Legalization: Panacea or Pandora's Box?

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I. Introduction

Legalization of drugs has recently received some attention as a policy option for the United States. Proponents of such a radical change in policy argue that the "war on drugs" has been lost; drug prohibition, as opposed to illegal drugs themselves, spawns increasing violence and crime; drugs are available to anyone who wants them, even under present restrictions; drug abuse and addiction would not increase after legalization; individuals have a right to use whatever drugs they wish; and foreign experiments with legalization work and should be adopted in the United Slates. In this, its first White Paper, the Center on Addiction and Substance Abuse at Columbia University (CASA) examines these propositions; recent trends in drug use; the probable consequences of legalization for children and drug-related violence; lessons to be learned from America's legal drugs, alcohol and tobacco; the question of civil liberties; and the experiences of foreign countries. On the basis of its review, CASA concludes that while legalization might temporarily take some burden off the criminal justice system, such a policy would impose heavy additional costs on the health care system, schools, and workplace, severely impair the ability of millions of young Americans to develop their talents, and in the long term overburden the criminal justice system.

Drugs like heroin and cocaine are not dangerous because they are illegal; they are illegal because they are dangerous. Such drugs are not a threat to American society because they are illegal; they are illegal because they are a threat to American society.

Any relaxation in standards of illegality poses a clear and present danger to the nation's children and their ability to learn and grow into productive citizens. Individuals who reach age 21 without using illegal drugs are virtually certain never to do so. Viewed from this perspective, substance abuse and addiction is a disease acquired during childhood and adolescence. Thus, legalization of drugs such as heroin, cocaine, and marijuana would threaten a pediatric pandemic in the United States.

While current prohibitions on the import, manufacture, distribution, and possession of marijuana, cocaine, heroin, and other drugs should remain, America's drug policies do need a fix. More resources and energy should be devoted to prevention and treatment, and each citizen and institution should take responsibility to combat drug abuse and addiction in America.

II. How Did We Get Here?

In the last half of the 19th century, opiates and cocaine were widely and legally available both in their pure form and as ingredients in patent medicines promoted as remedies for everything from hay fever and sinusitis to arthritis and depression. Heroin and cocaine were touted as non-addictive painkillers and as cures for morphine and alcohol addiction. But as the 20th century began, the U.S. had between 250,000 and 400,000 cocaine and opiate addicts,1 and concern rose about the addictiveness and destructive nature of these drugs.

This concern over the effects of the legal use of drugs led to federal and state actions. The Pure Food and Drug Act of 1906 mandated that patent medicine labels clearly list as ingredients certain drugs, such as opiates and cocaine. This requirement prompted a decline in use of these medicines. By 1914, all but two of the 48 states decided to restrict the use of cocaine. In that year, with passage of the Harrison Act, Congress required those who distribute and possess drugs to register with the federal government and buy tax stamps.2 In 1919, the Supreme Court interpreted provisions of the Harrison Act as making it illegal for a doctor to prescribe narcotics to addicts for the purpose of maintaining their addiction.3

During the 1930s, as cocaine and opiate use declined, public attention shifted to marijuana (which was still legal). The Marijuana Tax Act of 1937 required all marijuana dealers to register and pay an occupational lax, as well as a tax on each transaction. Because few tax stamps were ever issued, the Act effectively made marijuana illegal.4 The Boggs Act of 1951 and the Narcotics Control Act of 1956 established federal mandatory minimum sentences for illegal drug sales and possession, which varied by the type and amount of drug.5

The Controlled Substances Act of 3970 divided drugs into five schedules according to their potential for abuse and medical uses. Schedule I drugs, including heroin, lysergic acid diethylamide (LSD), and marijuana, have the highest potential for abuse, cause physical or psychological dependence, and have no accepted medical use. Drugs such as cocaine, morphine, phencyclidine (PCP), and tetrahydrocannabinol (THC), the active marijuana ingredient, with high potential for abuse but restricted medical applications, are in Schedule II. The remaining regulated drugs--including anabolic steroids (Schedule III), tranquilizers such as Librium and Valium (Schedule IV), and Robitussin with codeine (Schedule V)--all have accepted medical uses and are scheduled according to their potential for abuse and dependence.6 Also in 1970, the Racketeer-Influenced and Corrupt Organizations (RICO) and Continuing Criminal Enterprise laws added as a sanction forfeiture of profits from drug trafficking.

Temporarily rescinded in 1970 by the Comprehensive Drug Abuse Prevention and Control Act, mandatory sentences were re-instituted in 1984. Their use was expanded in 1986, 1988, and 1994. As a result, judges may not impose sentences below specified minimum levels regardless of any mitigating factor except cooperation in the prosecution of other offenders. Prior convictions for drug dealing increase the length of mandatory sentences.7

While the same drugs are illegal in all 50 states and many have adopted schedules similar to those of the federal government, state penalties for possession and distribution vary widely, particularly with respect to marijuana. In a few states, possession of small amounts of marijuana is a civil violation punishable by fine rather than a criminal offense. Today, 32 states have mandatory minimum sentences; 14 distinguish between crack and powder cocaine.8 All states impose forfeitures similar to those of the federal government. Like the federal government, states set higher penalties for selling drugs to minors and outlaw possession of drug paraphernalia and operation of premises where drugs are sold and used.9

International treaties have also been central to drug control efforts. The Shanghai Opium Commission (1909) and the International Conference on Opium (1911-1912) spurred passage of the Harrison Act in 1914. In 1961, the United Nations Single Convention on Narcotic Drugs established standard regulatory drug schedules for its signatories. At the 1988 U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 43 signatories, including the United States, agreed to share evidence, seize drug-related assets, relax bank secrecy rules to inhibit money laundering, and permit extradition and prosecution of drug law violators. In 1986, Congress banned foreign aid to countries that do not cooperate with tile U.S. or take adequate measures on their own to prevent drug production, trafficking, and money laundering.10

Thus, legalization of currently prohibited drugs would violate international treaty obligations, which commit countries to keep those drugs illegal, as well as repeal decades of domestic drug control legislation.

III. Legalization, Decriminalization, Medicalization, Harm Reduction: What's the Difference?

The term "legalization" encompasses a wide variety of policy options from the legal use of marijuana in private to free markets for all drugs. Four terms are commonly used: legalization, decriminalization, medicalization, and harm reduction--with much variation in each.

Legalization usually implies the most radical departure from current policy. Legalization proposals vary from making marijuana cigarettes as available as tobacco cigarettes to establishing an open and free market for drugs. Variations on legalization include: making drugs legal for the adult population, but illegal for minors; having only the government produce and sell drugs; and/or allowing a private market in drugs, but with restrictions on advertising, dosage, and place of consumption. Few proponents put forth detailed visions of a legalized market.

Decriminalization proposals retain most drug laws that forbid manufacture, importation, and sale of illegal drugs, but remove criminal sanctions for possession of small amounts of drugs for personal use. Such proposals suggest that possession of drugs for personal use be legal or subject only to civil penalties such as fines. Decriminalization

is most commonly advocated for marijuana.

Medicalization refers to the prescription of currently illegal drugs by physicians to addicts already dependent on such drugs. The most frequently mentioned variation is heroin maintenance. Proponents argue that providing addicts with drugs prevents them from having to commit crimes to finance their habit and insures that drugs they ingest are pure.

Harm reduction generally implies that government policies should concentrate on lowering the harm associated with drugs both for users and society, rather than on eradicating drug use and imprisoning users. Beginning with the proposition that drug use is inevitable, harm reduction proposals can include the prescription of heroin and other drugs to addicts; removal of penalties for personal use of marijuana; needle-exchange programs for injection drug users to prevent the spread of AIDS and other diseases that result from needle sharing among addicts; and making drugs available at low or no cost to eliminate the harm caused by users who commit crimes to support a drug habit.

Variations on these options are infinite. Some do not require any change in the illegal status of drugs. The government could, for instance, allow needle exchanges while maintaining current laws banning heroin, the most commonly injected drug. Others, however, represent a major shift from the current role of government and the goal of its policies with regard to drug use and availability. Some advocates use the term "harm reduction" as a politically attractive cover for legalization.

IV. Where We Are

Most arguments for legalization in all its different forms start with the contention that the "war on drugs" has been lost and that prevailing criminal justice and social policies with respect to drug use have been a failure. To support the claim that current drug policies have failed, legalization advocates point to the 80 million Americans who have tried drugs during their lifetime. Since so many individuals have broken drug laws, these advocates argue, the laws are futile and lead to widespread disrespect for the law. A liberal democracy, they contend, should not ban what so many people do.11

The 80 million Americans include everyone who has ever smoked even a single joint. The majority of these individuals have used only marijuana, and for many their use was brief experimentation. In fact, the size of this number reflects the large number of young people who tried marijuana and hallucinogenic drugs during the late 1960s and the 1970s when drug use was widely tolerated. During this time, drug use was so commonly accepted that the 1972 Shafer Commission, established during the Nixon Administration, and later, President Jimmy Carter called for decriminalization of marijuana.12

Since then, concerned public health and government leaders have mounted energetic efforts to de-normalize drug use, including First Lady Nancy Reagan's "Just Say No" campaign. As a result, current users of any illicit drugs, as measured by the National Household Survey on Drug Abuse, decreased from 24.8 million in 1979 to 13 million in

1994, a nearly 50 percent drop. (Throughout this paper, "current" drug users refers to individuals who have used drugs within the past month, the definition used in most drug use surveys.) Over the same time period, current marijuana users dropped from 23 million to 10 million and cocaine users from 4.4 million to 1.4 million.13 The drug-using segment of the population is also aging. In 1979, 10 percent of current drug users were older than 34; today almost 30 percent are.14

With these results and only 6 percent of the population over age 12 currently using drugs,15 it is difficult to say that drug reduction efforts have failed. This sharp decline in drug use occurred during a period of strict drug laws, societal disapproval, and increasing knowledge and awareness of the dangers and costs of illegal drug use.

Several factors, however, lead many to conclude that we have not made progress against drugs. This feeling of despair stems from the uneven nature of the success. While casual drug use and experimentation have declined substantially, certain neighborhoods and areas of the country remain infested with drugs and drug-related crime, and these continuing trouble spots draw media attention. At the same time, the number of drug addicts has not dropped significantly and the spread of HIV among addicts has added a deadly new dimension to the problem. The number of hardcore cocaine users (as estimated by the Office of National Drug Control Policy based on a number of surveys including the Household Survey, Drug Use Forecasting, and Drug Abuse Warning Network) has remained steady at roughly 2 million.16 (Throughout this paper, "hardcore" users refers to individuals who use drugs at least weekly.) The overall number of illicit drug addicts has hovered around 6 million, a situation that many experts attribute both to a lack of treatment facilities17 and the large numbers of drug-using individuals already in the pipeline to addiction, even though overall casual use has dropped.

Teenage drug use has been creeping up in the past three years. In the face of the enormous decline in the number of users, however, it is difficult to conclude that current policies have so failed that a change as radical as legalization is warranted. While strict drug laws and criminal sanctions are not likely to deter hardcore addicts, increased resources can be dedicated to treatment without legalizing drugs. Indeed, the criminal justice system can be used to place addicted offenders into treatment. In short, though substantial problems remain, we have made significant progress in our struggle against drug abuse.

V. Will Legalization Increase Drug Use?

Proponents of drug legalization claim that making drugs legally available would not increase the number of addicts. They argue that drugs are already available to those who want them and that a policy of legalization could be combined with education and prevention programs to discourage drug use.18 Some contend that legalization might even reduce the number of users, arguing that there would be no pushers to lure new users and drugs would lose the "forbidden fruit" allure of illegality, which can be seductive to children.19 Proponents of legalization also play down the consequences of drug use, saying that most drug users can function normally.20 Some legalization

advocates assert that a certain level of drug addiction is inevitable and will not vary, regardless of government policies; thus, they claim, even if legalization increased the number of users, it would have little effect on the numbers of users who become addicts.21

The effects of legalization on the numbers of users and addicts is an important question because the answer in large part determines whether legalization will reduce crime, improve public health, and lower economic, social, and health care costs. The presumed benefits of legalization evaporate if the number of users and addicts, particularly among children, increases significantly.

Availability

An examination of this question begins with the issue of availability, which has three components:

--**Physical,** how convenient is access to drugs.

--**Psychological,** the moral and social acceptability and perceived consequences of drug use.

--**Economic,** the affordability of drugs.

Physical

Despite assertions to the contrary, the evidence indicates that presently drugs are not accessible to all. Fewer than 50 percent of high school seniors and young adults under 22 believed they could obtain cocaine "fairly easily" or "very easily."22 Only 39 percent of the adult population reported they could get cocaine; and only 25 percent reported that they could obtain heroin, PCP, and LSD.23 Thus, only one-quarter to one-half of people can easily get illegal drugs (other than marijuana). After legalization, drugs would be more widely and easily available. Currently, only 11 percent of individuals reported seeing drugs available in the area where they lived;24 after legalization, there could be a place to purchase drugs in every neighborhood. Under such circumstances, it is logical to conclude that more individuals would use drugs.

Psychological

In arguing that legalization would not result in increased use, proponents of legalization often cite public opinion polls which indicate that the vast majority of Americans would not try drugs even if they were legally available.25 They fail to take into account, however, that this strong public antagonism towards drugs has been formed during a period of strict prohibition when government and institutions at every level have made clear the health and criminal justice consequences of drug use. Furthermore, even if only 15 percent of the population would use drugs after legalization, this would be triple the current level of 5.6 percent.

Laws define what is acceptable conduct in a society, express the will of its citizens, and represent a commitment on the part of the Congress, the President, state legislatures, and governors. Drug laws not only create a criminal sanction, they also serve as educational and normative statements that shape public attitudes.26 Criminal laws constitute a far stronger statement than civil laws, but even the latter can discourage individual consumption. Laws regulating smoking in public and workplaces, prohibiting certain types of tobacco advertising, and mandating warning labels are in part responsible for the decline in smoking prevalence among adults.

The challenge of reducing drug abuse and addiction would be decidedly more difficult if society passed laws indicating that these substances are not sufficiently harmful to prohibit their use. Any move toward legalization would decrease the perception of risks and costs of drug use, which would lead to wider use.27 During the late 1960s and the 1970s, as society, laws, and law enforcement became more permissive about drug use, the number of individuals smoking marijuana and using heroin, hallucinogens, and other drugs rose sharply. During the 1980s, as society's attitude became more restrictive and anti-drug laws stricter and more vigorously enforced, the perceived harmfulness of marijuana and other illicit drugs increased and use decreased.

Some legalization advocates point to the campaign against smoking as proof that reducing use is possible while substances are legally available.28 But it has taken smoking more than 30 years to decline as much as illegal drug use did in 10.29 Moreover, reducing use of legal drugs among the young has proven especially difficult. While use of illegal drugs by high school seniors dropped 50 percent from 1979 to 1993, tobacco use remained virtually constant.30

Economic

By all of the laws of economics, reducing the price of drugs will increase consumption.31 Though interdiction and law enforcement have had limited success in reducing supply (seizing only 25 percent to 30 percent of cocaine imports, for example)32 the illegality of drugs has increased their price.32 Prices of illegal drugs are roughly 10 times what they would cost to produce legally. Cocaine, for example, sells at $80 a gram today, but would cost only $10 a gram legally to produce and distribute. That would set the price of a dose at 50 cents, well within the reach of a school child's lunch money.34

Until the mid-1980s, cocaine was the drug of the middle and upper classes. Regular use was limited to those who had the money to purchase it or got the money through white collar crime or selling such assets as their car, house, or children's college funds. In the mid-1980s, the $5 crack cocaine vial made the drug inexpensive and available to all regardless of income. Use spread. Cocaine-exposed babies began to fill hospital neonatal wards, cocaine-related emergency room visits increased sharply, and cocaine-related crime and violence jumped.35

Efforts to increase the price of legal drugs by taxing them heavily in order to discourage consumption, if successful, would encourage the black market, crime, violence, and corruption associated with the illegal drug trade. Heroin addicts, who gradually build a tolerance to the drug, and cocaine addicts, who crave more of the drug as soon as its effects subside, would turn to a black market if an affordable and rising level of drugs were not made available to them legally.

Children

Drug use among children is of particular concern since almost all individuals who use drugs begin before they are 21. Furthermore, adolescents rate drugs as the number one problem they face.36 Since we have been unable to keep legal drugs, like tobacco and alcohol, out of the hands of children, legalization of illegal drugs could cause a pediatric pandemic of drug abuse and addiction.

Most advocates of legalization support a regulated system in which access to presently illicit drugs would be illegal for minors.37 Such regulations would retain for children the "forbidden fruit" allure that many argue legalization would eliminate. Furthermore any such distinction between adults and minors could make drugs, like beer and cigarettes today, an attractive badge of adulthood.

The American experience with laws restricting access by children and adolescents to tobacco and alcohol makes it clear that keeping legal drugs away from minors would be a formidable, probably impossible, task. Today, 62 percent of high school seniors have smoked, 30 percent in the past month.38 Three million adolescents smoke cigarettes, an average of one-half a pack per day, a $1 billion a year market.39 Twelve million underage Americans drink beer and other alcohol, a market approaching $10 billion a year. Although alcohol use is illegal for all those under the age of 21, 87 percent of high school seniors report using alcohol, more than half in the past month.40 These rates of use persist despite school, community, and media activities that inform youths about the dangers of smoking and drinking and despite increasing public awareness of these risks. This record indicates that efforts to ban drug use among minors while allowing it for adults would face enormous difficulty.

Moreover, in contrast to these high rates of alcohol and tobacco use, only 18 percent of seniors use illicit drugs, which are illegal for the entire society.41 It is no accident that those substances which are mostly easily obtainable--alcohol, tobacco, and inhalants such as those found in household cleaning fluids--are those most widely used by the youngest students.42

Supporters and opponents of legalization generally agree that education and prevention programs are an integral part of efforts to reduce drug use by children and adolescents. School programs, media campaigns such as those of the Partnership for a Drug-Free America (PDFA), and news reports on the dangers of illegal drugs have helped reduce use by changing attitudes towards drugs. In 1992, New York City school children were surveyed on their perceptions of illegal drugs before and after a PDFA

campaign of anti-drug messages on television, in newspapers, and on billboards. The second survey showed that the percentage of children who said they might want to try drugs fell 29 points and those who said drugs would make them "cool" fell 17 points.43 Another study found that 75 percent of students who saw anti-drug advertisements reported that the ads had a deterrent effect on their own actual or intended use.44

Along with such educational programs, however, the stigma of illegality is especially important in preventing use among adolescents. From 1978 to 1993, current marijuana use among high school seniors dropped twice as fast as alcohol use.45 California started a $600 million anti-smoking campaign in 1989, and by 1995, the overall smoking rate had dropped 30 percent. But among teenagers, the smoking rate remained constant--even though almost one-quarter of the campaign targeted them.46

In separate studies, 60 to 70 percent of New Jersey and California students reported that fear of getting in trouble with the authorities was a major reason why they did not use drugs.47 Another study found that the greater the perceived likelihood of apprehension and swift punishment for using marijuana, the less likely adolescents are to smoke it.48 Because a legalized system would remove much, if not all of this deterrent, drug use among teenagers could be expected to rise. Since most teens begin using drugs because their peers do49--not because of pressure from pushers50--and most drugs users initially exhibit few ill effects, more teenagers would be likely to try drugs.51

As a result, legalization of marijuana, cocaine, and heroin for adults would mean that increased numbers of teenagers would smoke, snort, and inject these substances at a time when habits are formed and the social, academic, and physical skills needed for a satisfying and independent life are acquired.

Hard Core Addiction

A review of addiction in the past shows that the number of alcohol, heroin, and cocaine addicts, even when adjusted for changes in population, fluctuates widely over time, in response to changes in access, price, societal attitudes, and legal consequences. The fact that alcohol and tobacco, the most accepted and available legal drugs, are the most widely abused, demonstrates that behavior is influenced by opportunity, stigma, and price. Many soldiers who were regular heroin users in Vietnam stopped once they returned to the United States where heroin was much more difficult and dangerous to get.52 Studies have shown that even among chronic alcoholics, alcohol taxes lower consumption.53

Dr. Jack Homer of the University of Southern California and a founding member of the International System Dynamics Society estimates that without retail-level drug arrests and seizures--which reduce availability, increase the danger of arrest for the drug user, and stigmatize use--the number of compulsive cocaine users would rise to between 10 and 32 million, a level 5 to 16 times the present one.54

Not all new users become addicts. But few individuals foresee their addiction when

they start using; most think they can control their consumption.55 Among the new users created by legalization, many, including children, would find themselves unable to live without the drug, no longer able to work, go to school, or maintain personal relationships. In fact, as University of California at Los Angeles criminologist James Q. Wilson points out with regard to cocaine,56 the percentage of drug triers who become abusers when the drugs are illegal, socially unacceptable, and generally hard to get, may be only a fraction of the users who become addicts when drugs are legal and easily available--physically, psychologically, and economically.

VI. Harming Thy Neighbor and Thyself: Addiction and Casual Drug Use

To offset any increased use as a result of legalization, many proponents contend that money presently spent on criminal justice and law enforcement could be used for treatment of addicts and prevention.57 In 1995, the federal government is spending $13.2 billion to fight drug abuse, nearly two-thirds of that amount on law enforcement; state and local governments are spending at least another $16 billion on drug control efforts, largely on law enforcement.58 Legalization proponents argue that most of this money could be used to fund treatment on demand for all addicts who want it and extensive public health campaigns to discourage new use.

With legalization, the number of prisoners would initially decrease because many are currently there for drug law violations. But to the extent that legalization increases drug use, we can expect to see more of its familiar consequences. Costs would quickly rise in health care, schools, and businesses. In the long term, wider use and addiction would increase criminal activity related to the psychological and physical effects of drug use and criminal justice costs would rise again. The higher number of casual users and addicts would reduce worker productivity and students' ability and motivation to learn, cause more highway accidents and fatalities, and fill hospital beds with individuals suffering from ailments and injuries caused or aggravated by drug abuse.

Costs

It is doubtful whether legalization would produce any cost savings over time even in the area of law enforcement. Indeed, the legal availability of alcohol has not eliminated law enforcement costs due to alcohol-related violence. A third of state prison inmates committed their crimes while under the influence of alcohol.59 Despite intense educational campaigns, the highest number of arrests in 1993--1.5 million--was for driving while intoxicated.60 Even if, as some legalization proponents propose, drug sales were taxed, revenues raised would be more than offset by erosion of the general tax base as abuse and addiction limited the ability of individuals to work.

Like advocates of legalization today, opponents of alcohol prohibition claimed that taxes on the legal sale of alcohol would dramatically increase revenues and even help erase the federal deficit.61 The real-world result has been quite different. The approximately $20 billion in state and federal revenues from alcohol taxes in 199562 pay for only half the $40 billion that alcohol abuse imposes in direct health care costs,63

much less the costs laid on federal entitlement programs and the legal and criminal justice systems, to say nothing of lost economic productivity. The nearly $13 billion in federal and state cigarette tax revenue64 is one-sixth of the $75 billion in direct health care costs attributable to tobacco,65 to say nothing of the other costs such as the $4.6 billion in social security disability payments to individuals disabled by cancer, heart disease, and respiratory ailments caused by smoking.66

Health care costs directly attributable to illegal drugs exceed $30 billion,67 an amount that would increase significantly if use spread after legalization. Experience renders it unrealistic to expect that taxes could be imposed on newly legalized drugs sufficient to cover the costs of increased use and abuse.

Public Health

Legalization proponents contend that prohibition has negative public health consequences such as the spread of HIV from addicts who share dirty needles, accidental poisoning, and overdoses from impure drugs of variable potency. In 1994, more than one-third of new AIDS cases were among injection drug users who shared needles, cookers, cottons, rinse water, and other paraphernalia; many other individuals contracted AIDS by having sex, often while high, with infected injection drug users.68

Advocates of medicalization argue that while illicit drugs should not be freely available to all, doctors should be allowed to prescribe them (particularly heroin, but also cocaine) to addicts. They contend that giving addicts drugs assures purity and eliminates the need for addicts to steal in order to buy them.69

Giving addicts drugs like heroin, however, poses many problems. Providing them by prescription raises the danger of diversion for sale on the black market. The alternative--insisting that addicts take drugs on the prescriber's premises--entails at least two visits a day, thus interfering with the stated goal of many maintenance programs to enable addicts to hold jobs.

Heroin addicts require two to four shots each day in increasing doses as they build tolerance to its euphoric effect. On the other hand, methadone can be given at a constant dose since euphoria is not the objective. Addicts maintained on methadone need only a single dose each day and take it orally, eliminating the need for injection.70 Because cocaine produces an intense, but short euphoria and an immediate desire for more,71 addicts would have to be given the drug even more often than heroin in order to satisfy their craving sufficiently to prevent them from seeking additional cocaine on the street.

Other less radical harm reduction proposals also have serious flaws. Distributing free needles, for example, does not guarantee that addicts desperate for a high would refuse to share them. But to the extent that needle exchange programs are effective in reducing the spread of the AIDS virus and other diseases without increasing drug use, they can be adopted without legalizing drugs. Studies of whether needle exchange programs increase drug use have generally focused on periods of no longer than 12 months.72 While use

does not seem to increase in this period, data is lacking on the long-term effects of such programs and whether they prompt attitude shifts that in turn lead to increased drug use.

Some individuals do die as a result of drug impurities. But while drug purity could be assured in a government-regulated system (though not for those drugs sold on the black market), careful use could not. The increased numbers of users would probably produce a rising number of overdose deaths, similar to those caused by alcohol poisoning today.

The deaths and costs due to unregulated drug quality pale in comparison to the negative impact that legalization would have on drug users, their families, and society. Casual drug use is dangerous, not simply because it can lead to addiction or accidental overdoses, but because it is harmful per se, producing worker accidents, highway fatalities, and children born with physical and mental handicaps. Each year, roughly 500,000 newborns are exposed to illegal drugs in the womb; many others are never born because of drug-induced spontaneous abortions.73 Newborns already exposed to drugs are far more likely to need intensive care and suffer the physical and mental consequences of low birth weight and premature birth, including early death.74 The additional costs just to raise drug-exposed babies would outweigh any potential savings of legalization in criminal justice expenditures.75

Substance abuse aggravates medical conditions. Medicaid patients with a secondary diagnosis of substance abuse remain hospitals twice as long as patients with the same primary diagnosis but with no substance abuse problems. Girls and boys under age 15 remain in the hospital three and four times as long, respectively, when they have a secondary diagnosis of substance abuse.76 One-third to one-half of individuals with psychiatric problems are also substance abusers.77 Young people who use drugs are at higher risk of mental health problems including depression, suicide, and personality disorders.78 Teenagers who use illegal drugs are more likely to have sex79 and are less likely to use a condom than those who do not use drugs.80 Such sexual behavior exposes these teens to increased risk of pregnancy as well as AIDS and other sexually transmitted diseases.

In schools and families, drug abuse is devastating. Students who use drugs not only limit their own ability to learn, they also disrupt classrooms, interfering with the education of other students. Drug users tear apart families by failing to provide economic support, spending money on drugs, neglecting the emotional support of the spouse and guidance of children, and putting their children at greater risk of becoming substance abusers themselves.81 With the advent of crack cocaine in the mid-1980s, foster care cases soared over 50 percent nationwide in five years; more than 70 percent of these cases involved families in which at least one parent abused drugs.82

Decreased coordination and impaired motor skills that result from drug use are dangerous. A recent study in Tennessee found that 59 percent of reckless drivers who, having been stopped by the police, test negative for alcohol on the breathalyzer, test positive for marijuana and/or cocaine.83 Twenty percent of New York City drivers who die in automobile accidents test positive for cocaine use.84 The extent of driving while

high on marijuana and other illegal drugs is still not well known because usually the police do not have the same capability for roadside drug testing as they do for alcohol testing.

The Workplace

Currently, three-quarters of illegal drug users are employed full or part time;85 15 percent of them admit to working under the influence of drugs.86 These workers impose costs on their employers and eventually society through their decreased productivity, health care needs, workplace accidents, and absenteeism. They drive buses and trucks, operate nuclear power plants, run the air traffic control system, perform surgery, deliver mail, and teach children.

Workers who use cocaine and marijuana are twice as likely to be absent from work and to be injured, and one and a half times more likely to be involved in an accident.87 Overall, workers who use drugs are three times likelier to be late for work, 10 times likelier to miss work, and three to six times likelier to injure themselves or others. Drug-using workers are responsible for 40 percent of industrial fatalities and experience more than 300 percent higher medical and benefits costs.88 In 1991, lost productivity due to illegal drugs totalled $50 billion.89 With evidence of the health and workplace costs and consequences of drug use continuing to increase, it would be irresponsible to take action likely to increase such use.

VII. Crime and Violence

Legalization advocates contend that drug-related violence is really drug-trade-related violence. They argue that what we have today is not a drug problem but a drug prohibition problem, that anti-drug laws spawn more violence and crime than the drugs themselves. Because illegality creates high prices for drugs and huge profits for dealers, advocates of legalization point out that users commit crimes to support their habit; drug pushers fight over turf; gangs and organized crime thrive; and users become criminals by coming into contact with the underworld.90

Legalization proponents argue that repeal of current laws, which criminalize drug use and sales, and wider availability of drugs at lower prices will end this black market and thus reduce the violence, crime, and incarceration associated with drugs.

Researchers divide drug-related violence into three types: systemic, economically compulsive, and psychopharmacological.91

--**Systemic violence** is that intrinsic to involvement with illegal drugs, including murders over drug turf, retribution for selling "bad" drugs, and fighting among users over drugs or drug paraphernalia.

--**Economically compulsive violence** results from addicts who engage in violent crime in order to support their addiction.

--**Psychopharmacological violence** is caused by the short or long-term use of certain drugs which lead to excitability, irrationality and violence, such as a brutal murder committed under the influence of cocaine.

Legalization of the drug trade and lower prices might decrease the first two types of violence, but higher use and abuse would increase the third. Dr. Mitchell Rosenthal, President of the Phoenix House treatment centers warns, "What I and many other treatment professionals would expect to see in a drug-legalized America is a sharp rise in the amount of drug-related crime that is not committed for gain--homicide, assault, rape, and child abuse. Along with this, an increase in social disorder, due to rising levels of drug consumption and a growing number of drug abusers."92

In a study of 130 drug-related homicides, 60 percent resulted from the psychopharmacological effects of the drug; only 20 percent were found to be related to the drug trade; 3.1 percent were committed for economic reasons. (The remaining 17 percent either fell into more than one of these categories or were categorized as "other.")93 U.S. Department of Justice statistics reveal that six times as many homicides, four times as many assaults, and almost one and a half times as many robberies are committed under the influence of drugs as are committed in order to get money to buy drugs." Given these facts, any decreases in violent acts committed because of the current high cost of drugs would be more than offset by increases in psychopharmacological violence, such as that caused by cocaine psychosis.

The threat of rising violence is particularly serious in the case of cocaine, crack, methamphetamine, and PCP--drugs closely associated with violent behavior. Unlike marijuana or heroin, which depress activity, these drugs cause irritability and physical aggression. For instance, past increases in the New York City homicide rate have been tied to increases in cocaine use.95

Repeal of drug laws would not affect all addicts in the same way. Addicts engage in criminal behavior for different reasons. A small proportion of addicts is responsible for a disproportionately high number of drug-related crimes and arrests. Virtually all of these addicts committed crimes before abusing drugs and use crime to support themselves as well as their habits. Their criminal activity and drug use are symptomatic of chronic antisocial behavior and attitudes. Legally available drugs at lower prices would do little to discourage crime by this group. For a second group, criminal activity is associated with the high cost of illegal drugs. For these addicts, lower prices would decrease drug-related crimes. For a third group, legally available drugs would mean an opportunity to create illegal diversion markets, as some addicts currently do with methadone.96

Legalization advocates point to the exploding prison population and the failure of strict drug laws to lower crime rates.97 Arrests for drug offenses doubled from 470,000 in 1980 to 1 million in 1993.98 Some 60 percent of the 95,000 federal inmates are incarcerated for drug-law violations.99

Rising prison populations are generated in large part by stricter laws, tough enforcement, and mandatory minimum sentencing laws-policy choices of the public and Congress. But the growing number of prisoners is also a product of the high rate of recidivism--a phenomenon tied in good measure to the lack of treatment facilities, particularly in prison. Eighty percent of prisoners have prior convictions and 60 percent have served time before.100 Despite the fact that more than 60 percent of all state inmates have used illegal drugs regularly and 30 percent were under the influence of drugs at the time they committed the crime for which they were incarcerated,101 fewer than 20 percent of inmates with drug problems receive any treatment.102 Many of these inmates also abuse alcohol, but there is little alcoholism treatment either for them or for those prisoners dependent only on alcohol.103

While strict laws and enforcement do not deter addicts from using drugs, the criminal justice system can be used to get them in treatment. Because of the nature of addiction, most drug abusers do not seek treatment voluntarily, but many respond to outside pressures including the threat of incarceration.104 Where the criminal justice system is used to encourage participation in treatment, addicts are more likely to complete treatment and stay off drugs.105

VIII. The Lessons of Prohibition

Legalization advocates often cite the era of national alcohol prohibition from 1920 to 1934 to support their case. As ratified in the 18th Amendment, Prohibition banned the "manufacture, sale, or transportation of intoxicating liquors within, the importation thereof into, or the exportation thereof from the United States. . . ."106 Proponents of legalization contend that the failure of the 18th Amendment supports their argument that prohibitions of this kind of individual behavior are not effective.107

There are two important distinctions between Prohibition and current drug laws. First, Prohibition was in fact decriminalization because possession for personal consumption was not illegal. Second, alcohol, unlike illegal drugs, has a long history of widespread social acceptance and use in our culture dating at least as far back as the Old Testament and Ancient Greece. Largely because of this, the public and political consensus favoring Prohibition was short-lived. By the early 1930s, most Americans no longer supported it. Today, on the other hand, the public overwhelmingly favors keeping illegal drugs illegal.108

Despite these differences, which made alcohol prohibition more difficult to enforce than current drug laws, Prohibition reduced the amount of alcohol consumed, as well as the incidence of alcohol-related medical problems and violence. At the beginning of the 20th century, Americans consumed 2.6 gallons of alcohol per person. By 1919, when 36 of the 48 states had established some form of prohibition, this amount dropped to 1.96 gallons per person. In 1934, the first full year after repeal of national Prohibition, alcohol use stood at .97 gallons per person. From then on, consumption rose steadily to its present level, roughly three times as a high as immediately after Prohibition.109

Death rates from cirrhosis of the liver corroborate available consumption statistics. Cirrhosis death rates fell from 12 per 100,000 in 1916 to 5 per 100,000 in 1920, and remained at that level throughout Prohibition before beginning lo rise steadily again after repeal.110 Among men such rates declined even more sharply, from 29.5 per 100,000 in 1911 to 10.7 per 100,000 in 1929.

The decrease in consumption had other positive health consequences. Admissions to mental health institutions for alcoholic psychosis dropped by more than 60 percent from 1919 to 1922. Arrests for drunkenness and disorderly conduct dropped 50 percent between 1916 and 1922, and welfare agencies reported dramatic declines in the number of cases due to alcohol-related family problems.111

Prohibition did not generate a crime wave. Homicide experienced a higher rate of increase between 1900 and 1910 than during Prohibition, and organized crime was well established in cities before 1920.112

Legalization proponents also argue that during Prohibition, an increased number of drinkers died from the consumption of dangerous wood and denatured alcohol, which were used as substitutes for commercial alcohol, just as today addicts die from impure drugs. The data do not bear this out. Through 1927, the rate of death from these substitutes remained nearly constant at its 1920 level.113

These facts are presented solely to set the record straight and to dispel the exaggerated or false consequences often attributed to Prohibition. They are not an argument for the resumption of Prohibition, but they do offer some lessons on the relevance of illegality to reducing drug use.

IX. The Lessons of Legal Drugs

Legalization proponents point out that alcohol and tobacco cost society much more in lost productivity, increased health care, and criminal justice expenditures and lead to more deaths than all illegal drugs combined.114 From that, they conclude that we spend too much time and energy fighting illegal drugs, as compared to legal drugs. Alcohol and tobacco are indeed responsible for far more deaths and costs to society than illegal drugs, but this is precisely because alcohol and tobacco are legal and therefore widely available, used, and abused.

Illegal drug-related deaths are estimated at 20,000 annually. Tobacco is responsible for more than 400,000 deaths and alcohol for more than 100,000 deaths every year.115 Fetal alcohol syndrome is the leading known cause of mental retardation.116 Smoking by pregnant women kills up to 7,000 newborns annually and leads to as many as 141,000 miscarriages.117 Cigarettes are as addictive as heroin and spawn health problems ranging from lung cancer to emphysema and heart disease.118 Of the $29 billion in Medicare costs attributable to substance abuse in 1993, 80 percent was related to smoking. Seventy percent of the $21 billion that Medicaid spent because of substance abuse is due to cigarettes and alcohol.119 Of the $66 billion that substance abuse costs federal health and

disability entitlement programs, $56 billion are attributable to alcohol and tobacco.120

The high costs attributed to legal drugs do not indicate that we are concentrating prohibition on the wrong drugs, but rather that when drugs are legal, and therefore widely acceptable and available, they adversely affect more individuals and require more attention and resources. Indeed, the nation's experience with tobacco and alcohol send a warning about the dangers of making illegal drugs readily available.

Another argument made by legalization proponents is that the general decrease in consumption rates of both legal and illegal drugs in the past 15 years has nothing to do with law enforcement policy, but rather with education and increased societal concern with personal health.121 Yet despite widespread awareness of the risks of smoking and heavy media attention to tobacco-related problems, roughly 25 percent of Americans continue to smoke,122 and smoking is on the rise among young people.123 On the other hand, the number of illegal drug users has dropped by half over the last 15 years, to 6 percent.124 Arguing that we should treat illicit drugs as we do tobacco, using education instead of prohibition, also implies a false dichotomy between education and prohibitive laws. In curbing illegal drug use, when law enforcement and education complement and reinforce each other, they are most effective.

There are more than 50 million nicotine addicts, some 18 million alcoholics and alcohol abusers, and 6 million illegal drug addicts. Making illegal drugs legal would drive the number of marijuana, heroin, and cocaine users closer to the number of alcohol and tobacco users.

X. Marijuana

Marijuana is the most commonly used illegal drug in the United States and its use is particularly high among adolescents. Because relatively little street-level violence attends the marijuana trade, the legalization debate here centers on how harmful the drug is to the user, whether marijuana use leads to the use of harder drugs, whether marijuana use would increase, and whether any increase would translate into a decrease in alcohol use.125

While not as dangerous as snorting cocaine or shooting heroin, smoking marijuana is clearly detrimental both physically and mentally. The effects of one marijuana joint on the lungs are equivalent to four cigarettes, placing the user at increased risk of bronchitis, emphysema, and bronchial asthma. The active ingredient in marijuana remains in the brain, lungs, and reproductive organs for weeks. Marijuana weakens the immune system,126 and regular use can disrupt the menstrual cycle and suppress ovarian function.127 Regardless of socioeconomic status, prenatal use of marijuana by the mother appears to reduce significantly the IQs of babies.128 Marijuana impairs short-term memory and ability to concentrate when its young users are in high school and college.129 And marijuana use diminishes motor control functions, distorts perception, and impairs judgment, leading among other things to increased car accidents and vandalism.

The link between the use of marijuana and the subsequent use of harder drugs has been the subject of much debate, with supporters of marijuana legalization arguing that many individuals who smoke marijuana never use hard drugs. True, yet the statistical association between the teenage use of marijuana and the later use of hard drugs such as cocaine is powerful. While a biomedical or causal relationship between the two has not been established, 12 to 17 year-olds who smoke marijuana are 85 times more likely to use cocaine than those who do not. Adults who as adolescents smoked marijuana are 17 times likelier to use cocaine regularly. Sixty percent of adolescents who use marijuana before age 15 will later use cocaine. These correlations are many times higher than the initial relationships found between smoking and lung cancer in the 1964 Surgeon General's report (nine to ten limes), high cholesterol and heart disease in the Framingham study (two to four times), and asbestos and lung cancer in the Selikoff study (five times).130

Marijuana use has been associated with many high-risk behaviors among young people. According to the Centers for Disease Control, adolescents who smoke marijuana are twice as likely to attempt suicide and carry a weapon as those who do not. Adolescent marijuana smokers are three times as likely to have sex and far more likely to do so without a condom, putting themselves at much greater risk of teen pregnancy and sexually transmitted diseases.131

Past experiences with marijuana decriminalization illustrate the consequences of more tolerant policies. During the 1970s, 11 states decriminalized personal possession of marijuana by making the offense a civil violation punishable by a fine. In 1975, the Alaska State Supreme Court decriminalized at-home personal use of small amounts of marijuana for individuals older than 19. By 1988, 12 to 17 year-olds in Alaska were smoking joints at more than twice the national average. Marijuana use became part of the lifestyle of many teenagers and the age of initiation declined.132 Because of this, in a 1990 referendum Alaskans voted to recriminalize personal possession.

Proponents of legalization cite several surveys and studies which report that when Oregon, Maine, and California decriminalized marijuana, rates of use among teenagers did not increase significantly.133 These surveys, however, have severe shortcomings. They lack controls for other historical and demographic factors, such as sex, income and education, and employ vaguely defined measurement criteria to estimate the prevalence of marijuana use.134 They do not reflect the impact of legalization on long-term usage rates because they were conducted only one to three years after decriminalization laws were passed, and they fail to recognize that even minimal annual increases in use become significant when they accumulate over time. Though reported marijuana use increased only slightly following decriminalization, the time period surveyed was not long enough to allow the educational and attitude-forming aspects of the previous strict drug laws to dissipate.

Some supporters of legalization argue that usage rates in states that decriminalized increased no faster than in states that did not. This comparison is problematic because many states that did not decriminalize reduced penalties for marijuana use, and others

chose not to enforce laws prohibiting personal use of marijuana. During the 1970s, many states and the federal government adopted more tolerant attitudes towards the drug. Nationwide, use rose significantly during this time, reaching almost 40 percent of high school seniors before beginning its long decline in 1979.135

Teenagers are not likely to stop using alcohol when they begin smoking marijuana. An examination of nationwide usage rates of marijuana and alcohol reveals that these drugs are not substitutes. While on individual occasions, teens may choose to get high on either marijuana or alcohol, these drugs are often used together. From 1975 to 1978, as the percentage of teens using marijuana increased from 27 percent to 37 percent, the percentage of teens who drank increased from 68 percent to 72 percent. Marijuana use then dropped to 12 percent of teens by 1992; alcohol use dropped to 51 percent. The recent rise in teenage marijuana use has been accompanied by little change in the percent of students who drink.136

Proponents of legalization argue that while smoking pot has detrimental health and social effects, so does use of our two legal drugs, alcohol and tobacco, and to be consistent, we should legalize marijuana. But legalizing marijuana would add a third drug that combines some of the most serious risks of the other two.137 Marijuana offers both the intoxicating effects of alcohol and the long-term lung damage of tobacco. It would be irresponsible to legalize marijuana and create a third legal drug, especially when we are still learning about its physical and psychological health effects as well as its relationship to other drugs and a variety of dangerous behaviors. One of the most serious drawbacks of marijuana legalization, Harvard University drug policy expert Mark Kleiman notes, is its "virtual irreversibility if it goes badly wrong."138

XI. Individual Liberty or Public Liability: Drug Use and Civil Liberties

Arguing that individuals have a right to use drugs, some legalization proponents view drug use as an issue of civil liberties.139 Citing John Stuart Mill's On Liberty, these libertarians argue that the state has no right to interfere in the private lives of citizens; only when an action directly harms someone else may the state step in to regulate it.140

Mill's conception of freedom, however, does not extend to the right of individuals to enslave themselves or to decide that they will give up their liberty. As Mill wrote, "The principle of freedom cannot require that he should be free not to be free. It is not freedom to be allowed to alienate his freedom."141 Clearly, drug addiction is a form of enslavement; it "alters pathologically the nature and character of abusers," according to Dr. Mitchell Rosenthal.142 Addicts are often constrained by the drug from holding meaningful employment, having stable and productive social relationships, and exercising many of their rights. Often they are compelled to act in ways that lead to a deprivation of their future liberty. Thus, the state can take action to free an addict from the bonds of chemical dependency and to prevent those bonds from forming.143 Indeed, to preserve and nourish individual and collective freedom, the state has an obligation to take such action.

Moreover, Mill's contention that the state can only regulate those actions that directly affect others--among the most expansive views of privacy and individual rights--does not apply here because drug abuse directly harms others. From the abused spouse and drug-damaged newborn, to co-workers and those who do not know the addict but pay taxes to treat the addiction and its consequences, an individual's drug use reverberates throughout society. Certainly if the state has a compelling interest to ban lead paint, asbestos insulation, unsafe toys, and flammable fabrics, then it should ban cocaine, heroin, hallucinogens, and marijuana. Refusing to include drug use in the right to privacy, the U.S. Supreme Court has blessed state laws that prohibit even the sacramental use of peyote.144 State courts, like those of New York, have held that possession of marijuana in the home is not protected by the right to privacy.145

Mill would argue that when addicts harm someone else because of their addiction, the government should not prevent individuals from using drugs, but punish them only for the particular crime committed. But applying this principle to pragmatic public policy limits government action only to manifestations of the problem. There is little sense to government policies that allow individuals to use drugs, then imprison them for acting in ways that result from their use, only to release them with the same problem so that they will, in all probability, act again in the same way for the same reasons. Such policy would compel society repeatedly to suffer the consequences--increased violence, higher health care costs, and lower productivity--of someone else's actions before being able to act.146

Society and social institutions have changed markedly from Mill's day. The present health care, welfare, social service, and economic systems tie us closely together. While they provide us a degree of security and interdependence never before experienced, they also modify our freedom to act as we please. The fad that our society does not allow addicts to die alone in a gutter, but instead places them in a hospital and bears the costs of their care, gives the state an interest in preventing an individual from becoming addicted.

XII. The European Experiences

Many legalization advocates point to the policies of European countries as models for approaches to the American drug problem. They claim that some countries, notably the Netherlands and Great Britain, are more innovative because their aim is to minimize the harmful impact of drug use on the user and society, even if this requires some degree of legalization.147

While the Netherlands' laws regarding illegal drugs remain unchanged, Dutch enforcement policy since 1976 has distinguished between "drugs presenting an unacceptable risk" (commonly termed "hard drugs," such as cocaine and heroin) and "cannabis products."148 Special "coffee shops" have been established where anyone over 15 can purchase marijuana. Legalization proponents claim that this policy has not increased drug use among young people or the population in general and that little crime exists in Holland.149

These claims are not supported by the facts. Though marijuana use did not explode

immediately following decriminalization, it has recently been increasing, suggesting that the effects of decriminalization may only be fully realized in the longer-term. Between 1984 and 1992, Dutch adolescent marijuana use increased nearly 200 percent;150 over the same period, marijuana use among American adolescents plummeted 66 percent. Since 1988, the Dutch have seen a 22 percent increase in the total number of registered addicts, and a 30 percent increase, from 1991 to 1993, in the number of registered cannabis addicts.151 Several marijuana "coffee shops" in Amsterdam have already been shut down for illegally selling hard drugs. The City Council is awaiting new directives from the national government before deciding on proposed restrictions to prohibit the opening of new shops, raise the minimum age for purchase to 18, and force the shops to close earlier. The goal of all of these regulations is to cut the number of "coffee shops" in half.152

Increased usage and addiction in Holland lias been accompanied by a 60 percent increase in crime, most of it property crime, between 1981 and 1992.153 Amsterdam has twice as many police officers relative to its population as the average American city.154 Despite the Netherlands' tolerant drug policies, the number of organized crime groups shot up from 3 in 1988 to 93 in 1993.155

The other country that legalization advocates cite favorably is Great Britain for its policy of allowing specially licensed doctors to prescribe drugs to addicts.156 These arguments have been bolstered by the claims of one British doctor, John Marks, who says that by prescribing heroin to addicts, he has lowered the rate of addiction, reduced crime, and increased the addicts' health.157 His statistics, however, do not distinguish between patients on heroin and methadone, and the successes he claims are based on his anecdotal evidence without independent substantiation.

Nationwide, British doctors maintain 17,000 heroin addicts on methadone and less than 400 on heroin. Given the 150,000 heroin addicts in England, claims that maintaining a few hundred of them on heroin has driven drug dealers and drug-related crime from the streets are unfounded. There has been no movement among doctors in England to adopt heroin maintenance on a large scale.158

In general, much confusion surrounds British policies. Until 1968, the government allowed all doctors to prescribe drugs to addicts in the context of their medical treatment, but this policy failed to contain the problem of addiction. Doctors carelessly or willfully abused their privilege and unlawfully supplied drugs to many individuals. Addicts diverted legally obtained drugs to the general population. In response to increasing rates of addiction, Britain mandated in 1968 that only doctors specially licensed by the Home Office could prescribe illegal drugs and that doctors must register all addicts with the Home Office.159 Roughly 100 doctors are currently licensed, of whom less than 20 prescribe such drugs.160

The rate of increase in heroin addiction in England subsequently slowed until the late 1970s, when a large influx of black market heroin from southwest Asia fueled a sudden increase in new addicts that continued through the 1980s.161 This increase was not, as

some legalization proponents claim, due to the fact that the British, following the American lead, adopted harsher drug laws. On the national level, the government responded to this increase in addiction by emphasizing supply reduction, prevention, and criminal justice deterrents. Local level officials responded by emphasizing harm reduction and loosely enforcing anti-drug laws. These conflicting national and local approaches persisted until the late 1980s, when concern over the spread of AIDS by injection drug users prompted national policy makers to shift towards such harm reduction programs as needle exchanges and condom distribution.162

In short, the increasing number of addicts in Britain was not a result of strict national laws and "zero tolerance" policies. Rather, these policies were a response to the increased addiction. Moreover, strict national anti-drug laws mean little if local enforcement is lax.

One celebrated experiment in harm reduction and drug tolerance is less often mentioned now that it has been terminated. Beginning in 1987, Switzerland allowed all addicts and users to congregate in a park-the "Platzspitz," or "Needle Park," as it became known—in the center of downtown Zurich, where they could buy and use drugs freely. Strict enforcement of anti-drug laws continued in the rest of the city and country. Like many proponents of harm reduction, Swiss policy makers believed that if drug dealing and use was going to happen anyway, it might as well occur in the open where the police and health officials could monitor it. In Needle Park, public health officials gave addicts free needles, condoms, medical care, counseling, and the opportunity for treatment.163

This experiment in harm reduction had unintended consequences. The number of addicts in the park increased from a few hundred in 1987 to 20,000 in 1992. Twenty-five percent came from outside Switzerland, drawn to the park by its tolerant policies. Drug-related violence and crime rose rapidly in the area; 81 drug-related deaths were recorded in 1991, double the previous year. The city's chief medical officer reported that doctors were resuscitating an average of 12 people a day who had overdosed, and up to 40 on some days.164

Because of these high costs, the park was closed in 1992, but the fallout from this policy was damaging. The heroin-related death rate in Switzerland had become the highest in Europe and North America.165 Addicts wandered the city streets and open air markets proliferated. Three years after the experiment ended, Swiss police tried to disperse the continuing drug bazaar that had moved to an unused railroad station.166 To deal with their burgeoning heroin problem, Swiss authorities have since begun an experiment with heroin prescription for addicts. That Switzerland's tolerant policy has proved difficult to reverse even after its harmful consequences became apparent serves as a warning to those who claim that we can quickly reverse liberal drug policies if they have negative consequences.

Italy is infrequently mentioned by advocates of legalization despite its lenient drug laws. Personal possession of small amounts of drugs has not been a crime in Italy since 1975, other than for a brief period of "recriminalization" between 1990 and 1993 (though even then Italy permitted an individual to possess one dose of a drug).167 Under

decriminalization, interpretation of the precise quantity allowed was left to individual judges, but generally, possession of two to three daily doses of drugs such as heroin was exempt from criminal sanction. Today, Italy has 300,000 heroin addicts,168 the highest rate of heroin addiction in Europe.169 Seventy percent of all AIDS cases in Italy are attributable to drug use.170

In contrast, Sweden offers an example of a successful restrictive drug policy. Sweden has tried a variety of approaches to drugs (though none have involved legalization) since its first experiment with the prescription of drugs, particularly amphetamines, to addicts in 1965. This experiment ended two years later because eligible addicts diverted prescribed drugs to friends and acquaintances and, contrary to the expectation that freely available drugs would decrease crime among addicts, crimes committed by legal users increased.

In 1972, Swedish policy shifted towards harm reduction; enforcement became more lax, concentrating primarily on drug kingpins. Arrests for drug offenses dropped by half and police allowed possession of up to a week's supply of a drug. During this lime drug use remained high and heroin use began on a large scale.

By 1980, increasing deaths from heroin use shifted public opinion and government policy toward a more restrictive approach to drugs. The aim of Swedish drug policy, like that of the United Stales, became a drug-free society. Possession of anything more than a single joint of marijuana was punished; drug arrests tripled in three years. In 1982, Sweden introduced mandatory treatment commitments. During the 1980s, drug use declined rapidly, particularly among the young. By 1988, the percentage of military conscripts using drugs fell by 75 percent; current use by ninth graders dropped 66 percent. The population of drug users aged considerably; in 1979, 37 percent of daily drug users were under 25; in 1992, only 10 percent were.171

The claim that liberal drug policies in some European nations stand as a success story, when measured against the facts, is specious. The United States need not experiment with liberalization of drug laws when ample evidence exists of its failure in other nations.

XIII. Where Do We Go From Here?

For all of the above reasons, particularly the increased numbers of users and addicts and the threat to our children, CASA believes that legalization would open a dangerous Pandora's box. The claimed panacea--make drugs legal and the problems associated with illegal drugs will disappear--is illusory.

Most legalization proposals are short on details: How are drugs to be distributed? What will be the strength of the drugs sold? How old would you have to be to get drugs? Would you have to qualify as an addict to be eligible? If so, how would you qualify? How could we prevent diversion of drugs to non-addicts? Who would sell drugs? How could we prevent children from getting drugs?172 The difficulty of answering these

questions and their implications for how abuse and addiction might spread signals the dangers of legalizing drugs.

Legalization is a policy of despair, one that would write off millions of our citizens and lead to a terrible game of Russian roulette, particularly for children. It is not born of any new evidence regarding the nature of addiction or the pharmacological, public health, or criminal effects of drug use. At the beginning of the century, the devastating and visible results of widespread recreational opiate and cocaine use prompted the first anti-drugs laws. With so much more knowledge about the devastating consequences of drug use, it would be foolhardy to turn back the clock.

We have not yet mounted an all-fronts assault on illegal drug use in America, a fact reflected in the recent increase in teenage drug use. Strict drug laws and a "zero tolerance" philosophy should be followed and energetically enforced. We should provide equal protection in the enforcement of drug laws by ending the acceptance of drug bazaars in Harlem, Southeast Washington, D.C., and South-Central Los Angeles, which would not be tolerated in Manhattan's Upper East Side, Georgetown, or Beverly Hills. This should be coupled with expanded opportunities for treatment,173 strengthened prevention campaigns, and increased research efforts to make treatment and prevention more effective.

Research on abuse and addiction has been woefully underfunded. Today, the National Institutes of Health spend almost $5 billion in research on cancer ($2 billion), AIDS ($1.4 billion), and cardiovascular diseases ($1.3 billion), but only about 10 percent of that amount on research on addiction and abuse of illegal and legal drugs--the largest single cause and aggravator of all three of these killers.174 If a mainstream disease like diabetes or cancer affected as many individuals and families in this country as substance abuse and addiction do, this nation would mount an effort on the scale of the Manhattan Project to deal with it.

Prevention is the least expensive way to reduce the burden of drugs on our society; a dollar spent on prevention saves up to $15 in health care, criminal justice, and other costs.175 An aggressive strategy of prevention should be aimed at the entire population, with special attention to those currently at high risk of drug abuse.176 Prevention programs should target children and adolescents, because, with few exceptions, individuals who go from age 10 to 20 without trying illegal drugs will never use them.

Treatment is both absolutely and relatively cost-effective. It pays for itself over time by saving seven dollars in criminal justice, health care, and welfare costs for every dollar invested.177 To reduce heavy cocaine use, an additional dollar spent on treatment is seven times more cost-effective than an additional dollar spent on domestic enforcement and 20 times more cost-effective than attempting to control supply in source countries.178 Still, more research is needed to raise treatment success rates, as well as to discern which types of treatment are most effective for which individuals.

Court-imposed treatment should be expanded and combined with programs that re-

integrate the ex-offender into the community by providing continued substance abuse counseling and support groups, as well as education and job training. Treatment and aftercare can decrease recidivism by giving ex-offenders a new chance to become productive members of society. Eight hundred thousand imnates have prior convictions. If treatment reduced recidivism by just 20 percent, there would be 160,000 fewer inmates; a 50 percent reduction would mean 400,000 fewer inmates.

The objective of a drug-free America, brushed aside by advocates of legalization,179 is a statement of hope that a generation of children can come of age largely free of the life-destroying effects of illegal drugs.180 Our policies should aim to reduce drug use and addiction to a marginal phenomenon and to rehabilitate drug abusers. At its best, America strives to give all its citizens the chance to develop their talents. Cornering millions of people into drug addiction insults this fundamental value and demeans the dignity to which each citizen is entitled.

NOTES

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