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HARM REDUCTION AND DRUG POLICY:

IMPLICATIONS FOR SOUTH AFRICA

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I. INTRODUCTION AND THEORY

Psychoactive substances have been used for social or religious purposes around the globe for millennia. However, in modern times, their inherent properties and hazards have been exaggerated or misrepresented. They are illegal, even feared. Yet, the futility of eradication efforts exemplifies the fact that drugs are here to stay.

There is no doubt that the abuse of these substances by a small percentage of users does result in significant damage. However, the standard prohibitory regimes compound the problem by treating the possession and use of these substances as a criminal rather than a health matter. Drugs and their users have been demonised and relegated to the fringes of mainstream society. Social reactionists provide a theoretical basis for this process in matters that often appear to have been tailored to their work.

Harm reduction initially developed as a treatment perspective however its features also imply a much broader philosophy. Its central tenet is to diminish the damaging effects of substance use and it has, so far, been accepted in an unelaborated form in South Africa's National Drug Master Plan.

The underlying values of harm reduction result in different approaches for interventions in treatment (including prisons) and education. It complements a larger sociology of drug use that eschews the value-driven and deterministic elements of other approaches. Instead, it believes that there can be no progress in controlling substance use until certain social justice issues are addressed.

The issue of substance abuse in South Africa has grown in importance since the democratisation of the country and the establishment of the international illicit drug trade.
The problem of substance abuse follows closely on the heels of this activity. The key question is: what policy will South Africa adopt?

The possibilities in this regard are diverse. Perhaps a few lessons can be learned by looking at

the comparison of the United States and the Netherlands. Though by no means representing the only or most extreme perspectives, they contrast a prohibitory regime as opposed to a more regulatory one. Experiences of developing countries will also be considered.

1. Venerable Cultures and Ancient Substances

The use of psychoactive substances dates back through all recorded history and probably beyond (Heath, 1998: 139).[1] Coca, for example, has been used by indigenous South American people for social, religious and nutritive reasons for thousands of years. The use of hallucinogenic cacti such as peyote and mescaline is a long-standing rite of native people in Mexico and the southwestern United States (Heath, 1998: 142-143).

"Soother of Grief" to ancient Hindus, the use of marijuana[2] dates back to 5000 or 6000 B.C. Stone tablets from Babylonian times (circa 3000 B.C.) also record its purpose as an analgesic and anti-depressant. It was contemporaneously recognised in China as the "Liberator of Sin" and recommended for treatment of diseases ranging from constipation to menstrual pain (Bensusan, 1971: 35).[3]

The Khoi were already smoking it from clay pipes when Jan van Riebeek arrived in the Cape[4] and may have been introduced to the subcontinent by "the very first waves of Bantu invaders from the North" (Bensusan, 1971: 35). Alternatively - or in addition - to this pre-colonial importation, it may

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[1]Heath also lists examples of animals that intentionally ingest naturally occurring psychoactive substances.

[2]*Cannabis sativa* is otherwise known as hemp, dagga, weed, pot, rope, ganja, zol, reefer, grass, tea, bud, herb, kif (North Africa), bhang (India; it translates to bhangi in Swahili, Mbanzhe in Venda, or mbangi in Shangaan), Intsangu (Zulu), Umya (Xhosa), Matakwane (Sotho), Suruma (Mozambique), and chamba (Malawi - more than one tourist has instead obtained chambo, the local catch). (See Bensusan, 1971: 39.)

[3]The recognised medical uses of marijuana give posthumous recognition to Peter Tosh's assertions in the song "Legalize it". Like the ancient Chinese, I can personally vouch for the near-miraculous relief provided for the effects of malaria, which I had contracted while working in northern Mozambique. A non-user objectively observed the positive effects. A friend later informed me that this treatment was common in the area.

[4]"Dagga" stems from a Khoi term (Bensusan, 1971: 35).

also have been brought to southern Africa via Mozambique and India by Portuguese traders and to the Cape by Asian slaves (ibid). In any case, it is currently widely grown and consumed across the continent.

2. Deviancy and the Labelling Process.

Modern societies have developed a fascinating paradox in their attitudes towards psychoactive substances. On the one hand is the vilification and prohibition of "drugs";[5] on the other hand is their unassailable place in modern culture.

If drugs have always existed in societies, how have they come to be demonised? Merrill notes, to the certain envy of harm reductionists, that any issues concerning drugs were treated as a health problem and not a criminal one before their prohibition (1988: 5). If there actually is a "drug problem", then it has also always been there and only public attitudes have changed (1988: 5).[6] Motivations of moralism are common features as is the "blind prejudice" of stereotyping (Young, 1971: 57).

Labelling theory has been accused of neglecting primary deviance, especially where violence is concerned (Liska, 1981: 141). However, these are normally predatory offences where there is a stronger consensus of values (Braithwaite, 1989: 4). Drug crimes are often a simple violation of

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[5]The definition of "drugs" requires some elaboration. The Oxford Dictionary is unhelpful since it restricts the noun to a "medicinal substance" or a "narcotic, hallucinogen or stimulant", especially one that causes addiction. Clearly these descriptions are inadequate since, even if alcohol, tobacco and caffeine are not included, there are still other classes of drugs such as depressants which are missing. Instead of looking at pharmacological categories, my view takes into consideration their psychoactive properties but, unless otherwise mentioned, is restricted to substances, which are currently illegal.

[6]100 years ago in the United States, the per capita addiction rate to opiates (legal at that time) was much the same as at the time of this article. Society was unaware of any problem, there were no drug laws and, no enforcement mechanisms were necessary (Merrill, 1988: 4).

absolutist norms, the typical 'victimless crime' (Young, 1971: 96).[7]

Labelling theorists best describe the social harm resulting from absolutism in values, a key tool in demonising drugs and their users. It reinforces the view that "social groups create deviance by making rules whose infraction constitutes deviance" (Becker, 1963: 9).[8] Rules are created and enforced using economic and political "power differentials" that are rooted in social position (ibid: 17-18). These rules give rise to "conflict and disagreement, part of the political process of society" (ibid: 18). Deviant phenomena are "a normal and inevitable part of social life, as is their denunciation, regulation, and prohibition" (Matza, 1969: 13).

a) Absolute versus Relative Values

Becker describes the genesis of a crusade by "moral entrepreneurs" whose proponents view a certain type of conduct as wrong, even evil. Religion is often alleged in their attempts to have rules made that "correct" this behaviour (1963: 147-48). These crusaders are typically from a dominant class and direct themselves to those people lower in the social hierarchy. Generally more concerned about the ends than the means, they are often accompanied in their quest by self-interested supporters (1963: 149-150). Indeed, the humanitarianism of moral entrepreneurs may be suspect in itself, providing a veil for moral indignation or other hidden agendas (Young, 1971: 99).

The result of this crusade may be a rule, often in the form of a prohibition or ban that becomes the value-laden basis for labelling. Matza notes that this "moral transformation" carries an element of guilt, the purpose behind the ban. Leviathan then "bedevils" those people who have violated it (1969: 147). While the "wrongminded" may be able to manage or neutralise this guilt, it is a reflection of their

[7]Young attributes the development of "crimes without victims" to another labelling theorist, Edwin Schur.

[8]"Deviant" simply refers to a person who has strayed from a path or standard (Matza, 1969: 10).

capacities to cope with the situation rather than the "inconsequentiality" of Leviathan's intention (1969: 146).

The actual labelling of the deviant is an action that Becker describes as one of the most important stages in developing an accompanying behavioural pattern (1963: 31). Matza obviously agrees:

> "To be cast a thief, a prostitute, or more generally, a deviant, is to further compound and hasten the process of becoming that very thing"

b) Subcultures: Developing a New Image and Values

This drastic new "public identity", well suited to drug users, reveals him or her as different from the majority (ibid: 32) and fits the mould of Becker's "outsider".

Having had a rule enforced against them, a drug user may not accept this judgment as legitimate or competent and may see their judges as outsiders (Becker, 1963: 1-2). With this "emancipated view", a drug user may counter conventional arguments against substance use by resorting to the "folklore" or relative values of their group (ibid: 73-74).[9] Thus, to properly comprehend a member's behaviour, one must understand the group's way of life (ibid: 79).

Even more intricate is the case of youth where there may be an ambivalent, "private" morality of mainstream values that co-exists uneasily with subterranean ones. Though the two codes are concurrent, the expression of subterranean values is delayed until a proper opportunity arrives (Sykes & Matza, 1957: 716). However, repeated deviance among youth is a group rather than an individual effort (1961: 105).

Becker quotes the anthropologist Everett Cherrington Hughes to stress the point of subcultural

[9]Regarding marijuana, Becker (p. 74) lists the most common justification as its relative innocuousness in comparison to legal practices such as tobacco smoking and drinking.

values:

> "Wherever some group of people have a bit of common life with a modicum of isolation from other people, a common corner in society, common problems and perhaps a couple of common enemies, there culture grows" (1963: 80).

If this culture is contained within but remains distinct from the predominating culture, it may be recognised as a subculture (ibid: 82).

c) Pathology versus Diversity

"I went back to my mother
I said I'm crazy Ma help me
She said I know how it feels son
Because it runs in the family"

- The Who, Quadraphenia

The hegemony of absolutism not only forces people out of the larger society, it compounds the polarisation from deviant subcultures by trying to eliminate them. This goal is motivated by the view that "the conceivers of social pathology...tended to equate conventional morality with health" (Matza, 1969: 57). The notion of pathology with its "unscientific and moralistic overtones" (ibid: 64) is often maintained by absolutists without any "technical mapping" of the deviant subculture (ibid: 65). In terms of youth, subterranean values may be activated even though the majority of society is "too timid to express" them (Sykes & Matza, 1957: 717). Young (1971: 55) stated most succinctly:

> "To suggest that a person with different norms from oneself is psychologically inadequate is merely a very convenient method of negating any argument as to the validity of one's own way of life."

Cohen notes that issues of criminal deviancy produce absolute values in the form of "justice,

social good, individual liberty, compassion", competing elements that cannot be fairly prioritised (1985: 244-45). A singularly moral attitude with reference to pathology would appear to be essential in overcoming these contradictions and continuing the crusade. It contrasts sharply with "appreciating" one's subject and thus attaining a deeper understanding (Matza, 1969: 15-16).[10]

d) Determinism versus Willed Behaviour

Becker and Matza meticulously dismantle the notion that deviancy is somehow deterministic. They examine the amorphous wants and inclinations (often driven by nothing more sinister than curiosity) that are gradually moulded into more definite behavioural patterns. By looking at the social implications of one's ambiguous physical experiences, "the deviant behaviour...produces the deviant motivation" (Becker, 1963: 42) and not the converse implicit in the deterministic view.

These factors are not merely dichotomised into determinism versus free will. Having dispensed with determinism altogether, Matza explains that:

> "To recognise and appreciate the meaning of being willing is by no means to assert the existence of a free will...Free will as the phrase itself implies, takes will out of context, converting it inexorably into an abstraction of as little use as any other" (1969: 116).

The state of willingness is "the human leap that allows an open process to continue" (ibid). To continue along the path of deviancy is not a mechanistic "yes or no" choice but one that is influenced by a variety of factors including socialisation and current social circumstances. By crossing the "invitational edge", the person has merely opened themselves up to "conversion" (ibid: 117). However, a great deal of self-discovery is undergone before the willingness survives reconsideration (ibid: 118-119). To convert is to become deviant, a process that is in no way preordained (ibid: 107).

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[10]"Appreciation" should avoid the tendency to ignore or downplay characteristics, which might be considered

The timing of this process may coincide with Cohen's description of an "illusory quest" for "order and symmetry". In times of crisis, people may exchange their "doubts and agonies" for the reassurance of determinism and absolutism. They seek unobtainable generalist solutions for the discrete nature of a "historical juncture" (Cohen, 1985: 244). Science and politics are thus used as substitutes for difficult moral decisions (ibid: 245).

Yet, the notion of a common morality (based on factors other than absolutism and determinism) need not be dispensed with in favour of a "rampant and mindless relativism" (Matza, 1969: 12). If one considers the combination of pluralism in conjunction with dynamic and ambiguous standards, then a common morality may indeed exist (ibid). In such a climate, deviant phenomena are commonly sensed and understood, and not considered as particularly problematic (ibid).

e) The Media and Popular Culture

The labelling process is greatly influenced by the type of information disseminated to the public (Cohen, 1972: 16). "News" is filtered through the media and shaped by subjective perceptions and utilitarian concerns such as circulation numbers (ibid).

One of the four main groups who are prone to acting against drug users,[11] the media resort to the "newsworthiness" of "moral indignation" as a particularly effective and oft-used tactic in grabbing public attention (Young, 1971: 103). With imputations of hedonism and underproductivity, it provides a convenient clash with established Western middle class norms of industriousness and responsibility (ibid: 99).

In fact, media portrayals have the potential of increasing the level of deviance. Stereotypical

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"distasteful", thus romanticising the phenomenon (1969: 15-16).

[11] Young lists the others as moral crusaders, experts and law-enforcement agencies (1971: 102).

portrayals are inevitable as the information passes from the primary source through the media and is converted into a consumable product (Cohen, 1972: 18). The perception of their own deviancy increases as they gravitate towards other similarly placed groups and thus reinforces the prospects of even more deviant acts (ibid). The circle is completed when these groups are exposed to further punitive actions by conformist groups (ibid).

i) Techniques of Distortion

Distortion by exaggeration in the media is a common occurrence, particularly with "sensational headlines", "melodramatic vocabulary" and the magnification of the importance of the incident (ibid: 31). Complementing political objectives, wittingly or not, the media often portray the worst case of deviancy as common, a tactic used in campaigns against drugs (Reinarman & Levine, 1995c: 359).

Perhaps in an effort to 'milk' a story or theme for its maximum news value, predictions are another form of distortion and are a common ploy in focusing continuing attention on a particular issue (Cohen, 1972: 39). Even when subsequent (non)events only partially or even completely fail to live up to media expectations, the self-fulfilling prophecy is completed by emphasising concording events and downplaying contradictory ones (ibid).

The "spurious attribution" of qualities[12] is further meant to support a belief or action (ibid: 54) and simultaneously reinforces the original clash of values, identification, and alienation of the deviant. Because of their often vulnerable position in society (due partly to existing stereotypes), ethnic

[12]In terms of Mods and Rockers, the media resorted to such pejorative terms as "grubby hordes of louts and sluts", "bovine stupidity" and "their innumerable boring emotional complexes". The latter reference, more than just a stereotypical epithet, is particularly effective in reinforcing a pathological perspective for a deviant phenomenon, one appropriate for public consumption. To be fair to the media (admittedly quite difficult at times), Cohen (p. 54) approves Matza's findings that more informed attitudes, such as those of positivist criminology, also reflect this tendency, if less maliciously.

minorities, immigrants or youth are always strong candidates for these links (Reinarman & Levine, 1995a: 1). From a psychoanalytic angle, the apprehensions of a population are thus projected onto a "safely remote and outcast group, unconsciously but effectively pointing to a scapegoat" (Heath, 1998: 137).

Particularly powerful is the manipulation of the media by moral crusaders. However ill defined or unattainable their goals, they funnel information through the media, thereby using them as a tool in attempt to manipulate public opinion. This occurrence was typical during the War on Drugs; public opinion surveys showed that, not only was the public's reaction reflective of this campaign but that it was shaped by it (Reinarman & Levine, 1995b: 23-24; Heath, 1998: 136). When political and media attention shifted to other topics, so too did public support. By then, however, the War had become institutionalised (Reinarman & Levine, 1995b: 24).

ii) But When It Comes to the Bottom Line...

Metaphorically turning from the section on world news to the entertainment page, one can see how a subculture can be reconstituted in a sanitised and appealing mass media image. One result, as Cohen suggests with his study about Mods & Rockers, is that the alter ego can be separated and marketed commercially, while the 'evil' side remains available for vilification.

Cohen provides an example of how the Mods became "stylized" into a fashion statement by an adult generation. Yet, by receiving their information second-hand through the media, they missed the whole point behind "the clothes, the pills and above all the music" as "catalysts and modes of expression" (1972: 188).[13]

[13]Sumner also announced that "we [hippies] were all...utterly and completely deviant. It wasn't true, but it was just so funny to see the outrageous social reaction of the establishment. Even funnier, but not so ha-ha, was the fact that they

The unappealing elements are negatively portrayed, played down or not mentioned at all while more marketable features are emphasised. The mere possibility that drug use may have played a positive[it.] role in the performer's career as opposed to being a mere nemesis is heresy.[14] Thus, although Miles Davis died from complications relating to AIDS contracted during his long-time use of intravenous drugs, it is not a fact likely to be included in the liner notes of his CD's. Jack Kerouac wrote the manuscript for his critically acclaimed work of the Beat Generation, On The Road, in three weeks while under the constant stimulation of Benzedrine yet had the good sense to die a sociably acceptable death from the effects of alcohol abuse.[15] Janis Joplin, recognised as one of the great performers of the 1960's, was a regular heroin user; that she was probably dead before she hit the ground after shooting up is merely portrayed as the coda to her career.

Contrarily, the combination of youth, illicit drugs and the development of a positive self-concept is not a new belief (Schaffer Library, 1999: 3) but one that is unlikely to be given much press. Nobody is suggesting that people, especially youth, *should* take drugs. However, "subterranean traditions" of "rebelliousness" are largely the domain of youth (Matza, 1961: 104). Youth (and adults) will continue to use drugs. The climate in which this experimentation and consumption takes place is really where politics and the media have their effect.

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never really did get the point, and it was at root not so much a claim for the value of different lifestyles as a point about the dubious politics and morality of labelling people" (1994: 230).

[14][14]Reinarman and Levine note that drug users "have won Nobel Prizes, Pulitzer Prizes, Oscars, Emmys, Grammys" and occupy every profession (1995c: 358).

[15]The Beat Generation and the jazz world were two distinct but related drug-using cultures (Charters, 1991).

II. HARM REDUCTION

"I have never seen or heard of a psychotic morphine addict...In fact addicts are drearily sane"

- William Burroughs, The Naked Lunch

1. Introduction and Basic Philosophy

Harm reduction is very much what the name indicates - diminishing the damage that results from drug use. Harm reduction, in line with the thinking of labelling theorists, considers psychoactive substances as an established and normal part of society. It concentrates on minimising the damaging consequences of substance use, not on attempting to eradicate them (Erickson, CMJA: 1997). This tenet, along with other fundamentals, existed in an unorganised fashion for years before the name "harm reduction" was actually applied to it.[1]

The newness of harm reduction is reflected in two statements about its indefinite nature. Des Jarlais, while denying that there is consensus, elaborates a "working list" of "basic components" (1995: 10). Contrarily, Erickson states that there is agreement on "certain premises" (CMJA: 1997). It may well be that the rapidly evolving concept has simply been more firmly shaped in the two years between the articles.

In any case, they agree on the following:

a) Nonmedical drug use produces significant but differing levels of social and individual harm;

b) Policies and programs relating to drug use must eschew symbolism and concentrate on real impact. Pragmatism must predominate over appearance;

[1]The earliest "formal statement" on harm reduction stems from a publication regarding solvent sniffing by the Institute for the Study of Drug Dependence in London ("Teaching about a volatile situation") in 1980. Schaffer Library, 1999: 2.

c) Drug use is primarily a health issue. The health of the user and the community are also indivisible. This holistic approach necessitates integration and not marginalisation;

d) The complex nature of harm resulting from drug use demands a wide range of interventions - (Erickson, 1997:CMAJ; Des Jarlais, 1995: 10-11).

Inevitability, harm, pragmatism, health and intervention are the broadly defined key words. Because of its malleable nature, harm reduction can be applied contextually, "new practices tailored to local conditions" (Reinarman & Levine, 1995c: 357). It is thus sensitive to the equally inevitable politicisation of its implementation.

2. A Shift in Mentality: From Crime to Health

"I never had any problems with drugs, only policemen" - Keith Richard ʃ

The belief that drug use must be eradicated is essentially irreconcilable with the presumption that drugs were, are and will always be a part of our society. While curtailing both drug use and the number of users remains a natural part of harm reduction, priorities must be reset so that this goal is no longer the primary one (Duke & Gross, 1993: 280).

Any attempts at eradicating drug use must be accompanied by persuading users into abstention. Yet, the erratic (at best) effectiveness of abstinence-based treatment reflects the fact that many users simply do not want to abstain and are therefore "poor prospects" for these programs (Duke & Gross, 1993: 280). Absolutist eradication efforts tend to ignore the modern reality and complexities of drug

availability and use (Erickson, 1997: CMAJ).

Implicit in harm reduction policies is that only a small percentage of drug users find themselves in a situation that is "dangerous to health, obsessive, destructive of the user's values, incapacitating, or criminogenic" (Duke & Gross, 1993: 280). Badly set priorities in this regard mean that huge amounts of resources are wasted (ibid). Shifting from a criminal to a health perspective engenders basic attitudinal changes that move from eradication to informal control (Collison, 1993: 385). The most obvious - and probably most damaging - attempt at eradication is through punitive prohibition's precedence over social welfare. People who are "*in* trouble" instead are conceptualised as people "who *make* trouble" (Reinarman & Levine, 1995b: 37 - authors' emphasis).

This scheme assumes that all currently illegal drugs are dangerous and that users are likely candidates for addiction. (Without these assumptions there would be even less reason to criminalise the substance use.) Drug abuse is indeed a moral problem but one built around competing moralities and not the simplistic version that is used to support attempts at eradication. They are not issues that can be solved by trying to ban drugs and punish their users (Reinarman & Levine, 1995c: 359).

This approach also clashes with harm reduction in its attitude to the individual's social franchise (ibid). Prohibition, punitiveness and formal state controls largely serve only to drive the user out of mainstream society. In contrast to informal control, they tend to neglect "the strong causal connection between social justice and public health" (ibid).

The nexus between drugs and crime, while still of an indeterminate nature, has been much discussed (Ball, 1991: 40). Thus, in considering drug abuse as a health matter, one should not simply dismiss any related criminality. (The nature of the criminality is another matter entirely.) Crimes that cannot be justified by drug use, especially those that seriously harm other people, must be left for the

criminal justice system (Duke & Gross, 1993: 281; Collison, 1993: 385). Nevertheless, the majority of substance users - like the majority of drinkers - are not deviants but mere mortals who consume drugs in moderation and seek only to enhance their lives (Reinarman & Levine, 1995c: 359).

3. Different Models of Drug Use

a) The Medical Model

Harm reduction is composed of principles that more resemble a constitution and not set formulae. The range stretches from medical models to sociological ones. More radical views also exist though the central tenet of pragmatism is a limiting factor.

Abstention is the primary goal of the medical model. Its structure, still the predominant one, relies on the motivation of the substance user to discard any resort to drugs (Collison, 1993: 389). However, this approach is fundamentally flawed in that most drug users seek only credible information and guidance, or to change the pattern of their usage (ibid: 390). Motivation is frequently transient and, especially with orders made by the criminal justice system, inherent delays may well outlast it (ibid: 391).

Abstention implies that drug addiction is a disease, a biochemical reaction accompanied by an uncontrollable desire for more drugs (Schaler, 1998: 236-37). Supporters of the medical model point to research that indicates possible genetic links with alcoholism (ibid: 244).[2] However, these findings do not explain why people without a supposed predisposition towards addiction become alcoholics nor why people with such inclinations do not become addicted. The implications for other substances are also not clear (ibid).

Under this model, temperate consumption is "heresy", an inherently unmanageable lifestyle that

is reflective of a user's denial (ibid).[3] Addiction is equated to loss of control in a process where the element of volition is entirely absent (ibid: 239). The line between heavy consumption and addiction remains unclear.

Collison makes some significant general points about the "motivated victim" playing a "'sick'" role as an expedient for treatment within the court system (1993: 390). In fact, offenders may be cynically motivated (in which case treatment will be ineffectual and just another type of sentence) or not motivated at all; they may manipulate their way into treatment or forego it completely, their personal needs notwithstanding (ibid: 390-91). In the end, they may be motivated to do no more than pass up the "disease-model defense" (Schaler, 1998: 235),[4] the opportunity to be a victim and, instead, be labelled a criminal (Collison, 1993: 235).

b) Pharmocentrism

A so-called "pharmocentric" perspective is based mostly on information disseminated from the media and police (Cheung & Erickson, 1995: 187). It concords with Young's view that moral absolutists tend to concentrate on the drug and not the group itself. The significance of the drug-taking activity thus becomes disproportionately emphasised while there is a fundamental lack of understanding about the group (Young, 1971: 60). It emphasises only the substance's pharmacological properties and humans become simple "biological organisms" who respond to the drug's effects (Cheung & Erickson, 1995: 187). The singular nature of this concept is similar to that of the medical model in that the drug is reputed to induce pathology (addiction) whereas the other maintains that the addicted user is inherently diseased. In each case, no regard is given to factors outside the simple

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[2]This discussion centers on the dopamine D2 receptor gene and its connection to alcoholism.
[3]Schaler (p. 236) notes that some people would consider denial a disease in itself.

pharmacology/physiology equation.

Others also reject the view that all addictions are the same (Murray, 1991: 38). Criticising the emphasis on pharmacological classifications of addictions (for example, "alcoholics" or "crackheads"), Murray states that:

> "It is the heterogeneity of the substance abusing population, rather than its homogeneity, which is of increasing interest, both in the community...and in prison settings" (ibid).

The "uniformity myth" of addiction is thus discarded in favour of examining addiction evolution and maintenance in the individual. This analysis then becomes crucial in treatment and behaviour modification (ibid).

c) The Sociological Model

The sociological perspective of drug use contrasts sharply with the medical model. Both views may be incorporated as harm reduction policies although the sociological model makes more thorough use of its principles.

Reinarman and Levine outline the "drug, set and setting" approach (1995a: 9):

> "...in addition to the interaction between the molecules of the substance and the cells of the human body, drug effects are shaped by *the psychological mind-set of the user* - his or her expectations, mood, mental health, purposes, and personality - and by *the social setting of use* - the characteristics of the situation of use, the social conditions that shape such situations and impinge upon the users, and the historically and culturally specific meanings and motives used to interpret drug effects."

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[4]Schaler (p. 235) notes that this "defence" may provide more moral than legal sanctuary. S. Rothfuchs – Harm Reduction

Just as any drug can be abused, any drug may also be used without abusive consequences; thus, no drug is intrinsically abusive (Schaffer Library, 1999: 3).[5] The sociological perspective does not neglect the pharmacological properties of drugs, especially their psychoactive effects and "addictive liability" (Cheung & Erickson, 1995: 187). However, "addiction" has been progressively blurred and leads to easy claims due to the difficulty in confirming their veracity. It has also acquired the "mysterious" meanings of an "ill-defined disease rather than an ordinary human problem" (Erickson & Alexander, 1998: 272).

To the sociological perspective, addictive liability indicates a behavioural dysfunction, a compulsion that dictates the user's life (ibid: 272-73; 283).[6] It presumes that substance use "does not occur in a social vacuum", and that psychological and socio-economic factors also have a significant impact on the person's behaviour (ibid).

A more complete and individualised picture of drug users emerges. Perhaps most importantly, it addresses the issue of why some people become addicted and why most others do not (Reinarman & Levine, 1995a: 9). "User rationality", the knowledge of potentially harmful effects and the resulting choice to minimise use or temporarily abstain is exactly the type of element for which the medical or pharmocentric model cannot make allowance (Cheung & Erickson, 1995: 187). Likewise, the user's "stake in conventional life" regarding employment, family and other responsibilities remains a critical factor in decisions that control consumption (ibid: 188).

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[5]Tobacco appears to be the only drug where abusers outnumber users (Schaffer Library, 1999: 3).

[6]Erickson and Alexander (1998: 272) derive their concept of addictive liability from the World Health Organization's definition of "drug dependence". They also note that current writings on drugs distinguish addiction (compulsive drug seeking behaviour) from dependence (normally associated with tolerance and withdrawal)(ibid).

c) Other Models

There are also various other models for viewing drug use. Schaler discusses a moralistic one where, as he describes, "addiction is considered to be the result of low moral standards, bad character, and weak will" (1998: 237). The absolutist nature of this perspective is obvious and founds policies such as the American War on Drugs. Drug use is labelled a "plague" or "epidemic" (ibid: 238), yet the terms are used with reckless alternation between their medical and metaphorical meanings. The "will" element - that drug users are weak or pathetic individuals lacking only in moral gumption - sneaks a sociological element into it (ibid: 237) albeit one that would have little appeal to sociologists who consider themselves above such moralising. It is the punitive basis, "paternalistic and mechanistic" (ibid: 238), for moral entrepreneurs who launch crusades against drug use.

Shaler (ibid: 237) also lists a "free-will" model that follows the sociological one. Nonetheless, some comment on it is warranted.

The term "free-will" is contentious in itself, especially when used in the context of environmental factors as Schaler does (ibid). Socio-economic elements would clearly exercise a limiting force over will. As Matza pointed out, free will is an abstraction that takes will out of context (1969: 116). Though Schaler may well have intended this meaning, a continuum of exercisable will constrained by varying factors, the use of "free-will" is nonetheless unfortunate.

It is implicit in rational choice theory (as is the notion of retribution) where there is little room for other factors that may influence a person's decision (Torres, 1996: 18). When combined with various degrees of deterrence and incapacitation, it comes ever closer to the moralistic model.

4. Harm Reduction and Appropriate Models of Drug Use

Categories based on legality or potential for abuse are a feature of prevention-based programs, employed to avoid the unwieldy task of discouraging all drug use. Many existing policies are "binary" or bifurcated into a legal/illegal division and unitary regarding solutions, that is, abstention. Yet, these distinctions are usually arbitrary because of the fact that all drugs may be abused and all of them are also illegal under certain circumstances (Schaffer Library, 1999: 3). Contrarily, harm reduction holds a unitary attitude towards drugs (that is, reducing the damage resulting from the use of all drugs) but is multimodal regarding interventions (ibid).

This latter point is not meant to imply that harm reduction cannot be implemented under drug policies that maintain similar distinctions. A drug policy provides something of a toolkit for harm reductionists; the impact may merely be limited to the amount of tools one has at their disposal.

The multidisciplinary perspective of harm reduction indicates a holistic approach to drug issues. Its amoralism also makes questions of "right and wrong" or other value-laden arguments regarding drugs irrelevant. Diversity and pluralism are strong complements to this approach.

The basis for harm reduction is that drug use always has and will exist in society, the same foundation from which labelling theorists depart. Analysing the type of drug, psychological set, and social setting (Reinarman & Levine, 1995a: 10) is natural to this strand of sociology since, as noted by Cheung and Erickson (1995: 187), substance use does not happen in isolation from society. Some harm reductionists explicitly and wholeheartedly endorse the labelling view of drugs and deviancy (Reinarman & Levine, 1995a: 10-11).[7]

Nevertheless, the sociological model has not cornered the market on harm reduction implementation. A medical model employing concepts of disease is also adaptable and has been

recommended by the American Medical Association (AMA). Described as the "middle ground" for its ability to compromise full legalisation of drugs and yet still offer effective solutions, a medical model of harm reduction is strongly promoted by the AMA (Cotton, 1994: 1641). Quoting various medical experts in the field of drug use, they (not surprisingly) repeatedly portray addiction as an affliction and a problem of human "biology" (ibid: 1642). They characterise addiction as a chronic disease that is like any other "disability" and addicts are therefore "entitled" to treatment (Cotton, 1994: 1642). Medical therapy would be the "cornerstone" in their harm reduction policy (ibid: 1641).[8]

This attitude reflects the comment of Reinarman and Levine that the AMA is not exactly known for its "radical stands" on matters concerning public policy (1995c: 347).[9] Indeed, if a positivist harm reduction policy based on pathology and determinism is possible, then the AMA appears to have found it. Cotton even hazards a comment that harm reduction emphasises "caring over incarceration" to the point where decriminalisation or tolerance of some drug use may be necessary.

Harm reduction may not be entirely consistent with the pseudo-religious[10] experience of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), the most famous of all disease model treatment approaches. Participants simulate a religious conversion and necessarily adopt a "disease identity" or risk the label of being in denial (Schaler, 1998: 244-45). The success of these programs is undeniable although, as Torres notes, this fact may be due to newly learned coping skills, a feature of sociological treatment. Instead of resorting to psychoactive substances, an AA or NA member may call their sponsor or attend a meeting for support (1996: 20). There is no real evidence to suggest that

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[7]Specifically, Outsiders by Becker.

[8]In fairness, medical solutions are key components in harm reduction that include, for example, maintaining opiate-addicted patients with methadone or other substances, including the opiate itself.

[9]They also include the American Bar Association and the American Public Health Association (both of which have also called for reform of drug policy) in this comment.

[10]If one accepts the most basic definition of "religion" from the Oxford Dictionary (that is, a particular system of faith and worship), then the unhyphenated term is more appropriate. Schaler notes that several courts in the United States have

this effectiveness - whether AA/NA or other disease model treatment - is due to addressing an underlying pathology (ibid: 21).

Schaler notes the sociological view that this coercive intersection between disease adoption and conversion is directed towards a moral and not medical remedy (ibid). From a labelling perspective, the outsider has an opportunity to (re)enter the majority group if their current values and lifestyle are discarded in favour of new ones. Failure to do so results in more stigmatisation and the reinforcement of this process.

In some (if not all) respects, the AMA has overcome its "opiophobia" and "pharmacological Calvinism"[11] by recognising that addiction is best treated with more sensitivity towards the user and discarding notions of punishment (Reinarman & Levine, 1995c: 347). That drug abuse should be treated as a "health and social problem" instead of a criminal issue figures strongly in their position (Marwick, 1994: 1635). Cotton also states that "[a]ddiction is the single most stigmatized public health problem in [the United States]" (ibid, 1642). Tangible medical treatment, unlike AA/NA, is not based on conversion to a "faith" but on the use of agonist[12] and antagonist[13] medication.

Harm reduction may even be feasible under a punitive rational choice model. This statement, however, comes with the monumental caveat that the punishment incorporates treatment whether in prison or as part of probation. Liberal legal and civil rights assume a greater importance under this

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deemed AA and NA as religions and not forms of medicine. (1988: 245).

[11]These fears were at least partly the result of criminalising drugs and punishing physicians who medically maintained their patients' opiate habits (Reinarman & Levine, 1995c: 347).

[12]Drugs that satisfy the craving of the abused substance such as methadone.

[13]Drugs that obstruct the psychoactive effects of the abused drug such as naltrexone. It can be used with clonidine to ease opiate withdrawal symptoms. After detoxification and combined with therapy, it is an opiate-free alternative to methadone maintenance (Duke & Gross, 1993: 299).

Buprenorphine is both an opiate agonist and antagonist. It eases withdrawal as well as alleviating the opiate craving. For unknown reasons, it may even be a cocaine agonist. No antagonists to cocaine were available (ibid: 299-300).

The unknown as much as the known effects of these drugs demonstrate the unnecessary harm of harshly

scheme and create the battleground for the type and extent of treatment.

5. Education

Education is particularly important to an overall youth policy since research has shown that the earlier a person experiments with drugs, the better their chances of becoming drug dependant later in their life (Duke & Gross, 1993: 285). Traditional education programs, aimed at discouraging use, contrast with harm reduction's goal in providing reliable information on safe drug use.

Current drug education programs incorporate a preventative abstinence mentality. Use is presented as abuse, the negative aspects are emphasised, and non-consumption is presented as the social norm (Erickson, 1997: CMAJ). Criticism of prevention-based programs' effectiveness is not difficult to find with some critics even suggesting that this type of program does more harm than good (ibid).

The widely implemented DARE (Drug Abuse Resistance Education) program appears to have an initial effect although this "success" fades after approximately two years. STAR (Students Taught Awareness and Resistance) seems more promising in reducing substance use among youth with its main differentiating feature being community and parental involvement (Duke & Gross, 1993: 286-87).

However, these and similar preventative programs are thought to be fundamentally flawed in that they are incongruent with the messages received by youth by the greater social setting (Erickson, 1997: CMAJ). In noting that no conventional program reduces alcohol consumption among teenagers, Duke and Gross point out that, though they may be taught otherwise in school, they are surrounded by the consumption of alcohol in daily life (1993: 287). This situation highlights criticism that these programs do little to prepare the youth for the "real" world (Erickson, 1997: CMAJ).

One may again also become mindful of subterranean values. The conversion of adult drug and alcohol practices into caricatures by youth should come as no wonder (Sykes & Matza, 1961). Wheeling in Officer Friendly as part of a drug education program hardly seems convincing when his or her alter ego is busting you or your buddy for possessing a small amount of marijuana. In line with labelling theory, a youth drug user will become stigmatised by both the education program and perhaps also the criminal justice system. In their alienation, they are reticent to seek assistance and may have other inclinations towards deviance reinforced (Erickson, 1997: CMAJ).

Harm reduction education, though still in its infancy, takes an entirely different approach. Prevention still underlies it but it is directed at drug abuse and not use (Schaffer Library, 1999: 2), a strategy that is directly at odds with the disease or pharmocentric model of addiction.

Harm reduction recognises that certain psychosocial features of youth ("curiosity, a willingness to experiment and the definition of personal boundaries")[14] must be considered in the development of their independent decision-making abilities (Erickson, 1997: CMAJ). Positive features from other programs may be gleaned and forged with harm reduction materials. Their success must be measurable in terms of reduced harm, an objective and multi-faceted examination that includes but does not focus on prevalence (ibid).

6. Research and Social Justice

In 1994, the Surgeon General of the United States, Jocelyn Elders, suggested that the legalisation of illicit drugs might reduce crime. In an effort to draw public attention to the issue, she recommended that the issue be further examined (Marwick, 1994: 1635).

Apparently, her strategy worked. In a virtual frenzy of vilification, she was

misrepresented and attacked by her media and political critics, and distanced from a supposedly friendly White House (ibid).

This reaction demonstrates the mammoth task faced by drug policy reformers in the United States although the same sentiment exists to a greater or lesser degree virtually everywhere. The mayor of Baltimore, Kurt Schmoke, has stated that national leaders, driven by politics and emotion, were unwilling to collect the necessary data required for an objective national drug policy (Skolnick, 1994: 1636). The reaction to Elders' comment illustrates the "strong emotional commitments to cultural traditions that demonize selected psychoactive drugs" (Des Jarlais, 1995: 11).

In contrast, certain features of harm reduction require a base of knowledge from which to structure policies. Its objectivity and pragmatism are particularly well-suited to a rational analysis of the situation. In fact, failure to do so would distinctly grate against harm reduction principles. Comments like the one by Elders catalyse the debate about the negative health and social effects of relying on criminal laws and stigmatisation to reduce nonmedical drug use (ibid).

A climate of demonisation and prohibition affects research in a number of ways. On the one hand, prohibition "generates disease, crime and corruption", reinforcing stereotypes and skewing perceptions of the situation (Cotton, 1994: 1635), a negative effect that could be neutralised through decriminalisation, legalisation or at least a more temperate criminalising attitude. On the other hand, heavy restrictions on illegal drugs are "thwarting scientific investigation into the value of these agents in medical therapy" as well as limiting the range of potential treatment for addiction (ibid). Thus, prohibition retards positive progress in specialised

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[14] A bumpersticker reads "HIRE A TEENAGER while they still know everything". S. Rothfuchs – Harm Reduction

research dealing with the medical and nonmedical use of drugs (ibid).

If harm reduction research is based on "epidemiologic data about the actual incidence of real negative consequences" of drug use (Schaffer Library, 1999: 3), then some misleading indicators must also be set straight. One crucial aspect of focusing on harm is that it would take the emphasis away from mere prevalence. For example, in evaluating drug prevention programs, the limited value of prevalence rates indicates nothing about harm but merely the overall number of people using drugs (ibid; Erickson, 1997: CMAJ). It is entirely possible for prevalence to increase but, with proper harm reduction policies, actual damage may decrease (Schaffer Library, 1999:3). Without data on harmful activities such as polydrug or heavy use, conclusions drawn about education programs (or other issues) could be "fallacious".

Most drug abuse happens in places beyond the normal state net and can be viewed as a self-limiting matter. With or without formal treatment, serious drug abusers either learn to control their habit or perish. Thus, research on treatment strategies must be carefully interpreted, especially when using a criterion as potentially misleading as prevalence (Duke & Gross, 1993: 297).

Despite the emotions attached to the legalisation/decriminalisation debate, the sociological viewpoint more strongly asserts that punitive drug laws cause serious damage and thus need to be reformed (Reinarman & Levine, 1995c: 355; Erickson, 1997: CMAJ). Reassessing the illegality of drugs (especially in view of the racial and class demographics of use and punishment) also injects harm reduction with its strongest and most direct element of social justice.

The above discussion perhaps gives the impression that harm reduction and decriminalisation/legalisation face the same struggle for acceptance everywhere. This is, of

course, untrue. The Netherlands, Australia and Britain, *inter alia*, have relatively long-standing harm reduction policies that have crossed from being controversial to mundane. None have formally legalised drugs and the level of decriminalisation varies. Nevertheless, the advancement of the drug debate in these countries was raised to a new level (even without legalisation) when they implemented harm reduction policies.

In a context where drugs are criminalised, a balance will always have to be struck between the individual's rights on one hand and the "potent tools" of government policies on the other (Des Jarlais, 1995: 11). Any debate about harm reduction and rights, however, must include the broader perspective of socio-economic rights (especially considering the emphasis on health issues) or at least personal integrity and security.

If one views these rights in combination with harm reduction's outreach, reintegration and research strategies, then a limited but significant example of social justice emerges, that of the fatal drug overdose. Skolnick notes that current policies in the United States inhibit the collection of "vital" data in this area and that the number of such deaths are unknown (1994: 1636). Also not known is the drug or drugs commonly involved, details of the victim, and - most significantly – whether the death could have been avoided. Fully implemented harm reduction policies would have an important role in answering all these questions and, by bringing the user back into the larger community (or at least maintaining contact from a distance), lessen the opportunity for such occurrences.

The interrelationship of these individual rights to community interests must also be noted. To do otherwise artificially limits the discussion to a legal one that is of a libertarian nature (ibid) when the issues extend far beyond these boundaries. Also, the esoterics and abstractions of

legalistic arguments can be fundamentally at odds with harm reduction's pragmatism and confines progress to the four walls of the legal system. The term "social justice" as an integral feature of harm reduction connotes a far broader vision than simple criminal justice.

7. Competing Policies

a) Crack and the War on Drugs

If any drug this century has epitomised the irrational, even hysterical, response to a particular drug, then crack is it. Driven by moral entrepreneurs and manipulated by politicians, crack somehow must find a place of distinction among similar crusades. Never has a pharmocentric hysteria been so effectively induced at the highest levels of government through the mass media.[15] Rarely has a national drug policy been so tellingly revealed as misguided, even in view of previous prohibitionist crusades.

The "crack scare" was not the first demonisation of a specific drug (Reinarman & Levine, 1995b: 19).[16] It was, however, probably the most sophisticated in its manipulation, hidden motives and prejudices.

"Cooking" cocaine with bicarbonate of soda concentrates it in a crystalline form. Thus, crack is able to feed the smoker's brain more pure cocaine than its powder form, providing a similarly more intense rush that abates even more quickly. A strong desire to repeat the euphoric high often follows and, like powder cocaine, initiate a binge of consumption (ibid: 18-19). Crack

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[15]The setting is, of course, the United States. Johnson et al note that in 1986, at the peak of this campaign, Time and Newsweek featured five cover stories about crack.

[16]It was not even the first against cocaine, crack's parent drug. The Harrison Act 1914, the first anti-drug legislation in the US, was formulated largely as a result of this campaign. Then came successive crusades against alcohol, marijuana and heroin (Reinarman & Levine, 1995a: 6).

users themselves[17] suggest that crack was not any more "instantly addicting" than other drugs such as powder cocaine, heroin or marijuana (Johnson et al, 1995: 280).

Perhaps this latter statement downplays the pharmacological effects of crack - or perhaps not. There has been much discussion about the effects of crack and their link with violence. Yet, a wide-ranging study that focused exactly on this topic found that there was little evidence to support it (Johnson et al, 1995: 278-279). Crack is a potentially hazardous substance but for more reasons than its simple chemical properties.

The results, in view of previous studies of other drugs, were not surprising. Subjects without a violent history before their crack use rarely initiated violent behaviour after beginning to use the drug regularly. Contrarily, those people who had histories of violence before regular crack use tended to repeat this behaviour after using crack regularly. As a whole, they found that crack users were only slightly more prone to commit aggravated assault and rape than non-users (ibid: 281-282). The only non-drug criminality that showed any significant increase contemporaneous with the introduction of crack was prostitution; women who worked in the sex trade before the arrival of crack substantially increased their participation after becoming involved with it (ibid: 281). However, the authors add the caveat that the exact nature of this connection is not known and requires more research. Also, women who had not acted as prostitutes before using crack were found not to have participated afterwards (ibid).

Another study that is at variance - if not in conflict - with these findings measured the possible influence of crack in robbery and burglary rates for 142 American cities from 1984 to 1992. Their hypothesis was that, with the ascendance of crack use, there was often a decline in

[17]Far from being "drug naive", this group in Johnson et al's study were veterans of steady illegal drug use (1995: 280).

burglaries and concomitant rise in robberies (Baumer et al, 1998: 336). However, their suggestion that the availability and use of crack was at least partly responsible for an increase in violent crime and decline in property crime during this period (ibid: 317) seems, at best, tenuous.

Firstly, they concede their heavy reliance on the inherently hazardous validity of drug arrest rates (ibid: 337). They also neglect to mention the government's War on Drugs, the exponential increase in drug-related arrests and how these factors could potentially skew the results.

Secondly, their underlying presumption is greatly influenced by pharmacology. Crack users, having 'binged' away their money for the "incessant satisfaction" or, alternatively, insatiable desire, of crack become "[d]esperate to generate cash by any means necessary" (ibid: 318). This view is suggestive of the notion that crack leads to "instantaneous addiction". Yet, this is a dubious assumption when one considers the lack of scientific support as well as the sociological evidence. Most people who try crack do not continue to use it, let alone become addicted to it (Reinarman & Levine, 1995a: 3). While Baumer et al consistently refer to "use" and "user" (scrupulously avoiding any reference to "abuse", "addiction" or "addicts"), they do not narrow these terms. To them, mere use - casual, habitual or otherwise - at least partly prompts the divergent trends in burglary and robbery.

Their explanation for users' resort to robbery also appears to be a bit dubious. Night robberies best correspond with the night-time/early morning prevalence of crack use and are an expedient to quick cash. Cash itself is preferable to the overabundant, ill-gotten booty of burglary in crack prevalent neighbourhoods, the glut of household goods apparently due to the desperation of crack users (Baumer et al, 1998: 318).

The study prompts more questions than it actually addresses. If crack users are so desperate, then surely their first act upon securing more cash would be to score more crack, regardless of the time of day. Under such circumstances of pharmacological compulsion, one would expect that crack addicts would follow a more intermittent pattern of consumption/crime rather than one that is largely confined to night and early morning.

The assertion that the effects of crack somehow compel people to crime also flies in the face of research that demonstrates that a majority of users felt no craving after using it (Cheung & Erickson, 1995: 186). If this fact was attributable to sociodemographics,[18] then this avenue was completely overlooked in the study by Baumer et al.

Such issues as the pre-crack criminal and drug histories of addicts are also unexplored.[19] To assert that a relatively small number of crack users[20] - as opposed to an even smaller number of abusers - are responsible for inverting basic national (though apparently not without deviation) trends in crime requires a fairly drastic leap of faith.

The study does demonstrate one certainty: the precarious, even misleading, nature of using simple prevalence rates to explain far more complex situations. One could almost believe that the authors fell victim to the media hype and moral crusading that surrounded crack.

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[18]Cheung and Erickson note (1995: 186-87) that their study was done in the context of powder cocaine users where crack was used additionally and not alternatively.

[19]To be fair, Baumer et al state that they "are at a loss" as to other possible factors in these robbery and burglary trends and call for others to undertake related research (1998: 338).

[20]Reinarman and Levine note that, contrary to popular misconception, crack was never widely used in the United States or elsewhere (1995a: 3).

b) Cracked Politics in the United States

When President George Bush held up a bag of 'rock' on national television in 1989 and claimed that it was seized in Lafayette Park across the street from the White House (Reinarman & Levine, 1995b: 22-23), he conveyed a message far greater than he actually intended. Demonstrating what he claimed was the insidious presence of crack, in fact, he exemplified a moral entrepreneurial spirit with the full might of Leviathan behind him. With the willing participation of the media, techniques of distortion were used to demonise crack and their users (an easy task considering that crack smokers are largely comprised of the most disadvantaged urban populations in the United States), and constructed a reality that suited his own purposes (ibid: 23).

By that point, Bush's administration stood to gain or lose a great deal with this "reality". He necessarily had to convince the American public that this pervasiveness not only existed but posed a threat to his constituency, middle and upper class voters in the United States. No matter that the crack dealer in question had to be lured from a poor African American area to Lafayette Park since the drug could not be obtained anywhere near the White House (ibid: 22). Telling, at best, a contrived tale (and, at worst, a barefaced lie) was merely a means justified by the War on Drugs.

One could hardly imagine a drug policy more vindictive and, ultimately, ineffective. Beginning with the end of alcohol prohibition, it has been waged over the last 80 years (Smith, 1988: 5). However, marshalled by Nancy Reagan's Just Say No campaign beginning in 1983, the War became a more refined effort at linking drug issues to political expediency (Reinarman &

Levine, 1995b:38).[21] The promotion of "traditional family values"[22] and the well-timed hysteria about crack, the "chemical bogeyman", made the perfect scapegoat for the genuine problems that beset the country (ibid). Crack, users and traffickers were easy targets for a moralistic assault by an absolutist political movement that, together with the media, demonstrated little understanding or regard for the real underlying problems of drug use (Welch, 1997: 51).

As Nadelmann points out, American drug policy has preferred "rhetoric to reality, and moralism to pragmatism" and the War on Drugs "has made matters worse, not better" (1998: 111). Driven by "prohibitionist economics and morals indifferent to the human consequences of the drug war", the federal budget regarding drug matters grew from $1 billion (1980 - the year that Reagan took power) to $16 billion (1997), the vast majority of funds being directed at reducing the supply of illegal drugs (ibid).

Prohibition combined with punitiveness has stretched the justice and corrections systems to their respective limits and resulted in immeasurable human costs. In 1980, the total number of people incarcerated for drug offences in the United States was about 50, 000. In 1997, the number had octupled to about 400, 000 (Nadelmann, 1998: 112). Not only have numbers increased but tougher sentences as well as mandatory minimum penalties mean that the average length of incarceration has also increased; over 15% of these prisoners in 1995 were non-violent drug offenders with no criminal history (ibid).

Perhaps these policies would be more palatable had they achieved some arguably positive results - or at least part of their objectives. Yet, apart from imprisoning a significantly greater number of people and increasing the number of convictions, these policies have had little positive

[21]The authors, quoting a report in Time magazine state that the image-conscious Ms. Reagan needed a vehicle to make her appear "more caring and less frivolous" (1995: 38).

impact (Nadelmann, 1992b: 21) except possibly for traffickers who are able to rake in higher prices for their products (ibid: 22). As adults were being incarcerated in increasing numbers and for longer periods, children were recruited to perform local drug vending duties, another unintended but negative consequence for which the prohibitionist policies and youth justice system were unprepared (Nadelmann, 1992a: 307).

The one "success" that prohibition can claim has boomeranged to exacerbate the situation. By concentrating on the supply-side, American authorities have lessened the flow of marijuana from abroad. However, many traffickers have converted to more compact and valuable, and less detectable drugs such as cocaine. At the same time, fine homegrown is now abundantly available on the streets of the United States (ibid: 300).

While use has levelled off, crack's "set and setting" are the inner-city poor whose reality is formed by poverty, racism and other related factors (ibid: 12). Its easy "neighbourhood-based" production and distribution (Reinarman & Levine, 1995a: 2) combined with the largely unaffected supply of raw materials helped crack to proliferate. The marginalised lifestyle is often at odds with a policy of drug war as well as the moral implications stemming from it. Government authority carries far less weight in areas where, in lieu of constructive social policy that addresses local problems, "antidespondents" such as crack help one cope with the stresses of life (ibid: 13). As Smith notes, the War on Drugs is based on "the myth that human behaviour can be changed by legislation" (1988: 5).

Further marginalisation becomes obvious. Nadelmann refers to "labeling" the tens of millions of illicit drug users as one of the most difficult costs to assess is:

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[22]Discipline, asceticism and retribution for those who stray (Reinarman & Levine, 1995b: 88).

"the cynicism that such laws generate toward other laws and the law in general; and the sense of hostility and suspicion that many otherwise law-abiding individuals feel toward law enforcement officials" (1992a: 307).

Nadelmann and other writers make a strong pluralist case for 'alternative' morality, one that may include decriminalisation of currently illegal drugs. This morality is also inclusive of the same societal elements victimised by absolutism, an (re)integrative feature with which most harm reductionists would agree.

For example, Nadelmann notes what to many is the obvious hypocrisy in criminalising some drugs and yet maintaining the legality of alcohol and tobacco. Yet, the latter two substances "are responsible for many times more social and health costs than all illicit drugs combined" (1995: 309). This fact is reflective of previous drug wars and find its root in the accompanying moral prejudice of such campaigns (ibid). He notes that punishing people for behaviour that does little or no harm to anyone else or themselves (a working definition for "victimless crime), and "rationalizing the justice" of these punishments may be the greatest harm of prohibition (ibid: 310).

Noting similar hypocrisy, one writer recalls a story at an international conference where the Scottish minister for health, a notorious tobacco addict, was asserting that the United Kingdom's coca eradication efforts in Colombia were actually contributing to development. He was then asked by another delegate how the United Kingdom would feel at a Saudi Arabian offer to bomb whiskey distilleries in Scotland (Slavin, 1995: 36).

This writer, a Catholic priest,[23] maintains that:

[23]In the tradition of other Catholic priests and nuns known as Marxist liberation theologists who performed valuable activist work with people who opposed repressive governments in Central and South America during the 1970's and 1980's.

> "If this is to prove a really Catholic conference we should insist on a healthy theology of the drugs part of creation as something good in itself" (ibid: 38).

Slavin gently criticises the Vatican's punitive mentality towards drugs even when alcohol is used in its "most sacred rite". Abuse is the problem and, especially among the poor, efforts must be made to prevent it. Religion, he believes, would assist in this respect although it is not compatible with drug *dependence*. He also calls for chaplains not only to care for "prisoners and the wounded" but also to coordinate information and efforts (ibid).

c) War and Social Injustice

Crack in the United States is largely consumed by a segment of society that is also underrepresented politically. Tying an easily demonised substance - crack - to a "troubling subordinate group" (Reinarman & Levine, 1995a: 2) such as African Americans and Hispanics who populate the inner-cities in great numbers (Welch, 1997: 45) seemingly poses little problem. Not only issues of race arise but also of class. Welch notes that the War on Drugs "is also structured around "biases" since most incarcerated drug offenders are also from "lower classes" (ibid).

Lurid politics succeeded in its self-fulfilling prophecy: the more you look, the more you find. During the height of the War on Drugs in the mid-1980's, crack was specifically targeted by the then-mayor of New York City, Ed Koch, and Harlem congressman Charles Rangel who also mobilised the police, media and other agencies. As more crack offenders were arrested, they were also treated noticeably more harshly by the justice system. There is some evidence that this differential treatment was at least partly the result of political pressure (Reinarman & Levine, 1995b: 47, note 4). This bias is

evident in draconian legislation that provides a mandatory five year federal sentence for possession of five grams of crack as opposed to the 500 grams of powder cocaine that are required to incur a similar penalty. While the American Sentencing Commission found no pharmacological differences between the two substances, they reported that 27% of powder cocaine defendants but 88% of crack defendants were African American. African Americans convicted of drug offences composed 91% of the increase in prisoners in federal institutions (Lindesmith Center, 1996: 2).

d) Making Peace with Drugs

Considering the "hyperbole epidemic" that accompanied the War on Drugs (Reinarman & Levine, 1995b: 21), one could easily form the impression that prohibition is the *only* policy. Yet, this is obviously not the case.

Until the early 1970's, Dutch and American drug policy were of the same prohibitory nature. However, having learned a few lessons from the social upheaval of the 1960's, government attitudes to, not just drugs, but also abortion, prostitution and homosexuality changed (Bullington, 1995: 219). On these and other issues, the Dutch government developed a "pragmatic, rational and dispassionate approach" (ibid).

Though the term "harm reduction" had not yet been coined, the new Dutch policy that amended the previously prohibitory act was based on its principles. The founding belief was that eliminating illegal drug use was not a practical goal even if a 'drug-free' society were desirable. Drugs were decriminalised - not legalised - and the bifurcation between "hard" and "soft" drugs was maintained in an effort to separate the two groups (ibid: 221). While this division may not concord with a unitary view of psychoactive substances, Dutch authorities claim some success in that fewer

youths there are experimenting with cocaine (Nadelmann, 1998: 123). The objective and amoral information programs (Bullington, 1995: 235) helped to inform these choices.

The government's responsibility was reassessed as one that would minimise the damage of drug use, even if criminal prosecutions had to be dropped in favour of providing assistance to the user (ibid: 220-21). The possession of a small amount of drugs (hard or soft)[24] and the sale of minor quantities of cannabis in coffee shops, while still technically illegal,[25] would not be prosecuted (ibid: 221-222).

Thus, the conscious choice was made to no longer label and ban young drug users and to impose sanctions only when drug-related crimes or large scale trafficking were committed (ibid: 222). Recognising that users of hard drugs should not be driven away but integrated as much as possible, cocaine and heroin along with hygienic equipment are provided through government clinics and treatment is readily available (Heath, 1998: 151).

Perhaps the most serious criticism is that harm reduction's neutrality and pragmatism actually promotes drug use. Yet, the Dutch experience speaks against - or at least does not confirm - this view. Cannabis consumption initially ebbed after its decriminalisation in the mid-1970's; although some figures show a gradual increase since then, the statistics are still well below their counterparts in the United States (Nadelmann, 1995: 304). There is also much to be said about creating an informed and responsible environment for the inevitable experimentation by youth, a situation that can easily tolerate higher rates of prevalence. In the end, the Dutch government appears to have succeeded in their goal of making drug use "boring" (ibid).

The Netherlands has taken control by eschewing punitiveness for constructive intervention. Effective outreach programs directed at elusive users have established contact with at least 70% of

[24]In the case of soft drugs (marijuana and hashish), the limit would be 30 grams.

[25]Through this technicality, the Dutch government maintained its international commitments (Bullington, 1995: 223).

addicts; in the United States, the percentage is thought to be about 15%. By "normalizing" drug use as a health matter and maintaining standards of purity and hygienic use, serious diseases such as HIV infection[26] and hepatitis B have been effectively controlled even among high risk users (Bullington, 1995: 225). The number of deaths resulting from overdoses, harm emanating from adulterants used to 'cut' drugs, and other consequences of hard drug use in a criminalised setting have been reduced and stabilised in the Netherlands (Duke & Gross, 1993: 304; Nadelmann, 1995: 298).

The Dutch have no monopoly on harm reduction policies. More geographically confined programs in other countries have also met with a great deal of success. Harm reduction policies of needle exchanges, prescribed drugs and providing first-time possession offenders with information about health and treatment instead of arrest have been introduced in Liverpool and Edinburgh. As a result, the rate of HIV infections among intravenous drug users has declined dramatically. Drug-related crime, as in the Netherlands, has also been reduced. Perhaps most importantly (since it tends to underlie all these positive effects), users are reintegrated so that they "are able to lead useful, productive lives" (Heath, 1993: 304; Bullington, 1995: 234).

These programs are not without their failings. In the Netherlands, for example, Surinamese and Moluccans are a disproportionately large component of the addict population. Yet, they have also been reticent in participating in government sponsored programs and, thus, pose future challenges for outreach programs (Bullington, 1995: 234).

Along with the above places, Australia has also introduced similar harm reduction policies. Rational and informed debates not driven by moral entrepreneurs or "prohibitionist ideologues" resulted in a high level of awareness and understanding of the health and social issues of drug use with

[26]As of 1993, about 8% of AIDS patients in the Netherlands were intravenous drug users. This figure compares to about 26% in the United States (Duke & Gross, 1993: 304).

alcohol receiving due attention (Mugford, 1995: 203).

Although superficially similar to American cities, the difference in Australian urban structures gives a radically different context for drug use. Unlike the United States, Australia is a more efficient welfare state with different racial dynamics and no comparable economic underclass. This set and setting, combined with objective policies of pragmatism, means that there is virtually no demand for crack in Australia (ibid: 205).

Nonetheless, those who advocate continuing on the same path in the United States seem intent on disregarding experiences domestically and abroad. Characterising sociological factors as merely "blaming society for drug use" or "[s]ocial rules are for other people, not for them [drug users]" is symptomatic of moralistic thickheadedness that precludes discourse at any deeper level (Tully & Bennett, 1992: 66).[27] At least writers like Wilson (1992) have no illusions that the quest for eradication is a moral one. Another tendency is to distil the issues down to a narrow legalistic one of competing rights between the individual and the community (ibid: 67). In fact, their *interrelationship* is a complex one that cannot be simply separated from other key elements. Some would even claim that the analogous alcohol prohibition was a "success" because it allegedly reduced prevalence (Moore, 1992: 95).[28] Unfortunately, the author omits to mention that the greatest damage caused during this period was not prevalence of alcohol use but the opportunity provided for organised crime to establish their Black Market operations, a situation that is indeed comparable to modern-day American drug policy (Heath, 1998: 142).

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[27]I take *extreme* umbrage at the authors' assertion that "American and Canadian societies have a long history of taking appropriate measures to protect people from their own unwise actions" (1992: 66). They omit to mention gun laws, crime rates and social welfare policies, factors that place Canadian attitudes considerably closer to those in the United Kingdom or Australia. If Canadians really need to be protected from themselves, as they assert, then they will do it in a manner that is not automatically transferable to the American experience.

[28]Matza, among others, disagrees with the assertion that prohibition succeeded in reducing alcohol consumption. It merely redirected trends away from beer and towards the home production of wine and spirits (1969: 154).

Harm reduction policies have proven that they can exist in this environment of animosity with needle exchange programs established in "pockets" of the United States, particularly in New Haven, Connecticut (Duke & Gross, 1993: 305). After overcoming political and legal obstacles, clearly demarcating their health objectives, some myths were then dispelled about intravenous (IV) drug use. Firstly, the IV subculture had been either misunderstood or misrepresented when it was wrongly believed that needle sharing was an unassailable rite - the evidence demonstrates otherwise. Secondly, in confirmation of the results of similar programs, this policy did not encourage use. Most importantly, the program appears to have succeeded in reducing HIV infection among IV drug users, its goal from the outset (ibid).

8. Harm Reduction and Prison Treatment

a) Treatment during incarceration

One might wonder why treatment is necessary at all in prison. Notions of idealism, principle and the sterile conception of a prison atmosphere would dictate that such contraband would be difficult, if not impossible, to obtain. Under these circumstances, a substance abuser would simply undergo a de facto[it.] "cold turkey" program.[29] The realities of illegal drug availability and abuse in prison are radically different. Gangs, constant user company, senses of displacement, survival and other stress factors, are circumstances that make prisons the ideal breeding ground for drug use and abuse (PSJ, 1995: 1). This same environment leads to a higher risk of addiction after entering prison (Uchtenhagen, 1997: 56; Walker, 1995: 35). These inmates

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29Tamlyn & Billings (1995: 29) note anecdotal evidence that many medical and disciplinary staff still believe that withdrawal without an accompanying medical program is the best method.

pose a particular problem because, in treating the prisoner's habit, staff must also recognise the ready availability of drugs (Tamlyn & Billings, 1995: 29).

The Black Market in drugs thrives, perhaps even more so inside than out, regardless of the strategies adopted by the prison service (ibid: 28) and provides ample room for problems such as corruption and debt. In Britain, these factors have led to goods or money being coerced on the inside from family members on the outside (ibid). Violence is inherent at all levels. Both prisoners and staff agree that illegal substances (in this instance, including alcohol) are a significant contributing factor (Bond, 1995: 34).

Thus, whatever the causal relationships of drugs and crime, their combination is a volatile one, whether in or outside prison. Paradoxically, prisons (under a controlled setting) are also ideal opportunities to provide treatment, partly because of this high concentration of drug offenders (Mahon, 1997: 1), and especially since many prisoners reassess their drug habits after being (re)incarcerated (Tamlyn & Billings, 1995: 28). Time is one of the few resources that is in abundance and, perhaps for the first time in their lives, prisoners may begin to understand the cycle of habitual drug use (Inciardi et al, 1994: 34).

i) Therapeutic Communities

Prison Therapeutic Communities (TC's) appear to have a rather large advantage over their community counterparts. TC's are usually seen as being a favourable lifestyle to the general prison population and therefore do not suffer the high drop out rates of the latter (Lipton, 1998: 25).[30]

The two best reasons for providing drug treatment to the over-demand of prisoners are

[30]Program effectiveness in the community was confined to those relatively few people who stayed within the TC for more than three months (Lipton, 1998: 25).

i) Conventional criminal sanctions do not work to reduce recidivism among drug offenders;

ii) Treatment *does* work in reducing the recidivism of drug offenders, in prison and out (Falkin et al., 1994: 31-32).

The authors cite a number of studies in support of these two assertions. As well as diminishing the chances of rearrest, treatment during incarceration offers evidence that an offender will spend longer periods in the community between arrest, and remain incarcerated for less time if rearrested (Peters et al., 1993: 32; Torres, 1996: 29). Significantly, initial indications are that "very high risk"[31] offenders prone to violence may be effectively treated under these programs (Lipton, 1998: 39).

Not only are extensive prison treatment programs promising for reducing crime "on the outside", they also present an opportunity for enhanced security during incarceration. Dramatic reductions have been shown in the number of offences committed and their associated violence in American prisons (Lipton, 1998:3) as well as British ones (Bond, 1995: 34). Less "bullying", a higher standard of prisoner work and, perhaps most significantly, a higher quality of life for both prisoners and staff are all positive spin-off effects (ibid).

Although largely a separate issue, substance abuse among prison staff is strongly related to their work environment and remains a serious problem. There are a number of innately stressful elements of corrections work (for example, shiftwork and lack of support from management or

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for more than three months (Lipton, 1998: 25).

[31]That is, "chronic" users with a predatory criminal history.

the public) that are exacerbated by a tense work atmosphere (Stock & Skultety, 1994: 66). Any relief under these conditions provided by treatment to prisoners would no doubt be welcome by staff.

American public attitudes are not commonly associated with charity towards criminal offenders. Yet, there is strong reason to believe that a majority would favour drug treatment if it led to a reduction of crime and greater safety in the community (Corrections Today, 1994: 154).

One must also consider the persuasive power of cost-effectiveness (Knight et al, 1997: 98). Even the most expensive programs have returned more than their costs in terms of "crime, health care and lost productivity"; Aids was not even a substantial factor in the calculation of these savings (Duke & Gross, 1993: 297). One could therefore surmise that effective treatment, whether in the community or in prison, would serve public interests as well as popular desires better than strictly punitive policies.

b) Harm Reduction and Therapeutic Communities

TC's are communities in the true sense, places where a new "culture" of "resocialization, behavioural modification and training in self-discipline and self-awareness" is created; substance abusers live in this environment for nine to fifteen months (Duke & Gross, 1993: 294). The piecemeal development of treatment in prison means that institutions have often implemented markedly different approaches. In Britain, for example, Swaleside prison has evolved a cognitive therapy approach (Walker, 1995: 35) as opposed to Downview prison which uses both disease-oriented treatment such as AA and NA as well as certain cognitive, behavioural and emotional

therapies (Bond, 1995: 32-33).[32] Both programs are oriented towards abstinence although, at least at Downview (where the benefits of "clean living" are strongly promoted), no punishment is meted out to prisoners who fail drug tests (ibid: 34).[33]

An attitude more reflective of harm reduction is found in the PSJ Commentary which recommends education "and not a moral crusade" and speaks of "minimising health risk[s]" (1995: 2). It warns against the inherently punitive nature of urine testing as being confrontational".[34] It also states that without needle exchanges and condom distribution, any attempts at rehabilitation and education will be for naught (ibid).

In fact, the length of time in treatment (as with outpatient programs) is the best indicator for success, with recidivism strongly inversely related duration (Lipton, 1998: 28). This finding partly explains why, in community TC's, court-ordered clients had a better prospect for success than volunteers (ibid: 25). Because of its scarcity and cost, treatment is largely directed at polydrug users with "serious criminal behavioural problems or major adaptational impairments" (ibid).[35] TC's lay at the abstinence end of the harm reduction continuum. They are the final stage towards total non-use of drugs for offenders who have demonstrated an inability or unwillingness

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[32]Behavioural therapy breeds "positive conduct by teaching individuals not to accept their own anti-social actions"; behavioural expectations are made clear from the start.

Cognitive methods, individually or in groups, assists residents in seeing errors in their thought processes. Thinking patterns are examined to evolve better decision-making capabilities.

Emotional therapy deals with unresolved issues regarding interactions with other people. It may involve techniques of transactional analysis (assessing the person's role during interactions) and psychodrama (exploring emotions and thoughts that inhibit coping skills) (Inciardi et al, 1994: 36).

A fascinating example of psychodrama role-playing is contained in "Junkie Script" (Gregory, R., 1995, Journal of Offender Rehabilitation 22:157-161). Developed by imprisoned female addicts, it demonstrated the characters (for example, prostitutes, pimps, johns and family), emotional interactions, lifestyle and social contexts of a female heroin substance abuser.

[33]They are "regress[ed] within the differential regime" and have additional privileges denied (Bond, 1995: 34).

[34]Contrarily, one prison officer notes the bonding that occurs between prisoner and guard during "delivery" of the sample. He asserts that their mutual embarrassment reflects the commitment by both parties to the treatment process (Bond, 1995:34).

[35]Combined with some form of aftercare where it is available.

(especially in view of their criminal histories) to moderate their use (ibid: 292). Unlike the neutrality of harm reduction towards drug use, the use of all psychoactive substances is usually prohibited in a TC and urinalysis is normally used as enforcement.

Occupational as well as psychotherapy may be used and, after detoxification, treatment therapies are generally the same for all TC members (ibid). The consistency of TC results indicates that these programs are "stable and replicable" despite the differences in the type of client, staff and settings (Lipton, 1998: 20).

Harm reduction policies can form the "intermediate" step, the link between general prison populations and the rigors of the TC (Rotgers, 1998: 113). In recognising that drug use and abuse is a seeming inevitability of prison life, harm reduction has been used particularly to address the spread of HIV/AIDS through less damaging intravenous drug use (Rotgers, 1998; Nelles, 1997). By respecting an individual's state of readiness and the continuum of change, harm reduction can also provide the catalyst for prisoners to seek further treatment when better prepared (Rotgers, 1998: 112) and thus represent a diminished chance of failure in the TC.

Mahon notes that, even though most high-risk users are incarcerated at some point, the development and implementation of harm reduction policies in prison have not kept pace with those outside (1997: 1-2). Divergent approaches to criminal justice mean that research is first necessary to establish a "culturally and politically informed approach" although existing programs for prisoners offer adaptable models (ibid: 2). She concludes that this slack in implementation must be tightened up so that prisoners necessarily become a focus of harm reduction (ibid).

In prison, harm reduction must strike a fine balance between pragmatism, objectivity and any activist inclinations. Nelles remarks that the implementation of harm reduction policies in

prison vary, depending greatly on the people involved (1997: 3). Nevertheless, legal prohibition must be strictly adhered to, even when it increases high-risk behaviour (Nelles, 1997: 2). Practical and sensitive responses that meet political opposition[36] are absolutely essential in ensuring that harm reduction policies in prison are implemented (ibid). Prohibition (where it exists) must be respected to avoid misinterpretations of harm reduction's goals (ibid) and activism left for debates outside prison walls.

Contrarily, harm reduction's general philosophy of incremental change means that the user cannot be "pushed artificially through the stages" (Rotgers, 1998: 112).[37] Even when duration of treatment can be assured, failure is often the result of improperly matching program components to the individual's level of change (ibid). Contextual improvements (such as providing bleach and syringe cleaning kits) may overlap with cognitive methods (health workers engaging users in a dialogue while distributing materials) but they do not prematurely force users into reducing or stopping their drug intake (ibid). Under the right circumstances, the availability of contextual programs may lead users themselves to initiate further treatment (ibid).

Success should not only be measured in terms of completion of the TC program and/or simple non-recidivism. A harm reduction approach recognises that many drug-using offenders will not be appropriate for TC's, whether for their ability to maintain a non-abusive drug lifestyle, their inappropriateness based on TC admission criteria[38] or other reasons. As with programs outside prison, diminishing the damage of use or abuse is sought. Thus, in terms of criminality,

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[36]One wonders what issue could be more easily manipulated politically than an already demonised group of drug using criminal offenders.

[37]Rotgers notes that there are generally five stages of cognitive and behavioural change before significant reduction or abstention is achieved.

[38]For example, criteria for admission to the Amity Prison TC in California require: a history of drug abuse; demonstrated positive participation during incarceration (or at least no negative prison record involving violence, weapons and sex offences over the preceding five years); no record of child sexual abuse or mental illness

greater periods between recidivism and the degree of offence (particularly the (non)factor of violence) are equally important in measuring the reduction of harm.

If prison drug use is indeed inevitable (Tamlyn & Billings, 1995: 28), especially when risk in prison is measured partly in terms of sharing syringes, abusing prescribed drugs and unprotected sex during "situational homosexuality" (ibid: 31). It must be linked to a number of other contextual and behavioural improvements that lead to results such as a better quality of life for prisoners and staff (Lipton, 1998: 12).

c) Implications beyond Prison

In-prison treatment should not be considered a "panacea" for the complex problems posed by drug using offenders. Many people, especially those offenders whose criminal history predates their drug abuse, can be expected to have further problems with the law. Even with post-release treatment in the community, the fall from abstinence is always near (Peters et al, 1993: 36). Positive effects through in-prison treatment can be achieved considerably more thoroughly than just through the promotion of abstinence.

(Lipton, 1998: 16).

III. SOUTH AFRICA

1. Current Situation

Drugs and crime are co-variants that must first be contextualised. In the southern African region, some general factors that impact on this relationship are: poverty; social injustice in terms of demographics and quality of life; "dislocation" caused by migrant labour; and political tension (Simon, 1998:1). One might add the criminal justice system to this list.

As opposed to the rest of the sub-continent, South Africa is considerably more urbanised and populated. Its infrastructure and economy are also more developed (ibid). However, the long-term consequences of apartheid aggravated the poverty and inequality (ibid). South Africa is no longer able to shield itself behind policies of protectionism and the illegitimate security mechanisms of apartheid. The turbulence of democratic transition has been accompanied by unmet domestic problems as the nation attempts to wobble to its feet socially and economically (NCPS, 1995: 2). In the meantime, it has become a favourite conduit for international drug trafficking because of its porous borders and entry points (Simon, 1998: 2).

Expectations for material improvement domestically have also been unmet and led to a particular South African anomie. Differential access to resources such as education and the lack of opportunity for economic gain have largely been unaffected by political change (Simon, 1998: 6; NCPS, 1998: 4). Because of apartheid, disparate access cleaves along racial lines with opportunities for generating income particularly scarce for "the majority of South Africa's historically disadvantaged black population" (Kibble: 5). Crime has often been justified on the basis of these frustrations (NCPS, 1998: 4).

The government regards crime prevention as a "national priority" (ibid). However, current policy regarding drugs has been described as "fragmented and ad hoc" (Kibble: 2). The government has

recently addressed the issue of substance use more specifically with the proposal for a National Drug Master Plan (NDMP).

2. Drug Use and Trade

Marijuana, *dagga*, is widely cultivated (currently estimated at 80,000 hectares) and consumed in southern Africa for recreational, religious and medicinal uses (Kibble: 6).[1] Enforcement of laws against dagga has traditionally been lax, especially against the possessor and small-dealer level. This fact is attributable to factors such as a lack of resources and a concentration of attention higher up the distribution chain (Kibble: 6). As elsewhere, dagga is consumed at virtually all levels of society and is popularly considered to be harmless (ibid). This perception may also unofficially influence enforcement, especially at the local level where government agencies are in closer proximity to the community. Nevertheless, disparate enforcement can easily be a means to discrimination or corruption, and has broader negative implications regarding laws against dagga and laws generally.

Dagga's widespread cultivation, especially in the Eastern Cape and KwaZulu-Natal, can partly be explained by tradition, a suitable climate,[2] and the lack of other meaningful income opportunities (ibid). Whole communities participate in and are economically dependent on this production. Crops are grown secretly and spotty eradication efforts[3] are usually met with immediate replanting (ibid). This persistence is easily understood when one considers that a single hectare may yield 2,100 kilograms of dagga (SAIIA: 138) and may bring in upwards of R8000 per ton (Kibble: 6). These same communities also depend on remittances from migrant workers (Simon, 1998: 4), an increasingly

[1]Here must be made special mention of latter-day Rastafarians, their holy ritual of smoking dagga, and their small but growing part of township life.

[2]Often offering three harvests a year (Kibble: 6).

precarious reliance in view of the current economic climate and, for example, the recent retrenchments in the mining industry.

Mandrax has, for many years, ranked second on the list of choices for illicit drugs in South Africa. While its position may soon be displaced by drugs new to the country (particularly crack), its use is still widespread, especially in the Western Cape. Manufacture of the drug has been established locally (including Mozambique and Zambia) since its production in India was banned in 1994 (ibid: 7).

Like elsewhere, the "massive abuse" of alcohol in South Africa is indisputably the most damaging form of overconsumption (Kibble: 15). This assertion is supported by Simon (1998: 2) who notes that health professionals in South Africa have stated that alcohol (along with tobacco and the growing abuse of prescription drugs), "create a far more widespread and costly problem to the health of the population at large and to the economy".

While information is scant both in quantity and reliability (a universal reality concerning drug use in South Africa), available statistics from drug abuse treatment agencies confirm that alcohol is overwhelmingly the substance most abused (SACENDU, 1998). The per capita intake of alcohol and tobacco in South Africa already ranks among the highest in the world (Abrahamson & Boyd, 1998: 57) and immoderation in their use should be a huge cause of concern in itself (ibid; Nadelmann, 1992: 306).[4]

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[3]SANAB states that this fact is not reflective of a softer attitude towards dagga but a lack of means (SAIIA: 138).

[4]"Alcohol is not only implicated in antisocial behaviour more than any other drug, but it is "generally the drug most

3. "New" Drugs and Increasing Use

a) Crack

Most indications are that crack is becoming a growing issue in South Africa's urban centres (SAIIA: 139; Kibble: 7; SACENDU, 1998: 79). This trend may be due to various factors but likely not some of those listed by the SAIIA.

As mentioned above, crack is a drug whose setting is usually moulded by poverty, racism and other human troubles inherent in disadvantaged places (Reinarman & Levine, 1995: 12-13). With little to lose and a smaller stake in conventional society, crack users appreciate the euphoric but "brutally brief rush" (ibid: 19). The South African inclination to smoke drugs also must be noted (Kibble: 7). More affordable and less subtle than powder cocaine, it is better suited to the retreatist goal of "escaping misery" (ibid: 5). It is also an ideal means to earn an income - especially in view of the possible profit margins (SAIIA: 140).[5] Combined with the fact that abusers typically have fewer means to cope with drug problems, crack spells real trouble if the situation is permitted to degenerate.

Yet, as serious as these concerns are, pharmacological "scare tactics", especially if they become integrated into education programs, can only exacerbate the situation. Labelling crack as "highly addictive" and linking its effects with possible (but unproven) violent behaviour (SAIIA: 139-140) without mention of "set and setting" only reinforces stereotypical views of the drug and its users.[6] The report also neglects to mention that the overwhelming amount of violence associated with crack (or any other drug) is not due to pharmacology but to trafficking (Johnson et al, 1995: 282; Harrison et al,

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often linked with serious crime"" (Goldman, 1991: 167).

[5]Estimated to be anywhere from 100% to upwards of 200% (SAIIA: 140).

[6]These terms are used rather recklessly and no references are provided. Perhaps the author was watching the Take 5 youth television show on June 23, 1999. A SANAB officer, a panel member during a discussion about drug abuse, somberly noted, "You can have a drink of alcohol once a night for five years and not become addicted but if you smoke crack twice, you'll become addicted." He did not indicate whether this rather incredible addictive property applied only to the police or, contrarily, the population of the real world.

1992: 423).

Kibble[7] (p. 8) also falls prey to a less direct crack/violence association. A "self-reinforcing cycle of violent behaviour associated with crack, gangs and crime" (ibid) is exactly what has *not* been substantiated in the United States. Although there was a commensurate involvement of gang members in the growing trade, their link was "principally an issue of use" (Klein et al, 1991: 623). While gang and drug problems often did meet, distribution of crack was still in the hands of regular drug dealers, not the gangs themselves (ibid: 647). Violence, as usual, should be largely attributed to the trade rather than effects.

b) Heroin

Although most heroin that enters the country illegally is in transit to Europe or North America, there is a small but growing market in South Africa (SAIIA: 140; Kibble: 8). While one source believes that its use is tied largely to intravenous injection and thus raises concerns about increased HIV infection (SAIIA: 140-41), Kibble (p. 7) states that heroin consumed here, in line with other drug use, is smoked and not usually injected. While prevalence appears to be rising, the current price of heroin (anywhere from R100-300 per gram. SACENDU, 1998: 51) make it unaffordable for all bu the more upmarket drug consumers (Simon, 1998: 7).

The SAIIA document has factual information of interest but its analysis and propositions are hackneyed and superficial. At times, it even tends towards the hysterical. For example, if heroin really "stands frighteningly apart from other drugs in terms of its more seriously addictive qualities" (p. 141), then how does its addictive liability compare with the already "highly addictive" crack? And nicotine?

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[7]Despite a more insightful and balanced attitude.

Perhaps the author is one of the many who:

> "have surely overestimated the seductive powers of heroin. We have also given it more credit for pleasure than it deserves" (Goldman, 1991: 161).

One of my law school colleagues also happened to be a regular heroin and methadone user, a fact I only learned after knowing her for two years. She told me that a person had to work at being a heroin addict. A good deal of evidence backs her up and indicates a year or more duration before addiction begins (ibid).

Another of the SAIIA's muddled discussions concerns addiction founded on the following "research" (endnote 12, p. 171):

> "This is a personal opinion based on discussions and experiences in dealing with drug users, who frequented a place of entertainment."

One wonders if these were the same types of bars where Howard Becker hung out. There is little value dwelling on the many other baseless or misinformed assumptions. The report merges a wholesale adoption of the medical model (with blind acceptance of the notions of pathology and pharmacological determinism) with a badly articulated moralism which implies that, not only can drug use be eradicated, it must be eradicated.

"Drug abuse and crime are what we choose to make them" (Goldman, 1991: 155). They are behaviours that are influenced by criminal justice systems, the media, politics, social, psychological, physiological and pharmacological factors (ibid). Unfortunately, the SAIIA report tends to consider only the latter two elements in its analysis.

c) Other Drugs

There are a host of other substances that, although largely inconsequential in terms of prevalence, may gain further in popularity. They include MDMA (Ecstasy), amphetamines, LSD, solvent inhalation, and over-the-counter and prescription medication. In terms of the first three substances, they appear to be largely 'niche' drugs that are used primarily in the club scene (SACENDU, 1998: 71). RaveSafe notes that the problem is not prevalence but quality control (ibid); interestingly, they have noted a decrease in "bad trips" that *prima facie* affirms a system of informal guidance and education within the subculture.

Perhaps an area whose future impact may be underestimated is that of over-the-counter and prescription medicines (Simon, 1998: 2). The easily availability of, for example, Grandpa headache powders in combination with Coca-cola needs to be investigated, if only to establish some basic demographics. Solvent sniffing is already worrisome because of its association with children in poor urban areas or, even more problematically, streetchildren (ibid).

Finally, alcohol and drug abuse cannot, for practical purposes, be separated from one another. Yet, one can presume that legal substances such as alcohol, pharmaceuticals and solvents (and tobacco) still cause far more damage than all illicit drugs combined. The essential problem is that the growing drug trade in other substances - crack and heroin, for example - has the potential to become much more influential in ways that, at this point, are almost unforeseen and not well understood. In a place like South Africa - where factors such as poverty, disillusionment, existing crime and race and class divisions make the perfect manure bed for the seedlings of substance abuse - there could indeed be a problem.

4. South African Policy

a) The NDMP[8] - Cavalry Charge Without the Horses

The NDMP has barely made its opening statement before its intentions are betrayed. Quoting former president Mandela no less (p. 3), it states that "alcohol and drug abuse are social pathologies that need to be combatted". Largely confirmed by confrontational attitudes throughout the document, the broad implications of this phrase are that substance abuse is a social disease and its users "infected". The inclination towards hyperbole is continued in the very next sentence when it states that substance abuse is not merely a contributing factor or correlative, but a "major cause" of virtually every serious problem in South Africa today.[9]

It lays further groundwork for this philosophy by noting that the increase in substance abuse is principally due to "social and political transformation" domestically and reintegration internationally. South Africa has become a "natural target" for international drug traffickers (ibid). That South Africa's poverty and existing crime (transformation notwithstanding) provide some ideal precursors for widespread drug abuse is unmentioned until later in the document.

Unfortunately, the NCPS offers almost no support in the way of policy. It is linked almost exclusively to international organised crime, yet substance abuse is implicit throughout many other aims and objectives of the document. The simple lack of awareness is almost shocking.

Further evidence of a confrontational attitude occurs in the choice of terminology. In noting the lack of a co-ordinated effort to reduce problems stemming from drug abuse, the NDMP states that

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[8]The draft of July 1998. References have been crosschecked with the later version of 26 October 1998 and any differences noted.

[9]The list runs: "crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, the escalation of chronic diseases, such as AIDS and TB, injury and premature death." However, on p. 22, they state that "the precise relationship between substance abuse and crime is therefore hard to determine". One wonders how much is known about substance abuse and the rest of the list.

this factor has had a negative impact on the "fight against drugs" (ch. 1, s. 4). The interceding point that "meagre resources" have been mismanaged and others have not been procured is well taken. However, shortly thereafter, it notes that these factors mean "the war against drugs has been waged neither effectively nor on all fronts" (ibid). Thus, in a backward, almost sneaky manner, South Africa has re-invited itself to battle.

The Vision (ch. 2) is rather more visionary than far-sighted or practical. The primary domestic goal of the NDMP is to "build a drug free society", something that has never existed in South Africa nor is it imaginable even if one excludes currently licit drugs and uses the most repressive possible tactics to attempt to achieve this goal.[10] At least it dispenses with the often problematic distinction between 'use' and 'abuse' by aiming for total eradication, as fanciful as such a goal is. In fact, there is no noted difference between these terms in the NDMP and the implication is the pathological one that all use is really abuse.

If one takes the government at their word, then the very next sentence indicates a drastically different attitude. In reinforcing the notion of South Africa's emerging human rights culture, the NDMP states that energies are being devoted "exclusively to the well being of our citizens". Although these statements are not inherently at odds, the reality of phrases such as "war" and "drug free society" on the one hand, and "human rights culture" and citizens' "well-being" on the other is an enormous incongruity.

The laudable goal of creating economic opportunities and "a better life for all" to address the causes of substance abuse indeed sees societal factors as having a major role. This view is, at best, fragilely complementary but, more likely, contradictory of the "pathology" philosophy, one that generally considers substance abusers as "sick" and not afflicted by a range of other factors.

Couching the well-being of a citizenry in terms of human rights would normally indicate a broad and progressive vision of a problem. Especially when considering the social and economic rights enshrined in South Africa's Constitution (Act 108 of 1996), one might think that the NDMP is actually considering substance abuse as a health issue rather than a matter of wiping out drug use and abuse from society.

There is further confirmation of a broader view when it lists a range of factors that influence social, cognitive and behavioural functions (p. 10).[11] The War rhetoric is also tempered by a professed balance in approaching the issues of supply and demand. Yet, the references to treatment are vague and unassertive. The clear attitude throughout the document is that, first and foremost, substance use and abuse is a criminal matter that will be addressed through law enforcement (Abrahamson & Boyd, 1998: 58).[12]

Abrahamson and Boyd note that the War's failure regarding supply and its near-complete neglect of treatment has resulted in this policy being "the foremost threat to human rights and public health in the United States" (1998: 58). The irrationality of official American responses to issues such as crack use, race and class dynamics, and the appearance of similar trends in South Africa should sound serious warnings, not the desire to emulation.

Yet, the South African government seems intent on copying, for example, the utter failures of eradication attempts (domestically and abroad) (NDMP: 55). While stating that there were "significant successes" in eradication of illegal crops, this rhetoric only suits those who would embark on a war

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[10]Of course, President Mbeki would have to lead by example by abstaining from his beloved Scotch.

[11]They include "unemployment, low self-esteem, educational failure, boredom and physical, psychological or family problems".

[12]Perhaps they are only a series of Freudian slips, but the NDMP repeatedly lists justice agencies ahead of other ones. Under Objectives, it lists crime ahead of youth, and health and welfare as areas of focus. Under Correctional Services, monitoring drug abuse arrestees would, *inter alia*: "identify opportunities for...intervention by the police, criminal justice, correctional services, health and welfare sectors." One might think that arresting drug abusers would be more than

against drugs. Programs in South America, particularly Colombia and Bolivia, are driven by political interests that clearly conflict with any goals of pragmatism and local social justice, and have been notable for their effects of further impoverishing peasant coca farmers and degrading the environment. The entire "philosophy" of trying to eradicate a plant that has been entrenched in cultural and social life for centuries, and that provides the only viable cash crop, seems fundamentally misguided.

As Atkins notes, eradication "carries a high cost to society, aggravating existing conflict, provoking wider instability and ultimately impeding attempts to control the drugs trade by any method" (1995: 47). In appeasing international donors and alien political policies, already repressive or unstable governments in developing countries have introduced "crude" legislation that succeeds mostly only in perpetrating serious violations of human rights (ibid: 45, 48). In the end, the ample land available to cultivate the crop simply means that eradication usually just displaces it elsewhere (ibid).

This situation bears significant parallels to South Africa. The only candidate for eradication is dagga yet the NDMP as well as the SADC Regional Drug Programme (a document that is worrying in itself) seem intent on this goal. Despite its social establishment, economic viability and easy relocation (factors that are of equal or greater significance than in South America), these documents show no restraint and take little cognisance of these factors. It also ignores the reality of lack of resources and non-enforcement trends.

The SADC document even goes further than the NDMP, clearly equating all dagga use to misuse, to the point where it describes a "traditional abuse" of the plant (1998: 5). Dagga is identified as "the main problem in the region" which necessitates "stringent actions to combat both the production and abuse of this controlled substance" (ibid). It only recognises two pages later that alcohol is inseparable from the control and treatment of other substances, and that its damage is seen by

the general public as being worse than all illicit drugs combined (ibid: 7). This paragraph, the only clear reference to the dangers of alcohol, is then promptly ignored throughout the remainder of the document.

The SADC program firmly maintains that no discussion can take place about legalisation or decriminalisation because of fears of a "snowball" effect and international commitments. It is an obviously misleading assertion that appears to have been included - in line with similarly misconstrued information - merely to justify the belligerent and "dangerously quixotic" tone of the War on Drugs (Abrahamson & Boyd, 1998: 59).[13]

The SADC program (p. 6) and NCPS (s. 4, "Organised Crime") also inflame problems that any society seeking to reinforce justice would wish to avoid by inarticulately linking the drug trade with illegal immigrants. By most accounts, xenophobia is a growing and worrying trend in South Africa (Kibble: 11; Simon, 1998: 5). On the other hand, transnational crime implies the involvement of foreign citizens from various continents, including SADC countries, as well as a growing number of South Africans (Simon, ibid: 5). The use of 'legal' and 'illegal' has also become blurred to the point of indistinction. For example, are they 'illegal' by virtue of their *alleged* drug trading (spurious attributions of Nigerians that have become popularised, particularly in the media)? Or for reasons that have more to do with the Department of Home Affairs? It has manifested itself in the identification and vilification of Nigerians, a peculiar "anti-black" phenomenon that has become popular in South Africa (Kibble: 11). Although only one of many ironies exhibited in this xenophobia, it is the most obvious one regarding drug trafficking.

[13]Similar terminology in the previous version of the NDMP was criticised by Abrahamson and Boyd. They state that this type of language "affirmatively censors and deceives" by precluding constructive debate on the subject and

b) Harm Reduction

Harm reduction is embraced rather cautiously, prefaced by the warning that it is not to be confused with legalisation or decriminalisation (p. 29). What the NDMP now appears ready to consider, though, is the prospect - not of confusing - but of integrating harm reduction principles with decriminalisation. However, harm reduction in South Africa requires some contextualisation without the scenario of drug legalisation or decriminalisation.

Ironically, harm reduction's pragmatism prompts the NDMP to the realisation that "it is unlikely that a totally "drug-free" society is ever attainable" (p. 29). While the NDMP scores points for listing some of the basic principles correctly, it uses policies for heroin users as examples of harm reduction that, at this point, have only the most minimal of application to South Africa. In fact, the principles favourably cited are ideally geared towards education, particularly youth. RaveSafe, a small but brave organisation that has a well-defined niche in both socio- and narco-demographics has already achieved arguable success. Avowedly harm reductionist, they dispense objective and factual information at raves and similar events (ibid: 72).

However, extensive research must first precede the formulation of policies and curricula. South Africa poses a unique situation in several respects, one of them being its experience and ready consumption of mandrax. Access to townships is also often problematic, just as the accessibility of the information might be if not properly founded. Perhaps the most practical feature of harm reduction education is that it does not condescend or preach. This point is particularly important for potential 'streetwise' audiences of prisoners or township youth whose close proximity and exposure to psychoactive substances may start at an early age.

To its credit, the NDMP recognises and elaborates the need for a broadly based research

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misrepresenting the nature of international commitments (1998: 59). S. Rothfuchs - RSA

philosophy involving a range of stakeholders (p. 46). Efforts would also include funding procurement and the dissemination of local research results. However, the Central Drug Authority and its secretariat, the lynchpin in implementing the NDMP, needs to be independent (especially fiscally) to make real progress when speaking of research and treatment. If it remains a mere "reporting and advisory" body without the ability to take its own initiatives (Parry, 1998: 61), then issues of policy and implementation may be politicised and bureaucratised while pragmatic action based on an informed stance would be relegated to the backseat.

Treatment is currently accessible along race and class lines, and urban geography often dictates who has an opportunity to receive treatment. Gender is also a factor though its implications regarding treatment is not well known (SACENDU, 1998: 36-37). Predictably, the more disadvantaged communities have the least access yet they are generally the ones who require it the most. Harm reduction's approach of outreach and establishing contact would be an invaluable tool in, first, identifying problems and, secondly, actively and practically addressing them.

i) Harm Reduction in Prison

The NDMP appears not to have eschewed harm reduction and, in fact, the terminology crops up rather unexpectedly at times. One of its objectives under "Crime" (p. 11) is "to reduce the level of drug misuse in prisons". If one takes a genuine harm reduction approach, then the implication is that drug use in prisons is inevitable and should be approached from a health perspective. The NDMP is, at best, ambiguous in this respect and does not clearly map out a truly progressive role for an area where huge gains could potentially be made.

Properly implemented prison treatment programs could not only demonstrate a reduction in

drug-related crime but also inject a huge measure of social justice into this process. The symbolic value of reaching some of the poorest parts of the population could be invaluable, particularly if it were designed for a juvenile institution. Modest success with a pilot program could begin to dispel the (largely correct) notion that South African prisons are merely institutions of criminal learning and activity.

Would such a proposal be problematic because of gangs? Probably, but the real question would add "more than elsewhere"? If similar programs can be implemented, effectively and cost-effectively, in countries that also have serious prison gang problems, then the prospects of, for example, a pilot harm reduction program incorporating a prison TC at least need to be investigated in South Africa. For that matter, any viable combination of cognitive/behavioural counselling, life/coping skills and dramatherapy should be considered. While the NDMP professes that the Department of Correctional Services is currently examining the problem of drug arrestees and prisoners, long-standing scepticism of this department, its closed nature, and other related features mean that the administration of the department may pose greater challenges to treatment than the actual implementation (see Giffard, 1997).

Nevertheless, prisons are also ideal locations for harm reduction education as well as treatment. Drugs and their relationship to prison culture in a developing country offer a unique opportunity that could feed back into the harm reduction movement and broaden its understanding and approach.

c) Decriminalisation

As if to tease those people who have been calling for dagga's decriminalisation or legalisation, the NDMP has significantly changed its tone on this subject. It moved from a flat "no" in July to a

"needs to be researched thoroughly" in October. It only proves that criminality is what you make it.

Realism would seriously consider at least the decriminalisation of dagga. With the paucity of resources available to reduce supply and demand, concentrating on substances that cause the most damage would seem logical - if there were money to pursue this goal. If illicit substances are to remain illicit, then focusing on the potentially more damaging ones such as crack, mandrax and possibly heroin would appear obvious. Yet, prosecuting (much less imprisoning) people for possession of small amounts of these drugs seems a wasteful, alienating experience. One need also consider the prejudices of enforcement in calculating the costs. It is an oft-repeated assertion but any decriminalisation/legalisation argument includes it: prohibition only creates a Black Market that is lucrative territory for larger criminal elements. Instead of fighting it, the government should attempt to outmanoeuvre it. Confrontation through the criminal justice system is largely unnecessary when one takes control through regulation instead of prohibition.

Alcohol will no doubt remain the most damaging substance for some time, whether alone or in polyusage, and should therefore receive due attention in terms of education and treatment. For that matter, the potential damage of other legal substances such as easily available solvents and pharmaceuticals also needs to be considered seriously.

Decriminalising dagga could be partly explained in terms of reducing crime that stems from the personal use or cultivation of marijuana. It would come as a huge relief to communities in the most underdeveloped parts of the country. It would also recognise the reality of South Africa's own diversity regarding marijuana's traditional use as well as the modern evolution of Rastafarianism.

IV. CONCLUSIONS - Drugs and Development in South Africa

The United States spends tens of billions of dollars a year to intercept less than 10% of the drugs within the country (Abrahamson & Boyd, 1998: 58), proving only that wars are expensive. Southern Africa as a whole can hardly afford to throw around that kind of money in such an ultimately futile manner.

In South Africa, substance abuse is not just a health or criminal matter. It plays a role in a range of other developmental issues such as gender relations, employment and education (ibid, 62). A war in South Africa may well repeat the experience of other developing countries and drive out the already most marginalised segments of society, whether a peasant farmer in the Eastern Cape or a Rasta on the Cape Flats. One would think that, with South Africa's prisons already bursting at the seams, the NDMP would try to find less-criminalising methods of dealing with the problem.

Instead of investing in expensive technology to fight an almost certain losing battle, South Africa should investigate the moral dimensions of a society at peace. Unlike the United States, there is much less to be gained by mixing domestic politics with foreign policy. Pragmatism would link substance abuse with other development issues and attempt to evolve solutions to the situation. Diverting some of the supply reduction funding into productive, largely labour-intensive human technologies that in turn are invested into human development in the community and in prison should be considered.

Rurally, SADC should be looking at ways of addressing substance abuse without victimising peasant farmers, a seemingly obvious but apparently elusive suggestion. Atkins' words ring true for the whole region:

> "We would argue, therefore, that there can be a high price to pay for forcible eradication. When that price is increased poverty, social instability, and conflict in societies where

democracy is still fragile and shallow, we think that price too high" (1995: 47).

Economic factors far beyond the control of domestic governments have foiled simple crop substitution (ibid: 50). There is also the phenomenon of "parallel development" where, rather than alternatives, they are additions to a farmer's illicit crop (Blickman, 1999: 14). In other developing countries such as Thailand and Turkey, opium production only declined when socio-economic conditions - irrespective of drug control policies - improved enough for alternatives to be found (ibid).[14]

In South Africa's case, one would require considerably more information before tackling this problem. One option would be to simply allow farmers to grow dagga. Thoughtlessly pumping money into destructive eradication efforts clearly leads nowhere, regardless of the NDMP's claims. Contrarily, economically activating this same portion of the population appears a perfectly attainable goal if given conducive circumstances of legality. Following models such as the Netherlands or Australia, there are innumerable ways of decriminalising or legalising - if not other drugs - then at least cannabis. Licensing small-holders to grow low-octane hemp for purposes other than smoking should also be considered (Kibble: 7). Why bother with alternatives when you already have a high yielding, low maintenance crop? They don't call it weed for nothing.

Demand for drugs will be inextricably linked to the development of the country as a whole. If potential abusers can be given a bigger stake in conventional society and their "user rationality" confirmed, then the groundwork will have been laid for fundamental changes in a number of respects. However, drugs must first be considered a health issue to let informal social regulation have its effect. Without this element of social justice, South Africa stands to lose much more than it can gain in terms

[14]In which case the cultivation of opium moved to Burma, and Iran and Afghanistan, respectively (Blickman, 1999:

of substances and their use.

As usual, the SAIIA report is way off the mark. It states (p. 52): "youth subculture is quickly spreading a benign image of drugs around the globe." It just might be that occasional use under the right circumstances is benign and that there are really greater issues in question. Youth subcultures throughout recorded time may well have had the same experience.

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