PART FOUR

Getting Specific

We're not really going to get anywhere until we take the criminality out of drugs.

George P. Shultz
McNeil-Lehrer News Hour
December 18, 1989

Drugs are not dangerous because they are illegal; drugs are illegal because drugs are dangerous.

David Griffin
Canadian Police Association spokesman
2001

Legalization

Current Controversies: Drug Legalization

Scott Barbour

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In August 1999, federal agents announced that they had broken up one of America's twenty largest drug rings in a yearlong operation dubbed "Operation Southwest Express." In all, agents indicted 100 suspects, arrested 77, and seized 5,622 pounds of cocaine, two tons of marijuana, $1 million in cash, two Ferraris, a Land Rover, and seven weapons. In the process, they disrupted a network of smugglers and dealers that were bringing drugs into the country from Mexico through El Paso and supplying several major cities in the eastern and Midwestern United States, including Chicago, New York, and Boston.

While officials consider drug busts like Operation Southwest Express crucial to America's antidrug efforts, critics of the nation's drug war contend that breaking up one drug ring will have virtually no impact on the availability of drugs. Due to the great demand for illegal drugs in America—and the astronomical profits to be made by supplying them—another drug operation will quickly replace every one dismantled by the federal government. As David D. Boaz, vice president of the Cato Institute, states, "As long as Americans want to use drugs, and are willing to defy the law and pay high prices to do

so, drug busts are futile. Other profit-seeking smugglers and dealers will always be ready to step in and take the place of those arrested."

The debate over law-enforcement tactics like Operation Southwest Express reflects the larger debate over drug legalization. Critics of the war on drugs, such as Boaz, contend that drug prohibition is a futile, costly effort that has failed to reduce drug use. They point out that the drug war costs the federal government more than $16 billion a year and that billions more are spent at the state and local levels. As a result of this massive antidrug campaign, four hundred thousand Americans are imprisoned for drug law violations. Sixty percent of federal prisoners and 25 percent of state and local inmates are held on drug charges—mostly for the relatively minor offenses of possession or low-level dealing to fund their personal use.

Despite this enormous effort, drug war opponents argue, drugs remain readily available and their use is increasing. In 1998, the Monitoring the Future Survey conducted by the University of Michigan reported that 90.4 percent of high school seniors say marijuana is "fairly easy" or "very easy" to obtain. The National Household Survey on Drug Abuse (NHSDA), conducted annually by the U.S. Department of Health and Human Services, found that the number of drug users in America has increased from 12 million in 1992 to 13.6 million in 1998. The number of teens reporting drug use within the prior month increased from 5.3 percent in 1992 to 11.4 percent in 1997. Although that number dropped slightly to 9.9 percent in 1998, it still remains well above the 1992 level. Among young adults age eighteen to twenty-four, drug use has risen from 13.3 percent in 1994 to 16.1 percent in 1998. According to opponents of drug prohibition, these numbers are proof that the war on drugs is failing.

Rather than continuing to wage this disastrous war, critics assert, America should legalize drugs. Supporters of legalization contend that easing the nation's drug laws would have numerous benefits. Perhaps most importantly, they say, it would destroy the black market for drugs and the criminality that surrounds it. If drugs were legal

and available in the legitimate marketplace, drug smugglers and their networks of dealers would be put out of business. Drug gangs would no longer engage in violent battles for turf. Inner-city children would no longer be lured into drug-dealing gangs. As the American Civil Liberties Union (ACLU) puts it, drug legalization "would sever the connection between drugs and crime that today blights so many lives and communities."

Specific proposals for how to implement legalization vary widely. Libertarians advocate eliminating all federal drug laws. Others call for more modest reforms. Some focus exclusively on legalizing marijuana—either for medical purposes or more general use—while others want laws against all drugs relaxed. Some call for outright legalization, whereas others promote decriminalization—keeping laws on the books but reducing them to misdemeanor offenses or enforcing them selectively. Some favor legalizing all drugs but under a system of strict governmental regulation. Despite their differences, all advocates of legalization share the conviction that the current prohibitionist drug policies are not working—that they are in fact making drug-related problems worse—and that liberalization of the nation's drug laws is the only solution.

Opponents of legalization acknowledge that the war on drugs has not succeeded in eliminating drugs from society, but they reject the charge that the effort has been a total failure. While drug use has risen in many categories since the early 1990s, they concede, it is still much lower than it was in the 1970s, prior to the launching of the drug war. In 1979, according to the NHSDA, 14.1 percent of Americans surveyed reported having used an illegal drug during the previous month. That number declined to a low of 5.8 percent in 1992, and although it has since risen to 6.4 percent in 1997, it still remains well below the 1979 level. Drug use among teens shows a similar pattern, dropping from 16.3 percent in 1979 to 5.3 percent in 1992, then rising and falling and eventually hitting 9.9 percent in 1998.

Thus, while the drug war has not wiped drugs off the American scene, supporters maintain, it has clearly impacted drug use.

Legalization opponents also reject the argument that liberalizing drug laws would benefit society. They insist that legalizing drugs would inevitably lead to an increase in the use of newly legalized drugs such as marijuana, cocaine, heroin, and amphetamines. As Barry R. McCaffrey, the director of the Office of National Drug Control Policy, states, "Studies show that the more a product is available and legalized, the greater will be its use." This increased drug use would cause a variety of problems, including a decrease in workplace productivity and a rise in automobile and on-the-job accidents, health problems, addiction, and crime. Joseph A. Califano Jr., the president of the National Center on Addiction and Substance Abuse at Columbia University (CASA), explains that although legalization may result in a short-term decrease in drug arrests, the long-term consequences would be devastating: "Any short-term reduction in arrests from repealing drug laws would evaporate quickly as use increased and the criminal conduct—assault, murder, rape, child molestation, and other violence—that drugs like cocaine and methamphetamine spawn exploded."

Opponents of legalization insist that America must continue its antidrug campaign. Some support efforts to reduce the supply of drugs by disrupting international drug cartels and arresting smugglers and dealers. Others favor reducing the demand for drugs through treatment and education. Still others call for a comprehensive approach combining both supply and demand control elements. Despite these differences, all agree that relaxing the drug laws is not the answer to the nation's drug problem. As stated by Charles B. Rangel, a Democratic Congressman from New York, "Rather than holding up the white flag and allowing drugs to take over our country, we must continue to focus on drug demand as well as supply if we are to remain a free and productive society."

The debate over drug legalization, while rooted in real-world con-

cerns over crime, violence, and public health, is also about values. Often a person's position on the issue is based less on the practicality of maintaining or dismantling the nation's drug laws than on underlying beliefs about the morality of drug use. This moral dimension of the drug legalization debate adds another layer of complexity to an already difficult issue.

The Case for Legalisation: Time for a Puff of Sanity

The Economist

A series of articles entitled "High Time" appeared in the *Economist* on July 28, 2001, presenting the case for drug legalization in the United States. The following selection is the editorial expressing this position.

It is every parent's nightmare. A youngster slithers inexorably from a few puffs on a joint, to a snort of cocaine, to the needle and addiction. It was the flesh-creeping heart of *Traffic*, a film about the descent into heroin hell of a pretty young middle-class girl, and it is the terror that keeps drug laws in place. It explains why even those politicians who puffed at a joint or two in their youth hesitate to put the case for legalising drugs.

The terror is not irrational. For the first thing that must be said about legalising drugs, a cause the *Economist* long advocated and returns to this week, is that it would lead to a rise in their use, and therefore to a rise in the number of people dependent on them. Some argue that drug laws have no impact, because drugs are widely available. Untrue: drugs are expensive—a kilo of heroin sells in America for as much as a new Rolls-Royce—partly because their price reflects the dangers involved in distributing and buying them. It is much harder and riskier to pick up a dose of cocaine than it is to buy a bottle of whisky. Remove such constraints, make drugs accessible and very much cheaper, and more people will experiment with them.

A rise in drug-taking will inevitably mean that more people will become dependent—inevitably, because drugs offer a pleasurable

experience that people seek to repeat. In the case of most drugs, that dependency may be no more than a psychological craving and affect fewer than one in five users; in the case of heroin, it is physical and affects maybe one in three. Even a psychological craving can be debilitating. Addicted gamblers and drinkers bring misery to themselves and their families. In addition, drugs have lasting physical effects and some, taken incompetently, can kill. This is true both for some "hard" drugs and for some that people think of as "soft": too much heroin can trigger a strong adverse reaction, but so can ecstasy. The same goes for gin or aspirin, of course; but many voters reasonably wonder whether it would be right to add to the list of harmful substances that are legally available.

OF MILL AND MORALITY

The case for doing so rests on two arguments: one of principle, one practical. The principles were set out, a century and a half ago, by John Stuart Mill, a British liberal philosopher, who urged that the state had no right to intervene to prevent individuals from doing something that harmed them, if no harm was thereby done to the rest of society. "Over himself, over his own body and mind, the individual is sovereign," Mill famously proclaimed. This is a view that the *Economist* has always espoused, and one to which most democratic governments adhere, up to a point. They allow the individual to undertake all manner of dangerous activities unchallenged, from mountaineering to smoking to riding bicycles through city streets. Such pursuits alarm insurance companies and mothers, but are rightly tolerated by the state.

True, Mill argued that some social groups, especially children, required extra protection. And some argue that drug-takers are also a special class: once addicted, they can no longer make rational choices about whether to continue to harm themselves. Yet not only are dependent users a minority of all users; in addition, society has

rejected this argument in the case of alcohol—and of nicotine (whose addictive power is greater than that of heroin). The important thing here is for governments to spend adequately on health education.

The practical case for a liberal approach rests on the harms that spring from drug bans, and the benefits that would accompany legalisation. At present, the harms fall disproportionately on poor countries and on poor people in rich countries. In producer and entrepot countries, the drugs trade finances powerful gangs who threaten the state and corrupt political institutions. Colombia is the most egregious example, but Mexico too wrestles with the threat to the police and political honesty. The attempt to kill illicit crops poisons land and people. Drug money helps to prop up vile regimes in Myanmar and Afghanistan. And drug production encourages local drug-taking, which (in the case of heroin) gives a helping hand to the spread of HIV/AIDS.

In the rich world, it is the poor who are most likely to become involved in the drugs trade (the risks may be high, but drug-dealers tend to be equal-opportunity employers), and therefore end up in jail. Nowhere is this more shamefully true than in the United States, where roughly one in four prisoners is locked up for a (mainly non-violent) drugs offence. America's imprisonment rate for drugs offences now exceeds that for all crimes in most West European countries. Moreover, although whites take drugs almost as freely as blacks and Hispanics, a vastly disproportionate number of those arrested, sentenced and imprisoned are non-white. Drugs policy in the United States is thus breeding a generation of men and women from disadvantaged backgrounds whose main training for life has been in the violence of prison.

LEGALISE TO REGULATE

Removing these harms would bring with it another benefit. Precisely because the drugs market is illegal, it cannot be regulated. Laws can-

not discriminate between availability to children and adults. Governments cannot insist on minimum quality standards for cocaine; or warn asthma sufferers to avoid ecstasy; or demand that distributors take responsibility for the way their products are sold. With alcohol and tobacco, such restrictions are possible; with drugs, not. This increases the dangers to users, and especially to young or incompetent users. Illegality also puts a premium on selling strength: if each purchase is risky, then it makes sense to buy drugs in concentrated form. In the same way, Prohibition in the United States in the 1920s led to a fall in beer consumption but a rise in the drinking of hard liquor.

How, if governments accepted the case for legalisation, to get from here to there? When, in the 18th century, a powerful new intoxicant became available, the impact was disastrous: it took years of education for gin to cease to be a social threat. That is a strong reason to proceed gradually: it will take time for conventions governing sensible drug-taking to develop. Meanwhile, a century of illegality has deprived governments of much information that good policy requires. Impartial academic research is difficult. As a result, nobody knows how demand may respond to lower prices, and understanding of the physical effects of most drugs is hazy.

And how, if drugs were legal, might they be distributed? The thought of heroin on supermarket shelves understandably adds to the terror of the prospect. Just as legal drugs are available through different channels—caffeine from any café, alcohol only with proof of age, Prozac only on prescription—so the drugs that are now illegal might one day be distributed in different ways, based on knowledge about their potential for harm. Moreover, different countries should experiment with different solutions: at present, many are bound by a United Nations convention that hampers even the most modest moves towards liberalisation, and that clearly needs amendment.

To legalise will not be easy. Drug-taking entails risks, and societies are increasingly risk-averse. But the role of government should be to prevent the most chaotic drug-users from harming others—by robbing

or by driving while drugged, for instance—and to regulate drug markets to ensure minimum quality and safe distribution. The first task is hard if law enforcers are preoccupied with stopping all drug use; the second, impossible as long as drugs are illegal. A legal market is the best guarantee that drug-taking will be no more dangerous than drinking alcohol or smoking tobacco. And, just as countries rightly tolerate those two vices, so they should tolerate those who sell and take drugs.

Against the Legalization of Drugs

James Q. Wilson

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In 1972, the president appointed me chairman of the National Advisory Council for Drug Abuse Prevention. Created by Congress, the Council was charged with providing guidance on how best to coordinate the national war on drugs. (Yes, we called it a war then, too.) In those days, the drug we were chiefly concerned with was heroin. When I took office, heroin use had been increasing dramatically. Everybody was worried that this increase would continue. Such phrases as "heroin epidemic" were commonplace.

That same year, the eminent economist Milton Friedman published an essay in *Newsweek* in which he called for legalizing heroin. His argument was on two grounds: As a matter of ethics, the government has no right to tell people not to use heroin (or to drink or to commit suicide); as a matter of economics, the prohibition of drug use imposes costs on society that far exceed the benefits. Others, such as the psychoanalyst Thomas Szasz, made the same argument.

We did not take Friedman's advice. I do not recall that we even discussed legalizing heroin, though we did discuss (but did not take action on) legalizing a drug, cocaine, that many people then argued was benign. Our marching orders were to figure out how to win the war on heroin, not to run up the white flag of surrender.

That was 1972. Today, we have the same number of heroin addicts that we had then—half a million, give or take a few thousand. Having that many heroin addicts is no trivial matter; these people deserve our attention. But not having had an increase in that number for over fifteen years is also something that deserves our attention. What happened to the "heroin epidemic" that many people once thought would overwhelm us?

The facts are clear: A more or less stable pool of heroin addicts has been getting older, with relatively few new recruits. In 1976 the average age of heroin users who appeared in hospital emergency rooms was about twenty-seven; ten years later it was thirty-two. More than two-thirds of all heroin users appearing in emergency rooms are now over the age of thirty. Back in the early 1970s, when heroin got onto the national political agenda, the typical heroin addict was much younger, often a teenager. Household surveys show the same thing—the rate of opiate use (which includes heroin) has been flat for the better part of two decades. More fine-grained studies of inner-city neighborhoods confirm this. John Boyle and Ann Brunswick found that the percentage of young blacks in Harlem who used heroin fell from 8 percent in 1970–71 to about 3 percent in 1975–76.

Why did heroin lose its appeal for young people? When the young blacks in Harlem were asked why they stopped, more than half mentioned "trouble with the law" or "high cost" (and high cost is, of course, directly the result of law enforcement). Two-thirds said that heroin hurt their health; nearly all said they had had a bad experience with it. We need not rely, however, simply on what they said. In New York City in 1973–75, the street price of heroin rose dramatically and its purity sharply declined, probably as a result of the heroin shortage caused by the success of the Turkish government in reducing the supply of opium base and of the French government in closing down heroin-processing laboratories located in and around Marseilles. These were short-lived gains for, just as Friedman predicted, alternative sources of supply—mostly in Mexico—quickly emerged. But

the three-year heroin shortage interrupted the easy recruitment of new users.

Health and related problems were no doubt part of the reason for the reduced flow of recruits. Over the preceding years, Harlem youth had watched as more and more heroin users died of overdoses, were poisoned by adulterated doses, or acquired hepatitis from dirty needles. The word got around: heroin can kill you. By 1974 new hepatitis cases and drug-overdose deaths had dropped to a fraction of what they had been in 1970.

Alas, treatment did not seem to explain much of the cessations in drug use. Treatment programs can and do help heroin addicts, but treatment did not explain the drop in the number of *new* users (who by definition had never been in treatment) nor even much of the reduction in the number of experienced users.

No one knows how much of the decline to attribute to personal observation as opposed to high prices or reduced supply. But other evidence suggests strongly that price and supply played a large role. In 1972 the National Advisory Council was especially worried by the prospect that U.S. servicemen returning to this country from Vietnam would bring their heroin habits with them. Fortunately, a brilliant study by Lee Robins of Washington University in St. Louis put that fear to rest. She measured drug use of Vietnam veterans shortly after they had returned home. Though many had used heroin regularly while in Southeast Asia, most gave up the habit when back in the United States. The reason: Here, heroin was less available and sanctions on its use were more pronounced. Of course, if a veteran had been willing to pay enough—which might have meant traveling to another city and would certainly have meant making an illegal contact with a disreputable dealer in a threatening neighborhood in order to acquire a (possibly) dangerous dose—he could have sustained his drug habit. Most veterans were unwilling to pay this price, and so their drug use declined or disappeared.

RELIVING THE PAST

Suppose we had taken Friedman's advice in 1972. What would have happened? We cannot be entirely certain, but at a minimum we would have placed the young heroin addicts (and, above all, the prospective addicts) in a very different position from the one in which they actually found themselves. Heroin would have been legal. Its price would have been reduced by 95 percent (minus whatever we chose to recover in taxes). Now that it could be sold by the same people who make aspirin, its quality would have been ensured—no poisons, no adulterants. Sterile hypodermic needles would have been readily available at the neighborhood drugstore, probably at the same counter where the heroin was sold. No need to travel to big cities or unfamiliar neighborhoods—heroin could have been purchased anywhere, perhaps by mail order.

There would no longer have been any financial or medical reason to avoid heroin use. Anybody could have afforded it. We might have tried to prevent children from buying it, but as we have learned from our efforts to prevent minors from buying alcohol and tobacco, young people have a way of penetrating markets theoretically reserved for adults. Returning Vietnam veterans would have discovered that Omaha and Raleigh had been converted into the pharmaceutical equivalent of Saigon.

Under these circumstance, can we doubt for a moment that heroin use would have grown exponentially? Or that a vastly larger supply of new users would have been recruited? Professor Friedman is a Nobel Prize–winning economist whose understanding of market forces is profound. What did he think would happen to consumption under his legalized regime? Here are his words: "Legalizing drugs might increase the number of addicts but it is not clear that it would. Forbidden fruit is attractive, particularly to the young."

Really? I suppose that we should expect no increase in Porsche sales if we cut the price by 95 percent, no increase in whiskey sales

if we cut the price by a comparable amount—because young people only want fast cars and strong liquor when they are "forbidden." Perhaps Friedman's uncharacteristic lapse from the obvious implications of price theory can be explained by a misunderstanding of how drug users are recruited. In his 1972 essay he said that "drug addicts are deliberately made by pushers, who give likely prospects their first few doses free." If drugs were legal it would not pay anybody to produce addicts, because everybody would buy from the cheapest source. But as every drug expert knows, pushers do not produce addicts. Friends or acquaintances do. In fact, pushers are usually reluctant to deal with nonusers because a nonuser could be an undercover cop. Drug use spreads in the same way any fad or fashion spreads: Somebody who is already a user urges his friends to try, or simply shows already eager friends how to do it.

But we need not rely on speculation, however plausible, that lowered prices and more abundant supplies would have increased heroin usage. Great Britain once followed such a policy and with almost exactly those results. Until the mid-1960s, British physicians were allowed to prescribe heroin to certain classes of addicts. (Possessing these drugs without a doctor's prescription remained a criminal offense.) For many years this policy worked well enough because the addict patients were typically middle-class people who had become dependent on opiate painkillers while undergoing hospital treatment. There was no drug culture. The British system worked for many years, not because it prevented drug abuse, but because there was no problem of drug abuse that would test the system.

All that changed in the 1960s. A few unscrupulous doctors began passing out heroin in wholesale amounts. One doctor prescribed almost 600,000 heroin tablets—that is, over thirteen pounds—in just one year. A youthful drug culture emerged with a demand for drugs far different from that of the older addicts. As a result, the British government required doctors to refer users to government-run clinics to receive their heroin.

But the shift to clinics did not curtail the growth in heroin use. Throughout the 1960s the number of addicts increased—the late John Kaplan of Stanford estimated by fivefold—in part as a result of the diversion of heroin from clinic patients to new users on the streets. An addict would bargain with the clinic doctor over how big a dose he would receive. The patient wanted as much as he could get, the doctor wanted to give as little as was needed. The patient had an advantage in this conflict because the doctor could not be certain how much was really needed. Many patients would use some of their "maintenance" dose and sell the remaining part to friends, thereby recruiting new addicts. As the clinics learned of this, they began to shift their treatment away from heroin and toward methadone, an addictive drug that, when taken orally, does not produce a "high" but will block the withdrawal pains associated with heroin abstinence.

Whether what happened in England in the 1960s was a mini-epidemic or an epidemic depends on whether one looks at numbers or at rates of change. Compared to the United States, the numbers were small. In 1960 there were sixty-eight heroin addicts known to the British government; by 1968 there were two thousand in treatment and many more who refused treatment. (They would refuse in part because they did not want to get methadone at a clinic if they could get heroin on the street.) Richard Hartnoll estimates that the actual number of addicts in England is five times the number officially registered. At a minimum, the number of British addicts increased by thirty-fold in ten years; the actual increase may have been much larger.

In the early 1980s the numbers began to rise again, and this time nobody doubted that a real epidemic was at hand. The increase was estimated to be 40 percent a year. By 1982 there were thought to be 20,000 heroin users in London alone. Geoffrey Pearson reports that many cities—Glasgow, Liverpool, Manchester, and Sheffield among them—were now experiencing a drug problem that once had been largely confined to London. The problem, again, was supply. The

country was being flooded with cheap, high-quality heroin, first from Iran and then from Southeast Asia.

The United States began the 1960s with a much larger number of heroin addicts and probably a bigger at-risk population than was the case in Great Britain. Even though it would be foolhardy to suppose that the British system, if installed here, would have worked the same way or with the same results, it would be equally foolhardy to suppose that a combination of heroin available from leaky clinics and from street dealers who faced only minimal law-enforcement risks would not have produced a much greater increase in heroin use than we actually experienced. My guess is that if we had allowed either doctors or clinics to prescribe heroin, we would have had far worse results than were produced in Britain, if for no other reason than the vastly larger number of addicts with which we began. We would have had to find some way to police thousands (not scores) of physicians and hundreds (not dozens) of clinics. If the British civil service found it difficult to keep heroin in the hands of addicts and out of the hands of recruits when it was dealing with a few hundred people, how well would the American civil service have accomplished the same tasks when dealing with tens of thousands of people?

BACK TO THE FUTURE

Now cocaine, especially in its potent form, crack, is the focus of attention. Now as in 1972 the government is trying to reduce its use. Now as then some people are advocating legalization. Is there any more reason to yield to those arguments today than there was almost two decades ago?[1]

I think not. If we had yielded in 1972 we almost certainly would

1. I do not here take up the question of marijuana. For a variety of reasons—its widespread use and its lesser tendency to addict—it presents a different problem from cocaine or heroin. For a penetrating analysis, see Mark Kleiman, *Marijuana: Costs of Abuse, Costs of Control* (Westport, Conn.: Greenwood Press, 1989).

have had today a permanent population of several million, not several hundred thousand, heroin addicts. If we yield now we will have a far more serious problem with cocaine.

Crack is worse than heroin by almost any measure. Heroin produces a pleasant drowsiness and, if hygienically administered, has only the physical side effects of constipation and sexual impotence. Regular heroin use incapacitates many users, especially poor ones, for any productive work or social responsibility. They will sit nodding on a street corner, helpless but at least harmless. By contrast, regular cocaine use leaves the user neither helpless nor harmless. When smoked (as with crack) or injected, cocaine produces instant, intense, and short-lived euphoria. The experience generates a powerful desire to repeat it. If the drug is readily available, repeat use will occur. Those people who progress to "bingeing" on cocaine become devoted to the drug and its effects to the exclusion of almost all other considerations—job, family, children, sleep, food, even sex. Dr. Frank Gawin at Yale and Dr. Everett Ellinwood at Duke report that a substantial percentage of all high-dose, binge users become uninhibited, impulsive, hypersexual, compulsive, irritable, and hyperactive. Their moods vacillate dramatically, leading at times to violence and homicide.

Women are much more likely to use crack than heroin, and if they are pregnant, the effects on their babies are tragic. Douglas Besharov, who has been following the effects of drugs on infants for twenty years, writes that nothing he learned about heroin prepared him for the devastation of cocaine. Cocaine harms the fetus and can lead to physical deformities or neurological damage. Some crack babies have for all practical purposes suffered a disabling stroke while still in the womb. The long-term consequences of this brain damage are lowered cognitive ability and the onset of mood disorders. Besharov estimates that about 30,000 to 50,000 such babies are born every year, about 7,000 in New York City alone. There may be ways to treat such infants, but from everything we now know the treatment

will be long, difficult, and expensive. Worse, the mothers who are most likely to produce crack babies are precisely the ones who, because of poverty or temperament, are least able and willing to obtain such treatment. In fact, anecdotal evidence suggests that crack mothers are likely to abuse their infants.

The notion that abusing drugs such as cocaine is a "victimless crime" is not only absurd but dangerous. Even ignoring the fetal drug syndrome, crack-dependent people are, like heroin addicts, individuals who regularly victimize their children by neglect, their spouses by improvidence, their employers by lethargy, and their coworkers by carelessness. Society is not and could never be a collection of autonomous individuals. We all have a stake in ensuring that each of us displays a minimal level of dignity, responsibility, and empathy. We cannot, of course, coerce people into goodness, but we can and should insist that some standards must be met if society itself—on which the very existence of the human personality depends—is to persist. Drawing the line that defines those standards is difficult and contentious, but if crack and heroin use do not fall below it, what does?

The advocates of legalization will respond by suggesting that my picture is overdrawn. Ethan Nadelmann of Princeton argues that the risk of legalization is less than most people suppose. Over 20 million Americans between the ages of eighteen and twenty-five have tried cocaine (according to a government survey), but only a quarter million use it daily. From this Nadelmann concludes that at most 3 percent of all young people who try cocaine develop a problem with it. The implication is clear: Make the drug legal and we only have to worry about 3 percent of our youth.

The implication rests on a logical fallacy and a factual error. The fallacy is this: The percentage of occasional cocaine users who become binge users *when the drug is illegal* (and thus expensive and hard to find) tells us nothing about the percentage who will become dependent when the drug is legal (and thus cheap and abundant).

Drs. Gawin and Ellinwood report, in common with several other researchers, that controlled or occasional use of cocaine changes to compulsive and frequent use "when access to the drug increases" or when the user switches from snorting to smoking. More cocaine more potently administered alters, perhaps sharply, the proportion of "controlled" users who become heavy users.

The factual error is this: The federal survey Nadelmann quotes was done in 1985, before crack had become common. Thus the probability of becoming dependent on cocaine was derived from the responses of users who snorted the drug. The speed and potency of cocaine's action increases dramatically when it is smoked. We do not yet know how greatly the advent of crack increases the risk of dependency, but all the clinical evidence suggests that the increase is likely to be large.

It is possible that some people will not become heavy users even when the drug is readily available in its most potent form. So far there are no scientific grounds for predicting who will and who will not become dependent. Neither socioeconomic background nor personality traits differentiate between casual and intensive users. Thus, the only way to settle the question of who is correct about the effect of easy availability on drug use, Nadelmann or Gawin and Ellinwood, is to try it and see. But that social experiment is so risky as to be no experiment at all, for if cocaine is legalized and if the rate of its abusive use increases dramatically, there is no way to put the genie back in the bottle, and it is not a kindly genie.

HAVE WE LOST?

Many people who agree that there are risks in legalizing cocaine or heroin still favor it because, they think, we have lost the war on drugs. "Nothing we have done has worked" and the current federal policy is just "more of the same." Whatever the costs of greater drug use, surely they would be less than the costs of our present, failed efforts.

That is exactly what I was told in 1972—and heroin is not quite as bad a drug as cocaine. We did not surrender and we did not lose. We did not win, either. What the nation accomplished then was what most efforts to save people from themselves accomplish: The problem was contained and the number of victims minimized, all at a considerable cost in law enforcement and increased crime. Was the cost worth it? I think so, but others may disagree. What are the lives of would-be addicts worth? I recall some people saying to me then, "Let them kill themselves." I was appalled. Happily, such views did not prevail.

Have we lost today? Not at all. High-rate cocaine use is not commonplace. The National Institute of Drug Abuse (NIDA) reports that less than 5 percent of high school seniors used cocaine within the last thirty days. Of course this survey misses young people who have dropped out of school and miscounts those who lie on the questionnaire, but even if we inflate the NIDA estimate by some plausible percentage, it is still not much above 5 percent. Medical examiners reported in 1987 that about 1,500 died from cocaine use; hospital emergency rooms reported about 30,000 admissions related to cocaine abuse.

These are not small numbers, but neither are they evidence of a nationwide plague that threatens to engulf us all. Moreover, cities vary greatly in the proportion of people who are involved with cocaine. To get city-level data we need to turn to drug tests carried out on arrested persons, who obviously are more likely to be drug users than the average citizen. The National Institute of Justice, through its Drug Use Forecasting (DUF) project, collects urinalysis data on arrestees in twenty-two cities. As we have already seen, opiate (chiefly heroin) use has been net or declining in most of these cities over the last decade. Cocaine use has gone up sharply, but with great variation among cities. New York, Philadelphia, and Washington, D.C., all report that two-thirds or more of their arrestees tested posi-

tive for cocaine, but in Portland, San Antonio, and Indianapolis the percentage was one-third or less.

In some neighborhoods, of course, matters have reached crisis proportions. Gangs control the streets, shootings terrorize residents, and drug dealing occurs in plain view. The police seem barely able to contain matters. But in these neighborhoods—unlike at Palo Alto cocktail parties—the people are not calling for legalization, they are calling for help. And often not much help has come. Many cities are willing to do almost anything about the drug problem except spend more money on it. The federal government cannot change that; only local voters and politicians can. It is not clear that they will.

It took about ten years to contain heroin. We have had experience with crack for only about three or four years. Each year we spend perhaps $11 billion on law enforcement (and some of that goes to deal with marijuana) and perhaps $2 billion on treatment. Large sums, but not sums that should lead anyone to say, "We just can't afford this anymore."

The illegality of drugs increases crime, partly because some users turn to crime to pay for their habits, partly because some users are stimulated by certain drugs (such as crack or PCP) to act more violently or ruthlessly than they otherwise would, and partly because criminal organizations seeking to control drug supplies use force to manage their markets. These also are serious costs, but no one knows how much they would be reduced if drugs were legalized. Addicts would no longer steal to pay black-market prices for drugs, a real gain. But some, perhaps a great deal, of that gain would be offset by the great increase in the number of addicts. These people, nodding on heroin or living in the delusion-ridden high of cocaine, would hardly be ideal employees. Many would steal simply to support themselves, since snatch-and-grab, opportunistic crime can be managed even by people unable to hold a regular job or plan an elaborate crime. Those British addicts who get their supplies from government clinics are not models of law-abiding decency. Most are in crime, and though their

per capita rate of criminality may be lower thanks to the cheapness of their drugs, the total volume of crime they produce may be quite large. Of course, society could decide to support all unemployable addicts on welfare, but that would mean that gains from lowered rates of crime would have to be offset by large increases in welfare budgets.

Proponents of legalization claim that the costs of having more addicts around would be largely if not entirely offset by having more money available with which to treat and care for them. The money would come from taxes levied on the sale of heroin and cocaine.

To obtain this fiscal dividend, however, legalization's supporters must first solve an economic dilemma. If they want to raise a lot of money to pay for welfare and treatment, the tax rate on the drugs will have to be quite high. Even if they themselves do not want a high rate, the politicians' love of "sin taxes" would probably guarantee that it would be high anyway. But the higher the tax, the higher the price of the drug, and the higher the price the greater the likelihood that addicts will turn to crime to find the money for it and that criminal organizations will be formed to sell tax-free drugs at below-market rates. If we managed to keep taxes (and thus prices) low, we would get that much less money to pay for welfare and treatment and more people could afford to become addicts. There may be an optimal tax rate for drugs that maximizes revenue while minimizing crime, bootlegging, and the recruitment of new addicts, but our experience with alcohol does not suggest that we know how to find it.

THE BENEFITS OF ILLEGALITY

The advocates of legalization find nothing to be said in favor of the current system except, possibly, that it keeps the number of addicts smaller than it would otherwise be. In fact, the benefits are more substantial than that.

First, treatment. All the talk about providing "treatment on demand" implies that there is a demand for treatment. That is not

quite right. There are some drug-dependent people who genuinely want treatment and will remain in it if offered; they should receive it. But there are far more who want only short-term help after a bad crash; once stabilized and bathed, they are back on the street again, hustling. And even many of the addicts who enroll in a program honestly wanting help drop out after a short while when they discover that help takes time and commitment. Drug-dependent people have very short time horizons and a weak capacity for commitment. These two groups—those looking for a quick fix and those unable to stick with a long-term fix—are not easily helped. Even if we increase the number of treatment slots—as we should—we would have to do something to make treatment more effective.

One thing that can often make it more effective is compulsion. Douglas Anglin of UCLA, in common with many other researchers, has found that the longer one stays in a treatment program, the better the chances of a reduction in drug dependency. But he, again like most other researchers, has found that drop-out rates are high. He has also found, however, that patients who enter treatment under legal compulsion stay in the program longer than those not subject to such pressure. His research on the California civil commitment program, for example, found that heroin users involved with its required drug-testing program had over the long term a lower rate of heroin use than similar addicts who were free of such constraints. If for many addicts compulsion is a useful component of treatment, it is not clear how compulsion could be achieved in a society in which purchasing, possessing, and using the drug were legal. It could be managed, I suppose, but I would not want to have to answer the challenge from the American Civil Liberties Union that it is wrong to compel a person to undergo treatment for consuming a legal commodity.

Next, education. We are now investing substantially in drug-education programs in the schools. Though we do not yet know for certain what will work, there are some promising leads. But I wonder

how credible such programs would be if they were aimed at dissuading children from doing something perfectly legal. We could, of course, treat drug education like smoking education: Inhaling crack and inhaling tobacco are both legal, but you should not do it because it is bad for you. That tobacco is bad for you is easily shown; the Surgeon General has seen to that. But what do we say about crack? It is pleasurable, but devoting yourself to so much pleasure is not a good idea (though perfectly legal)? Unlike tobacco, cocaine will not give you cancer or emphysema, but it will lead you to neglect your duties to family, job, and neighborhood? Everybody is doing cocaine, but you should not?

Again, it might be possible under a legalized regime to have effective drug-prevention programs, but their effectiveness would depend heavily, I think, on first having decided that cocaine use, like tobacco use, is purely a matter of practical consequences; no fundamental moral significance attaches to either. But if we believe—as I do—that dependency on certain mind-altering drugs is a moral issue and that their illegality rests in part on their immorality, then legalizing them undercuts, if it does not eliminate altogether, the moral message.

That message is at the root of the distinction we now make between nicotine and cocaine. Both are highly addictive; both have harmful physical effects. But we treat the two drugs differently, not simply because nicotine is so widely used as to be beyond the reach of effective prohibition, but because its use does not destroy the user's essential humanity. Tobacco shortens one's life, cocaine debases it. Nicotine alters one's habits, cocaine alters one's soul. The heavy use of crack, unlike the heavy use of tobacco, corrodes those natural sentiments of sympathy and duty that constitute our human nature and make possible our social life. To say, as does Nadelmann, that distinguishing morally between tobacco and cocaine is "little more than a transient prejudice" is close to saying that morality itself is but a prejudice.

THE ALCOHOL PROBLEM

Now we have arrived where many arguments about legalizing drugs begin: Is there any reason to treat heroin and cocaine differently from the way we treat alcohol?

There is no easy answer to that question because, as with so many human problems, one cannot decide simply on the basis either of moral principles or of individual consequences; one has to temper any policy by a commonsense judgment of what is possible. Alcohol, like heroin, cocaine, PCP, and marijuana, is a drug—that is, a mood-altering substance—and consumed to excess it certainly has harmful consequences: auto accidents, barroom fights, bedroom shootings. It is also, for some people, addictive. We cannot confidently compare the addictive powers of these drugs, but the best evidence suggests that crack and heroin are much more addictive than alcohol.

Many people, Nadelmann included, argue that since the health and financial costs of alcohol abuse are so much higher than those of cocaine or heroin abuse, it is hypocritical folly to devote our efforts to preventing cocaine or drug use. But as Mark Kleiman of Harvard has pointed out, this comparison is quite misleading. What Nadelmann is doing is showing that a *legalized* drug (alcohol) produces greater social harm than *illegal* ones (cocaine and heroin). But of course. Suppose that in the 1920s we had made heroin and cocaine legal and alcohol illegal. Can anyone doubt that Nadelmann would now be writing that it is folly to continue our ban on alcohol because cocaine and heroin are so much more harmful?

And let there be no doubt about it—widespread heroin and cocaine use are associated with all manner of ills. Thomas Bewley found that the mortality rate of British heroin addicts in 1968 was 28 times as high as the death rate of the same age group of nonaddicts, even though in England at the time an addict could obtain free or low-cost heroin and clean needles from British clinics. Perform the following mental experiment: Suppose we legalized heroin and

cocaine in this country. In what proportion of auto fatalities would the state police report that the driver was nodding off on heroin or recklessly driving on a coke high? In what proportion of spouse-assault and child-abuse cases would the local police report that crack was involved? In what proportion of industrial accidents would safety investigators report that the forklift or drill-press operator was in a drug-induced stupor or frenzy? We do not know exactly what the proportion would be, but anyone who asserts that it would not be much higher than it is now would have to believe that these drugs have little appeal except when they are illegal. And that is nonsense.

An advocate of legalization might concede that social harm—perhaps harm equivalent to that already produced by alcohol—would follow from making cocaine and heroin generally available. But at least, he might add, we would have the problem "out in the open" where it could be treated as a matter of "public health." That is well and good, *if* we knew how to treat—that is, cure—heroin and cocaine abuse. But we do not know how to do it for all the people who would need such help. We are having only limited success in coping with chronic alcoholics. Addictive behavior is immensely difficult to change, and the best methods for changing it—living in drug-free therapeutic communities, becoming faithful members of Alcoholics Anonymous or Narcotics Anonymous—require great personal commitment, a quality that is, alas, in short supply among the very persons—young people, disadvantaged people—who are often most at risk for addiction.

Suppose that today we had, not 15 million alcohol abusers, but half a million. Suppose that we already knew what we have learned from our long experience with the widespread use of alcohol. Would we make whiskey legal? I do not know, but I suspect there would be a lively debate. The Surgeon General would remind us of the risks alcohol poses to pregnant women. The National Highway Traffic Safety Administration would point to the likelihood of more highway fatalities caused by drunk drivers. The Food and Drug Administration

might find that there is a nontrivial increase in cancer associated with alcohol consumption. At the same time the police would report great difficulty in keeping illegal whiskey out of our cities, officers being corrupted by bootleggers, and alcohol addicts often resorting to crime to feed their habit. Libertarians, for their part, would argue that every citizen has a right to drink anything he wishes and that drinking is, in any event, a "victimless crime."

However the debate might turn out, the central fact would be that the problem was still, at that point, a small one. The government cannot legislate away the addictive tendencies in all of us, nor can it remove completely even the most dangerous addictive substances. But it can cope with harms when the harms are still manageable.

One advantage of containing a problem while it is still containable is that it buys time for science to learn more about it and perhaps to discover a cure. Almost unnoticed in the current debate over legalizing drugs is that basic science has made rapid strides in identifying the underlying neurological processes involved in some forms of addiction. Stimulants such as cocaine and amphetamines alter the way certain brain cells communicate with one another. That alteration is complex and not entirely understood, but in simplified form it involves modifying the way in which a neurotransmitter called dopamine sends signals from one cell to another.

When dopamine crosses the synapse between two cells, it is in effect carrying a message from the first cell to activate the second one. In certain parts of the brain that message is experienced as pleasure. After the message is delivered, the dopamine returns to the first cell. Cocaine apparently blocks the return, or "reuptake," so that the excited cell and others nearby continue to send pleasure messages. When the exaggerated high produced by cocaine-influenced dopamine finally ends, the brain cells may (in ways that are still a matter of dispute) suffer from an extreme lack of dopamine, thereby making the individual unable to experience any pleasure at all. This would explain why cocaine users often feel so depressed after enjoying the

drug. Stimulants may also affect the way in which other neurotransmitters, such as serotonin and noradrenaline, operate.

Whatever the exact mechanism may be, once it is identified it becomes possible to use drugs to block either the effect of cocaine or its tendency to produce dependency. There have been experiments using desipramine, imipramine, bromocriptine, carbamazepine, and other chemicals. There are some promising results.

Tragically, we spend very little on such research, and the agencies funding it have not in the past occupied very influential or visible posts in the federal bureaucracy. If there is one aspect of the "war on drugs" metaphor that I dislike, it is the tendency to focus attention almost exclusively on the troops in the trenches, whether engaged in enforcement or treatment, and away from the research-and-development efforts back on the home front where the war may ultimately be decided.

I believe that the prospects of scientists in controlling addiction will be strongly influenced by the size and character of the problem they face. If the problem is a few hundred thousand chronic high-dose users of an illegal product, the chances of making a difference at a reasonable cost will be much greater than if the problem is a few million chronic users of legal substance. Once a drug is legal, not only will its use increase but many of those who then use it will prefer the drug to the treatment: They will want the pleasure. Whatever the cost to themselves or their families, they will resist—probably successfully—any effort to wean them away from experiencing the high that comes from inhaling a legal substance.

IF I AM WRONG . . .

No one can know what our society would be like if we changed the law to make access to cocaine, heroin, and PCP easier. I believe, for reasons given, that the result would be a sharp increase in use, a

more widespread degradation of the human personality, and a greater rate of accidents and violence.

I may be wrong. If I am, then we will needlessly have incurred heavy costs in law enforcement and some forms of criminality. But if I am right, and the legalizers prevail anyway, then we will have consigned millions of people, hundreds of thousands of infants, and hundreds of neighborhoods to a life of oblivion and disease. To the lives and families destroyed by alcohol we will have added countless more destroyed by cocaine, heroin, PCP, and whatever else a basement scientist can invent.

Human character is formed by society; indeed, human character is inconceivable without society, and good character is less likely in a bad society. Will we, in the name of an abstract doctrine of radical individualism, and with the false comfort of suspect predictions, decide to take the chance that somehow individual decency can survive amid a more general level of degradation?

I think not. The American people are too wise for that, whatever the academic essayists and cocktail-party pundits may say. But if Americans today are less wise than I suppose, then Americans at some future time will look back on us now and wonder, what kind of people were they that they could have done such a thing?

Decriminalization

Alternative Perspectives on the Drug Policy Debate

Duane McBride, Yvonne M. Terry-McElrath, and James A. Inciardi

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The decriminalization position emerged most clearly during the past decade. Supporters forcefully argued that current national drug policy has failed to prevent recent increases in youth drug use while succeeding in eroding basic civil rights, overwhelming the criminal justice system, and eroding public support for law enforcement. Many of those who today advocate for decriminalization previously supported medicalization or some type of mild regulation. However, they have become much more radical: They believe that almost any type of government prohibition or regulation is doomed to failure and will bring about enormously negative civil and moral consequences. As Arnold Trebach has said, "I have come to believe that the urban situation in America is so desperate as to demand the nearly immediate dismantling of drug prohibition" (in Trebach & Inciardi, 1993, p. 13).

Decriminalization has many similarities to other "reform" posi-

tions: It consistently calls for more humane treatment of drug addicts, including physician treatment. The position also seems to advocate elements of harm reduction: Supporters want accurate, scientifically based information about drugs and their real effects available to the public. Most also urge distribution of paraphernalia as the avenue of the safest possible use. Decriminalization also resembles the legalization/regulation perspective in that supporters wish to immediately remove criminal penalties from drug use. However, one crucial difference divides the two positions. That difference rests on John Stuart Mill's philosophy as presented in his book *On Liberty* (1921). Mill concluded that the government has no business prohibiting or even regulating the personal choice of free citizens (for further presentation of the decriminalization perspective, see Trebach in Trebach & Inciardi, 1993, as well as the bimonthly journal *Drug Policy Letter*).

Unlike other perspectives along the drug policy continuum, the decriminalization approach does not attempt to develop complex alternatives that involve using government-mandated harm reduction, public health education, prevention, or intervention. It does not necessarily advocate utilizing the medical community to manage addiction. It certainly does not want the increased complexity of governmental regulation. The decriminalization perspective seems to imply that all other alternatives have many of the same inherent weaknesses that bedevil current prohibition policy: namely, that any attempt by government to regulate drugs has an inherent potential for abuse.

The decriminalization perspective simply wants to eliminate laws that prohibit or regulate the manufacture or distribution of current illegal drugs. While there are partial and full decriminalizers, the basic position is that of libertarianism. As such, government should not be involved in either prohibition or regulation of the private behavioral or property choices of its citizens—even if such policies may be deemed to be in the interest of the citizens. Perhaps this is most clearly stated by Thomas Szasz (Friedman & Szasz, 1992): "I

favor free trade in drugs . . . in a free society it is none of the government's business what ideas a man puts into his mind, likewise, it should be none of its business what drugs he puts into his body." Friedman and Szasz (1992) essentially argue for a return to the consumerism policy of the 19th century with use levels determined by intelligent, educated consumers.

Another leading proponent of decriminalization, Arnold Trebach, also argues for giving back to people a right taken away from them by government early in this century—the right to freely choose to use drugs: "My preferred plan of legalization [decriminalization] seeks essentially to turn the clock back to the last century" (Trebach & Inciardi, 1993, p. 79). In a book entitled *Our Right to Drugs*, Szasz (1996) argues that drugs are a form of property and, as such, the government has no right to interfere with how free citizens use their private property.

This position has some attractive strengths. It is rooted in the basic assumptions of a free and democratic society. These include the assumption that citizens are self-governing and capable of exercising self-control and good citizenship without the paternalistic intrusiveness of government as overseer. Within this tradition, there is also the belief that a free society must accept as the price of freedom that a proportion of its citizens will make decisions that may be harmful to the health, happiness, or longevity of those citizens. This position seems to be, to an extent, in touch with the political trends of the era. There is currently little interest in a large intrusive government; indeed, there has been a devolution of authority from national government to local government to individual responsibility. Distrust of government is very high. Adoption of decriminalization-based policy would involve minimal government intrusion or regulation. This perspective further points toward the enormous amounts of money that would be saved as inappropriate governmental intrusion into private citizen choices is eliminated. A decriminalization policy would allow the police to focus on behavior that clearly harms other citizens while

preventing the justice system from interfering with individual behavior that harms no one but the user (see Stares, 1996a, 1996b).

CRITICISMS OF DECRIMINALIZATION

Each of the other drug policy positions has implicit or explicit criticisms of decriminalization (see Inciardi in Trebach & Inciardi, 1993, for a comprehensive critique of decriminalization). Basic criticisms of decriminalization focus on a significant underestimation of the social and economic harm of increased drug use, a misunderstanding of the nature of addiction and initiation processes, and a naive confidence in the free market. Critics of decriminalization argue that harm resulting from drug abuse is not individual but systemic. It thereby fulfills the criteria elucidated by Mill (1921) to warrant societal concern. Harms arising from drug abuse include psychopharmacological effects related to violence as well as significant health care costs. Substance use plays a significant role in accidents that also injure nonusers. In addition, the nostalgic view of 19th-century America may not be reflected in the reality of those who experienced that century. It was a century without access to health care and without any type of welfare safety net. There was minimal recognition of governmental or societal responsibility for those who needed health or human services. Although government is reducing its sense of responsibility for many of these services, there still seems to be an expectation of some responsibility for its citizens. We are no longer in a society of isolated nonintegrated parts. It may be difficult to separate what is only harmful to the individual from what is also costly to society. If there is an expectation of societal aid, then there may be an expectation of societal regulations. Indeed, Szasz (1996) argues that as long as society makes others pay for the health care costs of drug users society will have the incentive to regulate drug use. Szasz appears to advocate dismantling publicly funded health care and plac-

ing the responsibility of payment on those who make the choice to use drugs (Szasz in Buckley & Nadelmann, 1996).

It also seems that the decriminalization position may not recognize the complexity or implications of addictive substances in a free market treatment. The very nature of addiction limits free choice. One can perhaps construct a notion that free choice occurs the first few times an individual uses an addictive substance, but that choice disappears as addiction becomes an experienced reality. This position further fails to recognize the role that advertising can be allowed to play in a free market economy. The logical culmination of a true policy of decriminalization whereby there is only minimal if any governmental regulation or penalties would be an equally free environment for advertising drugs. In turn, this onslaught of publicity would have serious ramifications on youth populations.

Serious questions should be raised about the ability of youths, some as young as 13, to have the information, critical capacity, and wisdom to make a free choice about a substance that is highly addictive. A truly unregulated free market would have few if any barriers to prevent drug use by youths. It is self-evident that decriminalizers do not advocate drug use by youths nor see youths as necessarily having the capacity to make informed decisions about drug use. Rather, decriminalizers focus on drug use as an adult choice. However, as noted by Califano (1997), initiation of drug use usually occurs prior to age 21. The data simply do not support the assumption that drug use is an adult choice. Increasingly, it is the choice of youths aged 12 to 17 both for initiation and continuing use. Recently released data from the National Household Survey show that about 11% of youths aged 12 to 17 used an illegal drug in the past month. About 30% reported use in the past year. Further, youths aged 12 to 17 were more likely to use an illegal drug in the past month than individuals aged 26 and over (CESAR, 1998). These data indicate that it is not adults who are choosing to use drugs; rather, it is the very population that decriminalizers say they specifically do not wish

to see using drugs—America's youths. Decriminalization policies would seem to be particularly weak in preventing youth drug use.

A focus on decriminalization for a national drug policy also raises serious questions about our current national expectations of a free market. Our society and the world in general seem to be enamored with the concept. The free market is seen as providing the best chance for economic strength, political freedom, civil rights, and, it appears, even human happiness. This era seems to have extraordinary faith in the free market to solve everything, even drug abuse. The free market may be the best producer of high-quality, cost-effective products and services, but it may not be the best policy for dealing with addictive substances. Issues of marketing, target marketing, and the human cost of increased drug abuse seem to be naively ignored by advocates of decriminalization. The effective critical capacity that is applied by decriminalizers to the current prohibition position seems strangely absent in the examination of their own assumptions and the very real consequences that might result from the adoption of this position.

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The Decriminalization Alternative

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The following excerpt first appeared in "The Decriminalization Alternative" in *Drug Policy and the Decline of American Cities* (New Brunswick, NJ: Transaction Publishers).

Despite billions of dollars spent in reducing the supply of drugs and incarcerating millions of drug users, public policy has been unable to reduce accessibility to drugs over the long run.

In the meantime, the illicit drug industry has become a growth industry in American cities. High profits, induced by a supply-side oriented drug policy, have attracted tens of thousands of low-skilled, undereducated youth into a violent industry that threatens to rip apart the social fabric of inner-city neighborhoods. The widespread use of force and rejection of the rule of law is undermining the very institutions necessary to sustain long-term economic growth.

Moreover, trends in contemporary urban policy reinforce this breakdown of institutions by encouraging the breakdown of the rule of law in the legitimate economy. While the aboveground economy lacks the violent characteristics of the drug trade, personal politics is becoming more important than the adherence to basic rules that protect people and businesses from the arbitrary will of politics. The rising authority of the local state is contributing to a parallel degeneration of the institutions necessary for promoting economic growth.

Public policy plays a vital role in providing an environment capa-

ble of nurturing economic development. Current drug policy is inconsistent with obtaining more far-reaching goals such as establishing a framework that allows cities to prosper. Rather than reduce the threat of the drug economy to America's central cities, current drug policy enhances it. Ultimately, the only solution will be to significantly reduce the influence of a violent drug trade in the social and economic environment of the city.

TOWARD A DEMAND-ORIENTED DRUG POLICY

While the United States is far from a "nation of addicts," it has certainly become a nation of drug users. Over 100 million people use alcohol and over 50 million use tobacco. In addition, almost 30 million use marijuana, 6 million use cocaine, and almost 1 million use heroin. These categories, of course, are not strictly additive. Almost all of those who use illicit substances also drink and smoke. These numbers, then, may actually overstate drug use since they ignore the proportion of multiple drug users (people who smoke and drink, or use cocaine and drink, etc.). Moreover drug use does not imply drug addiction, nor drug abuse.

American drug policy has concentrated almost completely on the supply-side, focusing on interdiction, crop reduction strategies in foreign countries, and the incarceration of drug traffickers. On the local level law enforcement agencies have emphasized drug trafficking and intra-state interdiction.

Demand-side strategies have almost exclusively been directed at incarcerating users for possession. In the early days of the drug war, these efforts relied on a "buy and bust" strategy. More recently, private and public agency drug testing programs have been implemented to increase the personal risks of drug use. Testing positive for drug use can lead to unemployment or, in some cases, jail.

Virtually every observer of the drug war acknowledges that an exclusively supply-side strategy will not work. In fact, most contem-

porary observers acknowledge current drug control strategies are largely ineffective.

In this chapter, the data and arguments of previous sections will be marshaled to propose an alternative strategy: decriminalization. Decriminalization is not advanced as a panacea for the drug problem, nor as analogy for drug addicts. On the contrary, decriminalization is proposed as a fundamental shift in strategy from a supply-side approach to a demand-side approach more consistent with the political, economic, and cultural traditions of the United States. The shift will provide a better foundation for public policy as a first step toward a solution. . . .

DECRIMINALIZATION AS A POLICY OPTION

The prospects for significant decriminalization appear slim in the early 1990s. Yet, a "legalization debate" sprouted during the late 1980s that has legitimized serious discussion of the topic. The effects of drug trafficking emerged as one of the preeminent concerns in public opinion and public policy. As the War on Drugs failed to produce significant results (e.g., decreases in crime rates, supplies of drugs, etc.), dissenters from the current prohibitionist strategy emerged in the public debate.

Conservative icon William F. Buckley endorsed legalization in 1985, beginning what seems to be a steadily rising tide in favor of the movement. By the 1990s, "thinking the unthinkable" became standard fare in drug policy debates.[1] Other "legalizers" include former San Jose police chief Joseph McNamara, Baltimore mayor Kurt Schmoke, former secretary of state George Shultz, Arnold Trebach of the Drug Policy Foundation, and federal judge Robert Sweet.

The legalization movement is distinctive, gaining notoriety

1. For a popular review of the pros and cons of legalization, see George J. Church, "Thinking the Unthinkable," *Time*, 20 May 1988, pp. 12–19.

through support from nonliberal sectors of the political landscape. Political conservatives have joined with civil libertarians in the growing call for decriminalization of major drugs. Buckley, for example, switched his original position favoring drug prohibition (for heroin in the 1970s) to comprehensive legalization in the 1980s. Economists Milton Friedman, Thomas Sowell, and the influential *Economist* magazine have also taken public positions in favor of legalization. The Cato Institute has also developed an active policy research agenda exploring the decriminalization of drugs.

Of course, legalization advocates have been around for decades. Milton Friedman has been advocating drug legalization since the early 1970s, when a widespread movement surfaced to decriminalize marijuana. In 1975, the state of Alaska effectively legalized small amounts of marijuana by interpreting the state's constitutional protection of privacy to include the cultivation and use of marijuana for personal use. Currently, eleven states have decriminalized the possession and use of marijuana by reducing punishment and sentencing. Even predating this movement, however, libertarians have argued that the decision to use drugs was personal and should not be a concern of government.

The biggest boost for the legalization movement may have come in 1988, when Baltimore mayor Kurt Schmoke advocated decriminalization. A former prosecutor, Schmoke argued that decriminalization should at least be part of a national debate on the future of drug policy. The weight of a big-city mayor, grappling with the drug problems in the "trenches" of America's inner cities, placed enough pressure on Congress that hearings were held on drug legalization in 1988.

Intellectually, legalization received a boost from a young academic at Princeton University. Ethan Nadelmann wrote several influential articles in the periodicals *Foreign Policy*, *Science*, *The Public Interest*, and the *New Republic* that significantly improved the respectability of prolegalization advocates. As the legalization movement

gained grudging popular acceptance, early advocates of decriminalization such as Arnold Trebach (a moderate by contemporary standards) found an increasingly receptive audience.

Despite its high media profile, decriminalization represents an ad hoc collection of proposals. Some proponents intend to legalize only the use and sale of marijuana. Others advocate the comprehensive legalization of all psychoactive substances. Still other variations of decriminalization argue for the legalization of use and possession, but not trafficking in large amounts of drugs. Indeed, a significant weakness of the "legalization movement" according to its opponents, has been its lack of consensus concerning a practical policy position.

None of the advocates of drug decriminalization suggest that their approach will "solve" the drug problem. Rather, they advocate legalization as a first step toward a better and more effective public policy. In addition, few advocates propose legalization in desperation. On the contrary, most proponents have arrived at their position after careful reflection on the problem and the role of public policy. Decriminalization represents an approach to looking at the drug problem rather than a schedule of specific policy recommendations. As Ethan Nadelmann observes,

> In its broadest sense . . . legalization incorporates the many arguments and growing sentiment for de-emphasizing our traditional reliance on criminal justice resources to deal with drug abuse and for emphasizing instead drug abuse, prevention, treatment, and education, as well as noncriminal restrictions on the availability and use of psychoactive substances and positive inducements to abstain from drug abuse.[2]

Thus, decriminalization represents a *strategic shift* in drug policy away from treating drug abuse as a law enforcement problem to treating drug abuse as a behavioral problem. In this sense, decriminali-

2. Ethan A. Nadelmann, "Drug Prohibition in the United States: Costs, Consequences, and Alternatives," *Science* 245, no. 4921 (1 September 1989): 939.

zation represents a *policy shift* from the supply-side strategy dominating the War on Drugs to a demand-side strategy emphasizing the human and social consequences of drug abuse.

Ultimately, use becomes a social problem when drugs are abused, becoming privately and socially disruptive. Like alcohol, the major drugs—marijuana, cocaine, and heroin—can be used without this use inevitably leading to addiction or socially disruptive behavior. Ultimately, the causes of drug abuse are far more complex than the legal system is capable of addressing. Decriminalization proposes a more realistic foundation and informed attitude toward drug use, focusing on the harms of abuse (rather than mere use) and addiction.

A move toward decriminalization requires that public policy toward illicit drugs be reconstituted on a fundamentally different foundation. Rather than focusing on which drugs would be legalized and how they would be regulated, the decriminalization alternative focuses on how drug abuse is viewed and interpreted through the legal system and public policy. Drug decriminalization acknowledges that addicts cannot be cured by throwing them in jail. The current law enforcement system virtually ignores the complexities of addiction and other behavioral aspects of drug use, such as the psychological and social profile of the individual and the family context.

On the supply side, the decriminalization alternative acknowledges that the "drug trade" is an economic development issue and problem. The drug trade, like much black-market activity, flourishes in poverty and economic deprivation. By removing the profits from the drug trade, American cities can more effectively address inner-city development problems, particularly in minority communities.

ARGUMENTS FOR DECRIMINALIZATION

Arguments for the decriminalization of drug use in the United States claim several origins. This, in part, reflects the diversity of backgrounds from which legalizers and decriminalizers have emerged.

Some, such as Arnold Trebach, have extensive clinical and academic experience in drug treatment and policy analysis. Others, such as Ira Glasser of the American Civil Liberties Union and Steven Wisotsky of the NOVA Law School in Florida, approach the subject from a civil libertarian and legal background. Still others, such as Mayor Kurt Schmoke, Judge Robert Sweet, and Police Chief Joseph McNamara, have come to their position after a long, bitter experience fighting the War on Drugs in the streets and courts. Although the individuals cannot be lumped together as if they have the same interests and backgrounds, decriminalization arguments can be broken down into at least four broad categories: libertarian, cost-benefit, public health, and economic development. . . .

The Libertarian Position

One of the oldest arguments favoring decriminalization has come from civil libertarians such as psychiatrist Thomas Szasz[3] who focus on the role government plays in the lives of individual citizens. Constitutionally, every citizen has a right to privacy and the absence of the arbitrary intrusion of government into their personal lives. The War on Drugs directly intervenes into personal life by attempting to control voluntary, noncoercive behavior among citizens even when their behavior does not injure others. Indeed drug enforcement is especially difficult precisely because drug trafficking is a voluntary activity and drug use occurs in private.

Despite the perceived harmfulness by prohibitionists, drug use is a voluntary activity and unlikely to inflict injury on an uninvolved third party. For libertarians, the only time a role for the state can be justified is when drug use jeopardizes the health and welfare of others

3. For a brief discussion of Szasz's perspective and a thoroughly libertarian argument, see Thomas Szasz, "The War Against Drugs," *Journal of Drug Issues* 12, no. 2 (Winter 1982): 115–22; and the path-breaking work *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers*, rev. ed. (Holmes Beach, Fl.: Learning Publications, 1985).

(e.g., driving under the influence, assault under the influence, drug use during pregnancy, etc.).

Broadly interpreted, the libertarian argument often parallels more traditional objections to the separation of Church and state embedded in the First Amendment. Issues of morality and religion should not be a concern of the government. As long as drug use is considered a moral issue, the government does not have standing in regulating its use.

Government agencies are liberalizing statutes regulating the power of law enforcement personnel to seize private property, even when the property cannot be directly linked to the commission of a crime. In some cases, the requirement that criminal punishment can be imposed only after someone is proven guilty "beyond reasonable doubt" is retreating to "probable cause." Libertarians further argue that the War on Drugs threatens the civil liberties that provide a stable foundation for democratic government. In the long run, democratic societies cannot afford to wage such a socially destructive (and ultimately divisive) war.

In an open letter to Drug Czar William Bennett, economist and Nobel Laureate Milton Friedman may have summarized the libertarian's worst fears of the end result of the War on Drugs. Writing in the *Wall Street Journal*, Friedman implores,

> Every friend of freedom . . . must be as revolted as I am by the prospect of turning the United States into an armed camp, by the vision of jails filled with casual drug users and of an army of enforcers empowered to invade the liberty of citizens on slight evidence. A country in which shooting down unidentified planes "on suspicion" can be seriously considered as a drug-war tactic is not the kind of United States that either you [Bill Bennett] or I want to hand on to future generations.[6]

6. Milton Friedman, "An Open Letter to Bill Bennett," *Wall Street Journal*, 7 September 1989, reprinted in *The Crisis in Drug Prohibition*, ed. David Boaz (Washington, D.C.: Cato Institute, 1990), 114–16.

Given the risks to democratic government, in practice the War on Drugs is a counterproductive exercise of government coercion.

To maintain consistency, libertarians argue, all psychoactive substances would have to be banned, not just politically unpopular drugs. The prohibition on marijuana, cocaine, and heroin is hypocritical given the widespread acceptance of alcohol and tobacco in American culture. Indeed, the health consequences of alcohol and tobacco loom far larger than currently illicit substances. Since the cultural restrictions on the use of marijuana, cocaine, and heroin are much more severe than for tobacco and alcohol, many libertarians perceive drug prohibition as an attempt to enforce a narrow set of values rather than serious concern over the harms of drug use.

One of the most significant obstacles faced by libertarians is their small numbers. As a voting bloc, libertarians remain a smaller proportion of the American electorate than conservatives (who agree with state intervention on moral issues) and populists (who agree with state intervention on both moral and economic issues) according to recent estimates by pollsters and political scientists. A study of the California public found that only 14 percent of the voting public could be classified as libertarian.[8]

Cost-Benefit Analysis

Although the libertarian argument is the oldest argument in favor of decriminalization, the argument that may have had the most impact on current public opinion is the cost-benefit perspective. Many of the most visible advocates of drug decriminalization fall (publicly) into this category. In essence, the cost-benefit argument claims that the costs of waging a drug war are simply too high to continue. While these costs may include the abridgement of civil liberties, they also include the crime and violence associated with drug prohibition, the

8. Mervin Field, "Trends in American Politics," in *Left, Right, and Babyboom: America's New Politics*, ed. David Boaz (Washington, D.C.: Cato Institute, 1986), 15–21.

health-care crisis resulting from contaminated drugs (as a result of poor quality control), the effects on U.S. foreign policy, and the vast sums of money expended on law enforcement.

Among the most prominent cost-benefit decriminalizers might be David Boaz, the executive vice president of the Cato Institute in Washington, D.C.; James Ostrowski, a lawyer in Buffalo, New York; Ethan Nadelmann, a professor of public policy at Princeton University; William F. Buckley, Jr., conservative columnist and prominent author; and federal judge Robert Sweet of New York.

Buckley, writing in 1985, may have summed up the attitudes of most legalizers when he noted,

> It is hardly a novel suggestion to legalize dope. Shrewd observers of the scene have recommended it for years. I am on record as having opposed it in the matter of heroin. The accumulated evidence draws me away from my own opposition, on the purely empirical grounds that what we have now is a drug problem plus a crime problem plus a problem of huge export of capital to the dope-producing countries.[9]

Cost-benefit arguments emphasize the impracticalities of a drug prohibition policy given the physical limitations on jails, prisons, and courts and the geographic limitations on successfully controlling the supply of drugs. Decriminalizers conclude that, ultimately, public expenditures on drug prohibition strategies are a "black hole" for government spending. The only people who gain are employees of law enforcement agencies and the drug traffickers. Richard Cowan, a frequent writer for the conservative political magazine *National Review*, argues that the "narcocracy" is the primary reason drug prohibition persists despite widespread empirical evidence that the policy is a failure.[10]

9. William F. Buckley, Jr., "Legalize Dope," *Washington Post*, 1 April 1985, sec. A, p. 11.

10. Richard C. Cowan, "How the Narcs Created Crack," *National Review* 38, no. 23 (December 1986): 28–29.

Ultimately, the costs to society do not warrant the continuation of drug prohibition given the potential benefits of a legalization strategy. David Boaz of the Cato Institute enlists the cost-benefit position as an important supplement to a more general libertarian argument:

> We can either escalate the war on drugs, which would have dire implications for civil liberties and the right to privacy, or find a way to gracefully withdraw. Withdrawal should not be viewed as an endorsement of drug use; it would simply be an acknowledgement that the cost of this war—billions of dollars, runaway crime rates and restrictions on personal freedom—is too high.[11]

While decriminalizers do not argue that legalizing drugs would solve the problems of drug abuse, they do argue society would reap important benefits by reducing crime and black-market profits and avoiding the wholesale scrapping of the Bill of Rights.

Public Health

A third general category of arguments among the decriminalizers involves public health. The most vocal advocates of this position may be Kurt Schmoke and Arnold Trebach. Trebach favors effective decriminalization for drug use and possession. Rather than consider users of illicit drugs "enemies of the state," a more rational approach is to treat addicts and drug abusers.[13] Education and treatment, Trebach believes, is far more effective than making the "drug problem" a "criminal problem" where resources are squandered on ineffective and inhumane supply-side strategies (e.g., interdiction, crop eradication, and arresting small-time dealers).

11. David Boaz, "Let's Quit the Drug War," *New York Times*, 17 March 1988.

13. Arnold S. Trebach, *The Great Drug War: And Radical Proposals That Could Make America Safe Again* (New York: Macmillan, 1987). Trebach does not believe in the legalization of all drugs. Publicly, he favors the legalization of marijuana although he thinks it should be taxed heavily and the proceeds used to fund drug treatment (see pp. 368–69).

Kurt Schmoke also criticizes the current drug prohibition strategy for treating drug abuse as a criminal problem rather than a health problem. Calling for a drug war led by the surgeon general rather than the attorney general, Schmoke argues that drug abuse will be curtailed only when drug users recognize the dangers of the substances they ingest. Further, throwing addicts in jail will not provide the treatment they need to "kick" their habit. In fact, based on some of the evidence presented in the previous chapter, prison may increase exposure to major drugs.

The most compelling public health argument, however, may be associated with the reduction in crime that would result from decriminalization.[15] Drug prohibition feeds a criminal element that fears itself more than the criminal justice system. The profits gleaned from illicit drug trafficking spark violence and crime that could be largely eliminated by adopting a comprehensive decriminalization policy.

At its core, the public health approach calls for a comprehensive reorientation of drug policy away from treating abuse and addiction as a legal problem to an education and treatment problem. The current policy, through its focus on criminal justice solutions, ignores the human dimensions of addiction, abuse, and crime.

Economic Development

The final argument for decriminalization emphasizes the economic development consequences of the current drug strategy. This approach to the drug problem has received little systematic attention. Newspapers, television, and some economists have focused on the economics of the drug trade, detailing its multifaceted distribution system, but few have delved deeply into the potential consequences for economic development in cities. The implications of drug prohibition extend far beyond their impact on users and the narrow

15. Kurt Schmoke, "Drugs: A Problem of Health and Economics," *Washington Post*, 15 May 1988; reprinted in Boaz, *The Crisis in Drug Prohibition*, 9–12.

world of the drug trafficker. They influence the way of life in American inner cities.

Through drug prohibition, public policy has created a vast black market for illicit substances, fueling violence and disrespect for law and human life. These values become an essential element of survival in economically devastated urban areas that offer few legitimate opportunities for employment. When those opportunities exist, as the case of Washington, D.C., clearly illustrates, they are far less attractive (financially) than the potential gains from drug trafficking.

The economic development perspective focuses on the implications for a system that trains young workers in an industry marked by violence and deceit, and transfers them into the legitimate economy. While many have learned some skills (e.g., counting, inventory control, supervision), the values are less consistent with the requirements of normal business activity in the legitimate economy.

Drug prohibition works against the best interests of the community by dampening the incentives for its citizens to pursue economically productive and prosperous employment in the legitimate sector. Drug prohibition encourages new entrants into the labor force to emphasize short-term gains through drug trafficking rather than the long-term gains from legitimate employment and occupational training. Ultimately, the current policy is pushing the inner city even further toward economic destruction by weakening the institutional foundations necessary for a productive and prosperous society.

ARGUMENTS OPPOSING LEGALIZATION

The decriminalization alternative remains unpopular among most leading scholars and policymakers. Former drug czar William Bennett publicly called the idea "stupid" and suggested that many of its advocates are racist.[16] Others, such as Congresswoman Patricia

16. William Bennett's remarks occurred after federal judge Robert Sweet in New York announced he was in favor of legalization in December 1989.

Schroeder (D-Colorado), oppose decriminalization because they fear the United States will become a "nation of addicts."[17] Others, basing their recommendations on more scholarly assessments of the drug problem, oppose legalization because they feel the increase in the number of addicts would not justify the benefits of legalized use.[18]

Like the arguments for decriminalization, general themes are detectable in their opposition. Prohibition proponents argue that the decriminalizers ignore the public health consequences of increased drug use, that legalization will feed the criminal element, and, perhaps most important, society cannot appear to condone or encourage drug use.

Public Health Consequences of Legalization

Most prohibition proponents emphasize that prohibition works from a public health perspective. Any reduction in the price, either through criminal sanctions or the price system, will increase the number of drug users. The higher levels of drug use inevitably place more burdens on the health care system. Moreover, prohibition proponents note that during alcohol prohibition, diseases associated with alcohol consumption actually declined.

A decriminalization strategy will doom society as the number of addicts increases dramatically. Senator Alfonse D'Amato (R-New York), for example, is quoted as saying legalization would lead to "a society of drug-related zombies."[19] A. M. Rosenthal, a columnist for the *New York Times*, claims that advocating the legalization of drugs

17. This claim was made by Representative Schroeder during a debate on drug legalization sponsored by *Firing Line*.

18. See John Kaplan, *The Hardest Drug: Heroin and Public Policy* (Chicago: University of Chicago Press, 1983); Mark A. R. Kleiman, *Marijuana: Costs of Abuse, Costs of Control* (New York: Greenwood Press, 1989).

19. Quoted in "Bennett: Legalized Drug Idea 'Stupid,'" *USA Today*, 18 December 1989, sec. A, p. 3.

is the same as advocating slavery.[20] By reducing the price of drugs, legalization would induce millions into a life of addiction which, according to Rosenthal, is a virtual state of bondage. Charles Krauthammer, an editor for the *New Republic*, summarized the argument when he wrote, "In order to undercut the black market, legalization must radically reduce the price of drugs. And the price of drugs is the surest predictor of use. Drugs are like any other commodity, the lower the price, the higher the consumption."[21] Ultimately, prohibitionists say, the drug problem would become much worse if legalization were effective. Moreover, even though alcohol and tobacco are legalized, their legal status does not support legalizing another harmful substance.

James A. Inciardi, director of the Division of Criminal Justice at the University of Delaware and a leading opponent of legalization, suggests that the very mechanism legalizers rely on to reduce the harms of drug use will exacerbate them. One of the most "powerful aspects of American tradition," Inciardi notes, is "the ability of an entrepreneurial market system to create, expand, and maintain high levels of demand."[22]

The prohibitionists assume, of course, that the primary determinant of drug use is the drug's legal status or the price. In essence, they buy the strict economic argument that price and quantity demanded are inversely related. Indeed, even decriminalizers agree that lower prices will probably increase overall consumption. The point of disagreement revolves around the magnitude. Decriminalizers believe that other factors intervene irrespective of legal status and even price. Data does not exist capable of deciding this issue

20. A. M. Rosenthal, "Legalize Drugs: A Good Case for Slavery," *Dayton Daily News*, 7 January 1990, sec. B, p. 7. Reprinted from the *New York Times*.

21. Charles Krauthammer, "Mistakes of the Legalizers," *Washington Post*, 13 April 1990, sec. A, p. 25.

22. James A. Inciardi, "The Case Against Legalization," in *The Drug Legalization Debate*, ed. James A. Inciardi (Newbury Park, Calif.: Sage Publications, 1991), 56.

once and for all. The evidence presented [here], however, strongly suggests that the costs of addiction will increase only modestly.

Historically, consumers have reacted to information about drugs in dramatic ways. David F. Musto, a historian of drug laws, notes that the Pure Food and Drug Act of 1906 substantially altered the consumption of patent medicines when they were required to list narcotics as ingredients. Within a few years after the Act was passed, "it was estimated that patent medicines containing such drugs dropped in sale by about a third."[26] More recently, consumers have moved steadily toward less potent legal drugs such as light beer, wine coolers, and low-tar cigarettes.

Potential increases in drug use must also be compared to the costs of prohibition. A death resulting from an overdose may have substantially different consequences than a death resulting from a drug-related drive-by shooting. For example, if the government sends a soldier to war and he dies, few claim that the government is a murderer. If, on the other hand, the government kills civilians for reasons unrelated to national security or protecting its citizens, the action is considered murder and the perpetrators tried in criminal proceedings. The standard for evaluating death varies with the circumstances.

Similarly, an addict who dies from an overdose of drugs should not be compared to the gunning down of a nine-year-old child as a consequence of a drug market turf battle. The first case, while tragic, is at least controllable by the addict. The addict can choose when he or she will take drugs and from whom the drugs will be bought. To the extent that the drug overdose is due to imperfect information (e.g., there may be no way to test for drug quality), the death may also be a result of a prohibitionist policy that undermines competition aimed at ensuring quality products are placed on the market.

The latter death, however, is a symbol of how the rules of the

26. David F. Musto, *The American Disease: Origins of Narcotic Control*, exp. ed. (New York: Oxford University Press, 1987), 22.

game have changed and reflects the full force of the current prohibitionist policy. Prohibition engenders violent solutions to solving disputes. The result is a genuine breakdown of law and order and the significant discounting of human life. The death of a nine-year-old child is symptomatic of a shift in how individuals are relating to each other. Even if the child's death is a mistake, it becomes an accepted part of the trade and the risks of living in a drug neighborhood.

In the end, the legalization opponent is not willing to take the risk that the number of addicts will increase. "True, there is a large segment of people who won't find drugs attractive," economist Peter Reuter observes, "but who wants to take the risk of seeing whether the number of those who want drugs is 500 percent greater than now, rather than only 50 percent greater."

Feeding the Criminal Element

A second argument advanced by decriminalization opponents is that legalizing the distribution of drugs would actually feed criminals and drug cartels. "What seems at least as likely," writes *Washington Post* columnist William Raspberry, "is the development of drug cartels with an interest both in increasing the number of drug users and in maintaining prices at levels that would ensure their profitability."[28] Existing organizations have proven extremely efficient in distributing drugs to consumers and they will likely continue. If drugs are decriminalized, the argument continues, the same people selling drugs now will be selling them later.

The drug cartels and the institutionalized violence seem an indelible characteristic of the drug market. Comprehensive decriminalization will not eliminate the criminals. After all, alcohol prohibition did not create the Mafia. Similarly, the Mafia remains even after Prohibition ended.

28. William Raspberry, "Don't Legalize Drugs," *Washington Post*, 26 May 1989.

Strong empirical and theoretical reasons exist suggesting that this is an unlikely consequence.[29] First, the argument assumes that the behavior tolerated and encouraged in the illegal drug market would persist in a legal drug market. This argument also ignores the importance of public policy in defining the environment, or rules of the game, for economic market activity. Although Prohibition did not create the Mafia, it provided the environment conducive to its growth and the consolidation of a large underworld of violence, corruption and arbitrary personal power. Similarly, prohibition has provided the incentive and fuel for the growth and consolidation of violent drug cartels. The characteristics of the illegal drug market suggest that it is an inferior system of distribution and production. A decriminalized drug environment would radically alter the character of drug markets. The ability to solve disputes peacefully through the court system would substantially reduce violence in the drug markets. Liquor stores are rarely fortresses. Alcohol is rarely bought or sold in open-air markets on street corners or in school-yards.

More important, drug-distribution systems that operate as legitimate businesses would grow and become even more efficient, competing for business by offering better service and better quality products. Accountability exists in illicit drug markets only at the end of a gun. In legitimate economic markets, accountability is more efficiently implemented through the profit and loss system. Stable and permanent locations are essential to ensure a stable and peaceful clientele and have proven time and time again to be superior to street peddling.

29. Inciardi, however, has argued that violence will escalate with legalization. While the violence associated with the drug trade might decrease, violence associated with the pharmacological effects of drug use would increase. Although the present author believes Inciardi's point is important, his conclusion that "in all likelihood *any declines in systemic violence would be accompanied by corresponding increases in psychopharmacologic violence*" (emphasis in original) seems much too strong given the evidence he presents. See Inciardi, "The Case Against Legalization," 58–59.

Society Cannot Condone Drug Use

Perhaps the most common argument invoked against decriminalization centers on morality and socially acceptable behavior. Drugs are bad and therefore society should not condone drug use. Anything short of comprehensive prohibition would send the "wrong signals" to children and adults concerning drug use. Government is viewed as a direct representative of the collective will of society.

This argument assumes that citizens take their cues concerning right and wrong from government policy or the legal system. If this were true, the fundamental principles of representative government have been turned on their head. While laws are reflections of culture, democratic governments are established to protect the rights of their citizens. Oftentimes, these rights conflict with broader social concerns. The law, for example, protects the right of the Ku Klux Klan to hold public rallies and demonstrations. This is not interpreted as public support for the goals, objectives, and beliefs of the Klan.

In contemporary democratic societies, moral values are not imposed by the state. More important, democratic governments are responsible for protecting individual rights rather than the collective rights of specific interest groups. While the government enforces the law, it cannot pass judgment on the correctness of the law.

A compelling argument can also be made that prohibition has supported the behavior prohibitionists want to discourage. Richard Cowan has noted that prohibition has created "accidental perversities" in drug consumption.[30] By making drug distribution a risky and expensive undertaking, the unintended consequences of government control have been to encourage the production, marketing, and consumption of more potent drugs that can be distributed more easily.

Intensified interdiction efforts encouraged drug traffickers to switch from marijuana, which is bulky and easily detectable, to

30. Cowan, "How the Narcs Created Crack," 28.

cocaine, which can be transported in small quantities. The reduction in imported marijuana has resulted in domestic cultivation of more potent strains. Similarly, the army's crackdown on marijuana in Vietnam led to a heroin epidemic. More recently, crack was developed (a technical innovation) as a potent, but cheap, alternative to cocaine capable of being marketed in poor sections of America's inner cities. In principle, every naturally grown drug could be substituted for by more potent designer drugs capable of being developed in the crudest chemistry labs. Thus, while consumers are opting for less potent legal drugs, public policy is encouraging the development and distribution of more potent illicit drugs. . . .

CONCLUSION

A substantial philosophical schism exists between decriminalizers and prohibitionists that significantly undermines the prospects for developing a "third way." Decriminalization and prohibition advocates operate from different sets of principles. On the one hand, those proposing decriminalization emphasize individual accountability and responsibility. The role of public policy centers on the protectionist state where personal rights and freedoms are defended.

On the other side, prohibition advocates emphasize the importance of collectivism. "Society" has an obligation to impose certain standards on individual behavior even when the behavior is voluntary and rational. Prohibitionists, unlike many decriminalizers, view the state as a unified expression of a collective will that supersedes voluntary and peaceful actions of individual citizens.

Prohibition proponents have criticized decriminalization advocates for not proposing specific policy recommendations. This criticism, however, is a red herring. A detailed policy recommendation presumes that a consensus exists that America's drug policy should be reconstituted on the principles of decriminalization. Any recommended strategy will not satisfy prohibition proponents because they

remain unconvinced that decriminalization is a legitimate or viable policy option.

The War on Drugs has created observable effects, many of them negative. Drug prohibition has not limited the accessibility of drugs for most potential users. On the contrary, drug accessibility has increased over the years. Yet, drug prohibition has resulted in huge drug profits that have facilitated the emergence of violent drug cartels. More peaceful, small-time traffickers have been excluded from legitimate economic markets, retreating to the violence of black-market operations. The black-market trade is an artifact of the legal system.

In the process, the War on Drugs is undermining the values that are essential components of the institutions favorable to economic development. By encouraging and sustaining an environment that reinforces violence and the arbitrary decisions of people instead of abstract principles embodied in the legal system, the respect for law and private property is weakened. Without these institutions, urban communities will continue to stagnate economically, further entrenching the underground economy as the foundation of the inner-city economic and social system.

Decriminalization will eliminate most (but not all) of the law enforcement problem that has emerged. It will also move public policy more in line with the principles necessary to promote economic and community development. As earlier chapters have attempted to outline, the "drug problem" today is largely a crime problem, manifesting itself in overcrowded jails, attenuation of civil liberties, and the expansion of the power of law enforcement agencies at the expense of freedom.

Decriminalization is offered as a first step toward refocusing drug policy on the human dimension. From a social perspective, the "drug problem" should encompass social controls over drug abuse and the consequences of addiction. Prohibiting any use of illicit drugs ignores the complexities of drug use and addiction. Decriminalization admits that not all drug use, like not all alcohol use, is drug abuse.

The argument for decriminalization rests on an understanding that America's current "drug problem" is not a "drug addiction" or a "drug abuse" problem. The harms associated with drug use and abuse revolve around the violence and apparent chaos in the inner cities, which, in turn, is an unintended consequence of public policy. Decriminalization would allow policymakers and policy analysts to focus on the consequences of drug use. The current regime concerns itself almost exclusively with the legal dimensions.

Broadly speaking, the decriminalization argument acknowledges that economics figures prominently in any solution to the drug problem. The foot soldiers of the drug industry are taken from the ranks of the unemployed with few realistic options in the legitimate economy. In addition, as long as a demand for illicit drugs exists, profits will persist. Eventually, as long as the industry remains underground, the effects will become violent and destructive. Only by acknowledging the limits of public policy in a free society and the fundamentally economic character of the drug problem in the United States can the problem be addressed substantively. Ultimately, decriminalization of heroin, cocaine, and marijuana provides the most realistic and progressive alternative.

The Great Drug Policy Debate—What Means This Thing Called Decriminalization?

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This selection was excerpted from "The Great Drug Policy Debate—What Means This Thing Called Decriminalization?" in *Confronting Drug Policy: Illicit Drugs in a Free Society* edited by Ronald Bayer and Gerald M. Oppenheimer (New York, NY: Cambridge University Press, 1993).

A profound sense of dissatisfaction characterizes the contemporary American discussion of drug policy. From across the political spectrum a chorus of critical voices is heard, linking those who most typically see each other as ideological antagonists. Their common platform asserts that prohibitionist policies that are given force by the criminal law have failed to prevent the use of drugs, and that efforts to restrict drug use have created a plethora of social evils far worse than the problem of drug use itself. Enormous resources are expended on the effort to interdict the international and domestic commerce in drugs. The courts are clogged with defendants arrested for violating the drug laws and the jails and prisons are filled with inmates convicted of violating those laws, whether by property crimes designed to pay the inflated black-market prices of illicit drugs or by acts of violence spawned by the struggles that pervade the underground economy. The streets of the urban ghettos have become wastelands

dominated by the often armed sellers, buyers, and users of drugs. HIV infection spreads among drug injectors under legal conditions that encourage the sharing of syringes and needles. Civil liberties are routinely violated as government agents prosecute the war on drugs. Only a radical change in policy, it is argued, will provide a remedy to this situation. Criminalization is a failure. Decriminalization must then be the answer.

BUT WHAT MEANS THIS THING CALLED DECRIMINALIZATION?

Beyond the common commitment to a break with the use of the criminal law as the primary social weapon in the struggle against drug use, there is little agreement. For the minimalists among the advocates of reform, what is necessary is an end to the prosecution of people who have drugs in their possession, or who are engaged in small-scale, street-level trade. For yet others decriminalization implies the need to medicalize the problem, replacing policemen with physicians, punishment with treatment. Finally, increasingly, some have come to believe that only a maximalist conception of decriminalization can meet the challenge created by the disaster that the enforcement of prohibition has produced. Legalization of drugs and creation of a regulated market like that now prevailing for alcohol would be, from this perspective, the only effective remedy to the crisis we are facing. Each of these conceptions of decriminalization entails very different adjustments in the dominant policy perspective, carries with it very different implications for the risks of increased drug use, implies very different standards of tolerance for drug use, and suggests very different roles for the functions of medicine and the criminal law.

It is a remarkable feature of the contemporary debate over the future of drug policy that it takes place with only the dimmest recognition of the extended and perspicuous discussion that centered on

drug policy in the period following World War II and that all but ended in the mid-1970s. This historical amnesia is the more striking because in virtually all respects the contemporary debate mimics what occurred in the earlier period. It is my purpose in this introduction to recall the earlier debate in order to place the current discussion into some perspective.

THE RISE AND DECLINE OF THE DECRIMINALIZATION DEBATE: POST–WORLD WAR II ERA

For much of this century the United States has sought to confront the challenge of drug use with policies derived from a prohibitionist perspective (Musto 1973). The sale, possession, and use of controlled substances was deemed an appropriate subject of the criminal law. Punishing violators of such restrictive statutes was to serve the ends of both specific and general deterrence. Physicians were restricted from prescribing a broad range of substances that were deemed to have no legitimate clinical purpose. Therapeutic options were virtually unknown, a reflection of both profound pessimism about the ability of medicine to help the drug user and the ideological dominance of those committed to law enforcement. In the face of periodic rises in drug use, public panic ensued. At such moments the severity of the punishment of drug law violators was intensified, the latitude available to judges to impose sentences restricted.

The Liberal Challenge

In the period following World War II, when an increase in heroin addiction provoked great consternation, American liberals took up the challenge of the broad critique of American narcotics policies (Bayer 1975a). Above all else, the liberal position was an exculpatory one, eschewing notions of blameworthiness and guilt that are central to the criminalization of drug use.

The perception of the addict as a victim of blocked opportunity was derived from the sociologists, to whom liberals turned for explanations of troubling behavior and who provided so much of the academic justification for the social policies with which liberalism came to be identified (Cloward and Ohlen 1960). Like the problem of juvenile delinquency to which it was so intimately linked in the public mind, addiction suggested to liberals the need to "finish the work of the New Deal" (*Nation* 1970, 228). This theme ran like a powerful leitmotif through virtually every discussion of heroin use in the journals of liberal opinion during the 1960s and early 1970s. Thus the *Nation* stated: "Society must come to realize that it is a cause—perhaps the major cause—of the affliction that it now observes with such fear and revulsion." Dr. Joel Fort, writing in the *Saturday Review of Literature*, underscored the extent to which addiction was perceived as an indication of social distress by referring to heroin use as a "barometer" of the extent to which society was characterized by "poverty, segregation, slums, psychological immaturity, ignorance and misery" (1962, 30).

Typically, the response provoked by this understanding involved calls for the full range of social programs that would get at the "root causes" of deviancy—programs designed to attack chronic unemployment and the grinding poverty of the underclass. Decrying the resources devoted to interdiction by the Nixon administration, the *Nation* asked: "Why . . . doesn't President Nixon devote more resources to the elimination of the social and economic problems which permit large scale drug abuse to take root?" (1971, 421).

Given the openness of postwar liberalism to deterministic theories of behavior, arguments for the psychopathological theories of heroin use seemed particularly congenial. The influence of mental health professionals—psychiatrists, psychologists, and social workers—on liberalism's perception of drug use cannot be overstated. Not only did they offer to explain discordant behavior in terms that avoided notions of personal guilt, but they also promised a technology of rehabilitation

untainted by the brutality of punishment. Thus, the disease concept of addiction provided liberals with a perfect mechanism for achieving the very corrective ends that conservative law enforcement approaches had failed to attain.

With addiction defined as the expression of an underlying psychological disease, liberals could propose a range of treatment alternatives to punitive incarceration. Outpatient clinics providing psychotherapy as well as inpatient, hospital-based treatment were to become, at different moments, the focus of the liberal and reformist approach to drug users. Although clinics might suffice if they could control the heroin user's behavior, quarantine in hospitals for the purpose of treatment might also be necessary to help the addict and to protect the community. Predisposed toward noncoercive solutions, liberalism was by no means unwilling to embrace the imposition of therapeutic solutions. Indeed, no less a figure than Justice William O. Douglas, the exemplar of liberal jurisprudence, wrote in *Robinson v. California*[1] that a state might determine that "the general health and welfare require that [addicts] be dealt with by compulsory treatment involving quarantine, confinement or sequestration."

But within a decade liberals had turned on such confinement as both expensive and ineffective. Writing in 1971, David Bazilon, the noted liberal U.S. Court of Appeals judge, who had done so much to open the legal process to psychiatry and the behavioral sciences, stated: "It certainly sounds more enlightened to treat the drug user than to punish him for his status. But my experience with the civil commitment process suggests that the differences between punishment and compulsory treatment do not justify the extravagant claims made" (Bazilon 1971, 48).

1. *Robinson v. California* 370 U.S. 676 (1962). This case declared that imprisonment of addicts for the status of addiction constituted cruel and unusual punishment.

Medicalization of Drug Addiction

Despite the disenchantment with compulsory closed-ward treatment—a reflection of the due process transformation that was affecting the willingness to tolerate benign confinement of juvenile and mental patients—the hold of the deterministic perspective did not waver (Gostin 1991). The *Robinson* decision had embraced the conception of addiction as a disease and thus had subverted the moral foundations for the use of the criminal law. "It is unlikely that any state at this moment would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with venereal disease. . . . Even one day in prison would be cruel and unusual punishment for the 'crime' of having a common cold."[2] But the Court had spoken only of the *status* of addiction. Its decision had not extended the exculpatory perspective to the acts associated with that status. For almost a decade, from the mid-1960s onward, legal commentators struggled with this issue and liberal analysts had sought to broaden the meaning of *Robinson* to include those behaviors inextricably linked to the "disease of addiction" (Bayer 1978a), just as they sought to protect alcoholics from imprisonment for acts of public drunkenness. Pharmacological duress was the doctrine employed in the effort to extend *Robinson*. Whereas the Supreme Court had protected the addict as an addict from punishment, the proponents of pharmacological duress sought to extend the protective scope of the court's decision to those whose addiction compelled them to purchase illicit drugs (Lowenstein 1967). "The commission of such offenses is merely an involuntary submission to [a] compulsion" (Goldstein 1973, 153). Some went further and sought to extend the doctrine to property crimes committed to obtain narcotics on the black market (*Georgetown Law Review* 1971). Although ultimately unsuccessful before the courts, the effort to win approval for the doc-

2. *Robinson v. California*, op. cit., 667.

trine of pharmacological duress underscored its proponents' determination to vanquish the still dominant status of the criminal law in the social response to drug use.

Paralleling the reformist assault on the theoretical and moral justifications for using criminal law in the struggle against drug abuse was a deep concern about how the efforts to incarcerate drug users and those engaged in the small-scale street-level trade in drugs were affecting the criminal justice system itself. Long a point made by the critics of prohibition, these concerns were ultimately to find expression from individuals whose commitment to the efficient functioning of the agencies of law enforcement drew them to the minimalist conception of decriminalization. "Addicts guilty of no other crime than illegal possession of narcotics are filling the jails, prisons and penitentiaries of our country," declared Judge Morris Ploscowe in an appendix to the joint American Bar Association–American Medical Association (1963) study of the narcotics problem in 1963. Almost ten years later, when the demand for a less punitive response to drug use had begun to have some impact, a state investigation in New York stated: "The Commission could only conclude that the narcotics law enforcement efforts by the police of New York City was [*sic*] a failure, and a monumental waste of time, of money and manpower. The evidence was clear and compelling that the police effort was directed at the lowest type of street violator, the addict, and that the police work was having no appreciable effect upon narcotics traffic in New York City" (New York State Temporary Commission Investigation 1973, 46).

The most striking feature of the liberal challenge to the prevailing perspective on drug abuse policy was, however, not simply its embrace of the conception of addiction as a disease, and its rejection of the centrality of law enforcement to the effort to limit drug use. Rather, it was the growing belief that efforts to prohibit the use of narcotics in the treatment of the illness of addiction were a profound mistake (Bayer 1975c). . . .

The Americanization of Narcotic Maintenance

In the period between the late 1950s and the mid-1960s reformers were increasingly vocal in their support for narcotic maintenance. That support found repeated expression in the journals of liberal opinion—*Commonweal*, *Commentary*, the *Nation*. The *New York Times* also spoke out editorially against the prohibitionist response to addiction. Invariably, the link between crime and drug use, so central to the prohibitionist perspective, was rejected. It was not heroin that produced crime, but rather prohibition that drove the addict to criminality. These arguments were shaped by and helped to shape the proposals of a number of reformist bodies (Berger 1956; New York Academy of Medicine 1955; American Bar Association–American Medical Association 1963). . . .

Heroin maintenance was never to become a viable political option in the United States. A sanitized version of narcotic maintenance, however, was to make striking inroads through the willingness of local, state, and, most important, federal agencies to fund the rapid expansion of methadone maintenance in the early 1970s. Methadone, a synthetic, long-acting narcotic that could be taken orally, met each of the challenges posed by reformers since the end of World War II (Dole 1965). Clinics could stabilize former heroin addicts so that they were no longer driven to seek illicit sources of narcotics; they permitted medical supervision of addicts, who in the past would have been the target of police surveillance; they could undercut the need to engage in crime to purchase heroin. It is not the least of the ironies of the methadone solution that it was given important federal support during the administration of Richard Nixon, who had denounced heroin maintenance as a "concession to weakness and defeat in the drug struggle, a concession which would surely lead to the erosion of our most cherished values for the dignity of man" (quoted in Bayer 1976, 264), and that it was ultimately, if grudgingly, accepted by

many black leaders who continued to denounce proposals for heroin maintenance as genocidal.

But the reality of methadone fell far short of the promise that advocates of narcotic maintenance had held out for two decades (Epstein 1974). It soon became clear that many addicts were uninterested in medically supervised care. What they wanted from narcotics was more than the stabilization of their condition. Dr. Robert Newman, director of the New York City Methadone Maintenance Program, drew the only possible conclusion:

> When someone wants a heroin treatment program, when methadone maintenance is available that person is saying he or she is unwilling to give up the narcotic effect that heroin will give. If the person no longer wanted to get high, then it would really be strange that he or she would prefer to go four or five or six times a day into a clinic where somebody is going to try to find a vein and inject some heroin. (*Contemporary Drug Problems* 1973, 180).

The Limits of Medicalization

It thus appeared in the early 1970s that the medical conception of decriminalization—at least insofar as heroin was concerned—had reached its limits. It was under these circumstances that liberal Republican Nelson Rockefeller of New York State, an architect in the mid-1960s of New York's compulsory closed-ward treatment approach to drug use and strong supporter in the early 1970s of methadone maintenance, made a radical and sweeping proposal for severe recriminalization of the problem (Bayer 1974). It was also under these circumstances that there first emerged a proposal that represented a radical departure from the reformist thrust of the past six decades. Medicalization had been the centerpiece of the call for decriminalization. Now some began to urge the demedicalization of addiction; but it was demedicalization of a very different kind from what Rockefeller was pressing. Adults who wanted to use drugs, including her-

oin, should be as free to purchase them as they were free to purchase alcohol.

While liberals and other drug reformers had little difficulty in supporting the legalization of marijuana, which was widely used by middle-class youth and largely viewed as relatively benign, this was not the case for heroin and other "hard drugs." The radical conception of decriminalization posed severe problems for liberals, who had deeply committed themselves to the view that narcotic use reflected the profound inequities of American social life and who believed that legalization would result in a sharp rise in drug use. As a consequence, fissures developed between those committed to the libertarian and to the social welfare traditions of liberalism. Nevertheless the call for legalization did find expression in the journals of liberal opinion (Bayer 1975b).

In a January 1972 editorial, entitled "Society Is Hooked," the editors of the *Nation* called for the "legalization of hard drugs and marijuana." Significantly, however, instead of portraying maintenance as a humane solution to the problems of addiction, as was the case when proposed by reformers like Lindesmith, the editors acknowledged that their program would in all likelihood result in the "epidemic . . . spread[ing] still more rapidly" (*Nation* 1972, 99–100). Gone, too, from the radical challenge to drug policy was the earlier article of liberal faith that addicts given access to heroin would be normal, that enforced abstinence was responsible for their dysfunctional state. Like the proponents of "harm reduction" almost 20 years later, those who pressed for radical change hoped only to contain the damages caused by drug use. But no other option seemed viable. With a pessimistic air, the editors of the *Nation* noted that society as well as the addict were "hooked"; there were no quick "fixes."

Liberal legal theorist Herbert Packer, who had long argued that the "victimless crimes" were an inappropriate target of the criminal law, also endorsed the legalization of all drugs. In "Decriminalizing Heroin," which appeared in the *New Republic*, he wrote: "Enforcing

personal morals through the criminal laws is one of this country's principal self-inflicted wounds. We can allow sick people—as we should allow nations to choose their own roads to hell if that is where they want to go—I should have thought that to be the most important lesson of liberalism" (Packer 1972, 11). Making drugs available to those who wanted them was no longer offered as a way of assisting the addict to live a "normal life" but, rather, as a way of giving him the option of traveling the "road to hell."

Nothing more tellingly reveals the difficulty that heroin legalization presented American liberals than the prolonged conflict it engendered within the American Civil Liberties Union. As early as 1970, some within the organization had begun to insist that John Stuart Mill's dictum on the sovereignty of the individual over his or her own self-regarding behavior be applied without modification to all drug use. Thus Jeremiah Guttman, a board member of the New York Civil Liberties Union, stated in a position paper designed to move the ACLU: "The right *not* to live should be as basic as the right to life. Whether a person chooses to end his life with a bullet through the brain, fifteen years of alcoholic indulgence, or five years of heroin should not be material" (cited in Bayer 1975b). In 1973 a committee of the board of directors of the ACLU that had considered the drug issue concluded that the libertarian commitment of the ACLU left no alternative but to endorse the freedom of adults to use narcotic and nonnarcotic drugs. The evidence it had considered had provided no justification for prohibition because no "direct" harms to others could be traced to drug use. Indeed the harm to others that could be traced to such use was a consequence of the prohibition itself. Only with those under 18 years of age was the physician to play a role as the source of a prescription for narcotics, and then only with parental consent.

This perspective, however, was not so easily accepted by the board of the ACLU, where strong social welfare concerns were raised by members fearful of the extent to which a free market in drugs would

have a profound impact on the nation's ghetto poor. Three years later, after considerable debate, when the ACLU board did adopt a new policy on drugs, it was riddled with the contradictions between, on the one hand, a libertarian model of decriminalization within which heroin would be sold under a regulatory regime similar to what prevailed for alcohol, and on the other hand, a medical model, which would require the use of prescriptions. "Nothing in this policy is to be construed as placing the ACLU in opposition to reasonable restraint such as already exists with respect to the production and sale of food, liquor, cigarettes, penicillin, insulin, methadone. . . ." (cited in Bayer 1978b).

The ACLU's tortured effort to confront the problem of narcotic drugs stood in sharp contrast to the ease with which the issue was resolved by two politically conservative libertarians, Milton Friedman and Thomas Szasz. . . . At the very moment when the ACLU was struggling with the heroin issue, Friedman wrote in *Newsweek*: "Do we have the right to use force directly or indirectly to prevent a fellow adult from drinking, smoking or using drugs? [The] answer is no" (cited in Friedman and Friedman 1984, 138–9). Beyond his principled position, however, Friedman pointed out that the course of legalization was dictated by pragmatic concerns. Prohibition did not work. It did not prevent drug use; it made the life of both the addict and the nonaddict more miserable. Underscoring a point that would assume great salience two decades later, he concluded: "Legalizing drugs would simultaneously reduce the amount of crime and improve law enforcement. It is hard to conceive of any other single recourse that would accomplish so much to promote law and order."

Like Friedman, Thomas Szasz was not burdened by welfare liberalism's conception of addiction as determined by social deprivation. Thus he was able to articulate a position on drug use derived exclusively from adherence to a radically individualistic perspective.

Although reference to the social response to addiction ran throughout Szasz's earlier, often polemical, attacks on the psychiatric

establishment, his first fully developed statement on the issue appeared in *Harper's Magazine* in "The Ethics of Addiction" (Szasz 1972). Starting from the premise that individuals are capable of freely choosing among differing behavioral patterns, Szasz noted that drug use and addiction were the results of just such personal decisions. Linking the freedom to use drugs with the right to exchange freely in ideas, he asserted: "In an open society it is none of the government's business what idea a man puts into his head; likewise it should be none of the government's business what drug he puts into his body" (75). For Szasz, then, the social response to addiction was a microcosm of the struggle between collectivist and individualist values. "We can choose to maximize the sphere of action of the state at the expense of the individual or the individual at the expense of the state" (79). The willingness to prohibit the use of drugs as medically unwise, and the role of physicians in enforcing prohibition and in treating drug users against their will, comprised for Szasz a paradigmatic expression of the baleful development of the "therapeutic state."

Two years later these arguments appeared in elaborated form in the book-length polemic, *Ceremonial Chemistry: The Ritual Persecution of Drug Addicts and Pushers*. Using imagery drawn from the history of religion, Szasz argued in typically hyperbolic fashion: "What exists today is nothing less than a worldwide quasi-medical pogrom against opium and the users of opiates" (45). "I regard tolerance with respect to drugs as wholly analogous to tolerance with respect to religion" (53).

It is important not to overstate the extent to which calls for the legalization of drugs had attained explicit support during the 1970s. What gave them resonance, however, was the radical ferment among intellectuals dating from the upheavals of the 1960s, a ferment that had subjected both the practice and ideology of social control to repeated attack. The "labeling" school sought to shatter the orthodox perspective on drug use and other detested forms of behavior (Becker

1963). Society created deviance out of difference (Kitsuse 1962). The process of labeling "deviant" behavior set in motion a series of events with dire consequences for people who were labeled as well as for society. Unlike the corrective posture of the "helping professions," the sociologists associated with the "labeling" school saw in behavioral diversity an intrinsic and vital aspect of social life (Matza 1969). To those drawn to the plight of psychiatric patients, the "antipsychiatrists" like Szasz and R. D. Laing suggested that medical dominance and control were every bit as repressive as the imposition of legal sanctions (Sedgwick 1972). Coercion by physicians buttressed the agencies of social control and imposed dreadful suffering on the patient.

Finally, for those concerned about the scope of the criminal law, the effort to restrict personal behaviors that posed no direct threat to others had created a "crisis of overcriminalization" (Kadish 1968). Gambling, prostitution, drug use, sexual behavior between consenting adults—the entire range of "victimless crimes"—had been mistakenly subject to the criminal law, with terrible consequences for the courts, the prisons, police departments, and the very status of the law. "The criminal law is an inefficient instrument for imposing the good life on others" (Morris and Hawkins 1970, 2).

The intellectual ferment of the 1960s and mid-1970s exhausted itself with little by way of demonstrable impact on the radical reform of drug abuse policy. The criminal law remained dominant, although the advocates of a therapeutic model had done much to reshape the social response to drug use. The most significant reflection of the effort to medicalize heroin addiction was in the methadone maintenance programs that had been provided with a niche in the clinical panoply. As the years passed, however, the initial therapeutic optimism that accompanied the rupture with the commitment to abstinence all but vanished. Methadone clinics were increasingly viewed with hostility, as community eyesores, where addicts met to engage in the commerce in drugs including methadone itself. Another change in outlook resulted when the fashion in drug use shifted from

heroin to cocaine, rendering irrelevant many of the arguments for maintenance therapy rooted in the psychopharmacology of opiate use.

Finally, liberal intellectuals lost the capacity to inform the policy agenda across the full range of domestic problems as an aggressively conservative national administration came to Washington in 1980. When a renewed assault on drug use took shape—with its battle cry of "zero tolerance"—and a revitalized commitment to law enforcement took form, directed at both the international commerce in illicit psychotropic substances and at street-level trade, little by way of broad countervailing perspective was left to express the concerns that had animated the debate in earlier years.

THE REVIVAL OF THE DRUG POLICY DEBATE

Although David A. J. Richards, the legal philosopher, argued in 1981 that respect for human rights necessitated legalization of drugs, albeit under the supervision of physicians (1981), and William Buckley, the editor of the conservative *National Review*, announced his support for drug legalization in 1985 (Buckley 1985), they were the exceptions. Little sustained discussion took place until 1988, when suddenly a plethora of articles appeared calling for the decriminalization of drug use. At times these articles suggested that only outright legalization of all drugs would represent a coherent response to the crisis of drug use in America's cities. Thus Arnold Trebach of the Drug Policy Foundation, a center committed to fostering reformist thought, wrote in a special symposium issue of the *American Behavioral Scientist*:

> I am now convinced that our society would be safer and healthier if all of the illegal drugs were fully removed from the control of the criminal law tomorrow. . . . I would be very worried about the possibility of future harm if that radical change took place, but less

> worried than I am about the reality of the present harm being inflicted every day by our current laws and policies. (1989, 254)

Others supported legalization for some drugs, medical control for others. Pete Hamill, the popular columnist, thus declared:

> After watching the results of the plague since heroin first came to Brooklyn in the early fifties, after visiting the courtrooms and the morgues, after wandering New York's neighborhoods . . . and after consuming much of the literature on drugs, I've reluctantly come to a terrible conclusion: The only solution is the complete legalization of these drugs. (1988, 26)

. . . From across the political spectrum the call for decriminalization has drawn support. U.S. District Court Judge Robert Sweet (Kleiman and Saiger 1990) and Baltimore's mayor, Kurt Schmoke (1989), have each denounced the prohibitionist strategy. Stephen J. Gould, writing in *Dissent* (1990), and Taylor Branch, in the *New Republic* (1988), have both issued attacks on the use of the criminal law. Most remarkable and in sharp contrast to the linkage between liberalism and drug reform in the 1950s, 1960s, and 1970s, noted conservatives in surprising numbers have been drawn to the reformist banner.

Nothing more distressed the conservative proponents of decriminalization than the commitment of the Reagan and Bush administrations to the ever greater reliance on the instruments of legal repression in the "war on drugs," a strategy that could only result in the enhancement of state power and the withering of freedom. In an open letter to William Bennett, the nation's "drug czar," Milton Friedman sought to recall the common principles that united conservatives in their opposition to the statist programs of their liberal opponents:

> The path you propose of more police, more jails, use of the military in foreign countries, harsh penalties for drug users and a whole panoply of repressive measures can only make a bad situation worse.

> The drug war cannot be won by those tactics without undermining the human liberty and individual freedom that you and I cherish. (cited in Reinarman and Levine 1990)

To cultural conservatives who rejected the radical individualism so central to libertarians of whatever political stripe, and whose ideological roots could be traced to Burke rather than Mill, all such characterizations of the effort to repress drug use were profoundly mistaken, subverting the prospects of human virtue upon which the very existence of civic life in a democratic society was dependent (Kleiman and Saiger 1990). Thus was William Bennett archly critical of the intellectuals and fellow conservatives who would desert the struggle against drug use.

> Drug use—especially heavy drug use—destroys human character. It destroys dignity and autonomy, it burns away the sense of responsibility, it makes a mockery of virtue. . . . Libertarians don't like to hear this. . . . Drugs are a threat to the life of the mind. . . . That's why I find the surrender to arguments for drug legalization so odd and so scandalous. (1990, 32).

Although their arguments are rooted in a very different political perspective on American social life, black leaders have been equally vehement in their reaction against the calls for decriminalization and especially toward the maximalist call for legalization. In part a reflection of the cultural conservatism of the black clergy, this response also reflects the despair of those who have seen their communities devastated by drug use and the drug wars and who fear that legalization would represent nothing more than the determination to write off an expendable population. Committed as they are to greater public expenditures for treatment, many leaders have denounced as genocidal the calls for legalization of drugs, and even for halfway measures motivated by the philosophy of harm reduction (Dalton 1989).

The Debate over Costs

Despite the expected ideological exchanges provoked by the call for fundamental drug policy reform, the crucial and most dramatic feature of the debate over decriminalization in the late 1980s has been the extent to which it has *not* been shaped by reference to issues of liberty and the role of the state as the guarantor of social cohesion. Rather a set of more prosaic concerns has dominated the debate: the social costs generated by the very effort to limit the social costs of drug use. Cost-benefit analysis has provided the yardstick of analysis (Warner 1991). It is the willingness to embrace that social accounting technique and to employ its apparently nonideological methods that has united the liberal and conservative critics of the status quo.

If the maximalist, radical option of legalization has drawn more support in the late 1980s than at any moment since the imposition of prohibition in the century's second decade, the structure of the argument made against the use of the criminal law has not changed much since the challenge to criminalization gained some currency in the post–World War II era. Indeed, if anything is striking about the contemporary debate, it is how reminiscent it is of earlier conflicts, despite its markedly more sophisticated character.

Although the upsurge of critical analysis had already begun, the appearance in the fall of 1989 of Ethan Nadelmann's "Drug Prohibition in the United States: Costs, Consequences and Alternatives" in *Science* marked an important juncture. Like those who preceded him, he painstakingly detailed the costs of drug prohibition. Vast expenditures—estimated at $10 billion in 1987—corruption, crime, violence, the spread of HIV infection, international misadventures could all be traced to the effort to suppress drug use and commerce. When balanced against the achievements, the price was for Nadelmann beyond all reason. But what of the potential costs that would follow upon legalization? Would drug use and, more important, the most disabling forms of drug use increase? These are questions that

Nadelmann approaches with some caution. His conclusions, however, are unmistakable: the risks of pursuing such an agenda have been exaggerated, even grossly distorted; the costs of not advancing a reform agenda—of legalizing cocaine, heroin, and "other relatively dangerous drugs"—are too great. Legalization would not only produce enormous benefits for society in general, and America's ghettos in particular, but would enhance the health and quality of life of drug users who would be assured of access to drugs whose purity could be vouchsafed through government regulation.

Nothing more tellingly distinguishes the proponents of legalization and their antagonists than the very different estimations of the potential consequences that might attend an end to prohibition (Inciardi and McBride 1990). James Q. Wilson's "Against the Legalization of Drugs," which appeared in *Commentary* magazine, represents a forthright challenge to Nadelmann's optimistic characterization. Legalization, Wilson asserts, almost certainly would produce a vast increase in drug use with devastating impacts on the most vulnerable.

The current great debate over drug prohibition is being conducted in the face of an irreducible level of uncertainty about the potential consequences of legalization. Although the antagonists each acknowledge that there are many unknowns about the consequences of taking even modest steps toward legalization, they bring fundamentally, and in most instances, unbridgeable assumptions about how the risks and benefits of reform should be weighed.

CONCLUSION

Despite the fact that the range of advocates for decriminalization is broader now than at any point in more than a decade, and that the coalition favoring a maximalist strategy of legalization is more vital than it has ever been since prohibition was instituted in the early part of the century, there is little reason to believe that the demand for

radical change will have an immediate impact on policy. In fact, the prospects for even minimalist steps toward decriminalization are far weaker than in the 1970s when, under the threat of returning heroin-addicted Vietnam soldiers, the U.S. government made a major commitment to the medical management of addiction, and when middle-class pressure moved the decriminalization of marijuana use and possession toward becoming a politically viable option in a number of states and local jurisdictions. Indeed, it is no small irony that the current move for decriminalization has arisen precisely at a moment when America may have entered a neoprohibitionist era, one in which the social tolerance for the use of intoxicants—both licit and illicit—may be declining.

What, then, is the significance of the debate over decriminalization? First, and perhaps most important, the sharp assault on the contours of American drug policy has exposed the profound imbalance between public expenditures for law enforcement designed to repress drug sales and use and the funds available for the treatment of individuals whose drug dependency has resulted in personal misery. Even some who reject the need for radical change now recognize that current efforts to support the treatment of drug users who express an interest in managing their addiction to opiates through methadone maintenance or in achieving abstinence from other drug use are grossly inadequate.

Second, the decriminalization debate has forced a consideration of the rationality of policies that currently prohibit the use of a wide range of drugs. By compelling a discussion of the extent to which our conventions have brought us to define some drugs as licit and others as illicit, causing us mistakenly to lump relatively less damaging drugs with more harmful substances, the proponents of decriminalization may foster a more reasoned discussion of public policy.

Finally, the advocates of decriminalization, no matter how limited or expansive their goals, have served to underscore the enormous economic and human costs of current prohibitionist policies. In so

doing they have encouraged the search for alternatives to repression: the willingness of a number of state and local governments to tolerate or fund needle exchange programs in an effort to interdict the spread of HIV infection provides a striking example of such newly found openness.

In the end, the call for decriminalization—however broadly or narrowly defined—has revitalized the public debate over the fundamental structure of American drug policy. It has thus made possible a serious examination of the appropriate role of the state in regulating the behavior of competent adults, as well as its obligation to foster the conditions necessary for the existence of civic life and to provide care for the most vulnerable and even for the most socially despised. Perhaps more important, the decriminalization debate has shattered—if only for a moment—the dead weight of tradition that for more than a decade served to close off the possibility of critical inquiry.

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Harm Reduction

Should Harm Reduction Be Our Overall Goal in Fighting Drug Abuse?

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This selection was excerpted from "Should Harm Reduction Be Our Overall Goal in Fighting Drug Abuse?" in *Point/Counterpoint: Opposing Perspectives on Issues of Drug Policy* (Boston, MA: Allyn and Bacon, 2003).

To say that we are waging a "war on drugs" is, in effect, communicating how serious we are in dealing with the problems of drug abuse in the United States. Using the metaphor of warfare, we recognize that there is an acknowledged enemy (drug abuse), there are victims or casualties (us), there are resources at our disposal to fight the necessary battles (federal and state governments, communities, parents, etc.), and there is a high price to pay (in excess of $18 billion of federal funds each year).

The implications of this real-life struggle, such as our overall strategy and ultimate goals, are also drawn in metaphorical terms. Do we want total victory and complete annihilation of the enemy? Or do we want some kind of negotiated settlement, some type of compromise, that gives us some semblance of peace and tranquility? If it is the former, then we require a total elimination, often expressed as "zero tolerance" of abusive drug-taking behavior in America. If it is the latter, then we require a good deal less. We desire, in that case, only a reduction of the harmful consequences of abusive drug-taking behavior, knowing fully well that a total elimination is unrealistic. This is essentially our dilemma, and the core issue for this chapter.

What does the American public really want? Which way should we direct our drug policies?

The harm-reduction approach in drug policy has its historical roots in the libertarian philosophy of the nineteenth-century philosopher John Stuart Mill who argued that the state did not have the duty to protect individual citizens from harming themselves. As Mill expressed it,

> The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. . . . Over himself, over his own body and mind, the individual is sovereign.

On the other hand, it is readily evident that drug-taking behavior does indeed harm other people. We can look to the violence of illicit drug trafficking and the disruption in the lives of drug abusers' families and friends. The question, according to those advocating a harm-reduction strategy, is to look for policies that reduce the harm that drugs do, both directly to the drug user and indirectly to others.

On the opposite end of the debate are advocates for a drug policy that is based upon the goal of absolute deterrence, brought about by law enforcement. Sociologist Erich Goode has put it this way:

> . . . they do not believe simply that law enforcement is more likely to "contain" or keep a given activity at a lower level than no enforcement at all. Even further, they believe (or, at least, in their speeches, they state) that law enforcement, if not restrained by loopholes, technicalities, and restrictions, will actually reduce that activity, ideally, nearly to zero. In short, we *can* win the war on drugs, the cultural conservative asserts, if we have sufficient will, determination, and unity.

Those who argue that a reduction of the harmful consequences of abusive drug-taking behavior is the optimal strategy can be seen as following a middle path between, on one hand, those who advocate

stronger law enforcement and interdiction efforts to eliminate all drugs and, on the other hand, those who advocate an approach in which presently illegal drugs are legalized and thus made available to the American public. Drug problems, as the harm-reductionists argue, are more a result of the harsh and absolutist system of prohibitions now in place than the drugs themselves. There is no doubt that the misery endured by drug-dependent individuals, their families and associates, and society in general is immense. The debate is in the strategy that is best suited to contend with the horrific conditions in which we now live. . . .

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A New Direction for Drug Education: Harm Reduction

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This piece originally appeared in "Harm Reduction: An Emerging New Paradigm for Drug Education," *Journal of Drug Education* 24 (4): 281–289 (Amityville, N.Y.: Baywood Publishing Company, Inc., 1994).

Harm reduction is a new direction for health education that has been developing in Western Europe and Australia. Instead of trying to prevent drug use, this new direction focuses on trying to prevent the harms associated with drug use. One of the most familiar examples of harm reduction is needle exchange, which has been effective in preventing HIV/AIDS among drug users.

Over the past two decades, drug abuse prevention in Western Europe and Australia has taken a new direction that has major implications for the future of drug education and drug abuse prevention here in the United States. This new direction was given the name "harm reduction" in a report of the British Home Office (1984) that described two alternate goals for drug abuse prevention programs—either reducing drug use or reducing the harms associated with drug use.

Since that time the International Conferences on the Reduction of Drug-Related Harm, held in Liverpool, England, in 1990, Barcelona, Spain, in 1991, Melbourne, Australia, in 1992, and Rotterdam, the Netherlands, in 1993, have illustrated the rapid growth of this

strategy in Western Europe and Australia while the 1994 conference in Toronto showed its recent encroachment in North America.

Earlier proposals for such an approach included the "casualty-reduction" approach to glue sniffing adopted by the Institute for the Study of Drug Dependence in 1980 and the proposal for "cultivating drug use" suggested by Duncan and Gold in 1983—using the word cultivation in the sense of promoting healthy and productive development, while weeding out tendencies toward abuse. Harm reduction has also been called damage limitation or harm minimization.

Whatever it is called, this new direction consists of a policy of preventing the potential harms related to drug use rather than focusing on preventing the drug use itself. It recognizes that as Moore and Saunders (1991, p. 29) state, "given the universality of drug use in human societies and the very real benefits that accrue from drug use, the usual prevention goal of abstinence from drug use for young people is unthinking, unobtainable and unacceptable."

Mugford (1991) says that a harm reduction approach accepts the fact that people will continue to use drugs no matter what the laws may dictate and asks how they can do so most safety. Such a strategy is consistent with human experience. Historically, all human cultures except Eskimos have accepted some form of recreational drug use and all attempts at prohibition of a drug once its use has been established have resulted in failure. . . .

Furthermore, harm reduction recognizes that measures intended to prevent drug use have often had the unintended effect of increasing the harms associated with drug use. Outlawing drugs results in the creation of black markets with associated corruption of law enforcers, violence between competing drug dealers, erosion of civil rights inevitable in policing a "victimless crime," and the seduction of youth into lucrative careers in drug dealing. A black market will sell illicit drugs to anyone regardless of their age or mental state. The strength, purity, and even the identity of drugs on the black market is uncertain, leading to adverse reactions and overdoses.

In one sense, harm reduction may be seen as a form of tertiary prevention (Duncan, 1988, pp. 50–51)—preventing the long-term harms that may result from drug abuse. Such harm reduction measures as methadone maintenance and needle exchanges constitute harm reduction in this sense.

Needle exchanges, for instance, have gained increasing support as the epidemic of HIV infection associated with intravenous drug use has motivated many public health and drug abuse authorities to rethink their priorities in dealing with IV drug use, moving them toward harm reduction. Mugford (1991), for instance, reports that Australian efforts combining needle exchange, education of drug users on proper syringe hygiene, and establishment of safe disposal points for used syringes in public restrooms have resulted in keeping the prevalence of HIV among drug users in Australia down to only 2 percent. This compares with the 50–70 percent HIV prevalence among drug users in large U.S. cities. In Switzerland, where HIV prevalence among drug users had reached nearly 50 percent, it has dropped to less than 5 percent since the Swiss adopted a harm-reduction policy (Rihs-Middel, 1993).

In another sense, however, harm reduction can be primary prevention. The essence of harm reduction in this sense is the recognition of the distinction between drug use and drug abuse. Just as it is a truth that any drug can be abused, it is a truth that any drug can be used without abuse. No drug is inherently abusive. Tobacco would appear to be the only drug for which it cannot be said that users outnumber abusers. The Epidemiologic Catchment Area Study (Anthony and Helzer, 1991, p. 124) has demonstrated that 20.3 percent of all users of illicit drugs have experienced a period of abuse at some time during their drug use history. Only 4.2 percent of current illicit drug users were dependent or abusers. The first symptoms of drug abuse typically occurred within two to three years after beginning illicit drug use and the median duration of a case of drug abuse/dependence was four to five years (pp. 133–135).

Harm reduction recognizes that preventing drug abuse is a different task from preventing drug use and may be both a more justifiable and a more achievable goal. Harm reduction can mean educating drug users on how to use drugs safely and responsibly. Duncan and Gold (1985, ch. 18) describe the types of responsibilities which drug users might be taught in harm reduction–oriented drug education. These include responsibilities regarding the situations under which drugs are used, health responsibilities, and safety-related responsibilities.

Situational responsibilities would include the responsibility for only using a drug in environments conducive to pleasant and rewarding experiences—avoiding use in hazardous or threatening environments. Another situational responsibility would be only using recreational drugs in social settings. A third would be to make provision in advance for anyone who should become severely intoxicated. Always having someone present who can assist knowledgeably in the event of untoward reactions to the drugs being used is another responsibility.

Health responsibilities would include not using recreational drugs when under severe stress or emotionally distraught. Another would be to avoid exacerbating any health problems through drug use. Drug use during pregnancy should be restricted to those drugs that will not place the unborn child at risk. Avoiding the use of drug combinations that can have dangerous interactions is another health responsibility. Another would be to avoid continued use of drugs for long periods of time.

Safety-related responsibilities would include avoiding the performance of complex tasks, such as driving or operating machinery, while using recreational drugs. Another would be to take the smallest possible dose to produce the desired effects. Altered consciousness is inappropriate in potentially dangerous or unknown settings.

Many health educators will be uncomfortable with this direction. They may see it as a surrender in the war on drugs. Others will see

it as a refocusing of our efforts on what really matters for health education—the prevention of health problems. It is the proper role of health educators to help people live healthier lives, not to act as moral police.

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Has the War on Drugs Reduced Crime?

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This selection appeared on *Close to Home Online—Viewpoints*: "Moyers on Addiction" available online at http://pbs.org/wnet/closetohome/viewpoints/html/crime.html.

Strong drug enforcement in the United States is correlated with dramatic reductions in crime, drug use, and drug addiction rates. Historically, permissive enforcement policies brought record murder and crime rates, peak drug use levels, and increased the addict population.

Drug arrest rates are not an accurate measure of how tough the nation is on drugs. There are three times as many alcohol related arrests than drug arrests—is alcohol policy three times tougher than drug policy? If we legalize drugs, we may triple the number of drug arrests. To measure drug enforcement strength one must examine what happens to those arrested. A good method is to track the number of persons incarcerated for every thousand drug arrests. Periods of weak and strong drug policy can then be compared.

Permissive drug policy was an abject failure in the United States. A drug criminal was four times more likely to serve prison time in 1960 than in 1980 and the incarceration rate plummeted 79 percent. This drug tolerant era brought a doubling of the murder rate, a 230 percent increase in burglaries, a ten-fold increase in teen drug use, and a 900 percent rise in addiction rates. The peak years for teen

drug use and murder were the same years that drug incarceration rates hit an all time low point.

From 1980 to 1997, the drug incarceration rate rose over fourfold and crime and drug use began a steady unprecedented decline. Murder rates fell by more than 25 percent, burglary rates dropped 41 percent, teen drug use reduced by more than a third, and heavy cocaine and heroin use levels fell. With peak drug incarceration rates, many cities, such as New York, reached record low crime levels.

Increasing the odds of imprisonment for drugs helped lower crime and drug use rates because major drug offenders, traffickers, and repeat felons were targeted—not minor drug possessors. Urban drug defendants are more likely to be repeat criminals than violent or property offenders. The hardcore drug felon often steals not just to buy drugs but also to pay bills and survive through a career of crime. Locking up career criminals is a very cost effective policy.

More than 95 percent of state prisoners are violent and repeat criminals. Under one-tenth of one percent of inmates are non-violent, first time marijuana offenders. Most state drug prisoners are traffickers or repeat and/or violent offenders. A federal marijuana inmate was involved with 3.5 tons of the drug on average; a crack offender averaged 18,000 doses. Federal agencies have almost no jurisdiction over violent street crime; that is why most federal cases involve major cocaine and heroin drug traffickers.

Are we getting too tough? Drug prison sentences have held fairly steady the past five years and drug inmate growth is slowing. Studies show that prison growth is the result of increasing the odds of imprisonment for all criminals and not from longer sentences being served. Mandatory minimum sentences have not caused court backlogs or dramatically longer terms, but they may be in part responsible for the tremendous success demonstrated by lower crime rates. One is more likely to go to prison for a federal gambling offense than for drug possession—and a tax law violator will serve more prison time!

Tougher drug policy also reduces addiction because the criminal

justice system is the number one source of treatment referrals. President Clinton credits the justice system for saving his brother's life and many treatment centers would shut down, and addicts would die, if drug laws were repealed. In 1991, a quarter of a million inmates received their most recent drug treatment while in prison.

History indicates that increasing the odds of hardcore drug criminals going to prison has been an extremely effective way to reduce violent and property crime and to lower addiction and drug use rates. The nation is still recuperating from twenty years of permissive drug policy. Current enforcement efforts must be sustained.

We may have found a good balance, and neither tougher nor weaker policy is called for. The real problem is that of the minor drug offender, who now often escapes any consequences at all. Zero tolerance through alternative sanctions must be applied, such as abstinence enforced through drug testing, fines, civil liability, loss of driving and other privileges, and treatment modalities to deter these users before they reach the hardcore criminal stage.

Snapshot

Reducing Harm: Treatment and Beyond

Drug Policy Alliance

This selection is available online at http://www.drugpolicy.org/reducingharm/treatmentvsi/.

Recent developments in criminal justice indicate the emergence of a national movement in favor of treating, rather than incarcerating, non-violent drug possession offenders. These developments include drug courts, local policies that favor treatment, and statewide ballot initiatives that divert nonviolent drug offenders to treatment instead of incarceration.

Public health approaches towards drug offenders have gained national attention and public support. In a recent survey sponsored by the Open Society Institute, "Changing Attitudes Towards the Criminal Justice Systems," 63 percent of Americans consider drug abuse a problem that should be addressed primarily through counseling and treatment, rather than the criminal justice system.

Arizona

In 1996, Arizonans voted in favor of Proposition 200, the Drug Medicalization Prevention and Control Act of 1996, which sends first and second time nonviolent drug offenders to treatment rather than incarceration. According to a recent report conducted by the Supreme Court of Arizona, Proposition 200 saved Arizona taxpayers $6.7 million in 1999. In addition, 62 percent of probationers successfully completed the drug treatment ordered by the court.

California

In November 2000, 61 percent of California voters passed Proposition 36, the Substance Abuse and Crime Prevention Act of 2000 (SACPA), an initiative aimed at rehabilitating rather than incarcerating nonviolent drug possession offenders. Under SACPA, certain persons convicted of nonviolent drug possession offenses are given an opportunity to receive community-based drug treatment in lieu of incarceration.

Prior to its passage, the independent Legislative Analyst's Office (LAO) predicted that by treating rather than incarcerating low level drug offenders, SACPA would save California taxpayers approximately $1.5 billion over the next five years and prevent the need for a new prison slated for construction, avoiding an expenditure of approximately $500 million. LAO estimated that SACPA would annually divert as many as 36,000 probationers and parolees from incarceration into community-based treatment.

Already, progress reports show that tens of thousands of offenders have been placed in community-based treatment instead of jail thereby improving public health and saving the state hundreds of thousands of dollars. Regulation of treatment facilities has resulted in increased quality and accountability for hundreds of treatment programs, and the overall capacity of these facilities has increased.

Maryland

Maryland's new treatment law immediately diverts several thousand prisoners into drug treatment, saving the state's taxpayers millions of dollars a year in the process. It also provides $3 million in additional funding for treatment and gives judges new discretion in sentencing.

Washington, DC

In November 2002, an overwhelming 78 percent of DC voters passed the drug treatment initiative, Measure 62. Under Measure 62 the city will provide substance abuse treatment instead of conviction or imprisonment to nonviolent defendants charged with illegal possession or use of drugs (except those drugs classified as Schedule I); provide a plan for rehabilitation to individuals accepted for substance abuse treatment; and provide for dismissal of legal proceedings for defendants upon successful completion of the treatment program. In addition to dealing with a lawsuit by the DC Corporation Council the measure will have to go through several steps before becoming law. Meanwhile, implementation strategies will take place outlining how treatment instead of incarceration may become a successful model in Washington, DC.