Linas Žalnieriūnas

The Search for Legal Coherence in the Criminalization or Decriminalization of Drug Possession

Factors Influencing Drug Use

Drug use can be traced back through centuries of human experience. Humans have an innate curiosity and a desire to explore their environment. This instinct extends to our interactions with the natural world, especially in terms of discovering the potential of different plants: different plants and the materials they produce may have provided advantages for survival (Sullivan *et al.* 2008, p.1237); may have led to the discovery of valuable resources for nourishment, healing, or for forging community bonds; may have provided adaptive benefits (Naranjo 1981, p.164); and may have brought a calm altered consciousness that brings a state of happiness. It is well known that people have long sought ways to alter their conscious state with natural substances such as coca leaves, cannabis, and opium poppies (Schultes *et al.* 2001). Ancient Hindu Vedic texts mention a substance called Soma, a ritual drink believed to provide spiritual experiences. Evidence suggests that the Sumerians were already familiar with opium by 3400 BC. They called it the "plant of joy," alluding to its recreational or medicinal use (Gootenberg 2022). Tribes in the New World used the hallucinogenic drink ayahuasca for centuries. Many South American cultures, such as the Maya and the Aztecs, used plants such as peyote and ayahuasca for spiritual and shamanic practices (Gootenberg 2022). As a result, scholars have emphasized the importance of drugs in ancient spiritual practices (McKenna 2004).

Today, drug use is a widespread phenomenon worldwide. The question is whether this phenomenon is natural to human nature or whether it is a need that has been artificially shaped by human beings themselves for different purposes throughout history. The search for pleasure is an important focus for understanding drug use, as people instinctively seek pleasure and avoid pain (Freud 1920, p.8). Drugs interact with the brain's reward circuitry to induce euphoric feelings, which is why some people find them highly desirable. In addition, drugs provide an "escape," i.e., a temporary break from the difficulties of life. For some, they help them to overcome mental health problems, trauma or stress (Khantzian 1985, p.1312). In addition, substances such as psychedelics have historically been used for self-knowledge and spiritual exploration, as they can induce profound experiences and provide insights into one's psyche and the universe (Smith 2000,

p.45). Modern lifestyles, characterized by rapid urbanization and technological advances, can lead to states of isolation, stress, and detachment, which can lead to drug use as a coping mechanism (Galea *et al.* 2005, p.1013).

If happiness is understood as an emotional and physiological response, often influenced by external events, internal cognitive processes, and biological factors, then from the perspective of biochemical science, it is possible that one of the primary reasons for drug use is the pursuit of obsession and the feeling of happiness. According to scientific sources, the natural level of happiness varies from one person to another, as it depends on different genetic markers in our bodies. For most people, the level of happiness is biochemically average, i.e., neither too high nor too low (De Neve *et al.* 2012, p.590). Therefore, it is possible that people with a naturally lower level of happiness tend to seek to increase their happiness through drug use, especially given that experiencing happiness due to environmental influences is quite difficult, as happiness-inducing factors such as receiving a promotion or a raise at work, winning the lottery, getting a new car, falling in love, having a child, overcoming pain, etc., are relatively rare events in our lives, or we quickly get used to them and stop enjoying them after a while. Meanwhile, the desire to feel happiness is more or less constant. Assuming that external events and circumstances make it increasingly difficult for people to experience permanent happiness, it is not uncommon to find ways to achieve pleasure and happiness by stimulating biochemical processes in the body with drugs.

In discussing these biochemical processes, it is noted that the neurochemical basis of happiness consists of three substances: serotonin, dopamine, and endorphins (Berridge and Kringelbach 2015). These chemicals are released during the perception of happy situations: pain relief, energy, mood elevation, falling in love, winning the lottery, getting promoted, winning a competition, having a baby, feeling physical closeness, etc., but they also occur during drug use. Serotonin, as a neurotransmitter, is important for its mood-regulating properties. Elevated levels of serotonin are often associated with mood elevation, while its deficiency can lead to depression (Young 2007). Dopamine, known as the "reward neurotransmitter," plays a key role in pleasure- and reward-seeking behavior. Happiness-inducing activities often stimulate dopamine release in the brain (Keighron *et al.* 2023; Wise 2008). Meanwhile, endorphins are the body's natural painkillers and mood enhancers. Many types of drugs stimulate the release of endorphins (Dietrich and McDaniel 2004). It is likely that the primary cause of drug use is the natural human desire to experience states of happiness and pleasure. Accordingly, narcotic substances can be divided into several main groups according to their effects on the human body and brain:

- *Stimulants* such as cocaine, amphetamines, MDMA (ecstasy), and Ritalin improve the mood, increasing alertness and energy. They also play a role in increasing levels of dopamine, a neurotransmitter that is vital for pleasure, motivation and motor function. For example, cocaine prevents dopamine from being reabsorbed, leading to increased feelings of euphoria (Volkow *et al.* 2019).
- *Depressants* such as alcohol, benzodiazepines and certain sleep medications such as zolpidem, Valium, Xanax, and barbiturates reduce (Central nervous system) CNS activity. These drugs induce feelings of relaxation, reduce anxiety, and slow down brain activity, leading to drowsiness or sedation (Bateson 2002).
- *Opioids* such as morphine, fentanyl, heroin, oxycodone (OxyContin), and hydrocodone (Vicodin) are primarily known for their painkilling properties. They can cause euphoria or drowsiness. Such drugs work by mimicking the body's natural endorphins and binding to opioid receptors in the brain, reducing pain perception (Volkow *et al.* 2020).
- *Hallucinogens* such as LSD, psilocybin (magic mushrooms), PCP (phencyclidine), and DMT (dimethyltryptamine) can dramatically alter perception, thoughts and feelings by acting on serotonin receptors in the brain. The changes caused by these drugs are often manifested as hallucinations – experiences in which people perceive things that are not really there (Nichols 2016).
- *Dissociative drugs* such as ketamine and dextromethorphan (found in some cough syrups) cause feelings of detachment from the environment and even from oneself. They work by inhibiting the NMDA receptor, which plays an important role in perception and consciousness (Zanos and Gould 2018).
- *Cannabinoids* – whether naturally occurring, such as THC (tetrahydrocannabinol in marijuana), or synthetically produced, such as Spice or K2 – interact with the brain's endocannabinoid system. This interaction can lead to changes in memory, mood and perception, and can result in the loss of anxiety and the relaxation of the body (Lu and Mackie 2016).
- *Inhalants* include a wide range of volatile substances, and substances such as nitrous oxide and amyl nitrate affect a variety of human mechanisms, for example by inhibiting neurotransmitter activity, which can lead to mental state-altering effects (Volkow *et al.* 2019).

Similarly to humans, many animals have neurotransmitter systems that can be modulated by a variety of substances, resulting in feelings of euphoria or altered states of consciousness. For example, Amazonian jaguars have been documented to consume parts of the *Banisteriopsis caapi* vine, resulting in a trance-like state

(Schultes and Raffauf 1990). In the insect world, ants catch and eat aphids not only because of their sweet secretions, but also because certain species of aphids produce chemicals that can help deter predatory ants (Detrain and Deneubourg 2008). These examples of human and animal behavior show beyond doubt that, in the early stages, drug use in the wild is in fact, a natural phenomenon, free of socio-cultural influence.

As a secondary cause of drug use, many drugs promote psychological and physical dependence due to the level and frequency of the release of the aforementioned happiness hormones and the constant need to maintain a state of happiness. Over time, higher and higher doses are needed to achieve the same level of happiness hormones. To deliberately stop using drugs and live with significantly lower levels of happiness hormones in the body is a challenge that is difficult to overcome. External factors can also be seen as a secondary cause of drug use, where well-developed drug supply chains make drugs easily and quickly available. In addition, globalization processes have led to the rapid spread of knowledge about countries where drugs are legalized, which creates an impression of justification in the mind and encourages people to try drugs in countries where they are legally traded. It is therefore undeniable that economic, cultural, and legal factors have also played a role in the spread of drugs in the more recent stages of human civilization. For example, the expansion of global trade and the development of sophisticated transport systems facilitated the movement of illicit drugs across national borders. Trade routes, especially those that are less controlled, provide opportunities for drug trafficking. Economic instability, poverty and the lack of employment opportunities in certain regions encourage individuals to choose drug trafficking as a source of income (UNODC 2018, 2023). Regions affected by political unrest or armed conflict are characterized by weak law enforcement, which creates a favorable environment for illicit drug cultivation, production and trafficking (UNODC 2023). The development of the internet and encrypted communication platforms has also facilitated a more discrete drug trade, leading to an increase in the number of online drug marketplaces on the dark web (Martin 2014). In some societies, the use of certain drugs is embedded in cultural or religious practices or is normalized, which has implications for their spread (Labate and Cavnar 2014). Different countries' drug policies can affect drug trafficking routes. For example, strict enforcement of drug control in one country may push drug trafficking to neighboring countries with more lenient policies (Bewley-Taylor 2012).

Drug use is essentially a dualistic phenomenon due to innate human tendencies and the influence of external factors. The primary causes of drug use are

deeply rooted in human nature, but the secondary causes of drug use are determined by changing social, cultural, and legal factors.

While some countries around the world have liberal policies on drug use, the possession of drugs is banned and criminalized in many parts of the world. This situation leads to a lack of legal coherence in this area. However, the criminalization or decriminalization of drug use is an ongoing process, and the issue of legal coherence has not yet reached its final stage.

Causes of Drug Criminalization

The process of criminalization of drug use is a result of the interaction and interplay of social, political, economic, and cultural factors that have occurred throughout world history. In this process, public health issues have become intertwined with broader social, political, and legal issues.

The main rationale for banning certain drugs is their harmful effects on public health. Medical evidence supports the harmful consequences of drug abuse, which have led to the imposition of strict legal measures. The increase in knowledge of neurobiology and human behavior has increased our understanding of the health consequences of drugs, and the following research is relevant to the health risks of drugs.

Experiments carried out in Rat Park in 1978 confirmed the profound effects of drugs on the development of addictions (Alexander *et al.* 1978). The National Epidemiological Studies on Drunkenness and Related Conditions (NESARC) have helped to shed light on the links between drug use and mental health disorders, with an emphasis on the interaction between mental health and psychoactive substance dependence (Hasin *et al.* 2007). Trials of methadone maintenance therapy in the 1960s confirmed findings of severe opioid dependence (Dole and Nyswander 1965). Internationally, the Global Burden of Disease Study, launched in 1990, summarizes global health problems related to psychoactive substance abuse by linking global morbidity and mortality to the use of various drugs (Degenhardt *et al.* 2018). Although various data show that statistics on drug-related deaths are complicated by the fact that the causes of death are not always correctly identified, the inclusion of deaths that are not directly attributable to drugs, but are related to their use, in these figures is important. As of 2019, the United Nations Office on Drugs and Crime (UNODC) estimated that around 585,000 people died as a result of drug use in 2017, which included indirect deaths, such as those caused by HIV and hepatitis C acquired through unsafe use (UNODC 2019). The World Health Organization (WHO) reported in its 2015 estimates that more than 450,000 deaths worldwide were attributable to

psychoactive substance use disorders, which include alcohol, tobacco, and illicit drugs (WHO 2015). In 2017, a high number of overdose deaths were observed (Wilson *et al.* 2020).

In addition, the link between drug use and mental disorders is increasingly well documented in contemporary literature. The therapeutic use of certain psychedelics contrasts sharply with the unpredictable consequences of their misuse (Smith *et al.* 2017; Di Forti *et al.* 2019; Hines *et al.* 2020). Studies specific to cannabis point to potential long-term mental health consequences, as chronic cannabis use has been associated with psychiatric disorders, particularly psychosis (Moffitt *et al.* 2007; Volkow *et al.* 2014).

In addition, drug abuse can be disruptive to society, leading to increased criminal activity, family disruption, and societal disintegration (Dhawan and Chopra 2020; Degenhardt *et al.* 2016). Substance abuse inevitably creates a significant workload on the healthcare infrastructure (Congressional Research Service 2020).

More recent research shows that the use of some substances contributes to recovery from post-traumatic stress disorder, and that such therapeutic use of narcotic substances (e.g., MDMA) has potential benefits, but that uncontrolled use, for example for recreational purposes, can have harmful effects. Therefore, studies support the benefits and necessity of controlled use of some substances (Mithoefer *et al.* 2018).

In summary, the main reason for drug prohibition is the harm to the health of individuals and society, based on various studies. Numerous empirical studies underline the multifaceted dangers of drug abuse and justify the strict legal regulation leading to drug prohibition.

A Brief History of Drug Prohibition

As described in the previous subsection, ancient civilizations have historically used drugs for a variety of purposes, including healing, pain relief, religious rituals, and spiritual quests. The pursuit of these goals has often facilitated the release of neurotransmitters such as dopamine, serotonin, and endorphins, leading to euphoric sensations. Over time, however, due to concerns about damage to human and public health, the use of specific drugs became restricted or banned altogether. On the other hand, the use of drugs in certain areas is legal in countries all over the world; for example, in the health treatment system, and the use of medicinal preparations with narcotic properties requires strict supervision and a doctor's authorization. However, the use of drugs for spiritual ceremonies and

religion, as well as for recreational purposes or pleasure, is prohibited in many countries.

The original prohibitions on drug use were based on the exclusive ability of authority figures, such as tribal leaders or seers, to obtain or have access to drugs. Other individuals did not have access to them.

Interestingly, the forerunner of modern drug prohibition was China, which restricted opium possession in 1729. Although opium's therapeutic properties were recognized, the 18th century saw an increase in recreational use, which made people who used it unwilling to work, with a negative impact on the economy. Thus, in 1729 Emperor Yongzheng of the Qing Dynasty imposed prohibitions, which became increasingly severe until the trade was banned altogether in 1799 (Spence 1999). This means that for more than 1700 years, humanity did not see a pressing need to prohibit drugs.

One of the first known pieces of drug control legislation was enacted in Great Britain in 1868—the Pharmacy Act, which restricted the sale of opium (Berridge 1999). It aimed to curb the recreational use of opium and the then-common practice of sedating babies with opium-containing "sedative syrups" (Berridge 1999). The British Pharmacy Act was one of the first attempts to regulate the sale of certain dangerous substances, including opium and its preparations.

The International Opium Convention, signed in The Hague in 1912, was one of the first international drug control treaties and was later incorporated into the League of Nations (McAllister 2000). The countries participating in the International Opium Convention were primarily the major players in the global opium trade: Austria-Hungary, Belgium, France, Germany, Italy, the Netherlands, Portugal, and the United Kingdom (and its possessions, including India). In addition to these European countries, countries such as the United States of America, China, Japan, Persia (now Iran), and Siam (now Thailand) were also signatories to the Convention.

The 1931 Convention on the Control of the Production and Distribution of Narcotic Drugs and the 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs were adopted. These Conventions expanded the scope of controlled substances and established new regulatory mechanisms. The Convention on the Control of the Production and Distribution of Narcotic Drugs (1931) controlled not only opium, but also other drugs and their precursors. Many countries in Europe, North and South America, Asia, and other parts of the world, such as the United Kingdom, France, Germany, the United States of America, Japan, and others, signed or later acceded to this Convention. The Convention for the Suppression of the Illicit Traffic in Dangerous Drugs (1936) was the first to criminalize the possession and distribution of narcotics.

The WHO, established in 1948 after the Second World War, played a central role in drug-related issues. Its pain management guidelines (WHO 1986) have had a major impact on the global approach to opioid prescription.

China, India, Indonesia, Japan, Malaysia, Pakistan, the Philippines, South Korea, Thailand, and many other countries are signatories to the Single Convention on Narcotic Drugs (1961), which sought to bring together in a single instrument a large number of international treaties on drug control. It is the founding document of modern international drug control and aims to combat drug abuse by consolidating previous treaties and including more types of narcotic substances.

In the United Kingdom, the Misuse of Drugs Act 1971 categorizes drugs into three harm categories, with penalties for possession and distribution (Bean and Nemitz 2004). In the same year (1971), the United Nations Convention on Psychotropic Substances was signed to control psychoactive substances such as amphetamines, barbiturates, benzodiazepines, and psychedelics. This treaty was developed in response to the widespread recreational use of many new psychotropic substances in the 1960s and aimed to limit the abuse of these substances while ensuring that they are not available except for medical and scientific purposes. A few years later, the US Drug Enforcement Administration (DEA), established in 1973, began to combat drug trafficking and abuse. In 1974, the National Institute on Drug Abuse (NIDA) was established in the US, focusing on research into drug use and addiction.

The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances was adopted in 1988 and was intended to create additional legal mechanisms to enforce the 1961 and 1971 Conventions, and to introduce measures against money laundering and the disposal of precursors.

The United Nations has operated mainly through three international drug control conventions: the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. These Conventions have had a major impact and shaped the global trajectory of drug regulation. However, since 1988, there have been no new Conventions, but only a number of resolutions, declarations, and other agreements that built on the previous Conventions.

In the 20th century, especially in the 1980s, drug prohibition became a symbol of the "war on drugs." This policy emphasized the use of harsh mandatory sentences for drug possession, leading to a rapid increase in the number of prisoners. This tough stance was eventually adopted by many countries around the world (Nellis 2016). On the other hand, recent global trends are moving

away from such strict policies, as it has become evident that strict drug policies have not solved the underlying problems and have not reduced harm, and the view that the war on drugs is over and the treatment of drug addicts has begun is coming to be accepted. This shift in thinking changes the course of legal coherence.

Factors Influencing Drug Categorization and Quantification in Europe

It is worth briefly discussing the content of drug criminalization in Europe. European drug prohibition policies, which have significant socio-economic health impacts, require careful study (Chatwin 2011) to justify which substances to criminalize and to set threshold values for illicit drug possession, which in many countries determine the nature and severity of legal consequences (EMCDDA 2020, 2023).

When discussing the criteria for drug prohibition, scientific bodies such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) conduct in-depth studies on substances to assess the nature of their harms, covering physical, psychological and societal aspects, and review detailed pharmacokinetic and toxicological data (EMCDDA 2011). Their analyses prioritize the biochemical interactions of drugs, the risk of overdose and long-term health effects. Policymakers consider societal consequences, such as propensity for drug-induced crime, economic, and other societal impacts. These considerations are heavily influenced by input from law enforcement agencies and socio-economic researchers (MacCoun and Reuter 2001). Many European countries are signatories to international treaties, such as the United Nations Convention on the Control of Drugs, which require Member States to criminalize specific substances.

Law enforcement authorities and courts are guided by these conventions and recommendations when interpreting and determining the quantities of specific drugs. A "small" quantity can generally indicate personal use, while "large" and "very large" quantities can indicate intent to distribute or traffic (Wouters *et al.* 2010). Regulators can use demographic analysis to identify prevailing patterns of drug use. Insights into the average daily or weekly intake of users can help to establish criteria for "low" levels (Caulkins and Pacula 2006). Medical bodies, such as the WHO's European Office and national health agencies, make recommendations based on health risks. Levels that approach potentially lethal doses or are likely to cause serious health complications are labelled "very high" (van Amsterdam *et al.* 2010). European countries often build on the practices of

neighboring countries or apply a harmonized approach that is similar across the EU, thus ensuring a certain degree of legal coherence (EMCDDA 2019).

Based on available evidence and societal norms, national parliaments or equivalent legislative bodies consider and formalize the list of banned substances and the limits on their possession. European states use expert advisory committees of scientists, medical doctors, law enforcement officials, and sociologists to make informed recommendations on drug classifications and quantities (Hughes and Stevens 2010; Heidt 2021). Some jurisdictions, as part of their appreciation of the principles of participatory democracy, conduct public consultations to capture public sentiment and concerns, thereby ensuring that policies are in line with the realities of the situation (Holland *et al.* 2023).

Politicians can be influenced by the government's policy stance on drugs. For example, a conservative government may advocate stricter rules and definitions, while a more liberal government may lean toward decriminalization and softer definitions. Countries in certain regions, such as the European Union, may harmonize their drug policies to a certain extent so that similar definitions of quantities may apply, ensuring legal consistency. Policymakers may look at the drug policies of other countries, particularly neighboring countries or countries with similar societal structures, to make decisions.

The overall impact on public health – both direct health effects and secondary effects such as drug-related crime or hospital admissions – can also be important in determining quantities. It is worth noting that drug quantity determinations are not static; they can change in response to new scientific discoveries, societal changes, or changes in political or public opinion.

Determining what constitutes a small, large, and very large quantity of drugs requires a multifaceted decision. This process is based on scientific research, societal norms, political considerations and international treaties or agreements. These quantities are usually determined in different countries based on data on lethal doses and harmful effects in toxicology reports. By understanding how drugs work in the body, decisions can be made about what constitutes a quantity for "personal use" and what constitutes a quantity for distribution. Substances that are highly addictive may be subject to stricter rules, and governments thus need to analyze patterns of drug use in their populations. This may mean determining the average amount that a user consumes per day or week, which may help to define the amount for "personal use." It is thus very important to distinguish between possession for personal use and intent to distribute.

However, there is no single overarching law in Europe that sets drug levels in all European countries, as drug policy is largely a matter for individual Member States. Nevertheless, there are institutions and instruments at the EU level that

provide guidelines, frameworks and recommendations on drug policy, including on drug quantity: the EMCDDA does not directly set legal thresholds, but provides analyses of drug trends that can be useful for national policies (EMCDDA 2019). The EU Drugs Strategy (2013–2020) and the EU Drugs Action Plan (2017–2020) do not set drug quantities, but provide an overarching policy framework. Council Framework Decision 2004/757/JHA sets out the imperative to apply minimum provisions on offenses and penalties related to drug trafficking. Although the Decision refers to quantities, it does not set specific thresholds, but emphasizes that offenses involving large quantities of drugs should be punished with more severe penalties. The precise definition of these quantities is left to the discretion of the Member States (Decision 2004/757/JHA, 2004). The United Nations drug conventions require signatories to regulate and control certain substances. However, the way in which each country defines quantities may vary (Chatwin 2011) because, as mentioned above, each EU Member State sets specific rules and limits in its national laws. For example, several countries have clear legal thresholds that distinguish between possession for personal use and trafficking. Portugal decriminalized the personal possession of all drugs in 2001. The law in Portugal allows the possession for personal use of up to 25 grams of cannabis, 5 grams of cannabis resin, 2 grams of cocaine, or 1 gram of MDMA. Possession of more than these quantities is prohibited (Hughes and Stevens 2010). In Spain, cannabis use and possession for personal use are allowed, but are regarded as administrative offenses if committed in public spaces. To differentiate personal drug use from trafficking, Spanish courts generally focus on the amounts seized. If these exceed the limits for each substance determined by the National Institute of Toxicology – 100 grams of marijuana and 25 grams of hashish – it is usually regarded as trafficking (Bąkowski, 2023). The Netherlands has a policy of tolerance toward cannabis possession, where possession of up to 5 grams of cannabis without intent to distribute is decriminalized. The cultivation of up to five plants is also decriminalized, but exceeding these quantities can lead to sanctions and possible prosecution (EMCDDA 2016). In 2010, the Czech Republic set the "legal" quantities of drugs for personal possession at 15 grams of cannabis or 1.5 grams of heroin. Quantities above these thresholds may be subject to legal sanctions and may be interpreted as intent to distribute (Belackova *et al.* 2017). Germany has a more ambiguous system. While there are no precise legal thresholds, the possession of a "small amount" for personal use may not be punishable, but this "small amount" varies depending on the federal state and the substance possessed, with up to 6 grams of cannabis generally considered legal in most territories (Werse and Morgenstern 2012). In Lithuania, possession of up to 5 grams of cannabis for personal use is considered to be a small amount.

Possession of more than 5 grams but less than 20 grams is considered to be a larger quantity, while possession of more than 20 grams is considered to be a large quantity, and more than 500 grams is considered to be a "very large" quantity and liability is incurred under the distribution article. It should be noted that in Lithuania, even possession of a "small quantity" is subject to criminal liability.

In conclusion, the complex policy of identification and quantification of illicit drugs in Europe calls for greater legal coherence, thus unifying the conditions for criminal liability and the structure of legal assessment. However, as the landscape of drug use and its consequences changes, so too must the regulatory frameworks to ensure that they remain sensitive, fair and coherent (Bühringer *et al.* 2014).

Consequences of the Criminalization of Narcotic Drugs

The criminalization of drugs, or the war on drugs, has a negative side in addition to its good intentions and results. From an economic point of view, the criminalization of drugs encourages the development of a black market, which deprives governments of potential revenues while reinforcing illicit revenues (Costa Storti and De Grauwe, 2009). The EMCDDA's European Drug Report provides a comprehensive overview of recent drug trends in Europe. The report estimates that the illicit drug market in the EU is worth around €30 billion annually (EMCDDA 2021). The UNODC estimates that the methamphetamine trade in South-East Asia generates $30–$61 billion annually (UNODC 2020). Meanwhile, an ONDCP report estimates that in 2010, Americans spent almost $100 billion on substances such as cocaine, heroin, marijuana, and methamphetamine (ONDCP 2014). However, due to clandestine black-market operations, it is difficult to accurately calculate the revenue generated by the shadow drug trade (EMCDDA 2019). In addition, significant financial resources are devoted to drug interdiction, law enforcement investigations, trials, and incarceration for drug-related crimes (Hughes and Stevens 2010). As a result, huge financial resources are devoted to combating this problem.

The war on drugs can also be said to be linked to deaths and violence. In Central and South America, where drug cartels have gained immense power, large-scale violence has resulted, and aggressive anti-drug campaigns, such as in Mexico, have generated high homicide rates, a significant proportion of which are attributable to drug-related clashes (Bagley and Rosen 2015). In Europe, which is grappling with a drug crisis, overdose deaths among those aged 50–64 increased by 69% between 2012 and 2021 in 13 EU countries, and a Norwegian review found that drug users have a risk of dying that is between 3 and more than

20 times higher than their peers in the general population. This increased risk is not limited to overdoses, but also includes deaths due to accidents, violence, various diseases, infections such as HIV and viral hepatitis, and suicide (EMCDDA 2023). The report also indicates that over the last decade, HIV outbreaks linked to the injection of illicit synthetic stimulants have occurred in six major European cities in five EU countries. Stimulant use is associated with a potentially higher incidence of injecting compared to heroin use, and the crushing and dissolving of crack cocaine and other pills by injecting also poses additional health risks. Such consumption patterns raise questions, for example, about the type and suitability of needles and syringes provided in street-based open drug consumption areas, which are usually characterized by multi-drug use. An additional concern is that service restrictions through COVID-19 sites have negatively affected testing for drug-related infections such as HIV and HCV and access to care for more vulnerable and marginalized groups of drug users, including those experiencing homelessness (UNODC 2023).

Worryingly, these deaths are not exclusively linked to the drug trade, but involve civilians as well as law enforcement and security forces. The grim reality is that global efforts to combat the drug menace, aimed at protecting public health, appear to be causing deaths in numbers that do not keep pace with the direct toll of drug use. This is why the term "war on drugs" is no longer appropriate, because in every war someone is bound to die. The term "war" is therefore being replaced by "control, assistance, or treatment" (Reuter 2013).

The health impact of criminalizing drugs is therefore debatable. Although criminalization is intended as a protective measure, it can unexpectedly increase health risks. For example, illicit drug users may avoid health services for fear of legal consequences, making it more difficult to access necessary treatment or preventive measures (Cook and Kanaef 2008). Such dynamics can lead to increased health complications, as seen in the increased prevalence of bloodborne diseases among injecting drug users in several European countries (EMCDDA 2023). Although some countries around the world have criminal codes that provide for exemption from criminal liability if a person goes to a treatment facility and voluntarily and without coercion transfers substances, in the absence of social programs to encourage this, few people take advantage of this norm and opportunity.

It should not be forgotten that, particularly in view of the prevalence of drugs, the vast majority of those arrested are young people who have a criminal record when prosecuted. This makes a large (and growing) proportion of society criminal, and this proliferation of convictions in society changes attitudes toward criminal responsibility, making it a normal outcome. As a result, criminal

responsibility is no longer an exceptional life event that is shameful and hidden, but on the contrary a widespread phenomenon, especially among young people. This results in a high number of convictions, especially in view of the opinion that the penalties for drug possession are very severe. In Lithuania, for example, this opinion is shared by legal scholars working in the judiciary.

In summary, while the criminalization of drugs is aimed at the public good, it has many negative consequences. Policymakers therefore need to consider these consequences when designing regulatory frameworks. However, countries such as Portugal, Spain, Switzerland, Belgium, the Netherlands, the Czech Republic, Uruguay, Mexico, Georgia, Luxembourg, Estonia, Colombia, Jamaica, Argentina, Costa Rica, Peru, Bolivia, and some states in the United States of America have advocated for some form of decriminalization, underlining the view that drug addiction is a public health challenge rather than a criminal offense (Hughes and Stevens 2012).

The Health-Oriented Decriminalization of Drugs

The decriminalization of drugs is a hot topic in contemporary global public health discourse and jurisprudence. The decriminalization of narcotic drugs essentially means the abolition of criminal liability for the personal use and possession of drugs.

The concept of the decriminalization of drugs should be linked to a legislative reorientation away from treating the disposal of drugs for personal use as a crime or a misdemeanor, and instead as an administrative offense (Chatwin 2011). This construction differs sharply from legalization – the deregulation of the prohibition of drug use, production and distribution (Hughes and Stevens 2010).

The general movement toward decriminalization in some countries can be explained in large part by greater awareness of the multiple health consequences associated with the use of psychoactive substances, as well as the perceived inefficiencies and harms associated with the fight against drug trafficking. Some authors argue that penal systems sometimes reinforce negative health effects without intending to do so, and facilitate the spread of pathologies such as HIV and hepatitis C among drug-using groups (Degenhardt *et al.* 2017, p.1201). As a result, contemporary policy is increasingly focusing on a health-centered approach. This includes initiatives such as syringe exchange services, controlled substance use sites and opioid substitution treatment interventions (Rhodes and Hedrich 2010), treating rather than judging users. The WHO and the EMCDDA have reaffirmed the importance of these health-oriented strategies, favoring them over punitive drug policies (WHO, 2014). The changing drug situation in

Europe poses new challenges for harm reduction interventions. Illicit drug use is recognized as contributing to the global burden of disease. Interventions to reduce this burden include prevention activities aimed at reducing or slowing down the rate of onset of drug use and offering treatment to those with drug problems. This complementary set of approaches is referred to by the generic name of harm reduction. This emphasizes non-judgmental work with drug users in order to reduce the risks associated with behaviors that are commonly associated with negative health consequences and to promote health and well-being more generally. Over time, such approaches have contributed to the fact that the number of new HIV infections related to injecting drugs in Europe is now relatively low compared to international standards.

The European Drugs Report 2023 states that harm reduction services have become increasingly integrated into the mainstream of drug users' healthcare delivery in Europe over the last two decades. Initially, the focus was on expanding access to opioid agonist treatment and needle and syringe programs as part of the response to high-risk drug use, primarily targeting injecting heroin use and the HIV/AIDS epidemic (EMCDDA 2023). The report also indicates that over the last two decades, in some EU countries, the harm reduction approach has been extended to other responses, including supervised drug consumption rooms and take-home naloxone programs to reduce fatal overdoses. Some countries also have drug testing centers set up to give people a better understanding of the substances in the illicit drugs they buy. For example, tablets purchased as MDMA may also contain adulterants and other drugs such as synthetic cathinones. As many synthetic stimulants and new psychoactive substances are currently available on the illicit market in the form of similar-looking powders or tablets, users may be increasingly at risk of being unaware of the specific stimulant or mixture of substances they are taking. A ban in this place would only increase the risk and danger to public health.

The latest report (EMCDDA 2023) also points out that although some harm reduction measures remain controversial in some European countries, the concept that evidence-based harm reduction measures are an important part of a balanced drug policy is generally accepted. Therefore, the context in which harm reduction services operate, the evidence base underpinning them and what constitutes quality standards of care in this field remain key areas for policy consideration. Looking ahead, the evolving health threats posed by Europe's dynamic illicit drug markets highlight the increasing need to assess new and evolving models of service delivery that may be needed to protect the health of people at risk of adverse outcomes arising from more complex patterns of use,

new substances and mixtures, or those associated with particular subgroups or environments.

Various interventions aimed at health promotion rather than prohibition have been effective in reducing the negative consequences associated with psychoactive substances, and countries have embarked on a transformative journey by combining their decriminalization principles with these health-oriented measures. Portugal is becoming a model for drug decriminalization. In 2001, faced with rising drug use mortality and HIV prevalence, the country took the bold step of universal drug decriminalization (Laqueur 2015). This transformative measure entailed a strategic departure from the use of punitive policies and a shift toward the development of public health and harm reduction systems. The reconceptualization of drug use within the public health spectrum was intended to create an environment conducive to the therapeutic and rehabilitative tendencies of drug users (EMCDDA 2011).

At the same time, the Netherlands has adopted a distinctive strategy. Although drugs were not fully decriminalized, at the end of the 1960s a "*gedoogbeleid*" – a manifesto of tolerance for the possession of small amounts of cannabis – was introduced. This doctrinal position stemmed from the desire to separate the markets for light and hard drugs and to reduce the risks for enthusiasts of light drugs (e.g. cannabis), while easing the burden on the judicial apparatus (MacCoun 2011).

In 2010, the Czech Republic announced that it had decriminalized small quantities of most recreational drugs. For example, legal provisions allowed individuals to possess up to 15 grams of marijuana or 1.5 grams of heroin without facing criminal consequences (EMCDDA 2010). Subsequent observations have shown a reduction in drug-related fatalities and a reduction in HIV transmission among injecting drug users. Despite these favorable results, cannabis use has increased (Csete *et al*. 2016).

Canada has legalized the use of marijuana but refrained from decriminalizing other drugs. The legalization of cannabis has led to a decrease in drug-related offenses and an increase in government revenue. However, the full impact of this paradigm shift on society and health has yet to be fully assessed (Rotermann 2020).

In addition to the countries mentioned above, others have relaxed their legal frameworks in relation to drugs, decriminalizing in one way or another the disposal of drugs for personal use. These countries include Spain, Switzerland, Belgium, Uruguay, Mexico, Georgia, Luxembourg, Estonia, Colombia, Jamaica, Argentina, Costa Rica, Peru, Bolivia, and some US states. This has led to a general

recognition that substance dependence requires interventions in the public health field rather than in the prosecution field (Hughes and Stevens 2012).

Although the overarching imperative of decriminalization aims to promote a more humane approach to drug users, this initiative remains unchallenged in European intellectual and legal circles (Montanari *et al.* 2022).

One of the main criticisms voiced by legal scholars is that decriminalizing drugs could lead to increased drug use. Although countries such as Portugal have not seen a significant increase in drug use after decriminalization (Laqueur 2015), this concern remains a topical debate, especially in the context of Central and Eastern Europe (Eastwood *et al.* 2016). The distinction between "personal use" and "intent to distribute" or "possession with intent to palliate" has been a persistent problem in several jurisdictions. This boundary is subject to *ad hoc* assessments in legal practice, which can lead to inconsistent legal decisions (Chatwin 2011).

International obligations, in particular the United Nations Drug Control Convention, often lead to legal disagreements and international implications when states' decriminalization policies are juxtaposed (Boister 2001). Some European health professionals and legal scholars argue that decriminalization can inadvertently lead to public health problems, including increased strain on health infrastructures and the potential spread of drug-related diseases if not properly managed (Rolles and Murkin 2013). On the other hand, public opinion may remain unchanged and dead set against decriminalization, so that stigmas associated with drug use may persist and entrenched attitudes may hinder the reintegration of drug users into society and undermine the decriminalization process itself (Ahern *et al.* 2007). It is necessary for legal scholars, policy makers, and society as a whole to understand, compare, and address the harms of drug criminalization and decriminalization. Only with this comprehensive understanding can robust and coherent legal frameworks be developed that are mutually consistent and focused on achieving the best possible outcome.

Various European examples, notably Portugal, the Netherlands, and the Czech Republic, have added the decriminalization of drugs to their legal frameworks in order to move from punitive measures to rehabilitative and public health-oriented strategies. One obvious benefit of decriminalizing drug use is the significant reduction in imprisonment for drug-related offenses. In Portugal, a decriminalization strategy implemented in 2001 led to a significant reduction in drug-related imprisonment, thereby easing the economic burden on the criminal justice system and significantly reducing the associated costs to society (Hughes and Stevens 2010).

Decriminalization, by its very nature, emphasizes that drug use is a health issue, not a criminal issue. In the Dutch context, the actual decriminalization of cannabis through the "coffee shop" system was associated with lower levels of heavy drug use, suggesting that decriminalization of light drugs may have led to a greater preference for these drugs and a greater refusal of heavier drugs, indicating a possible "separation effect" (MacCoun and Reuter 1997). In addition, in the Portuguese model, a focus on harm reduction, such as needle exchange programs and increased access to treatment, led to a significant reduction in drug-related deaths and HIV transmission rates (Greenwald 2009). Meanwhile, the Netherlands, which has partially legalized the cannabis trade, has generated substantial revenues from taxation of the cannabis sector. This financial flow not only boosts public coffers, but also takes control of the market away from illicit traffickers, thereby reducing the flow of related criminal offenses (Červený *et al.* 2017). Decriminalization also allows for a more rational use of law enforcement resources. For example, in the Czech Republic, where possession of small amounts of drugs was decriminalized in 2010, police efforts were directed toward more serious drug-related offenses rather than minor drug offenses, thereby optimizing the efficiency of the criminal justice apparatus (Eastwood *et al.* 2016). Accordingly, decriminalizing personal drug use weakens the social stigmas attached to it. This transformation fosters a more inclusive social environment in which rehabilitated drug users are more smoothly reintegrated, as observed in countries with rehabilitative and health-oriented approaches (Korf 2002).

In summary, the attempted decriminalization of drugs by European countries such as Portugal, the Netherlands, and the Czech Republic provides compelling empirical evidence that such legislative change can be beneficial from a legal, social, and economic perspective. For European countries considering similar paths, these success stories, which lead to tangible socio-economic gains, can be an important starting point.

Interim Findings

Drug use is determined by primary and secondary drivers of use. Primary drivers include natural human curiosity and the influence of biochemical processes in the human body, where drug users experience happiness and become addicted. Secondary factors are represented by drug supply systems and chains.

There are clear changes in the legal, cultural, and social processes around the world as decriminalization policies spread. The experience of countries that have decriminalized drugs shows that the consequences of such decriminalization practices are not inherently harmful, as previously thought. Countries with a

strict prohibition stance show an increase in drug consumption, while countries with a consistent decriminalization approach show a decrease in drug use, although there are discrepancies between the two scenarios, which call for a more detailed analysis of these figures. However, there is growing global momentum toward a coherent approach, as countries introspectively assess their established drug policies and consider more coherent and sustainable alternatives.

The key to this dialogue is to achieve legal coherence between criminalization and decriminalization, while trying to understand the possible consequences of drug-related legislation on people's consumption habits, thereby achieving consistency. Legal frameworks need to be formulated in a way that is consistent with public health objectives, ensuring that they do not discourage drug use and do not disproportionately punish users, especially those who only occasionally use light drugs without causing harm. The biggest threat is the lack of legal consistency, which leads to criminal consequences and the dangers of unregulated drug markets. The legal community and policymakers must take into account the good practices of countries that have decriminalized drugs when setting the future trajectory of global drug policy.

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Challenges, Discussions And/Or Solutions

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