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Commentary

Regulation of illegal drugs: an exploration of public health tools☆

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Abstract

This commentary explores the concept of a regulated market for currently illegal drugs. It details a variety of specific public health tools which could be used in a regulatory regimen to control access to these substances. The distinction between administrative and social controlling mechanisms is discussed. The author concludes that a regulated market for drugs founded on inclusive public health and moral principles is a rational approach to the pervasive global concern of illegal drugs in our society.
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There is currently a transition in the global debate over how illegal drugs are controlled. This debate is fuelled largely by the growing acknowledgement that criminal justice tools, in isolation, are ineffective at controlling the criminal, health and social problems associated with illegal drug use. The problems caused by drug prohibition have been well documented (Auditor General of Canada, 2001; Bertram et al., 1996; Haden, 2002; MacCoun & Reuter, 2001) and there is growing agreement that public health tools can be more effective at managing this pervasive social concern. A recent issue of the *International Journal of Drug Policy* explored the expanding global awareness of the failure of drug prohibition. In this issue, authors considered the current crisis this approach is facing (Levine, 2003; Wodak, 2003) and suggested ways of challenging the international treaties which dictate an enforcement based approach to drugs which are currently illegal (Bewley-Taylor, 2003).

In Canada, there have been several recent Federal reports which have recommended significant changes to our dominant enforcement model of drug control (Canada's Drug Strategy, 2001; Canadian HIV/AIDS Legal Network, 1999; Report of the Special Committee on Non-Medical Use of Drugs, 2002).

The debate has recently been advanced in Canada by a Senate Committee (The Special Senate Committee on Illegal Drugs, 2002), which moved beyond criticisms of prohibition and took a bold next step. This report suggested that a regulated market for cannabis would reduce many of the problems that are created by our current prohibitionist approach. After analysing data from many countries this report concluded that a regulated market would not significantly increase cannabis consumption. When presenting this report Senator Pierre Claude Nolin stated that while his report focused on cannabis, the conclusions were applicable to all currently illegal drugs (Nolin, 2003).

This commentary seeks to expand the discussion by exploring what the term "regulated market" means. In order to discuss the concept of a regulated market we need to move beyond the historical debate which only gives us two options: the dichotomy of criminalisation and legalisation. Criminalisation has clearly failed, as increased spending on enforcement strategies has not decreased availability of illegal drugs (US Department of Justice, DEA, 2003) and has been associated with other significant health (Canadian HIV/AIDS Legal Network, 1999; The National Action Plan Task Force, 1997; National Association for Public Health Policy, 2000; Wharry, 1999) and social (Brochu, 1995; Nadelmann, 1989; Riley, 1998) pathologies.

Currently there is no unified consensus of the definition of the word "legalisation" but there is general agreement amongst authors that legalisation is not desirable if this word is equated with an open free market. The models used to sell

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hot dogs and blue jeans do not work very well for chemicals which have significant potential for harm. We can predict that if we adopted a legalisation paradigm for the distribution of currently illegal drugs, which included advertising and promotion, we would have significant associated social and health problems. This paper assumes that there is a fertile middle ground between the polar opposites of criminalisation and free market legalisation where the principles of public health flourish. The aim of this commentary is to explore the concept of market regulation using a public health framework.

Regulatory options can be divided into two groups: those which are aimed at regulating the purchaser and consumer and those which are directed at regulating the product. North American society is skilled at regulating products, as we control content, packaging, price, distribution, advertising and marketing of a wide range of products like food, pharmaceuticals and alcohol. Our society, however, has yet to fully explore the numerous options available to regulate and/or restrict the purchasers and consumers of these products. This paper will explore a wide variety of possible regulatory mechanisms focusing on those who buy and use drugs.

The following is a list of 14 possible regulatory approaches and mechanisms that could be used for controlling drugs that are currently illegal:

Age: In Canada, there is provincial legislation which controls access to alcohol and tobacco based on age. In most provinces the legal drinking age is 19, although Alberta and Quebec allow young adults to drink at the age of 18. Access to tobacco in Canada is allowed at either age 18 or 19 depending on the province. It is a strange paradox in our society that we control the age of purchasers of alcohol and tobacco but we do not have any control of the age when illegal drugs can be purchased. Illegal drug dealers, who thrive under the "prohibition" model and predominantly target youth, never ask customers for age identification. It is, therefore, no surprise that youth drug use surveys indicate that young people have easier access to drugs than alcohol (The National Centre on Addiction and Substance Abuse at Columbia University, 2002).

Degree of intoxication: Currently, the sale of alcohol in Canada is restricted based on the degree of intoxication of the purchaser. Customers are refused service if they are perceived by staff to be engaging in high-risk substance using behaviour.

Volume rationing: The Netherlands restricts its "coffee shops" by volume rationing when selling cannabis products. Consumers are allowed to purchase a maximum of 5 g at a time. This amount is intended to supply an individual with enough for personal consumption for a few days. The concern that drugs might be smuggled into other countries could be reduced if the quantity an individual was allowed to purchase was limited to small amounts for personal consumption.

Proof of residency with purchase: In the Netherlands the "drug tourist" trade has been a mixed experience. Some "coffee shops" where cannabis products are sold are designed to target the tourist market. While tourists bring new money into the country they can also behave in socially undesirable ways. Societies that have formed relatively healthy, unproblematic relationships with a substance have gone through a process of developing culturally specific social controlling mechanisms which often manifest as ritualistic behaviours. "Drug tourists" who are not integrated into the culture may not adhere to these restraining social practices. This potential problem could be reduced if purchasers are residents of the country, province, city or neighbourhood.

Locations of use could be restricted: This controlling "technique" is currently used in Canada with alcohol (bars and home use) and tobacco (some indoor public spaces are smoke free). Location of substance use could vary depending on the potential for harm. For instance, use of injectable substances could be limited to supervised injection sites, smoking of heroin and cocaine could be limited to supervised consumption rooms, and weak oral solutions of drugs of known purity and quantity could be restricted to home use.

Required training prior to purchase: Drugs can be powerful substances that have a greater potential for harm when used by naïve users. Training programs could provide knowledge and skills to drug users with the goals of discouraging drug use, reducing the amount of drug use, or reducing the harm of drug use. Training programs could also raise awareness about addiction concerns, available treatment services, and other public health issues such as blood borne, and sexually transmitted diseases. Successful training program graduates could be issued a certificate which would have to be shown prior to purchase.

Registration of purchasers: Tracking of purchasers allows an opportunity for "engagement" and brief health focused education. This may also discourage some individuals from participation in the "program".

Licensing of users: Graduated licenses for new motor vehicle drivers could provide a model for licensed drug consumption. New drivers can be restricted where and when they drive and who they are permitted to drive with. Research as shown that having an experienced, responsible adult in the car and controlling for age and the number of other passengers with a new driver will diminish the chances of an accident (Insurance Institute for Highway Safety and Traffic Injury Research Foundation, 2003). New substance users could have similar controls implemented where time, place and associations are controlled. A graduated program in which, responsible, non-harmful drug use is modelled increases the chance of new users adopting benign relationships with drugs. Licenses could be forfeited in the event of conviction of driving under the influence, providing

drugs to unlicensed users, or public intoxication. As with a driver's license accumulated demerit points for multiple smaller infractions could also result in license suspension or removal. License suspension could result in the need to take further training to re-establish the license. Loss or suspension of a license would not prevent other civil or legal sanctions from occurring. Some careers may preclude the possibility of obtaining a license. Airplane pilots or taxi drivers, for instance, may not be allowed to have a license to purchase long acting drugs which impair motor skills. Transport licenses have gradings which allow for operation of different types of vehicles. Licenses for users could also specify different levels of access to different substances, based on training and experience.

Need to pass a test of knowledge prior to purchase: Potential customers may be required to demonstrate knowledge of safe use of the drug prior to purchase. A short test could be administered in the distribution centre, to allow staff to assess whether the customer has sufficient knowledge to use the substance in a manner which is likely to minimise harm.

Tracking of consumption habits: Registered purchasers could have the volume and frequency of purchases tracked. In British Columbia (Canada) this process of data collection is beginning to occur through a shared data system called "pharmanet" where consumption of prescription drugs is monitored. This data could be used to instigate "health interventions" from health workers (i.e. pharmacist or other health care worker) who could register concern about the individual's physical, social or emotional health and offer assistance if a problem is identified. Having health workers distribute drugs could result in the provision of written and verbal health related information about the drugs and drug interactions being made available to customers. Immediate personal feedback about consumption habits may have a moderating influence on patterns of use. Tracking of consumption habits may also be linked with purchase deterrents. The unit price of the product may be graduated so that the price goes up past a certain volume threshold.

Required membership in a group prior to purchase: Drug user's advocacy groups or unions can serve a variety of functions. Although they currently act as political advocacy groups and provide peer-based support and education for their members (Health Canada, Population and Public Health Branch, 2001) these functions could be expanded so user groups could have a greater influence over the behaviour of their members. These groups could then be engaged in a process where they played a more formal role in the regulation of consumption of substances. An example of a type of group that has a substantial influence over the behaviour of its members are the many discipline specific, professional regulatory bodies that provide practice guidelines for their members. These groups enforce norms in their members through a variety of peer processes and education. In the event that a member continues to practice outside the established norms of the discipline, the regulatory body can eventually refuse membership to an individual. This process produces shared responsibility between the group and its members. Shared responsibility within a drug user group could result in moderation of behaviour due to a similar peer educational process. Group licenses could be revoked in the event of frequent infractions (i.e. driving while intoxicated) by the group members.

Shared responsibility between the provider and the consumer: The roots of this concept are found in today's Server Intervention programs where providers of alcohol are partially responsible if an intoxicated customer is involved in an automobile accident (Single & Tocher, 1991). Sellers could be held partially responsible for the behavior of consumers. Providers may be required to supervise the environment where the drug is used and to restrict sales based on the consumer's behavior. Retailers could be fined or lose their sales license if customers are involved in accidents (automobile or other) or other socially destructive incidents for a specified period of time after the substance has been consumed. A balance would be needed where *both* the provider and the consumer were held responsible. Retailer responsibility should not absolve the consumer from receiving social or legal sanctions for undesirable behaviour.

Proof of dependence prior to purchase: Those who are assessed (by a health worker) to be substance dependent could be allowed to purchase a rationed amount to be used in designated spaces.

Proof of "need" prior to purchase: Our society may expand potential consumers to other groups beyond just those who are substance dependent. A number of currently illegal drugs (e.g. LSD and ecstasy) have been shown to have potential psychotherapeutic benefits if used in controlled therapeutic environments (Grinspoon & Bakalar, 1979). Registered and trained psychiatrists and psychologists could access substances for professional use with clients.

Another example of potential benefit can be seen by examination of groups like the Native American Church, which use peyote in accordance with ancient traditions. Anecdotal evidence indicates a reduction in alcoholism and violence in communities involved with this "peyote medicine" practice (Stewart, 1987). Research evidence indicates that consumption of ayahuasca, a plant based entheogen (a hallucinogenic drug used in shamanic rituals or religious ceremonies (Ruck et al., 1979) when used in South America in controlled ritualistic settings can produce a remission of psychopathology and improved social functioning in the participants (Grob et al., 1996). The definition of "proof of need prior to purchase" must be flexible

enough to allow for the potential of social or psychological benefits from drugs for specific members of our society.

Drugs vary widely in their potential for dependence, physical and psychological harm and potential benefit. It is, therefore, logical that a range of different regulatory techniques be utilised for different drugs and different preparations. Cannabis, ecstasy, LSD, heroin and crack cocaine, for example, each have completely different pharmacological properties and their ingestion produces very different behaviours. As the potential for benefit and harm varies widely between these fundamentally different groups of chemicals different regulatory mechanisms are warranted. This is why the regulatory options in this paper range from intrusive and controlling to non-intrusive. The goal of policy makers will be to match the drug with the appropriate regulation in a way which balances society's need to control (through formal and informal mechanisms) the behaviour of its members and each individual's right to freedom.

While the above regulatory tools range from intrusive to non-intrusive they are all administrative in nature. Drug use has, throughout the centuries, been managed in societies by non-administrative (and non-criminal) processes or social controls which often manifest as predictable drug using rituals. There are many examples of social rituals which control amount of consumption and constrain the behaviour of those involved. Restriction of alcohol to meal times is one example of a modern day social norm which controls for context, amount consumed, and length of time of use of this common sedative drug. The pairing of alcohol and food also reduces the physically harmful effects of alcohol as the food in the stomach slows alcohol absorption. Structured "coffee breaks" moderate consumption of this stimulant drug in mainstream society. The Native American Church's peyote ceremony is an example of a highly ritualised, sacred social control process which regulates a drug used by an indigenous group. Social controls can evolve to meet changing needs. The sacred rituals which control the use of ayahuasca in South America were started by aboriginal people but have expanded beyond this population to include many non-indigenous people (Grob, 1999).

A rational approach to drug control would stipulate that more intrusive and administrative levels of restriction be reserved for drugs which have greater potential for harm, and that social controls be used for drugs which have a lower potential for harm. When conceptualising a more functional paradigm for drug control we need to acknowledge that social controlling norms that promote non-harmful drug use behaviours will take time to develop.

There is significant complexity in any attempt to discuss realistic alternatives to drug prohibition. One of the issues is the need for alternatives to compete with the global drug black market which spawns significant health, social and economic pathologies and provides easy access to drugs. Challenging these illegal drug distribution networks is vital for the success of an alternate paradigm. Cannabis, for example, has proven to be very difficult to regulate in any

country partly due to the ease in which this hardy plant can be cultivated. A drug whose production is simple and widely available indicates the need for less restrictive regulatory mechanisms in order to challenge the economic realities of the black market. Drugs like methamphetamine, which are more complicated to manufacture and have the potential to produce greater social and individual harms, could have multiple restrictive regulatory mechanisms and still challenge the black market availability.

Another factor to consider in the discussion of a regulated market is the inclusion or exclusion of marginalised populations. Many Canadian reports have observed that criminalisation of drugs is a significant exclusionary force in society which results in the creation of marginalised populations (BC Aboriginal HIV/AIDS Task Force, 1999; Cain, 1994; Canadian HIV/AIDS Legal Network, 1999). The significant economic, social and individual costs of the politics of exclusion have been documented (Hermer & Mosher, 2002). Countries like the Switzerland and the Netherlands describe their goal as "normalisation" which is the same as "inclusion". The belief underlying the word "normalisation" is that if a country can engage and include drug users in mainstream culture this normative process will result in these individuals living more balanced and constructive lives.

Countries like Australia, Denmark, The Netherlands and Canada have drug user's advocacy groups contributing a significant perspective to the drug policy debate. Countries which support, fund and include these groups in a meaningful way have advantages for both mainstream society and these groups themselves as normalisation works in two directions. First, this increased participation in "normal" society enhances the ease of transition for members who wish to join the ranks of mainstream society; and second, this would allow "normal" society to influence the behaviour of the members of this group. This results in reduced harm to both individuals who use drugs and the society as a whole. Countries which support the concept of inclusion or normalisation are more able to entertain a serious discussion about more effective drug policies.

We need to ask new questions. The question "how do we stop drug use?" is not as useful as the question "how do we regulate the market for drugs in a way which increases social cohesion and minimises harms?". One of the themes of the above list of regulatory mechanisms is the intent to increase inclusion of marginalised populations and, therefore, improve a society's social cohesion. There are numerous individual, family and community benefits of increased social cohesion such as reduced crime rates (Braithwaite, 1989), improved economic functioning (Dayton-Johnson, 2001) and enhanced epidemiological health status indicators (Levy & Persosolido, 2002).

The debate about how to best control illegal drugs is as global as the distribution networks which supply these drugs. This worldwide discussion has resulted in the suggestion that a group of like-minded revision oriented countries take collective action to challenge drug prohibition

(Bewley-Taylor, 2003). This potential worldwide movement would be greatly assisted if there was a clear unified vision to which they aspired. The concept of a regulated market, based on the inclusive public health principles listed above could be a significant asset in the development of this shared vision.

Drug prohibition is a "blunt instrument" that paradoxically produces unregulated access to drugs. Currently, illegal drugs are too powerful to be left to the control of corrupt criminal organisations. A public health approach to market regulation which attempts to minimise harm to individuals, families and society as a whole, is a rational approach to this pervasive global health and social problem. This new approach needs to be guided not just by public health principles but also moral values. It is amoral to allow the continuation of an enforcement dominated drug control paradigm, which has so clearly failed to achieve its objectives, and has itself led to so much crime, disease, violence, corruption and death.

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