8-1-1996

Busted Policy: An Alternative To The Failed War On Drugs

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An alternative to the failed War on Drugs

BUSTED

This April, federal agents involved in Operation Zorro II made a hugely successful drug bust. They netted more than six tons of cocaine and half a ton of marijuana—drugs with a wholesale value of more than $100 million—and charged 136 people involved in a Mexican-run trafficking network linked to Colombian distributors. For some, these dramatic seizures were proof that America's "war on drugs" was working. But federal agents who worked on the case questioned its effect on price and availability. "I doubt whether even the huge amount of cocaine that was seized in this case ... would be much of a blip on the line as far as availability," said Charles Riley, chief of the FBI's organized crime/drug operations section.

At a time when U.S. spending on federal drug control efforts is at an all-time high, the public record is peppered with similar frank admissions by drug enforcement officials. There is a curious irony here: Time and again, U.S. officials acknowledge that drug enforcement campaigns will have little or no effect on the nation's drug problem—yet this recognition triggers an escalation rather than reevaluation of these campaigns.

For decades the central aim of American drug policy has been to eliminate all use of drugs such as cocaine, heroin, and marijuana by making the cost or risk of use prohibitively high. Using the threat of punishment backed by force, the drug war aims to make it more dangerous and costly for growers, refiners, smugglers, and dealers to produce and sell drugs—thus driving down production and availability, driving up prices, and discouraging consumers from buying and using drugs. A secondary strategy has been to raise the risk of use by threatening users with jail or other sanctions (such as loss of jobs, public assistance, or licenses). Relatively little attention is given to treatment and prevention.

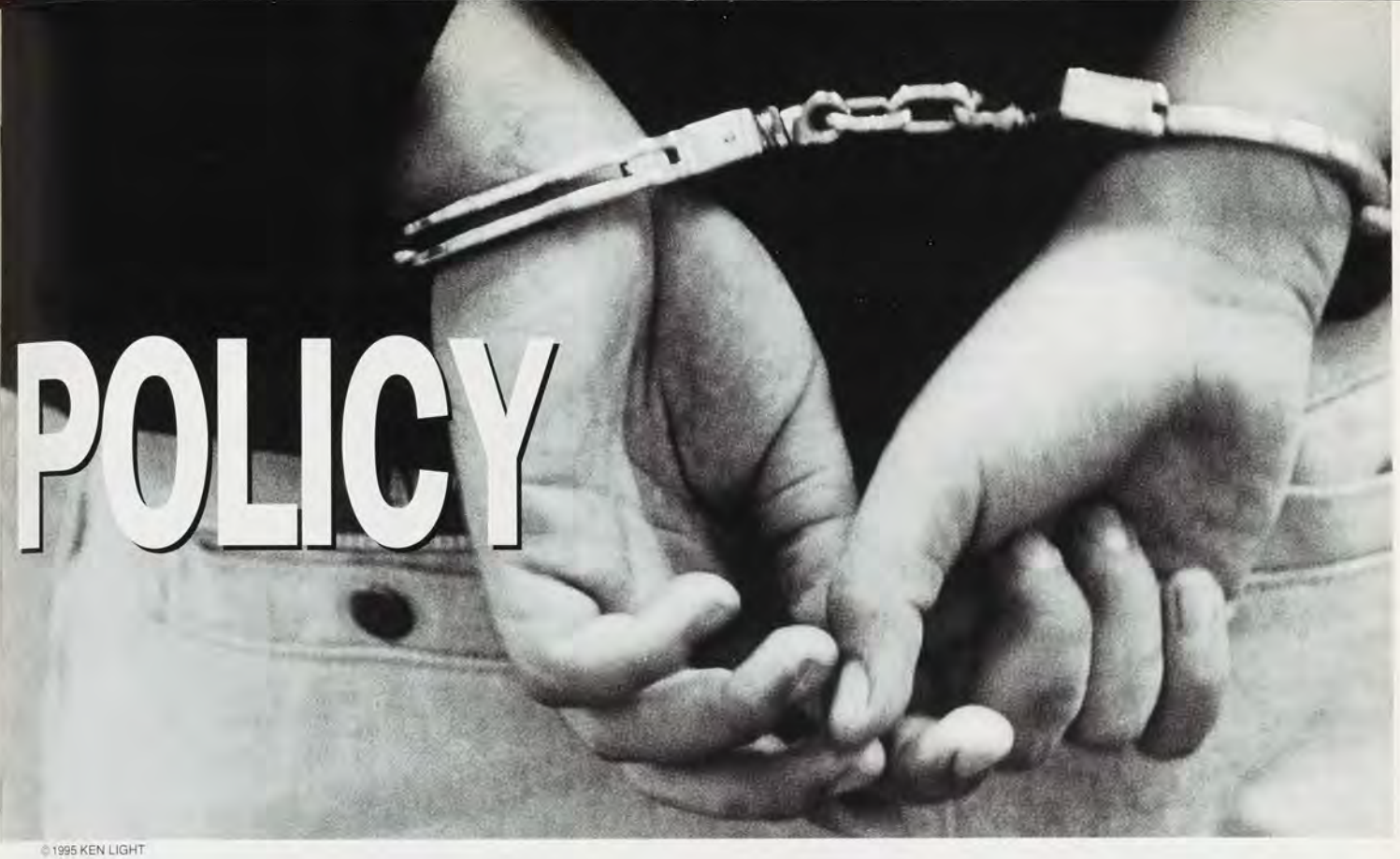
This approach to drug control is not new. Most Americans trace the current drug war to former President Ronald Reagan and First Lady Nancy Reagan's "Just Say No" campaigns of the early 1980s. But in fact America's war on drugs was launched in the 1920s, when Treasury Department agents charged with enforcing the 1914 Harrison Act took control of the drug supply out of the hands of doctors and pharmacists and began the effort to prohibit any sales or use. For decades this policy punished smugglers, dealers, and users as the enforcement effort gradually grew.

A major expansion of the drug war—and the first presidential "declaration of war"—came during the Nixon administration in 1970. The next significant expansion came under presidents Reagan and Bush in the 1980s. Since 1981, the U.S. has invested more than $65 billion in drug law enforcement, and today the annual budget for drug enforcement alone is more than $8 billion.

Instead of tilting at windmills in the struggle to chase down and eliminate the global drug trade, we should approach drugs as a public health problem, seeking to heal rather than punish drug abusers.

But the results of this high-cost drug-control campaign are dismal. Despite seemingly impressive statistics on the rising numbers of acres of drug crops eradicated, tons of cocaine seized, and traffickers or dealers jailed, levels of supply are as high as ever. Coca production in Latin America has remained relatively stable. There is no evidence of a decline in the amount of drugs crossing U.S. borders. And perhaps most important, the prices for a gram of both pure heroin and cocaine (as measured in 1994 dollars) have declined markedly in the last 15 years—all in the face of dramatic escalations in drug law enforcement spending.

Nor has the drug war reduced drug abuse and addiction. This failure is sometimes obscured by the fact that the number of so-called current users—people who have taken drugs within the past month—declined between 1985 and 1993 from 22.3 million to 11.7 million. According to White House reports, however, this drop is explained largely by a decline in casual marijuana use—a decline that began in 1979, well before the drug wars of the 1980s were underway. Meanwhile the more serious problems of abuse and addiction involving cocaine and heroin (often compounded by alcohol) are as bad as or worse than ever. According to the 1995 National Drug Control Strategy, the number of heroin addicts has remained at about 600,000 for the last



two decades, and there are indications that it may be growing again. Further, cocaine (and its derivative, "crack"), which raised few concerns in the late 1970s, claimed at least 2.1 million hardcore addicts by 1993. Even the intensive drug war assaults of the mid- to late-1980s failed to reduce levels of cocaine or heroin abuse. According to the government's own study, cocaine-related hospital emergencies increased by 22 percent between 1988 and 1993, while heroin-related emergencies rose 65 percent.

The Drug War Paradigm

Why do we continue to pursue the same strategy of tough enforcement—of chasing the drug supply and punishing drug users—in the face of such overwhelming evidence that the strategy is failing?

It's tempting to search for a simple explanation. Some blame presidential drug warriors such as Richard Nixon and Ronald Reagan for starting the spiral of increasing drug enforcement to further their law-and-order political agendas. But this does not explain why more moderate presidents, such as Gerald Ford, Jimmy Carter, and Bill Clinton, have also perpetuated and even escalated the war on drugs. Others point to partisan politics on Capitol Hill—and blame tough-on-crime Republicans for using the drug issue to drub the Democrats and gain votes. But in fact the policy has been largely bipartisan.

To really understand why the policy has persisted we must look deeper. We must confront the framework of assumptions behind the drug war that are (often unconsciously) shared by many Americans. And we must see how this paradigm operates politically.

The current policy is rooted in a moralistic and punitive "drug-war paradigm" that is accepted almost reflexively by many Americans. It is markedly different from the approach to drugs among many Europeans, Latin Americans, and others. And it did not always guide conventional wisdom or public policy in the United States.

The assumptions of the drug-war paradigm, created out of a series of political struggles early in this century, have become almost common-sensical today. They hold that drug use is morally wrong, that drug abuse and addiction are the fault of misguided or ignorant individuals, that drug-dependent people are criminals, that related problems such as disease and crime are caused primarily by drug-taking, that the government should try to stop all drug use as quickly as possible, and that "getting tough" is the only way to solve the problem.

These long-held assumptions have set a highly intolerant and punitive context for American drug-control politics. Elected officials believe they must out-tough each other to win votes and public support for their policies, and their political rhetoric, in turn, further reinforces the punitive paradigm. Efforts to institute alternatives—treatment, education, social reform—are made to seem "soft." Such alternatives are underfunded or dismissed and, when tried, they are often undermined and distorted by the punitive thinking of the drug war.

Politically powerful conservatives, meanwhile, are able to sustain the key symbols of the paradigm against challengers, attacking and demeaning critics and sidelining pragmatic alterna-

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Eva Bertram '86 and Professor of Political Science Kenneth Sharpe are co-authors, with Peter Andreas '87 and Morris Blachman, of Drug War Politics: The Price of Denial, *published this summer by University of California Press.*

tives. Less zealous conservatives and liberals, many of whom are skeptics or closet critics of the drug war, have been willing to go along or have chosen to remain silent.

Fundamental Questions

Understanding how this paradigm fuels the cycle of escalation and failure in the drug war helps focus attention on what it will take to turn things around. For policymakers to argue that the current drug strategy needs to be reevaluated and redirected would be to concede defeat in the moral crusade against drugs. Nor will generating a list of solid policy alternatives do the trick. Given the current punitive context, such alternatives routinely fail to enter the debate.

What is needed is to ask the fundamental questions: What kind of problem is the drug problem? What are the ends and means of drug control? What are we trying to control and why? And, given the character of the drug problem, what are the limits of what drug policy can achieve, and what is likely to work? In short, what is needed is a new debate and a new politics of drug control—one that, over time, will replace the current paradigm with a constructive alternative.

But what would an alternative paradigm look like? The most widely publicized is the free-market approach to legalization proposed by political libertarians, who define the drug problem in terms of the damage to individual freedom caused by the prohibition policy. They hold the notion of free choice as central. Though legalization advocates recognize that drug-taking can lead to addiction or to dangerous behavior, they would leave the choice to individual adults who are presumed to be responsible for any consequences to themselves or others. The state, they correctly emphasize, has done far more harm than good in attempting to control drug use.

The legalization approach captures an important critique of the drug war. Many of the problems attributed to drug-taking—especially drug-related crime—are in large part the consequence of the drug war policies themselves. Just as prohibition of alcohol in the 1920s created a violent and criminal black market in liquor, so too has drug prohibition produced the

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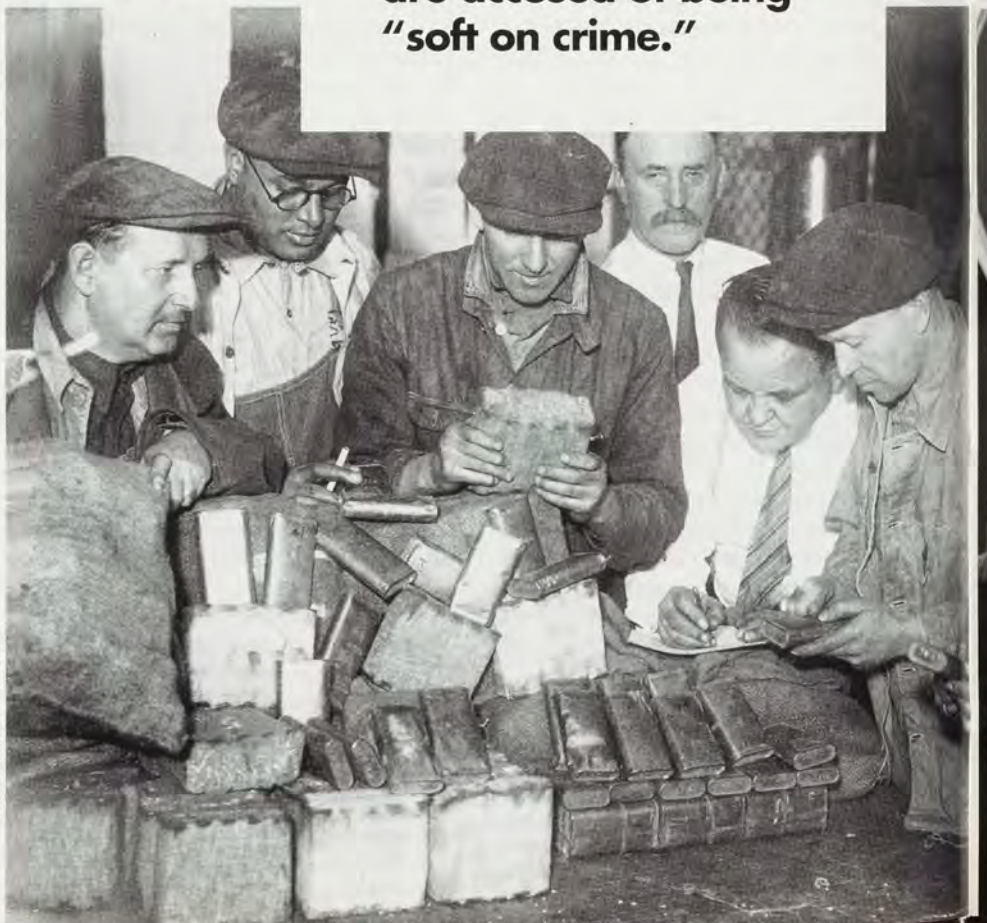
Despite billions spent on law enforcement, the drug supply is virtually unchecked, and street prices have fallen. Yet critics of the policy are accused of being "soft on crime."



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AP/WIDE WORLD PHOTOS

From opium busts in the 1920s (left) to the seizure of tons of drugs in the 1980s (top left and right), the federal government has pursued a zero-tolerance approach. Will politics prevent the current "drug czar," Gen. Barry McCaffrey (above), from making changes in U.S policy?

extraordinarily high prices and profits of the drug trade. Criminal organizations compete, often violently, for these high profits, and those suffering from drug addiction, particularly the poor, are led to commit crimes to pay the high prices. Ending prohibition, say the legalizers, would lower the price and the profits, and take much of the crime out of the drug problem.

Within today's punitive environment, it's not surprising that policymakers—and many citizens—have a hard time accepting this critique. The idea that drug control policies are in fact exacerbating some of the very problems they seek to solve is too counterintuitive and subtle a point to penetrate the symbolically-charged drug debate.

But there is another reason that the legalization paradigm has not taken deep root among the U.S. public. It leaves unanswered the question of what should be done about the harmful effects that drug addiction and dangerous drug use have on individuals and society. Some progressive advocates of legalization argue for adequate government services and regulation in order to address the health and other social effects of drug use, but the legalization framework itself does not provide adequate guidance to shape public judgement or public policy on this issue.

A Public Health Alternative

There is another alternative to the punitive paradigm that is as radical as it is simple: approach drugs as a public health rather than a crime problem. Seeking health as the goal of drug control would mean pursuing policies that heal rather than punish drug abuse and addiction. And it would mean approaching the control of the drug supply in terms of how best to further public health, rather than tilting at windmills in the struggle to chase down and eliminate the global drug trade.

What would it mean to think of drugs as a public health problem? Start with reconceiving the drug user. Caring for the health of people who abuse drugs means minimizing the harm they cause to themselves and others and promoting their physical and emotional well-being—not punishing or threatening them. But a public health approach does not stop at treating the individual physical or psychological problem of addiction. It recognizes that drug use and abuse have other effects—on families, neighborhoods, schools, and workplaces. A public health strategy would seek to minimize the harm a drug-dependent person may do to his or her social relationships. And it would minimize the threat the drug user may pose to the welfare of others, through policies that discourage violence, dangerous driving, irresponsible use of machinery in the workplace, and the spread of diseases such as AIDS.

Such an approach confronts not only the public effects of drug-taking, but also the social factors that can lead to drug-taking. There is always an element of individual choice in drug use and abuse, but experts in treating drug addiction have long known that choice is shaped and constrained by social factors. A person whose family and friends use drugs is more likely to do so. Someone with a family, home, and job who becomes addicted is better able to break an addiction than someone without these social supports. To treat drugs as a public health problem is to recognize that drug abuse and addiction are not simply the result of an individual defect (a weak will, a moral failing, a disease) but also of the broader social environment that is shaped in important ways by other public policies.

It is by no means simple or easy to confront the many social factors that feed the cycle of drug abuse and its harmful effects. But adopting this framework as a starting point makes it possible to reconceive the fundamental purposes and policies of drug control. The policy instruments—prevention, treatment, and law enforcement—may remain the same, but they take on different meanings and assume different priorities under a public health paradigm.

Consider prevention. Under the current punitive paradigm, prevention tries to stop any and all use, and the primary means is to scare or threaten users. Thinking about prevention this way excludes the possibility of employing the public health principle of preventing harm by teaching people safer drug use. Take the example of designated driver programs that aim to save lives by encouraging "designated drivers." For punitive preven-

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"Just say no to drugs," urged First Lady Nancy Reagan. But a person can say "no" to drugs only if he has something to say "yes" to. A public health approach would aim to improve the social and economic environment that breeds drug abuse.

tion advocates, in the words of one government publication: "materials recommending a designated driver should be rated unacceptable. They encourage heavy alcohol use by implying that it is okay to drink to intoxication as long as you don't drive."

Public health advocates may also wish to minimize drunkenness, but they are looking for ways to promote public safety and reduce harm. Instead of simply aiming at the impossible goal of "abstinence" or "no-intoxication," they realistically accept that there will always be some use and seek ways to save lives on the road.

This idea of promoting safe use—not simply no use—also undergirds public health efforts to stem the spread of AIDS by preventing intravenous heroin users from sharing infected needles, one of the major causes of the epidemic. Needle-exchange programs, introduced in parts of Europe and in some U.S. cities, encourage addicts to regularly turn in their used and contaminated needles in exchange for free sterile ones. Yet despite the fact that well-documented studies show that such programs have succeeded in reducing the rate of HIV infection by as much as one third, they, like designated driver programs, are opposed by advocates of punitive prevention.

Many programs do not simply exchange needles, but use the opportunity to encourage addicts to seek services such as drug treatment and include educational programs on sanitation and safe sex precautions. "Success" is not simply measured by abstinence from drug use, but by the slowdown in the spread of AIDS and the increase in the number of addicts who seek treatment.

Yet conceiving prevention under the punitive, prohibitionist paradigm rules out such public health measures. Today most states have laws prohibiting addicts from possessing injection equipment, and efforts to permit needle exchange often face fierce opposition. Robert Martinez, drug czar under former President George Bush, articulated the drug-war paradigm's assumptions when he argued that distributing needles "undercuts the credibility of society's message that drug use is illegal and morally wrong...."

Consider also efforts to educate young people about the dangers of drugs. Under the punitive paradigm, the focus of preventive education in schools is scare tactics (the "fear-arousal" approach) and moral appeals ("preaching" to students about the evils of using drugs and exhorting them to abstain). Evidence indicates that such efforts do not work. In the words of a 1990 congressional report, "Putting forth the idea that all illegal drugs are extremely dangerous and addictive, when young people subsequently learn otherwise through experimentation, discredits the message." Indeed the message often backfires, encouraging experimentation.

Envisioning preventive education in terms of public health would change not only its content, but its scope. It would aim to provide young people with information on the physical and psychological effects of all psychoactive drugs (including alcohol and other legal drugs)—as well as the effects that drug-taking can have on other things of value, such as work and relations with friends and family. Drug education for public health would also teach safer use—even while discouraging all use. Although promoting safer use is contradictory under a punitive paradigm that has "zero tolerance" as its goal, no such contradiction exists under a public health paradigm.

Inevitably there will be some experimentation and casual drug use despite the best efforts to discourage it. And those unwilling to abstain or unable to quit need to know which drugs are more addictive, which com-

Drug War Politics: The Price of Denial

A professor and two former students write a book together—seminar style.

Research collaboration between Swarthmore students and their faculty mentors is nothing new, but writing a book with a former professor several years after graduation has to be a bit unusual. *Drug War Politics: The Price of Denial* was co-authored by Professor of Political Science Kenneth Sharpe, his longtime collaborator, Professor Morris Blachman of the University of South Carolina, and two Honors graduates in Political Science, Eva Bertram '86 and Peter Andreas '87.

Bertram and Andreas had worked together before—not only as Swarthmore students, where they took a seminar together, but as Washington-based policy analysts.

After graduation, each travelled in South America. Andreas, thinking he might become a journalist, worked at *The Nation* and at *Foreign Policy* magazine, and is currently a research fellow at the Brookings Institution. Bertram worked with several national nonprofit organizations seeking to influence U.S. policy in Central America and to address violations of law and human rights in the region. Both are currently writing doctoral dissertations, Andreas in Government at Cornell and Bertram in Political Science at Yale.

In 1990 and 1991, Andreas and Bertram found themselves working together at the Institute for Policy Studies on several projects related to drug policy. They collaborated on a report of the

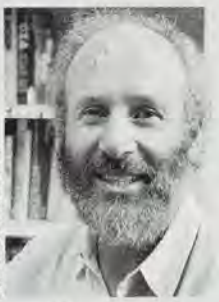
binations of drugs are particularly dangerous, how to prevent an overdose and what to do in the event of an overdose, what kinds of conditions make drug use more or less dangerous, and how to avoid dangerous behaviors (such as unsafe sex or driving) while intoxicated .

Treatment would also take on a different meaning under a public health paradigm. Treatment under the drug-war paradigm is largely a supplement to punishment. Both policy instruments have the same aim—to stop all drug use. This means that those who enter treatment but cannot kick the habit—quickly and permanently—are often abandoned. Some are offered treatment under the threat of severe punishment: you break your habit or you will be sent to jail. For those already in the criminal justice system, treatment works alongside punishment—drug offenders are treated to improve the deterrent value of prison, in the hope that they will not commit drug-related crimes upon release.

This approach to treatment is reflected in budget battles in Washington. "There's still almost a moralistic feeling," explained Dr. Herbert Kleber, a prominent drug official in the Bush Administration, "that asks 'Why should we be putting tax dollars into treating something that people have brought on themselves?'" Thus treatment providers are often forced to justify their services as a crime-prevention tool. In part as a result, treatment always gets short shrift in budget allocations (treatment and prevention together account for about 30

House Committee on Governmental Operations on the drug war in the Andes. The congressional report was widely circulated, and Andreas says that scholars and journalists in Latin America were quick to point out its conclusions: "'Look,' they would say, 'your own government's report says that this policy can't work.'"

Andreas and Bertram passed the report along to Sharpe, who was then studying drug policy as a national security issue. For years his research had been focused on politics and policy in Latin America. He and Blachman had co-written numerous articles together, plus a 1986 book, *Confronting Revolution: Security Through Diplomacy in Central America*. Sharpe's two other books have also examined aspects of Latin American politics, from the influence of multinational corporations in Mexico to peasant movements in the Dominican Republic. Andreas and Bertram proposed that Sharpe and Blachman work together with them on drug policy.



STEVEN GOLDBLATT '67

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The collaboration that ensued, lasting nearly six years before this summer's publication of the *Drug War Politics*, began with a winter 1991–92 article for *Foreign Policy* on the effects of the drug war in South America. Buoyed by the success of this project, the four embarked on a more comprehensive history and critique of the politics of U.S. drug control.

Sharpe describes the process of writing *Drug War Politics* as "organic." In many such books, co-authors divide the topic into chapters and independently write each section. It's often clear when you have passed from one writer's style to another's, but the writing—and thinking—in *Drug War Politics* is virtually seamless.

Bertram tells how they did it, seminar style: "We would sit down around a table and think through the argument together, brainstorming and testing different ideas. Someone would always be at the computer, typing all this up. We'd develop something, then print it out, read it, and react to it at a deeper level." Then, she says, one person would take on the task of drafting that particular section, then hand it over to another member of the group to be rewritten. The four co-authors spent scores of hours together—mostly at an old cabin near Sharpe's Vermont summer home—editing and revising until a complete book emerged.

Was there anything left of the teacher-student relationship as they worked on the book? Maybe at first, Bertram acknowledges, but "the brainstorming and writing process created a lot of room for thinking out loud, for checking each other. And constantly rewriting each others' work—that helped break down some of that."

She feels that she and Andreas "were able to bring a different kind of experience to the process. Our work on Capitol Hill had given us a certain sense of how people in Washington were thinking about this issue and of how policy was and wasn't made."

Their shared Swarthmore experience, says Andreas, also informed their analysis: "Swarthmore is a fertile environment for encouraging critical thinking in a systematic way, for challenging basic assumptions."

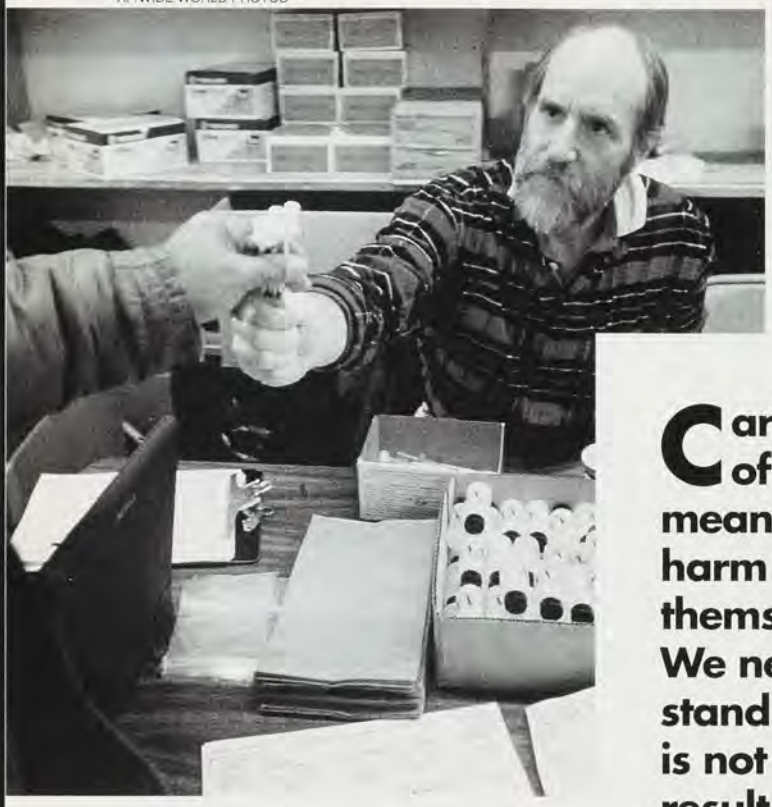
Sharpe adds that "scholarship at Swarthmore is not a passive process—you take on the big issues." *Drug War Politics* does just that, looking beyond the conventional wisdom on the issue and examining why Congress and successive administrations have not been able to act in a rational manner.

Can a book like this bring about a change in policy? Andreas hopes that it will be "a bridge-builder.... This isn't just an advocacy book. There's an underlying analysis of the reasons for these seemingly irrational policies. We try to show why there's so much persistence in the face of failure."

Sharpe, however, is not optimistic about the prospects for rapid change, especially in today's anti-crime environment. "Frankly, it's discouraging," he sighs. "The people who are actually suffering the most—the people who are abusing drugs—are not politically active. And change will not come from a new president or one of the political parties because there are far more votes to be had by defining drug use as a crime and using it to prove your toughness. We think that the 'front-liners'—the treatment professionals, social workers, police, judges, public defenders, and community activists—will have to be the ones to raise their voices for change."

—Jeffrey Lott

AP/WIDE WORLD PHOTOS



Caring for the health of drug users means minimizing the harm they cause to themselves and others. We need to understand that drug abuse is not simply the result of a weak will or a moral failing.

percent of the drug-war budget).

The reasoning of most legislators is simple: treatment might eventually reduce use and ease crime, but in the short term, wouldn't it be more effective just to lock such people up? And given the characterization of people who use or sell drugs as criminals, punishment—not "care"—seems more appropriate. Naya Arbiter, a therapy director in Tucson, explained: "Once we make drug addicts into the enemy, society has a tough time taking them back in. Why would the public want to pay for more treatment if they're dealing with the enemy?"

Under a public health paradigm, the aim of treatment would not be to complement punitive policies in the effort to suppress any and all use. In fact, total abstinence—"full recovery"—is only one goal for public health advocates. And for the majority of addicts admitted to most drug programs, an Institute of Medicine study reported in 1990, abstinence is not realistic. The aim of treatment is to reduce the range and degree of harms caused by use. It is not only to "reduce drug consumption but also to permit the responsible fulfillment of family roles; to help raise employment or educational levels; and to make the client less miserable and more comfortable physically and mentally."

Methadone maintenance, one of the most successful treatment programs for heroin addicts today, is based on such public health goals. Methadone, a synthetic opium derivative that stops the craving for heroin but lacks many of heroin's deleterious effects, is provided to addicts at clinics to help move them off heroin, into treatment, and out of crime. Some addicts eventually stop using both methadone and heroin, but many continue to take methadone for years and are able to lead healthier, more satisfying lives as parents, employees, and members of the community.

But methadone treatment—originally sold to the American public by President Nixon as a crime-fighting weapon—is continually under attack by those who think of treatment in terms of the punitive paradigm. Attempts to expand methadone clinics in 1988, for example, met with opposition by elected officials such as Rep. Charles Rangel (D–N.Y.), then-chairman of the House Select Committee on Narcotics. Rangel, who favored treatment programs designed to end drug use entirely, derisively labeled maintenance clinics "juice bars." He asked the General Accounting Office to review federally-regulated methadone treatment programs. Though the resulting report criticized uneven practices, it concluded that this form of treatment offered substantial benefits. Rangel chose to ignore this evidence and continued his attack. Such opposition is rooted in punitive assumptions—i.e. since methadone consumption is drug use, and drug use is wrong, it must be eliminated.

The approach to pregnant drug-using women under the two paradigms provides a further example. Drug-dependent pregnant women may give birth to newborns afflicted with fetal-cocaine syndrome or other health problems. Operating under punitive assumptions, legislators in a number of states have responded with threats to punish these women in order to discourage their drug use. Some states criminalize women who use drugs during pregnancy. Some allow newborns who test positively for drugs (and their siblings) to be taken from their mothers and placed in state custody. But from a public

AP/WIDE WORLD PHOTOS

Needle exchange programs (far left) are often opposed on the grounds that they encourage drug use, yet they are known to reduce the rate of HIV infection among intravenous drug users. Drug raids clog courts and prisons with drug offenders. In 1993, 61 percent of all federal prisoners were incarcerated because of drug crimes.

health perspective, such punitive measures seriously undermine the prospects for treatment. Fearing punishment and afraid to lose their children, many mothers choose not to seek drug treatment or the prenatal care that could dramatically improve the life chances of their children.

Perhaps most important, treatment under public health rejects the almost exclusive focus on the individual drug user emphasized by the punitive paradigm and insists on also doing something about the social environment that shapes the choices of those who abuse drugs. Particularly for substance abusers who are poor, homeless, or jobless, drug use is often seen as a "solution" to other problems that need fixing in their lives.

Without a "social stake," argues Thelma Brown of the Watts Health Foundation, treatment cannot succeed: "One of the highest causes of recidivism occurs when a client leaves treatment. He or she is likely to be forced to return to the very same environment that contributed to the addiction in the first place. What awaits this individual is lack of employment—and the old cycle of hopelessness and helplessness. . . . Upon completion of these [treatment] programs, provisions should be made for follow-through, such as providing jobs, training and education. . . . One can say 'no' to drugs, but we must provide something to which one can say 'yes.'"

A public health approach would not only redefine treatment and prevention, but also law enforcement policies. Under a public health paradigm, those who committed crimes or injured others under the influence of drugs would certainly be punished. But criminalizing drug users because they have a health problem would seem as misguided as jailing heavy drinkers and alcoholics. Given the aim to heal rather than punish those suffering from drug problems, a public health approach would decriminalize drug use and instead seek ways to draw users into the health care system.

Public health would also demand some regulation of the supply of dangerous drugs. Simply legalizing drugs such as cocaine and heroin would make them as readily and cheaply available as alcohol and tobacco, and market greed and competition would lead to continued wide-scale use and active promotion. Controlling supply, however, would only be one aspect of a public health agenda, not the primary, overriding feature it is in today's punitive paradigm; prevention and treatment would have primacy.

Conclusion

Developing a new approach to drugs in America is, of course, more than an intellectual exercise. The current punitive, drug war paradigm took hold as a result of years of political struggle—and reform will only come about through similar struggles.

Such struggles, our research shows, are unlikely to be led by politicians locked in a competition to outtough each other. They may, however, be led by those on the front lines of today's drug war, people who have firsthand experience of its failure. Judges cannot dispense justice because their courts are clogged with drug cases. Police charged with eliminating drug dealers find that there is an endless supply of new dealers to take the place of those arrested. Providers of drug treatment cannot secure sufficient funds to keep their offices open—yet more and more people are knocking on their doors, seeking help. Local communities are paying more in tax dollars, but drug abuse and violence continue unabated in many neighborhoods.

These contradictions constitute fault lines in the current drug-control system. Modest struggles for change are underway along these cracks, but they are unlikely to succeed in isolation. Drug problems and their policy solutions are too much a part of deeper social issues and struggles—over health care, urban decay, racism, and economic underdevelopment in our cities. But if such struggles are to create the possibility for reform aimed at public health, concerned citizens and front liners with practical experience in treatment, prevention, and criminal justice will have an invaluable role to play in charting a new politics of drug control. ■

AP/WIDE WORLD PHOTOS

At 13, this Louisiana girl is involved in the fight against drugs. But if she or someone she loves does take drugs, will treatment or punishment be a better solution?