# IN SUPPORT OF THE UN DRUG CONVENTIONS:

## THE ARGUMENTS AGAINST

## ILLICIT DRUG LEGALIZATION AND HARM REDUCTION

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## PREFACE

This paper was written to examine several drug legalization and non-abstinence based harm reduction arguments as they pertain to the UN international drug control Conventions. The Conventions are the Single Convention on Narcotic Drugs, 1961; the Convention on Psychotropic Substances of 1971; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 (hereinafter "the Conventions").

The UN system of drug control includes the Office of Drugs and Crime, the International Narcotics Control Board, and the Commission on Narcotic Drugs. The work of these bodies are positive and essential in international drug demand and supply reduction.

There was a need for a thorough review of international drug prevention policies in order to determine the effectiveness of the Conventions and if they needed to be strengthened instead of weakened. As a result of this review it is clear that the Conventions, and the positions of the International Narcotics Control Board INCB interpreting the Conventions, are proper and necessary.

### The United Nations Office on Drugs and Crime (UNODC)

UNODC is a global leader in the fight against illicit drugs and international crime. Established in 1997, UNODC operates in all regions of the world through an extensive network of field offices. UNODC is mandated to assist Member States in their struggle against illicit drugs, crime and terrorism. The three pillars of the UNODC work programme are:

1. Field-based technical cooperation projects to enhance the capacity of Member States to counteract illicit drugs, crime and terrorism;

2. Research and analytical work to increase knowledge and understanding of drugs and crime issues and expand the evidence-base for policy and operational decisions; and

3. Normative work to assist States in the ratification and implementation of the international treaties, the development of domestic legislation on drugs, crime and terrorism, and the provision of secretariat and substantive services to the treaty-based and governing bodies. [EN1]

### The Commission on Narcotic Drugs (CND)

The UN Economic and Social Council established the Commission on Narcotic Drugs in 1946 as the central policy-making body of the United Nations in drug related matters. The Commission enables Member States to analyze the global drug situation, provide follow-up to the twentieth special session of the General Assembly on the world drug problem and to take measures at the global level within its scope of action. It also monitors the implementation of the Conventions

and is empowered to consider all matters pertaining to the aim of the conventions, including the scheduling of substances to be brought under international control. [EN2]

**The International Narcotic Control Board (INCB)**

This paper will focus on the positions of International Narcotic Control Board because they have a very special position among these bodies. They interpret the Conventions and act in a quasi-judicial capacity in enforcing the Conventions. Their interpretations govern how the UN approaches enforcement of the Conventions.

**Approach of this paper**

First, this paper will provide the arguments in favor of legalization and non-abstinence based harm reduction and then the INCB position in opposition and then a factual response in support of the INCB position. This paper will argue that we should not go down the road of legalization/harm reduction but instead keep on the right track of a restrictive drug control policy.
In September 2008, the World Forum Against Drugs (WFAD) was held in Stockholm. The slogan of WFAD was "One hundred years of drug prevention - how do we move forward?" The first edition of this paper was distributed to each participant. This paper was requested by a group of NGOs that arranged the World Forum Against Drugs. The WFAD came out with a position statement against drug legalization (attached).

We hope this paper will be helpful in understanding the international drug control system and will provide arguments the readers can use in their own countries in the debate about drug policy.

## BACKGROUND AND THE NEAR FUTURE

In 2009, there will be a high level meeting of the UN Commission on Narcotic Drugs (CND) as a follow-up to the United Nations General Assembly Special Session (UNGASS) on drugs held in New York in 1998. The 2009 CND meeting will evaluate what has happened during the last ten years regarding the UN international drug control Conventions. The INCB will also be dealing with these issues.

Prior to the CND meeting there will be a strong effort by some non-governmental organizations (NGOs) to weaken the Conventions and the INCB. They will argue that the Conventions need to be changed or “reinterpreted” in order to pave the way for legalization of drugs and their version of “harm reduction.” The legalizers’ version is non-abstinence based “harm reduction” that accepts drug use and seeks to minimize the harmful effects of drug use yet allows drug users to continue to use drugs. They claim that not all illicit drug use is harmful and that people should be able to use drugs. They think that treatment should not always be aimed at helping drug users to become drug free. They claim that the Conventions need to be “modernized” and that the Conventions are “out of touch with reality.” However, it is the legalizers’ version of harm reduction that is out of touch with reality. True harm reduction is preventing drug use and helping drug users into treatment aimed at helping them to be drug free.

The legalizers will also continue their attacks on the INCB who they see as an obstacle to their plans because the INCB opposes drug legalization and non-abstinence based harm reduction.

The legalization advocates will argue for:

1. legalizing drugs (lowering or ending penalties for drug possession and use - particularly marijuana);

2. so called “medical” marijuana;

3. non-abstinence based harm reduction programmes such as: needle exchange, “safe” injection sites, heroin distribution to addicts, and testing of ecstacy tablets (to make sure they are “safe” before use);

4. industrial hemp;

5. including drug users as equal partners in making policy;

6. greater “human rights” protection for drug users.

References

The English words are sometimes spelled here as they are spelled in the UK and not the US. For example, the word programme will be used instead of program. Offence will be used instead of offense, etc.

[EN1] http://www.unodc.org/unodc/en/about-unodc/index.html

[EN2] http://www.unodc.org/unodc/en/commissions/CND/index.html

## THE FUNCTIONS OF THE INTERNATIONAL NARCOTICS CONTROL BOARD (INCB)

The INCB is the independent and quasi-judicial monitoring body for the implementation of the Conventions. It was established in 1968 in accordance with the Single Convention on Narcotic Drugs of 1961. It had predecessors under the former drug control treaties of the League of Nations. The INCB are the guardians of the Conventions and they are being attacked because of it.

The functions of INCB are laid down in the Conventions. [FN1] The INCB interprets the Conventions and acts in a quasi-judicial capacity to enforce the Conventions. Their interpretation of the Conventions govern how the UN approaches enforcement of the Conventions and how the member states act within the Conventions. The INCB is responsible for reviewing whether measures taken in a country are in line with the Conventions.

The Board has, over a period of many years, expressed its views on the compatibility of such measures with the Conventions. This paper will discuss how they have interpreted the Conventions and if their interpretations are correct.

References

[FN1] INCB Mandates and Functions, for all eleven functions see: http://www.incb.org

## TYPES OF DRUG LEGALIZATION

The term “legalization” can have any one of the following meanings:

1. **Total Legalization** - All illicit drugs such as heroin, cocaine, methamphetamine and marijuana would be legal and treated as commercial products. No government regulation would be required to oversee production, marketing, or distribution.

2. **Regulated Legalization** - The production and distribution of drugs would be government regulated with limits on amounts that can be purchased and the age of purchasers. There will no criminal or civil sanction for possessing, manufacturing, or distributing drugs unless these actions violated the regulatory system. Drug sales can be taxed.

3. **Decriminalization** - Decriminalization eliminates criminal sanctions for drug use and provides civil sanctions for possession of drugs.

## THE INCB STATEMENT ON DRUG LEGALIZATION

The INCB issued a position on legalization of drugs that first states the argument of the legalizers and then provides a response. The INCB position was obtained from their annual reports on their website - http://www.incb.org. Each paragraph in the annual report is numbered. The year of the annual report is at the end of each of the below quotes from the INCB.

The view of the INCB on the question of legalization of the non-medical use of drugs was expressed in their Report from 1992.

16. Turning to the main arguments put forward by those in favor of legalization, examination of just three of those arguments will serve to illustrate some of the concerns of the Board. Advocates of legalization suggest that:

(a) legalization is justified, since law enforcement has failed to control illicit supply or to reduce illicit demand. This argument, however, ignores the fact that legal sanctions have helped to deter or delay potential abusers, thereby limiting the growth of the illicit market;

(b) given current levels of access to illicit drugs, legalization would only have a minimum adverse impact on current drug abuse levels and would thus generate few additional health, safety or behavioral problems. This argument, however, ignores the potential expansion of demand by individuals and society, particularly among young people, which could follow the removal of legal barriers, the freeing of entrepreneurial initiative and the lowering of market prices. It also ignores the possibility that there may be a substantial increase in economic and social costs, particularly to health-care systems (given the

global experience with alcohol and tobacco abuse). This may include a sharp increase in costs resulting from accident-related injuries and other health-related problems;

( c) Legalization would remove evils created by drug laws, such as corruption, violence and drug-related crime, which are worse than the drugs themselves. This argument assumes that drug-related black markets and corruption would significantly decline, but surely no community would accept making available, without any restriction, all drugs of abuse to all existing and potential abusers (including children) at sufficiently low prices. Even if one assumes that crime to support personal drug abuse may decline, crime committed under the influence of drugs, as well as chronic violence in the family and in the community, may increase. The assumption that organized criminal activity and related violence would significantly decrease may underestimate the capacity of organized crime to adjust to changing conditions without significant loss of economic, political or social power.

19. It appears that the basic aim of the advocates of legalization is to allow the recreational use of narcotic drugs and/or psychotropic substances. It must be noted that such a step would create a legal demand for those drugs and, consequently, the current restrictions in respect of supply (cultivation, production, manufacture, trade and distribution) would need to be abolished or fundamentally changed. History offers a good example of the consequences of such a change. The result would be similar to the situation of China in the nineteenth century, when, after the Opium War, the country was forced to accept the free availability of opium. Following that action, the number of opium addicts in the country increased drastically to an estimated 20 million.

20. The availability of narcotic drugs and psychotropic substances is limited not only by the provisions of the international drug control treaties but by national pharmaceutical laws and regulations. The majority of narcotic drugs and psychotropic substances are pharmaceuticals that are currently subject to twofold regulations: restrictions designed to prevent drug abuse; and prescribing and dispensing limitations designed to prevent health injuries and to promote compliance with good clinical practice. Without removing public health regulations, it would be impossible to ensure the availability of opiates, stimulants (cocaine or amphetamines), barbiturates, benzodiazepines etc. for recreational purposes.

21. It can be assumed that advocates of the legalization of some narcotic drugs and/or psychotropic substances do not intend to ruin the pharmaceutical regulatory system, but the maintenance of this system with the simultaneous legalization of, say, heroin or cocaine, would create an absurd situation: restrictions would apply to less addictive or non-addictive pharmaceuticals, but not to members of the same pharmacological categories having greater abuse potential and dependence producing properties.

22. Most of the debates on legalization of the non-medical (i.e. recreational) use of drugs are at present centered on cannabis. Since the adoption of the 1961 Convention, very potent new products like cannabis oil or hashish oil (e.g. cannabis concentrate) have appeared on the illicit markets and new technologies have been applied to increase the THC content of cultivated cannabis plants. In this context, the Board would like to draw the attention of industrialized countries to the fact that in 1961 they initiated the introduction of the international control of cannabis at a period when serious cannabis abuse problems did not exist in their countries. Countries in which cannabis consumption was traditional implemented the provisions of the 1961 Convention. If cannabis were to be legalized, the responsibility of industrialized countries would be enormous: they would be obliged to justify, at the same time, their 1961 decision to prohibit cannabis and their new decision to add cannabis to other legalized substances like alcohol and tobacco.

23. The arguments put forward by advocates of legalization, although well-intended, can appear to be logical and simple when they are not; they do not withstand critical evaluation and they tend to run contrary to general experience. The proposals in favor of legalization have tended to present possible

legalization benefits against the costs of maintaining existing legal controls, without adequately addressing themselves to either the benefits of those controls or the social and economic costs of removing them. As the Board sees it, legalization advocates have not yet presented a sufficiently comprehensive, coherent or viable alternative to the present system of international drug abuse control. The Board firmly believes that permitting the recreational use of drugs would have a substantial and irreversible adverse impact on public health, social well-being and the international drug control system. INCB Report 1992

### Marijuana

The legalization argument is primarily driven by those who want to legalize marijuana. The INCB notes that:

22. Most of the debates on legalization of the non-medical (i.e. recreational) use of drugs are at present centered on cannabis. INCB Report 1992

## LEGALIZATION WILL INCREASE DRUG USE AND DRUG ADDICTION

The advocates of drug legalization claim that legalizing drugs would decrease addiction rates in two ways (1) People (particularly young people) use drugs because they are illegal and the users get a thrill from breaking a social taboo. Legalization will remove this incentive. (2) If drugs were legalized, civil society could spend the money that we presently spend on the criminal justice system on treatment of addicts and that would reduce addiction. [FN1]

This argument does not work when we consider that drugs such as cocaine, heroin, and marijuana are dangerous and highly addictive. The scholarly opinion and historical evidence are clear that if these drugs are legalized, then the rates of drug use and addiction will climb. This will lead to misery, death, social disorder and massive spending. [FN2]

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## WE CANNOT LEGALIZE MARIJUANA BECAUSE ITS USE HAS DESTRUCTIVE HEALTH AND SOCIAL CONSEQUENCES.

Most of the arguments in favor of drug legalization focus on marijuana. However, marijuana is far more powerful today than it was years ago and it serves as an entry point for the use of other illegal drugs. This is known as the "gateway effect." Despite arguments from the drug culture to the contrary, marijuana is addictive. This addiction has been well described in the scientific literature and it consists of both a physical dependence (tolerance and subsequent withdrawal) and a psychological habituation. [FN1]

According to a US report released in June of 2008, the levels of THC - the psychoactive ingredient in marijuana - have reached the highest ever amounts since scientific analysis of the drug began in the late 1970s. The average amount of THC has now reached average levels of 9.6 percent (the highest level in one of the samples was 37.2 percent). This compares to the average of just under 4 percent reported in 1983. Additionally, higher potency marijuana may be contributing to a substantial increase in the number of American teenagers in treatment for marijuana dependence. According to the U.S. 2006 National Survey on Drug Use and Health (NSDUH), among Americans age 12 and older there are 14.8 million current (past-month; 6.0 percent) users of marijuana and 4.2 million Americans (1.7 percent) classified with dependency or abuse of marijuana. Additionally, the latest information from the U.S. Treatment Episode Data Set (TEDS, 2006), reports that 16.1% of drug treatment admissions were for marijuana as the primary drug of abuse. This compares to 6% in 1992. A similar trend is taking place in the Netherlands, where new data indicate that the number of people seeking assistance for cannabis there has risen, from 1,951 in 1994 to 6,544 in 2006 - a 235 percent increase. [FN2] In 2006, the average THC concentration in Dutch marihuana was 16% which is even higher than that in the US. [FN3]
Marijuana is an addictive drug. It poses significant health consequences to its users, including those who may be using it for "medical" purposes. In the U.S., marijuana is the number one drug that young people are in treatment for. [FN4]

The use of marijuana in early adolescence is particularly dangerous. Adults who used marijuana early were five times more likely to become dependent on any drug and eight times more likely to use cocaine and fifteen times more likely to use heroin later in life." [FN5]

### The damage to health caused by marijuana

Drug legalization advocates claim that marijuana is less dangerous than drugs like cocaine, heroin, and methamphetamine. Some European countries have lowered the classification of marijuana based on the false perception that it is less harmful. However, studies over the last few years give us a lot of new information about marijuana. They show that marijuana is not harmless but that it is toxic and addictive. Recent studies show the following destructive effects of marijuana use: [FN6]

birth defects
the worsening of pain
respiratory system damage
links to cancer
AIDS - marijuana opens the door to Kaposi's sarcoma
brain damage
strokes
immune system damage
mental illness
violence
infertility
hepatitis

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## LEGALIZATION OF DRUGS WILL CAUSE AN INCREASE IN DRUG PROBLEMS

Illicit drugs are addictive and dangerous. The legalizers may admit this but respond by saying that if we legalized them we would have less of a problem. They claim that making illegal drugs legal would not cause more drugs to be consumed nor would cause addiction to increase. They claim that many people use drugs moderately and that many would choose not to use drugs, just as many now abstain from alcohol and tobacco.

The lesson from history is that periods of lax controls are accompanied by increased drug abuse and that there is less drug abuse during periods of strong drug control. In the 1880s many drugs, including opiates and cocaine, were legal and were seen as benign medicine not requiring a physician’s oversight. Addiction was rampant with 400,000 opium addicts in the US which is twice as many per capita as there are today. By the turn of the century about one in 200 Americans was either an opium or cocaine addict. In response, the Federal Pure Food and Drug

Act of 1906 was passed that required manufacturers of patent medicines to disclose the contents of the medicines they sold. As a result Americans learned which of their medicines had heavy doses of cocaine and opiates and they could avoid them. The first broad anti-drug law in the US was the 1914 Harrison Act that contributed to a significant decline in narcotic addiction in the United States. The addiction rate in the US eventually fell to its lowest level in World War II when many addicts were forced to give up their drug habits due to a shortage of the drugs. The years after the war were relatively drug free. By the 1950s, the US Federal Bureau of Narcotics estimated the total number of addicts was only between 50,000 to 60,000. This is far lower than today. [FN1]

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## WE SHOULD KEEP STRONG PENALTIES FOR DRUG USE BECAUSE PENALTIES PROVIDE DETERRENCE.

The proponents of legalization claim that law enforcement is not winning the war on drugs. However, law enforcement serves many purposes in the anti-drug effort.

1. It exacts a high price from those who would profit from the misery and addiction of others, e.g., loss of freedom and seizure of their ill-gotten gains.

2. It keeps potential drug users from using drugs by virtue of the fear of arrest and the embarrassment of being caught.

3. It helps drug users/addicts into treatment through the use of laws and drug courts that offer treatment as an alternative to incarceration. [FN1]

4. Legal sanctions have helped to deter or delay potential abusers, thereby limiting the growth of the illicit market;

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## WE MUST PROTECT THE VICTIMS OF DRUG USERS

Drug users may commit murder, or child or spouse or elder abuse, or rape, property damage, assault and other violent crimes under the influence of drugs. The criminal justice system

protects the victims of drug users and can be used to get the drug users into treatment. The victims include:

**Children of drug users** - Many children have drug using parents and are abused or neglected by those parents. Drug use is not a victimless crime.

**Parents** - The parents who have addicted children or who have lost children to drugs need our support. We can help them to take legal action against those who gave the drugs to their children.

**Grandparents** - Many parents are addicted to drugs and as a result their children are being raised by their children's grandparents. In addition, many grandparents have addicted grandchildren.

**Victims of domestic violence** - Spouse abuse and abuse of relatives are caused by drug abuse.
**Students** - Students are often victimized by violent drug users in their schools. In addition, the ability of the school to provide an orderly learning environment is impaired by drug users.

**Drugged driving victims** - Many people are injured or killed by drugged drivers.

**Crime victims** - People who have been assaulted and/or been robbed by drug users or otherwise harmed by them deserve protection.

**Patients victimized by so called "medical"marijuana** - Ill people who choose to use marijuana instead of legitimate medicines may become sicker due to marijuana use.

**Elder abuse** - Many elders are abused by drug users.

**Sexual victims** - Drug use leads to sexual promiscuity and spread of AIDS and other blood borne infections. These victims need support and protection.

## TYPES OF DRUG RELATED CRIME

For the purposes of this paper, the crime caused by people to pay for their addiction is referred to as "purchase-related" crime. The crime committed by people while under the influence of drugs is "drug-induced" crime and the crime caused by organized criminals to supply drugs is "black market crime."

## PURCHASE - RELATED CRIME

The Legalizers claim that as legalized drugs become less expensive, addicts will no longer need to commit crimes in order to pay for their addiction. The problem with this claim is that some addictive drugs are already inexpensive. Marijuana, the most abused and addictive drug for young people, is very inexpensive. Some drugs can be manufactured in home laboratories. In addition, if drugs were sold legally and have to comply with government regulations and pay the

costs of taxes placed upon the legalized drug there is a question whether it is possible to reduce the current price of some drugs. [FN1]
However, if legal drug suppliers could undersell the black market by offering drugs at a lower price the rates of addiction would rise. Even supporters of drug legalization admit that “low prices would encourage use.” [FN2] A good example of this is cocaine. Once cocaine began being marketed in the high potency and low cost form of “crack,” addiction rates increased. [FN3] If addiction rates increase - so will purchase-related crime. Higher levels of drug use cause increased crime, especially property crime to pay for the drugs. [FN4]

Legalizing drugs would not reduce purchase-related crime, but may actually increase it for two reasons: (1) if we decrease the price of an addictive drug, addicts will merely buy more of it and need more money to buy drugs. (2) there will be more addicts stealing to meet living expenses such as food, rent, etc. [FN5] Drug abusing offenders are the most active criminals. Dependency on drugs drives people to commit crimes to generate income. Drug users, many of whom are unable to hold jobs, commit robberies and other crimes not only to obtain drugs, but also to purchase food, shelter, clothing and other goods and services. Even if drugs were legalized, addicts will still need to pay the rent and may resort to crime to do so. [FN6]

A study in the UK of heroin abusers showed that 90 per cent financed part of their habit from crimes such as shoplifting and burglary. [FN7] Another study found that almost 50 per cent of the total cost of theft in 1993 in England and Wales was drug-related. [FN8] In the UK addicts spend about £16,500 a year each on their habits and most of the money is from the proceeds of crime. [FN9] In the UK those who use heroin and cocaine are responsible for 50% of all crimes. [FN10]

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## DRUG-INDUCED CRIME

The advocates of legalization claim that drug users only damage themselves and therefore they have the right to use drugs. Others claim that if drugs were legal, crime and violence would decrease because it is the illegal nature of drug trafficking that fuels crime and violence, instead of the violent and irrational behavior that drugs themselves induce. The flaw in this argument is that most violent drug related crime is committed because people are under the influence of drugs. The use of drugs changes behavior and causes criminal activity because people will do things they wouldn't do if they were rational and free of the drug's influence. [FN1]

Psychoactive drugs have a powerful impact on behavior. This influences people to commit crimes that have nothing to do with supporting the cost of their drug use. Some offenders suffer emotional and/or brain damage due to drug use, which contributes to mental illness or anti-social behavior. Cocaine-related paranoia is an example. If drug use increases with legalization, so will many forms of violent crime such as assaults, drugged driving, child abuse, and domestic violence. [FN2]

If legalization will cause an increase in drug use, an increase in drug use certainly will create more criminal behavior. There is a strong connection between drug use and criminal behavior. Drug use studies show that two-thirds of all male and female arrestees tested positive for at least one drug. Cocaine was found in about one-half of males and females, and marijuana was found in 25% of the men and 20% of the women. Opiates were found in 10% of the men and women. Twenty-five percent of the total sample tested positive for more than one illegal drug.[FN3]

A survey of prison inmates showed that inmates report high levels of drug use prior to the commission of the crime for which they were incarcerated. In the month prior to the crime, 43% were using illegal drugs on a daily or near daily basis, and 19% were using heroin, methadone, cocaine, PCP, or LSD on a daily or nearly daily basis. The study also showed that 35% of the inmates reported they were under the influence of drugs at the time they committed the crime. Marijuana or hashish were most frequently used at the time of the crime.[FN4]

Approximately 80% of the inmates in a 1986 survey had used drugs at some time in their lives. Only 13% of inmates seemed to fit the pattern of drug addicts who committed the crimes for gain. Of those sentenced for robbery, burglary, larceny, or a drug offence, one-half were daily drug users, and about 40% were under the influence of an illegal drug at the time they committed the crime. The greater an inmate's use of major drugs, the more prior convictions the inmate reported. Twenty-eight percent of the state inmates reported past drug problems with such drugs as heroin (14%), cocaine (10%), and marijuana or hashish (9%). [FN5]

A US study of crime victims showed that 30 per cent perceived their attackers to be under the influence of drugs or alcohol. [FN6]

A study published in the International Journal of Addictions links homicides to the use of marijuana. Interviews with 268 inmates in prison for homicides in New York demonstrated that 71% used marijuana within 24 hours of committing the crime and that they were experiencing some effect from the drug at the time of the crime. Twenty-five percent felt that the homicide was related to their use of marijuana before the crime. [FN7]

In Europe, there has been a rise in reports of alcohol and drugs being used to immobilize victims for the purpose of sexual assault. Surveys in six EU countries show that up to 20% of women experience some form of sexual assault as adults. [FN8]

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## DRUGGED DRIVING

If legalizing drugs will increase drug use, then drugged driving will also likely increase. Many studies show a clear correlation between drug use and motor vehicle accidents, trauma, and dangerous driving. More drugged driving will mean more dead and injured drivers and their innocent victims. Recent studies of intoxicated driving suspects indicate that approximately one-third of those failing standard field sobriety tests will test positive for illegal drugs. [FN1] Drug

tests on the bodies of 168 fatally injured truck drivers found that marijuana was found in 13%; cocaine was found in 8% and amphetamines in 7%. [FN2]

The European Monitoring Centre for Drugs and Drug Addiction published a paper on Drugs and Driving in 2007. [FN3] Some highlights from the data on drugged drivers include:

Germany - 2.7 % were positive for benzodiazepines and 0.6 % for cannabinoids.

Netherlands - cannabis and benzodiazepines most prevalent substances.

Luxembourg, Finland, the United Kingdom and Norway - benzodiazepines most frequently found drug.

United Kingdom - benzodiazepines most frequently found drug followed by opiates and then cannabinoids.

Slovenia - drivers suspected of drug consumption found cannabis in 35.7 % of the drivers and benzodiazepines in 8.2 %.

Ireland - drivers below the legal limit for alcohol - 9 % tested positive for cannabinoids and benzodiazepines

Latvia - most frequent combination was amphetamines and cannabis, but combinations including benzodiazepines were also detected.

Sweden - drug-driving suspects contained THC in 25 % blood samples, while about 19 % contained diazepam.

Greece - drivers involved in accidents tested 4.0 % for both cannabinoids and benzodiazepines

France - drivers involved in an injury-causing accident - benzodiazepines, found in 14 % of samples and 10 % of the drivers positive for THC.

Czech Republic - drivers killed in traffic accidents most common drug found, after alcohol, were benzodiazepines (3.0 %) and THC (2.4 %), followed by stimulants (1.9 %).

Denmark, Finland, Iceland, Norway and Sweden - drivers killed in accidents - benzodiazepines were used as often as alcohol (21.4 % and 22.2 % respectively) and THC and amphetamines found in 10.5 % and 10.1 %.

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## BLACK MARKET CRIME

The legalization advocates fail to recognize that a high percentage of drug dealers and addicts were criminals first and foremost and they will continue their criminal behavior in order to acquire sources of income. Unless 100 percent pure drugs are given away to anyone, at any age, at a very low cost, a vast black market will remain. If an age is set for legal use such as 18 or 21, there will be a market for everyone under that age. People under the age of 21 consume the majority of illegal drugs, and so an illegal market and organized crime will remain and be focused on young people even more than now because that will be the only major market. Even the legalizers have not been willing to advocate legalization of drugs for minors.

In the US after Prohibition ended, organized crime continued in a variety of other criminal enterprises. We must remember that organized crime is composed of violent criminals. What will they do when the drugs they sell are under priced by a legal manufacturer such as a pharmaceutical company? The criminals will act violently to protect their place in the market. They have used violence in Columbia and other countries to take over or intimidate governments. These governments have thousands of well armed troops and police to protect them, but it is often to no avail. What protection would a pharmaceutical company have? If we think that organized crime will stop their crime - then we ignore reality. [FN1]

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## WHO'S REALLY IN PRISON FOR MARIJUANA?

Drug legalization advocates claim that prisons are overflowing with people convicted for only simple possession of marijuana. This claim is aggressively pushed by groups seeking to relax or abolish marijuana laws. A more accurate view is that the vast majority of inmates in prison for marijuana have been found guilty of more than simple possession. They were convicted for drug trafficking, or for marijuana possession along with other offences. Many of those in prison for marijuana entered a guilty plea to a marijuana charge to avoid a more serious charge. In the US, just 1.6 percent of the state inmate population were held for offences involving only marijuana, and less than one percent of all state prisoners (0.7 percent) were incarcerated with marijuana possession as the only charge. An even smaller fraction of state prisoners were first time offenders (0.3 percent). The numbers on the US federal prisons are similar. In 2001, the overwhelming majority of offenders sentenced for marijuana crimes were convicted for trafficking and only 63 served time for simple possession. [FN1]

### Plea Bargains Distort the Picture

The standard practice in drug cases is for the offender to be given the opportunity to plead guilty in exchange for lighter punishment thus sparing the taxpayers the expense and risk of a trial. If the offender is only charged with one crime, the prosecutor will typically offer a shorter sentence to a lesser charge. If the offender has multiple charges, the common practice is to dismiss one charge in exchange for a guilty plea to another lesser charge, especially if the government feels the offender can provide valuable assistance to law enforcement by providing information on drug trafficking.
Drug legalization advocates claim that nearly one-third of all federal drug defendants are charged with marijuana offences. [FN2] However, only a tiny percentage of that number are actually convicted for marijuana possession. [FN3]

There are a number of circumstances under which a simple-possession marijuana offender might receive a sentence to prison. For example, this may happen if:

1. the marijuana offence was committed while the offender was on probation or parole;

2. an offender charged with a more serious crime pleads guilty to the lesser offence of marijuana possession but as part of a plea bargain is required to serve a prison sentence;

3. the offender has a criminal history, particularly one involving drugs or violent crime;

4. the violation took place in a designated drug-free zone (such as on school property); or

5. the marijuana sentence runs concurrent with the sentence for one or more other offences;

### How Much Marijuana Did the Average Offender Possess to Get a Prison Sentence?

According to US Bureau of Justice Statistics estimates based on a survey of federal prisoners, the median amount of marijuana involved in the conviction of marijuana-only possession offenders was 115 pounds. [FN4] This is far more than is needed for personal use.

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## CONCLUSION TO LEGALIZATION AND CRIME

Currently, the criminal justice system is making use of community-based alternatives to incarceration. These alternatives allow offenders to return to the community under close supervision. The criminal justice system is responsible for getting thousands of offenders into treatment. Without criminal sanctions, these people would remain untreated. Few people seek treatment without the impetus of a significant event, such as arrest, to propel them to that solution. [FN1]

Our concern with drug-related crime should not overshadow the complex problems of drug use. We still do not understand exactly why people experiment with drugs and then become dependent on them. Our study of brain chemistry raises more questions than answers regarding the immediate and long-term effects of drugs on the brain. Without knowing more about the effects of drugs, legalization is a gamble that could encourage drug use and possibly lead to a new crime wave.[FN2]

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## THE ECONOMICS OF DRUG LEGALIZATION

The legalization theory holds once legalization is implemented that governments will save billions annually in drug enforcement and related court and prison expenses. In theory, these funds could then be redirected to drug abuse treatment programs. However, the increased billions in health/social expenditures related to the expanded level of drug use following from legalization would be more than the amounts saved from the law enforcement/criminal justice accounts. [FN1]

In addition to the concrete losses that are symbolized by those billions of dollars, we must also consider the destruction of lives, and the lost opportunities for self fulfillment and lost dreams and the spiritual losses of lost relationships, lost love and lost hope.

**Costs to the Taxpayer** - The drug legalization advocates claim that the funds allegedly saved from giving up on the drug problem can be better spent on education and social problems. However, compared to the amount of funding that is spent on other national priorities, drug control spending is minimal. In 2002, in the US, the amount of money spent by the federal government on drug control was less than $19 billion. These funds did not go to enforcement policy only. They were used for treatment, education and prevention, as well as enforcement. The US Drug Enforcement Administration was only given roughly $1.6 billion, an amount the US Defense Department runs through about every day-and-a-half or two days. In the fiscal year of 2002, the total federal drug budget was $11.5 billion. In contrast, the US spent about $650 billion on the nation's educational system. Our effort to provide education is a long-term social concern, with new problems that arise with each generation. This is similar to drug abuse and addiction and yet no one suggests that we give up on education. Isn't keeping young people off drugs and out of addiction just as important? [FN2]

The increased health/social costs related to expanded levels of drug use would be more than the amounts saved from the law enforcement/criminal justice costs. A study on US justice costs showed that relative to other government expenditures, criminal justice system expense is small, less than 3 percent of the budget when contrasted to national defence/international relations uses of over 18 percent, education 13 percent, and interest on the debt, almost 11 percent. [FN3]

**By far the most compelling economic argument against the legalization of drugs is the social costs associated with such a policy.**

**Social costs** - Using the US as an example, the social costs of drug use make it clear that the costs of controlling drugs are well worth it. Legalization will increase drug use and drug-related costs. A detailed look at the cost of drug abuse in the US was done by the US Office of National Drug Control Policy. They looked overall costs, health care costs, productivity losses, costs of other effects and crime related costs. [FN4]

**Overall Costs of Drug Use** - Total costs of drug use were $180.9 billion in 2002, increasing 5.34 percent annually since 1992. These costs are health care costs, productivity losses, and other costs. Costs in 1992 were $107.6 billion. The largest proportion of costs is from lost potential productivity, followed by non-health other costs and health-related costs.

**Health Care Costs** - Health-related costs were projected to total $16 billion in 2002. Substance abuse-related health care costs are projected to have risen 4.1 percent annually between 1992 and 2002.

**Productivity Losses** - By far the largest component of cost is from loss of productivity, at $128.6 billion. In contrast to the other costs of drug abuse (which involve direct expenditures for goods and services), this value reflects a loss of potential resources.

**Cost of the Other Effects** - The final major component of costs came to $36.4 billion in 2002. These primarily concern costs associated with the criminal justice system and crime victim costs, but also include a modest level of expenses for administration of the social welfare system. Between 1992 and 2002, the costs for the other effects of drug abuse rose at a 6.5 percent annual rate.

**Crime-related costs** - When these costs are aggregated a more complete picture is gained of the role of drug-related crime in the total economic impact. It is estimated that $107.8 billion, or almost 60 percent of total costs are related to crime.

**Comparison to health problems** - This study and prior estimates indicate that drug abuse is one of the most costly health problems in the United States. The estimates have followed guidelines developed by the U.S. Public Health Service for cost of illness studies. These guidelines have been applied in earlier studies of drug abuse in the U.S. (e.g., for 1992, 1985, 1980, and 1977), and to cost of illness studies for virtually all of the major health problems. Accordingly, these estimates can be compared meaningfully to estimates for e.g.. cancer, stroke, heart disease, diabetes, alcohol abuse and mental illness. The National Institute of Health collects and reports on cost estimates for the major health problems in the nation. Based on estimates from the 1990s employing generally comparable methodologies, drug abuse ($124.9 billion in 1995) is comparable to heart disease ($183.1 billion in 1999), cancer ($96.1 billion in 1990), diabetes ($98.2 billion in 1997), Alzheimer's disease ($100 billion in 1997), stroke ($43.3 billion in 1998), smoking ($138 billion in 1995), obesity ($99.2 billion in 1995), alcohol abuse ($184.6 billion in 1998) and mental illness ($160.8 billion in l992).

**Damage to families** - The issues regarding drug abuse and families are summarized in position papers prepared by UNDCP and the World Health Organization (WHO). [FN5] Studies show that illicit drug abuse has a strong correlation with the disintegration of the family. [FN6]

**Drug-effected babies** - Hundreds of thousands of babies in the US have the possibility of health damage due to their mothers' drug abuse. Estimates of drug-exposed babies range from 1 to 2 per cent of live births (40,000 to 75,000) to 11 percent of live births (375,000). [FN7] Cocaine use by mothers may increase risk of maternal complications, including abruptio placentai, pregnancy loss, and preterm labor and risk for fetal/neonatal problems including intrauterine growth retardation, reduced head circumference, prematurity, and increased perinatal mortality and developmental and behavioral problems. [FN8]

**Drug related deaths** - There are four sources generally accepted for reliable data about drug-related deaths in the U.S. The numbers are under reported, but no one has found a way to

systematically collect and report the numbers from year to year. The best data we can get shows drug-related deaths to number from about 16,000 to 20,000 per year in the US. [FN9]

**International**

Canada - In 1992, the costs of substance abuse (including alcohol and tobacco) were calculated at 2.7 per cent of the Gross National Product (GNP) with illicit drug abuse responsible for at least US$ 1.1 billion, the equivalent to 0.2 per cent of GDP or US$40 per capita. Looking at the economic costs of illicit drug consumption, 29 per cent were spent on law enforcement and 6 per cent on health care. The majority of costs (60 per cent of the total) were due to productivity losses. [FN10]

Australia - In a 1996 study in Australia the estimated the costs of drug abuse (including both licit and illicit substances) was the equivalent to 4.8 per cent of the GDP, with costs related to illicit drug abuse amounting to $1.2 billion (0.4 per cent of GDP or $70 per capita). [FN11]
Continental Europe - A study on Germany estimated the total costs of drug abuse, related criminal justice costs and prevention efforts as at least DM 13.8 billion (0.4 per cent of GDP). [FN12]

In Finland in 2004 the indirect costs of the use of drugs, including misuse of pharmaceuticals, was determined to be in the area of EUR 400 to 800 million, of which EUR 306 to 701 million was linked to the cost of life lost due to premature death and production losses amounted to EUR 61 to 102 million. [FN13]

In France in 2003 the social cost of illicit drug use was estimated at EUR 907 million. [FN14]

In Luxembourg in 2004 the social cost was estimated to be EUR 29.7 million. [FN15]

The economic and social costs of drug abuse in the UK account for between (10 billion and (18 billion each year. Approximately 250,000 “problematic drug users” create 99% of these costs. [FN16] In the UK it is estimated that drug addicts cost taxpayers over £800,00 over the addict’s lifetime but that this could be cut by more than £730,000 if they were successfully given treatment by the age of 21. [FN17]

If drug use goes up due to legalization so will all of its costs.

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[FN17] Addicts Cost Taxpayers 800,00 pounds, BBC June 14, 2008, http://news.bbc.co.uk/2/hi/uk_news/7454338.stm

## CHARACTERISTICS OF SUBSTANCE ABUSING EMPLOYEES

If we legalize drugs there will be more drug users and they will create more problems in the workplace. We already have too many drug-related problems in the workplace. Most drug users 18 and older are employed (75%). [FN1] The studies show that drug and alcohol use are serious problems that all employers have to deal with. [FN2]

According to several studies, employees who are illicit drug users have a high turnover rate and move from job to job and they are absent from work more often than other employees. [FN3] In addition, they are less productive. A study showed that almost 32% of employees had personal knowledge of a coworker whose substance abuse negatively affected his or her job performance. The survey indicated that 61% know employees who have shown up drunk or under the influence of drugs while at work. [FN4]

Drug using employees are not safe - As consumers we all pay for lost productivity and job-related accidents in the final costs of the produced goods and higher insurance premiums due to workplace accidents. Drug users are 3.6 times more likely to be involved in a work-related accident than non-using employees. [FN5]

### International

United Kingdom - Drug use has a strong correlation with unemployment. The 1992 British Crime Survey showed that life-time prevalence of drug abuse among the unemployed was 60 per cent higher than among the employed. [FN6]

Columbia - A survey carried out in Colombia showed that the prevalence of drug abuse among the unemployed was almost four times higher than among the employed. [FN7]

Europe - A study by the International Labour Organization (ILO) and the European Community showed that more than half of the interviewed employers' associations, enterprises and workers' organizations reported specific work performance impairments and absences from work as a result of substance abuse. [FN8]

Canada - A study of 2,000 members of the workforce of Alberta, Canada, showed that 1 in 16 persons had used illicit drugs, mainly marijuana, in the 12 months prior to the survey. [FN9]

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## LEGALIZATION WILL OPEN DRUG SALES TO MASS MARKETING AND EVEN BIGGER PROFITS FROM DRUG SALES

Legalization will not eliminate drug profits. It will simply shift them out of the pockets of traffickers and into the hands of legitimate businesses. Once this happens then it will be in the economic interest of businesses to promote their products and to package them in attractive ways. The legalizers may claim that the government can regulate this but how well has that worked with alcohol and tobacco? Once drugs are “legal” then drug sellers can hire lawyers and lobbyists and make donations to political campaigns to further their cause. They will pursue their marketing opportunities and will seek to reduce government regulation.

A revealing look at how the profit motive will take over is found in a Reuters story involving Warren Eugene, a pioneer of Internet gambling from Canada. His firm, Amigula/Medical Cannabis Inc., plans to grow and sell the marijuana to people authorized to use it for medical

purposes, and to those people not medically authorized. He wants his firm to become an international, publicly listed concern. Initially he will target medical users, but the market could grow if Canada decriminalizes the possession of up to 15 grams of cannabis, just over half an ounce. Canada has up to 400,000 users of medical marijuana. If each user buys C$1,000 (US $765) worth of marijuana a year, annual sales could reach C$40 million. Eugene wants to list his company on stock markets in Denmark, London, Amsterdam, Canada, Australia and Paris. Eugene states: "If marijuana works, I am going to go with opium next." [FN1]

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## THE TAX ISSUE

Some legalizers claim that if legalized drugs were taxed we could raise revenue for social programs. However, if we legalize drugs and tax them, we will have a black market that can sell the same drugs less expensively. This will also apply if we place a tariff on imported drugs as happened in the early twentieth century when opiates and other drugs were legal in the United States. Much of the opium used in the U.S. came from China, and “enlightened” lawmakers decided to place a tariff on the drug as a means of raising revenue. As a result, between 1866 and 1914, the duty on crude opium was 33% but on ready-to-smoke opium it was 97%. Although the tariffs produced income they also created smuggling to avoid paying the tariff. At one point, twice as much opium was smuggled into the U.S. as went through the legal channels. History proves it true again - tax equals black market. [FN1]

When we look at taxes on alcohol and tobacco model we see that very few of those tax revenues are used for social programs. The alcohol and tobacco companies use the profits from those products to support highly effective lobbying efforts to defeat legislation that might affect them negatively, as well as to prevent any increase in taxes on their products.

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## ALCOHOL AND TOBACCO AND DRUG LEGALIZATION

How legalization will result in increased use becomes clear when we consider the two current legal drugs - tobacco and alcohol. The users of these legal drugs far outnumber the number of users of illegal drugs. For example, in the US about 109 million people use alcohol at least once a month and about 66 million people use tobacco at the same rate, however, less than 16 million Americans used illegal drugs at least once a month (only 7.1 percent of the population). Alcohol is used by people in almost every age and socio-economic group. According to the 2001 US National Household Survey on Drug Abuse, 10.1 million young people aged 12-20 reported past

month alcohol use (28.5 percent of this age group) with nearly 6.8 million (19 percent) engaging in binge drinking. We can expect even more destructive statistics if drugs were made legal.[FN1] Advocates of drug legalization claim that since alcohol and tobacco may be freely consumed and they cause damage, it is unfair to make other drugs such as marijuana and cocaine illegal. But - who is it unfair to? It is certainly not unfair to the victims of drug use. Just because we have chosen to legalize some dangerous substances it does not follow that we should legalize all dangerous substances. In addition, alcohol and tobacco cause more damage because they are used more frequently thus the amount of damage they cause is also greater. The proper analysis is not to compare the damage caused by illegal drugs to the harm caused by alcohol under the present system, but instead is to compare the harms likely caused by legalized drugs to that caused by alcohol. [FN2]

Because we have two legal drugs which destroy lives is no reason to add more dangerous drugs to the legal list. The drug laws save millions of lives by keeping dangerous drugs illegal. The experience with alcohol is the strongest argument against legalization. [FN3]

Tobacco certainly tobacco kills people but it disingenuous to say that it is a more dangerous substance than either cocaine or marijuana as it effects human behavior. For while it may harm one's health, tobacco does not affect one's intellectual processing or decision-making ability. It does not cause violence or accidents. [FN4] Although tobacco may kill you, it does not lead to the types of bizarre, destructive behavior that is associated with illegal drugs.

Use of alcohol is somewhat harder to justify because it can it kill people and alter behavior and may encourage antisocial and destructive act. However, this does not mean that we must treat alcohol and drugs such as heroin and marijuana and cocaine as equivalents. First, heroin and cocaine are far more addictive. The addiction rate for cocaine may be as high as 75% while the addiction rate for alcohol is about 10%. [FN5] Far more young people are addicted to marijuana than alcohol. [FN6]

Most people consume drinks with alcohol as beverages and don't drink to become intoxicated, however, with drugs the sole purpose is intoxication.

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**ALCOHOL PROHIBITION**

Advocates of legalization claim that the US experiment with alcohol prohibition proves that problems result when a government attempts to make a popular substance illegal. The legalizers claim that there were increases in organized criminal organizations who sold alcohol illegally. The legalizers claim that it is better to legalize, tax and regulate drugs than to make them illegal.

A look at the history of Prohibition shows that this argument is deeply flawed for two reasons:

1. the circumstances surrounding Prohibition are so different than those of today that it is not helpful in analyzing present-day policy;

2. Prohibition was successful and did not create all the negative consequences that the legalizers claim it did.

David Teasley, an analyst with the Congressional Research Service of the US Library of Congress, did an in-depth analysis entitled, “Drug legalization and the Lessons of Prohibition.” Teasley concluded that

> A comprehensive analogy between Prohibition and the modern drug problem is problematic in at least two major ways. First between the two eras there are significant differences that tend to undermine the prolegalization analogy. Second, many arguments of the prolegalizers are weakened by their reliance upon a widely held set of popular beliefs about Prohibition rather than upon recent historical evidence. Such attempts to create this analogy based upon these popular beliefs about Prohibition serve only to confuse the debate over legalization of illicit drugs. [FN1]

What differences exist between the time of Prohibition and now? [FN2]

(1) During prohibition the government sought to restrict the consumption of alcohol although lacking the consensus of the nation. Even during Prohibition most people had experience with and accepted alcohol. That is not the same today for illicit drugs. Prohibition went against the national consensus whereas the current drug policies do not.

(2) Prohibition laws were different than illicit drugs laws today. During Prohibition it was only illegal to sell alcohol and not to drink it. Today, it is both illegal to sell and to possess and use illicit drugs. Today’s laws can be used to target the users while those of Prohibition could not.
(3) During Prohibition several US states did not support the federal laws and this caused tension between the state and federal governments and hampered effective prosecutions. Today, the states have signed the Uniform Controlled Substances Act, and a state/federal consensus exists not present during Prohibition.
(4) Criminal penalties for illicit drug use are more severe today than in the 1920's so there is a more potent deterrent effect.

(5) During Prohibition the US was “dry”while the international community was “wet” and thus the US was at odds with the international community (much alcohol was imported from Canada). However, today the international community is resolute when it comes to drug policy as witnessed by three UN convention on the use of illegal drugs.

(6) During Prohibition the structure of the government agencies designed to carry out the Prohibition laws was unstable, narrow and filled with political appointees. Today the US national drug strategy involves over a dozen federal agencies coordinated by the Office of National Drug Control Policy. The government bodies that enforce our drug policies are much larger, with better resources, and are much more professional than their Prohibition counterparts.

We cannot analogize the history of Prohibition with today's drug policies because there is not that much in common. Prohibition was on balance a successful policy for the following reasons:

1. There is no doubt that prohibition curbed alcohol abuse as its use declined by 30 to 50 percent. Deaths from cirrhosis of the liver fell from 29.5 per 100,000 in 1911 to 10.7 in 1929. Admissions to mental hospitals for alcohol psychosis fell from 10.1 per 100,000 in 1919 to 4.7 in 1928. Suicide rates decreased 50 percent and the incidence of alcohol-related arrests also declined 50 percent. [FN3]

(2) Prohibition did not cause an increase in the overall crime rate but there was an increase in the homicide rate. However, the increase in homicides occurred mainly in the African-American community, and African-Americans at that time were not the people responsible for trafficking in alcohol. [FN4]

We cannot legitimately compare Prohibition with our current efforts to control drugs because there are too many differences in the laws, the political establishment, the moral consensus, and the international community.

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## INDIVIDUAL RIGHTS AND THE LEGALIZATION OF DRUGS

Advocates of legalization use an individual autonomy argument that "its my body and I have a right to do with it as I please so long as I am the only one affected." The fatal flaw with this argument is that drug use does effect other people and society in many negative ways such as:

(1) Massive social and health costs.

(2) Drug use is connected to birth defects and problems with pregnancy. [FN1]

(3) Drug abuse is closely connected to child abuse. [FN2]

(4) Drug use causes a large number of automobile and other accidents

(5) Drug use causes a variety of workplace problems that effect other workers and consumers.

(6) Drug use causes crime unrelated to economic crimes to purchase drugs.

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## THE TOUGH PRACTICAL QUESTIONS REGARDING LEGALIZATION

In their 1993 report the INCB asked these tough practical questions regarding implementation of drug legalization:

17(a) What drugs would be legalized (cannabis, cocaine, crack (the free-base form of cocaine), heroin, hallucinogens, ecstasy? According to what criteria would they be legalized and who would determine those criteria?

(b) What potency levels would be permitted (5 per cent, 10 per cent or 14 per cent tetrahydrocannabinol (THC) content of cannabis; Burmese No. 3 grade, Mexican black tar or China white heroin)?

( c) Since legalization would entail the removal of prescription requirements for psychoactive pharmaceuticals, what would be done to control the adverse consequences of their non-medical use? How would the marketing of such new drugs be dealt with? Would they be permitted without even a qualifying period and evaluation? What would happen with designer drugs?

(d) Would production and manufacture be limited? If so, how would be limits be enforced (e.g. limited to home production for personal use or to cottage industries or to manor enterprises)?

(e) What market restrictions would there be? Would the private sector or the public sector or both be involved? How would price, purity and potency levels be established and regulated? Would advertising be permitted? If so, what drug would be advertised and by whom?

(f) Where would such drugs be sold (e.g. over the counter, through the mail, vending machines or restaurants)? Would the sale of such drugs be limited to dependent abusers? If so, how many and from which cities or countries? What about experimenters and those not yet granted dependent status?

(g) Would there be age limits for the use of legalized drugs and, if so, for which ones (e.g. access to cannabis at age 16, to cocaine at age 18 and to heroin at age 21)? Would there be restrictions on use because of impairment of function (e.g. restrictions on use by transport, defence, nuclear power and other workers)?

(h) For any restrictions found necessary or desirable, what agency would enforce the law, what penalties and sanctions would be established for violations and how would the risks of corruption and continued illicit traffic be dealt with? INCB Report 1993

The legalizers have yet to effectively answer these questions.

**NOW IS NOT THE TIME TO CHANGE THE CONVENTIONS. DEMAND AND SUPPLY REDUCTION AND DRUG CONTROL ARE WORKING.**

The major consumer of illegal drugs in the World is the US. The facts in the US provide for much optimism. The US has applied demand reduction, law enforcement, education and treatment to its drug problem. What are the results? There was a 33 percent reduction of the number of new heroin users from 156,000 in 1976 to 104,000 in 1999. [FN1] Drug control has reduced casual use, chronic use and addiction, and prevented others from starting to use drugs. Drug use in the US is down by more than a third since the late 1970s. This means that 9.5 million fewer people use illegal drugs and cocaine use has been reduced by an astounding 70% resulting in 4.1 million fewer people using cocaine. [FN2]

The recent evidence is clear that the US approach works. [FN3] Data released in 2008 from the University of Michigan's Monitoring the Future Study (MTF), the US Drug Enforcement Administration (DEA) System to Retrieve Information from Drug Evidence (STRIDE), and workplace drug tests performed by Quest Diagnostics showed that illicit drug use among young people continued to decline from 2001, with a 25 percent reduction in overall youth drug use over the last seven years. This means there are approximately 900,000 fewer young people using drugs today, compared to 2001. Additional declines in past-month youth use of specific drugs over the seven year period include:

25% reduction in marijuana use;
50% reduction in methamphetamine use;
50% reduction in Ecstasy use; and
33% reduction in steroid use.

The 2008 data show significant changes in the street-level price and purity of cocaine (key indicators of stress in the drug market) which suggests the supply of the drug on American streets is dropping. Positive drug tests for cocaine use among adults, as indicated by results of workplace drug tests nationwide, fell 38 percent from June 2006 through June 2008. Among young people, there was a 15 percent reduction in past-year use of cocaine from 2007–2008.

However, the 2008 data from the MTF Study shows a softening of youth anti-drug attitudes and beliefs (widely believed to be precursors of behavior) related to perceptions of harmfulness of marijuana and social disapproval of marijuana use. These counter trends occurred after drastic cuts to the US's largest youth drug education and prevention initiative, the National Youth Anti-Drug Media Campaign. Over the last nine years, Congress has slashed resources to this vital programme by 68 percent, from $185 million in 1999 to $60 million in 2008.

**Past drug control efforts**

In the US, 120 years ago, heroin and cocaine were legal and plentiful. What was the result? Addiction and crime problems were at an unprecedented high level. In 1880, there were over 400,00 opium addicts in the US. That's twice as many per capita as there are today. The US tried legalization and it led to increased drug abuse and social costs. [FN4]

Over the last four decades, policies of drug control can be broken down into two periods: the first, from 1960 to 1980 - a period of permissive drug laws; the second, from 1980 to present - a period of tougher drug laws. During the permissive years, drug crime incarceration rates fell almost 80 percent. In contrast, during the period of tough drug laws, drug incarceration rates rose almost 450 percent. These two periods had far different consequences. During the permissive years, drug use among adolescents climbed by more than 500 percent. During the tougher years, drug use by adolescent students decreased by more than a third. Although there may not be a one-to-one correlation between tougher drug laws and a declining rate of drug use, the drug abuse rates between the two eras of drug enforcement are striking. [FN5]

In the US it was strong drug law enforcement that ended America's first drug epidemic that lasted from the mid-1880s to the mid-1920s. By 1923, about half of all inmates at the Federal penitentiary in Leavenworth, Kansas, were there for violations the first US drug legislation, the Harrison Act. It was tough drug law enforcement that did much to create the US's virtually drug-free environment of the mid-20th Century. [FN6]

The policy of drug control in the US also impacts crime in general. For example, a 2001 study by the British Home Office found that violent crime and property crime increased in the late 1990s in every wealthy country except the US. [FN7]

**The public rejects legalization**

The public rejects legalization. A Gallup poll reported that over 80% of Americans held that legalizing drugs was a bad policy and a large majority feared legalization would lead to increases in addiction, drug overdoses, drug-related crime and drug use by children. [FN8] There is a strong movement in Europe to oppose legalization and harm reduction. The organization European Cities Against Drugs (ECAD) is pushing back against legalization and harm reduction. [FN9]

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## NEW APPROACHES TO DEMAND REDUCTION AND DRUG CONTROL ARE WITHIN THE CONVENTIONS

As a practical response to drug abuse, there was a shift in criminal justice system to provide treatment for non-violent drug users with addiction problems, rather than incarceration. As a result, the criminal justice system actually serves as the largest referral source for addiction treatment programs. The INCB supports dealing with drug abusers through alternative non-penal measures involving treatment, education, after-care, rehabilitation or social reintegration. In their 1992 report they noted that the parties to the Conventions “may choose to deal with drug abusers through alternative non-penal measures involving treatment, education, after-care, rehabilitation or social reintegration.” [FN1]

References

[FN1] INCB Report 1992 paragraph 15 c

## DRUG COURTS ARE EFFECTIVE TOOLS TO REDUCE DRUG USE AND ADDICTION

Drug treatment courts are an example of the balanced approach to fighting drug abuse and addiction. Drug courts seek to intervene and break the cycle of alcohol and drug addiction, crime, and child abuse. The drug court process begins when an offender is referred to a special court with support staff. Drug court participants undergo intensive substance abuse treatment, case management, drug testing, supervision and monitoring with immediate sanctions and

incentives. The drug courts utilize judges, prosecutors, defence counsels, drug treatment specialists, probation officers, law enforcement and correctional personnel, educational and vocational experts, community leaders and others whose goal is to help addicts recover from their addiction and stay recovered. The courts may also provide ancillary services such as mental health treatment, family therapy, job skills training and anger management. Drug courts planning involves criminal justice, child protective services, treatment, law enforcement, and educational and community anti-drug and alcohol organizations. [FN1]

Drug courts work. Research shows that more than 50 percent of offenders convicted of drug possession will return to criminal behavior within a few years. In contrast, those who complete a drug court have lower rates of recidivism that range from 2 to 20 percent. The drug court is successful because it forces the addict to stay with the program. The addict cannot simply quit treatment when he or she feels like it. [FN2]
UNODC and drug courts

The United Nations Office on Drug and Crime has this to say about drug courts: [FN3]

> The UN 1988 Drugs Convention, UNGASS Guiding Principles on Demand Reduction and related Action Plan specifically target drug-abusing offenders and call on governments to take effective multidisciplinary remedial initiatives. Drug Courts can be a very effective element in an overall package of responses.

UNODC's Legal Advisory Programme works closely with professionals, practitioners and organizations in an informal Drug Court network. [FN4]

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[FN4] http://www.unodc.org. Go to the section on legal tools and then to UNODC and Drug Treatment Courts ("Drug Courts")

## THE OLD HARM REDUCTION MODEL DOES NOT WORK.

What is “harm reduction?” In the past is has meant drug legalization and/or programmes that accept drug use and seek to minimize its harms.

The International Harm Reduction Association defines “harm reduction” as:

> policies, programmes and projects which aim to reduce the health, social and economic harms associated with the use of psychoactive substances.

> There are two main pillars that guide harm reduction. One is a pragmatic public health approach, and the other is based within a human rights approach. Both share an ethos that changing human behaviour must be a facilitative and cooperative process which respects the dignity of the individual. Harm reduction avoids moralistic, stigmatizing and judgmental statements about substance use and users. It avoids value laden language (such as drug abuse( and addict(). Harm reduction approaches also seek to identify and advocate for changes in laws, regulations and policies that increase harms, or which hinder the introduction of harm reduction interventions. [FN1]

The Beckley Foundation defines it as follows:

> The defining feature of harm reduction programmes is their focus on the prevention of drug-related harm rather than the prevention of drug use itself. [FN2]

Examples of this type of harm reduction programs are: needle exchange programs, drug substitution programs, ecstasy tablet checking. These programs are not abstinence based.

**The INCB Position**

The INCB has a position on harm reduction. They believe that we should focus on demand reduction not harm reduction as the means of relieving human suffering. Demand reduction are measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances such as prevention of drug use and treatment. INCB Report 2003

References

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**THE INTERNATIONAL EXPERIENCE WITH LEGALIZATION AND NON-ABSTINENCE BASED HARM REDUCTION**

**ALASKA USA** - In 1975, the Alaska Supreme Court ruled that the state could not interfere with an adult's possession of marijuana for personal use at home. This became a green light for marijuana use. The ruling was limited to persons 19 years of age or older but adolescents increasingly began using marijuana. In 1988, a University of Alaska study showed that the state's 12 to 17-year-olds used marijuana more than two times the national average for their age group. As a result, Alaska voted in 1990 to recriminalize possession of marijuana. [FN1]

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**THE NETHERLANDS** - The Netherlands chose to liberalize drug policy to its regret. For example in the 1970s, “coffee shops” emerged in the Netherlands offering marijuana products for sale. Even though possession and sale of marijuana are not technically legal, the coffee shops were permitted to sell marijuana under certain restrictions to include a limit of no more than 5 grams sold to a person at any one time. [FN1]

The Dutch saw the use of marijuana among young people more than double. The use of ecstasy and cocaine by 15-16 year olds rose significantly. [FN2] After marijuana use became normalized, consumption among 18 to 20 year-olds nearly tripled - from 15 per cent to 44 per cent. It has since declined due to a anti-marijuana programme by the government. [FN3]

The government also looked again to law enforcement by announcing a “Five Year Offensive against the Production, Trade, and Consumption of Synthetic Drugs.” They also established the Penal Care Facility for Addicts similar to the Drug Courts in the US. This facility is designed to detain and treat addicts (of any drug) who repeatedly commit crimes and have failed voluntary treatment facilities. The offenders may be detained for up to two years, during which time they will go through a programme of detoxification and training for social reintegration. [FN4]

By 2004, the government of the Netherlands formally announced its mistake. The government of the Netherlands stated that “cannabis is not harmless - either for the abusers or for the community." The Netherlands began to implement an action plan to discourage cannabis use. The action plan to discourage cannabis use includes elements such as drug prevention campaigns, mass-media anti-drugs campaign, increased treatment efforts to cannabis users, and encouragement of administrative and criminal law enforcement efforts. This brings the Netherlands "closer towards full compliance with the international drug control treaties with regard to cannabis." [FN5]

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[FN2] Home Affairs Select Committee Report: The Government's Drug Policy: Is it Working?, Memoranda of Evidence - no.16 (submitted by the Criminal Justice Association)

[FN3] What Americans Need to Know about Marijuana," ONDCP, Page 10; the DEA Position On Marijuana, DEA.gov; Collins, Larry. "The Netherland’s Half-Baked Drug Experiment." Foreign Affairs Vol. 73, No. 3. May-June 1999: Pages 87-88; The DEA Position On Marijuana, DEA.gov; Netherlands Soft Policy on Drugs May Harden as Public Complains About Junkie Criminals, Wall Street Journal, March 11, 1994

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**THE UNITED KINGDOM** - The United Kingdom also tried the relaxation of drug laws regarding marijuana and heroin. Until the mid-1960s, physicians were allowed to prescribe heroin to certain classes of addicts. As a result, the political scientist James Q. Wilson noted that, "a youthful drug culture emerged with a demand for drugs far different from that of the older addicts." Large numbers of addicts chose to not participate and continued to get their heroin from illicit drug distributors. [FN1]

In 1978, experts from British Columbia in Canada made the following conclusions regarding the UK Programme:

While some success is claimed in terms of reducing the incidence of young users, the following findings have also been noted:

1. The British approach has failed to attract a majority of addicts;

2. Many registered addicts continue to turn to illicit sources of drugs;

3. Many registered addicts do not decrease their dosage over time;

4. Many registered addicts continue to be involved in criminal activity;

5. Many registered addicts are chronically unemployed or do not earn enough to look after themselves;

6. The death rate of registered addicts is much higher than that of the general population and may be higher than that of North American addicts;

7. Since 1960, there has been a dramatic increase in the English addict population;

8. The black market for heroin continues to thrive;

9. Law enforcement appears to remain a necessary, costly and complex control measure.

In view of the above, it is felt that the application of the British approach to British Columbia would present serious dangers! [FN2]

In the 1980s the UK began to phase out these programs in favor of methadone treatment because the number of addicts increased 100% between 1970 and 1980. [FN3]

The UK is now changing its policies

Four years ago the UK downgraded the illegal status of marijuana from a more serious offence to a lesser offence. In 2005, during a general election speech to concerned parents, British Prime Minister Tony Blair noted that medical evidence increasingly suggests that cannabis is not as harmless as people think and warned parents that young people who smoke cannabis could move on to harder drugs. [FN4]

In 2008, just four years after the status of cannabis was downgraded, the UK government upgraded the classification of marijuana from a class C to class B offence and they announced a new system of escalating penalties for adults caught in possession of small amounts of marijuana. This will replace the current system of police warnings. Officers will now be able to arrest first-time offenders. The UK government took this action because of the "more lethal quality" of the cannabis now available. The government believes that marijuana is a gateway drug and that reclassification was needed to "send a message to young people that it was unacceptable." There will also be more robust enforcement of laws banning the supply and possession of marijuana and a new approach to tackling marijuana farms and organized crime. The government will also work with the Association of Chief Police Officers (ACPO) to use existing laws to curtail the trade in marijuana paraphernalia. [FN5]

References

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[FN2] John S. Russell and Andre McNicoll, The British Experience with Narcotic Dependency, Province of British Columbia Ministry of Health, Alcohol, and Drug Commission, April 1978.

[FN3] Letter from John C. Lawn to Joseph E. DiGenova, U.S. Department of Justice, Drug Enforcement Administration, June 3, 1988, see also Christoph Borkenstein, A Few Aspects of British Drug Policies - an outside view, Forensic Science International, 1993.

[FN4] "Blair's Concern on Cannabis." The Irish Times. 4 May 2005. See also, Russell, Ben. "Election 2005: Blair Rules Out National Insurance Rise." The Independent (London). 4 May 2005; The DEA Position On Marijuana, DEA.gov

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**SWEDEN** - In 1965 Sweden had an experimental project for the legal prescription of drugs but the legally prescribed drugs were increasingly diverted to the illicit market. The number of arrested people showing signs of intravenous drug use rose in Stockholm from 20 per cent in 1965 to 33 percent in 1967 and by 1967 almost all doctors in the project had stopped prescribing drugs. [FN1]

References

[FN1] Sweden's Successful Drug Policy: A Review of the Evidence, UNODC, February 2007

**BELGIUM** - A study showed that cannabis use has risen in 10 to 18 year olds since Belgium loosened its marijuana laws. [FN1]

References

[FN1] The Cannabis Smokescreen: Cannabis Use Among Young People in Belgium is Rising. Jon Eldridge, Expatica (Netherlands), July 2003

**CANADA** - In Canada, marijuana use among adolescents increased from the 1990s as young people became confused about the state of Canadian federal marijuana law in the wake of an aggressive decriminalization campaign. Marijuana use among Canadian youth has steadily climbed to surpass its 26-year peak, rising to 29.6 per cent of youth in grades 7-12 in 2003. [FN1]

References

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**SWITZERLAND** - The liberalization of drug laws in Switzerland has also produced damaging results. Switzerland became a magnet for drug users from many other countries. In 1987, Zurich permitted drug use and sales in a part of the city that became known as "Needle Park." In five years the number of regular drug users at the park swelled from a few hundred to about 20,000 and the area around the park became crime-ridden, forcing closure of the park. [FN1]

References

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**SPAIN** - An article in the Economist in 1987 noted that has been legal to use, but not sell, cocaine and heroin in Spain and Italy and they had the highest rates of both drug use and overdose of all European countries. [FN1]

References

[FN1] The Economist, April 18, 1987; Gabriel G. Nahas, A Battle Won, a Stalemated War, and A New Strategy (position paper)

## EUROPEAN CITIES AGAINST DRUGS OPPOSE LEGALIZATION/HARM REDUCTION

In 1994, a number of European cities signed a resolution titled European Cities Against Drugs (ECAD), commonly known as the “Stockholm resolution.” [FN1]

ECAD has 256 signatories from 28 countries. 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.

Their mission statement takes a strong position against legalization of drugs and it acknowledges that Europe is in trouble with drugs.

> The abuse of illegal drugs is a growing problem all over Europe. Various actions are taken by the European Union, the member states and capitals, cities and municipalities to counteract the problems. However, there is a lack of a common strategy and common goals in the combat against drugs. In addition, some countries and cities in Europe are actively advocating the legalization of drugs and promote a policy which actively undermines other countries' efforts to limit supply and demand of drugs.
>
> Europe has become a centre for drug trafficking, distribution and consumption of drugs. The spread of drugs is the result of a shattered and resigned and often reactionary policy. Millions of Europeans are affected directly by this policy as drug addicts, parents, relatives or victims of crimes. Drugs claim many victims and cause rejection and suffering.
>
> There can be no other goal than a drug-free Europe. Such a goal is neither utopian, nor impossible. Too often, however politicians and others seem to act according to what they think is possible to do, rather than what is necessary to do.
>
> Cannabis products are narcotic drugs
>
> All forms of differentiation between so-called "soft" and so-called "hard" drugs must cease. The use of cannabis is detrimental to the health, causes passivity and is addictive. Cannabis and certain other drugs, in some countries regarded as being "soft" should be viewed as other types of narcotic substances in control policy, rehabilitation and preventive measures.
> Stop commercial outlets for narcotic drugs
>
> Commercial outlets for narcotic drugs, including coffee shops, and other open drug markets or drug scenes in European cities must be closed immediately. Police must be given the authority to act in order to stop the open commercial outlets quickly and effectively.
>
> Put an end to all legal distribution of narcotic drugs
>
> The so called "scientific" projects for distribution of heroin is nothing but an attempt to legalize drugs through the back door. This must be prevented by authorising the United Nations Drug Control Programme (UNDCP) to withdraw all import licenses for heroin, when the heroin is intended for use by drug addicts.

References

[FN1] http://www.ecad.net

## THE SUCCESSFUL SWEDISH MODEL

In February 2007 the UN Office on Drugs and Crime released a study entitled: Sweden's Successful Drug Policy: A Review of the Evidence. [FN1] The Swedish drug control policy has been guided by the goal of achieving a drug-free society and the unequivocal rejection of drugs and their trafficking. The report noted that:

> It is difficult to establish a direct and causal relationship between specific policy measures and the resulting drug situation. Nevertheless, in the case of Sweden, the clear association between a restrictive drug policy and low levels of drug use is striking.

In 1969, the Government of Sweden approved a ten-point programme for increasing public efforts against the drug problem. The ten-point programme was heavy on law enforcement measures but also covers demand reduction issues, in particular, the provision of treatment services to addicts and the prevention of drug abuse.

References

[FN1] Sweden's Successful Drug Policy: A Review of the Evidence. February 2007 the UN Office on Drugs and Crime. http://www.unodc.org; Risk of Legalising Cannabis Underestimated: A Comparison of Dutch and Swedish Drug Policy, Criminal Justice Association, February 2002

## THE NEW VIEW OF HARM REDUCTION - A MORE INCLUSIVE AND REALISTIC CONCEPT

The previous concept of "harm reduction" was aimed at HIV and AIDS and other blood borne infections programmes such as needle exchange and injection sites. These programmes accepted drug use and sought to minimize the harms of drug use and were not primarily aimed at preventing drug use or helping people to become drug-free. However, there is now a new international concept of "harm reduction" that lists the blood borne infection programmes as just a subset of overall harm reduction. In the 2008 meeting of the Vienna NGO committee that had input from over 500 non-governmental organizations (NGO's), the participants issued a declaration defining "harm reduction" as: "meaning efforts primarily to address and prevent the adverse health and social consequences of illicit/harmful drug use, including reducing HIV and other blood borne infections." They then defined illicit/harmful drug use as "drug use where action is necessary, including but not limited to prevention or intervention in the fields of criminal justice, education, health care, social support, treatment or rehabilitation." Thus drug use prevention, education, treatment and law enforcement are now the major part of harm reduction and the previous harm reduction programs aimed at blood borne infections are now just a subset. "Harm reduction" now primarily includes demand and supply reduction and drug use prevention. The only sure way to prevent drug related harm is to prevent drug use. [FN1]

The INCB has noted that "harm reduction" programmes that are not aimed at prevention of drug use or at helping drug users to become drug-free can play a part in a comprehensive drug demand reduction strategy but such programmes should not be carried out at the expense of other

important activities to reduce the demand for illicit drugs, for example drug abuse prevention activities. [FN2]

References

[FN1] Beyond 2008, Vienna, Beyond 2008 Declaration;
http://www.unis.unvienna.org; Nicholas.Austin@draftfcb.com

[FN2] INCB Report 2003 paragraph 219

## HEROIN AS "MEDICINE"

The legalizers claim that heroin should be used in the same manner that morphine is presently used. They claim that because morphine does not always relieve pain the next step is to use heroin. However, heroin and morphine differ from one another. Heroin is more potent and achieves peak pain control and mood elevation effects faster but both pain control and mood elevation are more prolonged with morphine. This makes it a better drug to use. [FN1] In addition, besides morphine, there are many other opiates already available under present pharmaceutical laws. If there are problems with pain it is most likely that physicians fail to prescribe proper dosages of existing medications. In addition, increased medical use of heroin increases the risk of diversion for illegal use and would increase the risk of burglaries at pharmacies and hospitals. [FN2]

References

[FN1] Robert L. McCarthy and Michael Montagne, The argument for therapeutic use of heroin in pain management, American Journal of Hospital Pharmacists, May 1993.
[FN2] Arthur 0. Lipman, The argument against therapeutic use of heroin in pain management, American Journal of Hospital Pharmacists, May 1993.

## DOES THE "MEDICAL" USE OF SMOKED MARIJUANA VIOLATE THE UN CONVENTIONS?

Under the INCB definition of "medical" use for a controlled substance, medical use must be approved by the competent regulatory authority of a country and its usefulness as a medicine recognized by the medical community. In the US smoked marijuana for medical use is not recognized by the US Food and Drug Administration and therefore medical use of smoked marijuana violates the UN Conventions. The FDA released a position statement where they stated that smoked marijuana will not be approved because marijuana has a high potential for abuse, has no currently accepted medical use in treatment in the United States, and has a lack of accepted safety for use under medical supervision. Furthermore, there is currently sound evidence that smoked marijuana is harmful. [FN1]

A review of the research on smoked marijuana was conducted by the US Institute of Medicine. The Institute did not recommend the use of smoked marijuana, but did conclude that active

ingredients in marijuana (cannabinoids) could be isolated and developed into a variety of pharmaceuticals such as Marinol, a drug already approved by the government. [FN2]

For a detailed report on the facts about “medical” marijuana, contact the Drug Free Schools Coalition at: drugfreesc@aol.com

References

[FN1] Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine." U.S. Food and Drug Administration, April 20, 2006. http://www.fda.gov/bbs/topics/NEWS/2006/NEW01362.html

[FN2] Marijuana and Medicine: Assessing the Science Base. Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors. Division of Neuroscience and Behavioral Health, Institute of Medicine, National Academy of Sciences. National Academy Press, Washington D.C., 1999; http://www.nap.edu/html/marimed

## HEROIN MAINTENANCE

The legalization advocates claim that in the interest of “harm reduction” that we should provide heroin to addicts who cannot or will not become abstinent. The theory is that if we give drugs to addicts they will not commit crimes to pay for drugs.

ECAD has a position on this issue:

> The so called "scientific" projects for distribution of heroin is nothing but an attempt to legalise drugs through the back door. This must be prevented by authorising the United Nations Drug Control Programme (UNDCP) to withdraw all import licenses for heroin, when the heroin is intended for use by drug addicts. [FN1]

In the UK until the mid-1960s, physicians were allowed to prescribe heroin to certain classes of addicts. Experts from British Columbia in Canada who evaluated the programme found that the application of the British approach would present serious dangers. The UK programme was faded out. [FN2]

Drugs on prescription - the Stockholm experiment

In 1965, an experimental project was launched for the legal prescription of drugs, the idea being to limit the harmful effects of drug use, both on society and individual abusers. Problems became apparent soon after the experiment had started. As the legally prescribed drugs were increasingly diverted to the illicit market, the project drew criticism from the police and the drug prosecutor. The proportion of arrested people showing signs of intravenous drug use rose in Stockholm from 20 per cent in 1965 to 33 percent in 1967. By 1967 almost all doctors in the project had stopped prescribing drugs. [FN3]

References

[FN1] http://www.ecad.net

[FN2] John S. Russell and Andre McNicoll, The British Experience with Narcotic Dependency, Province of British Columbia Ministry of Health, Alcohol, and Drug Commission, April 1978.

[FN3] Sweden's Successful Drug Policy: A Review of the Evidence, UNODC, February 2007

## INJECTION ROOMS

Injection sites are locations where drug users can administer drugs under supervision and supposedly hygienic conditions. [FN1]

The INCB positions on this issue are found in their reports:

437. Some States in Europe have established so-called "shooting galleries", where drug abusers can administer drugs under supervision and supposedly hygienic conditions. The Board urges those States to consider carefully all the implications of such "shooting galleries", including the legal implications, the congregation of addicts, the facilitation of illicit trafficking, the message that the existence of such places may send to the general public and the impact on the general perception of drug abuse. INCB Report 1998

224. The Board reiterates that article 4 of the 1961 Convention obliges States parties to ensure that the production, manufacture, import, export, distribution of, trade in, use and possession of drugs is to be limited exclusively to medical and scientific purposes. Therefore, from a legal point of view, such facilities violate the international drug control conventions. INCB Report 2003

### The INCB Position on Injection Sites Is Correct Based on the Research

What does the research say about the impacts of these sites and what level of confidence do we have in this research? In 2006, Garth Davies did a comprehensive review of the scientific literature on injection sites for Addictive Drug Information Council. [FN1] He noted that the sites:

> arose during times of converging epidemics, when problems related to both public disorder and public health were perceived to be out of control. With regard to public disorder, open drug scenes and street drug markets where characterized by threatening congregations of addicts, rampant criminal activity, public injecting of drugs, and improperly discarded syringes and other detritus.

He also noted that the sites

> held the promise of lessening some of these symptoms. In terms of public health, many countries were experiencing frightening escalations in the rates of infectious diseases, including HIV, AIDS and Hepatitis C (HCV). Curbing risk behaviors associated with injection drug use, such as syringe sharing, reusing syringes, and using unsanitary equipment was seen as an important step toward reigning in this epidemic.

However, he discovered that there was a lack of quantitative evaluations of these facilities in the public health literature. "As a result, any decisions on whether to establish, continue, or expanding existing facilities are being made in a vacuum, on the basis of potentially incomplete and one-sided data."

In concluding his study he found that due to the methodological and analytical problems of the research all the claims of success from these programs are open question and the following questions remain unanswered:

Have they reached the population they were intended to reach?
Have they encouraged the use of services?
Have they improved health?
Have they reduced drug overdose problems?
Have they reduced public disorder and crimes?

References

[FN1] Garth Davies, The Impacts of Supervised Injection Facilities: A Critical Review Addictive Drug Information Council, November 13, 2006, www.adicbc.com

## NEEDLE EXCHANGE PROGRAMMES

Needle exchange programs are part of the old “harm reduction” strategy. While these programs are widely used there are still questions about their effectiveness especially if they do not have a drug treatment referral component. The public health benefits and social effects of needle exchange programs are at best uncertain, and at worst can be devastating to both addicts and their communities. The following questions are raised about these programs.

1. Have needle exchange programs been sufficiently proven to reduce the epidemic of HIV or HCV infection among injection drug users? There is enough scientific evidence to raise grave doubts about these programs. [FN1]

NEPs may not retard the spread of HIV because HIV is transmitted primarily through high-risk sexual contact, even among IV drug users. Contrary to prior assumptions, recent studies on the efficacy of NEPs have discovered that it is not needle exchange, but instead, high-risk sexual behavior which is the main factor in HIV infection for men and women who inject drugs, and for NEP participants. A recently released 10-year study has found that the biggest predictor of HIV infection for both male and female injecting drug users (IDUs) is high-risk sexual behavior and not sharing needles. High-risk homosexual activity was the most significant factor in HIV transmission for men and high-risk heterosexual activity the most significant for women. The study noted that in the past the assumption was that IDUs who were HIV positive had been infected with the virus through needle sharing. The researchers collected data every 6 months from 1,800 injection drug users in Baltimore from 1988 to 1998. Study participants were at least 18 years of age when they entered the study, had a history of injection drug use within the previous 10 years, and did not have HIV infection or AIDS. More than 90 percent of them said they had injected drugs in the 6 months prior to enrolling in the study. In their interviews, the participants reported their recent drug use and sexual behavior and submitted blood samples to determine if they had become HIV positive since their last visit. The study showed that sexual behaviors, which were thought to be less important among IDUs, are the major risk for HIV seroconversion for  both men and women. ]FN2[

If the above conclusions are correct, the very presumption of NEP efficacy becomes suspect. Indeed, the use of needle exchange programs to address a problem which is caused primarily by high-risk sexual behavior would seem to be highly misguided.

Clean needles, even if they in fact prevent HIV, will do nothing to protect the addict from numerous more imminent fatal consequences of his addiction. It is both misleading and unethical to give addicts the idea that they can live safely as IV drug abusers. Only treatment and recovery will save the addict.

There is ample evidence to suggest that very fundamental premises used to justify and support NEPs are seriously flawed. First, NEP participants routinely continue to share needles, and large percentages of the NEP participants are HIV positive, meaning that NEPs do nothing more than continue the spread of HIV (and HCV). Significantly, no one has been able to explain satisfactorily why enhanced needle availability in and of itself would discourage needle sharing: needle sharing is an intrinsic aspect of IV drug use, and a NEP-issued needle will transmit HIV as well as any other needle.

2. Do needle exchange programs reduce substance abuse or encourage substance abuse? Indeed, the correlation between the rise of NEPs and the explosion of IV drug use, if it is a coincidence, is a remarkable one. Dispassionate observers will look at the current epidemic of heroin and IV cocaine use as a tragedy that might have been averted, or mitigated, but for the misguided mercies of the NEP concept.

3. Are needle exchange programs destructive to the communities in which they are used? While the benefits of NEPs may be in doubt, the costs to the surrounding communities are very real. The overwhelming majority of communities dread the prospect of a local NEP, for self-evident and well-documented reasons. [FN3]

4. Do needle exchange programs send a message to children that drug use is acceptable? Children see discarded needles in the street and see that addicts are helped by society to be addicts. The message is clear - drug use is acceptable.

References

[FN1] Testimony on needle exchange of David G. Evans, Esq. before the New Jersey Senate. Available if requested by e-mail from drugfreesc@aol.com; Loconte, Joe, Killing Them Softly," Policy Review, The Heritage Foundation, 214 Massachusetts Ave. NE, Washington, DC 20002 (August, 1998)

[FN2] Mathias, Robert, High-Risk Sex Is Main Factor in HIV Infection for Men and Women Who Inject Drugs, NIDA NOTES Staff Writer, NIDA Notes, (National Institute on Drug Abuse, Washington, DC) Volume 17, Number 2 (May 2002) Source: Strathdee, S.A., et al. (Sex differences in risk factors for HIV seroconversion among injection drug users.( Archives of Internal Medicine 161:1281-1288, 2001)

[FN3] The Ottawa Citizen (Ontario, Canada) May 15, 2008, http://www.canada.com/ottawacitizen/news/city/story.html?id=dc28b619-6f84-421d-8440-cda183c46abb. Council seeks $100,000 for needle-exchange cleanup. The City of Ottawa will be asking the province for a matching $100,000 contribution for a stepped-up programme to recover discarded needles after the Ontario government initially rejected an initial request for $200,000. Since the needle-exchange programme began in 1991, the city has been under pressure to deal with the proliferation of discarded needles, which many residents consider a public safety issue.

## INDUSTRIAL HEMP

Advocates for drug legalization claim that we should legalize hemp, the plant from which we get marijuana, because hemp could be used as fiber to make clothing and as alternatives to lumber, and paper products. However, there are no economically or environmentally sound reasons for hemp cultivation. This is just a strategy to normalize marijuana.

In the 1940s the use of nylon and other synthetic fibers rendered hemp products all but obsolete. Because of its psychoactive properties production of hemp for other than industrial use or research in the United States became illegal 1970.[FN1]

The drug legalizers have a “bring back hemp” campaign aimed at students who are being recruited into the pro-drug ideology by the use of false economic and environmental claims. [FN2]

Better alternative products exist. [FN3] The U. S. Department of Agriculture and other research shows that the hemp market will be only a small, thin market and is not really economically viable as a fiber or a food or a cosmetic. [FN4]

Hemp is not an environmentally friendly crop because there is a fertilization requirement and the need to deal with insect pests and the use of fungicides to treat the seeds. Hemp creates more soil nutrient depletion than cotton, flax, and grain crops.[FN5]

The European community discourages hemp production and believes that the use of hemp for human consumption will contribute to making the use of marijuana acceptable. [FN6] In 1999, the government agency Health Canada, conducted an assessment of human health problems from ingestion of hemp food and cosmetics and pointed out that there were potential health risks from hemp consumption to the brain, the reproductive system, and cognitive and motor skills.[FN7] Cultivation of industrial hemp as a commercial crop would necessitate enormous monitoring costs to prevent it from being diverted to the illegal drug use market.[FN8]

References

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[FN3] ONDCP Statement on Industrial Hemp, Office of National Drug Control Policy, July 29, 1997 www.whitehousedrugpolicy.gov/policy/hemp; Vantreese, Valerie, University of Kentucky, Department of Agriculture Economics, as quoted in Industrial Hemp: Legislative Briefing, January 1999 and January 2001. www.uky.edu/Classes/GEN/101/Hemp/welcome.html

[FN4] Industrial Hemp in the United States: Status and Market Potential, United States Department of Agriculture, January 2000, (www.ers.usda.gov/publications/ages001E/ Scroll & click Full Report); Atchison, Joseph E., Atchison Consultants, Inc., Sarasota, FL, "Putting the Use of Hemp (Cannabis sativa) as a Papermaking Raw Material Into the Proper Perspective," Prepared for Presentation at a DEA sponsored Conference on Hemp

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## ECSTASY TABLET TESTING

In some countries where Ecstacy is used there are programmes for having the composition and quality of the Ecstacy tested and then returned to the drug users to inform them if the drug is impure or adulterated. This is part of the old “harm reduction.”

The INCB has taken a position on this program.

225. In some countries where the abuse of synthetic drugs, mainly amphetamine-type stimulants, has become widespread, authorities have provided facilities for having the composition and quality of the drugs, usually in tablet form, tested and then returned to the drug abusers, informing them about the results of the test, in particular to warn them if the drug is impure or adulterated. The Board has been concerned that such practices conveyed the wrong message on the risks of drug abuse and provided a false sense of safety for drug abusers, thereby running contrary to drug abuse prevention efforts required from Governments under the international drug control conventions. The Board notes the announcement of the Government of the Netherlands, one of the first countries where such drug testing had been introduced, that the programme of pill testing at parties and clubs had been terminated in order to avoid the projection of messages counterproductive to drug abuse prevention efforts. INCB Report 2003

Tablet testing will change young peoples’ perception of drug use

The benchmark surveys of drug use show that when young people believe a drug is harmful, the fewer young people use that drug. [FN1] Tablet testing does not deter drug use and actually makes it easier. It sends the wrong message.

References

[FN1] Monitoring the Future, National Institutes of Health, National Institute on Drug Abuse, available on the Internet at www.monitoringthefuture.org; Overview of Findings from the 2002 National Survey on Drug Use and Health (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03- 3774). Rockville, MD; Conducted for SAMHSA (the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services) by North Carolina's Research Triangle Institute.

## INCLUDING DRUG USERS AS EQUAL PARTNERS IN MAKING POLICY

All persons who are effected by drug use have something to share and they deserve compassion. Treatment programs need to hear from their clients so that they can gain further insights in how to be helpful. However, some illicit drug users, who do not wish to be abstinent, are now asking for a place at the policy table and to be part of making policy decisions. As illicit drug users who choose to use drugs they do not support the best goal for those addicted to drugs which is abstinence. Until they decide to accept abstinence as a goal and to comply with the law, they can provide input but should not be equal partners. Their mere presence at the policy table undermines our efforts for a drug free society.

## HUMAN RIGHTS ISSUES

All UN programmes strive to protect human rights. What is and is not a human right in the drug abuse context is open for interpretation. Some believe that they have a human right to use drugs. Some others believe that they have a human right to a drug free society. There is nothing in the Conventions that interferes with fundamental human rights.

### ABOUT THE AUTHOR

Attorney David G. Evans, Esq. is the Executive Director of the Crime and Justice Project of the Drug Free Projects Coalition. The Crime and Justice Project is dedicated to developing common sense solutions to the problems of drug and alcohol use and crime and law. Mr. Evans also has a law practice concentrating on consulting, and state and federal litigation in the areas of employment law, personal injury, criminal defense, substance abuse, drug and alcohol-free workplaces, drug and alcohol testing and governmental affairs. He was a Research Scientist in the Data Analysis and Epidemiology Services Unit of the Division of Alcoholism and Drug Abuse in the New Jersey Department of Health. He analyzed the legal and regulatory requirements regarding: drug and alcohol abuse, research and data collection, courts, criminal justice, domestic violence, drug-free workplaces, juveniles, confidentiality, treatment, drug testing, AIDS, drug use forecasting, and discrimination. Prior to that he was the manager of the New Jersey Intoxicated Driving Programme and served as a Trial Attorney, with the New Jersey Public Defender and he was the Coordinator of Citizen Action and Research of the New Jersey Association on Corrections.

He currently is a Special Advisor to the Drug Free America Foundation and to Save our Society From Drugs. He also serves as the Executive Director of the Drug Free Schools Coalition an organization that advocates for drug free schools and student drug testing.

He has written five books: (1). Federal and State Guide to Employee Medical Leave Benefits and Disabilities Law, Thomson/West, Rochester, NY, 1999; (2). Designing an Effective Drug-Free Workplace Compliance Program, Thomson/West, Rochester, NY, l993; (3). Drug Testing Law, Technology, and Practice, Thomson/West, Rochester, NY, l990; (4) Kids, Drugs, and the Law, Hazelden Publishers, Center City, Minnesota, 1985; (5) A Practitioner's Guide to Alcoholism and the Law, Hazelden Publishers, Center City, Minnesota, 1983

He served on the faculties of the John Jay College of Criminal Justice and the Rutgers School of Alcohol Studies where he taught courses on substance abuse, crime, and the law. He was also on the faculty of Kean College where he taught a course on the legal aspects of medical records.

In 2003 Mr. Evans received the McGovern Award. The award recognizes innovations in drug abuse prevention. Recipients of the award are selected on the basis of their impact on drug abuse policy by developing intellectually sound ideas that have the promise of substantially reducing substance abuse. Mr. Evans received the award because of his work nationally as an advocate for student drug testing.