Illicit IV Drugs: A Public Health Approach

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Abstract: This article explores, from a public health perspective, the harm done by Canadian drug laws, to both individuals and society. It challenges the perceived dichotomy of legalization and criminalization of intravenous drugs. The article then expands the discussion by exploring eight legal options for illicit drugs and examines how these options interact with; the marginalization of users, the illicit drug black market, and levels of drug consumption. While the main focus of this article is intravenous drugs, it draws some lessons from cannabis research.

Résumé: Cet article explore, d'un point de vue de santé publique, le dommage causé aux individus et à la société par les lois canadiennes sur les drogues. Il met en question la dichotomie percue entre la légalisation et la criminalisation des drogues injectées. De plus, l'article explore huit options légales pour les drogues illicites, et examine l'effet que chaque options pourrait avoir sur la marginalisation des utilisateurs, le marché noir de la drogue, et le niveau de consommation de ces drogues. Bien que cet article traite surtout des drogues injectées, certaines de ses conclusions proviennent de la recherche sur le cannabis.

Keywords: Harm Reduction, drug policy reform, drug legalization, drug prohibition, IV drug use

Historically, substance abuse services have had “abstinence” as the dominant goal and as a result of this focus, programs for individuals who currently use drugs have not been well represented in the service spectrum. The HIV/AIDS and Hepatitis C epidemics among intravenous drug users have led to the discussion of new public health “harm reduction” service principles which begin to address the specific needs of this drug using population.

From this debate, there is mounting evidence that Canadian drug laws are actually contributing to the harm done to society, and individuals who use/abuse currently illegal drugs. Many reports[1,2,3,4,5,6,7,8] have identified some aspects of our drug laws that are problematic from a public health perspective. These reports, which focus on injection drug use, document how our drug laws produce many harms to both users and communities including, increased HIV, crime, overdoses, unsanitary injection techniques, and the marginalization of drug users.

Now that the public debate on Canada’s drug laws is expanding, it is timely to broaden the discussion of the public policy options beyond the usual criminalization or legalization dichotomy. It is commonly assumed in many media reports that these are the only two policy options available, and these terms are rarely defined. Often those who question the validity of criminalization of drug users are assumed to be pro-legalization[9] (and those who do discuss legalization issues rarely define what legalization means). This legalization / criminalization dichotomy is both false and a

needless limitation of the available alternatives. Balanced articles which explore the middle ground are rare[10,11].

The goal of this article is to clarify the available options in terms of legal controls over drugs and to discuss how these different options impact levels of consumption, and the marginalization of drug users. The aspect of black market or criminal activity is also discussed, as this issue is strongly impacted by drug policy and is often not included in drug policy discussions.

There are eight options available to Canadians in terms of legal controls over drugs:

1) **"Free market" legalization:** An open "free market" system could be used to sell drugs. This would include promoting, advertising and finding creative ways to maximize sales and use of these substances.
2) **Legalization with "product" restrictions:** Under this model, product restrictions can be aimed at manufacturers, packagers, distributors, wholesalers and retailers. Drug packaging, marketing and method of sale would be specified. Advertising and promotion would be prohibited. Drugs would be sold in plain packaging with standardized weights. Retail outlet location, days and hours of operation would be controlled. The strength, formulation, method of use, and retail price of the drug would be regulated. The goal of these restrictions is to make the merchandise as neutral (or unattractive) as possible. Our society uses many "product" restrictions currently. Prescription drugs and tobacco have restrictions aimed at packaging and labeling, and when alcohol is sold, packaging and retail outlets are controlled.
3) **Market Regulation:** This model would include all of the "product" restrictions as outlined above, and would also restrict purchasers. Restrictions on purchasers could include:
   - age of purchaser,
   - degree of intoxication of purchaser,
   - volume rationing,
   - proof of "need" in order to purchase,
   - required training for purchasers,
   - registrations of purchasers,
   - proof of residency with purchase.
   - limitations in allowed locations for use.

   This option is about regulating access to drugs. Using this option, a health care worker (e.g. nurse, counsellor, social worker) could assess the "customer" on a variety of factors, including degree of addiction, documented need, residency and age. These "customers" could then be registered, enrolled in a training program and allowed to purchase a rationed amount, from licensed outlets, to be used in designated spaces (i.e. safe injection facilities, consumption rooms, home use). An active integrated prevention/public health education program integral to this model would also restrict customers. Currently our society uses some "customer" restrictions in sales of alcohol, where age and degree of intoxication of purchaser are factors in the sale. This option could be expanded considerably, beyond the alcohol sales model, to assist in bringing regulation to this currently uncontrolled market.

4) **Allow drugs to be available on prescription:** Physicians could be allowed to prescribe currently illegal drugs for medicinal or maintenance purposes. Currently a special license is required to prescribe our only "maintenance" drug, methadone. The special license requirement results in some physicians opening specialized methadone clinics with hundreds of patients who, to the distress of local communities, congregate in the neighborhood. Allowing *all* doctors to prescribe drugs like heroin and cocaine might dissipate drug abusing communities as this would increase the options available to addicts. Increasing the number of physicians who could prescribe these drugs may help to desegregate this disenfranchised population and promote reintegration into mainstream communities.
5) **Decriminalization:** The existing laws could be changed to remove legal sanctions. With "decrimalization", criminal prosecution is not an option for dealing with drugs. This term is often confused with the term "legalization" which specifies how drugs can be legally available. The term "decriminalization" is limited in its utility, as it only states what will *not* be done and does not explain what legal options *are* available. Proponents of "decriminalization" usually distinguish between personal use, and trafficking and smuggling. Those who profit from the black market would still be subject to criminal charges but personal use would not be subject to legal sanctions. Decriminalization, or benign neglect, means ignoring the problem and results in unregulated access to drugs of unknown purity and potency.
6) ***De facto* decriminalization or *de facto* legalization:** In this context, "*de facto*" means to collectively agree to ignore existing laws without changing them. For many years the Netherlands have maintained the laws prohibiting the possession and sale of marijuana while allowing both of these in practice. In Canada this option would allow for a transition period, or social experiment, to test out any policy options which are being considered.
7) **Depenalization:** While existing laws are maintained, the penalties for possession could be significantly reduced. Penalties under this option are: discharges, diversion to treatment instead of jail for significant charges (possession of large amounts and trafficking), and "parking ticket" status for possession of small amounts of drugs for personal consumption. Reduction of criminal charges, for possession of drugs, does not remove personal responsibility for an individual's behavior, like driving while intoxicated or violence.
8) **Criminalization:** All existing laws prohibiting currently illegal drugs could continue to be enforced. Individuals caught possessing or trafficking drugs can be charged, given criminal records (which can impact future employment and travel), fined and/or incarcerated.

All of the above options have different benefits and costs that need to be evaluated as our societies' drug polices develop. These alternatives need not be mutually exclusive, as what is appropriate for one drug may not be suitable for others. Each drug must be considered independently where the harms of criminalization are weighed against a realistic evaluation of potential health harms.

The first issue to consider is the damage to our society caused by the creation of a black market which is produced by the process of criminalization. In addition to being an

effective distribution system for drugs, the illegal black market spawns significant social pathologies including:

- increased transmission of HIV and the societal burden of AIDS[12,13,14]
- corruption[15,16,17,18,19,20]
- violence [21,22,23,24]
- crime [25,26,27,28,29]
- destabilization of governments [30,31, 32]
- destabilization of world markets[33]
- criminalization of youth[34]

The criminalization of drugs creates a black market which functions to grow, manufacture and traffic illegal drugs. The black market results in crimes committed to purchase the drugs and launder the illegal money, and violence used to enforce the illegal transactions. The black market distribution systems vary significantly for different drugs. The marketing process for marijuana is very different from the process used to distribute heroin and cocaine. Marijuana can be easily grown by users, so decriminalization may not lead to an increase in black market activity and consequently an increase in associated health and social problems.

Decriminalization alone, of heroin and cocaine, would likely produce significant social problems. As these drugs cannot be grown by the users, they are dependant on a criminal distribution system which supplies these drugs. *De facto* decriminalization of heroin and cocaine was tried for 8 years between 1986 and 1994 in Zurich, Switzerland. During this time in “needle park”, there was no penalty for drug use and over 1000 intravenous drug users congregated daily. This social experiment was closed due to increased violence, HIV infections, robberies and drug deaths. From this European experience, it is predictable that the black market activity of these two drugs will expand considerably in Canada, if possession and/or use of these substances is only decriminalized. The black market for heroin and cocaine is created and maintained with “criminalization”, “depenalization”, “*de facto* decriminalization” and “decriminalization”. It would be diminished with “prescription availability”, and reduced or eliminated with the legalization options.

The second factor to be considered is the impact that each of these eight legal options has on the societal marginalization of drug abusers, which in turn, creates significant public health problems. The isolation and segregation of addicts has been documented frequently[35,36,37,38], and marginalization is known to be significant in continuing the process of addiction. The two policy alternatives: “market regulation” and “prescription availability” would increase contact with health service providers, thus reducing the isolation experienced by many addicts.

A third issue to be considered when evaluating these drug policy options is the relationship between legal status and level of consumption. Many people in our society believe that legal sanctions are required to reduce drug consumption. There is a fear that implementing non-prohibitionist policies will result in significantly escalated drug consumption and associated health and social problems. Research to date, which

focuses mainly on cannabis use, does not support this conclusion[39]. During the 1970's eleven American states depenalized marijuana with no increase in consumption.[40] Several jurisdictions in Australia have depenalized minor cannabis offences without increasing use[41] and the Netherlands have experienced *de facto* legalization for many years and the per capita consumption of cannabis is less than the United States which currently engages in strong prohibitionist policies.[42] Spain no longer prosecutes private usage of any recreational drug, and drug use has dropped[43]. While legal sanctions are not required to reduce drug consumption, we have learned that allowing the free market to promote products like alcohol and tobacco, will increase usage. The compelling conclusion is that public health tools ("market regulation", public education programs, and "prescription availability") offer the most effective ways to control drug consumption and related social problems. Public health options offer the middle ground between the extremes of the free market and criminalization.

If removal of legal sanctions does not increase consumption of drugs it is useful to ask "what does increase drug consumption?". Poverty, exposure to violence, childhood abuse and neglect, social disconnectedness, poor role models, exposure to drug using peers, unemployment, and inadequate housing are some of the factors that influence both drug use and abuse. Exposure to legal sanctions appears to be a negligible factor when drug use is seen in the larger psycho/social (or public health) context.

Our current policy of criminalization paradoxically creates unregulated access to drugs. Youth comment that drugs are easier to access than alcohol, which is regulated.[44] The options of "decriminalization", "*de facto* decriminalization", and "depenalization" also allow for unregulated access. The options of "prescription", and "market regulation" all regulate, and therefore control the drug market. Our current lack of control produces many social and individual harms. One example of reducing this harm through regulating the "product" would be to make weak oral preparations, less expensive than more harmful, concentrated intravenous preparations.

The current debate on cannabis control reform provides useful commentary on the larger debate concerning all currently illegal drugs. Eric Single is a Canadian researcher who has been contributing to the drug prohibition debate for decades. His work on the legal options for cannabis suggests three alternatives for reform: depenalization, decriminalization and legalization. He observes that there is no right policy option as the goal is to achieve the delicate balance between reducing the social and financial costs of prohibition and protecting individuals from negative health impacts. He suggests avoiding the high moral ground and focusing instead on what works. Our policies need to be based first and foremost on evidence[45].

To support evidence-based drug control policies, we need to collectively recognize that our current "war on drugs" policies have done us all more harm than good. Movies like "Traffic", television shows like CBC Witness "Stopping Traffic: The War Against the War on Drugs", and books like "Drug Crazy"[46] are all raising public awareness about the failures of our current prohibitionist policies. As public perception shifts, the political will

to provide leadership in the discussion of our options will materialize, and the vital public health research which is needed to evaluate potential policy changes will be funded.

If our society begins a process of evidence based policy, new issues will be discussed and new programs will evolve. Data collection will begin to distinguish between drug use and drug abuse. Possible benefits of some drug use will be acknowledged and factored into the "harm/benefit equation". Prevention programs will engage youth with an honest discussion of both risks and attractions of drug use. The "health" response and the "enforcement" response will cooperate in providing a singular approach to drug use and abuse. Programs and policies will be based not on fear and politics but on evidence and willingness to experiment until effective "drug management" tools are utilized.

As the debate on harm reduction and drug policy reform intensifies, our understanding of these eight policy options and their health, social and criminal consequences needs to be expanded and developed. The process of examination of these eight legal options for all currently illegal drugs will produce significant benefits for society, drug users and drug abusers. The desired end result is an evolution of our illegal drug laws and policies. Canadian society will not manage its "drug problem" effectively until we reach a place where addiction is viewed first and foremost through the lens of public health, and addicts and drug users are treated with dignity and respect.

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