PREFACE

THE VARIETIES OF DRUG CONTROL AT THE DAWN OF THE TWENTY-FIRST CENTURY

The world now has a century of experience with refined cocaine and heroin and has observed their consequences. For most of that century, as many citizens in the industrialized nations experimented with those drugs, their governments experimented with various forms of legal prohibition. A few countries—most notably the Netherlands, Great Britain, and Switzerland—have been willing to test a wide range of control strategies. Most others—including the United States—have generally tinkered at the margins of a narrow criminal justice model, perhaps augmented with minimal provision of public drug treatment.

Some foreign experiences have long been a staple of the American drug debate—most notably the British experience with prescription heroin in the mid-twentieth century and Dutch de facto cannabis legalization since the late 1970s. In the absence of careful scholarly description, U.S. observers have been free to characterize such experiences in whichever way serves their rhetorical purposes. For example, a rapid increase in the minimal base rate of heroin use in Britain in the late 1960s became the basis for a charge that the British system of heroin prescription had failed; we discuss below a more reasonable interpretation of this experience.

Only recently have scholars, policy analysts, and policy makers from different nations begun to look outside their own boundaries to see what might be learned from experiences abroad (e.g., Estievenart 1995; MacCoun and Reuter 2001a, 2001b; Reuband 1995).

This special issue describes the experiences of eleven nations: Australia, Canada, Colombia, Denmark, France, Iran, Jamaica, Mexico, Portugal, Russia, and Sweden. Each of these countries is confronting the various public health and public safety problems caused both by domestic drug consumption and by the legal prohibition of these substances. Some countries confront a second drug problem as well, one that can dwarf the first: they are home to major drug trafficking organizations. And several of these countries must contend with the direct and indirect effects of an aggressive U.S. campaign to stem the flow of drugs.

THE PITFALLS OF CROSS-NATIONAL DRUG POLICY ANALYSIS

The obstacles to rigorous cross-national comparative work are daunting in any domain, but particularly so for psychoactive drug use because of its illicit and heavily stigmatized nature. Indeed, no other nation comes close to the United States with respect to the breadth and depth of its measurement of drug use and drug-related problems, and yet a recent National Academy of

Science panel found the state of U.S. drug policy assessment and analysis to be quite inadequate for making informed decisions (Manski, Pepper, and Petrie 2001). (Whether American politicians would actually avail themselves of better information is an open question; see Schecter 2002 [this issue]; MacCoun 2001.)

There are four basic analytical challenges for cross-national drug policy analysis:

Data scarcity. With respect to the prevalence and incidence of illicit drug use, few nations have anything comparable to the federally funded National Household Survey on Drug Abuse (posted annually at http://www.samhsa.gov/oas/nhsda.htm) and the University of Michigan's Monitoring the Future annual high school senior survey (posted annually at http://monitoringthefuture.org/) in the United States. Until recently, only the Netherlands and a few isolated cities had anything more than occasional ad hoc prevalence surveys. As a result, until recently, there were few years in which any more than a handful of national estimates were available for comparison (see MacCoun and Reuter 2001a). Time series are almost nonexistent. The creation of the European Monitoring Center on Drugs and Drug Abuse has brought major improvements, but the series still cover only a few years.

Poor data quality and comparability. Existing drug data series are rarely created for research purposes but instead reflect the activities of various public and private agencies—police arrests, court sanctions, customs seizures, and emergency room overdoses (Manski et al. 2001). As such, they are neither pure measures of drug prevalence nor unambiguous indicators of policy preference. Making matters worse, similar bureaucracies in different nations rarely adopt the same definitions of such seemingly basic concepts as drug-related death, drug possession arrest, and so on. For example, French medical examiners are much more reluctant to classify a death as drug related than are German medical examiners. Whether through duplicity or incompetence, American commentators routinely compare data on, say, Dutch versus U.S. marijuana use without equating the years, age ranges, or question wording underlying the estimates. Indeed, our own efforts to produce defensibly comparable cross-national estimates of marijuana use have been controversial (see MacCoun 2001 and the correspondence section of the *British Journal of Psychiatry* throughout 2001).

There are reasons to believe these data problems will become less severe in the coming years. Cross-national work in drug policy is being facilitated by increasingly sophisticated data collection and coordination efforts, including the World Health Organization's European survey of drug use among school children (Hibell et al. 1997), the Pompidou Group's multicity study (Hartnoll 1994), and especially the periodic monographs assembled by the European Monitoring Centre for Drugs and Drug Addiction (2000).

Weak causal inference. Finally, even where suitable data exist, correlational evidence provides only weak evidence on the consequences of drug policies (Manski et al. 2001; Shadish, Cook, and Campbell 2001). Making matters seemingly worse, the paucity of strong time-series data largely preclude rigorous econometric analyses. Yet we would argue that an acknowledgement of the necessity of weak causal inference hardly implies that nothing can be learned. Later in this article, we will attempt to explicate some of the alternative and reciprocal pathways linking cultures, drug policies, and drug-related outcomes.

Unknown generalizability. We stipulate that nations and cultures differ in myriad ways, making cross-national generalization hazardous. This problem differs from that confronting within-nation research (across jurisdictions, settings, investigators, and periods) in degree rather than kind—external validity is always uncertain in policy research (Shadish, Cook, and Campbell 2001). It is too easy to simply reject cross-national evidence out of hand when one dislikes the conclusions. The important analytic question is, When does a difference truly make a difference?

Arguably, generalizing from historical evidence on drug policy is more problematic than generalizing across modern cultures. Surely the sociological distance between the United States of 1910 and the United States of today is in many ways larger than the current cultural gap separating the Netherlands, Sweden, and the United States. Most industrialized nations experienced major drug epidemics in the 1970s or 1980s, triggered perhaps by Western counterculture but later fueled by the development of increasingly large-scale and sophisticated trafficking networks. The sheer scale of the modern problem weakens the relevance of preepidemic historical analogies. The British heroin prescription regime of the mid-twentieth century provides an illustration (MacCoun and Reuter 2001a, chap. 12). Many Americans have noted that the British made heroin legally available before 1967. In support of legalization, some then cite the rarity of heroin addiction during most of that period. Critics respond by citing the large percentage increase in the addict rate when a few doctors began reckless prescribing. But in fact there is much less here than meets the eye. The pre-1967 regime was not legalization, and not, in legal terms, very different from what replaced it. The growth that led to the 1967 change involved in absolute terms only a few hundred heroin users. Britain's major heroin epidemic occurred much later and—as noted above—was not unlike that experienced in other industrialized nations.

THE BENEFITS OF CROSS-NATIONAL DRUG POLICY ANALYSIS

Despite these obvious barriers to rigorous analysis, we see a great value in more cross-national work. There are vigorous debates about the future of drug policy in the United States, Canada, Latin America, Europe, and the Antipodes. The options under debate include the perennial budgetary battles

between supply and demand reduction efforts but also more dramatic possibilities such as medical marijuana, decriminalization, commercial legalization, heroin maintenance, and a range of harm reduction interventions. Elsewhere, we review the available theory and evidence for these options in detail (MacCoun and Reuter 2001a).

Confident policy forecasting is precluded by the absence of a strong theoretical foundation. Though glib pronouncements are frequently made on the basis of simple back-of-the-envelope economic models, these analyses are almost certainly crude caricatures of the reality of drug markets. We know far too little about the structural relationships among relevant variables or the relevant parameters (see Caulkins and Reuter 1998; Manski et al. 2001). For example, until fairly recently, it was assumed without evidence that hard-drug addicts are quite insensitive to price—in economic jargon, it was thought that demand was relatively price inelastic. Recent estimates have seriously challenged this view, at least for cocaine (Caulkins and Reuter 1998).

And progress in such debates is hindered by what social scientists would call restricted range in the independent variable—few nations have experimented with enough policy variations to learn much from their own experiences. But cross-national comparisons reveal that radical new ideas in one country are sometimes old hat in another. Heroin prescription regimes are one example. The recent Swiss trials in heroin maintenance are more innovative in their scope and design, but there are several precedents: the British experience discussed above, a brief flirtation with heroin prescription in Sweden in the 1960s (Lenke and Olsson 2002 [this issue]), and even Iran's program of opium ration coupons in the early twentieth century (Raisdana 2002 [this issue]).

All the nations discussed in this issue have adopted some form of legal prohibition against drugs such as cannabis, cocaine, heroin, and the psychedelics. Indeed, each of the nations is a signatory to the major international treaties requiring them to prohibit recreational use of heroin, cocaine, and marijuana. The treaties are the 1961 Single Convention on Narcotic Substances, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances (see Estievenart 1995). These documents have probably played some role in constraining national legal experimentation.

The Dutch cannabis regime is the only contemporary model that approximates legalization of a major recreational drug currently banned in the United States. Despite its de jure cannabis prohibition, the Netherlands has adopted a formal nonprosecution policy for possession and sale of less than five grams of cannabis, and cannabis is widely available for retail sale in Dutch coffee shops and in some nightclubs (MacCoun and Reuter 2001b). Nonetheless, cannabis is formally illicit, and the production and wholesale distribution of cannabis are subject to significant enforcement activities.

Despite the universality of drug prohibition, there are important variations in the aggressiveness of legal sanctioning against drug possession and drug use. Spain and Italy have "depenalized"—a term we prefer to the more ambiguous "decriminalized"—possession of all street drugs. In various degrees, the Netherlands, parts of Australia, the United States, and Germany have depenalized marijuana possession. Portugal (van het Loo, van Beusekom, and Kahan 2002 [this issue]), Switzerland, and most recently, England are in the process of doing the same. Nations also differ in their formal treatment policies, including the availability and accessibility of public treatment and of methadone maintenance. Drug treatment can seem like a more tolerant alternative to criminal justice sanctioning, but there is a concern with net widening both here and abroad (see Covington, cited in Manski et al. 2001). Court-mandated treatment is an increasingly common alternative to traditional drug sentencing in the United States (and is being extended in California to be the only possible sentence for some categories of offenders), but Sweden is distinctive in its use of mandatory treatment even for those not formally prosecuted for a drug offense.

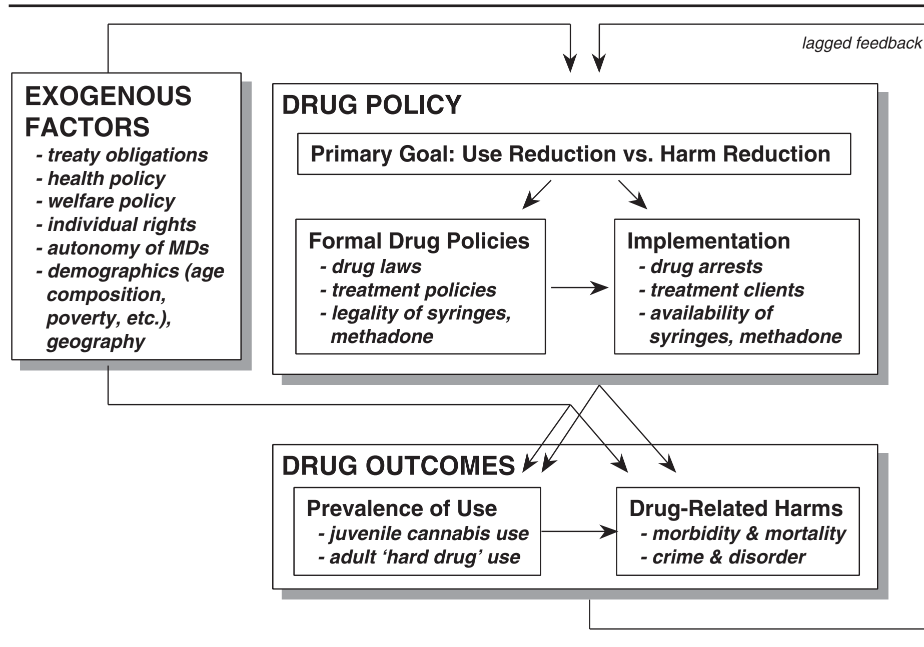
A dozen U.S. states have decriminalized marijuana possession to some extent, and simple cross-sectional and longitudinal analyses in the United States and Australia suggest no impact on marijuana prevalence. Needle exchanges have been evaluated fairly rigorously in the United States and several other countries, with favorable results. Italy offers an intriguing natural experiment in hard-drug decriminalization, having decriminalized possession in the mid-1970s, *re*criminalized possession in 1990, and re*de*criminalized possession in 1993. Alas, the paucity of prevalence data renders the resulting experiences highly ambiguous. (For more detail on these issues, see MacCoun and Reuter 2001a.)

ANALYTIC FRAMEWORK

As an overview to the articles of this special issue, we offer in Figure 1 a general analytical framework for thinking through the complex set of causal relationships among cultures, governments, drug policies, drug use, and drug outcomes (see MacCoun and Reuter 2001a, chap. 10). Our hope is that the framework, once articulated, will seem obvious, though the principles we articulate here are routinely overlooked or ignored in drug policy debates on both sides of the Atlantic. It is tempting to think in terms of a simple causal chain: goals → policies → implementation → prevalence of drug use → prevalence of drug harms. Figure 1 suggests that the situation is almost certainly more complex.

Four points stand out. First, many exogenous factors influence both drug policy and drug outcomes: international treaties, health and welfare policies, individual rights, the authority and autonomy of physicians, and sociodemographics. Second, goals directly influence not only formal policies but also their implementation. Indeed, in some nations (most notably the

FIGURE 1
ANALYTIC FRAMEWORK LINKING DRUG POLICIES AND OUTCOMES



Netherlands), implementation more closely reflects national goals than do formal drug laws. Third, formal policies have symbolic influences that transcend the intensity of their implementation; they make moral statements and thus influence the perceived fairness and legitimacy of authorities, which in turn influences compliance. Fourth, formal policies and their implementation each have a direct influence on drug-related harms that may be largely independent of their effects on levels of drug use. This is the central insight of the European harm reduction movement. And finally, prevalence and harms have a lagged feedback effect on drug policy; for example, European drug policies have evolved considerably during the past two decades in response to a heroin epidemic (beginning in the 1970s) and an AIDS epidemic (surfacing in the 1980s). A liberal policy in a nation with a severe drug problem may be a response to perceived failure of an earlier, more repressive, policy. That the problem remains severe is not necessarily a failure of that new policy but perhaps a reflection of the intractability of severe drug addiction in a cohort of long-time users. Preventing a worsening of that problem may itself be a significant accomplishment.

Measuring the extent of a nation's drug problem requires more than estimating the number of persons using illicit drugs. Drugs differ in the damage that they cause users (e.g., cocaine's acute and chronic harms are greater than those of cannabis) and in the damage that their users cause to the rest of

society. There may also be differences in the ways in which the drugs are used, which would have important consequences for the extent of harms suffered by users. For example, many Dutch addicts have long preferred smoking heroin to injecting it, a cultural norm that surely helped reduce HIV transmission in the 1990s.

We give particular emphasis to the many exogenous factors that influence both drug policy and drug outcomes: international treaties, health and welfare policies, individual rights, the authority and autonomy of physicians, and sociodemographics. The articles in this issue provide many examples.

The word "culture" can too easily become a fig leaf hiding our naked ignorance of the epidemiology of recreational drugs, but there is little doubt that broader social trends shape both drug use and drug policies. The countercultural movements of the 1960s and the 1970s (the hippies, the Yippies, the Provos, and so on) have been noted already. Other examples include the Swedish alcohol temperance movement (Lenke and Olsson 2002), the breakdown of the Soviet Union (Paoli 2002 [this issue]), and the Islamic revolution in Iran (Raisdana 2002).

Choices are also clearly influenced by political values and definitions of what constitutes the drug problem. American commentators have long parsed the topic of drug policy into two competing visions: public health versus criminal justice, with the former approvingly cited as a more tolerant alternative to the American predeliction for the latter. There is clearly a large grain of truth to this scheme. No country in Europe experiences anything remotely approaching the criminal violence associated with the drug trade in the United States. So it is perhaps understandable that Americans, uniquely among citizens of rich nations, have largely construed the problem as one of crime control. Mexico (Chabat 2002 [this issue]), Colombia (Thoumi 2002 [this issue]), and Jamaica (Jones 2002 [this issue]) do have very high levels of drug-related violence, and violence does indeed figure prominently in the debates about drugs in those nations.

Yet European experiences suggest that the opposite pole—the public health perspective—is far from being a homogeneous category and indeed is hardly incompatible with cultural intolerance. The Swiss have been more willing than almost anyone to experiment with medical alternatives to prison for opiate addicts, yet they also have the highest drug arrest rates in Western Europe (MacCoun and Reuter 2001a, chap. 10). Sweden is, by European standards, remarkably intolerant in its antidrug rhetoric and its drug laws, yet it is more generous than the tolerant Dutch in its investment in services for drug addicts. According to Gould (1988),

> from an Anglo-Saxon point of view, we may shrink from the coercive measures and illiberal controls the Swedes are prepared to adopt, but on the positive side it can be said that they show more concern than we do over the damage people do to themselves through the consumption of alcohol and the taking of drugs. (P. 127)

Nations also differ in their traditions of physician autonomy and authority. In Britain, the relative power of the medical profession and its determination to allow physicians full autonomy has probably been the principal explanation for the continuation of the right to prescribe heroin to addicted patients. Lenke and Olsson (2002) and Bergeron and Kopp (2002 [this issue]) discuss changes in the attitudes of Swedish and French physicians, respectively, toward their proper role in illicit drug problems.

The vagaries of geography are another example of important exogenous factors. In his masterful book *Guns, Germs, and Steel*, Jared Diamond (1997) argued persuasively for the dramatic and largely underestimated role that purely geographic factors—ease of transit, climate, flora, and fauna—have played in the shaping of world history. The history of drug consumption and production provides ample illustrations. In this special issue, Chabat, Thoumi, and Jones each discuss the role of local climate on drug cultivation in Mexico, Colombia, and Jamaica, respectively.

Location relative to major markets also influences problems and policies. Mexico has been called a “natural smuggling platform” for the United States, while Colombia’s role as principal heroin producer to the U.S. market is also a consequence of the ease of shipment compared to cheaper producers such as Afghanistan and Myanmar. Jamaica is an attractive supplement to Mexico for transshipment purposes. Iran is yet another nation cursed by location. Though not close to large and rich consumer markets, it has been for the past decade the most convenient route for the export of Afghan heroin to Western Europe. Elsewhere, we discuss other examples, including the distinctive spread of HIV among injection drug users across Southern Europe or the influence of Rotterdam’s international port in shaping the Netherlands’ dominant role in European drug interdiction statistics (MacCoun and Reuter 2001a).

Most notably, several authors identify the United States, especially U.S. drug control officials, as a major exogenous force shaping their own nations’ drug policies (e.g., Chabat 2002 on Mexico; Thoumi 2002 on Colombia; Laursen and Jepsen 2002 on Denmark; Bammer and colleagues 2002 [this issue] on Australia). Indeed, this is the central theme of the articles by Jones (2002) on Jamaica and by Schecter (2002) on U.S. misrepresentation of Canadian needle-exchange research findings. But the United States is not unique in its international lobbying role. For example, Laursen and Jepsen (2002) cite Swedish efforts to influence Danish drug policy. And the Netherlands has been under enormous pressure to “harmonize” its drug policies with those of other European Union states (MacCoun and Reuter 2001a, chap. 11).

OVERVIEW OF THE ARTICLES

We have organized the articles into three sections, by geography and wealth.

The wealthy West

The first section describes the problems and responses of wealthy Western nations with respect to a variety of drug problems that have generally worsened since the 1960s. Lau Laursen and Jorgen Jepsen (2002) chronicle the evolution of Denmark's drug policy during a thirty-year period, characterizing it as highly ambivalent, a mix of soft rhetoric at the political level and conservative policies in practice. Though there are some pragmatic innovations that could be characterized as harm reduction, such as the creation of a free marijuana sales zone in the town of Christiana and the liberal dispensation of methadone, these do not come from any clearly articulated vision of drug policy.

This contrasts sharply with the experience of Sweden, as summarized by Leif Lenke and Boerje Olsson (2002). Though there have been brief periods of experimentation, most notably with maintenance programs for methamphetamine users and heroin users in the 1960s, Sweden's policy has had a consistently repressive character, supported by powerful nongovernmental organizations and professional groups. Rates of drug use and drug-related problems have been notably low relative to other European nations during a long period; there is vigorous debate about how much this reflects the tough policy.

France and Portugal are of particular interest because each has recently seen sharp changes in drug policy in recent years, each with its own dynamic. Henri Bergeron and Pierre Kopp (2002) describe the role of French health professionals in overcoming long ideological resistance to any but an abstinence philosophy. In a very short period in the mid-1990s, they promoted and developed a system of treatment based on maintenance of heroin addicts on methadone and a relatively new drug, buprenorphine. Although it is too early to judge its success, this new policy has produced huge increases in the number of users in treatment. In Portugal, as chronicled by Mirjam van het Loo and colleagues (2002), professional opinion also played a decisive role. In this case, a commission of experts from a variety of backgrounds were asked to provide recommendations to deal with the rising use of drugs, particularly heroin. The commission developed an explicit harm reduction approach, which was then the basis for a sweeping legislation that went into effect in 2001; no outcome results are available.

Australia is the most explicitly harm reductionist nation among those discussed in this issue. Gabriele Bammer and colleagues (2002) describe a policy that has, even in the face of rapidly increasing heroin deaths and other drug-related problems, maintained programs aimed at helping users cope with their problems. Enforcement has been aggressive, and there has been resistance to a number of harm reduction interventions (safe injecting rooms, trials of heroin maintenance).

The western hemisphere

For three of the nations discussed in this issue (Colombia, Jamaica, and Mexico), U.S. consumption and U.S. international policies are the dominant realities both for policy making and in the generation of problems. Mexico has served as a principal foreign source of the major U.S. drugs for decades. Not only does it produce much of the heroin, methamphetamine, and marijuana consumed in the United States; it has for at least a decade served as the primary transshipment route for cocaine from the Andes. Jorge Chabat (2002) describes how this has created newly violent and powerful criminal groups, even though Mexican drug use remains at modest levels. Mexican policy makers, facing the wrath of a dominant neighbor, have had little room for flexibility in policy making.

What U.S.-destined cocaine is not shipped through Mexico comes through the Caribbean, and Jamaica plays a particularly prominent role. Marlyn Jones (2002) describes how drug trafficking has exacerbated the long-standing problem of politically related gang violence by increasing both the moneys and the weapons involved. Again, the United States looms as the dominant external political force pushing for aggressive enforcement, with decertification and both financial and immigration sanctions as powerful weapons.

Colombia is the principal production source of cocaine and (more recently) heroin for the United States. Francisco Thoumi (2002) relates this role to the chronic instability of Colombia, a long tradition of international smuggling, and a lack of civil society. The large earnings from the cocaine trade have again exacerbated the political violence by increasing the financial stakes. U.S. pressure for extradition of major traffickers has forced the Colombian government to enact legislation that in the late 1980s led to the most serious attack by criminal groups on central government. Drug use is a relatively minor concern of Colombian drug policy; instead, policy has been focused on trafficking and related corruption and violence.

The transition countries

Iran and Russia present the case of nations in transition in many senses. Letizia Paoli (2002) chronicles the development of a new drug problem in Russia, following the collapse of the Soviet Union. In 1990, Russia had a very modest level of drug use, primarily supplied domestically. By the end of the decade, it had been fully integrated into the international drug market, particularly for heroin, and indicators of drug use and problems had soared. The policy response has been highly intolerant. Even legislation aimed at emphasizing treatment for drug possession offenses has largely been subverted to allow the police maximum power over arrested drug users. There is little political debate around the issue in the midst of a period of fundamental economic and social change.

Iran has a much longer history of dealing with opiate abuse. Fariborz Raisdana, in collaboration with Ahmad Gharavi Nakhjavani (2002), shows

how Iran has struggled throughout the twentieth century to deal with a very salient problem of opiate addiction and trafficking. Policies have shifted frequently between harsh punishment and efforts to regulate use of heroin and opium. The Islamic revolution of 1978 brought to power a government employing draconian punishments of both users and sellers. Faced with a continued high rate of addiction, the past decade has seen experimentation with much more therapeutically oriented approaches. At the same time, notwithstanding aggressive border enforcement, Iran has suffered from its role as the main transit country for heroin exiting from Afghanistan on the way to Europe.

Two articles are not country specific. Martin Schechter (2002) describes how politicians in the United States knowingly and extensively distorted the results of a major study of needle exchange in Vancouver. His article illustrates graphically how much the United States stands out from other nations in the aggressiveness and politicization of drug policies.

Finally, money laundering controls, the subject of Michael Levi's (2002 [this issue]) article, represent the ultimate instance of international interdependence centered on drug policy. A new regulatory regime has been created that governs the banking systems of almost all developed nations, justified by the belief that illegal drugs account for a substantial fraction of suspicious financial transactions, particularly across national borders. Total money seizures from this system, though large in absolute terms, are minimal when compared to the (probably inflated) estimates of world drug expenditures. Money laundering controls may serve other purposes well, particularly in the new fight against international terrorism, but are unlikely to do much to reduce drug problems.

CONCLUSIONS

As so often is the case with cross-national comparisons, one learns first what is feasible. The Dutch have shown that harm reduction can be used as a principle to consistently guide decisions and have some successes to show and no disasters to hide. Portugal's sudden shift to harm reduction (van het Loo, van Beusekom, and Kahan 2002) will allow testing of whether the Dutch experience represents something idiosyncratic about the Netherlands. Denmark has experience with liberal prescription of methadone (Laursen and Jepsen 2002), which may be highly relevant as the United States considers relaxation of its current tough regulation of opiate maintenance. The Swiss trials show that heroin maintenance programs can operate in an orderly and systematic fashion for the benefit of a substantial fraction of the clients. These ought to be important facts for drug policy debates in the United States.

But even societies less similar to the United States than those of Western Europe can provide useful insights. U.S. policies toward Jamaica and Mexico impose a high cost; wrapped in moralistic rhetoric, they force on these nations

the burden of dealing with American problems. Understanding what these nations might do if they were given their own options and could focus on the welfare of their own citizens would help the United States to act as a better citizen in the world. Iran's experiences with different regulatory regimes aimed at allowing use for those already addicted while suppressing the black market could, with more data, contribute to discussion of different options within a general prohibition framework.

Drug policy, as we have suggested throughout this article, is the result of many forces. A better understanding of what has been tried elsewhere and what has come of it should be one influence.

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