



Drug Policy: Failure at Home

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 of these wars rely upon coercion. Abroad, military force and violence in Colombia and elsewhere are being unleashed largely 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—and street drug sellers. 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 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 keep whites from mingling with Chinese immigrants and to stigmatize Chinese laborers competing with white immigrants for employment. 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 assured 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 convince conservative Southern members of Congress to accept this substantial expansion of federal power, promoters of the law exploited racist myths, depicting "cocainized" Negroes as the principal cause of rape of white women.

Exaggerated claims that drugs cause 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 a 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 safe maintenance of addicts.

Enactment of the 1937 Marihuana Tax Act was a reprise of 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. In the mid-1950s, such fear mongering turned eastward. Ambitious politicians pushed for mandatory minimum sentences for drug peddling 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 noticed among poor and working-class people of color. Drug use also became widespread among the U.S. armed forces in Southeast Asia.

Politicians eagerly responded. New York Governor Nelson Rockefeller (R), harboring presidential hopes, hyped the drug epidemic and legislated long prison sentences for offenders. President Richard 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, and because he feared that drug addiction among GIs in Vietnam would further fuel public opposition to the war in Southeast Asia. Tragically, however, his harsh rhetoric fostered a climate of hostility toward those with drug problems. Current policies perpetuate Nixon's martial language while de-emphasizing treatment.

Key Points

- The U.S. war on drugs at home and abroad both rely on coercion and disproportionately target the poorest and lowest level participants in the drug trade.
- U.S. antidrug policy has had racist overtones and is driven by political opportunism, not by considerations of effectiveness or justice.
- The policy, which emphasizes law enforcement instead of effective demand-control measures, hasn't reduced deaths, drug abuse, drug availability, or the spread of disease.

Problems with Current U.S. Policy

The problems of the U.S. drug war at home and abroad are inextricably linked. Washington's war on drugs has not achieved its goals of reducing either the quantity of drugs or the level of drug consumption in the United States. Despite decades of the drug war, addicts and more casual consumers spend between \$40 and \$50 billion a year on illegal drugs. Instead, both sides of the drug equation—drug traffickers and drug enforcement—operate extraordinarily lucrative industries, providing both licit and illicit incomes to criminal syndicates, corporations, politicians, and law enforcement bodies in the U.S. and abroad. Both traffickers and enforcement personnel have a vested interest in protecting the current “war on drugs” model.

Federal spending on antidrug programs has grown from slightly more than \$1 billion in 1981 to roughly \$19.2 billion in 2001, with two-thirds of these funds directed at enforcement and interdiction programs. Within the U.S., an additional \$30 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 billions of dollars in prison construction. The drug war has helped earn the U.S. the dubious distinction of having more prisoners per capita than any other country.

Most incarcerated drug offenders have not committed a violent crime. Those advocating tough law enforcement policies stress that drug users account for 80% of crime in the United States, but 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. If crime reduction and prevention were viewed as genuine policy objectives, drug treatment would be made readily available to addicts. Yet in 1998, 2.9 million drug addicts—57% of those needing treatment—remained untreated, a number not much improved from a decade before.

Four trends over the last couple decades indicate that 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 16,926 in 1998, and the death rate has grown from 3.2 per 100,000 in 1979 to 6.3 in 1998. 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%. Higher strengths pose much greater

risks of overdose deaths among vulnerable novice users and former addicts who relapse.

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 1999—of arrests in America. Although 37% of those arrested for drug 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 convicted blacks serve time. Blacks convicted of drug trafficking are incarcerated for 26% longer on average than whites; overall, the average black serves an 18% longer sentence than a comparable white criminal.

In addition, “racial profiling” practices by police mean that 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, have their families dislocated, and see 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 sellers dilute their product with a wide variety of substances unsuitable for injection into the bloodstream. Other deaths arise from diseases such as HIV and hepatitis C, spread by sharing contaminated, forbidden needles.

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 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 routinely recruited into drug trafficking. Children are less reliable witnesses in court than adults and are almost never undercover police officers. The stiff penalties for adult drug dealers encourage these adults to recruit minors to sell, because, if caught, these children 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. Half of all FBI-led police corruption cases involve drugs. In 1992, Detroit's chief of police went to prison for 10 years for embezzling more than \$2 million in antidrug funds.

Key Problems

- Current U.S. drug policy does not meet any of its goals. Instead, it is supporting two lucrative industries—drug enforcement and drug trafficking—both with vested interests in protecting the status quo.
 - Washington's enforcement-oriented strategy has generated millions of arrests and hundreds of thousands of prisoners, most of whom are black or Latino.
 - Cost-effective treatment for hard-core drug addicts receives woefully inadequate funding and support.
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Toward a New Foreign Policy

A more enlightened U.S. foreign policy on drug control will necessarily mean major changes in U.S. domestic drug policy. Current consideration of alternative drug strategies is dominated by political cowardice and hot-button rhetoric. When Gov. Gary Johnson (R-NM) bravely suggested drug legalization, no politicians publicly joined him. Instead, President Clinton's drug czar,

Gen. Barry McCaffrey, led a political attack, calling Johnson "irresponsible." And Rep. Bob Barr (R-GA) suggested that global philanthropist George Soros be investigated for racketeering offenses, just because he funded criticism of national drug policy.

The public, however, has lost faith in the U.S. drug strategy. According to a March 2001 survey by the Pew Research Center, 74% of the public agrees that America is losing the war on drugs. Public dissatisfaction with

the antidrug strategy will not disappear by suppressing discussion of alternative strategies. Independent blue-ribbon commissions, faith communities, civic organizations, professional societies, and service clubs must undertake rational, cost-benefit, top-to-bottom reviews of drug strategies.

In the short term, increasing the availability of drug treatment on request 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 more cost-effective than imprisonment. A RAND Corporation analysis suggested that cocaine consumption could be reduced by 1% by spending either \$783 million in source countries, or \$366 million on international interdiction, or \$246 million on domestic enforcement, or just \$34 million on treatment.

About 2.1 million addicts were treated in 1998, but 2.9 million were unable to get treatment. The percentage of prisoners receiving drug treatment in prison decreased during the 1990s. For the poor and uninsured, publicly funded treatment is scarce.

Evaluations have found current youth drug-prevention-through-abstinence programs to be 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., promoting the use of designated drivers. A responsible-use approach to drugs would be honest, acknowledging that most youths stop with drug experimentation and never become addicts. Often programs that have nothing to do with drugs directly, such as Head Start and Big Brother/Big Sister, have dramatic effects in reducing youth drug use.

Drug abuse by women has been increasing more rapidly in the U.S. than has male drug abuse. Further research regarding female drug abusers and more treatment programs for women are vitally needed. In addition, discriminatory policies toward women should be stopped. Recently the U.S. Supreme Court (*Ferguson v. City of Charleston*) struck down warrantless South Carolina Police drug searches of poor, black, pregnant women at Charleston's principal hospital for indigent persons. Women should not be forced to give up their children to enter drug treatment programs.

Ninety percent of new AIDS cases among children under 13 are due to the sharing of used injection equipment by their mothers or fathers. All of these cases could be prevented if the federal government approved and funded syringe exchange, the nearly universal recommendation of public health authorities.

Drug offense sentences 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 permitted to prescribe marijuana and other appropriate pain relief. Studies show that doctors undertreat pain for 40-80% of their terminally ill patients.

It is likely that licensed and taxed drug distribution systems would be substantially less violent, less expensive, and more effective in reducing total harms than prohibition. Drug users would not need to be imprisoned, thus liberating substantial resources to pay for treatment. And a regulated drug industry would generate tens of billions of dollars in taxes.

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

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Key Recommendations

- Emotionally charged political discussion of drug policy must be replaced by honest study and rational discussion in the private sector.
- Reducing harm both from drugs and from antidrug policies is key to achieving a healthier, safer, more sober society.
- A comprehensive control structure including the licensing, taxing, and regulating of the drug trade and drug use should be considered.

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DrugSense
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Frontline: Drug Wars
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