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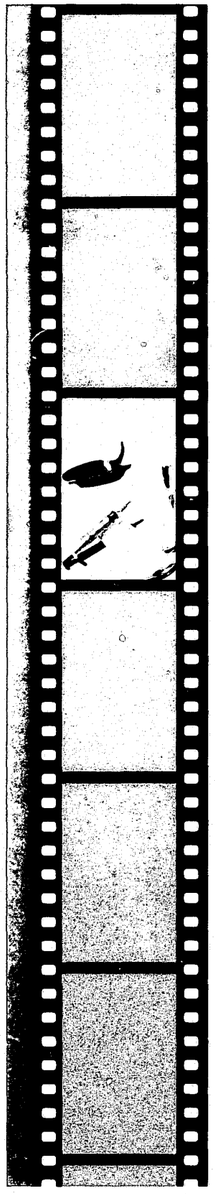

CRIME FILE

Heroin

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Your discussion will be assisted by your knowing what impact heroin use has had on the addicted and on the society at large, what preventive policies are available, and how these policies are changing in an effort to minimize the harmful effects of heroin use.

Introduction

Opium is the dried resin that is exuded when the base of the flower of the opium poppy is cut or lanced. Its major active ingredient, a white crystalline powder, was first isolated in 1803 and named "morphine." Five years later, a relatively simple chemical manipulation produced from morphine a new drug, heroin, which was about two to two and a half times as strong on a per weight basis.

Although heroin can be smoked or eaten, injection into a vein is the preferred means by which addicts in the United States take the drug. This is the most efficient method since none of the drug is then destroyed by fire or by gastric juices. Moreover, injection minimizes the time lag between the administration of the drug and the feeling of its effect. Many heroin addicts particularly value the "rush" that the injected drug gives them as it takes effect all at once.

Effects of Heroin

Heroin has many effects, but for our purposes only a few are important. It is considered by its users to be very pleasurable, and it is addicting. After use on a highly variable number of occasions, the body of the user adjusts biochemically to the drug, so that a cessation of drug use is accompanied by unpleasant physical symptoms—nausea, running nose, gooseflesh, and cramps.

Though withdrawal symptoms can be quite easily managed medically, it is much harder to keep an addict who has gone through withdrawal from becoming readdicted. The majority of addicts who are imprisoned for several years may go through withdrawal within the first few days after arrest, only to return promptly to heroin use upon their release.

Most heroin treatment is not a great deal more effective. After treatment, even that involving some prolonged period of isolation in a hospital or in a therapeutic community, ex-addicts will usually be released back into the milieu they knew best before their incarceration—typically the addict subculture in an area of high heroin use. Whatever the reason, heroin addiction, like alcoholism, is a condition characterized in part by changing use patterns—from periods of abstinence or moderate use to periods of compulsive use.

A primary reason for concern about heroin addiction in the United States today is the heroin addict's need to violate the law in order to raise sufficient funds to support the habit. There is some dispute about the total amount of money heroin addicts must obtain through criminal means, since neither the total number of addicts nor their average habit is accurately known. Nonetheless, a rough estimate is that there are 500,000 addicts whose average daily consumption of heroin has a retail cost of about $60 per day. The best estimates suggest that 60 percent of this roughly $15 billion per year is obtained from consensual crimes, such as prostitution and heroin sales, from welfare payments, and from occasional work. Most of the remainder, approximately $6 billion, comes from the commission of property crimes, such as burglary, shoplifting, and other "hustles."

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The legal system's treatment of heroin has been blamed, by some critics, for the high criminality of addicts. There is, of course, a serious methodological problem with this criticism since most heroin addicts were criminals before they first used heroin. Nevertheless, virtually every commentator examining the problem has concluded that the urgent demands of addiction cause addicts to commit crimes to pay for heroin and that the amount they must raise is enormously inflated because of the prohibition on commerce in the drug. (The morphine equivalent of $60 worth of heroin is available, by contrast, through legal medical channels for about 40 cents.) In all, the best estimate is that addicts commit about six times as many crimes while they are in a "run" of heroin use as when they are abstinent or using the drug irregularly.

Suggested Policy Changes

Various policies have been advocated to lower the impact of heroin addiction on our society.

1. ***Legalization.*** One possible policy is to treat heroin like alcohol, making it freely available. There are relatively few supporters for this policy because of our inability to predict the extent of heroin addiction in a modern industrial society that made the drug freely available. After all, at present, while some residents of our inner cities find heroin easy to obtain, most Americans do not come across the drug in their daily lives and most cannot obtain it without considerable inconvenience and without risking arrest or predation. Even if one were to conclude that the adult population would overwhelmingly resist the blandishments of easily obtainable heroin, our youth tend to be more experience seeking, present oriented, and risk taking. The addicting nature of the drug would make heroin use begun in youth likely to continue into adulthood, leading to a continuous and unpredictable growth in the addict population and to what might be a public-health catastrophe.

The uncertainties as to both the consequences of heroin addiction and the projected extent of addiction under a policy of free availability have prevented most advocates of changes from recommending this policy, even in preference to our current, costly, legal scheme. Moreover, although making heroin freely available would enable us to learn considerably more about the likely extent of heroin addiction and the harm the drug would do to the user and society, it is most unlikely that we will be able to convince ourselves in the foreseeable future that such a risk is worth taking.

2. ***Increased law enforcement.*** One obvious policy, "more of the same," contemplates a greater use of law enforcement, so as to make the prohibition work. Devoting more resources to law enforcement has in the past raised the risk and expense of supplying heroin, and thereby caused more theft by addicts to meet the more expensive costs of their habits. Nonetheless, the demand for heroin is not completely inelastic and it is not unreasonable to believe that drastically raising the price of heroin through law enforcement might lower the overall social cost of heroin addiction. Thus, if an addict required $10,000 per day for his habit instead of $60, he might simply have to give up the use of the drug.

Increased law enforcement efforts to choke off the supply of heroin might be directed at three different points in the chain of supply: sale within the United States, entry into the United States, and production outside the United States.

Preventing sale within the United States. We have already invested heavily in prevention of sale within the United States. However, our police have been distracted by many other problems. They have been subject to constitutional guarantees of privacy. And they have been tainted by corruption from the huge profits available in heroin trafficking. It is unlikely that we can overcome these problems and devote sufficiently vast additional resources to be able to push the cost of heroin beyond the capacity of most addicts.

This is the case whether law enforcement concentrates on big dealers or on street-level peddlers. The latter are relatively easy to catch, but there are so many of them that they could easily overload the criminal justice system. Moreover, their places can easily be filled from the large reservoir of addicts who, already stealing, would prefer a safer and more lucrative means of supporting their habits. The major traffickers are far less numerous but, having access to considerable resources, are much harder to catch. Moreover, as long as the profits in heroin trafficking are so huge it is likely that sophisticated criminals will continue to be drawn into the business of meeting the demand.

Preventing importation. Nor can we be much more optimistic about the second possibility—preventing the smuggling of heroin into the United States. Here we encounter the stark fact that the total heroin requirement of all American addicts for a year is, under today's conditions, probably less than 10 tons. When this is contrasted with the 100 million tons of freight brought into the United States and with the more than 200 million people who cross American borders each year, the magnitude of the interdiction task becomes clear. Although we may be able to improve our performance over the existing estimate of less than 10 percent of the heroin entering the United States, it is hard to believe that we can more than double or triple that percentage. If so, we would still fail to push the price of the drug out of the range most addicts could afford.

Preventing cultivation of opium. The third and final method of curtailing the supply, preventing the production of heroin outside the United States, would require control of poppy cultivation. This could be done either by buying up the entire crop, which is unfeasible because of the ease of diversion, or by forbidding opium poppy cultivation, which is complicated by serious problems in obtaining international cooperation. The relative smallness of the illegal market in the United States makes the problem especially difficult. The entire American heroin market could be satisfied from the production of 25 square miles of opium-producing land. Our efforts to prevent the growth of opium would have to be successful not only in areas such as Turkey, Iran, and India, where the governments have a reasonable degree of control over their populations, but also in areas such as Afghanistan and the Golden Triangle of Burma, Laos, and Thailand, where the plant is cultivated by tribes who are outside the control of any government.

3. ***The two-market approach.*** The most often advocated change in our heroin policy is to make it legal to supply heroin to addicts while keeping it illegal for the rest of the population. This is an attempt to divide heroin distribution into two distinct markets—one for addicts and one for nonaddicted users. The theory is that the drug should be made as expensive as possible for nonaddicts—the experimenters, the thrill seekers, the curious, and the weak—many of whom would eventually become addicted if they had access to cheap heroin. At the same time, heroin should be made as inexpensive as possible for the addict, whose demand for the drug remains constant within a wide price range and who must steal more to meet the price of the habit as the price rises. In creating a different price for each market, however, we are confronted with the textbook economics problem of "leakage" that faces any price-discriminating monopolist who wants to sell to different people at different prices. The problem would be to prevent addicts' need for money and their indifference to the criminal law from causing heroin to seep out of the low-priced addict market into the higher priced market for nonaddicts.

There are, in theory, several possible methods of giving addicts low-cost legal heroin and at the same time attempting to restrict resale into the nonaddict market. These methods are all loosely grouped under the general heading of "the British system," under which addiction is treated as a "medical problem."

The British system. The most obvious method of providing heroin for "addicts only" would be to have physicians or medical clinics determine the appropriate doses for addicts and give them the heroin to be used only in the presence of a dispensing agent. The major problem here is that the active life of heroin in the bloodstream is only about 6 hours. As a result, addicts would have to return to the dispensing authority several times a day. The resulting inconvenience would discourage them from accepting the heroin under these conditions and, even if they were prepared to do so, would make it almost impossible for them to lead any sort of normal lives—unless, of course, the number of dispensing authorities was extremely large. Although the problem of inconvenience would be reduced by having a dispensing clinic every few blocks in the neighborhoods inhabited by addicts, there would be other problems, including theft and diversion of the drug through corruption.

The system actually used in Britain has involved two major variations on this idea. Individual physicians were entrusted to prescribe the amounts they thought addicts needed to sustain their own habits. For some time this was effective—during the period when most British addicts became addicted because of medical treatment. They were not members of an addict subculture and were not likely to be criminally inclined.

This changed, however, around the mid-1960's when a relatively small number of American-style addicts began to appear in Britain. Their appearance, combined with a considerable degree of naiveté on the part of some British physicians, led in a short time to the destruction of the British system as it then existed. Physicians were too often tricked or otherwise induced into prescribing considerably more than these addicts needed. The addicts were not only prepared to sell their surplus but were able to find ready buyers among those previously unaddicted.

Between 1964 and 1968 the number of British addicts increased more than tenfold and, while the total number still amounted to fewer than 4,000, the trend was so alarming that the British government made major changes in the system. Although prescription of heroin to addicts continued, the prescribing power was moved from private physicians to clinics specifically set up for the purpose. These clinics were staffed by experts in heroin addiction who were considerably more suspicious of the addicts' stated requirements. The staff attempted to lower the addicts' dosages gradually so that eventually they could withdraw the addicts completely from opiates; the hope was

often in vain. After some years under this system, the British clinics gradually stopped prescribing heroin for the great majority of their clients. They have now switched over to methadone—a synthetic opiate developed in Germany during World War II—as a maintenance drug.

4. ***Methadone maintenance.*** Methadone is pharmacologically similar to heroin and hence blocks heroin withdrawal and prevents heroin use from becoming compulsive. Methadone, however, differs from heroin in three important ways. First, it can be taken orally far more easily than can heroin. Second, it can be prepared so that it can only be taken orally. Third, its effects last for a little over 24 hours—about four times as long as those of heroin. As a result, methadone, though equally addicting, is easier for the addict to take without experiencing the mood swings characteristic of the use of a short-acting drug by intravenous injection. Moreover, diversion is much less of a problem with respect to methadone since it is considerably easier for addicts to drink methadone mixed with orange juice once a day at a dispensing clinic than to report four times a day for heroin injections. After addicts are stabilized on methadone, they can be permitted to take several days' supply of the drug home with much less fear that they will be able to sell it illegally—at least at a price comparable to that of heroin. Even though the effects of methadone are less euphoric than those of heroin, and methadone is less appealing because it is impractical to inject, it still has value for addicts in staving off withdrawal symptoms.

Conclusions as to the efficacy of methadone maintenance under American conditions are still tentative. Treatment programs, which exist in almost all sizable cities, vary greatly. Some give all addicts methadone and provide virtually no other services. Others regard methadone merely as a method of "hooking" addicts so that they may be treated for their underlying psychological problems—both those antedating and those caused by their addiction. Finally, there are sizable variations in the reliability of data among programs.

A number of general statements may be made which seem to apply to most, if not all, of the methadone programs. Methadone maintenance "works" for around 30 or 40 percent of the addicts who undergo treatment. Moreover, the arrest rate of addicts drops dramatically when they enter methadone treatment. For instance, in one program where the addicts averaged two arrests per year before admission, the overall arrest rate of those who entered the program was reduced to about one-third of this figure, while among those who remained in the program at the time of the study, arrests had been cut to less than one-fifth the previous rate.

One may ask, then, why we cannot do better than this. As I have written elsewhere:

> There is no doubt, however, that methadone is not penicillin. Entirely apart from its inability to effect miracle cures, methadone maintenance suffers from another, more serious disadvantage.
>
> Typically, the patient with an infection has only that wrong with him; if that is cured, he is well again. The heroin addict, on the other hand, may labor under many additional handicaps to this social functioning—such as the lack of a high school diploma, functional illiteracy, the absence of a work record or any legitimate occupational skills, and the inability to receive help from any friends in a better position than his own. Whether or not these obstacles are traceable to his heroin addiction, they will remain after he ceases his heroin use...
>
> Probably the most important difference between methadone and penicillin, however, is the fact that, except for a very few allergic individuals, no one objects to being treated with penicillin. Though we may consider methadone a much better drug than heroin for the addict, he may prefer heroin, and hence not wish to be treated. Indeed, probably the greatest problem in making methadone maintenance more successful is that many addicts prefer their life on illegal heroin to that in methadone treatment.

There is no costless stable answer to the problem of heroin today in the United States. May be there will be one in the future—most likely at a time when, for reasons we do not understand, people lose interest in taking drugs for pleasure. Until then, we must simply do the best we can.

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Discussion Questions

1. Why are there so many heroin addicts in the United States?

2. Would legalizing heroin use substantially reduce the number of other crimes committed by addicts? What would be the consequences of such a move?

3. Should heroin, which is an especially effective painkiller, be made available for terminally ill patients for whom no legal painkiller is as effective?

4. Of the various policies advocated to attack heroin addiction, which do you prefer—legalization, more law enforcement, the "two-market approach," or increased treatment efforts?

5. What are the likely consequences of legalizing heroin?

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