



U.S. Drug Policy

By Eric Sterling, Criminal Justice Policy Foundation

Over a century ago, before the U.S. launched its war on drugs abroad, America commenced a domestic war on drugs. Both these wars rely upon coercion. Abroad, military force and violence are deployed against peasant farmers who grow opium, coca, and cannabis to support their families. Domestically, police operations and imprisonment are directed against drug users, most of whom never commit violent crimes. Both wars have disproportionately targeted the poorest and the lowest level participants in the narcotics commerce. These twin sides of U.S. drug policy have failed to reduce either the overall quantities of drugs produced and delivered or the number of seriously addicted drug abusers in the United States.

U.S. antidrug policy has historically been riddled with racism, and the policy has always entwined domestic and foreign policy considerations. Exploitation of exaggerated fears of drug users and drug traffickers—usually depicted as racial minorities or foreigners—has always been a staple of those promoting tough antinarcotics measures. The first American antidrug laws—penalizing the smoking of opium in San Francisco (1875)—were enacted to stigmatize Chinese laborers competing with white immigrants for employment and to keep whites from socializing with Chinese. Similarly, the alcohol temperance movement, closely affiliated

with the antinarcotics movement, had tendencies that were anti-Catholic, anti-Irish, anti-Italian, anti-Polish, and anti-Jewish.

The foreign policy considerations are also very old. Britain's victory over China in the Opium Wars of 1839-42 and 1856-58 helped assure British dominance in the lucrative opium trade between British-controlled India and China. When America became an imperial power, an early step in its control of the new empire was the prohibition of opium use in the Philippines in 1905. And the Shanghai Opium Commission of 1909,

portrayed as the West's effort to cure a "backward," non-Christian nation of its drug problem, was explicitly motivated by a desire to give Europe and the U.S. an advantage in trade negotiations with China. However, the dearth of U.S. domestic law against the use of narcotics impugned America's sincerity in this effort. To relieve this embarrassment, a multiyear effort to enact a

federal antidrug law culminated in the Harrison Narcotics Act of 1914.

To sell such a substantial expansion of federal power to conservative Southern members of Congress, promoters of the law exploited racist myths such as "cocainized" Negroes as the principal cause of rapes of white women. Exaggerated claims of drugs causing violence have been repeated time and again regarding marijuana, heroin, LSD, crack cocaine, and lately, methamphetamines.

Although hundreds of thousands of Americans were addicted to these drugs in the early 20th century, little crime was associated with such addiction. The Harrison Act was ostensibly a revenue and registration measure, but its zealous enforcement by Treasury Department officials led to near total prohibition of the use of heroin, cocaine, and opium. In one of the first federal interferences in medical practice, physicians were barred from prescribing narcotics for the maintenance of addicts.

Enactment of the 1937 Marijuana Tax Act was a reprise by whites seeking economic advantage, here against Mexican workers in competition for agricultural jobs during the Great Depression. The press carried sensational (but false) stories of marijuana-caused violence by Mexicans, and in the mid-1950s, such fearmongering turned eastward. Ambitious politicians—Congressmen Hale Boggs (LA) and Price Daniels (TX)—pushed for mandatory minimum sentences by promoting myths that "Red China" was distributing heroin to undermine the United States.

In the late 1960s, drug use increased in many parts of the world. In the U.S., recreational drug use—such as marijuana smoking and the use of LSD—skyrocketed among white youth protesting the unpopular war in Vietnam, the draft, and racial discrimination against African-Americans. Heroin addiction grew widely, but was most noticeable among poor and working-class people of color. Drug use also became widespread among the U.S. armed forces in Southeast Asia.

Politicians responded traditionally. New York Governor Nelson Rockefeller, still harboring presidential hopes, publicly hyped the drug epidemic and urged long prison sentences for offenders. President Nixon declared a "war" on drugs. In practice, his programs and legislation emphasized treatment for drug addicts—particularly rehabilitating heroin addicts with methadone—because he wanted lower crime rates to bolster his reelection bid. Tragically, however, his harsh rhetoric expanded a climate of hostility toward those with drug problems. Current policies perpetuate Nixon's military language while deemphasizing treatment.

Key Points

- U.S. antidrug policy historically has been coercive and has had racist and imperialist overtones. Policy is driven by political opportunism, not by considerations of effectiveness or justice.
- The policy hasn't reduced deaths, drug abuse, drug availability, or the spread of disease, and it emphasizes law enforcement instead of effective demand-control measures.
- The drug problem must be managed, regulated, and controlled like other complex problems such as pollution or nuclear weapons.

Washington's war on drugs has not achieved its stated goals of reducing either the quantity of drugs or the level of drug consumption in the U.S., as evidenced by the fact that addicts and more casual consumers spend between \$40 and \$50 billion a year on illegal drugs. Instead, both sides of the drug equation—drug trafficking and drug enforcement—have become extraordinarily lucrative industries, providing both licit and illicit incomes to criminal syndicates, corporations, politicians, and law enforcement bodies in the U.S. and abroad.

Federal spending on antidrug programs has grown from slightly more than \$1 billion in 1981 to roughly \$18 billion in 1999, with two-thirds of these funds directed at enforcement and interdiction programs. Within the U.S., an additional \$20 billion in state and local funds is spent on antidrug measures, mostly on imprisonment, policing, and prosecution. Over 400,000 persons are currently imprisoned for drug offenses at an annual cost exceeding \$8 billion, and the demand for more cells for drug offenders accounts for half the cost of new prison construction.

Those advocating tough law enforcement policies stress that drug users account for 80% of crime in the United States. However, the reality is that most drug users never commit any crime other than possessing an illegal drug. A criminal's use of drugs, on the other hand, simply demonstrates that those willing to steal or commit violence are also willing to break the drug laws. But most incarcerated drug offenders did not commit a violent crime. If crime reduction and prevention were viewed as genuine policy objectives, drug treatment would be made readily available to addicts. Yet in 1996, 3.3 million drug addicts—63% of those needing treatment—remained untreated, a higher number than in the previous five years.

Escalating expenditures and harsher drug war policies have not been effective. First, there are more deaths from drug abuse than ever. Deaths from drug-induced causes more than doubled from 7,101 in 1979 to 14,843 in 1996, and the death rate has grown from 3.2 per 100,000 in 1979 to 5.6 in 1996. Second, heroin and marijuana were easier for high school seniors to obtain in 1998 than at any time since students were first surveyed in 1975, and crack cocaine was easier to obtain than at any time in the last decade. Third, heroin and cocaine prices have fallen dramatically: from 1981 to 1998, the retail price of a gram of pure cocaine plummeted from \$379 to \$169, and the retail price of a gram of pure heroin dropped from \$3,115 to \$1,800. Fourth, drug purity has increased shockingly. Between 1981 and 1998, the purity of retail cocaine rose from 40% to 71%, while heroin purity soared five-fold from 4.7% to 24.5%. These changes pose much greater risks of overdose deaths, especially among vulnerable novice users.

In addition, current domestic drug policies are racist in effect, if not in intent. Drug offenses constitute the

largest category—over 1.5 million people in 1998—of arrests in America. Although 30% of all those arrested for crimes are black, 59% of those convicted of drug offenses and 63% of those convicted of drug trafficking are black. Furthermore, only one-third of convicted whites are sentenced to prison, yet one-half of arrested blacks go to prison, and the average black serves an 18% longer sentence (26% longer in the case of a drug trafficking conviction) than a comparable white criminal.

In addition, blacks are stopped and searched for drugs much more frequently than whites—when entering the country, driving, walking down the street, or simply standing in front of their homes. This persecution in the name of fighting drugs means that people of color are disproportionately imprisoned, their families dislocated, and their job and educational prospects destroyed.

The law enforcement-based strategy has also increased the health risks to drug users. Many deaths involve poisonings from contaminated drugs due to traffickers' sloppy production methods or because they dilute their product with a wide variety of items unsuitable for injection into the bloodstream. Other deaths arise from diseases such as HIV and Hepatitis C spread by sharing contaminated needles.

Furthermore, current antidrug policy encourages both violence and the inappropriate use of children. Cocaine and heroin are many times more valuable than gold, because they are illegal, and they are sold for cash. Thus drug markets are prime robbery targets. Every drug market requires armed men to protect the cash and drugs. Drug sellers hire men who have earned reputations for violence or have demonstrated their willingness to shoot people. In addition, children are being incorporated into the drug-trafficking system. Children are less reliable witnesses in court than adults and are almost certainly not undercover police officers. The stiff penalties for adult dealers also encourage the recruiting of minors to sell drugs, because, if caught, they are likely to be tried in juvenile court.

Drug-linked corruption of police and other law enforcement officers, and to a lesser extent judicial branch officials, is epidemic from coast to coast. For instance, in 1992, Detroit's chief of police went to prison for 10 years for embezzling more than \$2 million in antidrug funds, and half of all FBI-led corruption cases involve drugs.

Key Problems

- Current American drug policy does not meet any of its stated goals. Instead it is supporting two lucrative industries: drug enforcement and drug trafficking.
 - America's enforcement-oriented strategy has generated millions of arrests and hundreds of thousands of prisoners who are overwhelmingly black or Latino.
 - Cost-effective treatment for hard-core drug addicts receives woefully inadequate funding and support.
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The public is losing faith that enforcement is the most effective strategy. In February 1995, 50% of the U.S. public gave the federal government a grade of F or D for its handling of the drug problem; only 10% gave the government an A or B.

In the short term, increasing the availability of drug treatment on demand would be the most important and effective policy initiative. Drug treatment is not perfect—many addicts relapse. But relapse rates are comparable to the rates of those who fail to change their

behavior in dealing with chronic diseases such as diabetes or hypertension. Over time, many addicts are successful in quitting. A leading California study found treatment to be seven times as cost effective as imprisonment. A RAND Corporation analysis found that cocaine consumption could be reduced by 1% by spending \$783 million in source countries, \$366 million on international interdiction, \$246 million on domestic enforcement, or just \$34 million on treatment.

About two million addicts were treated in 1996, but 3.3 million were unable to get

treatment. The percentage of prisoners getting drug treatment in prison has decreased during the 1990s. For the poor and uninsured, publicly funded treatment is almost nonexistent.

Evaluations have found current youth drug-prevention-through-abstinence programs almost totally ineffective. Given that 50% of U.S. youth end up experimenting with drugs, a safety-first message needs to be adopted instead of focusing on total abstinence. Promoting responsible use is the current policy with alcohol, i.e., suggesting the use of designated drivers. A responsible-use approach to drugs would be honest, acknowledging that most youths stop with drug experimentation and do not become addicts. Often programs that have nothing to do with drugs directly, such as Big Brother/Big Sister, have dramatic effects in reducing youth drug use.

Drug abuse by women has been increasing in the U.S., while male drug abuse has been declining. More research regarding female drug abusers, as well as treatment programs for women, is vitally needed. In addition, discriminatory policies toward women should be

stopped. Women should not be forced to give up their children to enter drug treatment programs. Regrettably, the state of New York had to be sued before it would provide drug treatment to pregnant addicts.

Ninety percent of new AIDS cases among children under 13 are due to the sharing of used injection equipment by mothers or fathers. All these cases could be prevented if the nearly universal recommendations of public health authorities for syringe exchange were followed by Congress and the executive branch.

Sentences for drug offenses need to be reduced dramatically. Sixty percent of federal prisoners are drug offenders, and federal drug sentences are longer than those imposed for many violent crimes. Drug offenders should not be singled out for additional penalties, such as eviction from housing or denial of aid for higher education—especially when persons convicted of violent crimes are not subject to such penalties.

Physicians should be encouraged to prescribe marijuana and other appropriate pain relief. Studies show that doctors undertreat pain for 40%-80% of their terminally ill patients.

Current public debate of alternative drug strategies is reminiscent of the reaction faced by Galileo in the 17th century. Political cowardice and hot-button rhetoric too often dominate official discussion of drug policy. Clinton's drug czar, Col. Barry McCaffrey, recently attacked the governor of New Mexico's suggestion of drug legalization as "irresponsible." A decade ago, Bush's drug czar characterized discussion of drug legalization as "morally reprehensible." Yet the drug problem will not disappear by suppressing discussion of alternative strategies. Independent blue-ribbon commissions, faith communities, civic organizations, and service clubs must undertake rational, cost-benefit, top-to-bottom reviews of drug strategies.

The reality is that licensed and taxed drug distribution systems would be substantially less violent, less expensive, and more effective than prohibition. Drug users would not need to be imprisoned, thus liberating substantial resources to pay for treatment. A regulated drug industry would pay tens of billions of dollars in taxes.

An enlightened drug policy would recognize that drug use and drug abuse are two different matters, and such a policy would focus on reducing drug abuse. America has a genius for regulation, but that genius has not yet been applied to the drug problem.

Eric E. Sterling is President of the Criminal Justice Policy Foundation.

Key Recommendations

- Reducing harm both from drugs and from antidrug policies is key to achieving a healthier, safer, more sober society.
- Emotionally charged political discussion of drug policy must be replaced by honest study and rational discussion in the private sector.
- In the absence of comprehensive control by means of licensing, taxation, and regulation of the drug trade and drug use (for example legalization), there is little likelihood that the drug problem will change significantly.

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