Journal of Contemporary Health Law & Policy (1985-2015)

Volume 9 | Issue 1 Article 21

1993

To Take up Arms Against a Sea of Drugs

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I. ABSTRACT

Restricting availability is the major response to illicit drugs globally and has been adopted as national policy in almost all countries. The health, social, and economic costs of supply reductions, however, are substantial and are increasing for both injecting drug users (IDUs) and the general community. For many countries, the costs far outweigh the benefits. The possible impact of supply reduction drug policy on the spread of HIV-1 infection among IDUs is an all important but largely neglected consideration. The effectiveness of supply reduction policy is unlikely to be increased significantly by allocation of greater resources, by more vigorous implementation, or by adoption of new technology. A range of alternative, credible options, including controlled availability, deserve consideration. Controlled availability is feasible and plausibly has greater benefits and fewer health, social, and economic costs than supply restriction. Innovative methods of providing currently illicit drugs to those who are determined to consume them deserve careful evaluation and comparison against current policies.

II. INTRODUCTION

To decide whether current drug policy should be reviewed and possibly reformed requires that four basic questions be answered: (1) Is current policy working satisfactorily?; (2) If not, can it be modified to achieve satisfactory results?; (3) If not, do feasible, credible alternative options exist in comparison to present policy?; and (4) Are alternative options likely to be more effective than the present policy? Drug policy reform is desirable if the benefits of reform are to more significantly outweigh the costs than the benefits and costs arising from the present supply reduction policy. Policies always have to take local factors into account. A successful policy for Patagonia may be a disaster in Xanadu and vice versa.

It is difficult to resolve the impasse in the present drug policy debate without agreement on terms and objectives. Terms such as "legalization" and

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"decriminalization" are used widely but with a bewildering variety of meanings. If legalization means the legal provision "of a drug of addiction to a person known to be an addict," then a form of legalization has been accepted for over two decades in countries as diverse as the United States, Sweden, the United Kingdom, and Australia, where methadone maintenance programs have become well accepted.

Much of the confusion in the vigorous debate over drug policy results from a lack of clarity in the aims of the exercise. Should the objective of national responses to illicit drugs be the reduction, or elimination of drug use, or the minimization of harm consequent to drug use? If it is agreed that amelioration of the harmful complications of drug use is the desired objective, then it must be acknowledged that there are many ways by which this aim can be achieved. The reduction or elimination of drug consumption is but one approach. Alternatively, the same objective of reducing the sequelae of drug use could be achieved with unchanging, or even increasing drug consumption if the drug use could be rendered less hazardous. But if drug use is itself presumed to be evil, it follows logically that any consumption of specified drugs should be reduced, or preferably, eliminated.

The question of whether drug consumption or drug-related harm is the more appropriate target of government policy was clearly answered in a recent major policy statement by the United States:

> [W]e must come to terms with the drug problem in its essence: use itself. Worthy efforts to alleviate the symptoms of epidemic drug abuse—crime and disease, for example—must continue unabated. But a largely ad-hoc attack on the holes in our dike can have only an indirect and minimal effect on the flood itself.[1]

It seems absurd, however, to consider the use of heroin or cocaine as intrinsically evil. After all, several of the very drugs now considered taboo had for many years been regarded as useful members of the pharmacopeia of a number of countries without any question of their administration being considered a form of wickedness. Harm resulting from drug use is the more appropriate target of national and international drug policy, as was noted in an authoritative statement of Australian policy: "[T]he aim is to minimize the harmful effects of drugs on Australian society."[2] Recognizing that the reduction of drug-related harm should be the intended objective of national drug policy and that decreasing drug consumption is but one possible means of achieving this end is the first step to a more rational approach to drug policy.

1. OFFICE OF NATIONAL DRUG POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, NATIONAL DRUG CONTROL STRATEGY 8 (1989).

2. DEPARTMENT OF HEALTH, NATIONAL CAMPAIGN AGAINST DRUG ABUSE 2 (1985).

In order to decide whether reform of drug policy should even be considered, it is necessary to clarify first the intended benefits to be achieved and the specific costs to be avoided.[3] The adverse consequences of drug use can involve health, social, and economic domains, and these must be considered separately for individuals and societies.

III. Health Costs Associated with Illicit Drugs

The pooled mortality rates for injecting drug users was estimated from 12 to be 9.6 deaths/1,000 person-years, representing a relative risk compared to persons in the general population of similar age and sex of 17.1.[4] A far higher mortality rate, however, was recently reported of HIV-1 infected IDUs even before the onset of AIDS.[5] The injection of illicit drugs is, therefore, changing from what was once a slightly hazardous pastime to a high-risk behavior. In large parts of Europe, North America, and Southeast Asia, this transition has already occurred.[6]

Overdose has always been a major cause of death associated with IDU, although distinguishing between accidental and suicidal overdose is exceedingly difficult. Bacterial, viral, fungal, and parasitic infections continue to make an important contribution to morbidity and mortality in this population. In the era of AIDS, overdose still remains an important cause of death among IDUs and is possibly at least partly preventable because the concentration of street drugs is unknown. The uncertain concentration and microbiological and chemical adulteration of street drugs are responsible for the majority of adverse health consequences of illicit drugs. The common practice of sharing injection equipment, which also contributes substantially to the spread of a number of blood-borne infections in this population, forms part of the sub-culture of IDUs. In recent years, encouraging progress was made in reducing the extent of sharing injection equipment in a number of countries.[7] Deficiencies in quality control of street drugs and unhygienic

3. *See* Ethan A. Nadelman, *Drug Prohibition in the United States: Costs, Consequences, and Alternatives*, 245 SCIENCE 939-47 (1989) ("Drug legalization policies that are wisely implemented can minimize the risks of legalization, dramatically reduce the costs of current policies, and directly address the problems of drug abuse.").

4. *See* C.D.J. HOMAN ET AL., COMMONWEALTH DEP'T OF COMMUNITY SERVS. & HEALTH, THE QUANTIFICATION OF DRUG CAUSED MORBIDITY AND MORTALITY IN AUSTRALIA (1990).

5. Rand L. Stoneburner et al., *A Larger Spectrum of Severe HIV-1 Related Disease in Injecting Drug Users in New York City*, 242 SCIENCE 916, 918-19 (1988).

6. Alex Wodak & A. Moss, *HIV-1 Infection and Intravenous Drug Users: From Epidemiology to Public Health*, 4 AIDS §§ 105-109 (1990).

7. R.P. Brettle, *HIV and Harm Reduction for Injection Drug Users*, 5 AIDS §§ 125-136 (1990).

injection practices are exacerbated by the illegal status of street drugs and are not side-effects that can be reliably predicted from the pharmacology of the psychoactive ingredients. The health costs of drug use, however, are not restricted to IDUs. Several of the blood-borne infections such as hepatitis B or C are passed on from drug users to non-drug users. Non-drug using heterosexuals in most developed countries at present face the greatest risk of acquiring HIV-1 infection from sexual contact with an IDU.[8]

IV. THE SOCIAL COST OF INJECTING DRUG USE

The social costs of drug use are both substantial and diverse. Although in many countries drug users span the socio-economic spectrum, the consumption of using illicit drugs seems to be both a consequence and cause of poverty. In addition, for many if not most consumers, the consequences of illicit drugs includes being at times ostracized from families, losing children, being unemployed, having unsatisfactory personal relationships, being an inadequate parent, and spending long periods in prison. But the social costs of drug use are also high for societies and such costs include the destruction of neighborhoods and rampant criminality. Corruption of the criminal justice and political systems and infringement of civil liberties also seem to be common companions of supply reduction policies in many countries. None of these individual or community social costs can be attributed to the pharmacology of the drugs consumed. Rather, these costs stem from attempts to decrease drug use, or possibly to diminish drug-related harm by reducing drug use.

V. THE ECONOMIC COST OF INJECTING DRUG USE

The individual drug user pays an inflated price for intoxication from illicit compared to licit drugs. Most drug users, however, do not pay for the full cost of their drug use as this is largely passed on to non-drug users through property crime. It is difficult to estimate the full economic cost to society of illicit drug use which covers law enforcement efforts directed to suppress the cultivation, production, transport, sale, and consummation of specified substances; the expense of running courts and prisons; and insurance premiums and lost productivity. The cost of illicit drugs to the United States in 1983 was estimated to be $60 billion,[9] representing about half the estimated cost

8. Don C. Jarlais et al., *HIV Infection and Intravenous Drug Use: Critical Issues in Transmission Dynamics, Infection Outcomes and Prevention*, 10 REV. INFECTIOUS DISEASES 151-53 (1988). In New York City, 87% of the cases of heterosexual transmission have occurred from an IV drug user to a sexual partner who does not inject drugs. *Id.* at 152.

9. *See generally* RESEARCH TRIANGLE INSTITUTE, ALCOHOL, DRUG ABUSE &

of alcohol to the economy of the United States in the same year ($117 billion). It was conservatively estimated that in 1988 Australia spend a $258 million on law enforcement associated with illicit drugs.[10] This is equivalent to the annual cost in Australia of either running a 1,200 bed-hospital, incarcerating 8,000 prisoners or keeping 100,000 patients in methadone maintenance treatment. Once again, these costs should not be regarded as inevitable sequelae arising from the pharmacology of street drugs but rather as the costs incurred by law enforcement authorities intending to prevent the adverse consequences of illicit drug use.

VI. The Benefits of Illicit Drugs

It may seem perverse to consider even the possibility that illicit drugs could have benefits for some individuals or societies. But it is as important to assess the possible benefits of illicit drugs as it is to evaluate the effectiveness of attempts to diminish their supply. The global proceeds of the illicit drug industry now exceed $300 billion,[11] thus suggesting that there are major benefits for someone. Peasants growing opium poppies in areas where there are no roads, and doctors use opium as a traditional medicine to relieve pain, control diarrhea, and assuage hunger. For many families living in traditional growing areas, opium provides a few bright moments in a life of severe and unremitting hardship. For some, growing illicit drugs is a means of survival in a world of falling commodity prices and declining living standards. Whatever heroin may mean to communities and politicians in industrialized, and now some developing countries, for many farmers in the Golden Triangle and Golden Crescent, growing opium is a way of buying a kerosene lamp or bicycle or simply making ends meet. As stated in a recent U.S. report: "[P]easants have turned to cultivating the coca plant because it is the most lucrative cash crop, offering in one season an income equivalent to many a year's effort growing traditional crops."[12] With an increasing number of third world countries trapped by mounting debt, cultivating illicit drugs is a way of making ends meet.

> [I]t cannot be denied that Colombians in general have benefited to some extend from the huge infusion of cash and capital brought

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Mental Health Admin., U.S. Dep't of Health, Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness (1986).

10. D.J. Collins & H.M. Lapsley, National Campaign Against Drug Abuse Estimating the Economic Costs of Drug Abuse In Australia 86 (1991).

11. Bureau of International Narcotic Matter, U.S. Dep't of State, International Narcotics Control Strategy Report 48 (1990) [hereinafter Narcotic Matter].

12. Office of Atty. Gen., U.S. Dep't of Justice, Drug Trafficking: A Report to the President of the United States 19 (1989).

> about by the drug trade. It is believed, for example, that the Colombian Government was able to avoid rescheduling its foreign debt payments due to the positive economic effects of the drug boom.[13]

For the vast army of middle men, distributors, organizers, and the international underworld, there are rich pickings to be made from the transport and distribution of illicit drugs. This is not to commend or condone an illegal enterprise, but merely to note that there is a clear benefit to those willing to take the relatively small risks of heavy penalties which may result from successful detection and prosecution. The international terrorist organizations are also not unaware of the lucrative profits to be made from transporting a kilogram of heroin since its merchandise increases 1500 times. To the costs of attempting to diminish availability of illicit drugs should be added to the subsidy that this trade provides to a number of international terrorist organizations from the Shining Path (Sendoro Luminoso) of Peru to the Tamil Tifers in Sri Lanka.

Illicit drugs also provide employment to an army of customs officials, police officers, lawyers and drug treatment staff. The fact that supply reduction policies generate substantial legal employment is a benefit that cannot be denied. It is also undisputable that many IDUs derive exquisite pleasure from the consumption of illicit drugs. Moreover, for residents of deprived inner city neighborhoods in some western countries, involvement in the distribution of illicit drugs provides one of the few available albeit illusory escape routes from a lifetime of squalor, unemployment, and poverty.

VII. The Effectiveness of Supply Reduction Policies

Although one of the major objectives of attempts to restrict the supply of illicit drugs is the reduction of availability, it is difficult to find convincing evidence of a sustained decrease in the supply of psychoactive substances following the application of this policy. The vagaries of weather seem more likely than law enforcement efforts to decrease the global availability of drugs. A recent official U.S. report concluded that "global production of opium increased each year during the last decade and more than doubled between 1986 and 1990."[14] Global coca production increased 25% between 1989 and 1990.[15] The report continued by stating that "although precise information is difficult to obtain, it seems clear that worldwide abuse of drugs is increasing. A number of countries reported or were estimated to

13. *Id.* at 20.
14. Narcotic Matter, *supra* note 11, at 13.
15. *Id.*

have more intense drug abuse problems than in previous years."[16] It is not difficult to understand why supply reduction policy has been so unsuccessful. A study of the economics of drug markets and their interaction with law enforcement authorities observed that "[t]he 'success' of law enforcement in maintaining high prices is also its Achilles heel, creating extraordinary opportunities for extraordinary profits, thereby attracting entrepreneurs whom the law seeks to discourage by enforcement of the very law(s) which created profitable markets and attracted entrepreneurs in the first place."[17]

If evidence of the effectiveness of supply reduction policy in decreasing drug availability or drug-related problems is lacking, can there be any confidence that intensification or some other modification would be more successful? A recent study funded by the U.S. Department of Defense estimated the impact of increasing the effectiveness of interdiction of cocaine from 20% to 50% and determined that this would result in only a 4% increase in cocaine prices.[18] An earlier comprehensive review of strategies for controlling adolescent drug use in the United States concluded that "further increases in law enforcement effort are not likely to substantially reduce drug use,"[19] and "more intense law enforcement is not likely to substantially affect either the availability or the retail price of drugs in this country."[20] It is difficult to believe that the lack of evidence of the effectiveness of supply reduction policy reflects either insufficient allocation of resources, a reluctance to adopt stern measures, or patience in the effect of policies. Has the time not already come to conclude that supply reduction policies neither restrict significantly the availability of drugs nor decrease the incidence of drug-related problems? Can there be any confidence that intensification of application or other modification of these policies will be more effective? As George Schultz, former U.S. Secretary of State concluded, "the conceptual base of the current program is flawed and the program is not likely to work . . . . We need at least to consider and examine forms of controlled legalization of drugs."[21]

VIII. Alternatives to Supply Reduction Policy

Is there an alternative to supply reduction policy? The choice for policymakers is more extensive than selecting between existing policy and legaliza-

16. *Id.*

17. Steven Wisotsky, Breaking the Impasse in the War on Drugs 32 (1986).

18. *See generally* Peter Reuter et al., Sealing the Borders: The Effects of Increased Military Participation in Drug Interdiction (1988).

19. J. Michael Polich et al., Strategies for Controlling Adolescent Drug Use 155 (1984).

20. *Id.* at 157.

21. *Schultz on Drug Legislation*, Wall St. J., Oct. 27, 1991, at A16.

tion. A range of options is available.[22] Under total prohibition, the cultivation, production, use, possession, and sale of drugs are all prohibited and regarded as a criminal offense.[23] In the second option of modified total prohibition which is also referred to as "decriminalization," personal use, possession, and cultivation for personal use are defined as illegal but only attract nominal fines.[24] Supply is still regarded as a criminal offense, but the minimum quantity linked to a penalty can be varied. A third policy option is partial prohibition where personal use and cultivation are not considered an offense.[25] Public use, commercial cultivation and sale, however, remain illegal and subject to a set of variable fines. A fourth option is a user license system whereby some form of controlled use is permitted following the issuance of a license or registration.[26] A fifth option is free availability where there are minimal or no restrictions on availability.[27] These options originate from a Canadian Royal Commission on cannabis,[28] but they apply equally well to other illicit drugs, or for that matter, to legal drugs.

Most western countries in the nineteenth century permitted the use of currently illicit substances with relatively few regulations. In some countries, opium and later cocaine-containing compounds could be obtained from grocery stores and later from retail pharmacies. The foundation of the present system of supply reduction began with an International Conference in Hague in 1912.[29] This system has progressively intensified in recent decades by a number of international treaties and a proliferation of international regulatory authorities. There is little likelihood of returning to the nineteenth century laissez-faire system for psychoactive substances even though this was associated with relatively stable levels of consumption and apparently

22. *See* Greg Chesher & Alex Wodak, *Evolving a New Policy for Illicit Drugs*, 20 J. DRUG ISSUES 555-61 (1990) (stating that these alternative policies offer greater individual and societal benefits and fewer negative consequences). The options include: decriminalization; a selective moratorium on the application of drug laws as they apply to the drug users; availability on prescription by a medical practitioner; a legal market with controls similar to those presently exercised on alcohol and tobacco; regulated availability. *Id.* at 556-59.

23. *Id.* at 556.

24. *Id.*

25. *Id.* at 557.

26. *Id.* at 558.

27. *Id.* at 559-60.

28. GERALD LE DAIN ET AL., GOV'T OF CANADA, REPORT OF THE COMMISSION OF INQUIRY INTO THE NON-MEDICAL USE OF DRUGS 10 (1972) (discussing the treatment of opiate dependents) [hereinafter LE DAIN COMMISSION].

29. DAVID F. D. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL 49-52 (1973); K. BRUUN ET AL., THE GENTLEMEN'S CLUB: INTERNATIONAL CONTROL OF DRUGS AND ALCOHOL 1 (1975).

few opium or cocaine-related problems.[30] Speculation about a possible return to free availability is unhelpful as it is exceedingly unlikely that any western country in the foreseeable future could ever gather sufficient political support to countenance such a move or be able to extricate itself from relevant international treaty obligations. The development of rapid transport of goods between potential producer and consumer countries, ready availability of multiple use, cheap injection equipment and substantial third world debt may be some of the factors which prevent a return to the halcyon policies of yesteryear. But the association between the laissez-faire policies of western countries in the nineteenth century with relatively few observed problems contrasts starkly with the contemporary situation in which a plethora of response-related sequelae are all too evident and problems which are directly consequent on the pharmacology of illicit substances are remarkable for their comparative rarity.

The likelihood of success of a prohibition policy depends upon the demand for the psychoactive substance, the scope for illicit cultivation, production or concealed transport, and the availability of possible substitutes with similar properties. Prohibition can be a successful policy, as in the case of Mandrax (methaqualone-melsedin), where demand was modest, domestic productions were difficult, and other psychoactive substances were more readily available.

An alternative option to current policy which must be seriously considered is the controlled availability of current illicit substances. Such a system has been implemented in the United Kingdom to a greater or lesser extent since the 1926 Rolleston Royal Commission advised that prescribing opium for addicts was reasonable if the patient could not be withdrawn without serious withdrawal symptoms; if the patient were undergoing a gradual withdrawal; or if the patient needed the drug to lead a useful and normal life.[31] A similar approach was adopted in the United States when intravenous morphine was supplied to registered drug addicts from a number of centers across the country during the 1920s.[32] Morphine maintenance in the United States was regarded as a generally reputable operation, but the program came to an abrupt end because it was seen to be irreconcilable with the prevailing spirit of the prohibition of alcohol.[33]

In Britain, intravenous heroin, cocaine, and amphetamines have all at

30. *See* VIRGINIA BERRIDGE & GRIFFITH EDWARDS, OPIUM AND THE PEOPLE: OPIUM USE IN NINETEENTH CENTURY ENGLAND (1981).

31. ROLLESTON COMMITTEE, MINISTRY OF HEALTH, REPORT OF DEPARTMENTAL COMMITTEE ON MORPHINE AND HEROINE ADDICTION 19 (1926).

32. MUSTO, *supra* note 29, at 49-52.

33. LE DAIN COMMISSION, *supra* note 28, at 10.

times been legally prescribed since the Rolleston Royal Commission. The prescribing of oral methadone has become far more popular since the 1960s and prescribing of intravenous heroin, cocaine, and amphetamines is now uncommon. The only publishable study comparing the effectiveness of oral methadone and intravenous heroin produced equivocal results.[34] The Drug Dependency Clinic in Widnes, an outer suburb of Liverpool, briefly reported their innovative approach.[35] Following a clinical assessment, selected patients are provided with either oral methadone or heroin, cocaine or amphetamines in intravenous or smokable form. Unintended negative consequences have not been reported. As no formal external evaluation is yet available, it is not possible to say whether this clinic has been more successful in reducing the complications of street drug use than have other approaches. It is undeniable, however, that this policy is operationally feasible. It is possible to select patients who are suitable for this kind of treatment, chose to prescribe certain drugs and not others, and decide on the dose to be prescribed. Such innovative approaches need to be carefully and independently evaluated. It can be concluded confidently from the historical and contemporary experience with controlled availability in the United States[36] and United Kingdom[37] that this is a feasible alternative. Comparing the costs and benefits of controlled availability with supply reduction policy, however, requires more information than is available presently.

The spread of HIV-1 infection now presents the most serious complication of drug injecting both for IDUs and non-drug users alike was noted in a Scottish report soon after an epidemic of HIV was detected in Edinburgh that: "the gravity of the problem is such that on balance the containment of the spread of the virus is a higher priority in management than the prevention of drug misuse."[38] Drug policy, therefore, also needs to be considered from the perspective of the known or likely impact of HIV-1 transmission.[39] In the absence of any panacea, least worst solutions are the appropriate goal of the policy-maker.

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34. *See generally* Richard L. Hartnol et al., *Evaluation of Heroin Maintenance in Controlled Trial*, 37 ARCHIVES GEN. PSYCHIATRY 877-84 (1980). This study tested IDU's response to a maintenance program when treated with injectable heroin or oral methadone. *Id.* at 877.

35. J.A. Marks, *The North Wind and the Sun*, 21 PROCEEDINGS ROYAL COLL. PHYSICIANS EDINBURGH 319-27 (1991).

36. MUSTO, *supra* note 29, at 49-52.

37. Marks, *supra* note 35, at 319.

38. *See generally* SCOTTISH HOME & HEALTH DEP'T, HIV INFECTION IN SCOTLAND: REPORT OF THE SCOTTISH COMMITTEE ON HIV INFECTION AND INTRAVENOUS DRUG MISUSE (1986).

39. Alex Wodak, *The Connection Between HIV Infection in Injecting Drug Users and Drug Policy*, 1 INT'L J. DRUG POL'Y 22-23 (1990).

IX. The Plausibility of Controlled Availability

By supplying pharmacological preparations of currently illicit drugs in known concentrations together with sterile injection equipment, it is reasonable to assume that the number of deaths from accidental overdose, and microbiological and chemical contamination will be reduced substantially. As these are currently the major causes of heroin-related, or more correctly prohibition-related, heath problems, a reduction in morbidity and mortality among IDUs is plausible. By supplying ancillary vocational and counseling services to a larger proportion of drug users attracted into treatment by a greater diversity of options, it is likely that improved rehabilitation will also be achieved. Achieving a greater participation rate of illicit drug users in treatment is likely to lessen the social cost of drug use for individual drug users as well as for the broader community. If the cost of running a vastly expanded treatment service responsible for dispensing intravenous heroin, cocaine, and amphetamines is similar to that of oral methadone programs, the expenditure required is likely to be far less than that currently allocated to law enforcement responses to street drugs because drug treatment is far cheaper than incarceration.

Law enforcement will always have a critical role to play in response to currently illicit drugs just as it forms an important component of the control of legal drugs. Although there is insufficient evidence at present, and such evidence will probably never become available to compare directly the costs and benefits of current policies with controlled availability, a policy of controlled availability of illicit drugs with corresponding less emphasis on supply reduction would almost certainly result in a decrease in crime, less corruption, and fewer infringements upon civil liberties. An essentially health and welfare response would replace the current emphasis on law enforcement.

Unintended negative consequences of new policies would need to be anticipated and minimized. The difficulties of introducing controlled availability in Britain in the sixties and seventies should give pause for thought.[40] Were these difficulties the inevitable result of controlled availability, or were they peculiar to the system adopted? The lack of reports of similar difficulties in the sizeable morphine maintenance program implemented in the United States[41] suggests that these problems are not inevitable companions to controlled availability. A widespread system of controlled availability will almost certainly put more strain on the reputability of medical practice.

40. Gerry A. Stimson & Edna Oppenheimer, Heroin Addiction: Treatment and Control in Britain 49 (1982).

41. Musto, *supra* note 29, at 49-52.

Clearer guidelines and improved surveillance of doctors would probably need to be introduced. The financial savings resulting from the treatment of illicit drugs largely as a health and welfare, rather than as a law enforcement matter are likely to be substantial.

X. THE EFFECT OF CHANGING POLICY ON THE NUMBER OF DRUG USERS

One of the most prominent and persistent fears about any change in policy is the possibility that an increase in the numbers of persons using currently illicit drugs would follow reform. Unfortunately, we can only speculate as to the effect of changing policies on the number of drug users in a community. The experience of liberalizing policies on cannabis in a few states of the United States provides some guidance. No increase in marijuana use was attributed to decriminalization, but costs of law enforcement and prosecution fell.[42] The number of person consuming drugs should at any rate be less of a concern than the incidence and severity of drug-related harm.[43]

If a system of controlled availability resulted in an increase in the number of drug-users and we have no reason to suppose that this would be the case, but the incidence and severity of drug-related harm decreased because drug use became safer, this should be regarded as a positive outcome. And if the number of drug users remained unchanged, but drug-related harm decreased because drug use had become safer, would this not also be a consummation devoutly to be wished?

Supply reduction drug policies are supposed to suppress drug use by increasing the retail cost of illicit drugs through maintaining a high risk of arrest, prosecution, and punishment. This approach is also purported to deter drug use by raising the health and social costs of illicit drug consumption for consumers although again a considerable proportion of these penalties are passed on to the general community.

As a consequence of a supply reduction approach to illicit drugs, a pyramidal distribution system is established with user-dealers required to recruit new consumers to offset the high use of drugs. This type of distribution is an extremely efficient retailing system for merchandise where a monopoly of supply exits. It is difficult to imagine a more efficient system for recruiting drug users into a wholesale and retail illicit drugs distribution network than a supply-restriction drug policy which inadvertently ensures that the harm consequent on drug consumption for drug users and the general community

42. Eric W. Single, *The Impact of Marijuana Decriminalization: An Update*, 1989 J. PUB. HEALTH POL'Y 457, 462 (1989).

43. *Id.* at 462-63.

alike is maximized. One of the extraordinary features of the current drug policy debate is the failure to acknowledge the importance of market forces at a time when historical events taking place across the world serve to emphasize that they cannot be ignored.

XI. CONCLUSION

The increasing costs and limited effectiveness of present attempts to control the supply of drugs ultimately will force many countries to consider credible options. A system of controlled availability appears to be a feasible alternative worthy of consideration and careful evaluation.

Fundamentally, the choice for many countries lies between the present policy of supply restriction, which leads to criminals selling contaminated drugs of unknown concentration indiscriminately to any person who can meet the purchase price, and a system of controlled availability involving the dispensing of sterile drugs of known concentration to selected drug users who could be supervised and offered other forms of assistance. A system of controlled availability would not eliminate all of the many unhappy consequences of illicit drugs. It would not, for example, represent a satisfactory answer to recreational drug use. On present evidence, however, it can be concluded confidently that taking up arms against a sea of drugs does not by opposing them end them.