Michigan Law Review

Volume 82 | Issue 4

1984

The Hardest Drug: Heroin and Public Policy

Michigan Law Review

THE HARDEST DRUG: HEROIN AND PUBLIC POLICY. By *John Kaplan.* Chicago and London: The University of Chicago Press. 1983. Pp. xi, 247. $20.

Heroin addiction is one of America's most dramatic and intractable social problems. Its cost, measured in terms of death, disease, crime and law enforcement resources, is staggering. One is tempted, therefore, to seek dramatic solutions to the problem. However, as John Kaplan's[1] thoughtful, lucid, and comprehensive book *The*

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Hardest Drug demonstrates, there is no easy answer. Kaplan's interdisciplinary study of the United States' current efforts to control the heroin supply, and his insightful analyses of alternatives to the present system, such as legalized heroin and heroin maintenance, is an important contribution to the current debate on heroin policy.[2] More important, Kaplan advances a reasonable proposal to combat the spread of addiction. He recommends expansion of the government's use of methadone maintenance, a modest but authentic policy shift that is likely to control addiction more effectively and at a lower cost than other proposals.

In the first part of *The Hardest Drug*, Kaplan explores what we know and don't know about heroin addiction and, in the process, dispels a number of popular "myths." For instance, addicts do not necessarily use heroin either continuously or permanently, contrary to the "once-an-addict-always-an-addict" myth. Addicts can and do detoxify for short periods, and a substantial number "burn-out" and give up the drug completely. Heroin withdrawal, often portrayed as excruciating and life-threatening, is actually no worse than "a bad case of the one-week flu" (p. 35). Kaplan also exposes the "myth of the pusher." Heroin addiction, he demonstrates, typically spreads from peer group to peer group in a series of mini-epidemics. Pushers in fact rarely deal with new users; handing out "free samples" of heroin is both uneconomical and likely to lead to detection (pp. 25-32). As for the belief that addiction can be "cured," Kaplan presents two responses. First, the notion of a "cure" suggests the presence of "disease." Heroin addiction is no more a "disease" than is habitual smoking or over-eating, regardless of what the Supreme Court may believe.[3] Second, cure is particularly difficult because of the psychologically and physiologically addictive properties of heroin (pp. 38-51). Finally, Kaplan confronts the view that addicts are responsible for a large amount of the property crime in the United States. Although many addicts are unable to hold steady jobs and therefore must steal to support their habits, Kaplan shows that many researchers have grossly overestimated the amount of crime attributable to addicts (pp. 51-58).

In the second part of his book, Kaplan scrutinizes the government's current efforts to deal with heroin use and addiction by

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is the author of MARIJUANA — THE NEW PROHIBITION (1970) and, with Jerome H. Skolnick, CRIMINAL JUSTICE (3d ed. 1982).

2. *See also* J. CALIFANO, JR., REPORT ON DRUG ABUSE AND ALCOHOLISM (1982); A. TREBACH, THE HEROIN SOLUTION (1982).

3. In Robinson v. California, 370 U.S. 660 (1962), the Supreme Court held that heroin addiction was a "disease" and therefore not punishable. However, a state is permitted to punish the "symptoms" of this "disease," possession and use of heroin. Kaplan states: "If we really thought heroin addiction were a disease, this would be as logical as punishing someone for running a temperature, while refusing to penalize him for having the flu." P. 42.

strictly prohibiting the drug and concentrating law enforcement efforts on restricting the available supply of heroin. The government has been moderately successful in intercepting large shipments of smuggled heroin and crushing entire distribution systems by apprehending all of the top organizers. However, further reductions in the heroin supply are possible only if we are willing to devote massive amounts of scarce law enforcement and criminal justice system resources to the cause. Kaplan also points out the "boomerang" effect of a widespread prohibition: heroin supply reductions inevitably lead to higher street prices which force addicts to commit additional crimes to support their habits. He concludes that, to some, the social costs of a fully enforced prohibition outweigh the benefits.

In the remainder of the book, Kaplan examines the possible alternatives to the current prohibition. Kaplan first considers free availability of heroin as an alternative; libertarians and others have suggested that heroin, like alcohol and tobacco, be made cheaply available. Although free availability would substantially reduce addict crime and eliminate the costs of enforcing the prohibition, Kaplan makes a convincing argument that it would also lead to an unacceptably large increase in addiction. It is impossible to make even a rough estimate of the potential increase in the number of addicts, but Kaplan's examples and statistics demonstrate that widespread availability of opiates would lead to higher rates of use and addiction (pp. 112-14). Kaplan is concerned, and rightly so, about the impact that widespread addiction would have on social productivity. He notes that "virtually all governments have taken the view that they do have the right to interfere in the distribution of drugs which might produce widespread unwillingness or inability to work" (p. 133).[4] It is unlikely that widespread cultural rules for moderate or controlled heroin use will be developed in time to prevent such an epidemic under the free availability system (p. 146). Since so little is known about the potential effects of free heroin access in a society like ours, Kaplan refuses to draw any conclusions as to whether this proposal is better than the current prohibition, but one is left with the distinct impression that the risks that Kaplan predicts are unacceptably high.

The second alternative to the present system, heroin maintenance, has been widely advocated.[5] Maintenance programs typically make heroin legally available to addicts while continuing to prohibit sales to all others. Many people think of this as the "British Sys-

4. Kaplan does not object to increased addiction on health grounds. He argues that under conditions of legal heroin availability addicts would probably be healthier than most tobacco and alcohol abusers. P. 131. *But see* Wilson, *The Fix*, NEW REPUBLIC, Oct. 25, 1982, at 24, 25-26.

5. P. 153. The most recent proposal, based on the British experience, appears in A. TREBACH, *supra* note 2.

tem," although as Kaplan correctly points out, the British abandoned prescribing heroin to addicts several years ago.[6] In economic terms, heroin maintenance attempts to separate the addict and non-addict markets: addicts, whose demand is high and inelastic, would pay a low, government subsidized, price; non-addicts, whose demand is low and elastic, would continue to pay a high street price. Thus, addict crime is reduced by lowering the cost of the habit, while the legal and practical obstacles to new user access are retained. Kaplan's analysis of heroin maintenance is unique in that he distinguishes between two possible methods of implementation — the prescription system and the on-the-premises system — and points out that the method chosen may drastically effect the costs of a maintenance program. The prescription system, which allows addicts to pick up heroin from the local pharmacy, has the primary disadvantage of giving the addicts the opportunity to resell some or all of their prescription on the black market. The more they sell, the more heroin maintenance begins to look like free availability, with all of its difficulties (p. 163). The on-the-premises system, which requires that addicts receive their injections at the clinic, prevents the "leakage" problems but creates its own difficulties. Since addicts demand injections at least four times a day to stave off withdrawal, the on-the-premises system would require that addicts constantly travel to and from a distant clinic (p. 173). In addition, either method of implementing heroin maintenance runs the risks of mistakenly enrolling non-addicts and of prolonging addiction for those who might otherwise have "burned out" (pp. 179-81). The present prohibition, with all its faults, is probably preferable to a heroin maintenance scheme.

Kaplan's own proposal to deal with addiction, while not as dramatic as legalized heroin or heroin maintenance, is undeniably reasonable. He suggests that the government should expand the use of methadone maintenance as a substitute for heroin addiction. Methadone, currently in use in addiction clinics, prevents the symptoms of heroin withdrawal and need be taken only once a day. The addict

6. Doctors in England have in the past been permitted to treat addicts by prescribing heroin. Until the early 1960's, England had an extremely small addiction problem, and the majority of addicts had been accidentally "hooked" during the course of medical treatment with opiates. P. 157. With the explosion of recreational heroin abuse among the young in the 1960's, the British decided to limit the number of doctors who could prescribe heroin to addicts to physicians who were specially licensed to prescribe the drug. The majority of these licensed physicians practiced in government addiction clinics. P. 158.

In 1968, 60-80% of the addicts in the British treatment clinics were prescribed heroin. By 1980, only 7% were still receiving the drug; the rest had been switched to methadone. G. STIMSON & E. OPPENHEIMER, HEROIN ADDICTION: TREATMENT AND CONTROL IN BRITAIN (1982); *see also* A. TREBACH, *supra* note 2, at 199. The British have, for all practical purposes, abandoned the notion of maintaining addicts on heroin. P. 159. Kaplan makes a convincing argument for the proposition that even the limited success of the British system in its early years could not be replicated in America. Pp. 159-61.

can stabilize his life (p. 213) and perhaps hold down permanent employment. Although methadone treatment has been fairly successful in reducing addict criminality and helping the addict to abstain permanently from both heroin and methadone, Kaplan realizes that there are numerous difficulties in enticing addicts into such treatment. Therefore, he proposes to coerce addicts into treatment by allowing them to choose between a jail sentence for a heroin use crime and a stint in an out-patient methadone treatment program. Kaplan contends that this approach would be more cost-effective than simple incarceration and, in addition, might convince some addicts to give up drug abuse entirely.

Coerced methadone maintenance does not carry with it the unknown and potentially large risks that accompany free availability and heroin maintenance, but neither is it likely to produce substantial benefits. Kaplan is unable to support his guess that enough coerced addicts will abstain to make his proposal more effective than simple prohibition. He simply concludes that the low cost of methadone treatment in comparison with incarceration makes his proposal worth a try (p. 230). That Kaplan, in the end, is not able to produce a guaranteed quick-fix or a sure-fire solution is not surprising. His attempt throughout is to demonstrate the complexity of the problem and reveal which critical variables are truly unknown. Heroin *is* the hardest drug in the sense that there are no easy answers.

Kaplan's analysis of heroin as a social problem is intelligent, exhaustively researched, and convincing. The author manages to consolidate studies and information from a variety of fields, and he uses common sense to fill in the gaps. *The Hardest Drug* is burdened with neither the unnecessary technicality nor the ideological coloring that afflicts much of the literature in this area. Policymakers and social scientists alike will benefit from Kaplan's contribution to this important and growing body of scholarship.