LAW ENFORCEMENT MANAGEMENT INSTITUTE

A REPORT WITH RECOMMENDATIONS CONCERNING CHEMICAL ABUSE AND CHEMICAL-DEPENDENT PEOPLE

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INTRODUCTION

This study deals with chemical abuse and chemically dependency. The paper defines chemical abuse, progression to chemical dependence, recreational drugs, drug use, substance abuse by adolescents, drug use and law enforcement, prevention and education, treatment, the impact drug abuse has on our society, and asks if drugs should be legalized.

Chemical dependency is a chronic, progressive disease characterized by significant impairment directly associated with persistent and excessive use of a psychoactive substance.[1] Impairment may involve physiological, psychological, or social dysfunction. Chemical dependence is a disease which may progress over a period of time from months to years; since it is progressive, it gets worse if left untreated and causes physiological, psychological, or social dysfunction.

Physiological dysfunction consists of medical problems resulting from chemical dependency; psychological dysfunction consists of pathological mood states; social dysfunction involves problems with personal relationships (ex: family, friends, job, law).[2] Chemically dependent people use drugs almost every day; their tolerance increases to the point that very large quantities of a drug are required. Blackouts are more frequent; users prefer to take drugs by themselves rather than with friends; drugs become the major focus of the users' lives.

Most activities with chemically dependent people involve drugs and drug-using friends. Although users deny having a problem, family relationships, school, job performance, and health are affected by the dependence on drugs. The user may also have altercations with the law and be arrested for offenses involving alcohol, possessing controlled substances, disorderly conduct, and dealing drugs. Arbitrary stages of chemical dependency consist of: use, abuse, and dependence.

STAGES OF CHEMICAL ABUSE

Often the substance abuse begins as an addiction to cigarettes in adolescents. Smokeless tobacco is also a favorite among adolescents. Alcohol and marijuana use may follow.[3] Use is generally limited to weekends followed by some use during the week. Drug use takes place with friends, this stage is commonly referred to as social use.

The abusive stage begins when drug use escalates; users start maintaining their own supplies and may begin to use drugs alone rather than with friends. Use may occur only at night or on weekends. Users develop a degree of tolerance. They may develop some guilt about their use and occasionally suffer blackouts. They can also suffer from medical problems.[4] Progression from abuse to dependence is often referred to as crossing the wall because, in the use and abuse stages, an individual can cut back or stop using as circumstances dictate.

Denial is common among drug users and is the primary reason many people are addicted for years. Drug users become addicted to the feelings resulting from the use of the drug rather than from the drug. Drug addicts know they are hurting themselves but continue to use the drug. Addicts may develop behaviors such as manipulation, lying, self-pity, and irresponsibility that enables them to continue using drugs.[5] Addicts use eight tools to achieve denial; rationalization, projection, minimization, repression, suppression, isolation, regression, and conversion.

RECREATIONAL DRUG USE

Recreation is integral to the American lifestyle.[6] Drug use has historically, often been a part of recreation as well as a mode of recreation. Recreational drug use is the voluntary use of either legal or illegal substances for the satisfaction to be derived or for the perception that personal or social value will be achieved through drug use. Drug use is carried on in leisure time and is intended to produce pleasure and serve as a diversion to the pressures of daily living.[7] A person using drugs as a mode of recreation does so freely without any duress.

Although some people perceive that the recreational use of drugs produce pleasure, regular recreational use may produce physical, financial, psychological, spiritual, or social problems.[8] Addiction is a chronic progressive illness that is marked by a loss of predictable control. A person addicted to a drug has a desire or craving for the drug.

Some of the legal recreational drugs include; nicotine, caffeine, alcohol, and some volatile substances.[a] Nicotine is widely used in this country and includes cigarettes, cigars, plugs, snuff, and pipe tobacco. Caffeine is a mild central nervous system stimulant and is commonly found in coffee, tea, cocoa, colas, and chocolate. Caffeine is also found in over-the-counter drugs such as Anacin, Excedrin, and Vanquish. Alcohol use is the number-one drug problem in America. Alcohol is classified as a depressant and effects every organ in the body in short-term or long-term use. Volatile substances include adhesives, aerosols, solvents, and full gases. Most of these substances are inhaled and may include common household products.

The illegal drugs commonly used in recreational use include: marijuana, opiates, barbiturates, benzodiazepines, amphetamines, and psychedelics. Marijuana has a hypnotic, tranquilizing effect; it is usually smoked but can be taken by mouth. Opiates include heroin, opium, morphine, demerol, codeine, and Darvon. Use of these drugs effects the central nervous system and causes mood changes, mental clouding, and euphoria. Opiates may be ingested intravenously, smoked, swallowed or injected under the skin. Barbiturates are used as sedatives and are taken orally, intramuscular, and intravenously. Benzodiazepines, used as antianxiety agents and hypnotics, are widely prescribed and readily available. They may be taken orally, intramuscularly and intravenously.

Amphetamines stimulate the central nervous system. Most common forms include cocaine, amphetamine, and dextroamphetamine. The psychological effect of high dosage use may cause amphetamine psychosis or paranoid schizophrenia. Cocaine is the most commonly used recreational drug among the amphetamines.[10] Psychedelics causes intense effects on the mental processes of perception, thought, and feelings.

COMMONLY ABUSED DRUGS

Substance abuse by adolescents is a national problem demanding the attention of all professionals who work with young people.[11] The best source of data available on substance abuse among adolescents is the National High School Senior Survey, conducted by the University of Michigan's Institute for Social Research and supported by the National Institute on Drug Abuse. Every year since 1975 these self-administered questionnaires have been completed by approximately 17,800 seniors in 135 American high schools and approximately 1,310 college students each year since 1980.

The result is an annual report showing the prevalent use of various sub-classes of drugs, the trends in their use, and the students attitudes about substance abuse.[12] The 1989 survey demonstrated a decline through the 1980's in the use of illicit drugs by both high school and college students, a decline in alcohol use by high school students only, and no change in cigarette smoking by either group. Sub-group analyses showed males exceeded females in the use of all drugs except stimulants, tranquilizers, and cigarettes.

College-bound high school seniors had lower rates of alcohol, cigarette, and illicit drug use than seniors not headed for college. The greatest use of illicit drugs, especially cocaine was found in metropolitan areas. Marijuana and cigarette use was found to be the greatest in the Northeast, PCP use was greatest in the West, and sedatives and tranquilizers use was greatest in the South.

High school seniors reporting use of marijuana within the preceding year fell from 51% in 1979 to 30% in 1989.[13] Declines are thought to be due to the increased proportion of students who believe great risk is increased with regular marijuana use. High school students reporting use of cocaine at any time in their lives fell from 14% in 1987 to 8.5% in 1989.[14] There was no evidence showing that these declines were due to decreases in supply; both high school and college students reported an increase in availability.

There was no change in the perceived risk associated with alcohol use. Modest declines in its use were probably due to increased peer disapproval of heavy weekend drinking. For more than 50% of high school seniors who used cigarettes, marijuana, alcohol, or inhalants, initial experimentation with the drug began before the tenth grade.[15] Early initiation began before age 15 and as late as 24 with heavy subsequent use. Cocaine was the only drug that showed late beginning usage.

Heightened risk of adolescent substance abuse falls into three categories: family history, peer use, and individual characteristics. Factors related to family include use by parents, parental condoning of use, inconsistent or inappropriate discipline, physical or sexual abuse, geographic motility, and isolation of the family. In the pre-adolescent years, having friends who use drugs is a strong predictor of subsequent use.

Adolescents who use drugs or alcohol are more likely than others to be rebellious, alienated, sensation seeking, anxious, and depressed. Factors suggestive of substance abuse may include: a change in peer group, long periods away from home, mysterious telephone calls, avoidance of parents after parties, truancy, and delinquency.

D.I. Macdonald devised stages of drug use in assessing the adolescent's overall psychosocial function.[18] Stage 1 is referred to as learning the mood swing, the stage of first experimentation. This stage produces no obvious change in the adolescent's behavior. Stage 2 is seeking the mood swing, the stage in which drug use occurs several times a week, usually with friends. In this stage, school performance, choice of friends, mood, and duress may begin to change. In Stage 3, the adolescent becomes preoccupied with obtaining the drug and uses it on a daily basis. Psychosocial function deteriorates and fighting with family and peers increases.

By Stage 4, the adolescent requires the drug to make it through the day. Emotional and physical deterioration are evident. The addict needs institutionalizing.

ABUSIVE DRUG USE

Drug-taking usually occurs in progressively more hazardous and intrusive stages of use, abuse, and dependence. Initially, seeking drugs and low-level use are highly volitional, although such behavior is profoundly influenced by the environment. Progression is not inevitable; a minority of users progress to abuse, and fewer still to dependence.

The analysis of confidential, self-reported data from households, the homeless, and those in the criminal justice system yields a point prevalence estimate of 5.5 million who are dependent on or abusing drugs, people for whom drug treatment is clearly or probably appropriate.[17] Although complete abstinence from illicit drugs is a desirable goal of treatment, the ability to function in society is an appropriate definition of recovery.

Further goals focused on reducing street crime, developing educational or vocational capabilities restoring employment, averting fetal exposure to drugs, improving general health, psychological functioning, and family life.[18] Criminal justice agencies frequently make referrals to independent, community-based programs as part of probation or parole.

Chronic marijuana users may produce physical findings of substance use upon a physical examination by a physician such as [bronchitis, broncho-spasm, or sinusitis]. Neurologic examination may reveal memory loss, altered sense of time, and poor motor coordination.[19] Heavy users reported acute delirium, including disorientation and perceptual disturbance. Withdrawal symptoms occur in marijuana users; these include agitation, insomnia, and EEG abnormalities.

Cocaine users report, after prolonged use of the drug, nasal congestion sinusitis, nasal ulceration, or nosebleeds. Crack users may complain of sore throats. Parents of cocaine users may notice mood swings, erratic sleep, or memory impairment. During acute intoxication hypertension is present.

A recent study conducted by the Washington University School of Medicine in St. Louis, Missouri, found men who use cocaine may increase the risk that their offspring will be abnormal, because the drug binds tightly to sperm in test tubes.[20] The study raises the possibility that cocaine may piggyback onto sperm as they enter and fertilize eggs, or that the drug may damage male genes before fertilization. Although no studies of humans have conclusively linked male cocaine use with abnormal offspring, research on rodents indicates that males exposed to cocaine are more likely to have offspring with nervous, hormonal, or behavioral problems.[21] It has been shown that drugs in the bloodstream can enter the male reproduction tract in high concentration. Cocaine use by the father can affect brain development.

Crack is the most attractive drug among adolescents because it is sold in inexpensive, ready-to-use "rocks" that are easily carried and hidden. Smoking produces an immediate, intense "rush" that reverses poor self-image, anxiety, and social awkwardness. The quick "rush" that follows leads to rapid, repeated smoking and results in tolerance and dependency. Lethal reactions to cocaine and crack may cause malignant hypertension, stroke and seizures.

Inhalant use of violative substances remains common among adolescents. The effect occurs within seconds and resolves within fifteen minutes. Glue sniffing and inhalation of halogenated hydrocarbons are associated with sudden death in adolescents.

Amphetamines are also commonly abused. Amphetamine-like drugs are sold over the counter and can produce an "amphetamine high" when taken in large quantities. Signs of amphetamine use may include agitation, tremor, flushing, hypertension, and fever. Severe use can produce hypertensive crisis,seizures, and death.

PCP users are mostly adolescents. PCP is often mixed into marijuana and can be smoked, snorted, ingested or injected.[22] Low doses produce euphoria; moderate doses produce impaired perception, and large doses produce an anesthetic effect that can persist for weeks. Active and passive smokers may manifest a short-term psychosis. Physical examination during intoxication may reveal hypertension and hyperrelexia. Coma and seizures have also been reported.

Heroin use is thought to be uncommon among adolescents. Heroin can be inhaled, but the resulting nasal inflammation leads the user to employ "skin popping" or intravenous administration. Hepatitis is a common complication. Opiate addiction occurs with weeks after daily use begins. Signs of withdrawal include yawning, restlessness, hypertension, tremor, or fever. All adolescents addicted to opiated require inpatient detoxification followed by an aggressive drug addiction treatment program.

DRUGS AND LAW ENFORCEMENT

An estimated 5.2 million Americans are dependent on prescription sleeping pills, tranquilizers, stimulants, and pain medication.[23] Approximately six million people regularly use cocaine in the United States. The international drug industry is the largest growth industry in the world having an estimated annual revenue of $500 million-- more than the gross national products of all but a half-dozen major industrial nations.[24]

Illegal drug transactions in the United States are estimated to involve more that $100 billion annually. Drug abuse is thought to cost $177 billion in lost work time, accidents, treatment, legal assistance, and law enforcement.

It is estimated that 75% of all crime is related to drug use, drug selling, or related criminal activity. In 1988, the Texas Department of Public Safety confiscated 24,645 pounds of marijuana, 1.258 pounds of cocaine, and $2.9 million in currency. There were 850 defendants arrested on drug offense charges.[25]

In 1988, the DPS Drug Laboratory analyzed the following drugs; amphetamine, meth, cocaine, heroin, and marijuana. Amphetamine totals were 126 or (5%) of the caseload, methadone was 84 or (3%) of the caseload, cocaine was 591 or (23%) of the caseload, heroin was 152 or (6%) of the caseload, and marijuana was 1,227 or (48%) of the caseload.[26] These figures are taken from the Amarillo area.

In 1990, law enforcement agencies in the State of Texas reportedly seized 177,995 lbs. of marijuana, 2 lbs. of hashish, 12,710 lbs. of cocaine, 33 lbs. of hallucinogens drugs, 4,147 lbs. of precursor chemicals, and 574 lbs of other drugs.[27] In addition to the above drug quantities, there were 140 marijuana gardens, 31 wild marijuana fields, 101 cultivated marijuana gardens, and 18 marijuana greenhouses reported seized. During 1990, there were 173 clandestine labs reported seized.[28] The state total of arrests for 1990 include 2,599 juvenile males, 49,879 adult males, 380 juvenile females, and 9,526 adult females for drug abuse violations.

The Bureau of Justice National Update, October, 1991 issue revealed in a survey of jail inmates that more than 75% had used illegal drugs at some time, and 13% had committed their crime to get money for drugs.[29] Among inmates who had used drugs in the month before the offense for which they were convicted, 27% said they had committed the crime to get money for drugs.

Nearly one in three robbers and burglars said they had committed their crimes to obtain money for drugs. More than one in four convicted jail inmates said they were under the influence of drugs at the time of the crime. At least four of every ten convicted inmates in local jails said they were using drugs during the month before the crime; one of four said they were using cocaine or crack. Persons charged with drug offenses accounted for 23% of all persons held in local jails in 1989.[30] Half of the offenders convicted of a drug offense and sentenced to a local jail had a sentence of nine months or less, the same as in 1983.[31] Of those in jail for a drug charge, about one in three had been previously convicted of a drug offense.

In 1990, Americans spent more than $40.4 billion for illicit drugs, according to a new and "very tough" estimate of the illicit retail market.[32] The study estimates "the amount of money America's users actually took out of their pockets, or took out of other people's pockets to purchase drugs". Although illicit retail sales declined in the last three years, $40 to $50 billion was spent last year. Last year's totals included $17.5 billion for cocaine, $12.3 billion for heroin, $8.8 billion for marijuana, and $1.8 billion for other drugs.[33] The Pharmaceutical Manufacturers Association says Americans spent $38.6 billion on prescription drugs last year.

The societal issues consist of costs, health care implication, public safety, and prevention strategies.[34] Related costs include motor vehicle accidents, crime, and public and private property loss and damage. Health care implications result from side effects caused by taking drugs, an example would be a loss of body function through stroke or chronic cardiovascular illness.

Public safety has a major impact when the recreational drug user chooses to drive a motor vehicle while under the influence of drugs. The drug user may not demonstrate enough good judgement and coordination to avoid having an accident.

PREVENTION AND EDUCATION

Today, there is a more sincere effort in the area of prevention of drug abuse. Inherent to these prevention strategies are strong messages not to use drugs recreationally. These messages can be seen by radio, television, and the newspaper advertisements "Just Say No To Drugs". In addition there have been strong efforts by law enforcement agencies and legislatures to increase penalities on drug-related offenses for offenders. There have also been several programs started in the communities by law enforcement and other agencies to promote a drug-free community through educational efforts.

PREVENTION AND EDUCATION

The long-term benefit of the nation's intense educational effort, however, is working. In 1991, according to a survey conducted by the Partnership for a Drug Free America, drug abuse continued a five year decline, especially among young teenagers.[35] According to James E. Burke, chairman of the group, children have grown up hearing and seeing anti-drug messages in the media, classrooms, and home-- a message that seems to be having an effect.

DRUGS IN LAW ENFORCEMENT

There is also a critical problem in the United States related to societal issues and that is the issue of alcohol and drug abuse in the law enforcement profession.[36] Some studies indicate alcohol and drug abuse is more prevalent in law enforcement than in the general population. Contributing factors may include social attitudes, peer pressure, and job stress. A significant number of U.S. workers, including law officers, abuse alcohol and drugs on and off the job, endangering the health and safety of these workers, their co-workers and the public.

A survey of 2200 police officers in 29 police departments throughout the U.S. revealed that 23% had serious alcohol problems, and 10% had serious problems with other drugs.[37]
Some serious consequences result from the alcohol and drug abuse.

These include reduced job performance, absenteeism, tardiness, excessive sick leave, injury, increased cost of health benefits to all employees, and the safety and welfare of co-workers and the public. Hidden losses may include low morale, diversion of supervisory managerial time, friction among co-workers, damage to equipment, damage to the public image of law enforcement agencies, a mixed message to those entering the law enforcement profession, and a negative influence on community attitudes concerning alcohol and other drugs.

The first step in recognizing alcohol/drug abuse in law enforcement officers is understanding the reasons it is prevalent. These reasons include the social attitudes in the U.S. which encourage drinking and, to some extent, illicit drug use; job related stress in law enforcement; the police subculture creates and encourages drinking; and certain aspects of police work encourage drinking by their nature. The ultimate solution to alcohol and other drug abuse is prevention.

TREATMENT

On September 19, 1990, the Institute of Medicine of the National Academy of Sciences released a report on drug-treatment programs.[38] The committee found the drug problem to be a complicated composite that changes as the marketing, technology, and reputation of various drugs evolve.

There are several forms of treatment for drug use. These include methadone maintenance, therapeutic communities, outpatient non-methadone programs, chemical-dependency programs, and drug detoxification.[39] The most useful information on the effectiveness of treatment comes from several planned and natural experiments and multiple-site studies.

Methadone maintenance is an ambulatory treatment for opiate dependence. It is the most rigorously studied method of treatment and has the most consistently positive results. Therapeutic communities are usually residential programs with 9-to-18 month courses of treatment followed by continuing contact.

Outpatient non-methadone programs generally involve a six-month course of one or two visits per week for individual or group psychotherapy or counseling. Those admitted to outpatient non-methadone programs are generally not dependent on opiates, but span all categories of drug abuse and patterns of dependence.

Chemical dependency treatment is the predominant therapeutic approach taken by privately financed inpatient and residential programs.[40] The goal of chemical dependency treatment is abstinence from alcohol and drugs. The client is viewed as a victim of a disease process but also as the person with the primary responsibility for making behavioral changes that will promote abstinence, which will eliminate problems resulting from alcohol or drugs.[41] The CD approach views drug problems as having multiple causes; there is physiological phenomenon at work.

Sociocultural models explore the relation of drinking and drug problems to socialization processes and environments.[42] The CD treatment is an intensive, highly structured three-to-six week in-patient regimen. Clients begin with an in-depth psychiatric and psychosocial evaluation followed by a general education-oriented program track of daily lectures plus two to three meetings per week in small task oriented groups. Each client has a individual prescriptive track, meetings twice a week with a "focal counselor", and appointments with other professionals if medical, psychiatric, or family services are needed. Recently, there has been an increasing demand for emphasis on family.

Clients actively engage in developing and implementing a recovery plan, which is patterned on the twelve-step program of Alcoholics Anonymous.[43] Self-help is a large part of therapy. Aftercare is considered quite important in CD treatment and last as long as two years and range in intensity from a single monthly telephone follow-up to intensive weekly group therapy and individual counseling. In CD treatment, clients have more time for psychotherapy and educational work. The CD staff is a mixture of stable, recovering individuals and professional clinicians from traditional health care, mental health, and social service disciplines.[44] CD treatment is full of educational work, including writing, reading, and lectures. CD treatments play a major role in the drug treatment world.

Chemical dependency programs are generally residential or in hospitals, with a three to five week course (hence 28 day programs), followed by up to two years of prescribed attendance at self-help or weekly therapy groups.[45] They primarily treat alcoholism and have not been closely evaluated in the treatment for drug problems.

Drug detoxification is seldom effective in itself in producing recovery from dependence.[46] Drug detoxification may usually be undertaken safely on a residential, partial day care, or ambulatory basis. Although an important gateway to treatment it is not highly recommended as a method of treatment, mainly due to the high frequency of relapse.

Approximately 30% of the inmates of state prisons reported patterns of drug consumption serious enough to require treatment, and 15% have received some form of treatment during their current or previous terms of imprisonment.[47] At least two thirds of prison treatment, however, is equivalent to outpatient nonmethadone programs, self-help groups, or classroom drug education.

There are two highly contrasting sectors of treatment programs, public and private, distinguished most dramatically by their facilities, sources of revenue, and trajectories of growth. The public sector serves mostly the indigent, the uninsured, and the underinsured.[48]

In 1987, the private sector provided drug treatment to about 200,000 clients and had revenues of approximately $500 million, three fourths from private sources. The private sector treats mainly insured clients in chemical-dependency programs.

In Canyon, Tx, the CareUnit hospital program is available to adults and adolescents for the treatment of alcohol and drug abuse. The CareUnit Program is the largest privately operated alcohol and drug abuse treatment program in the United States.[49] The CareUnit Hospital Program is a medically-supervised treatment facility specializing in the rehabilitation of chemically-dependent adults and adolescents. It has a multi-modality program that treats chemical dependency as a family disease, providing psychological and sociological counseling and educational programs for both patient and family.

The CareUnit philosophy views chemical dependency as an illness which eventually results in grave consequences. Chemical dependency is largely misunderstood and its seriousness is often underestimated. As a multifaceted illness, chemical dependency does not appear in isolation. Family members and other significant persons suffer serious consequences and unknowingly contribute to the continuation of this illness.[50] Chemical dependency does not spontaneously improve without treatment. Denial and ignorance are the factors which most frequently foster the development and continuation of chemical dependency.

The CareUnit philosophy encompasses the belief that chemical dependency is a treatable illness. Those who suffer from chemical dependency are frequently in need of acute care. The CareUnit offers the person in need of detoxification the care needed in a medically safe, comfortable environment.[51]

Following detoxification and close medical monitoring, the CareUnit offers a high quality, comprehensive treatment program based on principles which have proven effectiveness and state-of-the-art treatment. The CareUnit recognizes that continuity of care is vital to recovery. Transitional Care provides support and encouragement for the patient and significant others once the inpatient stay is complete. The focus is on reinforcing the use of skills learned in treatment and applying these new skills in all areas of life.

The types of services provided by the CareUnit include alcohol abuse treatment program, drug abuse treatment program, medical treatment program, drug and alcohol outpatient treatment program, lifetime patient aftercare program, lifetime family treatment program, and other services provided by contract.

The programs are staffed by a medical director, medical physicians, psychologists, therapists, nurses, social workers, discharge planners, recreation therapists, and spiritual counselors.[52] Time was when chemical dependency treatment was abundant and accessible to virtually all in society who needed it.

Key Federal legislation spearheaded by Senator Harold E. Hughes of Iowa in 1970 led to great gains in the treatment field. It improved access to treatment for the indigent as well as for employed, insured Americans.[53] In the last few years, treatment opportunities have been greatly restricted and not even the employed, insured person can get appropriate treatment.

Most private sector treatment programs are operating at 40 to 50% capacity.[54] Michael Q. Ford, President of the National Association of Addiction Treatment Providers which represents more than 600 private-sector, nonprofit and proprietary chemical dependency treatment programs throughout the United States, says that in the last two years, his association has lost more than 100 members, and at least 60% of those have had to shut down.

An estimated 200 private-sector treatment programs have closed in the past two years. Even the most respected centers, such as Betty Ford Center and Hazelden Foundation, no longer have long waiting lists; in fact, they have empty beds. Our national treatment system is slowly being dismantled.[55] Why is this happening?

Essentially, restrictive third-party payment policies and a punishment-oriented public policy have combined to deny access to appropriate treatment for employed, insured Americans.[56] Three major myths have made treatment a target: (1) Treatment is overutilized; (2) treatment is too expensive and everybody stays 28 days or more; and (3) there is no correlation between the length of stay and patient success.

According to Michael Ford, Treatment is the answer and we need to convince the managed care companies and insurance companies, and, perhaps foremost, the employers who buy health care insurance, that treatment works and is a good value.[57] A report on drugs and drug dependency by the Royal College of Psychiatrists acknowledged that extreme responses, such as escalating punitive sanctions or legalizing drugs, are doomed are doomed to failure.[58]

The report also recommended that the public accept the realistic limitations of drug abuse prevention and treatment of legal sanctions against the use of drugs. Treatment should be targeted to specific populations and made more widely available, and prevention efforts should be increased.

LEGALIZATION AS A SOLUTION

The next question is, "Should drugs be legalized?" Amidst growing controversy about whether the drug war has been lost, won, or is worth fighting, the vast majority of clinicians in the addiction field have taken positions against the legalization of illegal substances.[59] Clinicians realize that there is no practical moral means to distribute drugs and thereby eliminate the illegal drug market and crime.

Many believe that free access to cocaine, whether sold over the counter or distributed by physicians, would lead to increased use and a higher frequency of divesting consequences such as paranoia, violence, child abuse, high risk sexual behavior, and addition.[60] In response to rising frustration with the high level of drug-related crime and homicides, increased social costs, corruption, and the spread of Aids, some influential voices have called for legalization of drugs.

Recently, the American Academy of Psychiatrists in Alcoholism and Addictions took a strong stand against legalization.[61] They were also joined by the American Medical Association. Many observers support approaches to the problem other than legalization, including increased allocation of resources for prevention and treatment of drug abuse. Others call for extension of punitive measures, which would require added law enforcement resources, expanded judicial services, and more prison cells.

There is no reason to hope that an analysis of the facts about drug use, abuse, treatment, and prevention and an improved dialogue between social scientists and public policy makers could lead to a more balanced and effective national drug control strategy.[62] Although such a strategy may not lead to elimination of current or future fads in substance abuse, it may help reduce the severity of their social impact and may result in a wiser use of available resources.

Those who favor legalization of drugs or liberalization of drug laws emphasize the individual's right to free choice, including the right to make decisions that may lead to self-harm.[83] They feel hopeless about the potential success of efforts to reduce the supply of narcotic drugs and suggest that revenues obtained from taxes on legalized drugs could be used for treatment and prevention. They argue that legalization could remove the profit motive, reduce marketing of currently illegal substances, and make new funds available for use in treatment.

Proponents of legalization argue that if substance use were made legal, drugs would be less of a symbol of the counterculture and would seem less like forbidden fruit. Legalization would help to destigmatize addicts and perhaps reduce prejudice against certain populations, such as poor urban minorities, in which drug abuse is endemic.[84] Decriminalization or legalization of substance use might also make some people less afraid of seeking treatment for addiction. Improved accessibility to treatment might indirectly reduce the spread of HIV infection.

Racketeering, gangsterism, and crime associated with drug use would decrease because legalization would reduce the profit that could be gained from illegal distribution.[85] Reduction in the need for prison space and law enforcement would make more money available for treatment and prevention. Tension with countries that are producers of illegal substances might also be reduced.

Proponents of legalization argue that if all drugs are not legalized, each drug should be considered separately based on health dangers it presents.[66] For example, a stronger case for legalization or decriminalization of marijuana could be made because the medical complications of that substance are arguably no worse than those of tobacco or alcohol. Marijuana use is widespread, and the courts hesitate to criminalize young users. Prolegalization forces point to countries in which marijuana as decriminalized but its use did not increase.

The civil libertarian position emphasizes the rights of individuals and families to make choices for themselves. Murray argued that individuals should be allowed to choose whether to live in areas where drugs are decriminalized and should be given vouchers to send their children to schools where principals are either lenient or intolerant toward substance use.[67] Proponents of legalization are also against random urine testing.

They argue that the right to freedom from unreasonable search and seizure should be protected. They also support addiction treatment on demand and programs in which used needles are exchanged for clean ones.[68] The major thrust of the legalization argument is to take the profit out of drug distribution, thereby reducing crime, and to use the savings for treatment and prevention.

The arguments against legalization emphasize that increased availability of drugs would to lead to increased craving, use, abuse, and addiction to illegal substances; that no amount of treatment resources will stem the tide; and that no moral distribution system is practical.[69] The current number of cocaine users in the United States is about six million. Some estimate that this number could triple if cocaine were legalized or even decriminalized.

Historical examples of societies in which certain drugs were legal support this estimate. In 19th-century England, where opiates were legal, the average Englishman consumed about 150 doses of laudanum per year, even the British prime minister was an addict.[70] Historically, societies have made substances illegal after epidemics of use contributed to a high prevalence of the medical, psychiatric, and social complications of addiction. In the United States, the Harrison Act of 1911 banned prescription of opium for this reason.

Increased availability and use of barbiturates and other narcotics would lead to greater tendencies toward overdose.[71] In addition, any medical distribution system would place the physician in the ethically compromising position of prescribing dangerous drugs that are known to have severe negative effects and that are especially dangerous to women of childbearing age and to persons already suffering physical and mental complications from addiction.

Even if drugs were legalized, profits could still be gained through illegal distribution. Cocaine now sells for $60 to $80 per gram. Free-market price would roughly be $3 to $4 per gram.[72] To maximize government revenue, to regulate use of the drug, and to restrict its availability through taxes, a gram of legal cocaine could be sold for $30 to $40. At that cost, criminal organizations could still profitably undercut legal prices. A legal selling price of $10 per gram, or 50 cents per dose, which might destroy the cocaine black market, would bring the cost within reach of lunch money for elementary school children.

The rapid rise in medical and psychiatric complications that would accompany increased drug use could not be offset by current treatments. Although these treatments are helpful, so far they have not been effective enough to eliminate demand.[73] In addition, increased drug use could bring with it an increase in the spread of AIDS. Legalization would most dramatically harm poor people who would be addicted in greater numbers.

Their communities would also experience greater suffering than more affluent communities from the moral corruption and social fragmentation caused by addiction. The greater the availability, the greater the problems in youth and vulnerable subpopulations such as the psychiatrically and medically ill.

Social sanctions seem to be effective in reducing the number of persons who experiment with and use substances in any given society.[74] Repeal of Prohibition was followed by a large increase in the use and abuse of alcohol and in the negative medical and psychiatric consequences of alcohol abuse.

Finally, legalization of marijuana and other drugs would give the wrong message about society's determination to stem the drug tide. Even if extreme punitive responses to distribution and use of illegal drugs might be effective, this strategy would entail a degree of social control that is not acceptable in our culture.[75] We must not forget what we have already learned about past drug epidemics and must do further research to determine the most effective means of developing a wise and balanced public policy against drug use and for prevention and treatment.

Finally, based on the material and evidence presented in this paper, I feel that drug use will continue to remain a problem not only for law enforcement agencies but for society in general. Studies have shown in the medical profession that legalizing drugs would also bring an increase in treatment costs and, possibly, a further increase in the spread of the HIV virus.

Countries that legalized the use of drugs, also showed an increase in usage and overdoses. Even if drugs were legalized in this country, it would continue to generate a profit through illegal distribution and still be a problem for the law enforcement profession. I feel that the one method of reducing the drug problem will be continued education in our society and developing a more wise and balanced public policy against drugs and for prevention and treatment.

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