In Opposition to Drug Legalization

*Mitchell Rosenthal**

INTRODUCTION

Should presently illicit drugs be legalized? There is no easy answer to this highly charged question, but advocates of legalization would have you believe otherwise. Many of the proponents of legalization base their arguments for legalizing currently illicit drugs on only some of the issues that are relevant to the debate while ignoring others. As proponents of legalization view drug abuse, it is drug-related crime and the cost of enforcing drug laws that seem most clearly to define the drug abuse problem. United States District Court Judge Robert Sweet, citing the number of drug law offenders and the high price of arresting, trying, and incarcerating these offenders, asserts that our present prohibitive policy has failed.[1] Ethan Nadelmann, a prominent legalization advocate, finds law enforcement efforts too costly and counterproductive.[2] Further, Nadelmann maintains that many drug-related problems are in fact caused by the drug laws themselves.[3]

What is missing from Sweet's and Nadelmann's arguments for legalizing drugs is a discussion of the behavioral dysfunction that results from drug abuse and that would create a high cost for soci-

---

* President of Phoenix House Foundation, a private, nonprofit drug abuse services agency providing treatment for adults and adolescents nationwide.

1 Address by Judge Robert Sweet, Cosmopolitan Club, New York City (Dec. 12, 1989) (copy on file with U.C. Davis Law Review). Proponents of legalization contend that present drug control policies have had little effect. *See id.*; Nadelmann, *The Case for Legalization*, in THE CRISIS IN DRUG PROHIBITION, 13, 14, 43 (D. Boaz ed. 1990). Yet, evidence of the recent rapid decline in overall drug use, *see* NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE: MAIN FINDINGS 13 (1988) [hereafter HOUSEHOLD SURVEY ON DRUG ABUSE] (stating that overall drug use declined significantly between 1985 and 1988), argues strongly that, far from failing, the present "demand reduction" strategy has achieved substantial success.

2 Nadelmann, *Drug Prohibition in the United States: Costs, Consequences, and Alternatives*, 245 SCIENCE 939 (1989).

3 *Id.*

ety if drugs were legalized. Advocates for the legalization of drugs often ignore the perspective of health care providers who treat drug abusers. Treatment professionals deal with personality disturbance, social dysfunction, educational and vocational deficits, and with *all* manifestations of drug-related disordered behavior. Thus, treatment professionals are not concerned with crime to the exclusion of other forms of behavioral and social disorder caused or exacerbated by drug abuse. From the perspective of treatment professionals, the high cost of criminalizing drugs tells only part of the story: criminalizing drugs may provide an effective check on the negative effects drug abuse has on individuals and society.[4]

This Article considers the issue of legalization from the perspective of treatment professionals. Part I details disordered behavior related to drug abuse. These disordered behaviors include mental illness, teenage suicide, and domestic violence. Part II analyzes the theoretical basis for drug prohibitions. Part II also discusses the validity of criminalizing other drugs while tobacco and alcohol remain legal. Part III examines modern drug treatment and the effect of prohibition, and alternatively legalization, on the treatment process. Part IV considers the potentially detrimental impact of legalization. Part IV also examines liberal drug policies in the Netherlands and Great Britain. In neither of these countries has legalization provided the panacea for which legalization advocates had hoped. Part V looks at the attitude toward legalization in communities facing serious drug abuse problems. Finally, Part VI proposes considering drug abuse as a public health issue. The Article concludes that legalization is far more likely to increase rather than reduce the social problems that derive, in whole or in part, from drug abuse. Further, treating drug abuse as a public health problem with appropriate public health remedies would provide more compassionate means of dealing with drug abusers than present drug laws allow.

I. Drug-Disordered Behavior

Drug abuse leads to disordered behavior.[5] One type of disorder caused by drug abuse is criminal activity.[6] While the criminal

---

[4] Yet, this Article argues for a more humane limit, in the form of civil commitment. *See infra* notes 88-89 and accompanying text.

[5] *See infra* notes 9-33 and accompanying text.

[6] Until recently, the crime rate among young Americans was increasing.

activity of drug abusers is a major societal concern, however, it is being overshadowed now by other drug-related disordered behavior.[7] Indeed, the fastest-rising costs of drug abuse today

---

This increase in the crime rate coincided with increasing drug use, as illustrated by a recent California study. *See* CALIFORNIA DEP'T OF JUSTICE, THE PREVALENCE AND INCIDENCE OF ARREST AMONG ADULT MALES IN CALIFORNIA (1987).

The researchers challenged the assumption that a relatively small number of criminals were responsible for the large number of crimes committed in their state. *Id.* at 1-2. To do this, they set out to discover the prevalence of arrest — how many people would be arrested in a given period of time. *Id.* at 2-3. They looked at all California men born in 1956, and (adjusting for migration) determined how many members of this group had been arrested between 1974 and 1985 (from the time they turned 18 until they were 29). *Id.* at 1.

Results showed that 35.4% of these men (more than one out of three) had been arrested — and nearly half of those men more than once. *Id.* at 3. In addition, 11% of the group had been arrested three or more times. *Id.* at 5. Moreover, 16.5% (or one out of six) had been arrested for FBI crime index offenses — murder, manslaughter, rape, robbery, burglary, felony assault, felony theft or larceny, and motor vehicle theft (none of them drug offenses). *Id.* at 3. Treatment professionals, looking at the astonishing prevalence of arrest in this group, see a strong connection to levels of drug use among this age group, which peaked during the very years studied by the California researchers.

Further, although overall crime rates, measured by victimization surveys of the Census Bureau, have declined in recent years, *see* Wilson & DiIulio, *Crackdown*, NEW REPUBLIC, July 10, 1989, at 21 (crediting this decrease to the aging of the baby boom generation and a shrinking segment of population in their "crime-prone" years), the proportion of crime committed by drug users has remained fairly constant.

In 1988, the National Institute of Justice's Drug Use Forecasting Program (Forecasting Program) estimated that 75% of felony arrestees nationwide were drug abusers. *Study: Drugs Linked to Most Felony Arrests*, Newsday, Mar. 28, 1990, at 31 (LEXIS, NEXIS library, Papers file). Only recently — in April, 1990 — have Forecasting Program studies (based on a 20-city survey, using urine samples taken at central booking facilities) revealed any reduction in the proportion of drug abusers among felony arrestees. *Id.*; Hemphill, *Turning a Corner on Crack*, Newsday, Oct. 11, 1990, at 3 (LEXIS, NEXIS library, Papers file).

[7] Advocates of legalization believe that drug users commit such crimes as robbery or burglaries largely in order to pay for their drug habits. *See* Ostrowski, *Thinking About Drug Legalization*, 121 POL'Y ANALYSIS 1, 11 (1989). Thus, they contend that if legalization lowered the price of drugs, drug users would commit fewer crimes. *See* Henderson, *A Humane Economist's Case for Drug Legalization*, 24 U.C DAVIS L. REV. 655, 660 (1991). Treatment professionals, however, have observed that many drug users commit crimes because of the behavioral effects of drug use. Thus, the criminal activity of

are associated, not with crime, but with homelessness, chronic mental illness, adolescent suicide and runaways, the spread of Acquired Immune Deficiency Syndrome (AIDS), domestic violence, child abuse, and the number of new drug-impaired, addicted, and abandoned infants.[8]

Drug abuse among the homeless is substantially higher than earlier estimates of thirteen to twenty-five percent.[9] It is prevalent not only among the single homeless but also among homeless mothers with children. At one New York City shelter for these women,[10] counselors estimate that approximately sixty percent of all mothers in residence abuse drugs — most often crack. The overall incidence of drug abuse among New York state's homeless adults may now be over fifty-five percent.[11]

Chronic mental illness in the United States today is inextricably linked with drug abuse. In New York State, between twenty-five and fifty percent of patients admitted to hospitals through emergency services are mentally ill drug abusers.[12] In Philadelphia, nearly fifty percent of the psychiatric patients in veteran administration hospitals abuse drugs.[13] Further, drug abuse may be the most significant determinant of readmission for schizophrenic patients.[14]

Drug abuse has also played a major role in teenage runaways and suicides. Youth advocates estimate that there are approximately 1.5 million teenage runaways on the streets.[15] As many as

---

drug users is less the result of drug laws or drug prices than a common manifestation of disordered behavior caused by drugs.

8 *See infra* notes 9-33 and accompanying text.

9 Whitman, *Shattering Myths About the Homeless*, U.S. NEWS & WORLD REPORT, Mar. 20, 1989, at 27. Welfare officials and advocates for the homeless have been reluctant to admit the extent of drug abuse among the homeless.

10 Phoenix House Foundation operates a small and separate treatment unit within this shelter.

11 Lowery, *Report: Homeless Drug Use Common*, Newsday, June 13, 1989, at 19 (LEXIS, NEXIS library, Papers file).

12 NEW YORK STATE OFFICE OF MENTAL HEALTH, REPORT OF THE TASK FORCE ON COMBINED PSYCHIATRIC, ADDICTIVE AND ABUSE DISORDERS, SECOND ANNUAL AND FINAL REPORT AND RECOMMENDATIONS 11 (1987).

13 *Id.*

14 Craig, Lin, El-Defrawi & Goodman, *Clinical Correlates of Readmission in a Schizophrenic Cohort*, 57 PSYCHIATRIC Q. 5 (1985).

15 *"Runaways," "Throwaways," "Bag Kids" — An Army of Drifter Teens*, U.S. NEWS & WORLD REP., Mar. 11, 1985, at 52.

seventy-five percent of these runaways abuse drugs.[16] Drug-using adolescents are three times as likely as adolescents who do not use drugs to attempt suicide.[17] Teen suicide has increased dramatically during the past few years, and is now the third leading cause of death for fifteen to twenty-four year-olds.[18]

Drug abuse has also increased the incidence of both domestic violence and child abuse and has significantly raised the number of children in foster care.[19] In New York City, there has been a 650 percent increase in child abuse over the past ten years, and a 400 percent increase in domestic violence.[20] The number of foster care children in New York City has doubled since 1985.[21]

Further, high levels of maternal drug abuse have resulted in the increased prenatal exposure of infants to drugs. An estimated eleven percent of new mothers used drugs during pregnancy in 1988.[22] This suggests that as many as 375,000 newborns had prenatal exposure[23] — a 300 percent increase from 1985.[24] Further,

---

16 *See* Wolinski, *Study Assails "Disarray" in State Services for Children*, L.A. Times, Mar. 6, 1987, at A3, col. 5 (stating that 75% of runaway youths in California engage in illegal drug use, prostitution, and other criminal activities).

17 Berman & Schwartz, *Suicide Attempts Among Adolescent Drug Users*, 144 AM. J. DISEASES CHILDREN 310 (1990).

18 *Id.*

19 There was a nearly 30% rise in the number of foster care children in the United States between 1987 and 1990. Besharov, *Crack Children in Foster Care*, CHILDREN TODAY, July-Aug. 1990, at 21, 23. California and New York together account for 55 percent of the increase. *Id.* The total number of children in foster care in the United States is over 340,000. HOUSE SELECT COMM. ON CHILDREN, YOUTH, AND FAMILIES, NO PLACE TO CALL HOME: DISCARDED CHILDREN IN AMERICA, H.R. DOC. No. 395, 101st Cong. 2d Sess. 19 (1989). This number is expected to grow to 550,000 by 1995. *Id.* Complaints of child abuse, throughout the United States, rose 82% after 1981, to reach 2.2 million late in the decade. Leefeldt, *Reforming the Delinquent Foster-Care System*, Wall St. J., Oct. 16, 1990, at A26, col. 3. Overall, domestic violence in the United States has increased sharply. National Coalition against Domestic Violence (NCADC), *Statistics from 1987 NCADC Domestic Violence Statistical Survey*.

20 Egan, *Chief Judge Says Crack May Overwhelm Courts*, N.Y. Times, Dec. 3, 1990, at B3, col. 5, col. 6.

21 *Id.* In Washington, D.C., the requests for foster care increased by 71% between 1985 and 1987, and welfare workers report that four out of five children have been removed from homes where there is drug involvement. Norris, *Drug Crisis Fueling Need for Foster Care*, Washington Post, Nov. 2, 1988, at A1, col. 5.

22 *The Crack Children*, NEWSWEEK, Feb. 12, 1990, at 82.

23 *Id.*

it is likely that 100,000 of these infants were exposed to crack.[25] In New York City, infants admitted to neonatal intensive care for drug-related reasons rose nearly forty percent each year between 1983 and 1987.[26] It is estimated that as many as five percent of all infants born in New York City, and ten percent of all nonwhite infants, will require such intensive care by 1995.[27]

The result of infant exposure to drugs is tragic. Infants exposed to crack, or "crack babies," are at risk of severe birth defects.[28] It appears that neurological damage caused by exposure to crack makes these infants disorganized, unresponsive, slow to learn, and difficult to control.[29] Further, crack babies are not unique. Dr. Judy Howard at UCLA, working with children of mothers who had chronically used cocaine, amphetamines, and PCP — as well as crack — found that more than thirty percent share what she describes as "a new kind of disability."[30] The Los Angeles school system has set up pilot classes to learn how to deal with the impulsive and uncontrollable behavior of these children.[31]

Finally, drug abuse has increased the spread of AIDS.[32] Legalization advocates and others contend that this problem should be addressed by distributing clean needles or free condoms and similar passive means.[33] Most treatment professionals, however, do not regard the AIDS problem as a separate phenomenon that free needles or free condoms can solve. They view it as another mani-

---

24 *Id.* One commentator disputes these estimates and puts the total of "drug-related births" no higher than 80,000 in 1989. Besharov, *supra* note 19, at 22.

25 Leefeldt, *supra* note 19, at A26, col. 1.

26 French, *Rise in Babies Hurt by Drugs Predicted*, N.Y. Times, Oct. 18, 1989, at B1, col. 5.

27 *Id.*

28 Newsweek, *supra* note 22, at 82-83.

29 *Id.*

30 Telephone Communication with Judy Howard, M.D., School of Medicine, UCLA (Nov. 7, 1990).

31 *Id.*

32 *See* Nadelmann, *Anyone Care What Works? Drug Plan Has Preventative Measures, but Not Enough for a Dividend*, L.A. Times, Sep. 6, 1989, § 2, at 7, col. 3. Infants are now the victims of Human Immunodeficiency Virus (HIV). The rate of transmission of HIV infection from mothers to their newborn children is approximately 40 to 50%. Klass, *AIDS: The Youngest Victims*, N.Y. Times, June 18, 1989, § 6 (magazine), at 34, col. 1, 35, col. 3.

33 *See, e.g.*, Henderson, *supra* note 7, at 665; *cf.* Nadelmann, *Drugs: The Case for Legalization*, Washington Post, Oct. 8, 1989, at C3, col. 1.

festation of the irresponsibility and disorder that characterizes so much drug abusing behavior and thus only being successfully addressed in the context of drug abuse itself.

Clearly, drug abuse leads to many types of disordered behavior. Legalization would exacerbate these problems because it would increase drug use.[34] The analysis of legalization advocates, however, tends to discount the social consequences of almost all forms of drug-related disorder other than crime.[35] Thus, arguments for legalization are flawed because they give only minimal consideration to current and future economic costs of noncriminal disordered behavior caused by drugs.

Disordered drug abusers and their children are enormous consumers of public services. They now place inordinate burdens on welfare, education, and child protective services. They contribute substantially to the escalating costs of health care. Further, there will be substantial future costs of medical care, public assistance, foster care, education, and subsequent support for today's drug-impaired infants and older children.

II. The Basis for Drug Prohibitions

A. The Need to Protect Society

Many legalization advocates appear to believe that the government criminalizes drugs only to protect individuals from the consequences of their own actions or to impose moral restraints on their freedom of choice. They seem to assume that drug abusers are otherwise normal people who happen to use drugs.[36]

Drug prohibitions, however, are arguably based on far more practical concerns. They are necessary because many drug abusers become harmful to other persons.[37] They threaten the rest of society because drug abuse lowers self-esteem, erodes character, and prompts behavior that is antisocial, often violent, and frequently criminal. When drug abusers are out of control they manifest an almost absolute indifference to the welfare of people

---

[34] *See infra* notes 65-66 and accompanying text.

[35] *See supra* notes 1-3 and accompanying text.

[36] This view would tend to discount most forms of drug-disordered behavior and mistakenly assumes that the primary dangers of drug abuse are physical rather than behavioral.

[37] *But see* Wilson & DiIulio, *supra* note 6, at 21-22 (acknowledging "an obvious moral reason for attempting to discourage drug use" is threat it poses to "the dignity, autonomy, and productivity of users").

around them. They place others in danger of their irresponsibility, risk-taking, violence, criminal activity, abuse, or AIDS infection.[38] Thus, drug laws are not meant to protect otherwise normal persons from themselves, but to protect society from persons who can easily lose the ability to function normally.[39]

B. Why Tobacco and Alcohol Are Not Criminalized

Advocates of legalization argue that tobacco and alcohol cause as many problems as currently illicit drugs.[40] Thus, they contend that it is inconsistent to criminalize such drugs as cocaine and heroin while tobacco and alcohol remain legal.[41] This argument, however, fails to distinguish important differences between illicit drugs on the one hand, and tobacco and alcohol on the other.

Tobacco is certainly as addicting and at least as physically harmful to the user as most illicit drugs. Tobacco use, however, while posing some threat to others, does not present the substantial threat to non-users and society in general that is presented by illicit drugs. Tobacco makes you your own worst enemy, while illicit drugs can make you everyone else's.[42] Thus, the justification for criminalizing illicit drugs, which is the potential harm to society,[43] is largely absent in the case of tobacco.

The drug-alcohol parallel, however, also raised by legalization advocates, cannot be so easily dismissed. Alcohol is no less mind-altering a substance than, for example, marijuana. Alcohol is our society's primary drug of abuse. Although consumed with relative impunity by the overwhelming majority of users, it is, nevertheless, responsible for more crime and social disorder than any other single substance.[44] Moreover, alcohol is the most physically

---

38 *See supra* notes 5-33 and accompanying text.

39 The treatment community does not contend that society is at risk from the behavior of *all* drug users, or even from the great majority of them. Although sustained use soon diminishes the capacity to perform normally — to hold a job, keep up with schoolwork, or maintain responsible social, sexual, or family relationships — it would be hard to justify drug prohibitions on this basis alone.

40 *See* Nadelmann, *U.S. Drug Policy: A Bad Export*, FOREIGN POL'Y, Spring 1988, at 83, 96.

41 *See* Nadelmann, *supra* note 2, at 943.

42 *See* Wilson, *Against the Legalization of Drugs*, COMMENTARY, Feb., 1990, at 21, 26 (stating that "[t]obacco shortens one's life, cocaine debases it").

43 *See supra* notes 37-39 and accompanying text.

44 U.S. DEP'T OF HEALTH AND HUMAN SERVICES, SEVENTH SPECIAL REPORT TO THE U.S. CONGRESS ON ALCOHOL AND HEALTH 268-69 (1990).

harmful of psychoactive chemicals.[45]

While treatment professionals consider alcohol to be, in some ways, a less threatening substance than marijuana,[46] this alone does not sufficiently justify the inclusion of marijuana and exclusion of alcohol from present drug prohibitions. In fact, the exclusion of alcohol derives not from any assessment of relative risk, but from the rejection of Prohibition by the American public in 1933.[47] Overall, Prohibition was a failure. Only a bare majority of Americans ever supported Prohibition and it was never possible to obtain the popular consensus necessary for success.[48] Such a consensus, however, does exist for present drug laws, which enjoy overwhelming public support.[49] The dichotomy then between alcohol and illicit drugs is not based on any sort of scientific or policy oriented justification: it is simply a matter of public preference.

III. Effective Drug Treatment

Treatment professionals view drug abuse as behavior that effective treatment can alter. Drug abuse is a disorder for which proven and predictably effective therapeutic regimens exist.[50] Treatment enables former abusers not only to overcome chemical dependency but also to change attitudes and values that prompt self-destructive and antisocial behaviors of all kinds.[51] In short,

---

45 This is due to the sheer volume required to achieve disinhibiting effects.

46 These include the ways in which marijuana is used, its function as a "gateway" drug, and its effects on the intellectual development of adolescents.

47 *See More Programs for Substance Abuse Taking Hold for Federal Workers*, 23 Gov't Empl. Rel. Rep. (BNA) No. 1109, at 543 (1985).

48 *See* Colston-Hayter, *Free Speech 2: If Bright's Bill Became Law, Criminals Would Run the Parties*, Independent, Mar. 3, 1990, at 12 (LEXIS, NEXIS library, Papers file).

49 *Poll Finds 90% Favor Keeping Drugs Illicit*, N.Y. Times, Sept. 15, 1988, at A26, col. 5.

50 *See, e.g.*, Phoenix House Statement of Information 2 (on file with U.C. Davis Law Review).

51 *Id.* In contrast, legalization advocates fail to appreciate what treatment can achieve. They seem to assume that "everything else has failed" and advance what many agree is a proposal of last resort.

Many positions taken by legalization advocates reflect considerable ignorance of both the nature of drugs and the capabilities of drug abuse treatment today. For example, in Great Britain, heroin has been legally prescribed for the maintenance of addicts. *See infra* note 73 and

the efficiency of drug abuse treatment is no longer in question.[52]

Successful treatment, however, requires the active participation of the patient[53] and a prolonged involvement in the treatment process. Active patient participation and prolonged involvement are often difficult to achieve. Few abusers are able to perceive a need for treatment. Because drugs have such powerful reinforcing properties, drug-use often becomes compulsive behavior. Indeed, a unique characteristic of drug abuse is its ability to mask symptoms from the victims themselves.[54] Most abusers experience few physical effects and do not recognize behavioral and psychological effects.[55] They do not realize when they are out of control.

For this reason, drug abusers are rarely prompted to cease drug abuse for any but the most compelling reasons. They generally will not seek treatment unless confronted by far less desirable alternatives. Thus, to achieve active patient participation and

---

accompanying text. Some legalization advocates now propose that cocaine also could be provided as a maintenance drug which would stabilize drug patients.

The rapid metabolization of cocaine, however, causes extreme mood swings. Thus, the nature of the drug makes it impossible to stabilize patients, which is, after all, the purported goal of maintenance. At no dosage can sustained comfort be achieved. Cocaine abusers will always crave more. And the more they receive, the more agitated and disordered they will become.

52 *See* INSTITUTE OF MEDICINE, TREATING DRUG PROBLEMS 132-99 (1990). The Institute's report strongly endorsed — as both effective and cost effective — the treatment methods developed over the past quarter century. *Id.* The Institute based its evaluation on a series of large-scale, long-term outcome studies that documented the impact of treatment on post-treatment behavior — specifically on drug use, criminality, and employment. *Id.*

53 For example, at Phoenix House Foundation the treatment program requires patients to participate in a number of activities, including seminars, classes, group and family therapy, work assignments, education, vocational counseling, job training and placement, and recreation. Phoenix House Statement of Information, *supra* note 50, at 2. Successful treatment does not depend upon the development of new medications, although these would doubtless prove valuable. Whether it is chemically-assisted or not, treatment for drug abuse is essentially behavioral and psychological and thus requires the active participation of the patient. It is the patient who must confront and resolve underlying emotional problems, anxieties, and fears.

54 *See generally* Alexander, *Bouncing Back From Crack: How Phoenix House Rescued a Bronx Science Junkie*, N.Y. MAG., Feb. 12, 1990, at 38.

55 *See id.* at 41-43.

prolonged involvement in treatment, some external pressure on the drug abuser is needed.

Families, friends, and employers often exert the external pressure that moves drug abusers to treatment.[56] For a good many abusers in treatment today, however, external pressure has come from the criminal justice system. Drug abusers placed in treatment as an alternative to incarceration generally fare as well as those who enter under less formal pressure. Indeed, the demonstrated effectiveness of treatment programs operating within a prison system make it clear that compulsion is no barrier to successful treatment outcome.[57]

Therefore, drug abuse professionals vigorously oppose the notion of legalization because it will remove a strong external pressure for drug abusers to seek treatment.[58] Treatment professionals recognize how today's treatment methods enable them to intervene successfully in drug abuse of even the most profound and disordering kinds. Thus, they support social policies that will most effectively motivate drug abusers to accept the treatment they can provide. Treatment professionals encourage intolerance for drug use and view disincentives, including the enforcement of drug laws, as potent adjuncts to treatment.[59]

---

[56] *Id.*

[57] H. Wexler & R. Williams, The "Stay 'N Out" Theraputic Community: Prison Treatment for Substance Abuse (Preliminary results presented at the American Criminological Association, San Diego, Cal, November, 1985).

[58] *See supra* notes 53-57 and accompanying text.

[59] Treatment professionals do not, however, believe that harsher drug laws are needed or special penalties are required for sales to mothers, to minors, or inside school zones. They do not endorse mandatory sentences or capital punishment for dealers of a designated size or scale.

Draconian measures simply do not work very well. If sufficiently severe, the mandatory sentence itself becomes the felon's best defense. Juries that would readily see a defendant imprisoned for one or two years are reluctant to convict when conviction means a mandatory eight to ten year prison sentence.

For drug laws to truly discourage drug traffic, dealers at all levels must fear not the severity of the sentence but the certainty of arrest, conviction, and imprisonment or an appropriate alternative. Better that 40 dealers each do six months than one does 20 years, while 39 range free. Further, although treatment professionals believe strongly in disincentives to drug use, they do not necessarily believe that drug abusers must be imprisoned simply because they break laws in order to use drugs.

IV. The Impact of Legalization

A. The Detrimental Effects of Legalization

While legalization would have a detrimental impact on treatment, it is hard to envision any compensating benefits. First, legalization would not eliminate the illegal drug market. No legalization formulation anticipates legal sales to minors. Further, few post-legalization scenarios would make available all presently illegal substances, including crack, ice, PCP, and the latest in "designer drugs." Thus, both youthful and adult consumers would turn to street dealers for whatever substances continue to be illegal.[60]

Nor would legalization eliminate drug-related crime. Even were there to be easy access to certain drugs, one cannot assume that drug-abusing criminals would cease robbing and stealing simply because legalization made low-cost drugs available to them. Drug abusers do not commit crimes only to buy drugs. Their criminal activity is generally a manifestation of disordered behavior.[61] Further, for many long-term abusers crime constitutes a significant source of income that does not necessarily have to go toward drugs.[62]

In addition, legalizing drugs would sanction their use and would curb society's growing intolerance for drug use.[63] This

---

[60] The persistence of an illicit market would be further ensured were legalization to involve less than full access to cocaine. *See* Musto, *Illicit Price of Cocaine in Two Eras: 1908-14 and 1982-89*, 54 Conn. Med. 321, 321-26 (1990). For example, prior to passage of the Harrison Narcotic Act, ch. 1, 73 Stat. 785 (1914) (repealed 1970), New York State law made a physician's prescription necessary for the legal purchase of cocaine. Musto, *supra*, at 321-22. As a result, an illicit market was created with prices that were much higher (in terms of the average hourly industrial wage) than street prices are today. *Id.* at 322-24.

[61] *See supra* notes 5-35 and accompanying text. Legalization will cause a sharp increase in the amount of drug-related crime that is not committed for gain. These crimes include homicide, assault, rape, and child abuse. This will result from a higher incidence of drug-related disorder, *see supra* text accompanying note 34, due to both higher levels of consumption and a greater number of abusers. *See infra* notes 65-66 and accompanying text.

[62] A year-long study of patients being provided with prescription heroin at a British clinic during 1975 and 1976 found that fully half were convicted of a crime during that period. Mitcheson & Hartnoll, *Prescribing Heroin: Does It Work*, Druglink July/Aug. 1990, at 18.

[63] Indeed, this is a stated goal of some legalization advocates. *See generally* Nadelmann, *supra* note 1.

increasing intolerance for drug use, however, along with diminished ambivalence about the enforcement of drug laws, has generated the pressure on drug abusers that has helped reduce their numbers in recent years and prompted substantially more of the drug-disabled to seek treatment.[64] Legalization, by sanctioning drug use, would erode much of the progress made in curbing drug abuse.

Finally, legalization will greatly increase drug abuse because it will both increase access to drugs and lower prices.[65] There also would be a greater proportion of heavy and high-risk drug use.[66] Absent disincentives and high prices, it is extraordinarily difficult for regular users to control the amounts they consume. Cocaine abusers in treatment almost uniformly report that cost alone limited their intake.

Understandably, it is heavy, high-risk users who most often become behaviorially disordered. Treatment programs show clearly that this most destructive form of drug abuse hits hardest at the most vulnerable segments of the population — the poor, the unemployed, the emotionally disturbed, children from disruptive homes, and school dropouts.

---

64 *See supra* notes 54-57 and accompanying text.

65 For example, heroin consumption was rising sharply at the start of the 1970s, when supplies were plentiful. Wilson, *supra* note 42, at 21. This "epidemic," however, ended between 1973 and 1975, as supplies tightened, prices climbed steeply, and purity declined. *Id.* The number of new heroin users fell and consumption rates flattened out. *Id.*

Price and supply also help to explain why so many heroin-abusing Vietnam veterans left their drug habits overseas. *Id.* at 22. Heroin use was widespread among soldiers in Vietnam, where the drug was cheap, potent, and easily acquired. *Id.* A study of Vietnam veterans three years after their return, however, found that only 43% of veterans addicted in Vietnam used any heroin after their return, and just 12% became re-addicted. Robins, Helzer, Hesselbrock & Wish, *Vietnam Veterans Three Years After Vietnam*, in YEARBOOK OF SUBSTANCE USE AND ABUSE 213, 222 (1980). Heroin was much harder to come by in the United States and sanctions against its use were much more severe. *Id.*

66 Today, as overall drug use declines, there is a persistence of heavy and high-risk use of the most potent and reinforcing substances. U.S. OFFICE OF NAT'L DRUG CONTROL POL'Y, LEADING DRUG INDICATORS 3-5 (1990). This form of abuse may well be increasing, for it is most prevalent among the very populations that are unsurveyed by the HOUSEHOLD SURVEY ON DRUG ABUSE, *supra* note 1.

B. Examples From Abroad

To support their case for ending drug prohibitions, proponents of legalization note liberal drug policies in the Netherlands and Great Britain that purportedly indicate the beneficial impact of drug legalization. On close examination, however, these examples offer little evidence of legalization's ability to achieve the desired ends.

In the Netherlands, the government allows open sales of marijuana and hashish and tolerates de facto legalization of other drug use.[67] Although the effect of these policies on drug use is somewhat unclear, surveys show that heroin abuse in the Netherlands tripled since adoption of the more liberal drug policies in 1976, from an estimated 5,000 addicts in 1977[68] to between 15,000 and 20,000 today.[69] Further, foreign drug addicts now flock to the Netherlands to take advantage of the liberal drug laws.[70]

Far more significant in terms of drug policy, however, is public questioning of the government's liberal stance.[71] If a consensus for drug criminalization did not exist in the Netherlands when the government first introduced its liberal policies, it apparently is beginning to exist there now. As public opinion has begun to shift away from prolegalization, the government has started to control drug dealers more vigorously.[72]

In Great Britain, the government has always permitted the prescription of heroin for the maintenance of addicts.[73] By the start of the 1980s, however, heroin prescriptions had diminished to negligible numbers as clinic physicians turned overwhelmingly to the prescription of oral methadone.[74] One study of two London

---

67 Verschuur, *Dutch Drug Policy Gains Ground*, L.A. Times, Mar. 4, 1990, at A11, col. 1.

68 Van de Wijngaart, *A Social History of Drug Use in the Netherlands: Policy Outcomes and Implications*, 18 J. DRUG ISSUES 481, 485 (1988).

69 *Id.*; Van de Wijngaart, *Heroin Use in the Netherlands*, 14 AM. J. DRUG & ALCOHOL ABUSE 125, 126 (1988).

70 Glass, *Western European Governments Unmoved by Calls for the Legalization of Drugs*, L.A. Times, July 10, 1988, at A12, col. 1.

71 Cody, *Amsterdam Cracks Down On Hard Drugs; Netherlands, In Shift of Policy, Steps Up Enforcement of Laws*, L.A. Times, Nov. 27, 1988, at A25, col. 1.

72 *Id.*

73 J. KAPLAN, HEROIN: THE HARDEST DRUG, HEROIN AND PUBLIC POL'Y 155-59 (1983).

74 *Id.* at 159. Although all physicians were once free to prescribe heroin, diversion of prescribed heroin to the illicit market during the 1960s caused the government to curtail prescription privileges in 1967. *See id.* at 158.

clinics found that physicians were giving heroin to only 5 out of 2,258 patients.[75] Another clinic ceased all heroin prescription when the staff decided that the main reason they had continued to maintain a few patients on the drug was to impress visiting Americans.[76]

To draw any lessons from the British experience, it is important to understand why physicians stopped prescribing heroin. The changeover to methadone occurred because British physicians found heroin to greatly inhibit social functioning.[77] It leaves addicts high much of the time and still in need of more heroin.[78] Also, it is impossible to find the correct dose that will maintain a patient in a stable state.[79] Although the clinics were prescribing huge doses, patients always sought more, and a good number were selling their heroin on the black market or trading it for other drugs.[80] Further, as some clinic physicians recognized, simply supplying drugs does not of itself solve a drug-user's problems.[81]

Liberal drug policies in the Netherlands and Great Britain reveal little to encourage belief in the beneficial impact of legalization. In the Netherlands drug abuse may well have increased since these policies were adopted.[82] Further, the Dutch public has become increasingly dissatisfied with these policies.[83] In Great Britain, all but a few clinic physicians abandoned heroin maintenance once a more appropriate alternative (oral methadone) became available. The reliance on these examples by advocates of legalization is no longer credible.

The government restricted prescription privileges to a limited number of specially licensed physicians, the great majority of whom worked in treatment clinics. *Id.* Some of these clinic physicians helped introduce to Britain the drug-free treatment methods then being developed in the United States. *Id.* at 159.

75 *Id.*

76 *Id.*

77 Telephone communication with G. Edwards, Addiction Research Unit, Institute of Psychiatry, University of London (Oct. 30, 1990).

78 *Id.*

79 *Id.*

80 *Id.*

81 Rosenthal, *The Therapeutic Community: Exploring The Boundaries*, 84 BRIT. J. ADDICTION 141 (1989). One commentator has stated that a physician is "not being a good doctor, prescribing a good drug, by giving people heroin." G. Edwards, *supra* note 77.

82 *See supra* notes 68-70 and accompanying text.

83 *See supra* notes 71-72 and accompanying text.

V. BATTLEFRONT COMMUNITIES

Legalization advocates rightly note that the conflict for control of the illicit drug market places a heavy burden on many poor, minority, and urban neighborhoods. Rival drug gangs often inflict violence in these areas. Nevertheless, neither these communities nor the public officials who represent them are calling for legalization. Indeed, intolerance for drug use and approval of drug laws runs highest in these communities.[84] In many of these areas antidrug activists patrol the streets.[85]

Of course, these communities have a desperate need for services other than law enforcement, including prenatal care and other health care, remedial and special education, counseling, and job training and placement. Legalization advocates contend that legalizing drugs would allow officials to concentrate their efforts in these areas rather than in law enforcement. No array of services, however, can overcome the social disorder drug abuse imposes on these communities.[86] Legalizing drugs would greatly increase this social disorder and more than offset any gains realized from increased services. Further, additional services alone are unlikely to improve the lives of drug abusers without first helping them to change drug abusing attitudes, values, and patterns of behavior.[87]

VI. PROPOSAL: MAKING DRUG ABUSE A "HEALTH" ISSUE

There is one area where the treatment community and legalization advocates might find common ground. Several proponents of legalization have expressed the desire to see drug abuse

---

84 *See* Wilson & DiIulio, *supra* note 6, at 23.

85 *Id.* at 24. Even if legalization reduced the present conflict between drug gangs in these communities, however, it would not necessarily put an end to the gangs. They would then turn to other avenues of criminal activity, just as organized crime did in 1933. In fact, overall levels of crime would rise as addict crime increased, reflecting the increase in heavy, high-risk drug use. Of course, all other forms of drug-related disordered behavior would increase. *See supra* text accompanying note 34.

86 *See supra* notes 5-35 and accompanying text.

87 This is a lesson treatment professionals have learned well. The comprehensive care that programs like Phoenix House Foundation provide includes education and vocational training and deals with job placement and housing. *See supra* note 53. Residents are able to benefit from these services, however, only after they have confronted the causes of their drug abuse and overcome the mind set that had conditioned them for failure.

considered an issue of health rather than an issue of criminal justice.[88] Treatment professionals have no argument with this proposal. They have long contended that drug abuse is indeed a public health problem that demands public health solutions independent of present drug laws.

One such public health solution would allow us to bring the most disordered and dysfunctional drug abusers into treatment by a more certain and humane route than through the criminal justice system. The mechanism to accomplish this is court-ordered mandatory treatment. Through civil commitment to treatment, the courts can employ civil law and achieve far more appropriate dispositions than criminal laws generally allow.[89]

This is not to suggest that every drug abuser is an appropriate subject for mandatory treatment. Civil commitment, however, is the most compassionate means our society has for dealing with the most troubled and troublesome members of the drug abusing population — deeply disordered persons and violent older adolescents, who are beyond the control of either their parents or the juvenile justice system. Further, civil commitment would provide a bottom-line disincentive to drug abuse and an inducement to abusers to enter treatment voluntarily.

CONCLUSION

Advocates of drug legalization generally define the drug abuse problem almost exclusively in terms of criminal activity. This view ignores the wide range of other drug-related disordered behavior and its enormous costs. Because legalization would increase both the extent and the degree of drug abuse, social disorder that derives from drug abuse would also increase.

Drug prohibitions are justified by the dangers that the disordered behavior of drug abusers pose to society. Intolerance for drug abuse, as well as prohibitions, serve to limit the spread of

---

[88] Valentine, *Baltimore Shifts Drug War to Human Front*, Washington Post, May 8, 1990, at E1, col. 1.

[89] Civil commitment is a legitimate public health strategy, and some states already have civil commitment statutes on the books that permit civil commitment for drug abuse treatment. *See* CAL. PENAL CODE §§ 4415(b)(3), 6029.1(5) (West 1982); NEV. REV. STAT. §§ 458.300-.350 (1985). Unfortunately, where they exist, they are rarely used. In New York State, civil commitment is no longer on the books, and it did not work very well when it was because the proven treatment strategies we have today did not then exist.

drug abuse and provide the external pressure for many drug abusers to seek treatment. Legalization, while eliminating these disincentives, would provide few, if any, compensating benefits. It would, for example, be unlikely to reduce the amount of drug-related crime.

Both advocates and opponents of legalization, however, may agree that drug abuse can be treated as a public health issue. Thus, society could employ both civil and criminal measures to address the drug problem and deal with drug abusers in more appropriate and compassionate ways than criminal law alone allows.