Does Europe Do It Better? Lessons from Holland, Britain and Switzerland

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

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

DECRIMINALIZING MARIJUANA: THE DUTCH COFFEE SHOPS

Dutch cannabis policy and its effects are routinely mischaracterized by both sides in the US drug debate. Much of the confusion hinges on a failure to distinguish between two very different eras in Dutch policy. In compliance with international treaty obligations, Dutch law states unequivocally that cannabis is illegal. Yet in 1975 the Dutch adopted a formal written policy of nonenforcement for violations involving possession or sale of up to thirty grams (five grams since 1995) of cannabis—a sizable quantity, since one gram is sufficient for two joints. Police and prosecutors were forbidden to act against users, and officials adopted a set of rules that effectively allowed the technically illicit sale of small amounts in licensed coffee shops and nightclubs. The Dutch implemented this system to avoid excessive punishment of casual users and to weaken the link between the soft and hard drug markets; the coffee shops would allow marijuana users to avoid street dealers, who may also traffic in other drugs. Despite some recent tightenings in response to domestic and international pressure (particularly from the hard-line French), the Dutch have shown little intention of abandoning their course.

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

From the mid-eighties Dutch policy evolved from the simple decriminalization of cannabis to the active commercialization of it. Between 1980 and 1988, the number of coffee shops selling cannabis in Amsterdam increased tenfold; the shops spread to more prominent and accessible locations in the central city and began to promote the drug more openly. Today, somewhere between 1,200 and 1,500 coffee shops (about one per 12,000 inhabitants) sell cannabis products in the Netherlands much of their business involves tourists. Coffee shops account for perhaps a third of all cannabis purchases among minors and supply most of the adult market.

As commercial access and promotion increased in the eighties, the Netherlands saw rapid growth in the number of cannabis users, an increase not mirrored in other nations. Whereas in 1984 15 percent of 18- to 20-year-olds reported having used marijuana at some point in their life, the figure had more than doubled to 33 percent in 1992, essentially identical to the US figure. That increase might

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have been coincidental, but it is certainly consistent with other evidence (from alcohol, tobacco and legal gambling markets) that commercial promotion of such activities increases consumption. Since 1992 the Dutch figure has continued to rise, but that growth is paralleled in the United States and most other rich Western nations despite very different drug policies—apparently the result of shifts in global youth culture.

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

Treating Heroin Addicts in Britain

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

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

"Heroin-Assisted Treatment": Swiss Experience

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

Then in January 1994 Swiss authorities opened the first heroin maintenance clinics, part of a three-year national trial of heroin maintenance as a supplement to the large methadone maintenance program that had been operating for more than a decade. The motivation for these trials was complex. They were an obvious next step in combating AIDS, but they also represented an effort to reduce the unsightliness of the drug scene and to forestall a strong legalization movement. The program worked as follows: Each addict could choose the amount he or she

wanted and inject it in the clinic under the care of a nurse up to three times a day, seven days a week. The drug could not be taken out of the clinic. Sixteen small clinics were scattered around the country, including one in a prison. Patients had to be over 18, have injected heroin for two years and have failed at least two treatment episodes. In fact, most of them had more than ten years of heroin addiction and many treatment failures. They were among the most troubled heroin addicts with the most chaotic lives.

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

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

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

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

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

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