

**RAND**

*Comparing Western European  
and North American  
Drug Policies*

*An International  
Conference Report*

*Peter Reuter, Mathea Falco,  
Robert MacCoun*

*Drug Policy Research Center*

The research described in this report was supported jointly by the German Marshall Fund, Grant 5-60105, and by the Alfred P. Sloan Foundation, Grant 90-2-5.

**Library of Congress Cataloging in Publication Data**

Comparing Western European and North American drug policies : an international conference report.

p. cm.

Based on conferences held in Washington, D.C., and Bellagio, Italy, 1991.

"Authors: Peter Reuter . . . [et al.]."

Includes bibliographical references.

"MR-237-GMF/SF."

ISBN 0-8330-1431-5

1. Narcotics, Control of—Cross-cultural studies—Congresses.
2. Drug abuse—Government policy—Cross-cultural studies—Congresses. I. Reuter, Peter, 1944- .

HV5801.C5773 1993

363.4'5'094—dc20

93-28666

CIP

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## PREFACE

This report briefly documents a project begun in 1990 as an effort to illuminate the similarities and differences among European and American drug policies and drug problems. The report is based on conferences held in Washington, D.C., and Bellagio, Italy, in 1991. The project was supported by a grant from the German Marshall Fund and draws on another RAND study funded by the Alfred P. Sloan Foundation. The report is intended for anyone interested in drug policy in the United States, Canada, and Western Europe.

The opinions expressed here are solely the responsibility of the authors. James Kahan and David Kirp provided helpful reviews of a draft.



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## SUMMARY

In Western Europe, the United States, and Canada in the last decade, illegal drugs have become a significant public policy issue. There is a growing interest in comparing and understanding the experiences of different nations. This report offers such a comparison. It summarizes the deliberations of officials and experts representing eight nations who participated in a December 1991 meeting on drug policy held in Bellagio, Italy. It also draws on a May 1991 conference of researchers from Western Europe and North America held in Washington, D.C.

It is clear that the scale, nature, and perception of the drug problem are very different in the various countries. The United States is more adversely affected by illicit drugs than are any of the other nations considered here. The share of its population using and abusing drugs is larger than that of the other countries, and the damage they cause themselves and others is more serious. Moreover, the United States is affected differently than the others because of the uniquely high level of violence associated with both drug distribution and use. In Canada and Western Europe, with less well-armed criminals, the levels of violence have been quite low. All the Western European nations have experienced a moderately serious epidemic of heroin addiction; however, none has so far had significant problems with cocaine, notwithstanding the large quantities of cocaine seized in the past five years. Compared with Europe, Canada has had even more modest problems with both heroin and cocaine.

These differences help explain the diverse perceptions of the nature of the drug problem and the appropriate response to it. In the

United States, the drug problem is seen primarily as a crime problem for which tough law enforcement is the appropriate response. In some Western European nations, including Italy, the Netherlands, Spain, and Switzerland, much more emphasis has been given to the health consequences of drug addiction, and there has been a reluctance to use the criminal law against users at all. Other Western European nations, notably Germany, Norway, and Sweden, have viewed drug use as a moral issue. They have also used criminal law against users, but not nearly as aggressively as has the United States. It is impossible to assess the success of these different policies because of the multiplicity of factors contributing to the respective problems and the policies to respond to those problems. For example, the United States, with the most severe problem, has the toughest policy; the Netherlands, with perhaps the least severe problem, has the most tolerant policy. On the other hand, firmly prohibitionist Norway has less of a problem than highly tolerant Spain. Many other factors, such as the more even income distribution and generous income support schemes in the Netherlands and Norway, may be more important than drug policy in explaining these differences.

European drug policies have been in a state of flux in the 1990s. Switzerland, having abandoned the open dealing areas such as the Platzspitz in Zurich, is planning a major experiment in heroin maintenance. Italy in 1990 recriminalized drug use after 15 years of decriminalization; in 1993 it reversed that decision, changing the law once again back to decriminalization. Germany is now considering increasing the availability of methadone and needle-exchange programs. Continued, systematic assessment of these policy experiences will help provide guidance for the future. But such assessment should build on better monitoring systems and more effort at evaluation. Western Europe as a whole has clearly underinvested in such monitoring and relies too heavily on American research on the effectiveness of prevention. The long-planned European Drugs Monitoring Center ought to make a significant contribution to monitoring and evaluation.

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## COMPARING WESTERN EUROPEAN AND NORTH AMERICAN DRUG POLICIES

### BACKGROUND: THE PROBLEM

Drug policy is currently the subject of intense political debate on both sides of the Atlantic. The United States, which relies primarily on law enforcement (as reflected in the annual *National Drug Control Strategy* documents<sup>1</sup>), is urging European governments to adopt more punitive policies, particularly toward users. Such policies are summarized in the term, “user accountability.” Within Europe, there has been considerable variation in approaches. That variation is becoming still more pronounced as some governments are moving toward stricter enforcement of drug prohibitions, largely in response to concerns about drug-related crime and rising overdose deaths, while others are moving toward more harm-reduction-oriented policies, largely because of AIDS.

European drug laws—and their apparent successes and failures—are often used as debating points in discussions of drug policy in the United States. Some advocates of legalization point to the low numbers of heroin addicts in Great Britain during the period when any physician could provide heroin to his or her addicted patients. Opponents point to the rapid increase in those numbers toward the end of that period. The success of the Dutch experience with con-

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<sup>1</sup>Office of National Drug Control Policy, *National Drug Control Strategy*, Washington, D.C.: U.S. Government Printing Office (GPO), annual.

trolled legal availability of cannabis (marijuana) is also fiercely debated in the United States.

Yet, beyond occasional newspaper accounts, very little comparative information on drug policy and drug problems between North America and Western Europe is available. Europeans know much more about American policies, in part because the U.S. government has so energetically exported such policies. This proselytizing by the United States often leads officials to make distorted characterizations of less punitive approaches, which are, in the heat of debate, sometimes denigrated as “soft on drugs” or “dangerously permissive.” In fact, the letter of European, U.S., and Canadian drug laws is remarkably similar: The two major international drug treaties—the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances—require governments to prohibit the nonmedical use of heroin, cocaine, marijuana, and other mood-altering drugs. All European governments have done so, including the Netherlands, which has not formally legalized any of those drugs.

Significant variation emerges not so much in Western drug laws but in their implementation and in related social policies. The variations reflect divergent perceptions of the drug problem as well as differing historical experiences in dealing with drug addiction. This report briefly documents a project begun in 1990 as an effort to illuminate the similarities and differences among European and American drug problems and policies.

In the initial phase of the project, drug policy researchers and experts were recruited from Canada, France, Germany, Great Britain, Italy, Norway, Spain, and the Netherlands. Each was asked to write a paper describing the drug problems and policies of his or her nation over the past 20 years. The papers provided a framework for comparative analysis. This group, together with a dozen other researchers (predominantly from the United States), met for two days at RAND in Washington, D.C., in May 1991.

The second phase of the project engaged European and American government officials in informal discussions of their respective national responses to the drug problem; some nongovernmental experts were also included. Representatives from Canada, Germany, Great Britain, Italy, the Netherlands, Spain, Switzerland, and the

United States participated; a list of participants is provided in the Appendix. The meeting, held in December 1991, at the Rockefeller Foundation Conference Center in Bellagio, Italy, built on the work of the earlier discussions in Washington. At Bellagio, the governmental participants were freed from their usual constraints as official defenders of their governments' policies and were able to explore alternative policies without an overriding political agenda. To encourage candid participation at Bellagio, we agreed not to attribute comments to particular individuals. Despite some fundamental philosophical differences, a substantial consensus emerged.

The Bellagio discussions and the Washington conference papers form the basis of this short report. The main themes of the report reflect the collective thinking of the group. The conclusions are strictly our own.

## COMPARING DRUG PROBLEMS

Both the government officials and the researchers who participated in this project generally agreed that the drug epidemic—in classic public health terms—has largely subsided in Europe and America: The numbers of new drug addicts each year are many fewer than they were at the peak of the epidemic in each country, and the addict population is aging in almost all the countries. Nonetheless, in many countries, drug abuse and its related harms, including crime and AIDS, remain significant problems and show little sign of abating. Before describing what is known about such problems, we briefly discuss the limitations of the available national drug data.

### Monitoring Problems

At present, comparisons of national drug data often raise as many questions as they answer. For two decades the United States has conducted national general-population drug use surveys. The surveys provide a basis for continuing trend analysis,<sup>2</sup> although there is considerable controversy about the resulting estimates of the num-

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<sup>2</sup>The National Institute on Drug Abuse conducts an annual National Household Survey on Drug Abuse. It now interviews 32,000 persons annually.

ber of persons using drugs frequently.<sup>3</sup> In Europe, prevalence estimates are available only occasionally; they usually have to be cobbled together from law enforcement data (e.g., number of drug arrests) and public health data (e.g., number of admissions to treatment). The availability and reliability of these data vary widely, making accurate projections difficult. Changes in procedures can have substantial effect. For example, Britain changed its method for counting the number of addicts in treatment and the resulting figure rose from 9,000 in 1987 to 18,000 in 1990. It is unclear whether this rise reflects an increase in the treated population or better recording. Most data sources also tend to obscure illicit drug use among more affluent groups who rarely come into contact with police or public treatment facilities.

Apparent anomalies arise frequently. For example, the Netherlands and Germany report the lowest rates of drug abuse in Europe, whereas Italy and Spain report the highest.<sup>4</sup> Yet, in Germany, drug-overdose deaths have been rising rapidly since 1987, and the German rate of drug-related deaths now surpasses that of most other European countries. At the same time, cocaine seizures in Italy jumped 60 percent in 1991. But officials do not know whether this jump reflects the impact of the new, stricter drug law passed in 1990 (generating more intense enforcement), growing cocaine traffic on the part of the Italian Mafia serving the entire Western European market, or an incipient Italian cocaine epidemic. Although various hypotheses can be advanced to explain these developments, the true picture is likely to remain murky without national drug use surveys to collect data comparable to those from the United States.

The European Community has been working for six years to develop a European "observatory" that would encourage regular surveys modeled on the U.S. National Household Survey and would harmonize monitoring systems. This effort at harmonization has been stalled by unrelated political difficulties, and at this writing (August 1993) the member nations have still not approved the establishment

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<sup>3</sup>On these estimates and the related controversies see Reuter, P., "Prevalence Estimation and the Policy Process," *Journal of Drug Issues*, Spring 1993, pp. 167-184.

<sup>4</sup>These statements are based on prevalence rates in household surveys of drug use and estimates of the prevalence of heroin addiction.

of the “observatory.” Until it is set up, comparative analysis is likely to continue to be difficult.

### **Interpreting the Indicators**

Comparisons require not only more consistent data collection but also clarity about the meaning of particular data sets. Too often the rise in a single indicator, such as the number of drug-related deaths, is interpreted as evidence of an impending epidemic, when the totality of available indicators tells quite another story.

In the United States, heroin addiction spread rapidly in the 1960s and early 1970s, but it appears to have been fairly constant for more than 15 years. Officials currently estimate the number of heroin addicts between 600,000 and 800,000. In the last five years, however, the price of heroin has declined sharply from the prevailing U.S. prices between 1975 and 1985,<sup>5</sup> and purity has increased, indicating greater availability and the possibility of a new outbreak of addiction. Over the same period, reports of medical emergencies involving heroin have risen slightly, a sign that heroin use may again be increasing, with some users now smoking it. However, the continued aging of those showing up in emergency rooms with drug problems and the modest figures for heroin use among arrestees indicate that no epidemic of new use has yet actually started.

Most Western European countries also experienced a heroin epidemic between the late 1960s (Great Britain, Germany, and the Netherlands) and early 1980s (Spain), often originating among young people drawn to the drug culture. In recent years, the rate of initiation into heavy heroin use has declined, and the problem has moved away from middle-class youth, settling into lower social and economic groups. Although admissions to treatment are still primarily related to heroin, the addict population is growing older, an indication that, in Europe, the epidemic is abating too.

Yet, with the exception of the Netherlands, heroin-related deaths and arrests are not declining, suggesting that most of those who became

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<sup>5</sup>BOTEC Analysis Corporation, *Heroin Situation Assessment: A Working Paper Done for the Office of National Drug Control Policy*, Cambridge, Mass., 1992.

heroin addicts are still addicted. The graphs in Figures 1 and 2 present rates of heroin addiction and heroin overdose death in the United States, Canada, and selected European countries in 1989, for comparison. The United States has been as severely affected by heroin as any of the other nations.

The comparative experience with cocaine, however, has been very different. In the United States, cocaine abuse reached epidemic proportions in the 1980s, involving all socioeconomic groups. The introduction of cheap, smokable crack cocaine in 1985 accelerated the drug's spread, particularly among users unable to afford the more expensive, powdered cocaine. Crack became widespread in the inner city, contributing to the rise in violent street crime. Social tolerance for cocaine within mainstream America rapidly eroded once its health dangers became apparent, particularly after the death of two sports stars from cocaine overdose in 1986. In 1985, an estimated 12 million Americans used cocaine at least once that year.

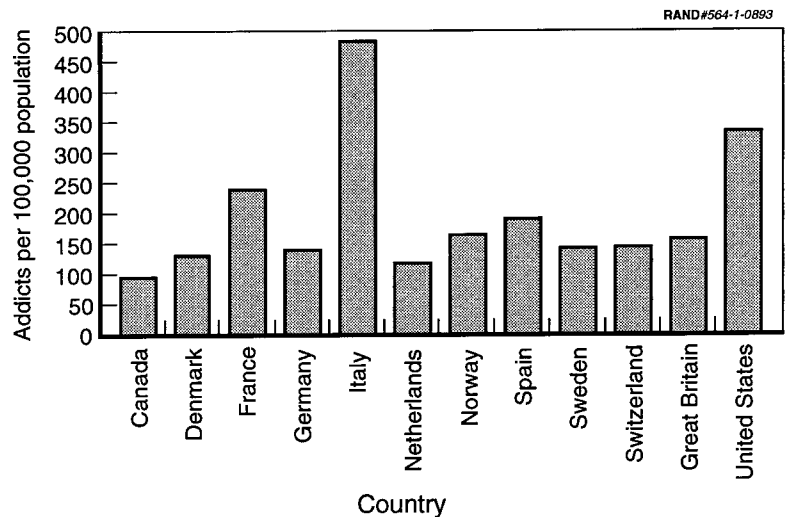


Figure 1—Estimated Prevalence of Heroin Addiction, Circa 1990



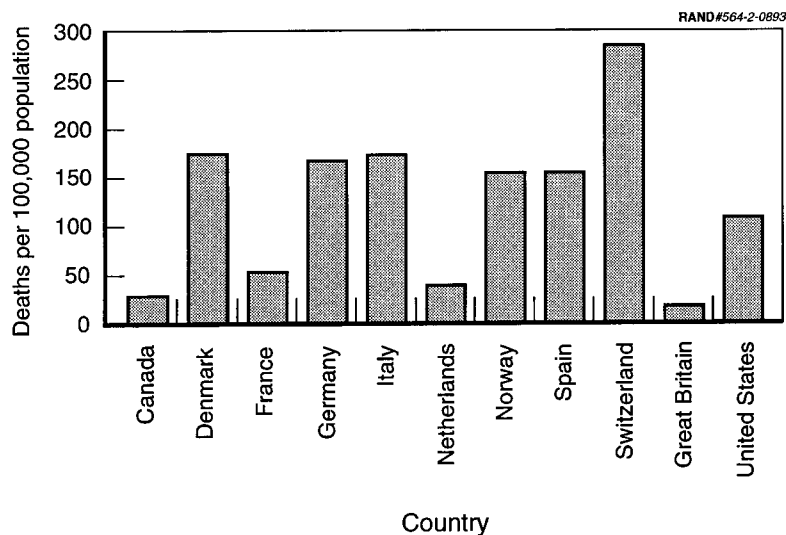


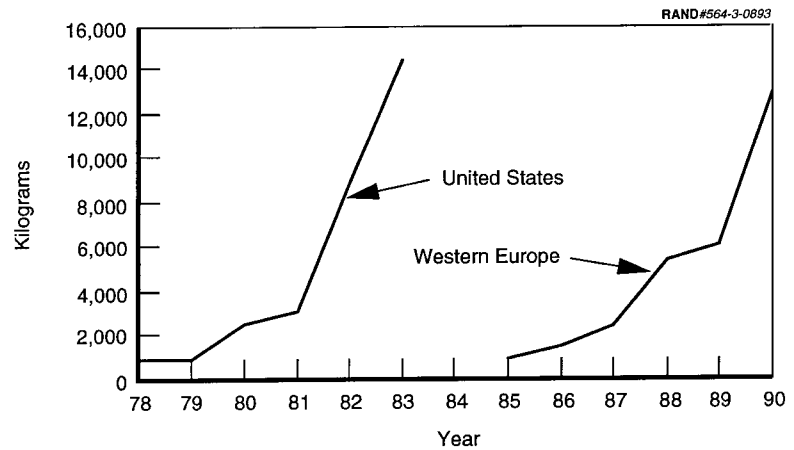
Figure 2—Heroin Death Rates, Circa 1989

By 1990, this figure had dropped by half. Nonetheless, experts estimate that 1.8 to 2 million Americans remain addicted to cocaine.<sup>6</sup>

In Europe, on the other hand, there is very little evidence that cocaine has become a significant problem. Yet there are indicators that cocaine availability has risen in recent years, as South American traffickers seek new markets for their expanding cocaine production. Unprecedented cocaine seizures, particularly in Spain and Italy, the major southern points of entry, point to these massive increases in the transatlantic cocaine traffic; whereas 650 kilograms were seized in 1985, by 1990 the figure was 12 tons, almost exactly paralleling the increase in the United States between 1979 and 1984.<sup>7</sup> This parallel is depicted in Figure 3.

<sup>6</sup>See, for example, U.S. Senate Judiciary Committee, *Hard-Core Cocaine Addicts: Measuring and Fighting the Epidemic*, Washington, D.C.: U.S. GPO, 1990.

<sup>7</sup>The U.S. seizure figures have continued to rise; the 1991 federal total was over 100 tonnes.



SOURCE: U.S. data—U.S. Customs, Coast Guard, and Drug Enforcement Administration; European data—INTERPOL.

Figure 3—Cocaine Seizures in the United States, 1978–1983, and in Western Europe, 1985–1990

Prices in Europe also seem to have declined, although they remain well above U.S. levels—the opposite pattern to that for heroin. But the traditional indicators of a drug epidemic—medical emergencies, overdose cases, a growing demand for treatment—are still not evident throughout Europe. Only in Spain is there some indication: Almost 40 percent of all persons entering treatment (almost all for heroin abuse) report cocaine as a secondary drug of abuse. One explanation may be that cocaine remains largely a middle- and upper-class drug, as it was in the United States in the 1970s and early 1980s. Whatever health problems occur at these social levels are handled mostly through private physicians rather than public hospitals and clinics; they would then not show up in many official indicator systems. Moreover, crack, which is more rapidly addictive than powdered cocaine, has not yet appeared in sizable quantities in Europe, although some British sources report signs of growing availability in poorer areas of certain large cities.

Canada, despite its proximity to the United States, has not experienced major heroin or cocaine epidemics. Marijuana is the only widely used illegal drug, particularly among young people. Its use in Canada mirrors its continuing popularity in the United States and in Europe—although at lower levels than in the 1960s and 1970s. Canadian cocaine seizures have recently reached new highs, probably reflecting some transshipment to the United States as well as growth in the local user population.

In all nations it appears that marijuana use is a common behavior on the part of adolescents. In the United States, the 1991 survey reported that 24 percent of high school seniors had used marijuana in the previous year. The rates in some European surveys are lower but still quite high: In Oslo the 1989 annual youth survey figure was 19 percent and in Switzerland in 1990 it was between 6 and 10 percent. Only in the United States, however, does it appear that a substantial fraction of those who have tried marijuana have gone on to use it frequently.

### **Concomitant Social Factors**

But differences in nations' problems are more than simply differences in the prevalence of use or even abuse of a drug. In the United States, frequent drug users show extremely high rates of criminality and violence; in some cities, as much as 50 percent of the very large number of homicides may be drug related.<sup>8</sup> The violence of addict criminality in the United States simply reflects the extraordinary violence of crime in the United States generally, which, in turn, reflects the enormous stock of handguns among the citizenry: It is thought that perhaps 50 million handguns are in private hands, perhaps 100 times more per capita than in most European nations.

Heroin addicts in most European nations show high rates of involvement in crime; in some countries (e.g., Germany and Switzerland), however, they are seen as accounting for a small share of all property or violent crime. Such differences in the level of criminality and violence reflect, among other factors, the considerable variation

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<sup>8</sup>Goldstein, P., H. Brownstein, and P. Ryan, "Drug Related Homicides in New York; 1984 and 1988," *Crime and Delinquency*, Vol. 38, No. 4, October 1992.

in the social class of drug users: In the United States, drug addiction appears to be more concentrated among the less educated than is true for Europe.<sup>9</sup> Differences within Europe also reflect variation in geographic concentration: In Spain, the problem is almost exclusively confined to big cities, whereas in Germany it appears to be widely dispersed.

### CONTRASTING PERSPECTIVES

Nations differ not only in the severity of their drug problems but also in their perception of the nature of those problems.<sup>10</sup> For some, drug abuse is more a public health concern than a moral issue. Drug-related crime is seen as a function of factors other than drug use, such as poverty, unemployment, alienation, and the high price of drugs—essentially the Dutch view and, to a somewhat lesser extent, the Canadian view. In other nations, the perception is of the opposite relationship: Drug use is held responsible for wider social ills. In France, for example, public polls show that drugs are blamed for the perceived deterioration in the social environment, whereas in the United States, drug abuse has become almost synonymous with crime.

These perspectives play an important role in the policy differences across Europe. Within Europe, the Netherlands is most strongly identified with tolerant drug policies, although Spain has laws that are more explicitly tolerant. In 1990, after a heated national debate, Italy reestablished the criminal penalties for drug possession that were abolished in 1974, only to re-decriminalize drug possession in 1993. Spain is now the only country in Europe in which drug possession or use is not subject to criminal sanctions, although penalties for drug dealing have recently been increased. The Spanish govern-

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<sup>9</sup>The reasons for this difference in social class concentration of drug abuse are not apparent. The relatively weak social safety net in the United States may be an important factor.

<sup>10</sup>We speak of nations as units. Obviously, there is not uniformity within any one nation; but the perceptions here seem to be dominant views of the populace, usually reflected in government policy. Switzerland is an interesting exception. The German cantons, such as Zurich and Bern, have generally adopted harm-reduction policies, reflecting a strong public health concern. The French cantons, such as Lausanne and Geneva, are more strictly prohibitionist.

ment is currently considering administrative sanctions for drug use in public places, but there is no move to penalize private use.

At the other end of the policy spectrum lie most of the Northern European nations. France, Germany, and the Scandinavian countries are close to the American prohibitionist model, with clear declarations of concern about drug use *per se*. Great Britain falls between the two groups. In Britain, the principles of harm reduction are given wide play. Medical practitioners enjoy great autonomy in prescribing drugs, and methadone is readily available. In other respects, British policy looks little different from that of the rest of Northern Europe. The government rhetoric, particularly in the last five years, has emphasized the threat from drug trafficking and the necessity for harsh penalties against traffickers.

### Historical Legacies

Variations in national viewpoints often reflect different experiences with drug abuse.

The United States outlawed heroin and cocaine just after the turn of the century, largely because those drugs were associated in the public mind with immigrant groups and racial minorities, groups that were feared to be potentially violent and subversive.<sup>11</sup> A brief experiment in which narcotics were provided legally to addicts in public clinics ended in 1920. Since then, American drug policy has been dominated by the view that drug abuse can best be contained through enforcement of the criminal law rather than through provision of public health services to the addicted.

By contrast, the Dutch approach grew from governing Indonesia, where opium addiction was extensive in the period 1890–1940.<sup>12</sup> In 1894, after a lively public debate, the government established opium

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<sup>11</sup>Musto, David F., *The American Disease: Origins of Narcotics Control*, expanded ed., New York: Oxford University Press, 1987. The federal prohibition (the Harrison Act) was not enacted until 1914, but many states had passed criminal prohibitions before then.

<sup>12</sup>van Luijk, Eric, "A Lesson from History on the Issue of Drug Legalization: The Case of the *Opiumregie* in the Dutch East Indies (1890–1940)," Paper presented at the International Conference on Law and Society, Amsterdam, June 1991.

maintenance, which supported 150,000 addicts (at that time about 1 percent of the adult population) until Dutch rule ended after World War II. This long experience with maintenance shaped current Dutch policy, which officials describe as “pragmatic”—aimed at minimizing the most harmful effects of addiction rather than at tightly controlling drug use.

The British policy of allowing doctors to prescribe heroin and cocaine to their patients, even those who are addicted, is the legacy of many decades of giving the medical profession primary responsibility for dealing with addiction. The principal documents determining the British policy were prepared by committees dominated by doctors.<sup>13</sup> Until the late 1960s, drug treatment was provided almost entirely by general practitioners, who were permitted to maintain addicts on heroin.

However, as heroin diversion to the black market increased because of careless overprescribing by a few practitioners, the Home Office instituted stronger controls. Heroin maintenance was transferred to clinics, where addicts were required to go for their daily prescriptions. By the mid-1970s, most addicts had been shifted to methadone, a longer-acting narcotic than heroin, taken orally, which allows better social functioning; methadone also was consistent with the clinics’ increased emphasis on “treatment” rather than maintenance.

Even though the role of the physician has been circumscribed in the past two decades as concerns about drug diversion increased, the Home Office still permits specialist doctors considerable latitude. For example, several doctors are currently experimenting with providing cocaine- and heroin-laced cigarettes to their addicted patients, in the belief that doing so will reduce the incentive to enter the illegal drug market. By contrast, the United States does not permit the medical use of marijuana, even for such demonstrated applications as relieving nausea from chemotherapy and reducing

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<sup>13</sup>The Brain Committee of the 1950s and the 1920s’ Rolleston Committee, the two most influential official bodies historically, were both chaired by medical practitioners. Despite this fact, it is interesting to note that the system of regulation has been administered by the Home Office rather than the Ministry of Health.

intraocular pressure from glaucoma.<sup>14</sup> Nor can heroin be prescribed in the United States to relieve pain in terminal cancer patients, a practice common in many Western European nations. These restrictions reflect, at least in part, a concern with the symbolic effect of permitting use of drugs that have been at the center of the government's War on Drugs.

During the past two decades, the drug policies of Italy and Spain have been influenced by the fact that the great majority of addicts live with their families. Partly because of this link, drug users are viewed by the public less as a high-criminality underclass—a view that may play an important role in shaping public opinion about drug policy. Policies toward drug users have generally been more tolerant, relying on family support as well as social and health institutions, rather than the police, as the first line of defense. The growing criminality and visibility of Italian and Spanish addicts have been an influence in the shift toward more severe penalties in both countries. In Italy, the growing concern with the Mafia and the Mafia's role in the drug trades has also been important in this respect.

The rapid changes now occurring in east central Europe and the former Soviet Union may importantly affect European attitudes toward drug problems in the near future. Illicit drug production has expanded substantially in the newly independent Kazakhstan and Kyrgyzstan. Drug traffic is already emerging as an important means of livelihood for displaced former Soviet security and armed forces. Illicit drug abuse and crime, virtually unheard of under the Soviet regime, are now threatening to become major problems throughout the region. If the migrants now surging into Western Europe bring with them a new drug epidemic, it is possible that governments will adopt more punitive drug policies. The American experience suggests that, when addicts are viewed as aliens who threaten the established social order, the public response is to call on the police power of the state to suppress them.

Indeed, one common feature of the drug problem in many nations on both sides of the Atlantic is the emphasis on the role of foreigners as the principal traffickers: Colombians in the United States,

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<sup>14</sup>Doblin, R., and M. Kleiman, "Marijuana as an Antiemetic Medicine: A Survey of Oncologists' Experiences and Attitudes," *Journal of Clinical Oncology*, Vol. 9, July 1991.

Pakistanis in Great Britain, Iranians in Switzerland, and Turks in Germany. This view has facilitated the increase of penalties against trafficking.

## COMPARATIVE POLICIES

While officials on both sides of the Atlantic agree that major or high-level drug traffickers should be aggressively prosecuted, the consensus unravels over the question of how to deal with users and low-level dealers who are often themselves addicts. The United States strongly advocates “user sanctions” intended to punish illicit drug use, whereas most European countries, regardless of their drug laws, tend to rely on treatment in dealing with users even if they are also low-level sellers.

### **Punitive Policies—United States**

The reliance of the United States on criminal penalties is reflected in the numbers now being incarcerated for drug offenses. In 1981, 14,000 persons were given sentences of more than one year for drug offenses; by 1990, that figure had risen to almost 120,000. It is likely that another 250,000 to 350,000 have served shorter sentences in local jails. Although this population includes high-level dealers, the sheer numbers, as well as the circumstances of many of the arrests, suggest that a large fraction of those incarcerated were user-dealers, selling primarily to maintain their own consumption. As Professor Norval Morris, the Chair of the Bellagio meeting, described the American approach, “It is as if, for a headache, you have a choice only between an aspirin and a lobotomy.”

Such punitive policies appear to focus on the U.S. underclass: Although illicit drug use is widespread across American society, blacks and Hispanics are much more frequently punished for drug offenses. A recent study of drug selling in Washington, D.C., found that 99 percent of residents charged with dealing were black (in a city that is about 68 percent black) and that of those black males born in 1967 and living in Washington, D.C., about one out of six was charged with at least one drug offense between the ages of 18 and



20.<sup>15</sup> Nationally, African-Americans account for 12 percent of the total population but for 40 percent of those arrested for drug offenses. This disparity probably results from law enforcement's concentration on inner-city street markets for drugs, in which poorly educated African-American males are very much overrepresented—the source of considerable unease with current policy in the United States.

### **Contrasting Policies—Western Europe**

Despite considerable variations in practice, no European country relies as heavily as the United States on aggressive use of the criminal law as the primary means of reducing drug abuse. Nor does the burden of enforcement in Europe generally appear to rest so disproportionately on minorities or foreigners. Substantial immigration from North Africa, Asia, and the Middle East has not yet resulted in disproportionate numbers of prosecutions, even though much of Europe's illegal drug traffic comes from these regions. West Indians in Great Britain may be an exception in this respect; there have been frequent complaints of discriminatory enforcement of marijuana laws against West Indians.

In Germany, where the drug laws reflect a strict prohibitionist approach, judges are coming to believe that prison is not the right place for people with drug problems. The criminal justice system is generally used to support prevention and treatment. Judges have discretion to impose no penalties on first-time drug offenders. Judges give second-time offenders the choice between prison and treatment.

Nonetheless, a debate is developing in some German states and cities, notably Bremen and Hamburg, over whether marijuana possession should be exempt entirely. Early in 1992, a German appeals court judge overturned a conviction for marijuana possession on the grounds that it should not be subject to criminal sanctions, given that the state allowed the sale of alcohol. Several German cities have joined the Netherlands in petitioning the International Narcotics

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<sup>15</sup>Reuter, P., R. J. MacCoun, P. J. Murphy, et al., *Money from Crime: A Study of the Economics of Drug Dealing in Washington, D.C.*, Santa Monica, Calif.: RAND, R-3894-RF, June 1990.

Control Board (INCB) of the United Nations to request that cannabis be removed from the coverage of the international drug treaties. The INCB's *1992 Annual Report* took an adverse stand on this issue.

The 1990 Italian drug law gave judges wide discretion in punishing drug users. (The law established a table of drug quantities for distinguishing between users and dealers.) First-, second-, and third-time possession offenders faced administrative sanctions, such as the loss of a driver's license or passport, or could voluntarily enter treatment. Fourth-time offenders had to be remanded to treatment under court order. From July 1990, when the law took effect, to the end of 1991, 24,000 drug offenders were arrested, 250 of whom (mainly dealers) were sent to prison. Whether users should be prosecuted remains a hot political issue in Italy, since many voters believe prosecution is an inappropriate response to what is still largely seen as a social or family matter. Indeed, in April, a national referendum contained an item repealing the criminal prohibitions on possession for personal use; the repeal passed with 53 percent of the vote cast.

The Netherlands, which has the lowest incarceration rate in Europe (a rate that is only about one-eighth that of the United States), gives broad discretion to the police to decide whether to make drug arrests. Although the drug laws provide criminal penalties for sales and possession, they are rarely invoked, except against major dealers. Overriding regulation allows possession of 30 grams of marijuana for personal use. Some coffee shops are permitted to sell marijuana, but the police will close them down if they sell "hard" drugs such as cocaine and heroin. Police use the threat of arrest to contain drug-dealing within certain areas and to encourage addicts to seek treatment and health services. But drug enforcement is used as a vehicle of health and educational policy, rather than as an end in itself.

Figure 4 below shows the considerable difference between drug arrest rates in Europe and in North America. Even the most "punitive" European countries, such as Norway, where drug offenders compose half the population serving prison sentences of five years or more, have much lower arrest rates than the United States.

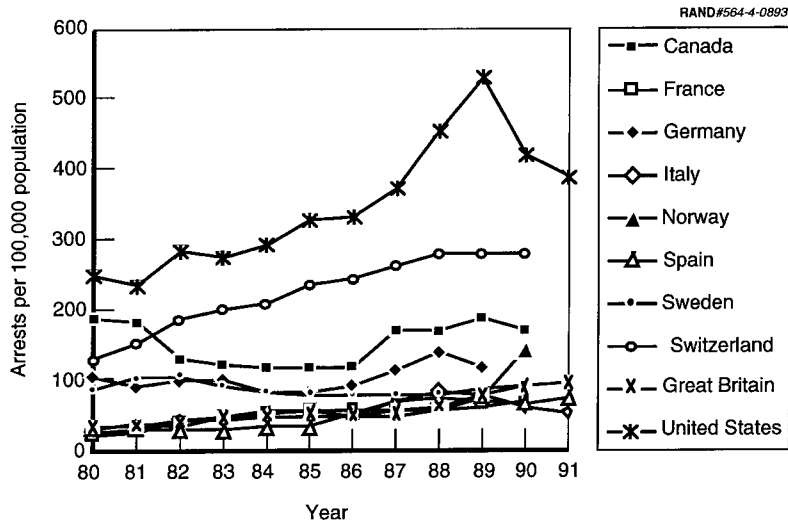


Figure 4—Drug Arrest Rates, 1980–1991

There are also significant differences in the accessibility of treatment. Most European nations aggressively seek to bring addicts into contact with treatment services. The Dutch government estimates that over 70 percent of Amsterdam’s heroin addicts are in contact with treatment or social services at some time during a 12-month period; many receive methadone from general practitioners. In Zurich, even after the closing of the Platzspitz, a park that served as an open-air market, numerous services are reaching out to heroin addicts in the main dealing areas, seeking to get them into methadone maintenance or some other form of treatment. In the United States drug treatment programs often have long waiting lists and are not integrated with other social services.

### Drug Testing

Another aspect of drug policy distinguishing the United States from Western Europe is the use of drug testing in many employment settings. In the United States, a majority of large employers test job applicants. The federal government has also imposed testing on

certain occupations (mostly in transportation industries) and on its own agencies. Testing is designed to encourage abstinence in the workforce and to get drug abusers to seek treatment. No European nation has encouraged testing; indeed, some have strongly resisted testing proposals by European branches of U.S. firms.

### EXPLORING ALTERNATIVE APPROACHES

The differences in drug policy reflect fundamental differences over the ultimate goals of drug control. In the United States, elimination of all drug use is the paramount objective, because drug use itself is regarded as an immoral, illegal activity and because it is believed that such use must cause major social and economic harm.<sup>16</sup> In Canada and most of Western Europe, drug enforcement itself is seen as possibly causing serious harms, principally by exacerbating crime, and occasional drug use is not viewed itself as a major concern. The primary goal, then, is to minimize the harms to individuals and society from both drug use and drug control.

In some countries, the rapid spread of AIDS among intravenous drug users has played an important role in shaping policy. The widely varying rates of HIV infection notwithstanding, drug users are now important transmitters of the virus on both sides of the Atlantic. In Italy, Spain and Switzerland, intravenous drug use is the primary risk factor for a majority of AIDS cases. In the United States, 29 percent of new AIDS cases in 1990 had intravenous drug use as a primary risk factor. In some cities, most notably New York, over 60 percent of heroin injectors were HIV positive. The prevalence of HIV among drug users is highest in Spain, Italy, and France; it is the lowest in the Netherlands and Great Britain. In the latter two countries, many addicts generally smoke rather than inject heroin and are therefore much less exposed to the spread of HIV through shared needles.<sup>17</sup>

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<sup>16</sup>Office of National Drug Control Policy, "Introduction," *National Drug Control Strategy*, September 1989.

<sup>17</sup>For a review of these figures see Brenner, H., P. Hernando-Briiongos, and C. Goos, "AIDS Among Drug Users in Europe," *Drug and Alcohol Dependence*, Vol. 29, 1991, pp. 171-181.

During the early 1980s, Great Britain shared the American view that eliminating illicit drug use should be the dominant goal of drug policy. However, in 1987, British policy shifted. The shift followed a report from the government's most significant advisory body declaring that, because of the devastating impact of AIDS, reducing the harms associated with drug use was more important than reducing drug use itself.<sup>18</sup> What reducing harms means in practice is a stronger emphasis on prevention and treatment than on law enforcement, as well as instituting programs that specifically try to modify the most harmful aspects of drug-taking, short of abstinence: For example, drug treatment programs focus less on keeping their patients free of illicit drug use and more on ensuring their health and social functioning; this focus is also found in Swiss treatment programs.

Despite their vastly different philosophical viewpoints on dealing with the drug problem, both Europeans and Americans are faced with the same challenge: how to engage drug addicts in efforts to modify the most destructive aspects of their behavior. In the following subsections, we describe alternative approaches to drug treatment that seek to deal with the pragmatic, harm-reducing aspects rather than the moral, abstract aspects of the problem. We focus on needle exchange, methadone maintenance, and zones of tolerance.

### **Needle-Exchange and Other Harm-Reduction Programs**

Needle exchange is the most controversial of the harm-reduction programs and illuminates the philosophical divide between the United States and other Western countries. Since the AIDS virus can be transmitted by sharing needles (through the exchange of blood and other fluids), providing clean needles to addicts is one way to lower the rate of infection. Proponents argue that such programs are humane efforts to reduce the spread of AIDS and other diseases, and to lower mortality among addicts. Opponents maintain that providing free needles encourages drug abuse, which is also potentially fatal. Moreover, they say, such programs do not work

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<sup>18</sup>Advisory Council on the Misuse of Drugs, *Report: AIDS and Drug Misuse*, London: HMSO, 1987.

because addicts continue to share needles as part of the drug-taking ritual.

Although needles can be legally purchased in pharmacies in 40 states in the United States, federal policy still prohibits federal funding for needle-exchange programs for addicts. Nonetheless, such programs have been developed in several states, sometimes in defiance of local law. In 1991, a New York judge overturned the conviction of three people who had distributed free needles to addicts, on the grounds that AIDS presented a greater public danger than drug abuse. In New York City, the Department of Health began a small, experimental needle-exchange program in March 1992, after an earlier program had been shut down by the mayor. Several weeks later, the federal director of the Office of National Drug Control Policy publicly criticized those programs as "immoral" because they encourage addiction.

Most European countries, irrespective of their drug policy orientation, now provide free needles to addicts.<sup>19</sup> In Germany, needles have always been readily available; but since the mid-1980s, when public concern about AIDS surpassed fears of addiction, needles have been free. In Great Britain, needle-exchange programs are regarded as a means of moving addicts down the hierarchy of risk toward abstinence, and engaging them with other social and health services. The Netherlands has had a similar experience: Needle exchange is just one part of a larger approach to treatment and counseling. Italy, where needles are available free from vending machines, is currently experimenting with one-time, self-blocking needles, which could reduce the likelihood of sharing.

Thus far, although formal research evaluations show high dropout rates, the European experience with needle-exchange programs has been encouraging. In Zurich, Switzerland, where free needles were provided for two years in the Platzspitz, HIV prevalence among intravenous drug users declined from 20 to 11 percent. Research in Great Britain shows similar results: The percentage of needle-

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<sup>19</sup>In Spain, needle-exchange programs are currently still being run on only a pilot basis. Sweden remains opposed to needle exchange, although two exchanges do operate. See Kirp, D., and R. Bayler, eds., *AIDS in the Industrialized Democracies*, New Brunswick, N.J.: Rutgers University Press, 1992.

exchange participants testing positive for HIV fell from 7 to 3 percent, and 27 percent of those who dropped out of the program remained in contact with other health agencies. German officials report that 70 percent of the addicts in needle-exchange programs stopped sharing needles entirely, indicating that they are responsive to health concerns, despite the destructiveness of drug use.<sup>20</sup>

The results of the little experience with needle exchanges available in the United States have also been positive. A carefully controlled evaluation of the needle-exchange program operated by Yale–New Haven Hospital in New Haven, Connecticut, reported declines in HIV prevalence of more than one third.<sup>21</sup> Yet, the assumption that drug addiction is a greater social threat than AIDS (which is invariably fatal) continues to govern U.S. policy toward needle exchange.

The debate on drug issues among Europeans and Americans also touches on whether to maintain heroin addicts on methadone, a long-acting, legal narcotic that can relieve an addict's craving for heroin if taken orally just once a day (compared with three or four times a day for injectable heroin). Extensive studies in the United States, Sweden, and Great Britain have found that the mortality, morbidity, and imprisonment of addicts maintained on methadone are less than half those of addicts who enter drug-free programs.<sup>22</sup> Treatment experts agree that methadone is the most thoroughly evaluated type of treatment and has shown the best overall results in mitigating the most damaging features of heroin addiction.

Yet methadone is attacked by many in the United States as immoral, likened to providing "money to bank robbers," in the words of one official. In its June 1988 report, the White House Conference for a Drug-Free America<sup>23</sup> criticized methadone as evil, although metha-

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<sup>20</sup>Indicating the difficulty of understanding the behavior of IVDUs with respect to HIV, we note that in Norway, the majority of intravenous drug addicts arrested reported that they had been voluntarily tested for HIV an average of three times.

<sup>21</sup>O'Keefe, E., E. Kaplan, and K. Khoshnood, *Preliminary Report: City of New Haven Needle Exchange Program*, New Haven, Conn.: New Haven Health Department, 1991.

<sup>22</sup>Gerstein, D. R., and H. J. Harwood, eds., *Treating Drug Problems*, Washington, D.C.: National Academy Press, 1990.

<sup>23</sup>*The White House Conference for a Drug-Free America (Final Report)*, Washington, D.C.: U.S. GPO, June 1988.

done is now legally dispensed to about 95,000 addicts in the United States, about one-sixth of the heroin-addicted population in the country.

In Europe, methadone has been accepted increasingly in response to the AIDS epidemic. Whereas before 1990, in Spain, methadone had been tightly controlled through central government clinics, in 1990, Spain made methadone widely available through private physicians and clinics. Great Britain moved to methadone maintenance in the mid-1970s, and the Netherlands, which also adopted methadone long before the AIDS epidemic, provides free methadone and clean needles from mobile buses. In Germany, the central government does not support methadone programs, in part because of the continuing opposition of the national medical association, which prefers drug-free treatment.<sup>24</sup> However, state governments are permitted to provide methadone along with a full range of social services. So far, there are fewer than a dozen methadone programs in Germany. The inclusion of methadone treatment under medical insurance coverage in April 1991 is expected to expand its availability.

Perceptions of the value of methadone maintenance differ over Europe, but most officials believe that it can play a useful role, particularly for addicts who have been unable to benefit from repeated attempts at drug-free treatment. They see methadone as one part of a mosaic of treatment modalities that enable the needs of particular patients to be matched to the most effective type of treatment.

To facilitate the provision of services to addicts and to confine illicit drug transactions, some European countries have recently experimented with creating "zones of tolerance," areas or parks in which illicit drug use is allowed. As a way of inducing drug users to stay in those zones, police in Frankfurt, Bremen, Hamburg, and Berlin do not arrest drug users in certain areas. Before the 1990 law that established penalties for possession, police in Milan allowed drug users to congregate behind the train station. The Dutch have long followed this approach of selective locational enforcement as a means of controlling drug-dealing and encouraging addicts to seek services.

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<sup>24</sup>Doctors in Germany, like many in Canada, the United States, and other countries, tend to view addiction as a psychosocial disease that cannot be treated with a drug.



Zurich's Platzspitz, the best known of these experiments, opened in 1988 in an effort to slow the spread of AIDS among intravenous drug users. Doctors and other professionals provided medical services, free needles, counseling, and hot coffee to addicts who congregated there. The well-publicized park attracted addicts from all over Switzerland, as well as sellers from all over Europe, and became notorious throughout the world. Crime rates rose moderately in the business district surrounding the park. This rise, together with the notoriety and the growing local expenditures on services for non-Zurich addicts, led to closure of the park in February 1992. Addicts with Zurich identity cards can now obtain clean needles, methadone, and other treatment services in clinics.

In engaging drug addicts in efforts to modify the most destructive aspects of their behavior, particularly needle-sharing, European countries are developing low-threshold, "user-friendly" programs that provide immediate access to services. In Madrid, a mobile bus offers counseling, referrals, and free condoms, but neither methadone nor clean needles, as the Dutch buses do. The Zurich experiment was designed to reach addicts who normally would not go to hospitals or other public institutions for help. It did so, but the public costs were too high. And not all these efforts have been successful; for example, a recent evaluation of the low-threshold methadone services in Amsterdam reported that they failed to improve the status (health and criminal behavior) of most of the clients.<sup>25</sup>

## Prevention

It is widely accepted by experts that prevention programs, aimed primarily at adolescents, are an important element of an effective long-term strategy for reducing national drug problems. Yet many Western European countries give little more than token support for such programs. In this respect the United States, despite its emphasis on law enforcement, has clearly been the leader in program de-

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<sup>25</sup>Hartgers, C., A. van den Hoek, P. Krijnen, and R. A. Coutinho, "HIV Prevalence and Risk Behavior Among Injecting Drug Users Who Participate in 'Low Threshold' Methadone Programs in Amsterdam," *American Journal of Public Health*, Vol. 82, No. 4, 1992, pp. 547-551.

velopment. However, it appears that less than half of all U.S. children actually receive prevention education in schools.

The Netherlands has a distinctive view of prevention. On the one hand, drug prevention is part of the normal school health education program. On the other hand, no effort is made to reach the general population with drug prevention messages outside of school. Instead, resources are focused on groups that are at high risk.

In Spain, the support for prevention in schools is primarily rhetorical. There are few accepted prevention models and considerable resistance from school officials to implementation. In Switzerland, prevention education has become a local political issue, with some cantons holding referenda on the content of curricula; many parents are apparently not happy to have schools dealing with such sensitive behaviors. The British government is trying to deal with the crude stereotypes of many parents, who see all illicit as equally dangerous but trivialize the dangers of solvent use (e.g., glue-sniffing). Solvents are widely used by younger adolescents and pose significant dangers both in the short and long run.

## CONCLUSIONS AND RECOMMENDATIONS

Although the letter of drug laws on both sides of the Atlantic is similar, the ways in which the laws are applied differ substantially. Beyond a clear consensus on the importance of prosecuting drug traffickers, Europe and the United States disagree on the appropriate goals of drug policy. And while the rhetoric of European governments ranges from the quite punitive tone of Germany, France, and Great Britain to the more tolerant tone of Spain and the Netherlands, practical policy differences are slighter, largely because in almost all instances (except perhaps for France and Norway) the highest priority is to reduce the harms arising from drug abuse, especially AIDS. Canada, despite its relatively higher rate of drug arrests, looks much more like Europe in general implementation of its policies, both in terms of drug problems and drug policies, than like the United States.

Some nations, such as Canada and the Netherlands, have explicitly linked policymaking for alcohol and/or cigarettes with that for illicit drugs. Such linking has been clearly rejected in other nations, such

as the United States and Italy, where the illegal drug problem has been seen as distinct from problems with other addictive substances. Although harmonization of policy does not mean that all such substances should be treated alike, it is likely to ensure better integration of health and regulatory policies for controlling a set of problems having common causes. It also symbolizes the differences between use and abuse.

In its heavy reliance on the criminal law to eliminate drug abuse, the United States stands alone. The number of those imprisoned annually for drug offenses has risen almost tenfold in the past decade, while crime rates (except for homicide) have declined. Even though the United States has the highest rate of serious drug abuse in the developed world, "reducing harm" is still a secondary goal, particularly if such measures involve implicit tolerance of addiction.

Federal officials in the United States point out that by reducing the number of drug users, the harms related to drug abuse are also reduced,<sup>26</sup> making needle-exchange programs and other special efforts unnecessary. But this argument runs up against the reality that treatment is currently available for less than one-third of those who need it in the United States.<sup>27</sup> Without treatment, there is very little hope that either drug addiction or AIDS will decline. Since 1988 there has been no significant decline in the number of deaths and drug-related emergencies recorded in the Drug Abuse Warning Network, and IVDU-related AIDS cases continue to rise.

European nations have less severe problems, but it is not clear that their policies do much to explain why. Both tough Norway and tolerant Netherlands have relatively modest problems. Tolerant Spain and tough France have quite severe problems. The most important differences may be in the general functioning and stability of families and social structure. But so little rigorous analysis has been done that at this stage one can report only impressions.

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<sup>26</sup>The characterization of the federal U.S. policy stance is based on that of the Reagan and Bush administrations and does not reflect any changes that might be introduced by the Clinton Administration.

<sup>27</sup>The Institute of Medicine estimated that, in 1988, 2.4 million persons were in clear need of treatment (see Gerstein and Harwood, *Treating Drug Problems*, 1990, p. 84 [footnote 22]). Admissions to treatment programs in 1987 totaled only 850,000.

Clearly, there is much that the Americans, Canadians, and Europeans can learn from each other. Research can help inform policy choices, as the positive assessments of needle-exchange programs have already done in various European countries and several American cities. In general, Western Europe has underinvested in monitoring the extent of drug problems. Major nations, such as France and Italy, have never conducted a general-population drug use survey and are instead forced to rely on imperfect indicators, such as drug-overdose deaths and admissions to treatment facilities, to obtain an understanding of the scale and nature of their drug problem—both of which rise long after the epidemic of initiation into addiction has started. Surveys, like other surveillance systems (e.g., emergency room admissions involving drugs, urinalysis of arrestees), are imperfect, but they can provide important data to be used with others for developing a better understanding of probable future patterns of drug problems in each society.

The Bellagio conference participants agreed that common “points of reference” on the most promising approaches to prevention would be helpful to them in shaping national drug policies. So, too, would a common framework for treatment, particularly in relation to the matching of clients with specific types of programs. It was agreed that the European nations have sponsored far too little research on these topics. Indeed, there are no European evaluations of prevention programs. Instead, European operators must rely on evaluations done in the United States, although it is clear that prevention is a cultural-specific activity; programs need to be adjusted to reflect the norms of individual nations and even subgroups.

The participants suggested that, since the United Nations and other regional organizations have not done so, independent, nongovernmental efforts might be more successful in developing basic prevention programs. Such programs should include the newly independent countries of east central Europe, which are now facing the threat of serious drug problems without the policy experience or social history of their Western neighbors. These struggling nations should not be left ignorant of the painful lessons of the past—both in the United States and in Europe—about what approaches are most effective in combating drug abuse and its related harms.

There has been far too little exchange of information among public and private drug experts across the Atlantic as well as within Europe. Although governments may continue to differ over the best ways to deal with drug abuse, we believe that the common Western experience can help inform policy choices in all of our countries.



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**PARTICIPANTS IN THE BELLAGIO CONFERENCE ON  
DRUG POLICY, DECEMBER 1991<sup>1</sup>**

CANADA

Jacques G. LeCavalier  
Canada's Drug Strategy,  
Policy, Planning and Information Branch  
Health and Welfare

GERMANY

Michaela Schreiber  
Regierungsdirektorin  
Federal Ministry for Youth, Family, Women and Health

ITALY

Guido Bertolaso  
Office of the Prime Minister

Ernesto Savona  
Department of Criminology  
University of Trent

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<sup>1</sup>The institutional affiliations provided here are those each participant had at the time of the conference.

THE NETHERLANDS

Eddy Engelsman  
Ministry of Welfare, Health and Cultural Affairs

SPAIN

Francisco Perez Perez  
The National Plan on Drugs  
Ministerio de Sanidad y Consumo

Teresa Salvador  
European Prevention  
Assessment System  
Center for Health Promotion  
Studies

SWITZERLAND

Dr. Med. Werner Fuchs  
Oberarzt  
Sozialpsychiatrischer Dienst  
Psychiatrischen Universitätsklinik Zurich

UNITED KINGDOM

Craig Muir  
Department of Health

L. P. Wright  
The Home Office

Virginia Berridge  
London School of Hygiene and  
Tropical Medicine



UNITED STATES

Mathea Falco (organizer)  
Cornell University Medical Center

Arthur Houghton  
Office of National Drug  
Control Policy

James Kahan  
RAND

Herbert Kleber  
Department of Psychiatry  
Columbia University

Robert MacCoun (rapporteur)  
RAND

Norval Morris (Chair)  
School of Law  
University of Chicago

Peter Reuter (organizer)  
RAND







*MR-237-GMF/SF*