PART SIX

A European Outlook

Now what I contend is that my body is my own, at least I have always so regarded it. If I do harm through my experimenting with it, it is I who suffers, not the state.

Mark Twain
The *New York Times*
February 28, 1901

The existing variation in drug policy among EU countries constitutes a series of natural experiments that should be carefully studied. The results could tell us a great deal about what is likely to work under what conditions. At the very least, the evidence to date suggests the need for a full democratic discussion of the Dutch model and all other drug policy options.

Craig Reinarman
The drug policy debate in Europe:
The case of Califano vs. The Netherlands.
International Journal of Drug Policy (1997)

Drug Intelligence Brief: The Changing Face of European Drug Policy

Drug Enforcement Administration

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Drug policy in Western Europe has always been experimental, but, in recent years, several countries have joined the Netherlands and Switzerland in their pursuit of alternative methods for dealing with the drug epidemic. Many Western European nations are refocusing efforts on the social welfare aspect of drug use and reducing their focus on the law enforcement response, while imposing stricter penalties on those organizations that supply illegal drugs. Some of the alternative measures that are gaining momentum in Western Europe include legalization, decriminalization, and harm reduction.

The U.S. Drug Enforcement Administration (DEA) defines "legalization" as "making legal what is currently illegal." At present, drug use is not a criminal offense in Austria, Belgium, Germany, Ireland, and the United Kingdom with only minor exceptions.[1] While some nations have taken steps authorizing referendums on the issue of legalization, as Switzerland did in 1998, most have preferred to

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1. In Belgium private drug use is not an offense, unless it occurs within a group. In Ireland and the United Kingdom, drug use becomes an offense only in reference to prepared opium.

approach the drug legalization issue by focusing on decriminalization.

DEA defines “decriminalization” as “the removal of, or reduction in, criminal penalties for particular acts.” Decriminalization of drug use and/or possession is a policy that is widely supported in most of Western Europe. Many nations’ drug policies have been a policy of de facto decriminalization for many years, but it is only recently that governments are changing their legislation to officially reduce or remove criminal penalties for acts such as drug use and possession. In several Western European nations, possession of small quantities of drugs will no longer result in a prison sentence, but rather in administrative sanctions that could include a fine and/or confiscation of driver’s license or passport.

Harm reduction is another policy option finding increasing popularity in Europe. Harm reduction can take on many forms and, according to the DEA, “is often used to describe specific programs that attempt to diminish the potential harmful consequences associated with a particular behavior.” Some of those programs include needle exchange, substitution treatment, maintenance treatment, and injection rooms. The degree to which these programs are incorporated into society depends on the country in question, with many nations developing pilot programs in an attempt to ascertain the advantages of such programs.

DRUG POLICY

While there are many similarities between drug policies, there is currently no consistent policy or law throughout Europe. The variety of laws and policies in place at the national levels makes it difficult to create a uniform European drug policy for the European Union (EU).[2] The EU has served as more of a forum of discussion or

2. Current EU member nations are: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom.

exchange of ideas rather than a resource or guide for individual government policy.

All EU member nations are signatories of the 1961, 1971, and 1988 United Nations (U.N.) Conventions.[3] Additionally, non-EU member nations, such as Norway and Switzerland, incorporate the regulations set out in the U.N. Conventions. However, through decentralized drug policy, decriminalization, and harm reduction measures, many nations have been able to relax drug laws without directly violating the conventions.

TRENDS IN DRUG POLICY

Decriminalization

While there are a variety of drug laws and policies in Western Europe, several trends are noteworthy. The trend toward the decriminalization of drug use and possession has become an important force in Europe. Although some countries, such as Belgium, Greece, Luxembourg, and Switzerland, took steps to remove criminal penalties for cannabis possession in the past year, other countries, such as Portugal, decriminalized all drug use and possession for personal use.

The decriminalization of minor drug offenses has resulted in much international criticism from organizations such as the DEA and the United Nations International Narcotics Control Board. However, decriminalization is not as radical a concept in Europe as may appear at first glance. A common misconception is equating decriminalization to legalization. In the Netherlands, for instance, cannabis possession is not legal, only tolerated by Dutch authorities. Based upon

3. The 1961 U.N. Single Convention on Narcotic Drugs places international control on more than 116 narcotic drugs. The 1971 U.N. Convention on Psychotropic Substances was designed to create a universal control on psychotropic substances, or mood-altering synthetic substances. The 1988 U.N. Convention against Illicit Trafficking in Narcotics and Psychotropic Substances was designed to combat trafficking in illicit substances.

the concept of the separation of markets,[4] "coffeeshops" began to emerge throughout the Netherlands in 1976, offering cannabis products for sale. While possession and sale of cannabis are not legal, coffeeshops are permitted to exist under certain restrictions.[5]

In 2001, Belgium, Finland, Greece, Luxembourg, Portugal, and Switzerland drafted, proposed, or approved legislation for the decriminalization of minor drug use and possession offenses—in most cases, for cannabis. The United Kingdom debated reclassification of cannabis in 2001, to lower penalties for cannabis possession. That same year, the Lambeth and Brixton areas of South London implemented a pilot program decriminalizing minor cannabis possession. Several other countries including Austria, France, and Italy decriminalized minor drug use and possession in the past decade. Ireland was one of the first countries to decriminalize drug possession with the inception of the Misuse of Drugs Act in 1977, which decriminalized minor cannabis possession. While not all European countries have changed their laws to reduce or remove penalties for minor offenses, all have taken steps to offer a variety of treatment and harm reduction measures.

Treatment and Harm Reduction

The prevailing belief in Europe is that drug addiction is an illness, not a crime. European countries, including those that have not formally decreased criminal penalties for offenses, are searching for alternatives to prison. In many cases, addicts have an option for treatment instead of penalties. Even Sweden, which has some of the most strin-

4. Under the concept of the separation of markets, the Dutch government is attempting to separate the hard drug market from the soft drug market to prevent soft drug users from interacting with hard drugs.

5. Coffeeshop restrictions include a limit of no more than 5 grams sold to a person at any one time, no alcohol or hard drugs, no minors, no advertising, and the shop must not cause a nuisance.

gent policies against drugs, offers a suspension of sentence for minor drug offenses in return for treatment under a treatment contract.

Treatment options are no longer limited to detoxification or methadone reduction. Several European nations, including Switzerland, offer maintenance programs. While the ultimate goal of treatment is abstinence, maintenance treatment, like other harm reduction measures, is designed to regulate the drug use of those who are not willing to seek traditional forms of treatment. Maintenance programs can consist of methadone, morphine, heroin, or another opiate. Methadone maintenance is the most common, but several countries, including Germany, are experimenting with distributing heroin itself.

In the 1970s, Switzerland pioneered methadone treatment for opiate addicts. Today, treatment for opiate addiction has expanded to include morphine treatment and, in 1994, heroin distribution for addicts. While Swiss heroin distribution has received international criticism, the Swiss public supports the program and, in 1999, overwhelmingly supported the program in a national referendum.

The rapid spread of the HIV virus among intravenous drug users in the 1980s forced governments to look for measures that would reduce the harmful effects of drug use for those who refused treatment. A wide variety of harm reduction measures have developed throughout Europe. Some of the most common measures include needle-exchange programs and consumption rooms. Countries such as Germany and Switzerland have created extensive harm reduction programs to include social reintegration skills for the addict; however, even the more conservative country of Finland is beginning to experiment with harm reduction measures.

The increased focus on health issues related to drug use has resulted in a flurry of proposals and programs to increase harm reduction measures across Western Europe. All regions in Belgium are implementing drug hotlines and HIV and hepatitis prevention programs. Needle exchange programs are widely used in France. In

1991, the French government approved an experiment allowing for the testing of methylenedioxymethamphetamine (MDMA), commonly known as Ecstasy, and other synthetic drugs at "rave parties." In Luxembourg, substitution treatment, needle exchange, and consumption rooms now have a legal basis since the passage of the law of April 27, 2001.

Since 1958, Norwegian law has allowed treatment as an alternative to prison for those convicted of drug offenses and, in 1991, introduced compulsory treatment for offenders. In 1996, the Norwegian government went a step further to include compulsory treatment for pregnant drug or alcohol users. Under the new provisions, the unborn child's safety and health are placed above the abuser's freedom to choose whether to seek treatment. To reduce the potential harm to the unborn child, a user may be kept in treatment for the duration of the pregnancy without her consent, provided voluntary treatment is not an option.

In 1988, Swedish law changed to allow for compulsory treatment of addicts. Under this law and the Care of Young Persons Special Provisions Act of 1990, the court may order treatment in the case of adult and juvenile offenders. In 2001, Dutch legislation went into effect regulating the Penal Care Facility for Addicts, a compulsory treatment facility for repeat offenders. The facility is based upon research favoring mandatory confinement for treatment, when voluntary treatment has failed.

Greek law also allows for detained compulsory treatment for addicts, but, in practice, the facilities do not exist, so addicts remain in prison. The criminal justice system also seems to be reluctant to order mandatory treatment, so many of Greece's harm reduction methods remain underutilized.

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ALTERNATIVES FOR THOSE IN THE PENAL SYSTEM

Removing addicts from penal institutions is only part of the problem. Dealing with the addict population already inside penal institutions is another problem. Spain, among other European countries, has implemented many of the same treatment and harm reduction measures—inside penal institutions as well as outside—to combat the drug epidemic. Methadone treatment and needle exchange programs are now available inside the Spanish prison system to address the inmate addict population.

Attempting to address drug issues in all strata of society, the Swiss government is taking steps to combat drug addiction inside the prison system. According to the Swiss Federal Office of Public Health, approximately one quarter of those in prisons or jails inject drugs. Some prisons have established drug-free wings, where inmates are voluntarily segregated from the prison populace and refrain from drug use; other prisons have installed methadone treatment programs; and some are experimenting with medically supervised heroin use. For addicts who do not seek treatment, the prison system offers several harm reduction measures including needle exchange, materials to disinfect needles, and distribution of condoms.

A pilot program, similar to the program in Switzerland, is underway in Belgium's prison system. Under this program, "drug free" sections or wings are established in prisons to segregate non-users in an attempt to prevent an increase in users in the penal system. Harm reduction measures are also imposed in prison facilities throughout Italy, where inmates with substance abuse problems may apply for treatment in place of their prison sentence. This measure can be used for inmates to start or re-start treatment.

Other countries, such as Portugal, are only looking at the feasibility of implementing programs in the prison system. Currently, there are no harm reduction measures available in the Portuguese prison system. A review of the Spanish prison system, and the harm

reduction measures in place there, has forced the Portuguese government to review the possibility of implementing a needle exchange program within its prison system.

INCREASED PENALTIES FOR TRAFFICKING

While focusing on treating and reducing the harm to the addict population, European nations are also focusing effort and funds against the supply of illicit drugs, increasing penalties against those who traffic in illicit substances. In countries such as Austria, France, Greece, Luxembourg, and the United Kingdom, drug trafficking can result in sentences up to life imprisonment. Europeans, while relaxing penalties against addicts, are focusing their attention on the dismantlement of organized drug trafficking organizations.

Drug trafficking is a serious offense in Western Europe resulting in a wide range of penalties. Leaders of drug trafficking organizations in Austria could be sentenced to 10 to 20 years in prison, but with the implementation of new legislation in 2001, they will now face the possibility of life imprisonment. In Luxembourg, if a trafficker supplies drugs to minors, the law allows for penalties up to lifelong forced labor, and in Norway, the most serious drug offenses are classified as those having "very aggravating circumstances." This categorization is usually reserved for the leaders of large international trafficking organizations; it contains a penalty (equivalent to murder) of up to 21 years in prison.

Over the past decade, the United Kingdom has continued to increase penalties for drug trafficking. In 1995, the 1994 Drug Trafficking Act was implemented and replaced the Drug Trafficking Offenses Act of 1986. While this Act applies only to England and Wales, Scotland and Northern Ireland have similar laws.[6] Under the

6. Similar regulations are contained in Scotland's Proceeds of Crime Act 1995, the Criminal Law (Consolidation) Scotland Act 1995, and Northern Ireland's Proceeds of Crime Order 1996.

Maximum Trafficking Penalties[a]

Country	*Penalty*	*Country*	*Penalty*
Austria	Life	Luxembourg	Lifelong forced labor
Belgium	20 years		
Denmark	10 years	Netherlands	16 years
Finland	10 years	Norway	21 years
France	Life	Portugal	25 years
Germany	15 years	Spain	23 years
Greece	Life	Sweden	18 years
Ireland	Life	Switzerland	20 years
Italy	20 years	United Kingdom	Life

[a]The maximum penalties may not be applicable in all cases. In many cases, the maximum penalty applies to extenuating circumstances, such as the death of a user.

Drug Trafficking Act, the court assumes that all current assets, including any owned by the offender during the previous 6 years, are the result of trafficking offenses. Unless the offender can prove otherwise, the court may seize these assets. The penal procedure (summary judgment or indictment) and the drug classification determine the trafficking penalties in the United Kingdom. The 1971 Misuse of Drugs Act divides controlled substances into three classes, A, B, and C.[7] Class A drug trafficking is punishable by up to life imprisonment and, in 2000, the Powers of the Criminal Courts Act established a minimum 7-year sentence for a third conviction of Class A drug trafficking. In 2001, the Criminal Justice and Police Act enabled the courts to strengthen controls on convicted traffickers. Through this act, the court can place a ban on all overseas travel of a convicted trafficker for up to 4 years, in an attempt to reduce his opportunity to re-engage in trafficking activities.

7. Under the Misuse of Drugs Act, substances are divided into 3 classes, A, B, and C. Class A substances are those considered to be the most dangerous, including opiates, cocaine, Ecstasy, and LSD. Class B substances are considered to be less dangerous and include cannabis, sedatives, less potent opiates, and synthetic stimulants. Class C substances are the least regulated and include tranquilizers and some less potent stimulants.

France has also consistently increased penalties for drug trafficking offenses. A 1986 law distinguished between penalties for trafficking and low-level drug dealing or selling, and a 1987 law increased the penalties for those who sell drugs to minors. This law expanded the focus of those prosecutable for drug trafficking offenses to include those who launder drug money. In 1994, the new Penal Code imposed the possibility of life in prison for leaders of organized drug trafficking organizations and up to 30 years for other members of the organization. The French government continued to expand its attack on drug trafficking with the imposition of a 1996 law that allows the boarding and inspection of vessels on the high seas that are believed to be involved in drug trafficking.

CONCLUSION

In several European countries, including Germany, Switzerland, and the United Kingdom, drug policy is implemented at the regional level, resulting in a diverse system throughout the country. Many of these alternative policies are relatively new and require more time to evaluate their effectiveness.

Nevertheless, the trend throughout Europe continues to be a relaxation of criminal penalties for minor drug offenses and an increase in penalties for trafficking, while improving treatment and harm reduction. According to Dutch authorities, harm reduction measures have resulted in significantly lowering their HIV infection rate and drug-related death rate. Unless time shows that these alternative policies have failed, Europe will continue to look toward decriminalization, harm reduction, treatment, and increased trafficking penalties to combat its current drug problems.

Recent Increases in Trafficking Penalties

Country	*Year*	*Penalty*
Austria	2001	Penalty increased to life in prison
Finland	1998	Those aware of an aggravated narcotics offense, but who do not alert authorities are punishable by up to 10 years[a]
France	1994	Penalties for leaders of organizations increased up to life
Greece	1993 & 1997	’93: Increased penalties for trafficking and penalized trafficking in precursors ’97: Penalties increased up to life for recidivist trafficker and dealing to minors[b]
Ireland	1996 & 1999	’96: Allows a person suspected of trafficking to be detained for a maximum of 7 days ’99: Increased the penalty for trafficking in quantities worth more than 10,000 Irish pounds to life and an unlimited fine[c]
Switzerland	1995	Introduced a tougher law aimed at foreign drug traffickers, allowing the detention of illegal residents for up to 9 months
United Kingdom	2000 & 2001	’00: Established a minimum 7-year sentence for a third conviction of Class A drug trafficking ’01: Allows the government to ban all overseas travel for convicted traffickers for up to 4 years

[a]An aggravated narcotics offense is one that involves a “very dangerous” substance or large quantities of it; considerable financial profit; the offender acts as a member of an organized drug trafficking group; serious danger is caused to the life or health of several people; or narcotics distributed to minors.

[b]In 1999, Greece made a slight switch, offering leniency to addicts who traffic to support their habit.

[c]Also introduced a minimum mandatory sentence of 10 years for such a trafficking offense. According to the United States Department of State’s INCSR 2001, during the first half of 2000, 6 cases fell under the purview of the 1999 Act and in not one case was the mandatory minimum sentence imposed.

Europe's More Liberal Drug Policies Are Not the Right Model for America

Drug Enforcement Administration

This selection was excerpted from "Speaking Out Against Drug Legalization," U.S. Department of Justice, Drug Enforcement Administration (March 2003).

Over the past decade, European drug policy has gone through some dramatic changes toward greater liberalization. The Netherlands, considered to have led the way in the liberalization of drug policy, is only one of a number of West European countries to relax penalties for marijuana possession. Now several European nations are looking to relax penalties on all drugs—including cocaine and heroin—as Portugal did in July 2001, when minor possession of all drugs was decriminalized.

There is no uniform drug policy in Europe. Some countries have liberalized their laws, while others have instituted strict drug control policies. Which means that the so-called "European Model" is a misnomer. Like America, the various countries of Europe are looking for new ways to combat the worldwide problem of drug abuse.

The Netherlands has led Europe in the liberalization of drug policy. "Coffee shops" began to emerge throughout the Netherlands in 1976, offering marijuana products for sale. Possession and sale of marijuana are not legal, but coffee shops are permitted to operate and sell marijuana under certain restrictions, including a limit of no more than 5 grams sold to a person at any one time, no alcohol or hard drugs, no minors, and no advertising. In the Netherlands, it is illegal to sell or possess marijuana products. So coffee shop operators must

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purchase their marijuana products from illegal drug trafficking organizations.

Apparently, there has been some public dissatisfaction with the government's policy. Recently the Dutch government began considering scaling back the quantity of marijuana available in coffee shops from 5 to 3 grams.

Furthermore, drug abuse has increased in the Netherlands. From 1984 to 1996, marijuana use among 18–25 year olds in Holland increased two-fold. Since legalization of marijuana, heroin addiction levels in Holland have tripled and perhaps even quadrupled by some estimates.

The increasing use of marijuana is responsible for more than increased crime. It has widespread social implications as well. The head of Holland's best-known drug abuse rehabilitation center has described what the new drug culture has created: The strong form of marijuana that most of the young people smoke, he says, produces "a chronically passive individual—someone who is lazy, who doesn't want to take initiatives, doesn't want to be active—the kid who'd prefer to lie in bed with a joint in the morning rather than getting up and doing something."

Marijuana is not the only illegal drug to find a home in the Netherlands. The club drug commonly referred to as Ecstasy (methylenedioxymethamphetamine or MDMA) also has strong roots in the Netherlands. The majority of the world's Ecstasy is produced in clandestine laboratories in the Netherlands and, to a lesser extent, Belgium.

The growing Ecstasy problem in Europe, and the Netherlands' pivotal role in Ecstasy production, has led the Dutch government to look once again to law enforcement. In May 2001, the government announced a "Five-Year Offensive against the Production, Trade, and Consumption of Synthetic Drugs." The offensive focuses on more cooperation among the enforcement agencies with the Unit Synthetic Drugs playing a pivotal role.

Recognizing that the government needs to take firm action to deal with the increasing levels of addiction, in April 2001 the Dutch government established the Penal Care Facility for Addicts. Like American drug treatment courts, this facility is designed to detain and treat addicts (of any drug) who repeatedly commit crimes and have failed voluntary treatment facilities. Offenders may be held in this facility for up to two years, during which time they will go through a three-phase program. The first phase focuses on detoxification, while the second and third phases focus on training for social reintegration.

The United Kingdom has also experimented with the relaxation of drug laws. Until the mid-1960s, British physicians were allowed to prescribe heroin to certain classes of addicts. According to political scientist James Q. Wilson, "a youthful drug culture emerged with a demand for drugs far different from that of the older addicts." Many addicts chose to boycott the program and continued to get their heroin from illicit drug distributors. The British government's experiment with controlled heroin distribution, says Wilson, resulted in, at a minimum, a 30-fold increase in the number of addicts in ten years.

Switzerland has some of the most liberal drug policies in Europe. In the late 1980s, Zurich experimented with what became known as Needle Park, where addicts could openly purchase drugs and inject heroin without police intervention. Zurich became the hub for drug addicts across Europe, until the experiment was ended, and "Needle Park" was shut down.

Many proponents of drug legalization or decriminalization claim that drug use will be reduced if drugs are legalized. However, history has not shown this assertion to be true. According to an October 2000 CNN report, marijuana, the illegal drug most often decriminalized, is "continuing to spread in the European Union, with one in five people across the 15-state bloc having tried it at least once."

It's not just marijuana use that is increasing in Europe. According to the *2001 Annual Report on the State of the Drugs Problem in the*

European Union, there is a Europe-wide increase in cocaine use. The report also cites a new trend of mixing "base/crack" cocaine with tobacco in a joint at nightspots. With the increase in use, Europe is also seeing an increase in the number of drug users seeking treatment for cocaine use.

Drug policy also has an impact on general crime. In a 2001 study, the British Home Office found violent crime and property crime increased in the late 1990s in every wealthy country except the United States.

Not all of Europe has been swept up in the trend to liberalize drug laws. Sweden, Finland, and Greece have the strictest policies against drugs in Europe. Sweden's zero-tolerance policy is widely supported within the country and among the various political parties. Drug use is relatively low in the Scandinavian countries.

In April 1994, a number of European cities signed a resolution titled "European Cities Against Drugs," commonly known as the Stockholm resolution. It states: "The demands to legalize illicit drugs should be seen against the background of current problems, which have led to a feeling of helplessness. For many, the only way to cope is to try to administer the current situation. But the answer does not lie in making harmful drugs more accessible, cheaper, and socially acceptable. Attempts to do this have not proved successful. By making them legal, society will signal that it has resigned to the acceptance of drug abuse. The signatories to this resolution therefore want to make their position clear by rejecting the proposals to legalize illicit drugs."

Snapshot

Does Europe Do It Better?

Robert J. MacCoun and Peter Reuter

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Listen to a debate among drug policy advocates and you're likely to hear impassioned claims about the brilliant success (or dismal failure) of more "liberal" approaches in certain European countries. Frequently, however, such claims are based on false assumptions. For example, we are told that marijuana has been legalized in the Netherlands. Or that addicts receive heroin by prescription in Great Britain.

Pruned of erroneous or excessive claims, the experience in Europe points to both the feasibility of successful reform of U.S. drug laws and the drawbacks of radical change. What follows are descriptions of some innovative approaches being tried over there, with judgments of their applicability over here. They fall into three broad categories: eliminating user sanctions (decriminalization), allowing commercial sales (legalization) and medical provision of heroin to addicts (maintenance).

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DECRIMINALIZING MARIJUANA: THE CASE OF THE DUTCH COFFEE SHOPS

Dutch cannabis policy and its effects are routinely mischaracterized by both sides in the U.S. drug debate. Much of the confusion hinges on a failure to distinguish between two very different eras in Dutch policy. In compliance with international treaty obligations, Dutch law states unequivocally that cannabis is illegal. Yet in 1976 the Dutch adopted a formal written policy of nonenforcement for violations involving possession or sale of up to thirty grams (five grams since 1995) of cannabis—a sizable quantity, since one gram is sufficient for two joints. Police and prosecutors were forbidden to act against users, and officials adopted a set of rules that effectively allowed the technically illicit sale of small amounts in licensed coffee shops and nightclubs. The Dutch implemented this system to avoid excessive punishment of casual users and to weaken the link between the soft and hard drug markets; the coffee shops would allow marijuana users to avoid street dealers, who may also traffic in other drugs. Despite some recent tightenings in response to domestic and international pressure (particularly from the hard-line French), the Dutch have shown little intention of abandoning their course.

In the initial decriminalization phase, which lasted from the mid-seventies to the mid-eighties, marijuana was not very accessible, sold in a few out-of-the-way places. Surveys show no increase in the number of Dutch marijuana smokers from 1976 to about 1984. Likewise, in the United States during the seventies, twelve U.S. states removed criminal penalties for possession of small amounts of marijuana, and studies indicate that this change had at most a very limited effect on the number of users. More recent evidence from South Australia suggests the same.

From the mid-eighties Dutch policy evolved from the simple decriminalization of cannabis to the active commercialization of it. Between 1980 and 1988, the number of coffee shops selling cannabis

in Amsterdam increased tenfold; the shops spread to more prominent and accessible locations in the central city and began to promote the drug more openly. Today, somewhere between 1,200 and 1,500 coffee shops (about one per 12,000 inhabitants) sell cannabis products in the Netherlands; much of their business involves tourists. Coffee shops account for perhaps a third of all cannabis purchases among minors and supply most of the adult market.

As commercial access and promotion increased in the eighties, the Netherlands saw rapid growth in the number of cannabis users, an increase not mirrored in other nations. Whereas in 1984 15 percent of 18- to 20-year-olds reported having used marijuana at some point in their life, the figure had more than doubled to 33 percent in 1992, essentially identical to the U.S. figure. That increase might have been coincidental, but it is certainly consistent with other evidence (from alcohol, tobacco and legal gambling markets) that commercial promotion of such activities increases consumption. Since 1992 the Dutch figure has continued to rise, but that growth is paralleled in the United States and most other rich Western nations despite very different drug policies—apparently the result of shifts in global youth culture.

The rise in marijuana use has not led to a worsening of the Dutch heroin problem. Although the Netherlands had an epidemic of heroin use in the early seventies, there has been little growth in the addict population since 1976; indeed, the heroin problem is now largely one of managing the health problems of aging (but still criminally active) addicts. Cocaine use is not particularly high by European standards, and a smaller fraction of marijuana users go on to use cocaine or heroin in the Netherlands than in the United States. Even cannabis commercialization does not seem to increase other drug problems.

TREATING HEROIN ADDICTS IN BRITAIN

The British experience in allowing doctors to prescribe heroin for maintenance has been criticized for more than two decades in the United States. In a 1926 British report, the blue-ribbon Rolleston Committee concluded that "morphine and heroin addiction must be regarded as a manifestation of disease and not as a mere form of vicious indulgence," and hence that "the indefinitely prolonged administration of morphine and heroin" might be necessary for such patients. This perspective—already quite distinct from U.S. views in the twenties—led Britain to adopt, or at least formalize, a system in which physicians could prescribe heroin to addicted patients for maintenance purposes. With a small population of several hundred patients, most of whom became addicted while under medical treatment, the system muddled along for four decades with few problems. Then, in the early sixties, a handful of physicians began to prescribe irresponsibly and a few heroin users began taking the drug purely for recreational purposes, recruiting others like themselves. What followed was a sharp relative increase in heroin addiction in the mid-sixties, though the problem remained small in absolute numbers (about 1,500 known addicts in 1967).

In response to the increase, the Dangerous Drugs Act of 1967 greatly curtailed access to heroin maintenance, limiting long-term prescriptions to a small number of specially licensed drug-treatment specialists. At the same time, oral methadone became available as an alternative maintenance drug. By 1975, just 12 percent of maintained opiate addicts were receiving heroin; today, fewer than 1 percent of maintenance clients receive heroin. Specialists are still allowed to maintain their addicted patients on heroin if they wish; most choose not to do so—in part because the government reimbursement for heroin maintenance is low, but also because of a widespread reluctance to take on a role that is difficult to reconcile with traditional norms of medical practice. Thus, one can hardly claim that heroin

maintenance was a failure in Britain. When it was the primary mode of treatment, the heroin problem was small. The problem grew larger even as there was a sharp decline in heroin maintenance, for many reasons unrelated to the policy.

"HEROIN-ASSISTED TREATMENT": THE SWISS EXPERIENCE

What the British dropped, the Swiss took up. Although less widely known, the Swiss experience is in fact more informative. By the mid-eighties it was clear that Switzerland had a major heroin problem, compounded by a very high rate of HIV infection. A generally tough policy, with arrest rates approaching those in the United States, was seen as a failure. The first response was from Zurich, which opened a "zone of tolerance" for addicts at the so-called "Needle Park" (the Platzspitz) in 1987. This area, in which police permitted the open buying and selling of small quantities of drugs, attracted many users and sellers, and was regarded by the citizens of Zurich as unsightly and embarrassing. The Platzspitz was closed in 1992.

Then in January 1994 Swiss authorities opened the first heroin maintenance clinics, part of a three-year national trial of heroin maintenance as a supplement to the large methadone maintenance program that had been operating for more than a decade. The motivation for these trials was complex. They were an obvious next step in combating AIDS, but they also represented an effort to reduce the unsightliness of the drug scene and to forestall a strong legalization movement. The program worked as follows: Each addict could choose the amount he or she wanted and inject it in the clinic under the care of a nurse up to three times a day, seven days a week. The drug could not be taken out of the clinic. Sixteen small clinics were scattered around the country, including one in a prison. Patients had to be over 18, have injected heroin for two years and have failed at least two treatment episodes. In fact, most of them had more than

ten years of heroin addiction and many treatment failures. They were among the most troubled heroin addicts with the most chaotic lives.

By the end of the trials, more than 800 patients had received heroin on a regular basis without any leakage into the illicit market. No overdoses were reported among participants while they stayed in the program. A large majority of participants had maintained the regime of daily attendance at the clinic; 69 percent were in treatment eighteen months after admission. This was a high rate relative to those found in methadone programs. About half of the "dropouts" switched to other forms of treatment, some choosing methadone and others abstinence-based therapies. The crime rate among all patients dropped over the course of treatment, use of nonprescribed heroin dipped sharply and unemployment fell from 44 to 20 percent. Cocaine use remained high. The prospect of free, easily obtainable heroin would seem to be wondrously attractive to addicts who spend much of their days hustling for a fix, but initially the trial program had trouble recruiting patients. Some addicts saw it as a recourse for losers who were unable to make their own way on the street. For some participants the discovery that a ready supply of heroin did not make life wonderful led to a new interest in sobriety.

Critics, such as an independent review panel of the World Health Organization (also based in Switzerland), reasonably asked whether the claimed success was a result of the heroin or the many additional services provided to trial participants. And the evaluation relied primarily on the patients' own reports, with few objective measures. Nevertheless, despite the methodological weaknesses, the results of the Swiss trials provide evidence of the feasibility and effectiveness of this approach. In late 1997 the Swiss government approved a large-scale expansion of the program, potentially accommodating 15 percent of the nation's estimated 30,000 heroin addicts.

Americans are loath to learn from other nations. This is but another symptom of "American exceptionalism." Yet European drug-policy experiences have a lot to offer. The Dutch experience with

decriminalization provides support for those who want to lift U.S. criminal penalties for marijuana possession. It is hard to identify differences between the United States and the Netherlands that would make marijuana decriminalization more dangerous here than there. Because the Dutch went further with decriminalization than the few states in this country that tried it—lifting even civil penalties—the burden is on U.S. drug hawks to show what this nation could possibly gain from continuing a policy that results in 700,000 marijuana arrests annually. Marijuana is not harmless, but surely it is less damaging than arrest and a possible jail sentence; claims that reduced penalties would "send the wrong message" ring hollow if in fact levels of pot use are unlikely to escalate and use of cocaine and heroin are unaffected.

The Swiss heroin trials are perhaps even more important. American heroin addicts, even though most are over 35, continue to be the source of much crime and disease. A lot would be gained if heroin maintenance would lead, say, the 10 percent who cause the most harm to more stable and socially integrated lives. Swiss addicts may be different from those in the United States, and the trials there are not enough of a basis for implementing heroin maintenance here. But the Swiss experience does provide grounds for thinking about similar tests in the United States.

Much is dysfunctional about other social policies in this country, compared with Europe—the schools are unequal, the rate of violent crime is high and many people are deprived of adequate access to health services. But we are quick to draw broad conclusions from apparent failures of social programs in Europe (for example, that the cost of an elaborate social safety net is prohibitive), while we are all too ready to attribute their successes to some characteristic of their population or traditions that we could not achieve or would not want—a homogeneous population, more conformity, more intrusive government and the like. It's time we rose above such provincialism.

The benefits of Europe's drug policy innovations are by no means decisively demonstrated, not for Europe and surely not for the United States. But the results thus far show the plausibility of a wide range of variations—both inside and at the edges of a prohibition framework—that merit more serious consideration in this country.