although average NSP coverage in Western Europe is far more extensive, there is still much room for improvement, especially in countries with very low provision like Greece and Germany (3 and 2 needle-syringes per user per year respectively; Mathers et al, 2010). Whereas these countries fortunately only have low HIV rates among injecting drug users (0.5% and 2.9% respectively; Mathers et al, 2008), other countries like France[8] (46 needle-syringes) and Spain (33 needle-syringes) would benefit from a rapid extension of their NSPs. Syringe sale in Sweden is still illegal, and only 2 NSP programs operated at Stockholm in 2010, although there have been political anouncements that there are more to come soon (IHRA, 2010a). A range of Western European countries display a fairly decent degree of NSP coverage, like Austria (176), Finland (166), Ireland (164), Portugal (199), the UK (188) and especially Norway, which distributes 434 needle-syringes per user per year, the highest amount worldwide (Mathers, 2010). These rates of NSP distribution come close to or actually meet the recommended standard of high coverage (200 needle-syringes per user per year), as it has been established in UN guidelines (WHO, UNODC & UNAIDS, 2009). However, the West European average with 59 needle-syringes is much lower (Mathers, 2010).

In the US, 186 sites providing NSP were operating in 2009 (Des Jarlais, 2009b), distributing an average of 22 needles per user per year (Mathers, 2010). This is little more than a tenth of the recommended amount and about half the Western European average, but the the provision rate is inclining. It is still too soon to evaluate the impact of the recently declared federal American support for NSPs (New York Times, 2009), but the next IHRA report on the Global State of Harm Reduction in 2012 should include first results.

About half of all problem drug users or about 680.000 people in the EU and Norway receive opioid substitution therapy for treatment. Although this is an adequate proportion, the distribution across the countries is far from equal, with only 2% of all subsitution treatments occuring in the 12 new, predominantly Eastern European member states which entered the EU

[8] France is also one of the few countries to report the proportion of drug users who access NSPs, and it is fairly low (4%) in comparison with Finland, where 81% of all injecting drug users are reached (Mathers, 2010).

since 2004[9] (EMCDDA, 2010a). Even though the EMCDDA reports that most legal barriers to the implementation of OST services have been reduced or eliminated, the majority of Eastern countries only provide very limited access. Slovakia only counts an average of 3 OST recipients per 100 injecting drug users, Estonia 7 and Lithuania 10 (Mathers et al, 2010). Western European nations reach significantly higher levels of coverage, with Austria, France, Germany, Ireland, Italy and Luxembourg reporting a proportion of more than 40% of problem opioid drug users in OST (EMCDDA, 2010a). This classifies as high coverage according to UN standards, as does a general ratio of OST recipients per 100 opioid injectors higher than 40 (WHO, UNODC & UNAIDS, 2009). In Western Europe, only Finland (7), Greece (38) and Norway (36) fall short of this recommendation (Mathers et al, 2010).

The distribution of OST services in the US is inconsistent as well, with around 1.400 facilities treating about 250.000 patients. The overall coverage only reaches 13 out of 100 injecting drug users (Mathers et al, 2010), a relatively low rate. In addition to inconsistent OST provision, there are other factors preventing injecting drug users from entering treatment, among them the lack of health insurance and/or sufficient financial resources as well as a general mistrust in the health care system (IHRA, 2010a).

Currently, American OSTs feature methadone and buprenorphine but no heroin-assisted treatment, and there are no safe drug consumption rooms. In Europe, all of the 90 drug consumption rooms operated in 2010 were concentrated in six Western European countries (Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland), spread out over 59 cities (IHRA, 2010a). A report conducted by the Independent Working Group (IWG) on Drug Consumption Rooms in the UK evaluated the growing body of evidence and concluded that they "should not be regarded as a radical policy option but, rather, as a rational and overdue extension to the Government's established harm reduction policy" (IWG, 2006: xii). So far, this recommendation has not been put into practice.

[9] Czech Republic, Cyprus, Estonia, Latvia, Lithuania, Hungary, Malta, Poland, Slovenia and Slovakia entered the EU in 2004, Bulgaria and Romania in 2007.

V. Why the "War on Drugs" originated in the US, not Europe

Now that we have explored European and American drug policy and shed more light on the problematic aspects involved, there is one specific question that needs to be addressed: Why is the situation in the US different from Europe? Which societal factors shaped the development of different approaches to drug legislation?

For a sociological review, it is helpful to place these transatlantic differences in a broader context of analysis. There are several legal, social and behavioral aspects that are subject to a long historical tradition of discrepancies between Europe and the United States. These more or less substantial differences not only have influence on the perceived cultural distance between the two continents, but also cause mutual misunderstandings and problems in communication when working together for a common goal, like reducing the negative impacts of drug consumption.

In this chapter, we will mainly look at sociological theory with regard to the historical civilizing process, and focus on some differences that are not only visible in everyday European and American life, but which will also help to explain why certain strategies of problem-solving are more prominent in some national settings than in others. Starting out with the stronger emphasis on personal accountability for drug addiction in the US, we will then cover differences in social standards of morality and their implications for drug using communities, followed by an overview of democratic tendences in the US that favor the transformation of moral controversy into political and legal measures. Finally, we will briefly touch upon the apparent American ambivalence between highly valued individual liberties on the one hand and a strong pressure for social conformity on the other.

5.1 The question of personal accountability for drug addiction

When a British doctor visited the US in 1922 to learn more about the practical implications of the Harrison Act and whether the United Kingdom should follow this legal example, he made a characteristic observation: "In the United States of America a drug addict is regarded as a malefactor, even though the habit has been acquired through the medicinal use of drug, e.g., of American soldiers who were gassed and otherwise maimed in the Great War." (Brecher, 1986: 6). Why is it that Americans generally credit drug users with a higher personal responsibility for their drug consumption in comparison to Europeans, who are more likely to view this behavior as the symptom of an illness? Based on Max Weber's classic analysis of the

religious origins of capitalism, "The Protestant Ethic and the Spirit of Capitalism" (first published in 1905), one could argue that a high validation of personal accountability for a person's choices was shaped by the strong influence Protestant communities had on American society. In fact, there are several character traits associated with this Protestant ethic ideology, which are believed to be more common among Americans than they are among Europeans. In the book, Weber argued that Protestantism in Northern Europe and consequently in the US was an important factor in the development of a capitalist economy: the reformation supported a strong professional engagement in the secular world and the accumulation of wealth for the purpose of investment, regarding hard work as a sacred duty and a Christian's true ambition (Weber, 2010). The rational pursuit of economic gain thus became a religiously motivated strive, with a tendency to view worldy success as an indicator for God's favor, a sign for the predestined selection of an individual to a state of grace. Predestination was especially pronounced among Protestant sects like the Calvinists or the Wesleyans, who often migrated to the US due to religious persecution and who preached "that the fruits of labour were the signs of salvation." (Mack, Murphy & Yellin, 1956). Subsequently, a lack of personal success is likely to be attributed to individual shortcomings rather than environmental factors or systematic disadvantagement (MacDonald, 1971). Personal virtues that were deducted from this general interpretation of the Protestant Ethic include self-discipline, thrift, the denial of pleasure for its own sake and individual activism to achieve success in life (Feather, 1984).

Although Weber's theory has inspired an intense debate over its accuracy, it has no doubt influenced the work on a variety of social issues, from the structure of the European and American social welfare systems (Segalman, 1968) to psychological research into character traits and personality (Mirels & Barrett, 1971). Even if the causal relationship between Protestantism and capitalism remains disputable, the characterization of the modes of conduct and intrinsic goals of the Protestant Ethic are widely recognized as valid (MacDonald, 1972). Empirical evidence from several studies supports the coherence of the aforementioned values. For example, the endorsement of Protestant Ethic values is positively associated with the willingness to take on responsibility for personally relevant outcomes in life (Migrels & Barrett, 1971), or, in other words, with a stronger belief in an internal locus of control (MacDonald, 1971). With regard to drug abuse, the conclusion is quite simple: a society with a strong perception of personal accountability is more prone to view drug dependence as a consequence from lacking self-discipline and insufficient effort to overcome the addiction. Hence, if the consumption of a substance is illegal and deemed a crime, the offenders have to take on re-

sponsibility for breaking the law and deserve adequate punishment. This background of moral reasoning favors a more punitive approach to drug policy, whereas a tendency to acknowledge drug addiction as a disease which limits personal accountability is more likely to produce less stringent laws, but a stronger focus on public health as the area that needs improvement.

The first scenario also entails a different evaluation of the harms caused by drug abuse. It is not just the act of lying and stealing that an addicted but otherwise respectful person would commit when their drug consumption is at stake. It is the drug itself that is credited with the property of corrupting an individual's behavior at a very profound level, making them weak-willed (for strong willpower would enable them to discontinue their drug use), tainting their character and changing their personality – the drug use as such, not just the immediate influence of the drug or the consequences of craving it. This furthers negative moral judgements about people who use drugs, and increases stigmatization, which in turn lowers the willingness of the general population to dedicate financial means to treatment and medical care for drug users, a vicious circle of marginalization and stigmatization that has already been mentioned[10].

From this point of view, the discontinuation of drug use is the most important aspect of treating and rehabilitating an addicted user, which makes it hard to advocate harm reduction methods like needle exchanges or opiod substitute therapies that appear to undermine this effort. On the other hand, the perception of drug addiction as an illness encourages the treatment of a person with all means available even without first eliminating drug use as the primary cause of harm. When targeting the negative effects of drug use to restore some normal functioning can be considered a worthwhile goal in itself, harm reduction methods are likely to be deemed legitimate options.

5.2 Morality and society's concerns about drug use

The American heritage of Protestant Ethic values like asceticism and self-discipline is only one of many issues that relates to moral concerns about drug use. The behavior as such is often associated with other social problems like prostitution and crime, which are subject to moral concerns and controversial debates themselves. Other problems surrounding drug consumption include child neglect, unreliability in the workplace, financial and emotional strains

[10] See chapter 2.3 on unintended consequences of drug legislation.

not just on the addicts, but also on their families and communities. The negative impact of drug abuse on society is immense, and the handling of this problem becomes a moral issue as well, because prohibitive drug laws do not only have the purpose of sanctioning drug offenders, but are also supposed to serve as a deterrent for potential users, especially young people who have been known to find drug use attractive.
Assuming that drug use is seen as a bad personal choice for selfish and frivolous reasons puts it in the same league as other criminal behaviors, implying that the person who uses drugs knew what they were risking and yet chose to do it anyway, a highly undesirable behavior for the members of any society. So how come the moral standards of an individual's choices are much more of a public issue in the US that influences drug politics and legislation?
Aside from a stronger Protestant influence on American society, there were some significant differences in the civilizing process of Europe and the US, which has been subject to considerable research. Norbert Elias' most famous work "The European Civilizing Process" (first published in 1939) has identified the most important mechanisms by looking at European history, inspiring Stephen Mennell to examine the situation on the other side of the Atlantic in order to see whether the same characteristics would manifest in the development of the American society. As it turns out, the more important role of morality in the public discourse on drug abuse can be traced back to a stronger emphasis on middle class values in the US, which shall be explained in more detail by comparing the respective historical tendencies in Europe and the USA (Elias, 1978b: 414-421).

During medieval times, the European nobility did not notably distinguish itself from other social classes with regard to their manners, and was almost constantly busy fighting wars over small territorial claims. The following court nobility developed during the pacification of the medieval nobility during a continuous monopolisation of power, at the end of which emperors or kings created large aristocratic courts like the ones in Paris or Vienna. Subsequently, the refinement of language, manners, taste and social activities became a significant feature to signal the dissociation between aristocracy and bourgeois. This was necessary because the latter had gained more and more importance, and the two classes inevitably became competitive: rich members of the historical middle class tried to gain more political influence and to extend their privileges, which happened at the expense of the aristocracy. Therefore, noble manners and a certain lifestyle evolved into a fundamental mechanism to express noble status and to maintain their distinctiveness as a class, since the cultivation of these manners took up time that the higher classes could more easily afford. As a consequence, socially ascending

members of the bourgeois started to imitate aristocratic manners, thus requiring constant modifications from the side of the nobility that led to more complexity in behaviors. Though this influence was sometimes mutual, the dominant tendency was the acquisiton and modification of manners from the nobility by the bourgeois, which over time trickled down to a broader spectrum of lower classes. Despite a few national differences with regard to the exact behavioral standards, manners and rules on impulse control, it is safe to speak of a general European development.

Elias distinguishes between two stages of this phenomenon: the first stage or assimilation is primarily shaped by the strengthening of the bourgeois and their imitation of courtly manners, the second stage or emancipation is characterized by increasing confidence of the lower class and the establishment of their own codes of conduct. As a result, contrast and tensions between bourgeois and aristocracy increased (Elias 1978b: 424). One area that was particularly affected by this stage of emancipation was the common perception of virtue as a bourgeois characteristic as opposed to aristocratic "frivolity". The tougher set of self-constraints for the middle classes arose mainly from the strong focus on professional activities and invoked values like chastity, temperance and diligence, as opposed to leisure, indulgence and promiscuity perceived to be common among the nobility. The consequences of this development include a stronger emphasis on and more rigorous standards for moral righteousness, as well as a higher number of taboos in physical and sexual matters (Elias 1978b: 255f).

Since the nobility in America was never as influential as in Europe and only present for a comparably short period of time, the American middle class did not have as much social competition. As a consequence, there was only little assimilation with aristocratic manners, which means that their influence on the American population was far less pronounced than in the case of Europe. Similarly, the emancipation of the American middle class happened earlier and without any real opposition, so that their self-confidence was more advanced and the typical bourgeois values became a stronger influence on the American society. Among other factors (for example the historically more important role of Puritan morality), this is one reason why the American approach to sexuality has often been deemed prude and hypocritical by Europeans.

Additionally, it has been argued that morals and values in the USA are somewhat anachronistical because there has not been much revision over the course of the last few centuries. Contrary to other parts of the world (especially Europe), there were no strong outside pressures forcing changes on the American lifestyle (Mennell, 2007: 47), challenging a discourse on the

country's moral standards. When Jean Baudrillard commented on how little Americans have changed over during the last 200 years, he attributed the conservation of 18th century perspectives on morality to the isolated geographical placement of the US, who are surrounded by two oceans and can thus be pictured as an island in the stream of time (Baudrillard, 1995: 128).

5.3 Democratic systems and their implications

In addition to a stronger sense of personal accountability for one's action and the more important role of morality as an issue in the public discourse on drug use, there are other differences between Europe and the US that directly affect the consolidation of drug laws. One of the most important aspects that will be analyzed here is the slightly different implementation of democracy on both sides of the Atlantic ocean. Guided by the question of how the concerns about drug use among the general population translate into prohibitive legislation, three aspects will be of special interest. First, we will have a look at the higher political power of majority opinions in the US, and how this compares to the more elitist influences on European policy making. Second, we will consider some implications of the American democratic system, especially with regard to the visibility of political measures for problems that affect the people's sense of security. Third, a glance at the seemingly ambivalent value of conformity in a majority-focused democracy like the US will conclude the chapter.

The importance of the majority

The American democratic system has been shaped by a variety of factors, and one of the first comprehensive evaluations on this topic was written by the French political scientist Alexis de Tocqueville, who travelled through the United States in 1831 and published his impressions and conclusions in the famous work "Of democracy in America". He also characterized the American as self-reliable, believing in personal responsibility and making one's own choices in life, which entails a certain scepticism towards too much guidance and counselling in political matters (Tocqueville, 1899)[11]. The democratic system could be seen as a manifestation of these attitudes, effectively turning people's opinion about societal issues into legislation, preventing the unwanted imposal of decisions made by any elitist class. Thus, the main task of any politician is to act according to the will of the majority, whether this reflects expert or scientific opinions on a subject or not.

[11] All citations from this reference refer to the electronic edition and thus do not include page numbers.

European democracies were shaped by different historical circumstances and were built on hundreds of years of aristocratic rule, which naturally influenced the following political systems. One very popular issue that illustrates these differences between Europe and the US is the case of capital punishment, which is currently executed in 38 federal states (after a nine year moratorium ending in 1976). Although one could argue that this situation reflects a divide in values (with European ethics being influenced by a long-lasting tradition of humanistic ideas, which were never quite as prominent in the American context of Protestant values), there is in fact better evidence to credit the respective democratic systems, since there have been majorities for the implementation of death penalties in many European countries as well[12].

Thus, it is important to look at the way in which the opinion of the general population shaped the legislation. Or, in case of many European countries, how the legal situation is likely to have influenced the public opinion: The democratic system in the US is more focused on directly implementing the will of the people, and if a majority is in favor of capital punishment, legislation is highly likely to accommodate this demand (Mennell, 2007: 153f). The will of the majority is the dominating power in politics, and "most of the American constitutions have sought to increase this natural strength of the majority by artificial means." (Tocqueville, 1899: volume 1, chapter XV). The fact that European countries have abandoned the death penalty and made its suspension a prerequisite for membership in the European Union can be traced back to a stronger top-down influence in the formation of public opinion led by intellectual elites of a humanistic orientation (Singh, 2007: 64f). As it has been discussed above, manners and social behavior from the upper classes had a sustained effect on the general population, and it is plausible to assume that this tendency holds also true for opinions and perspectives. After all, even though many European nations abolished death penalty while a majority of their citizens still supported it (Singh, 2007: 61), the number of its proponents dropped considerably nowadays, and opposition against capital punishment is fairly widespread. It can thus be concluded that the European conception of democracy exhibits certain elitist features, which are not as prominent in the US, and that political leadership in Europe often entails some sort of guidance in the shaping of public opinion.

With regard to drug use, several conclusions can be made: if public opinion in the US is dominated by a moral approach to the problem and thus supports a punitive legislation, then voters are likely to see their demands for more rigorous legal control fulfilled. As long as a

[12] As a matter of fact, majorities for the death penalty still exist in some countries, as a recent poll from Poland suggests (Lißman, 2006).

majority of people is willing to invest in law enforcement, policy makers are unlikely to take into account the scientific evidence that questions its efficacy.

The demand for visible political action

Another implication of the American democratic system is a stronger predominance of publicity effects in politics. Since Americans set a comparably high value on seeing their opinions put into practice, visible practical measures that gain attention from the media play a much more important role in American politics. This holds especially true when the general sense of security is threatened: if people perceive something to be dangerous with the potential to affect themselves, the demand for visible action is even higher due to the necessity of relieving the feeling of being at risk. With regard to drug use, harsh legal sanctions do not only make a good impression suggesting that the problem is actively dealt with, it is also more likely to produce more impressing media coverage for the occasional law enforcement success, like incarcerations of drug offenders or the confiscation of a high amount of drugs. "The tendency to mischaracterize and sensationalize the drug problem is, in part, a function of the political and public funding processes." (NIDA, 1990). Long-term efforts like the investment in better treatment options do not bring swift relief to the perceived threat of the drug problem, and even success along these lines (for example a decrease of problem drug users) is mostly a statistical phenomenon that usually does not make dramatic headlines in the media. Additionally, this also means that sometimes important, but not very popular issues of politics do not get enough attention and engagement from the public, which can further attempts to manipulate and utilize the perspectives of the general population. American politics has a reputation for the use of solemn and polemic rhetoric, often employing common fears and concerns, because „if you want to do anything in America, you have to scare the pants off the United States public" (Watt cited by Klebes, 1987: 59).

Democracy and the pressure to conform

The strong American emphasis on plebiscitary democracy has been criticized as a "dictate of majority" with regard to several issues, implying a common argument: the fact that the majority of people supports a notion does not necessarily means that it is the smartest choice. This is why education about the respective efficacy of various strategies in the handling of drug abuse is so essential, and it does not stop there. Education is also important with regard to the process of stigmatizing drug users and the employment of fear-inducing stereotypes: "These fears are grounded in some general assumptions about people who use drugs and drug mar-

kets, that government and civil society experts need to address by increasing awareness of some established (but largely unrecognized) facts." (Global Commission, 2011) Most importantly, it is necessary to communicate the differences between unproblematic and problematic drug use, with the latter only affecting about 10% of all drug users (UNODC, 2008). The development of more tolerance towards unproblematic drug use would help to relieve the negative effects of stigma, and it would counteract another consequence of a highly democratic society like the US: a tendency towards conformism.

At first glance, this seems like a paradox, since the American society is often seen as the birthplace of modern individualism and personal freedom. However, there have been critical voices about the negative influence of a strong emphasis on majority guidance in society ever since the US came into being, warning about the resulting pressure towards conformity in lifestyles (Diner, 2002: 52f). "I know of no country in which there is so little independence of mind and real freedom of discussion as in America." (Tocqueville, 1899: volume 1, chapter XV). When majorities are regarded as the fundamental instrument in deciding what is right for a society, it inevitably affects the social life as well – meaning that behaviors and opinions that do not conform with the majority of people are subject to critical judgement and less validation. This increases the pressure towards uniformity, and makes it more likely that individual interests do not receive enough attention when the interests of the public are concerned. Tocqueville refers to this tendency as "extemely natural to democratic nations and extremely dangerous" since this delicate balance between common good and individual rights can easily be tipped over in a negative direction, and "habits are formed in the heart of a free country which may some day prove fatal to its liberties." (Tocqueville, 1899: volume 1, chapter XV).

Discussion

The comparison between American and European approaches to drug policy is an intriguing, but challenging task. Although there is a substantial trend to more convergence in European drug policy, the individual national legislations differ dramatically. Also, while many countries embrace the EU strategy on harm reduction and implement the necessary interventions, there is still much work to be done, especially regarding the newer member states in Eastern Europe. Some progress is already visible: statistics indicate that health expenditures per drug user have significantly increased since EU accession (IHRA, 2010a).

The trend to harm reduction is obvious, but dependent on long-term commitment to evidence-based practice, for which there is still no consistent appreciation even in Europe. While needle exchange programs and opioid substitution therapy are now generally accepted among most policy makers, drug consumption rooms and heroin-assisted treatment are still controversial subjects, although there is enough evidence to legitimize their implementation on a wider scale. The next few years will show whether the official EU briefings on drug policy will find their way into national laws and intervention programs, and create visible results in future statistics on the extent of the drug problem in Europe. It will also be interesting to observe the continuing development of Europe as a global player in drug policy questions; the global presentation of European drug demand reduction strategies and harm reduction programs is starting to carry more weight, but still not near as unified and strong as the American prohibitionist position.

However, there is also a lot of variety with regard to drug policy in the USA, where the diversity among individual state laws creates almost a similar impression as the European situation. The provision of harm reduction services in the US is also inconsistent and dependent on local policies, with the disadvantage of little support from federal legislation. Still, recent developments also signal a certain willingness to review the prohibitionist American position on drug policy, which might have considerable implications for the global state of drug control.

It is important to note that the comparison between European and American characteristics in relation to drug policy could be extended to include several other interesting aspects. This paper was more focused on health-related issues of drug use, but other areas like crime and especially imprisonment are also extremely relevant and have already attracted a lot of attention. The US has the highest incarceration rates of drug users globally (Jelsma, 2011), which is not only an expensive and thus little efficient strategy to reduce drug consumption, but also

poses tremendous challenges to an appropriate harm reduction response. HIV infection rates are even higher among prison populations, who often have easier access to drugs than to sterile needles (WHO, 2009b). Imprisonment for drug offenses in Europe is notably lower, with the EU encouraging "development of alternatives to imprisonment and of drug services in prisons in Member States" (European Commission, 2008: 8).

International drug policy is currently in an interesting state on the brink of potential revision and reform. "Over the last decade rapidly widening cracks have begun to split global drug control consensus." (Jelsma, 2011: 2). These are most likely the results of a long struggle against the negative impact of drug use on society, now facing the violent side-effects of a criminal black market for illicit drugs, an HIV epidemic among injecting drug users, overcrowded prisons, and other social costs in addition to the original drug problem, without the consolation that we are getting any closer to the aspired goal of a drug-free world. "Suffice it to say that, from an historical perspective, one anti-drug effort followed another, many claiming success with only a modicum of evidence for support. In outlining the main entrants over the past century, we are struck by the fact that the legislation, in many cases, does not appear to learn from the past – that a supply reduction philosophy is not sufficient to stem the tide." (Harrison, Backenheimer & Inciardi, 1995: 241).
Nonetheless, the group of advocates for changes to the existing system of drug control is growing and receives increasing support from high-ranking officials. The Global Commission on Drug Policy, an activist group promoting an informed, science-based discussion about drug-related harms and legislation, includes political figures like Kofi Annan (former Secretary General of the UN) and Javier Solana (former EU High Representative for the Common Foreign and Security Policy). The engagement of social and political actors as well as scientists, law enformcement and health professionals may help to spread "the recognition of the global drug problem as a set of interlinked health and social challenges to be managed, rather than a war to be won." (Global Commission, 2011: 4).

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