

HEROIN AND THE WAR ON DRUGS: HOW WE GOT TO THIS PLACE AND HOW
WE MAY LEAVE IT

Article

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It is the function of justice to lead unequals to equality, and that only when this equality has been achieved is the task of justice achieved

St. Thomas Aquinas¹

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Introduction

This article will review the evolution of heroin control strategies in England and the United States for the last 100 years and new initiatives in Canada. It will examine the directions we have taken and some alternative ways of accomplishing our goals in a civil society. It may create controversy. But in a civil society, without questions and discussion, there can be no progress or justice.

Biochemical/Neuralgic Properties

Heroin is a subproduct of the juice of Papever Somniferum, the opium poppy. It is a diacetylmorphine, made by the chemical conversion of morphine, which is synthesized from opium. It is officially classified as an opioid and relieves pain, produces withdrawal symptoms and signs when the drug is stopped after chronic administration, and suppresses withdrawal signs and symptoms, which occur as a result of stopping chronic opioid administration. Heroin produces its effects in the central nervous system. These effects are

responsible for respiratory depression, delayed gastrointestinal motility, euphoria, and physical dependence.² When heroin is ingested, it metabolizes into morphine. The method of ingestion will determine the length of time for this conversion. Before the conversion is complete the heroin enters the brain, coating the neurons and inducing a brief euphoria or rush. The receptor sites trigger signs and symptoms that are known as being under the influence.³

Pain collides with pleasure

The opium poppy has been with us for time immemorial. It is mentioned in ancient writings before the Bible and continues to exist in society. Its use migrated among mid-east cultures into Asia. Having medicine, religious and euphoric uses, it is highly addictive and takes a terrible toll on individual, families and societies.

In the early 1800s, the adaptation of the hypodermic syringe and needle as an efficient vaccination delivery system led to the use of morphine as an analgesic for the victims of war. The first real tests of this technology and the mass-distribution of morphine were in the Crimean and U.S. Civil Wars. With these events came the other side of the two-edged sword: addiction. Legions of morphine-addicted soldiers led to what eventually became called the soldiers curse and a challenge to Victorian society. Eventually, doctors of the Bayer Company in Germany discovered the cure for morphia in the 1880s in a more powerful synthesis of opium: heroin.

Evolution of a cause

To many politicians and temperance leaders, the problem was seen in a racial context, to be treated as a scourge brought by the yellow peril. Sordid advertisements for dime novels outraged Victorian and puritanical morality. Political arguments by organized labor advocates, such as Dennis Kearny in 1870 San Francisco⁴, used race as a basis to decry the

use of opium and heroin and a reason to expel Chinese workers who would deflower young white women who were under its influence.⁵ America's first experimentation with an anti-narcotics law was the San Francisco Opium Ordinance of 1875. This was tied with extremist views that linked African-Americans to Asians as a vast conspiracy to destroy white homes while under the influence of both cocaine and heroin.⁶ Temperance leaders of the early 1900s saw it as an international problem requiring regulation and eventual prohibition.

Heroin can be tied to significant events in 20th-century drug control policy. Both the United States and Great Britain followed parallel courses in regulation but enforcement tactics and their views of the nature of the problem were different. In the United States a mixture of Puritan ethic, immigrant and racial intolerance, progressivism and the temperance movement combined to fuel a narcotics crisis. In England a concern that started out of concern for health and regulatory issues led to crime control tactics.⁷ The problems still exist but the resolutions are different.

The United States answer

1901 was a contradictory era of imperialism and progressive reform in the United States. To the average American, the most visible evil of the date was a saloon, crawling with immigrants whose votes could be bought by offering pints of beer. This social sinkhole was a source of evil, destroying American values. The logic was to eliminate the saloon, or better yet, eliminate alcohol and this cesspool of crime and weakness. The collision of social reform and religious fundamentalism brought narcotics into the formula in the early 1900s.

In 1908 the U.S. State Department Opium Commission met to open Chinese markets for American goods. The commission was to help China with their notorious opium problem in such a way that our moral superiority would be proven and we would also cut into the

British share of a profitable trade market. In subsequent meetings commissioners assumed opium and heroin addiction was a plague, like yellow fever or leprosy. The commission erroneously believed that United States opium problem was more serious than that of China.⁸

This does not deny a fact that there was an opium problem in the United States. The typical American addict was a middle-aged southern white woman abusing laudanum, an opium-alcohol mix for acute coughs. The most reasonable estimates put the number of U.S. addicts at about three people in 1000, or approximately 250,000 out all the total U.S. population of 76 million.⁹ Most became unwittingly dependent on a vast array of over-the-counter patent medicines which contained substances ranging from cocaine to morphine. Even cough syrup was spiked with heroin. For this reason and a growing awareness of the dangers of untested foods and drugs, the Pure Food and Drug Act of 1906 finally forced manufacturers to list ingredients on labels. When people came to realize their local elixir was laced with addictive drugs they stopped using it.¹⁰

American viewpoint of opium.

In 1914 Congress passed the Harrison Narcotics Act. It appeared to be no more than a tax code by requiring everyone in the medical drug trade to keep precise records. This had little do with addiction but rather focused on our obligations under international convention. However there were some interesting interpretations of this act. One clause that doctors saw as protecting them ended up outlawing ethical medical conduct. It stated that a physician could prescribe narcotics during professional practice only. The Treasury Department used this to define narcotics addiction as a bad habit not a disease so it became not only immoral, but illegal as well. They sincerely believed that narcotics addiction could be eliminated in America by the early 1920s.¹¹

But as early as 1914 Dr. Charles E. Terry, city health officer for Jacksonville, Florida, wrote, "...we had counted without the peddler. We had not realized that the moment restrictive legislation made these drugs difficult to secure legitimately, the drugs would also be made profitable to illicit traffickers." Dr. Terry also wrote, "One of the most important discoveries we made at that time was that the very large proportion of users of the drugs were respectable hard working individuals in all walks of life, that only about 18 percent could in anyway be considered as belonging to the underworld."¹²

Still, the Treasury Department's leadership felt that strict enforcement was the answer to eliminating heroin. From 1916 forward to 1920 the U.S. Treasury Department issued nearly 35,000 indictments¹³ against doctors who legally prescribed heroin. No cases went to court, but public opinion was changing. In 1900 addicts were seen as unfortunate citizens with a medical problem. The 1920s perception of drug addicts by an American public, jaded by the ravages of W.W.I, was that of twisted immorality and untrustworthiness. Commercial radio and religious temperance crusades brought this home to the American public.

While several Supreme Court cases served to reinforce the tax law aspect, Federal criminal enforcement continued. The cases of U.S. vs. Behrman, 285 U.S. 280 in 1924¹⁴ and Linder vs.U.S. in 1925¹⁵ are classics in which the court supported the rights of physicians to prescribe morphine for pain relief incident to addiction. Yet the United States continued on the path of enforcement and criminalization, which created a class of ostracized and social outcastes who needed help badly.

It also created an important perception of heroin use: the site as a den of iniquity or the shooting gallery. Our modern vision of heroin use focuses on a squalid apartment or trash-littered alley. Dazed and stumbling zombies strung out on heroin inhabit a twilight zone of

filth and decay. The remnants of their immoral lifestyle left strewn about for an innocent child to come upon and get addicted to heroin by osmosis. This perception has helped push heroin use and users beyond the margins of a society that at onetime saw it as a medical problem.

Between the 1930s and 1973 the Federal Narcotics Bureau evolved from an enforcement unit of a few hundred men to an international force and operation with over 4000 agents. The numbers game was played very seriously. In 1969 there were an estimated 68,000 heroin addicts.¹⁶ Two years later this official count jumped to 550,000, an eight-fold increase. Did record keepers at the Bureau of Narcotics create an 800 percent jump by an elaborate formula? In the election of 1972, the numbers were cut to 150,000 heroin addicts. The administration was able to take credit for an overnight cure of some 400,000 non-existent addicts.¹⁷

In July 1973, the Drug Enforcement Administration was created. While some see Richard Nixon as the founder of the War on Drugs, he actually was following in the footsteps of previous administrations that had used narcotics to advanced political careers. Nixon's political genius was in spotting waves of public anxiety¹⁸ before they crested and riding their popularity. What could be termed fear management was used to warn the country of a drug plague of unimaginable proportions. Because the distinction between marijuana and heroin was blurred, the overall number of drug users skyrocketed from several hundred thousand to nearly 45 million.

Drug economics and funding pumped into the drug war contributed to where we are and how we got to this place. In 1980, the federal budget for drug control was about \$1 billion.¹⁹ State/local budgets were perhaps three times that amount. By 1998, the federal drug control budget mushroomed to \$15.8 billion, two-thirds of it for law-enforcement agencies and

state/local funding was comparable.²⁰ The federal budget for 2000 is \$18.5 billion and 2001 will be \$19.2 billion, again, the state and local budgets should be 3 times that amount.²¹

Federal seizures in 1989 totaled 1311 kilograms.²² In 1990 this number was cut in half. The next 10 years saw total seizures range from 1448 kilograms in 1991 to 1094 in 1999. Yet the total estimated worldwide production of opium increased from 2500 metric tons in 1988 to 3400 metric tons in 1998.²³ Since opium is a crop and needs land to be cultivated, another measure of success of the war on drugs should be computed by a comparison of cultivation and eradication. The estimate of opium cultivated land has been approximately 220,000 hectares around the world since 1990. But total crop eradication in the same time frame only grew from 6500 hectares to 12,000 hectares per year.²⁴

Since the early 1970s the United States has previously capped the war on drugs at a price of nearly 300 billion dollars, not including the cost in human life, lost opportunities, and the creation of a national paranoia. It also created an interesting dichotomy. Just as addicts become hooked on drugs, police departments became addicted to forfeiture and grant money and the media became hooked on the drug war itself. Some politicians use crime and drugs synonymously, without regard for reality or problem solving.

Statistical information has been confusing but merits examination. In the 2000 Annual Report of the National Drug Control Strategy, Office of National Drug Control Policy, two sets of data are presented. The annual report presents a probability based population survey estimate rather than a mathematics model. Because of this difference the official reports estimates show a marked decrease of heroin users.²⁵ The numbers vary from 216,000 in 1996, 325,000 in 1997, and 210,000 in 1998. The National Drug Strategy report also shows a decrease of past year heroin users of 597,000 in 1997 to 530,000 in 1998.²⁶ But

these numbers must be evaluated with caution. Accurate measurement is rare because of the stigmatization of drug use and a lack of self-reporting unless incarceration is involved.

The British system

As a counterpoint to U.S. strategy, Britain regulates for a different purpose. The British experience of allowing doctors to prescribe heroin for maintenance has been criticized for more than in 70 years in the United States. In 1926 the Rolleston Committee concluded that morphine and heroin addiction should be regarded as a “manifestation of disease and not as a mere form of vicious indulgence.”²⁷ Further, this committee stated that indefinitely prolonging administration of morphine and heroin might be necessary for certain patients. This perspective led Britain to formalize a system in which physicians could prescribe heroin to addicted patients for maintenance purposes.

While most of the patients had become addicted under medical treatment and the customer base was limited to several hundred people, the system worked for four decades with few problems. Then in the early 1960s a handful of physicians irresponsibly prescribed heroin to users for purely recreational purposes. These users then recruited others. While this caused a sharp percentage rate increase, the overall numbers of addicts still remained at around 1500 registered addicts. Thus, in 1967, the Dangerous Drugs Act curtailed access to heroin maintenance and limited long-term prescriptions to a small number of specially licensed drug-treatment specialists. Simultaneously, oral methadone became available as an alternative maintenance drug. In 1975 only twelve percent of maintained opiate addicts were receiving care.²⁸ Today, fewer than one percent of maintenance clients receives heroin.²⁹ However specialists still can maintain addicted patients on heroin, if they wish. Most choose not to do so because the reimbursement for heroin maintenance is low.

In 1998 the National Treatment Outcome Research Study was commissioned by the the British Department of Health to review the effectiveness of drug treatment. This study and its scale is extremely rare. It was expensive financially and in terms of human scientific resources. The data collected by interview at treatment intake centers was an accumulation of nearly five years worth of hard work. Clients were divided between the most common services offered by the U.K.: rehabilitation and specialist inpatient treatment in residences and methadone maintenance and reduction in community settings.

These were not young people experimenting with heroin; they were severe or chronic users of this drug. Improvements following treatment were impressive, including substantial reductions in the use of heroin and other drugs. Abstinence rates for illicit opioids doubled.³⁰ While no conclusive statement could be issued that would define which is the best treatment, some essential points that can be taken seriously in United States are listed:

- Drug addiction treatment in Britain substantially reduces illicit drug use, crime and infectious disease transmission.
- Every Pound, approximately \$1.60 U.S. dollars, spent on treatment probably saves three Pounds on crime related expenditures and other costs. As treatment expands we can expect diminishing returns.
- Even established addicts previously resistant to treatment can benefit from further intervention.
- All drugs services should tackle alcohol abuse in their clients.³¹

Canadian innovations

Canada is another country with the problems of illicit drugs but found a medical use for legalized heroin: pain control. In 1984 the Minister of Health announced the legalization of heroin. But its use is restricted by a strict protocol. The effects of the government protocol means minuscule amounts of heroin have been used for medical purposes. Trends and

strategic applications in Canada are best typified in Vancouver, British Columbia.

Vancouver spends more money per person in dealing with illicit drugs than any other place in Canada. In 1997 the estimated cost to law enforcement and health care related to drug use was \$96 million a year.³² This unprecedented drug crisis and explosion of deaths through intravenous injection led to the creation of a plan to implement a European style approach to decriminalize heroin and restore responsibility to the lives of addicts. It was crafted in 2000 by Vancouver health professionals, police and Mayor Philip Owen.³³

A key component to this type of project would be cost. But which policy costs the most? Prohibition has certainly been costly in terms of lives, society and social structures. However, limited experiments do not even come close to actual costs of a nation-wide experiment for a county the size of the United States. With the cost to treat a single abscess on one addict nearly \$58,000.00 in San Francisco,³⁴ what are we willing to pay to prevent the problem?

Time to refocus

America has always had a drug/substance abuse problem. This abuse has continued into the new millenium. On October 17, 2000, President Clinton signed the Drug Addiction Treatment Law 2000³⁵. In one section of this new law, 86 years of attitude and treatment standards for heroin addiction were revolutionized. More accurately, doctors are able to treat addicts once more as they did before the 1930's. Under the law, doctors can now prescribe a revolutionary narcotic for treatment of heroin and painkiller addicts. Buprenorphine, a narcotic already used as an injectable painkiller with astounding success in France for nearly 8 years, has helped to reduce the numbers of existing heroin addicts.³⁶

Perhaps it is time to look at simple steps used around the world in other western nations.

- Prevention through better education that starts as early as the second grade.
- Treatment by early medical intervention and safe user sites to control and redirect the actions of addicts.
- Enforcement directed at mid and upper level dealers to reduce, displace and eliminate crime and improve the quality of life in our neighborhoods.
- Effective harm reduction to reduce the damage of drug abuse to addicts, their families and society.

We have all lived and worked with the problems caused by drug abuse and criminalization of drug use. To some extent we have supported both sides of this picture through our taxes and our votes. This cannot be ignored. The health crisis, which rooted itself so firmly in intravenous drug use, will not go away and will not stay limited to a narrow band of people. Long-term support must find advocates in all walks of life: judicial, enforcement, executive, legislative and medical at the minimum. But support should not be construed as advocating that one uses drugs to escape reality or even to make do in life from day-to-day. Support should acknowledge human frailties and offer a hand to people who are marginalized. The consequences can be a healthier, stable society.

This article has examined only a few issues of heroin. Decriminalization is not necessarily the best or only answer. Might the most appropriate solution to this disease be direct intervention of doctors who can prescribe heroin medically? Ethical issues spring from these questions and we need to listen to those issues carefully. The addict could be the best source to tell us what would really help bring them back into society. Might they be asked first?

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