

**Changing America's Drug War:
The Potential Implications of the Dutch Approach for
America's War on Drugs**

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Executive Summary

Over the past 30 years, America's war on drugs has cost federal and state governments billions of dollars and has led to the incarceration of hundreds of thousands of drug offenders. Despite these efforts, however, 46 percent of Americans admit to ever using an illicit drug, and nearly 15 percent admit to using an illicit drug within the past month. In contrast, in Dutch drug policy, the use of the criminal justice system is reserved for dealings with drug traffickers, while drug use itself is seen as a healthcare issue, and is instead combated with a wide range of programs from methadone maintenance to needle exchange. Even more striking is the fact that the use of marijuana is tolerated in Dutch society in certain settings, such as in licensed coffee shops.

By analyzing both American and Dutch drug policy, it becomes apparent that while the American war on drugs has proven costly both financially and socially, the Dutch approach has been largely successful at reducing the harms associated with drug use, such as addiction, overdose and HIV. At the same time, however, America's war on drugs is firmly entrenched in a nearly hundred year old tradition of drug prohibition and, as such, does not appear to be ending. Regardless of this fact, however, the Dutch approach nonetheless provides a "useful corrective" (Boyum, Reuter, 102) to American policy. More specifically, certain elements of the Dutch approach, such as tolerant marijuana policy and needle exchange, have valuable lessons for US policymakers even within the context of the war on drugs because of their ability to reduce the negative consequences of drug use without in turn increasing drug prevalence. Thus, even though the war on drugs seems destined to continue, the Dutch approach provides compelling evidence that this drug war can at least be improved.

I. Introduction

As stated by President George W. Bush, American drug policy is “inspired by a great moral imperative: we must reduce overall drug use because, over time, drugs rob men, women and children of their dignity and of their character”(Bush as quoted in *ONDCP 2008 National Drug Control Strategy*, iv). In striving to achieve this lofty goal, the United States has been embroiled in a nearly thirty year old “war on drugs” which has depended almost exclusively on the criminal justice system to reduce drug use by increasing the criminal sanctions faced by drug offenders. In conducting this war, the federal drug budget has increased sixteenfold since 1981 to its current level of over 13 billion dollars (*ONDCP FY 2009 Budget Summary*), and the number of drug offenders in prison has increased to over fourteen times its 1980 level (*Common Sense for Drug Policy*). Despite these stringent enforcement efforts, however, over 46 percent of Americans aged 12 and over admit to having ever used an illicit drug while nearly fifteen percent admit to using an illicit drug within the past year (*Common Sense for Drug Policy*). Furthermore, drug use in America appears more dangerous than ever, as illustrated by the fact that the number of drug induced deaths,^{*} or deaths resulting “directly from drug consumption, primarily overdose”(Robinson, Scherlen, 138), was 177 percent larger in 2000 than in 1979 even though the overall population grew by just 25 percent (Robinson, Scherlen, 140).

In light of these outcomes of America’s costly war on drugs, policymakers and academics alike have struggled to uncover alternative policies. Towards this end, the Dutch approach to drug policy provides a striking contrast to America’s drug war.

^{*} See glossary. All future ^{*} in text refer to glossary.

Rather than being driven by a moral obligation to eliminate drug use, drug policy in the Netherlands operates under the assumption that “it is not possible to totally ban drug use by means of firm government policy”(Ministry of Health, Welfare and Sport, *Drug Policy in the Netherlands*, 7). Thus, the Dutch government has decided to treat drug use as a healthcare issue instead of a criminal justice issue, and policy focuses on limiting the risks and harms faced by drug users and society, such as addiction, overdose and HIV, and not on reducing use. In fact, as will be shown, the Dutch government even tolerates the use of marijuana in certain cases, such as in licensed coffee shops*, in order to better target the risks of drug use.

This thesis will build on the work of those who have attempted to uncover alternative drug policies for America by first analyzing US drug policy, then analyzing Dutch drug policy, and lastly using the findings of these analyses to determine whether any elements of Dutch policy could prove valuable to US policymakers. However, by paying special attention to the histories and cultures of these two nations, the analysis reveals that the drug war is a well established component of American society and, as such, does not appear to be ending. Thus, rather than focusing on whether the US should adopt the Dutch approach to replace its current drug war, the goal here is instead to uncover whether any of the strategies employed by the Dutch government could be successful within the context of America’s drug war. What will be shown is that the tolerant marijuana policy and the widespread implementation of needle exchange programs that are found in the Netherlands can be useful to American policymakers even within the framework of the war on drugs because of their ability to reduce the negative consequences of illicit drugs without causing offsetting increases in overall use.

II. The Impact of Domestic Law Enforcement on America's "War on Drugs"

Introduction

The issue of illegal drugs rose to national prominence in America in the 1980s when crack cocaine “seemingly overnight became the dominant drug in US cities”(Katel, 12). The crack epidemic coincided with a loss of jobs and an historic crime wave in which the murder rate in Washington D.C. alone increased by 64 percent in 1988 (Katel, 12). The media termed crack “ ‘the biggest story since Vietnam,’ a ‘plague,’ and a ‘national epidemic’”(Robinson, Scherlen, 13) and, according to one survey conducted in August 1986, fully 35 percent of Americans considered drugs the nation’s “top priority”(Katel, 12). In response, President Ronald Reagan adopted a tough on crime approach and declared an all out war on drugs. Reagan more than doubled the drug control budget from \$800 million in 1981 to \$1.9 billion in 1987, and around 90 percent of this increase went to law enforcement programs targeted explicitly at reducing the prevalence of drug use through the utilization of police, prisons and the military (Cooper, 13).

Moving ahead to 2008, US drug policy is molded largely in the template laid out by Reagan; federal spending continues to increase, and policy remains focused largely on law enforcement. However, while this policy does have modest benefits, its emphasis on law enforcement has resulted in steep costs to both the government and society. Overall, this analysis will show that because of its emphasis on domestic law enforcement, American drug policy is ill-equipped to tackle the problem of illegal drug use.

Historical and Cultural Precedents

While America's current war on drugs was born in the 1980s as a response to the crack epidemic, it is actually the product of cultural and historical antecedents which date back to the early twentieth century. In fact, the Harrison Narcotics Act of 1914 "inaugurated the Drug Prohibition era in which we still live" (Webb and Brown as quoted in Robinson, Scherlen, 23). Interestingly, the Harrison Act, which was passed as a result of the approximately 250,000 opiate addicts in the US at the time as well as "fears about narcotics use, compounded by racial bias, gr[owing] with the rapid influx of opium-smoking Chinese railroad laborers in California" (Cooper, 11), was not prohibitory in principle. It simply required "registration with the Treasury Department to import, manufacture, sell, or dispense cocaine and opiates" (Robinson, Scherlen, 22) in the hopes of providing for the "orderly marketing" (Kappeler, Blumberg and Potter as quoted in Robinson, Scherlen, 22) of these drugs. In practice, however, "once the Harrison Act became law the criminalization process began in earnest" because of its use by the Supreme Court as justification for the decision in *Webb v. United States*, which "held that it was illegal for doctors to dispense prescription drugs to alleviate the symptoms of narcotics withdrawal" (Robinson, Scherlen, 23). As a result, the Treasury Department "began arresting doctors who wrote opiate prescriptions for addicts" (Robinson, Scherlen, 23), and law enforcement became a vital tool in America's attempt to combat illicit drugs.

The prohibition of illicit drugs continued in 1930 with the creation of the Bureau of Narcotics within the Treasury Department and the anti-marijuana campaign which followed. The use of marijuana by Mexican immigrants who were "seen as a threat to American culture and the American way of life" and portrayed as "drug-crazed

criminals”(Porter and Kappeler as quoted in Robinson, Scherlen, 23) generated “the same kind of racially motivated concern about narcotics use earlier targeted at Chinese immigrants”(Cooper, 11). Additionally, Bureau of Narcotics’ director Harry Anslinger boldly declared that marijuana “led users to murder and rape, and...was as strong as heroin and more harmful than opium”(Robinson, Scherlen, 24). Consequently, despite the testimony of a doctor before Congress who argued that “marijuana had legitimate medicinal uses” and the fact that the American Medical Association “urged Congress not to vote for the bill”(Robinson, Scherlen, 25), Congress passed the 1937 Marijuana Tax Act, which extended the drug ban created in the Harrison Act to include marijuana. Thus, while the passage of this act further reinforced America’s tradition of drug prohibition, it also established the importance of politics and scare tactics over expert opinion and empirical evidence in the formation of American drug policy.

While the Harrison Act and the 1937 Marijuana Tax Act remained dominant drug policy tools until the second half of the twentieth century, policy changes in the 1960s and 1970s helped to establish the war on drugs rhetoric which is still popular today. The 1960s saw the emergence of a “counterculture,” which consisted largely of “pot-smoking students and other protestors against US involvement in Vietnam”(Cooper, 12). Consequently, by “1969, America’s consumption of illegal drugs was shifting from a hidden, marginal activity to a symbol of youth revolt”(Katel, 10). Additionally, “thousands of Vietnam War veterans, introduced during the conflict to heroin produced in the Golden Triangle...returned addicted”(Cooper, 12).

In response to this changing drug climate, President Richard Nixon, who “came to office based in part on a pledge to restore ‘law and order’ ”(Battin et al., 34), became the

first president to formally declare a war on drugs. Ironically, Nixon's war on drugs emphasized the importance of treatment for addicts by "providing heroin addicts with methadone, which satisfies the drug craving without producing a high" and "establishing treatment programs for hard-core drug users rather than locking them up"(Katel, 11). However, despite Nixon's emphasis on drug treatment, his tough on crime rhetoric helped to establish the modern notion of a war on drugs and, once again, policies targeted a specific societal group, namely, the youth counterculture.

The formation of these different policies throughout the twentieth century reveals that America's contemporary war on drugs is not simply a rational response to a given problem, but is instead the product of nearly 100 years of historical developments. As will be shown, current policies are firmly rooted in the tradition of drug prohibition established with the Harrison Act of 1914, utilize the drug war rhetoric created by Nixon, and even have disparate racial impacts similar to those earlier policies had on Chinese and Mexican immigrants. Thus, regardless of the success, or lack thereof, of current policy, as the product of American history, the war on drugs is certainly far from over.

Goals and Objectives

The primary goal of American drug policy is to reduce the prevalence of illegal drug use. As opposed to focusing on the use levels of specific drugs, this goal pertains to the broader aim of reducing the overall "percentage of Americans who use drugs"(Robinson, Scherlen, 36). In fact, Congress stated in the 1988 Anti-Drug Abuse Act that "it is the declared policy of the United States Government to create a Drug-Free America by 1995"(1988 Anti-Drug Abuse Act) and, earlier this year, President George W. Bush

reiterated that drug policy is “inspired by a great moral imperative: we must reduce overall drug use because, over time, drugs rob men, women and children of their dignity and of their character”(Bush as quoted in ONDCP 2008 *National National Drug Control Strategy*, iv).

To attain this goal, US drug policy primarily utilizes a number of state and federal policies which call for strict law enforcement in order to increase the risks faced by drug users and dealers. On the federal level, the 1986 and 1988 Anti-Drug Abuse Acts, which still form the basis of US sentencing policy for drug offenders, attempt to reduce drug use by increasing the risks of incarceration. These acts established numerous mandatory minimum sentences for drug offenses involving certain quantities of a given drug. Among these mandatory minimums are five year sentences for either the possession of five grams of crack cocaine, approximately 10 to 50 doses, or the trafficking of 500 grams of powder cocaine, approximately 2,500 to 5,000 doses (known as the 100-to-1 drug quantity ratio) (The Sentencing Project, 1). As a result of this act, the average federal sentence for any drug trafficking offense stands at 75.6 months (Common Sense for Drug Policy), while the average sentence for simply the possession of crack cocaine stands at 10 years, 1 month (Moore).

This emphasis on crack cocaine is likely indicative of the prevailing view when these acts were passed that crack was “the wave of the future”(Gross) and, therefore, minimizing its use could have a uniquely dramatic impact on attaining the overall goal of reducing drug prevalence. In fact, these acts originated largely in response to the “heightened political concern and national sense of urgency surrounding drugs generally and crack cocaine specifically”(US Sentencing Commission 2002, 7) that existed at the time. Thus, while

these acts established mandatory minimum sentences for numerous drug offenses, their focus was primarily with crack cocaine.

In addition to federal sentencing guidelines, many states have developed their own sentencing laws in order to increase the risks faced by drug users. Overall, “twenty-seven states use some form of sentencing guidelines” and “mandatory minimum penalties exist in 41 states for certain drug offenses (*e.g.*, trafficking, repeat trafficking, repeat possession, and sale of drugs within a certain distance of a protected area, such as a school or a playground)”(US Sentencing Commission 2007, 99).

Furthermore, while the penalties in some states are in fact lighter than federal penalties, decisions regarding whether to prosecute drug offenders at the state or federal level often work to ensure that drug offenders receive punitive sentences. In federal cases, “drug quantities tend to cluster around the mandatory minimum threshold quantities and Department of Justice testimony confirms the role that mandatory minimum threshold quantities might play in prosecutorial decision-making”(US Sentencing Commission 2007, 111). According to US Attorney Alex Acosta, “often it is the case that if you have enough to go after someone at a particular level, rather than push the envelope, rather than spend more time gathering more evidence, rather than make a case more complex, a prosecutor will say this is enough to go and obtain the result that we believe is warranted”(Acosta as quoted in US Sentencing Commission 2007, 111). Consequently, the decision-making process regarding whether drug offenses will be tried at the state or local level further increases the risks faced by drug offenders because it leads to drug offenders being tried at whichever level they can be most easily convicted.

The risks faced by drug offenders can be increased additionally by laws which are not specifically geared towards drug use. For example, the implementation of the “three strikes” law in certain states, which calls for a “third felony conviction resulting in life imprisonment as well as mandatory lengthy prison sentences for nonviolent crimes”(Gerber, 147), can dramatically increase the risks associated with drug use and trafficking. While this legislation targets all crimes, “drug use is the most common third strike”(Gerber, 148) and, in California, as of 1995, “more people had been sentenced under [the] three-strikes law for simple marijuana possession than for murder, rape and kidnapping combined”(Gerber, 147).

Law enforcement strategies aimed at reducing drug use also take the form of police initiatives. The logic behind such strategies is that “getting arrested is enough to scare many people straight”(Katel, 6), and a heightened police presence increases this risk of arrest, as illustrated by the fact that in 2006 there were 1,889,000 drug arrests, and 829,627 were for marijuana. In contrast, in 1980, there were only 580,900 drug arrests (Common Sense for Drug Policy).

Two examples of police initiatives are street sweeping, which involves a “massive police presence concentrating on a specific area, ideally operating 24 hours a day”(Bean, 129) and focused crackdowns, which “concentrate on specific drugs, on specific streets or on specific features of the market”(Bean, 130). Policing initiatives are often instituted at state and local levels, but they can also be instituted federally by the Drug Enforcement Administration (DEA) (ONDCP *FY 2008 National Drug Control Strategy Budget Summary*, 80).

While the domestic law enforcement strategies outlined above do not account for the entirety of US drug policy, as the subsequent analysis of the drug control budget will show, such strategies are the primary means with which the government attempts to achieve its goal of reducing drug prevalence.

The Drug Control Budget

The prominent role of domestic law enforcement in US drug policy is apparent when analyzing the drug control budget. However, contrary to this claim, the *FY 2009 National Drug Control Strategy Budget Summary* as published by the Office of National Drug Control Policy (ONDCP), which is the federal office responsible for “establish[ing] policies, priorities, and objectives for America’s drug war” (Robinson, Scherlen, 40), seems to indicate that federal spending is distributed fairly evenly between punitive, preventive and rehabilitative strategies. According to this budget, the federal government spent \$13.844 billion on drug control in 2007, with \$3.06 billion (22.1 percent) going to treatment, \$1.84 billion (13.3 percent) going to prevention, such as anti-drug television ads targeted at teenagers, \$3.18 billion (25.3 percent) going to interdiction, \$2.02 billion (11 percent) going to international measures such as crop eradication and, lastly, \$3.75 billion (27.1 percent) going to domestic law enforcement. The budget also indicates that approximately \$714 million was allocated for state and local assistance*, defined as “federal drug control assistance to help state and local law enforcement entities reduce drug-related violent crime and the availability of illegal drugs” (ONDCP *FY 2009 National Drug Control Strategy Budget Summary*, B3). In this *FY 2009 National Drug Control Strategy Budget Summary*,

while the highest proportion of money is allocated for domestic law enforcement, it does not seem as if this area dominates the budget.

The *FY 2009 Budget*, however, does not paint an accurate picture of drug war spending. Prior to the release of the *FY 2003 Budget Summary*, in a largely political move, the ONDCP changed the method which it used to calculate the drug control budget, removing “those dollars spent related to the war on drugs unless they related directly to judgments about drug policy”(Robinson, Scherlen, 2007). According to the ONDCP, this change occurred because the budget should “reflect only those expenditures aimed at reducing drug use rather than, as in the past, those associated with the consequences of drug use”(ONDCP 2002 *National Drug Control Strategy*, 33). As a result, criminal justice costs such as law enforcement, courts and corrections came to be viewed as merely “consequences” of drug use and were eliminated from the calculation of the drug control budget. When considering that since the enactment of mandatory minimum sentences in 1986 the budget for the federal Bureau of Prisons increased by 1,954 percent from \$220 million in 1986 to over \$4.3 billion in 2001 (Common Sense for Drug Policy), the potential impact of this change in budget calculation becomes evident. These costs are now “periodically”(ONCDP 2003 *National Drug Control Strategy*, 6) reported in the document entitled *The Economic Costs of Drug Abuse in the United States*, as published by the ONDCP, where they are treated as results of drug use and not of drug policy.

In 2002, the last year for which criminal justice costs were included in the calculation of the budget, the drug control budget was both costlier, at \$18.8 billion, and less balanced. Overall in 2002, \$9.46 billion, or 50.5 percent of the federal drug control budget was allocated for domestic enforcement. In contrast, only 19.1 percent of the budget was

spent on treatment, with 11 percent spent on prevention. The figure concerning state and local assistance was also much higher in 2002 than in 2007, standing at \$2.15 billion (ONDCP *FY 2003 National Drug Control Strategy Budget Summary*, 9).

In addition to federal spending, state and local spending on the drug war further highlight the drug war's focus on domestic law enforcement. In looking beyond federal spending, "virtually every law enforcement agency has a drug budget, including...three out of four state level agencies, and more than nine out of ten local agencies"(Robinson, Scherlen, 41). While the most recent data regarding state spending on the drug war is from 1991, state spending in that year, which stood at an estimated \$12.7 billion, dwarfed federal spending by \$1.7 billion (Boyum, Reuter, 44). In addition, "The Census estimates for 1991 showed the state and local expenditures to be even more enforcement-oriented than those of the federal government" and "it is very likely that this continues to be true"(Boyum, Reuter, 44). Consequently, when state spending is considered on top of federal spending, domestic law enforcement strategies receive an even more disproportionate share of drug control resources.

In sum, in looking at spending on the drug war, it becomes apparent that domestic law enforcement has consumed billions of state and federal dollars, and has received the lion's share of the overall funding allocated to the drug war. This fact further highlights the war on drug's overall dependence on domestic enforcement measures in combating illegal drugs.

Benefits and Risks

The primary benefit of America's use of domestic law enforcement to combat illegal drugs is that this strategy has the potential to keep overall drug use lower than it

otherwise would be. This fact does not imply that under US drug policy “drug use is eliminated or even that it is consistently reduced until it reaches some minimum or acceptable level”(Robinson, Scherlen, 179), but rather that it is quite possible that drug use would be higher under other strategies. For example, “most experts say [legalization] would almost certainly lead to increased drug use”(Cooper, 5).

At the same time, however, it is difficult to say whether US drug policy has been successful in attaining its goal of reducing the prevalence of use. This is partly because the varying methods in which the level of drug use is approximated make it very difficult to draw conclusions regarding increases or decreases in use. For example, in looking at lifetime drug use* statistics, which indicate the number of Americans who have ever tried an illegal drug, “there clearly were no declines in lifetime drug use among Americans”(Robinson, Scherlen, 156) over the period from 1990 to 1998, and in 2006, this figure stood at a strikingly high 111,774,000 Americans (Office of Applied Sciences 2006, 228). However, in looking at past month drug use* statistics, which measure the number of people who used an illegal drug in the past month, there appears to be “a slight decline in current drug use” (Robinson, Scherlen, 157) over the period 1990 to 1998. More specifically, according to the National Household Survey on Drug Abuse (NHSDA), “which samples residents, ages twelve and older, of known household addresses”(Boyum, Reuter, 15), past month drug use of any illicit drug stood at 6.6 percent in 1991 and decreased to 6.2 percent in 1998 (Office of Applied Studies 1998, 27). Yet, despite this decline in current (past month) drug use, in looking specifically at adolescents aged twelve to seventeen, past month drug use increased from 5.8 percent in 1991 to 9.9 percent in 1998 (Office of Applied

Studies 1998, 30). Clearly, different drug statistics can tell different stories about the level of drug use.

Furthermore, even when the statistics point to a decline, it is unclear whether this decline is a result of drug policy. For instance, despite the fact that “in much of the country the crack epidemic was in decline by 1996”(Golub, Johnson, 11), it is not necessarily the case that this decline resulted from the strict penalties established for crack offenses. It is also possible that the decline of the crack epidemic resulted from the fact that drug epidemics typically go through phases of “incubation, expansion, plateau, and decline”(Golub, Johnson, 11); a cycle which can be caused simply from the introduction of new drugs leading to declines in the use of older drugs. Overall, despite the possibility that “drug use is lower under prohibition than it would be in some other approach,” the truth is that “drug use fluctuates over the years, despite what the ONDCP does in the drug war”(Robinson, Scherlen, 179).

Outside of its effects on drug use levels, current policy provides political benefits to supporters. By stressing domestic law-enforcement and taking a hard-line approach to drugs, politicians are given the opportunity to “maintain a line between moral behavior and immoral behavior – moral people and immoral people” and the “the rhetoric of the war on drugs, like that of being tough on crime, brings out the vote”(Gerber, 117). Thus, regardless of the actual effects of law enforcement strategies on drug use and the associated social harms, the war on drugs nonetheless provides politicians with the opportunity to showcase their moral fiber.

The primary risks surrounding the US war on drugs concern imprisonment. When considering that in 2006 there were 20.4 million past month illicit drug users (Office of

Applied Sciences 2006, 232), it becomes evident that “there are so many drug offenders that it is fiscally and practically unrealistic to incarcerate more than a small number of them”(Gerber, 119). As a result, policies such as the 1986 and 1988 Anti-Drug Abuse Act, which attempt to use incarceration to reduce drug use, run the risk of leading to severe prison overcrowding. In fact, “if we wanted to double the number of traffickers now incarcerated, our prisons would not hold them”(Gerber, 119).

US drug policy also runs the risk of failing to adequately address the harms associated with drug use, such as drug addiction, overdose and HIV. As Robert MacCoun and Peter Reuter note, “by almost exclusively relying on use reduction...Americans are foregoing opportunities to reduce harm directly”(MacCoun, Reuter, 386). While proponents of current policy may argue that “reducing use is the best way to reduce harm”(MacCoun, Reuter, 387), when considering that “there are more deaths from drug abuse than ever”(Sterling), the failure of use reduction policies to adequately address the harms associated with drug use seems realistic. In fact, the number of deaths from drug induced causes more than doubled, from 7,101 to 16,926, between 1979 and 1998 (Sterling).

Unintended Consequences and Social Costs

Overall, the US war on drugs has led to the incarceration of over 400,000 drug offenders at an annual cost of over \$8 billion (Sterling). Currently, there are 250,900 drug offenders in state prison, and 86, 972 in federal prison. In contrast, these figures stood at 19,000 and 4,900, respectively, in 1980. Furthermore, since the implementation of the 1986 Anti-Drug Abuse Act, the incarceration rate in the US has increased from between 90 and 120 people in prison per 100,000 residents to its present rate of 738 prisoners per 100,000 residents, which is the highest rate in the world (Common Sense for Drug Policy).

However, while these numbers clearly indicate that the war on drugs has worked to incarcerate an extremely high quantity of drug offenders, a major unintended consequence of drug policy is that it has failed to catch the most serious and violent offenders. Currently, “only one-quarter of state drug inmates have a prior conviction for a violent crime, while nearly half have no prior nondrug conviction and were involved only in a minor[non-violent] role in their current offense”(Boyum, Reuter, 95). Furthermore, on the federal level, despite a pronounced hard line approach to dealing with crack cocaine, 55.4 percent of those sentenced in 2005 were classified only as street-level dealers*, while importers/high level suppliers* and organizers/leaders*, comprised only 7.6 percent and 5.2 percent, respectively, of those sentenced. Overall, the non-violent prisoner population in the US is larger than the combined populations of Wyoming and Alaska.

These imprisonment trends present numerous costs to society. In order to accommodate this mass influx of drug offenders, “nationwide spending on corrections has increased faster than any other government category in the past decade”(Gerber, 143), and such spending has diverted money away from other programs, such as education. In California, for example, in 1985 three percent of the state budget was designated for prisons and 18 percent for education. By 1994, these figures stood at eight percent for each and, in 1999, California spent more to incarcerate people than to educate its college age population (Gerber, 143). While it is improbable that every dollar spent on imprisonment would otherwise have been spent on education, the fact “that many states now spend more on corrections than any single budget item” certainly indicates that spending on imprisonment has “taken money from...other social programs which address crime causes more economically and permanently than imprisonment”(Gerber, 141). Furthermore, the

imprisonment of nonviolent drug offenders signifies a further cost to society because in order to accommodate nonviolent offenders sentenced on mandatory minimums, it is often the case that more serious, violent offenders are given early release. Indicative of this trend is the fact that, “in 1992, violent offenders, on average, were released after serving less than half their sentences”(Gerber, 103).

The US war on drugs has also had disparate racial effects on blacks and whites. This has resulted largely because of the different federal penalties for crack and powder cocaine, “the former used mainly by blacks and the latter mainly by whites”(Austin et al.). When considering that 67 percent of all cocaine offenses involve black offenders being sentenced under the more stringent crack cocaine guidelines (US Sentencing Commission 2007, 16), the ways in which the sentencing distinction between crack and powder cocaine can disproportionately target African Americans become apparent. In 1986, before the enactment of federal mandatory minimums, the average federal drug offense sentence for blacks was only 11 percent longer than for whites but, in the four years following the implementation of mandatory minimums, the average sentence for blacks increased to 49 percent longer than for whites(Common Sense for Drug Policy). Furthermore, regarding strictly the chances of being incarcerated, “African American drug defendants have a 20 percent greater chance of being sentenced to prison than white drug defendants”(The Sentencing Project, 4).

This racial disparity exists on the state level as well, as indicated by the fact that the number of blacks in state prisons for drug offenses, 133,100, accounts for 53.05 percent of the total number of state prison inmates serving time for drug offenses (Common Sense for Drug Policy). This statistic is even more striking when considering that African

Americans comprise only 13 percent of the American population. Overall, evidence on the federal and state levels indicates that the use of domestic law enforcement to curb illegal drug use has worked to disproportionately target the black population.

Conclusion

In analyzing the goals, costs, benefits and unintended consequences of using domestic enforcement to combat illegal drugs, it is apparent that the modest benefits of current policy do not justify the costs. While prior to the start of the contemporary war on drugs, President Jimmy Carter stated; “Penalties against drug use should not be more damaging to an individual than use of the drug itself”(Carter as quoted in Marshall, 18), policymakers have not heeded his advice, as current penalties against drug use have come at exorbitant costs not just to individual drug users, but also to society and the government. Unfortunately, though, when considering that “the United States has waged periodic wars on drugs for most of its existence”(Gerber, Jensen, 1), the prospects for ending the current drug war seem bleak. What remains to be seen, however, is whether realistic prospects for change exist even as the drug war persists. The following analysis of the Dutch approach to drug policy will be useful in answering this question.

III. The Netherlands' Unique Approach to Drug Policy

Introduction

In the Netherlands, illicit drug use emerged as a prominent social issue in the 1960s. During this decade, “the phenomenon of illegal drug use had spread sufficiently to generate widespread confusion, anxiety and some moral outrage in general Dutch society”(Leuw, 26) because “marijuana, and to a lesser degree, amphetamines were more visible and its use was no longer restricted to artists, students, and so on”(de Kort, 16). At the same time, however, “serious drug problems were still quite rare”(Leuw, 27), and though there were reports of health troubles and drug-related criminality, they “were too small in numbers (no more than several hundreds) to be a genuine cause for concern”(Leuw, 27). Thus, “drug use had come to the public consciousness against the backdrop of a relatively mild dispute of lifestyles and value systems, and not against a background of criminality, pathology and deeply rooted social conflict”(Leuw, 27).

Within this social context, the Dutch government passed the Revised Opium Act of 1976, which still forms the basis of modern Dutch drug policy. Rather than adopt the American war on drugs model, this act “rejected law enforcement as the main answer to the illegal drug problem”(Leuw, 33), and instead created a policy aimed not at reducing drug prevalence, but at “prevent[ing] or limit[ing] the risks of drug use to individuals, their immediate environment and society”(Ministry of Health, Welfare and Sport *Progress Report on the Drug Policy of the Netherlands*, 5). While this policy has been both praised as a “rational, pragmatic [approach] calculated to reduce risk taking behavior”(Duncan, Nicholson, 12) and lambasted as an “ ‘unmitigated

disaster' ”(McCaffrey as quoted in Bullington 1999, 1), in actuality, the Dutch approach falls in between these two appraisals. Overall, the following analysis will show that drug policy in the Netherlands has been largely successful at reducing the harms associated with drug use, but is nonetheless far from a panacea.

Historical and Cultural Precedents

Interestingly, the emergence of the Dutch approach to drug policy in the 1960s and 1970s can be largely attributed to the lack of a preexisting drug policy tradition in the Netherlands. Quite different from the situation in the US, where concern over drug use dates back to the early part of the twentieth century and the passage of the Harrison Act, in the Netherlands, “the issue of drug taking as a focal and public social concern hardly existed before 1965”(Leuw, 24). In fact, much of Dutch drug policy prior to this date was “incurred under international agreements”(Buning, Korf, 117), such as the Hague Opium Convention of 1912, which mandated that all participating countries “enact legislation to limit the production and sale of drugs to medicinal purposes only”(de Kort, 10). Thus, “while the first Dutch drug law dates from the early twentieth century (the Opium Act of 1919)”(Buning, Korf, 116), its passage “was not really prompted by any drug problem existing in the Netherlands at the time,” but rather by diplomatic pressure from the US, “who began to express concern that a conspiracy existed against the American ‘crusade’ against drug use”(de Kort, 10).

Consequently, the Opium Act of 1919, which made illegal both drug trading and transportation (de Kort, 19), came into being with “little enthusiasm”(Buning, Korf, 117), and the “notion that it was possible to eliminate international illegal drug smuggling was

referred to as the ‘American position’ ”(de Kort, 11). In fact, the Netherlands had even “hoped to reserve the right to withdraw from the Opium Convention in case of conflicting interests”(de Kort, 11). As a result of these attitudes, “in the first decades after the Act took effect, instances of enforcement were few”(Buning, Korf, 117). Overall, “active enforcement of the Opium Act mainly affected a handful of Chinese immigrants in Rotterdam and Amsterdam,” but even then, “the emphasis was on smugglers and dealers, whereas the users themselves were largely left in peace”(Buning, Korf, 117). Therefore, the passage of the Opium Act in 1919 did not initiate an era of drug prohibition in the Netherlands.

Because of the general “lack of concern about domestic drug use”(de Kort, 9) throughout much of the early twentieth century, a Dutch drug “ideology never developed”(de Kort, 17). There was no “moral entrepreneur, like the Federal Bureau of Narcotics in the US”(de Kort, 17) to propagate certain beliefs about drugs, such as that of marijuana as a “ ‘killer weed’ ” or a “ ‘youth drop-out drug’ ”(de Kort, 17). Additionally, while the use of drugs, especially marijuana, was seen as countercultural, the Dutch counterculture was “not relegated to a marginal social position”(de Kort, 18). Instead, this group “was partly absorbed into the conventional political culture”(Leuw, 25) in the form of a political party known as the Provos. In Amsterdam, the Provos even “won some seats in the city council” and “occasionally blowing pot during its meetings was one way make it clear that simple prohibition would no longer do as the mainstay of drug policy”(Leuw, 25). Therefore, even when drug use expanded in the 1960s, there was no “strongly held belief system about the evils associated”(de Kort, 17) with illicit drugs.

Thus, in stark contrast with the US where the policy response to drug problems in the 1980s was simply an extension of a preexisting prohibition approach, when the issue of illicit drugs rose to prominence in the Netherlands in the 1960s, the Dutch government was able to respond unencumbered by preconceived notions. As a result, the Dutch government passed the Revised Opium Act of 1976, and the modern Dutch approach to drug policy was born.

Goals and Objectives

According to the Ministry of Health, Welfare and Sport, which coordinates drug policy in the Netherlands, “Dutch policy assumes that it is not possible to totally ban drug use by means of firm government policy”(Ministry of Health, Welfare and Sport, *Drug Policy in the Netherlands*, 7). Therefore, instead of targeting drug prevalence, Dutch policy is concerned with “the prevention of drug abuse and the limitation of the risks and harm that drugs can cause – either for the user, his environment, or society as a whole”(Ministry of Health, Welfare and Sport *Drug Policy*, 1). More specifically, as stated by the Ministry of Health Welfare and Sport, there are three aims of current policy: to “reduce demand for drugs, reduce supply of drugs and the risks to drug users, their immediate surroundings and society”(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 10).

In order to achieve these goals, the Dutch government believes that a “ ‘penal law approach of drug users is inadequate’ ”(Baan Commission as quoted in Leuw, 32). Thus, instead of relying on law enforcement, Dutch policy distinguishes between both marijuana and hard drugs (heroin, cocaine etc.) with “unacceptable health

risks*”(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 8), and between drug addicts and drug traffickers.

In the case of marijuana policy, the Dutch government attempts to limit the risks faced by cannabis users by “keep[ing] the social environment of young people who use cannabis separate from those where the use or trade in hard drugs occurs”(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 9). Even though Dutch law states that “the sale of both hard drugs and cannabis is a punishable offense”(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 17), because “cannabis is not very physically toxic” and “neither fatal overdoses nor physical dependency can occur”(Borst-Ellers, Sorgdrader, Kohnstamm), the Dutch allow for its sale in licensed coffee shops which are prohibited from selling hard drugs and from selling to minors. In adopting this strategy, the Dutch government believes that “separating the soft- and hard-drug markets might actually weaken any gateway effect”(MacCoun, Reuter, 261) between marijuana and other drugs. Thus, Dutch cannabis policy attempts to reduce the risks faced by drug users by working to prevent marijuana users from experimenting with hard drugs.

In addition to this distinction between marijuana and hard drugs, Dutch drug policy also hinges on a distinction between drug users and drug traffickers. In the case of the former group, drug use is not even illegal in the Netherlands, and the “authorities view hard drug users through the healthcare lens”(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 8). Consequently, “there is a wide range of provisions designed to manage potential social and health problems related to drug use”(Ministry of Health, Welfare and Sport, 7), such as needle-exchange and low-threshold treatment.

Programs such as these are pivotal in the Dutch government's attempt to reduce the risks to drug users and society because they strive to "prevent addiction from resulting in increased health problems, degeneration [and] the spread of diseases, including via used needles"(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 27). Needle-exchange programs, for example, are aimed directly at "curb[ing] the spread of AIDS by providing clean needles...for injection drug users"(Loyce, Jr. et al.), while low-threshold treatment programs, or programs with "very few barriers to the person wishing to enter treatment"(Duncan, Nicholson, 8), work to "prevent deterioration in the health of those involved and to promote stabilization of their addiction"(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 30), regardless of whether a patient is ultimately able to give up his drug habit. For instance, the free distribution of methadone* to heroin addicts seeks to both limit the risk of overdose and to provide for "improve[d] social functioning"(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 30). The importance of these programs to Dutch policy is clearly evidenced by the fact that "approximately 75 percent of drug addicts receive care of some kind"(Ministry of Health, Welfare and Sport *Drugs*, 1). In contrast, in the US it was estimated in 2001 that only 17 percent of those in need of treatment were able to receive it (Boyum, Reuter, 63).

While drug addiction is seen primarily as a health problem, the Dutch government utilizes the criminal justice system in dealing with drug traffickers in order to reduce the supply of drugs. Even though the use of drugs is not illegal in the Netherlands, the "trade, sale, production and possession [of more than .5 grams] of drugs is a punishable offense"(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 9), and

the “Dutch criminal investigation department has placed a high priority on dismantling criminal organizations that trade in cannabis or hard drugs”(Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 9). In fact, in 2005, 72 percent of all Dutch criminal investigations into organized crime targeted drugs (National Drug Monitor, 148), and the Dutch seized 1,900,000 ecstasy tablets that year; more than any European Union (EU) member state other than Belgium (EMCDDA Statistical Bulletin). Furthermore, “the combined length of the custodial sentences imposed for Narcotics Act [Opium Act] cases amounts to over a quarter of the total number of years in custody imposed for all offenses”(Ministry of Health, Welfare and Sport *Progress Report on the Drug Policy of the Netherlands*, 34).

Despite these statistics, however, “the starting point of the government is that criminal-law interventions should not result in additional harm to drug users”(Ministry of Health, Welfare and Sport, 17). Towards this end, the enforcement of drug laws is based upon the expediency principle*, meaning that “criminal prosecution can be refrained from for reasons of public interest”(Taekema, 183), and that “it is up to the prosecutor to decide whether or not the prosecution of a specific case is in the interest of society and whether or not prosecution is opportune”(Taekema, 184). As a result, despite the aggressive pursuit of drug traffickers, the Dutch government has managed to implement “penal law policy in the context of general social drug policy”(Leuw, 33).

In sum, rather than rely on law enforcement as the primary tool with which to combat illegal drugs, the Dutch government has reserved the use of this strategy for dealing with drug traffickers, and has implemented a wide range of alternative policies to tackle the other aspects of the drug problem. This approach to drug policy can be

characterized as harm reduction because of its clear focus on “protect[ing] the health of individual users and their environments by reducing the harms associated with drug use”(Solinge, 1).

Public Expenditure on Drug Policy

Despite the clear strategic differences between Dutch and US drug policies, several similarities appear when analyzing public expenditure on drug policy*, or “how much the government spends to counter the drugs problem”(Postma, 3). Numerous academic studies conducted over different periods of time and using different methodologies all agree that the Dutch approach is quite costly, and that, surprisingly, enforcement expenditures dominate the drug control budget.

In terms of overall cost, studies conducted by Kopp et al. and Postma both concluded that the Netherlands spends more on drug policy than most other EU member states. Although the figures presented in both studies vary dramatically due to the different methodologies used and the fact that, in the Netherlands, expenditures on different drug programs “are rarely identified as such in government budgets but are imbedded in broader budget categories”(Reuter, Ramstedt, Rigter, 3), even using the lower estimate reported in the Kopp et al. study, Dutch policy remains among the most expensive in Europe. According to this study, the Dutch public expenditure on drug policy was approximately €62.9 million per year in the 1990s, which amounts to approximately €9,737 annually per problematical drug user*. This latter figure was the third highest among EU member states and was more than double the equivalent figure in the US (Kopp, Fenoglio, 50). Additionally, in looking at drug policy spending as a

percentage of GDP, Dutch policy, at .13 percent, remains the third costliest in the EU, though this figure is lower than in the United States (.22 percent) (Kopp, Fenoglio, 46). The costliness of Dutch drug policy is only reinforced if we use the figures from the Postma study, which were based on a study by Reuter et al., in which the overall cost of Dutch policy was estimated at €2,186 million. In this case, the cost of Dutch drug policy as a percentage of GDP, at .66 percent, is the most expensive in the EU.

In addition to the high cost of Dutch drug policy, studies also reach the surprising conclusion that “enforcement dominates the budget”(Reuter, Ramstedt, Rigter, 33). Each of the studies mentioned estimates that law enforcement accounts for approximately 70 to 75 percent of the drug budget. For example, the Reuter et al. study, which provided the data for the Postma study mentioned earlier, divided government spending into four categories, and estimated that the Netherlands spent €42 million (2 percent) on prevention, €278 million (13 percent) on treatment, €220 million (9 percent) on harm reduction, and €1,646 million (76 percent) on enforcement (Reuter, Ramstedt, Rigter, 28). In contrast, the Kopp et al. study divided drug policy expenditure into two categories, namely health care and enforcement, and estimated that the Netherlands spent approximately €80.9 million (31 percent) on the former and €182 million (69 percent) on the latter (Kopp, Fenoglio, 30, 35). Thus, despite the reported differences in the Euro amounts spent by the Dutch government in the different areas of drug policy, when considering percentages, both studies reached the conclusion that law enforcement was the dominant expenditure. Even an older study by D.J. Kraan from the early 1990s determined that nearly 72 percent of Dutch drug policy expenditure went to law enforcement (Kraan, 297).

These spending patterns, however, are not indicative of a Dutch reliance on law enforcement in combating illicit drugs, but rather of the relatively high cost of imprisonment in comparison to alternative policy strategies. Quite simply, “imprisonment is expensive, and all the more expensive if imprisonment conditions are good”(Kopp, Fenoglio, 26), and in the Netherlands, these conditions are quite good. In fact, for “several categories of problematic inmates, such as drug addicts, drunken drivers, mentally ill inmates, and inmates representing high security risks, special wings have been established,” and the “principle of one inmate per cell has been maintained”(Erkelens, van Alem, 79). Because of these “favorable living conditions...the costs of imprisonment per inmate in the Netherlands is roughly twice as high as in the USA”(Kraan, 306), where it costs on average \$67.55 per day to incarcerate a single drug offender (Common Sense for Drug Policy).

Despite these high costs of imprisonment, the fact remains that “as befits a nation that has been very articulate about the many dimensions of drug problems, there exists a large number and variety of programs aimed at reducing drug problems”(Reuter, Ramstedt, Rigter, 27) in the Netherlands. However, enforcement nonetheless dominates the budget simply because these alternative programs are comparatively quite inexpensive; for instance “the roughly 45 involving less than 10 million Euros in total accounted for less than 15 percent of the estimated baseline aggregate”(Reuter, Ramstedt, Rigter, 27). In contrast, in the realm of enforcement, three items (policing, courts and detention) accounted for 58 percent of the total budget (Reuter, Ramstedt, Rigter, 29).

Overall, while the figures regarding public expenditure in the Netherlands indicate that the Dutch approach is quite expensive, they do not paint an accurate picture

of the choices made by the Dutch government in combating illicit drugs. Instead, these figures are more telling of the fact that even the Dutch approach to drug policy is unable to mitigate the high costs of law enforcement.

Benefits and Risks

The primary benefit of Dutch drug policy is its ability to reduce the negative consequences of drug use. Clearly indicative of this fact is the number of acute (overdose) deaths from drug use in the Netherlands. Throughout the 1990s, the Dutch acute death rate was “comparatively low, and it was declining or flat when many other nations’ rates were escalating dramatically”(MacCoun, Reuter, 275). More recently, in 2003, the Dutch acute death rate stood at .6 per hundred thousand citizens, which compares quite favorably to the figures in the United Kingdom (2.4), Finland (1.9), Germany (1.4), and most other EU member states (National Drugs Monitor, 84). The Dutch figure is even more striking in comparison with the US, where the acute death rate stands at 7.3 per hundred thousand (Eckholm).

HIV prevalence rates in the Netherlands also indicate the success of Dutch policy at reducing the harms associated with drug use. For example, one longitudinal study conducted in Amsterdam from 1985 through 2004 observed a “sharp drop”(National Drug Monitor, 75) in the percentage of drug users under thirty with HIV. More specifically, over the years 1985-1989, 33.3 percent of this group was HIV positive, whereas in 2004, this number was down to 6.6 percent (National Drug Monitor, 75). The results of this study are even more impressive when considering that Amsterdam has by far the highest rate of HIV infection among injection drug users of all the cities in the

Netherlands. Additionally, even Amsterdam's percentage of HIV infection among injection drug users, at 26 percent, is lower than the percentage in US cities such as New York and Miami, and European cities such as Paris (MacCoun, Reuter, 266).

Another benefit of Dutch drug policy is its ability to prevent hard drug use among marijuana users. While "American hawks argue that more lenient cannabis policies might lead to greater levels of hard-drug use"(MacCoun, Reuter, 261), in the Netherlands it seems "plausible that the coffee shop system has instead been an *impediment* to beginning heroin use"(Buning, Korf, 123). In the city of Amsterdam for example, "cannabis street trade has practically vanished"(Buning, Korf, 123) since the expansion of coffee shops, and "over 95% of the sale of soft drugs in downtown Amsterdam now takes place in coffee shops" where it is "as absurd to ask for hard drugs as it is to ask for a zebra steak at the average butcher"(Jansen, 172). In fact, in one study in which 216 "experienced Amsterdam cannabis users" were interviewed, "only four reported that cocaine could be purchased, and only one knew of heroin sales at a shop"(MacCoun, Reuter, 261).

Overall, the Dutch "heroin-using population is rapidly aging, suggesting that there are few new users"(Buning, Korf, 123). More specifically, in Amsterdam "the average age of methadone clients rose from 32 in 1989 to 45 in 2004"(National Drug Monitor, 67), and "in Rotterdam and Parkstad Limburg the average age of problem users between 1998 and 2002/2003 rose from 37 to 39"(National Drug Monitor, 67). Additionally, when looking at cocaine use instead of heroin use, "only 22 percent of those aged 12 and over who have ever used cannabis have also used cocaine," as compared with 33 percent in the US (MacCoun, Reuter, 261). Though it must be noted that "the probability of

hard-drug use among cannabis users might vary across nations for a variety of reasons unrelated to policy”(MacCoun, Reuter, 262), based on the statistics, “it seems reasonable to assume that [coffee shops] have helped to stabilize drug use in the Netherlands”(Buning, Korf, 123).

The primary risk of the Dutch harm reduction approach is that, by reducing the risks faced by users, or the “riskiness of drug use”(MacCoun, Reuter, 392), Dutch policy might lead to higher levels of drug use. In general, “when technological innovations successfully reduce the probability of harm given unsafe conduct, they make that conduct less risky”(MacCoun, Reuter, 392). Therefore, “if the perceived risks were motivating actors to behave somewhat self-protectively, a reduction in risk should lead them to take fewer precautions than before, raising the probability of their unsafe conduct to a higher level”(MacCoun, Reuter, 392).

On the surface, this form of compensatory behavior seems widespread among the Dutch population with regards to drug use. Because “problematic drug use is considered a social and medical issue, rather than a criminal one”(Solinge, 3), the “police leave drug addicts in relative peace”(Solinge, 2). Consequently, “rather than retreating to less visible parts of town” to minimize the risk of being caught, “Dutch drug addicts are often seen in the main shopping and entertainment areas of the cities”(Solinge, 2), and “many members of the public are moreover intimidated by the open drug scene at train stations, underground stations and other public places”(van Dijk, 380). One even witnesses “large clusters of unkempt, scrawny junkies of indeterminate age [who] sport dreadlocks and red-eyed, vacant stares”(MacCoun, Reuter, 238) on the walk down the main street into the city of Amsterdam from the central train station. These “vivid”(MacCoun, Reuter,

239) images have led foreign observers to boldly declare that the “ ‘Dutch policy on drugs is a disastrous mistake,’ ” that “ ‘drug use has increased by 250 percent in two years,’ ” and that “ ‘there’s plenty of heroin for sale in every Dutch coffee shop’ ”(Barnard, 1).

Despite the high visibility of drug use in the Netherlands, however, in actuality Dutch drug policy has not led to dramatic or unusual increases in drug use. In the case of cocaine for example, while in most EU member states “no more than about one percent of the population reports past year use of cocaine,” in the Netherlands this percentage stood at .6 percent, with only 3.4 percent of the population aged 15 to 64 ever using the drug (National Drug Monitor, 53). In contrast, in the United States, despite a law enforcement strategy centered on increasing the risks to drug users, these figures stood at 2.3 percent and 13.8 percent, respectively (National Drug Monitor, 53). Even in the case of marijuana, which can be bought in a coffee shop by anyone over the age of eighteen in the Netherlands, use is not uncharacteristically high: within the EU, Holland “occup[ies] a position halfway up the scale for cannabis use”(Ministry of Health, Welfare and Sport *Progress Report on the Drug Policy of the Netherlands*, 15). Additionally, the percentages of both lifetime use, at 22.6 percent, and past month use, at 3 percent, are significantly lower than in the United States, where 40 percent of those aged twelve and over reported ever using cannabis, with 6 percent reporting past month usage (National Drug Monitor, 53). Interestingly, in the Netherlands, “a remarkably subtle and nuanced set of vice policies has produced visible manifestations that are remarkably unsubtle” and give “an exaggerated impression of the true magnitude of Dutch drug problems”(MacCoun, Reuter, 239).

Overall, by targeting the consequences of drug use instead of drug use itself, Dutch policy has been able to minimize the number of drug overdoses, the rate of HIV infection, and the number of hard drug addicts. At the same time, although the increased visibility of drug use may lead observers to believe otherwise, the risk of increasing drug use as a result of minimizing the dangers associated with use has gone largely unfulfilled in the Netherlands. Thus, “the Dutch can make a good case that they have probably reduced serious drug problems while maintaining a humane relationship with their drug addicts”(MacCoun, Reuter, 278).

Unintended Consequences

Internationally, “Dutch drug policy is more explicitly tolerant than that of any other Western industrial nation”(MacCoun, Reuter, 238). As a result of international obligations such as the 1961 UN Single Convention, which mandated that signatories “limit ‘...the production, manufacture, export, import, distribution of, trade in, use and possession of drugs...’ ”(Blom, van Mastrigt, 256), the emergence of the Dutch approach occurred during a period when the drug policies throughout the world were being “molded in conformance with the U.S. concept favoring prohibition and repression”(Komer, 1). This uniqueness of the Dutch approach to drug policy in the context of a global war on drugs has led to the emergence of several unintended consequences.

One of these unintended consequences has been an increase in political pressure from foreign nations who blame Dutch policy for their own domestic drug problems. For example, in 1995, the French government termed the Netherlands a

“ ‘narcostate’ ”(MacCoun, Reuter, 249) and leveled critique at Dutch coffee shops by complaining that “in just a few hours drive, French people could openly buy cannabis in Holland and then bring it home with them”(Solinge, 5). Furthermore, France “accused the Netherlands of being the chief supplier of drugs to the French market,” even though, in actuality, “only a tiny proportion (less than 2 percent) of the cannabis in France had come from Holland”(Solinge, 5). By the end of 1996, this “drug policy dispute had brought all Dutch-French relations to a standoff”(MacCoun, Reuter, 249). Although a “face-saving agreement was finally reached”(MacCoun, Reuter, 249) in early 1997, this conflict is telling of the ways that Dutch drug policy can come under fire as a result of its unique approach.

The manner in which Dutch drug policy deviates from international norms has also had domestic consequences, such as drug tourism. Because “the Dutch authorities – in contradiction to the international standard – tolerate the controlled vending of soft drugs, customers and dealers from abroad are attracted to the Netherlands” and, consequently, “major Dutch cities like Amsterdam and Rotterdam and border municipalities liker Arnhem, Heerlen, and Venlo are popular destinations for users from abroad” (Taekema, 174). This phenomenon has had the most dramatic impact on Dutch municipalities close to the German border, such as Heerlen, “a relatively small town near to the border with Germany”(Taekema, 175). In this town, “expensive foreign cars with blinded windows drive in and out of the city area, creating an unpleasant atmosphere of criminality” and “addicts gather at public meeting points and needles used by heroin addicts and possibly infected with HIV linger in the open, sometimes in or near children’s playgrounds”(Taekema, 175). Additionally, in the town of Arnhem, drug

tourism reached such an unacceptable level that “citizens blocked the streets of their neighborhood to foreign ‘tourists’ and removed of their own accord drug addicts from the area”(Taekema, 175).

The emergence of drug tourism has also had the compound effect of further increasing political pressure from abroad, as illustrated by the conflict between Germany and the Netherlands in the 1980s. In this instance, “some 2,000 foreign heroin users per month – almost half of them from Germany – were discovered ‘hanging out’ in Amsterdam,” leading to a “diplomatic stir”(Solinge, 5) between Germany and Holland. According to the German government, the Dutch “liberal policies had caused a steady stream of Germans to travel to Amsterdam to buy cheap heroin”(Solinge, 5). In reality, however, the number of German drug addicts entering the Netherlands had more to do with “the repressive climate of Germany, combined with its dearth of care and treatment facilities,” and when the German government responded with “the implementation of more treatment facilities and less emphasis on law enforcement...the outflow of German addicts abated”(Solinge, 5) later in the decade.

Unfortunately, the efficacy of the Dutch approach to drug policy has been limited by the international proclivity towards prohibition policies. Thus, even though many of the unintended consequences described are not the result of flaws inherent in the Dutch approach, any evaluation of drug policy in the Netherlands must consider the international context within which it is implemented.

Conclusion

When considering the punitive nature of America’s war on drugs, “one of the most striking aspects of the Dutch strategy is its compassion”(Duncan, Nicholson, 11).

Rather than striving to eliminate the practice of illicit drug use, Dutch drug policy seems “to be driven by a genuine concern to prevent further human suffering and disease”(Duncan, Nicholson, 12). Towards this end, the Dutch approach has proven successful at mitigating many of the most serious consequences of drug use, such as addiction, overdose and HIV. At the same time, however, the Dutch approach remains expensive and has failed to eliminate the need for large expenditures on law enforcement. Furthermore, its effectiveness has been limited by the generally punitive nature of drug policies in other countries. In light of both these benefits and shortcomings, the following chapter will analyze whether any elements of Dutch policy can help the US further its own war on drugs, or whether the compassionate Dutch approach deviates too sharply from US policy for its lessons to be relevant.

IV. Towards a More Compassionate War on Drugs

Introduction

After analyzing the drug policies in the US and the Netherlands, what remains to be seen is whether there are any lessons to be learned by American policymakers from the Dutch approach. Clearly, the histories of illicit drug use and policy in both countries vary dramatically, as do the contexts in which the contemporary policy responses were formed and implemented, making it difficult to project the outcomes of the Dutch approach in the American setting. Furthermore, being firmly rooted in a nearly century old tradition of drug prohibition, the American war on drugs is unlikely to be abandoned in favor of alternative strategies any time soon. Despite these facts, however, the compassionate Dutch approach nonetheless appears to provide a “useful corrective” (Boyum, Reuter, 102) to the war on drugs because of its ability to minimize the negative consequences of drug use while emphasizing strategies outside the realm of law enforcement. In this sense, Dutch drug policy offers valuable lessons to US policymakers even within the context of the war on drugs. More specifically, by looking to certain elements of the compassionate Dutch approach, such as a tolerant marijuana policy and the widespread implementation of needle exchange, the US can reduce the social costs of current policy without losing sight of policy goals; additionally, policy changes of this magnitude appear far more likely than an end to the drug war.

Tolerating Marijuana Use

While tolerating certain levels of marijuana use seems contradictory to the US policy goal of reducing drug prevalence, as evidenced by the Dutch experience, this

approach can actually enhance America's war on drugs. When considering that the prevalence rate for marijuana in the Netherlands remains in line with EU averages and far lower than in the United States (National Drug Monitor, 53) while the percentage of marijuana users who have moved on to use cocaine (22 percent) is lower than in the United States (33 percent) (MacCoun, Reuter, 261), the potential contribution of Dutch marijuana policy to America's war on drugs becomes apparent. Based on these findings, it seems quite possible that US drug policy would be better equipped to reduce the use of hard drugs, without causing any offsetting increase in marijuana use, by incorporating a more tolerant marijuana policy. This outcome would constitute a net decrease in drug use, which is consistent with the goals of America's drug war.

Furthermore, even though the entire Dutch approach to drug policy is quite expensive, its strategy with marijuana could actually present the US government with an opportunity to lower both the financial and social costs of the drug war. According to one study conducted in 2000, the US government spent an estimated \$7.7 billion between the federal and state levels on marijuana prohibition (Egan, Miron, 27). Surely, tolerating certain levels of marijuana use could work to minimize this cost by reducing the resources expended by police forces, the judicial system and corrections agencies on criminalizing marijuana (Egan, Miron, 27).

Separate from these financial costs, marijuana prohibition also has dramatic social costs, many of which result from arrests. For instance, marijuana arrests, "even without serious penal sanctions, can cause great harm, as when an immigrant is deported solely on that basis" (Boyum, Reuter, 98). Additionally, marijuana arrests have reinforced the disparate racial outcomes of the war on drugs. In fact, even though as recently as 1992

“black arrest rates for marijuana possession were equal to those for whites,” by the year 2000, “black rates were twice as high”(Boyum, Reuter, 55). When considering that there were 829,627 marijuana arrests in the year 2006, representing 43.9 percent of the drug arrests that year (Common Sense for Drug Policy), the magnitude of these social costs becomes clear. Thus, by tolerating certain levels of marijuana use, as in the Netherlands, the US would not only have an opportunity to reduce the high price tag of marijuana prohibition, but also to reduce the social costs of the drug war.

Needle Exchange Programs

The Dutch experience also indicates that the widespread implementation of needle exchange programs could be a valuable addition to the US war on drugs. Throughout the Netherlands, there are currently over 130 needle exchange programs which work to reduce the spread of HIV by providing injecting drug users with clean syringes (Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 31). In fact, in Dutch cities “even some police stations will provide clean syringes on an exchange basis to people detained or arrested”(Riley, O’Hare, 10), and “outreach workers provide syringes for street users and even deliver to private homes of isolated addicts”(MacCoun, Reuter, 268). In contrast, in the US, which has a population over 18 times larger than the Netherlands, there are just over 200 needle exchange programs, and “due to the federal ban on syringe exchange enacted in 1988, states and cities have been limited to using scarce local funds to combat the damage that results from intravenous drug users sharing HIV-infected needles”(Loyce, Jr. et al.). Furthermore, “because prescription laws, paraphernalia laws, and local ‘drug free zone’ ordinances ban needle exchange in most of

the country...nearly half of the existing programs are operating illicitly or quasi-legally”(MacCoun, Reuter, 381).

However, despite the relative availability of clean needles in the Netherlands, the rate of injection drug use in Holland, at .3 per thousand population (EMCDDA *Country Data Sheets*), is the lowest in the EU, and the group of heroin addicts, as already shown, is rapidly aging (Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 29). In other words, the Dutch experience provides no evidence that the availability of clean needles leads to increases in heroin use. Furthermore, while US prohibitionists claim that needle exchange programs “send the wrong signal on drug use”(Cooper, 6), in reality, by leading to “important personal contact between drug users and health care workers”(Riley, O’Hare, 10) who distribute clean needles, these programs can actually work to deter drug use.

While this evidence indicates that needle exchange programs do not counteract the drug war’s stated goal of reducing drug prevalence, the primary benefit of these programs is their ability to reduce the social costs of drug use by curbing the spread of HIV. In addition to the Netherlands, needle exchange programs have been approved in “more than 20 nations from Europe to Canada”(Loyce, Jr. et al.), and there is now “clear direct and indirect evidence that attendance at syringe exchanges and increased syringe availability are associated with a decrease in risk (e.g., decreased sharing) as well as a decrease in harm (e.g., lower levels of HIV infection)”(Riley, O’Hare, 11). For example, a 1997 study in the *Lancet* medical journal, which “compared HIV infection rates among injection drug users in 81 cities around the world,” found that “in the 52 cities without needle exchange programs, the [HIV] rates increased on average 5.9 percent annually; yet

in those 29 cities with needle exchange programs, HIV rates dropped 5.8 percent annually”(Loyce, Jr. et al.).

Furthermore, within the US, the rate of new AIDS cases in Washington DC, which until recently was “the only city in the country barred by federal law from using local tax money to finance needle exchange programs”(Urbina), is ten times the national average, while in the country as whole it is estimated that “between 4,000 and 10,000 IDUs [injection drug users] in the United States would not now be infected with HIV had they had access to clean needles”(Riley, O’Hare, 11). When considering these statistics, the former US Health and Human Services Secretary Donna Shalala concluded that “ ‘a meticulous, scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs”(Shalala as quoted in Cooper, 6), which is telling of the ways in which the widespread implementation of needle exchange could enhance America’s war on drugs.

Prospects for Change

Regardless of the potential contributions of tolerant marijuana policy and needle exchange programs to America’s war on drugs, the relevance of the Dutch approach to American policymakers is largely dependent on the American political climate. Unfortunately, at first glance, there appears to be strong resistance to change in the realm of drug policy. Overall, “there is no ‘ripeness’ that might generate change”(MacCoun, Reuter, 376), and only one percent of Americans surveyed in June 2004 indicated that drugs were the biggest problem facing the nation (Robinson, Scherlen, 14). This figure is certainly far from “the threshold of public discomfort that encourages a political

candidate for major office to take the risks involved in promoting any change that can plausibly be interpreted as increasing the use of illegal drugs in the United States”(MacCoun, Reuter, 376).

Furthermore, regardless of the actual outcomes of current policy, American policymakers maintain that “we are winning”(ONDCP *2008 National Drug Control Strategy*, 57) the war on drugs, and the ONDCP repeatedly claims success at reducing drug use levels. For example, the *2000 National Drug Control Strategy* contained a graph which claimed that “since 1979, current drug use* is down substantially”(Robinson, Scherlen, 6), making no mention of the fact almost all of this decline occurred between 1979 and 1988. When considering that the ONDCP was not even established until 1988, it is obvious that this reduction in use could not be the result of ONDCP policy. More recently, in the *2008 National Drug Control Strategy*, the ONDCP described the drug problem as “one in retreat””(ONDCP *2008 National Drug Control Strategy*, 57). Quite simply, if policy evaluations refuse to accurately acknowledge the failures of current drug policy, then the war on drugs will surely persist.

However, while these facts reinforce the hypothesis presented earlier that the drug war is far from over, they do not preclude America from more incremental policy changes. In fact, the American public does seem ready to tinker with current drug policy, as illustrated by the fact that “74% of the public agrees that America is losing the war on drugs”(Sterling), according to a 2001 survey by the Pew Research Center. Additionally, a November 2003 Gallup Poll indicated that “75 percent of US adults favor allowing patients with a doctor’s prescription to possess and use marijuana,” and in November 2004 “voters passed 17 initiatives calling for reduced marijuana penalties in Alaska,

Montana Oregon, Ann Arbor, Mich., Columbia, MO., and several state districts in Massachusetts”(Marshall, 2), indicating that the American public does not blindly adhere to the war on drugs mantra. Overall, “ ‘every ballot initiative on medical marijuana that has been out there has won, often by very substantial margins’ ”(Nadelman as quoted in Marshall, 2), and according to the director of the Drug Policy Alliance, “which supports legalizing marijuana for medical purposes and personal use by adults,” it is “ ‘now safe to say that majorities in every state of the country support making marijuana legal for medical purposes’ ”(Nadelman as quoted in Marshall, 2).

Further indicative of the potential for change are the recent actions by Congress concerning the 100-to-1 drug quantity ratio. While as recently as 1995 Congress “expressly disapproved of [the US Sentencing] Commission’s guideline amendment addressing crack cocaine penalties”(US Sentencing Commission 2007, 1), in 2007 Congress was willing to accept the recommendations of this Commission and slightly modified the 100-to-1 drug quantity ratio, reducing the average sentence for crack cocaine possession to 8 years 10 months from 10 years 1 month. The federal prison population is also expected to decrease by 3,800 in fifteen years as a result of this change (Moore). Thus, while there are still numerous hurdles to ending America’s one hundred year policy of drug prohibition, there is still hope that more immediate change is possible

Conclusion

The Dutch experience with marijuana policy and needle exchange is telling of the ways in which the drug war can be modified to mitigate many of its most serious side effects. Furthermore, while the political climate in America indicates that there are still

numerous hurdles to ending the drug war, the public as a whole appears to be growing more willing to accepting modifications to the current drug war. In this sense, the Dutch approach not only presents useful strategies, but also realistic possibilities for America. Thus, even as the war on drugs continues onwards, by looking to the Dutch approach, one can begin to hope for the change to a more compassionate drug war.

V. Conclusion

In attempting to identify the specific elements of the Dutch approach which could benefit America's drug war, the research presented here signifies a modified take on the more standard question of whether Dutch drug policy should be a model for America. Numerous studies have attempted to answer this question, and almost all reach the conclusion that, given the numerous cultural and historical differences between the US and the Netherlands, "it would be naïve to think that the Dutch model could simply be transferred to the United States"(Haen Marshall, de Bunt, 213). Thus, by analyzing certain elements of Dutch policy within the context of the goals of the American war on drugs, the aim of this work was more practical; rather than determining whether America should adopt the Dutch model, the focus is instead on determining whether America could adopt any elements of Dutch policy given the current status of the war on drugs.

Overall, after analyzing both America's drug war and the compassionate Dutch approach to drug policy, it does appear that, short of abandoning the war on drugs in favor of an entirely alternative strategy, the prospects for real change in the realm of drug policy still exist in America. Despite the claims of drug war critics who maintain that "as long as the United States is guided by fundamental prohibitionism, aimed at the banishment of drugs and zero tolerance for drug use, there will be little room to learn from other countries"(Haen Marhsall, de Bunt, 213), the presence of strategies in the Netherlands which have the ability to reduce the consequences of drug use without in turn increasing drug prevalence indicate that this claim is not entirely true.

To prove this conclusion, more empirical research is needed into the direct effects of given strategies. While in the case of needle exchange, because of the large number of

countries in which these programs have been implemented, there is a significant body of evidence indicating their ability to combat the spread of AIDS (Loyce, Jr. et al.), this amount of evidence does not exist for other strategies. For instance, studies which directly analyze the strength of the causal relationship, as opposed to the association, between the presence of coffee shops and the decrease in hard drug use among marijuana users could work to quell the popular belief that tolerant marijuana policies cause “initiation of cannabis use [to] rise and that this will in turn lead to a higher prevalence of more dangerous drugs”(MacCoun, Reuter, 374). Despite these shortcomings, however, the Dutch experience with tolerant marijuana policy and needle exchange nonetheless provides compelling evidence that it is possible to change and improve America’s war on drugs.

Appendix A: Glossary

Coffee shops: The Dutch government allows for the sale of marijuana in licensed coffee shops. These coffee shops are required to follow certain guidelines, namely: (1) they may not sell more than 5 grams per person, per visit; (2) they may not sell hard drugs; (3) they may not advertise drugs; (4) they may not constitute a nuisance for surrounding businesses or residents; (5) they may not sell to minors and may not admit minors to the premises (Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 19).

Current Drug Use: Same as past-month drug use.

Drug Induced Death: Defined in the US as “deaths from dependent and non-dependent use of drugs (legal and illegal), but also poisoning from medically prescribed and other drugs”(Common Sense for Drug Policy). Drug induced deaths result directly from drug consumption, primarily overdose, and in 1995 it was estimated that overdose accounted for 90 percent of drug induced deaths (Robinson, Scherlen, 138). In contrast, drug related deaths include other causes of death which may be a product of drug use, such as AIDS infection.

Expediency Principle: The enforcement of drug laws in the Netherlands is based on this principle, which means “criminal prosecution can be refrained from for reasons of public interest”(Taekema, 183). The opposite of the expediency principle is the legality principle, which “compels a prosecutor to prosecute if the law provides a legal basis to do so and if his case is strong enough to be taken to court”(Taekema, 183). The American criminal justice system is based upon the legality principle.

Importer/high level dealer: Defined by the US Sentencing Commission as a drug offender who “imports or supplies large quantities of drugs, is near the top of the distribution chain, and has ownership interest in the drugs”(US Sentencing Commission 2007, 18). This category represents the most major level of involvement, out of 8 total levels, in a given offense.

Life-Time Drug Use: A statistic which measures the number of people who have ever used an illicit drug in their life time.

Methadone: A drug containing opium which is given to heroin addicts as a drug substitute. Despite being addictive, methadone can be taken orally in pill or liquid form and in precise doses, thus minimizing the risk of overdose. Additionally, methadone’s effects last 24 hours, as opposed to just a few hours for heroin. Thus, rather than being seen as a stimulant, methadone is seen by the Dutch government as a drug for treating heroin addicts (Ministry of Health, Welfare and Sport *Drug Policy in the Netherlands*, 30).

Organizer/Leader: Defined by the US Sentencing commission as a drug offender who “organizes or leads a drug distribution organization, cultivates or manufactures a controlled substance, or provides money for importation or distribution of drugs, or

launders sales proceeds”(US Sentencing Commission 2007, 18). This category represents the second most major level of involvement in a given offense.

Past-month Drug Use: A statistic which measures the number of people who have used an illicit drug within the past month.

Problematical Drug Use: Defined throughout the European Union as “addiction by intravenous injection, or regular and long term opiate, cocaine and/or amphetamine use”(Kopp, Fenoglio, 29).

Public Expenditure on Drug Policy: This quite simply refers to what the government spends to counter the drugs problem.

State and Local Assistance: Defined by the ONDCP as “federal drug control assistance to help state and local law enforcement entities reduce drug-related violent crime and the availability of illegal drugs”(ONDCP *FY 2009 Budget Summary*, B3).

Street-Level Dealer: Defined by the US Sentencing Commission as a drug offender who “distributes retail quantities (less than one ounce [28 grams] directly to users”(US Sentencing Commission 2007, 18). Of the eight categories, this category represents the third most minor (or fifth most major) level of involvement in a given drug offense.

Unacceptable Health Risks: In distinguishing between marijuana and hard drugs, the Dutch government, based on the expert recommendations of a commission headed by Pieter Baan, “a psychiatrist and expert in rehabilitating drug addicts who was serving time at the Dutch Office of Mental Health”(Collins, 82), determined that hard drugs present unacceptable risks such as addiction, disease and overdose to users and, therefore, could not be tolerated in the same way as marijuana.

Appendix B: Literature Review

The literature regarding the drug policies of America and the Netherlands is primarily divided among three categories: (1) pertaining to US policy, (2) pertaining to Dutch policy and (3) pertaining to whether the Dutch approach should act as a model for America. In the first category, the political and academic dialogue is in near universal agreement that the war on drugs is both flawed and problematic. Much of the literature has taken different routes in reaching this conclusion, however; with some authors targeting specific elements of policy that are problematic, such as the 100-to-1 drug quantity ratio, some concentrating on whether the goals of current policy are appropriate given the nature of the drug problem, and still others taking a more general criminological approach in order to show that either the use of law enforcement to target personal drug use is impractical or that the goals of imprisonment are not consistent with the goals of the drug war. The most extreme critiques of US drug policy not only claim that policy is ineffective and expensive, but that it is also the cause of many of the social harms currently associated with illegal drug use, such as the fact that, despite increasing enforcement pressure, deaths from drug abuse doubled between 1979 and 1998 (Sterling).

On the other side of the debate, arguments in support of current US drug policy come disproportionately from policymakers who, at some point, were involved in forming current policy. Their propositions center on logical arguments in support of domestic law enforcement and claims-making that the role of treatment and prevention in current policy have been underestimated by critics. For example, Robert L. DuPont, the former drug czar under presidents Ford and Carter, stresses the utility of law enforcement

programs by arguing that “drug prohibition has been far more effective in reducing drug use than the use of persuasion – without arrests – has been in reducing cigarette and alcohol abuse”(Katel). Overall, however, outside this small realm of current and former policymakers, the academic literature overwhelmingly supports the claim that US drug policy is fatally flawed.

In looking at the Dutch approach to drug policy, the academic literature does not reach the same level of agreement as with US policy. While some revere Dutch drug policy as “a workable, pragmatic system of drug control that clearly serves them very well”(Bullington 1999, 1) and as a “rational, pragmatic [approach] calculated to reduce risk taking behavior”(Duncan, Nicholson, 12) others, such as Larry Collins, have lambasted the Dutch approach as “half-baked.” Collins even declares that Holland has emerged “as the drug capital of Europe”(Collins, 84) because of its liberal drug policy. American policymakers by and large back the claims of Collins, as illustrated by former drug czar Barry McCaffrey’s declaration that Dutch drug policy is an “ ‘unmitigated disaster’ ”(McCaffrey as quoted in Bullington 1999, 1). However, when considering that to back this claim, McCaffrey cited that the Dutch homicide rate was more than double the US rate, when it is actually less than one-fourth of the US rate (Bullington 2004, 8), it becomes obvious that the claims of American policymakers regarding the Dutch approach should not be taken at face value.

Overall, the different opinions regarding the effectiveness of the Dutch approach result from disparities in the statistics being used. As illustrated by MacCoun and Reuter, the claims regarding the levels of drug prevalence in the Netherlands range from; “[marijuana] use among 13- to 25-year olds fell from 15 percent in 1976 to 2 percent in

1983”(Oakland Tribune Editorial as quoted in MacCoun, Reuter, 239) on one side to “the lifetime prevalence of marijuana use among Dutch adolescents is 30.2 percent; the US prevalence is 10.6 percent”(Housman as quoted in MacCoun, Reuter, 239) on the other. Such contradictory statistics make evaluating the Dutch approach confusing. However, by looking at the data presented by the Netherlands National Drug Monitor in its annual drug prevalence reports, the data presented by the European Monitoring Center on Drugs and Drug Abuse (EMCDDA) and the arguments made in numerous academic studies, such as that of MacCoun and Reuter, it becomes apparent that neither extreme claims of success nor failure are accurate.

In actuality, Dutch drug use is in line with EU averages, and use is even lower among certain drugs, such as cocaine, which indicates that Dutch drug policy has not really had any profound effect either way on influencing drug prevalence. However, in light of the successes policy has had in reducing the harms of use, a reasonable assessment of drug policy is that “the Dutch can make a good case that they have probably reduced serious drug problems while maintaining a humane relationship with their drug addicts – a good case though not an unassailable one”(MacCoun, Reuter, 278). It is quite possible that many of the reports which strongly criticize the Dutch approach were heavily influenced by the heightened visibility of drug use in the Netherlands; however, as shown, this high level of visibility does not indicate high levels of use.

Another contentious issue within the literature evaluating the Dutch approach concerns the level of government spending on drug policy. Throughout most of the EU, the Netherlands included, there is no document equivalent to the annual ONDCP *National Drug Control Strategy Budget Summary* which attempts to indicate the public

expenditure allocated for drug policy. Instead “expenditures on these different programs are rarely identified as such in government budgets but are imbedded in broader budget categories” and, furthermore, “budget methods differ so greatly that it is difficult, if not impossible, to develop a single set of estimates that allow for systematic comparison in all the dimensions of interest to policy makers; over time, across countries and among sectors”(Reuter, Ramstedt, Rigter, 3). Thus, the “precision of current expenditure estimates is very low”(Reuter, Ramstedt, Rigter, 2), and different studies, with different methodologies, have all reached significantly different estimates regarding the level of public expenditure on drug policy in the Netherlands. For example, a study by Reuter, Ramstedt and Rigter, which uses a top-down approach to estimate government spending, meaning this study looked to “ministerial expenditure or budgets and reasons from this, which parts may be attributed to the drug problem”(Postma, 40), estimated public expenditure on drugs in the Netherlands to be €1,186 million. In contrast, a study by Kopp and Fenoglio estimated the public expenditure on drugs to be €62.9 million.

In light of these disparities, in drawing conclusions about government spending on drug policy in the Netherlands, one must rely on the principle of triangulation, which “suggests that flawed sources of data are more informative when their lessons converge rather than diverge”(MacCoun, Reuter, 300). Clearly, the data on public expenditure is flawed; however, despite presenting divergent estimates regarding the Euro amount spent on drug policy in the Netherlands, all of the studies on this issue conclude that Dutch drug policy is costly. Furthermore, they all indicate that much of government spending is geared towards law enforcement. Even a study from a decade earlier, by Kraan, confirms these results. In this sense, even though there appears to be serious problems in the data

set regarding public expenditure on drugs policy, the conclusions that policy is expensive, and spending is mostly on law enforcement, seem reasonable.

Lastly, within the literature concerning whether the Dutch approach should act as a model for America, most authors begin by pointing out the flaws of US policy, and acknowledge the success the Dutch approach has had in limiting the negative consequences of drug use. Some, such as Duncan and Nicholson, additionally credit Dutch policy with “keeping the overall prevalence of illicit drug use much lower than in neighboring countries,” and declares that American “political leaders would have proclaimed victory in the war on drugs”(Duncan, Nicholson, 12) had US policy had the same successes as Dutch policy.

However, even the most optimistic interpretations of Dutch policy coupled with the direst interpretations of the war on drugs all fail to determine with any definitiveness whether the Dutch approach should act as a model for America. Each of these reports notes the numerous differences between US and Dutch society, including that “the Netherlands is a small country with a comprehensive public system of health insurance and a vast publicly funded system of welfare provisions and facilities,” in reaching the ultimate conclusion that “it would be naïve to think that the Dutch model could simply be transferred to the United States” (Haen Marshall, de Bunt, 213). Quite simply, “a country’s drug policy has to fit in with the nation’s characteristics and culture”(Barnard, 1), and the differences between the US and Holland are far too numerous to ever accurately determine whether the Dutch approach could fit within the framework of American society.

By identifying elements of the Dutch approach which could improve America's drug policy even as part of the war on drugs, the research presented in this thesis attempted to avoid the pitfalls of previous works concerning the appropriateness of the Dutch approach for America. By analyzing certain aspects of Dutch policy through the lens of drug war goals, certainly some of these cultural differences could be regulated because policies which fit within the framework of America's war on drugs presumably must also fit, for the most part, within the framework of American society. In this sense, this work does not represent a theoretical analysis into what the best drug policy is, or an analysis of what drug policy the US should adopt; instead, it is an attempt at uncovering what the US can realistically do to improve its mightily struggling drug war.

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