Drug War Facts

Compiled and Maintained by
Common Sense for Drug Policy

Facts by Topic

Common Sense for Drug Policy
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Dear Reader:

This booklet is a snapshot of the current ***Drug War Facts,*** which is updated regularly and available on the Internet at: www.drugwarfacts.org

Drug War Facts addresses important criminal justice and public health issues.

Our mission is to offer useful facts with citations from authoritative sources to a debate which is often characterized by myths, error and emotion. We believe an informed society will generate wise policies over time.

For this revised edition, Doug McVay, Research Director, has added material from a variety of sources as well as updated certain data that appeared in earlier editions.

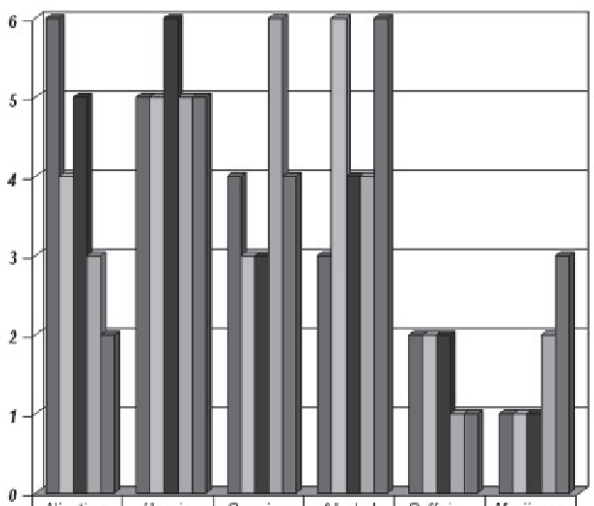
Questions, comments or suggestions for additions and modifications may be addressed to Doug McVay at the address above or via email at **dmcvay@drugwarfacts.org.**

Sincerely,

Robert E. Field, *Co-Chairman*

A

Addictive Qualities of Popular Drugs



	Nicotine	Heroin	Cocaine	Alcohol	Caffeine	Marijuana
Dependence	6	5	4	3	2	1
Withdrawal	4	5	3	6	2	1
Tolerance	5	6	3	4	2	1
Reinforcement	3	5	6	4	1	2
Intoxication	2	5	4	6	1	3

(Higher Number = Greater Effect)

WITHDRAWAL: Presence and severity of characteristic withdrawal symptoms.

REINFORCEMENT: A measure of the substance's ability, in human and animal tests, to get users to take it again and again, and in preference to other substances.

TOLERANCE: How much of the substance is needed to satisfy increasing cravings for it, and the level of stable need that is eventually reached.

DEPENDENCE: How difficult it is for the user to quit, the relapse rate, the percentage of people who eventually become dependent, the rating users give their own need for the substance and the degree to which the substance will be used in the face of evidence that it causes harm.

INTOXICATION: Though not usually counted as a measure of addiction in itself, the level of intoxication is associated with addiction and increases the personal and social damage a substance may do.

Source: Jack E. Henningfield, PhD for NIDA, Reported by Philip J. Hilts, New York Times, Aug. 2, 1994 "Is Nicotine Addictive? It Depends on Whose Criteria You Use."

B

Adolescents

1. **A federal report by the U.S. Center on Substance Abuse Prevention stated that "alternatives programming appears to be most effective among those youth at greatest risk for substance abuse and related problems." According to the report, alternatives are defined as "those that provide targeted populations with activities that are free of alcohol, tobacco, and illicit drugs."**

   Source: Maria Carmona and Kathryn Stewart, A Review of Alternative Activities and Alternatives Programs in Youth-Oriented Prevention (National Center for the Advancement of Prevention, under contract for the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention, 1996), p. 21, 3.

2. **Despite the fact that federal spending on the drug war increased from $1.65 billion in 1982 to $17.7 billion in 1999, more than half of the students in the United States in 1999 tried an illegal drug before they graduated from high school. Additionally, 65% have tried cigarettes by 12th grade and 35% are current smokers, and 62% of twelfth graders and 25% of 8th graders in 1999 report having been drunk at least once.**

   Source: Office of National Drug Control Policy, National Drug Control Strategy: Budget Summary (Washington DC: US Government Printing Office, 1992), pp. 212-214; Office of National Drug Control Policy, National Drug Control Strategy: 2000 Annual Report (Washington, DC: US Government Printing Office, 2000), p. 97, Table 4-2; Johnston, L., Bachman, J. & O'Malley, P., Monitoring the Future: National Results on Adolescent Drug Use Overview of Key Findings 1999, (Washington, DC: NIDA, 2000), pp. 3-6.

3. **Federal research shows that the ONDCP's anti-drug media campaign is ineffective. According to NIDA's 1998 Household Survey, exposure to prevention messages outside school, such as through the media, was fairly widespread but appeared to be unrelated to illicit drug use or being drunk. NIDA goes on to report that nearly 80% of youths who used illicit drugs and more than three-fourths of youths who were drunk on 51 or more days in the past year reported being exposed to prevention messages outside school.**

   Source: Office of Applied Studies, National Institute on Drug Abuse, National Household Survey on Drug Abuse: Main Findings 1998 (Rockville, MD: SAMHSA, US Department of Health and Human Services, March 2000), p. 174.

4. **Every year from 1975 to 1998, at least 82% of high school seniors surveyed have said they find marijuana fairly easy or very easy to obtain. In 1999, 88.9% of high school seniors said it was fairly or very easy to obtain.**

   Source: Johnston, L., Bachman, J. & O'Malley, P., Monitoring the Future: National Results on Adolescent Drug Use Overview of Key Findings 1999 (Washington DC: NIDA, 2000), p. 48, Table 6; online version of MTF survey.

Adolescents

5. The Center on Addiction and Substance Abuse reports that teenagers consider marijuana even easier to obtain than beer.

Source: Luntz Research Companies, National Survey of American Attitudes on Substance Abuse II: Teens and Their Parents (New York, NY: National Center on Addiction and Substance Abuse at Columbia University, 1996), Foreword by Joseph Califano.

6. "Our results are consistent in documenting the absence of beneficial effects associated with the DARE program. This was true whether the outcome consisted of actual drug use or merely attitudes toward drug use. In addition, we examined processes that are the focus of intervention and purportedly mediate the impact of DARE (e.g., self-esteem and peer resistance), and these also failed to differentiate DARE participants from nonparticipants. Thus, consistent with the earlier Clayton et al. (1996) study, there appear to be no reliable short-term, long-term, early adolescent, or young adult positive outcomes associated with receiving the DARE intervention."

Source: Lynam, Donald R., Milich, Richard, et al., "Project DARE: No Effects at 10-Year Follow-Up", Journal of Consulting and Clinical Psychology (Washington, DC: American Psychological Association, August 1999), Vol. 67, No. 4, 590-593.

7. A federally funded Research Triangle Institute study of Drug Abuse Resistance Education (DARE) found that "DARE's core curriculum effect on drug use relative to whatever drug education (if any) was offered in the control schools is slight and, except for tobacco use, is not statistically significant."

Source: Ennett, S.T., et al., "How Effective Is Drug Abuse Resistance Education? A Meta-Analysis of Project DARE Outcome Evaluations," American Journal of Public Health, 84: 1394-1401 (1994).

8. Dr. Dennis Rosenbaum, a professor at the University of Illinois at Chicago, recently completed a six-year study of 1,798 students and found that "DARE had no long-term effects on a wide range of drug use measures"; DARE does not "prevent drug use at the stage in adolescent development when drugs become available and are widely used, namely during the high school years"; and that DARE may actually be counter-productive. According to the study, "there is some evidence of a boomerang effect among suburban kids. That is, suburban students who were DARE graduates scored higher than suburban students in the Control group on all four major drug use measures."

Source: Rosenbaum, Dennis, Assessing the Effects of School-based Drug Education: A Six Year Multilevel Analysis of Project DARE, Abstract (April 6, 1998).

B

Adolescents

9. A federal report by the U.S. Center on Substance Abuse Prevention noted that "adolescence is a period in which youth reject conventionality and traditional authority figures in an effort to establish their own independence. For a significant number of adolescents, this rejection consists of engaging in a number of 'risky' behaviors, including drug and alcohol use. Within the past few years, researchers and practitioners have begun to focus on this tendency, suggesting that drug use may be a 'default' activity engaged in when youth have few or no opportunities to assert their independence in a constructive manner."

Source: Maria Carmona and Kathryn Stewart, A Review of Alternative Activities and Alternatives Programs in Youth-Oriented Prevention (National Center for the Advancement of Prevention, under contract for the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention, 1996), p. 5.

10. The World Health Organization noted that, while some studies indicate that adolescents who use marijuana might be more likely to drop out of high school and experience job instability in young adulthood, "the apparent strength of these cross-sectional studies … has been exaggerated because those adolescents who are most likely to use cannabis have lower academic aspirations and poorer high school performance prior to using cannabis, than their peers who do not."

Source: Hall, W., Room, R., & Bondy, S., WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use August 28, 1995 (Geneva, Switzerland: World Health Organization, 1998).

11. The Bureau of Justice Statistics reports that in general, the heavier the alcohol use, the more likely an adolescent will be involved with criminal behaviors.

Source: Greenblatt, Janet C., US Department of Justice, Bureau of Justice Statistics, Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems (Washington, DC: US Department of Justice, March 2000), p. 6.

12. Even after controlling for other factors (e.g., age, gender, family structure, income, past month marijuana use, etc.), there is "a relationship between past month alcohol use and emotional and behavioral problems. The relationships were particularly strong among heavy and binge alcohol use and delinquent, aggressive, and criminal behaviors."

Source: Greenblatt, Janet C., US Department of Justice, Bureau of Justice Statistics, Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems (Washington, DC: US Department of Justice, March 2000), p. 9.

Adolescents

13. The Bureau of Justice Statistics estimates that 2.8% of all children under age 18 have at least one parent in a local jail or a State or Federal prison – a total of 1,941,796 kids. One in 40 have an incarcerated father, and 1 in 359 have an incarcerated mother.

Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), p. 8, Table 18.

14. "Of the Nation's 72.3 million minor children in 1999, 2.1% had a parent in State or Federal prison. Black children (7.0%) were nearly 9 times more likely to have a parent in prison than white children (0.8%). Hispanic children (2.6%) were 3 times as likely as white children to have an inmate parent."

Source: Mumola, Christopher J., US Department of Justice Bureau of Justice Statistics, Incarcerated Parents and Their Children (Washington, DC: US Department of Justice, August 2000), p.2.

15. "A majority of parents in both State (62%) and Federal (84%) prison were held more than 100 miles from their last place of residence."

Source: Mumola, Christopher J., US Department of Justice Bureau of Justice Statistics, Incarcerated Parents and Their Children (Washington, DC: US Department of Justice, August 2000), p.2.

16. "The number of offenders under age 18 admitted to prison for drug offenses increased twelvefold (from 70 to 840) between 1985 to 1997. By 1997 drug offenders made up 11% of admissions among persons under 18 compared to 2% in 1985."

Source: Strom, Kevin J., US Department of Justice, Bureau of Justice Statistics, Profile of State Prisoners Under Age 18, 1985-1997 (Washington, DC: US Department of Justice, February 2000), p. 4.

17. Fifty-eight percent of offenders under 18 years of age admitted to prison in 1997 were black and 25% were white. In 1990, African-American youth comprised 61% of admissions and whites 21%. Still, the shift from 1985 to 1990 was more dramatic: During this period the percentage of African-American young people put in prison increased from 53% to 62%, and the percentage of whites fell from 32% to 21%.

Source: Strom, Kevin J., US Department of Justice, Bureau of Justice Statistics, Profile of State Prisoners Under Age 18, 1985-1997 (Washington, DC: US Department of Justice, February 2000), p. 6.

Common Sense for Drug Policy Presents The Facts:
Adolescents

Alcohol and Crime

C

1. **According to the federal Household Survey, there are more than 48 million Americans who use alcohol an average of one or more days each week of the year. This is more than the combined total number of Americans who have ever tried cocaine, crack, and/or heroin (29.7 million), and two and a half times the number of Americans who have used marijuana once in the last year (18.7 million).**

   Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, National Household Survey on Drug Abuse: Population Estimates 1998 (Washington DC: US Department of Health and Human Services, 1999), pp. 19, 25, 31, 37, 85, 91, 105.

2. **On an average day in 1996, an estimated 5.3 million convicted offenders were under the supervision of criminal justice authorities. Nearly 40% of these offenders, about 2 million, had been using alcohol at the time of the offense for which they were convicted.**

   Source: Greenfield, Lawrence A., US Department of Justice, Bureau of Justice Statistics, Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime (Washington, DC: US Department of Justice, April, 1998), p. 20.

3. **About 6 in 10 convicted jail inmates said that they had been drinking on a regular basis during the year before the offense for which they were serving time. Nearly 2 out of 3 of these inmates, regardless of whether they drank daily or less often, reported having previously been in a treatment program for an alcohol dependency problem.**

   Source: Greenfield, Lawrence A., US Department of Justice, Bureau of Justice Statistics, Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime (Washington, DC: US Department of Justice, April, 1998), p. 27.

4. **About a quarter of the women on probation nationwide had been drinking at the time of their offense compared to more than 40% of male probationers (figure 30). For those convicted of public-order crimes, nearly two-thirds of women and three-quarters of men had been drinking at the time of the offense.**

   Source: Greenfield, Lawrence A., US Department of Justice, Bureau of Justice Statistics, Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime (Washington, DC: US Department of Justice, April, 1998), p. 24.

5. **For more than 4 in 10 convicted murderers being held either in jail or in State prison, alcohol use is reported to have been a factor in the crime. Nearly half of those convicted of assault and sentenced to probation had been drinking when the offense occurred.**

   Source: Greenfield, Lawrence A., US Department of Justice, Bureau of Justice Statistics, Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime (Washington, DC: US Department of Justice, April, 1998), p. 21.

Alcohol and Crime

For a more complete perspective, also read related Drug War Facts sections on Comparative Dangers of Drugs, Crack, Drug Use Estimates, Gateway Theory, Marijuana, The Netherlands, Prison, Race and Prison, and Treatment.

Common Sense for Drug Policy Presents The Facts:
Alcohol and Crime

Annual Causes of Deaths in the US

D

Tobacco (Average 1990 - 94):	430,700[1]
Alcohol (1996):	110,640[2]
Adverse Reactions to Prescription Drugs (1982/1998):	32,000[3]
Suicide (1998):	30,575[4]
Homicide (198):	18,272[5]
All licit and illicit drug-induced deaths (1998):	16,926[6]
Non-Steroidal Anti-Inflammatory Drugs (1992):	7,600[7]
Marijuana:	0[8]

1. **According to the US Centers for Disease Control, from the beginning of 1990 through 1994 "2,153,700 deaths (1,393,200 men and 760,400 women; total annual average: 430,700 deaths) were attributed to smoking (19.5% of all deaths)." The CDC notes that "Cigarette smoking remains the leading preventable cause of death in the United States."**

   Source: "Smoking-Attributable Mortality and Years of Potential Life Lost," Morbidity and Mortality Weekly Report (Atlanta, GA: Centers for Disease Control, 1997), May 23, 1997, Vol. 46, No. 20, p. 449.

2. **According to the federal National Institute on Alcohol Abuse and Alcoholism, in 1996 an estimated 110,640 people in the US died due to alcohol.**

   Source: "Number of deaths and age-adjusted death rates per 100,000 population for categories of alcohol-related (A-R) mortality, United States and States, 1979-96," National Institute on Alcohol Abuse and Alcoholism, from the web at http://silk.nih.gov/silk/niaaa1/database/armort01.txt , last accessed Feb. 12, 2001, citing Alcohol Epidemiologic Data System, Saadatmand, F, Stinson, FS, Grant, BF, and Dufour, MC, "Surveillance Report #52: Liver Cirrhosis Mortality in the United States, 1970-96" (Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, Division of Biometry and Epidemiology, December 1999).

3. **According to Canadian researchers, approximately 32,000 hospitalized patients (and possibly as many as 106,000) in the USA die each year because of adverse reactions to their prescribed medications.**

   Source: Lazarou, J, Pomeranz, BH, Corey, PN, "Incidence of adverse drug reactions in hospitalized patients: a meta-analysis of prospective studies," Journal of the American Medical Association (Chicago, IL: American Medical Association, 1998), 1998;279:1200-1205, also letters column, "Adverse Drug Reactions in Hospitalized Patients,", JAMA (Chicago, IL: AMA, 1998), Nov. 25, 1998, Vol. 280, No. 20, from the web at http://jama.ama-assn.org/issues/v280n20/full/jlt1125-1.html , last accessed Feb. 12, 2001.

4. **The US Centers for Disease Control reports that in 1998, there were a total of 30,575 deaths from suicide in the US.**

   Source: Murphy, Sheila L., "Deaths: Final Data for 1998,"National Vital Statistics Reports, Vol. 48, No. 11 (Hyattsville, MD: National Center for Health Statistics, July 24, 2000), Table 10, p. 53.

5. **The US Centers for Disease Control reports that in 1998, there were a total of 18,272 deaths from homicide in the US.**

Annual Causes of Deaths in the US

Source: Murphy, Sheila L., "Deaths: Final Data for 1998,"National Vital Statistics Reports, Vol. 48, No. 11 (Hyattsville, MD: National Center for Health Statistics, July 24, 2000), Table 10, p. 53.

D

6. "In 1998 a total of 16,926 persons died of drug-induced causes in the United States (Table 20). The category 'drug-induced causes' includes not only deaths from dependent and nondependent use of drugs (legal and illegal use), but also poisoning from medically prescribed and other drugs. It excludes accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths due to mother's drug use." The total number of deaths in the US in 1998 was 2,337,256.

Source: Murphy, Sheila L., "Deaths: Final Data for 1998," National Vital Statistics Reports, Vol. 48, No. 11 (Hyattsville, MD: National Center for Health Statistics, July 24, 2000), pp. 1, 10.

7. "Each year, use of NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) accounts for an estimated 7,600 deaths and 76,000 hospitalizations in the United States." (NSAIDs include aspirin, ibuprofen, naproxen, diclofenac, ketoprofen, and tiaprofenic acid.)

Source: Robyn Tamblyn, PhD; Laeora Berkson, MD, MHPE, FRCPC; W. Dale Dauphinee, MD, FRCPC; David Gayton, MD, PhD, FRCPC; Roland Grad, MD, MSc; Allen Huang, MD, FRCPC; Lisa Isaac, PhD; Peter McLeod, MD, FRCPC; and Linda Snell, MD, MHPE, FRCPC, "Unnecessary Prescribing of NSAIDs and the Management of NSAID-Related Gastropathy in Medical Practice," Annals of Internal Medicine (Washington, DC: American College of Physicians, 1997), September 15, 1997, 127:429-438, from the web at http://www.acponline.org/journals/annals/15sep97/nsaid.htm , last accessed Feb. 14, 2001, citing Fries, JF, "Assessing and understanding patient risk," Scandinavian Journal of Rheumatology Supplement, 1992;92:21-4.

8. An exhaustive search of the literature finds no deaths induced by marijuana. The US Drug Abuse Warning Network (DAWN) records instances of drug mentions in medical examiners' reports, and though marijuana is mentioned, it is usually in combination with alcohol or other drugs. Marijuana alone has not been shown to cause an overdose death.

Sources: Drug Abuse Warning Network (DAWN), available on the web at http://www.samhsa.gov/ ; also see Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr., Marijuana and Medicine: Assessing the Science Base. Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999, available on the web at http://www.nap.edu/html/marimed/ ; and US Department of Justice, Drug Enforcement Administration, "In the Matter of Marijuana Rescheduling Petition" (Docket #86-22), September 6, 1988, p. 57.

Common Sense for Drug Policy Presents The Facts:
Annual Causes of Deaths in the US

Civil and Human Rights

E

1. **In 1999, 1,350 wiretaps were authorized by state and Federal courts. Of these, 978 – a total of 72.4% — were for drug investigations, 139 (10.3%) were for racketeering, 60 (4.4%) were for gambling, 62 (4.6%) were for homicide or assault, and only 7 – about half a percent – were for kidnapping.**

   Source: Administrative Office of the United States Courts, 1999 Wiretap Report (Washington, DC: USGPO, 2000), p. 17.

2. **Contrary to international standards, prisons and jails in the USA employ men to guard women and place relatively few restrictions on the duties of male staff. As a consequence, much of the touching and viewing their bodies by staff that women experience as shocking and humiliating is permitted by law.**

   Source: Amnesty International, "Not Part of My Sentence: Violations of the Human Rights of Women in Custody" (Washington, DC: Amnesty International, March 1999), p. 39.

3. **Retaliation for reports of abuse impedes women's access to protection of their human rights. One woman who won a lawsuit against the Federal Bureau of Prisons for sexual abuse reported that she was beaten, raped and sodomized by three men who in the course of the attack told her that they were attacking her in retaliation for providing a statement to investigators.**

   Source: Amnesty International, "Not Part of My Sentence: Violations of the Human Rights of Women in Custody" (Washington, DC: Amnesty International, March 1999), p. 59.

4. **Nationwide, one in every 20 black men over the age of 18 is in prison. In five states, between one in 13 and one in 14 black men is in prison. This compares to one in 180 white men.**

   Source: Human Rights Watch, Racial Disparities in the War on Drugs (Washington, DC: Human Rights Watch, 2000), from their website at *http://www.hrw.org/campaigns/drugs/war/key-facts.htm*

5. **Nationwide, black men are sent to prison on drug charges at 13 times the rate of white men.**

   Source: Human Rights Watch, Racial Disparities in the War on Drugs (Washington, DC: Human Rights Watch, 2000), from their website at *http://www.hrw.org/campaigns/drugs/war/key-facts.htm*

6. **"Most drug offenders are white. Five times as many whites use drugs as blacks. But blacks comprise the great majority of drug offenders sent to prison. The solution to this racial inequity is not to incarcerate more whites, but to reduce the use of prison for low-level drug offenders and to increase the availability of substance abuse treatment."**

   Source: Human Rights Watch, Racial Disparities in the War on Drugs (Washington, DC: Human Rights Watch, 2000), from their website at http://www.hrw.org/campaigns/drugs/war/key-facts.htm

7. The Mollen Commission was appointed to investigate corruption in the New York City Police Department. The Commission "found that police corruption, brutality, and violence were present in every high-crime precinct with an active narcotics trade that it studied, all of which have predominantly minority populations. It found disturbing patterns of police corruption and brutality, including stealing from drug dealers, engaging in unlawful searches, seizures, and car stops, dealing and using drugs, lying in order to justify unlawful searches and arrests and to forestall complaints of abuse, and indiscriminate beating of innocent and guilty alike."

Source: Cole, David, No Equal Justice: Race and Class in the American Criminal Justice System (New York: The New Press, 1999), pp 23-24.

8. In his book No Equal Justice, Georgetown Law Professor David Cole notes "The (Supreme) Court's removal of meaningful Fourth Amendment review allows the police to rely on unparticularized discretion, unsubstantiated hunches, and nonindividualized suspicion. Racial prejudice and stereotypes linking racial minorities to crime rush to fill the void."

Source: Cole, David, No Equal Justice: Race and Class in the American Criminal Justice System (New York: The New Press, 1999), p. 53.

9. In Maryland, a state survey of police traffic stops — ordered by the state court in response to state troopers' use of racial profiling — found that from January 1995 through December 1997, 70 percent of the drivers stopped on Interstate 95 were African Americans. According to an ACLU survey conducted around that time, only 17.5 percent of the traffic and speeders on that road were African American.

Source: Cole, David, No Equal Justice: Race and Class in the American Criminal Justice System (New York: The New Press, 1999), p. 36.

10. In his book No Equal Justice, Georgetown Law Professor David Cole notes, "A Lexis review of all federal court decisions from January 1, 1990, to August 2, 1995, in which drug-courier profiles were used and the race of the suspect was discernible revealed that of sixty-three such cases, all but three suspects were minorities: thirty-four were black, twenty-five were Hispanic, one was Asian, and three were white."

Source: Cole, David, No Equal Justice: Race and Class in the American Criminal Justice System (New York: The New Press, 1999), p. 50.

11. The report Justice on Trial from the Leadership Conference on Civil Rights notes that though "blacks are just 12 percent of the population and 13 percent of the drug users, and despite the fact

that traffic stops and similar enforcement yield equal arrest rates for minorities and whites alike, blacks are 38 percent of those arrested for drug offenses and 59 percent of those convicted of drug offenses. Moreover, more frequent stops, and therefore arrests, of minorities will also result in longer average prison terms for minorities because patterns of disproportionate arrests generate more extensive criminal histories for minorities, which in turn influence sentencing outcomes."

Source: Welch, Ronald H., and Angulo, Carlos T., Leadership Conference on Civil Rights, Justice on Trial: Racial Disparities in the American Criminal Justice System (Washington, DC: Leadership Conference on Civil Rights, May 2000), p. 7.

12. **"Black and Hispanic Americans, and other minority groups as well, are victimized by disproportionate targeting and unfair treatment by police and other front-line law enforcement officials; by racially skewed charging and plea bargaining decisions of prosecutors; by discriminatory sentencing practices; and by the failure of judges, elected officials and other criminal justice policy makers to redress the inequities that become more glaring every day."**

Source: Welch, Ronald H., and Angulo, Carlos T., Leadership Conference on Civil Rights, Justice on Trial: Racial Disparities in the American Criminal Justice System (Washington, DC: Leadership Conference on Civil Rights, May 2000), p. vi.

For a more complete perspective, read Drug War Facts sections on Alcohol, Crack, Drug Use Estimates, Prison, Race and Prison, and Women.

Common Sense for Drug Policy Presents The Facts:
Civil and Human Rights

Cocaine and Crack

1. **"The major routes of administration of cocaine are sniffing or snorting, injecting, and smoking (including free-base and crack cocaine). Snorting is the process of inhaling cocaine powder through the nose where it is absorbed into the bloodstream through the nasal tissues. Injecting is the act of using a needle to release the drug directly into the bloodstream. Smoking involves inhaling cocaine vapor or smoke into the lungs where absorption into the bloodstream is as rapid as by injection."**

   Source: National Institute on Drug Abuse, Infofax: Cocaine No. 13546 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/cocaine.html last accessed November 16, 2000.

2. **" 'Crack' is the street name given to cocaine that has been processed from cocaine hydrochloride to a free base for smoking. Rather than requiring the more volatile method of processing cocaine using ether, crack cocaine is processed with ammonia or sodium bicarbonate (baking soda) and water and heated to remove the hydrochloride, thus producing a form of cocaine that can be smoked. The term 'crack' refers to the crackling sound heard when the mixture is smoked (heated), presumably from the sodium bicarbonate."**

   Source: National Institute on Drug Abuse, Infofax: Cocaine No. 13546 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/cocaine.html last accessed November 16, 2000.

3. **"Although most cocaine in the USA is snorted intranasally, smoking crack cocaine has become widely publicized. The imported hydrochloride salt is converted to a more volatile form, usually by adding sodium bicarbonate, water, and heat. The converted material is combusted, and the resultant smoke inhaled. Onset of effect is quicker, and intensity of the 'high' is magnified. Use of crack by the urban poor and the criminal market for crack have become the most feared problems of drug abuse. Despite frequent predictions, crack use has not expanded to the suburbs or the urban middle class. Its continued use still occurs primarily in poor Americans."**

   Source: "Cocaine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195f.htm last accessed November 30, 2000.

4. **"There is great risk whether cocaine is ingested by inhalation (snorting), injection, or smoking. It appears that compulsive cocaine use may develop even more rapidly if the substance is smoked rather than snorted. Smoking allows extremely high doses of cocaine to reach the brain very quickly and brings an intense and immediate high. The injecting drug user is at risk for transmitting or acquiring HIV infection/AIDS if needles or other injection equipment are shared."**

Cocaine and Crack

Source: National Institute on Drug Abuse, Infofax: Cocaine No. 13546 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/cocaine.html last accessed November 16, 2000.

F

5. **"Some users of cocaine report feelings of restlessness, irritability, and anxiety. An appreciable tolerance to the high may be developed, and many addicts report that they seek but fail to achieve as much pleasure as they did from their first exposure. Scientific evidence suggests that the powerful neuropsychologic reinforcing property of cocaine is responsible for an individual's continued use, despite harmful physical and social consequences. In rare instances, sudden death can occur on the first use of cocaine or unexpectedly thereafter. However, there is no way to determine who is prone to sudden death."**

   Source: National Institute on Drug Abuse, Infofax: Cocaine No. 13546 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/cocaine.html last accessed November 16, 2000.

6. **"Because cocaine is very short acting, heavy users may inject it IV or smoke it q 10 to 15 min. This repetition produces toxic effects, such as tachycardia, hypertension, mydriasis, muscle twitching, sleeplessness, and extreme nervousness. If hallucinations, paranoid delusions, and aggressive behavior develop, the person may be dangerous. Pupils are maximally dilated, and the drug's sympathomimetic effect increases heart and respiration rates and BP."**

   Source: "Cocaine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195f.htm last accessed November 30, 2000.

7. **"An overdose of cocaine may produce tremors, convulsions, and delirium. Death may occur due to arrhythmias and cardiovascular failure."**

   Source: "Cocaine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195f.htm last accessed November 30, 2000.

8. **"When people mix cocaine and alcohol consumption, they are compounding the danger each drug poses and unknowingly forming a complex chemical experiment within their bodies. NIDA-funded researchers have found that the human liver combines cocaine and alcohol and manufactures a third substance, cocaethylene, that intensifies cocaine's euphoric effects, while possibly increasing the risk of sudden death."**

   Source: National Institute on Drug Abuse, Infofax: Cocaine No. 13546 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/cocaine.html last accessed November 16, 2000.

Cocaine and Crack

9. Research funded by the National Institute on Drug Abuse (NIDA) and the Albert Einstein Medical Center in Philadelphia states: "Although numerous animal experiments and some human data show potent effects of cocaine on the central nervous system, we were unable to detect any difference in Performance, Verbal or Full Scale IQ scores between cocaine-exposed and control children at age 4 years."

Source: Hallam Hurt, MD; Elsa Malmud, PhD; Laura Betancourt; Leonard E. Braitman, PhD; Nancy L. Brodsky, Phd; Joan Giannetta, "Children with In Utero Cocaine Exposure Do Not Differ from Control Subjects on Intelligence Testing," Archives of Pediatrics & Adolescent Medicine, Vol. 151: 1237-1241 (American Medical Association, 1997).

10. Well-controlled studies find minimal or no increased risk of Sudden Infant Death Syndrome (SIDS) among cocaine-exposed infants.

Sources: Bauchner, H., Zuckerman, B., McClain, M., Frank, D., Fried, L.E., & Kayne, H., "Risk of Sudden Infant Death Syndrome among Infants with In Utero Exposure to Cocaine," Journal of Pediatrics, 113: 831-834 (1988). (Note: Early studies reporting increased risk of SIDS did not control for socioeconomic characteristics and other unhealthy behaviors. See, e.g., Chasnoff, I.J., Hunt, C., & Kletter, R., et al., "Increased Risk of SIDS and Respiratory Pattern Abnormalities in Cocaine-Exposed Infants," Pediatric Research, 20: 425A (1986); Riley, J.G., Brodsky, N.L. & Porat, R., "Risk for SIDS in Infants with In Utero Cocaine Exposure: a Prospective Study," Pediatric Research, 23: 454A (1988)).

11. Among the general population there has been no detectable increase in birth defects which may be associated with cocaine use during pregnancy.

Source: Martin, M.L., Khoury, M.J., Cordero, J.F. & Waters, G.D., "Trends in Rates of Multiple Vascular Disruption Defects, Atlanta, 1968-1989: Is There Evidence of a Cocaine Teratogenic Epidemic?" Teratology, 45: 647-653 (1992).

12. The lack of quality prenatal care is associated with undesirable effects often attributed to cocaine exposure: prematurity, low birth weight, and fetal or infant death.

Sources: Klein, L., & Goldenberg, R.L., "Prenatal Care and its Effect on Pre-Term Birth and Low Birth Weight," in Merkatz, I.R. & Thompson, J.E. (eds.), New Perspectives on Prenatal Care (New York, NY: Elsevier, 1990), pp. 511-513; MacGregor, S.N., Keith, L.G., Bachicha, J.A. & Chasnoff, I.J., "Cocaine Abuse during Pregnancy: Correlation between Prenatal Care and Perinatal Outcome," Obstetrics and Gynecology, 74: 882-885 (1989).

13. "The proportion of high school seniors who have used cocaine at least once in their lifetimes has increased from a low of 5.9 percent in 1994 to 9.8 percent in 1999. However, this is lower than its peak of 17.3 percent in 1985. Current (past month) use of cocaine by seniors decreased from a high of 6.7 percent in 1985 to 2.6 percent in 1999. Also in 1999, 7.7 percent of 10th-graders had tried cocaine at least once, up from a low of 3.3 percent in 1992. The percentage of 8th-graders who had ever tried cocaine has increased from a low of 2.3 percent in 1991 to 4.7 percent in 1999."

Source: National Institute on Drug Abuse, Infofax: Cocaine No. 13546 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/cocaine.html last accessed November 16, 2000.

14. "Of college students 1 to 4 years beyond high school, in 1995, 3.6 percent had used cocaine within the past year, and 0.7 percent had used cocaine in the past month."

Source: National Institute on Drug Abuse, Infofax: Cocaine No. 13546 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/cocaine.html last accessed November 16, 2000.

15. "In 1998, about 1.7 million Americans were current (at least once per month) cocaine users. This is about 0.8 percent of the population age 12 and older; about 437,000 of these used crack. The rate of current cocaine use in 1998 was highest among Americans ages 18 to 25 (2.0 percent). The rate of use for this age group was significantly higher in 1998 than in 1997, when it was 1.2 percent."

Source: National Institute on Drug Abuse, Infofax: Cocaine No. 13546 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/cocaine.html last accessed November 16, 2000.

16. "Discontinuing sustained use of cocaine requires considerable assistance, and the depression that may result requires close supervision and treatment. Many nonspecific therapies, including support and self-help groups and cocaine hot lines, exist. Extremely expensive inpatient therapy is available."

Source: "Cocaine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195f.htm last accessed November 30, 2000.

Common Sense for Drug Policy Presents The Facts:
Cocaine and Crack

Cocaine and Pregnancy ("Crack Babies")

1. **Research funded by the National Institute on Drug Abuse (NIDA) and the Albert Einstein Medical Center in Philadelphia states, "Although numerous animal experiments and some human data show potent effects of cocaine on the central nervous system, we were unable to detect any difference in Performance, Verbal or Full Scale IQ scores between cocaine-exposed and control children at age 4 years."**

   Source: Hallam Hurt, MD; Elsa Malmud, PhD; Laura Betancourt; Leonard E. Braitman, PhD; Nancy L. Brodsky, Phd; Joan Giannetta, "Children with In Utero Cocaine Exposure Do Not Differ from Control Subjects on Intelligence Testing," Archives of Pediatrics & Adolescent Medicine, Vol. 151: 1237-1241 (American Medical Association, 1997).

2. **Well-controlled studies find minimal or no increased risk of Sudden Infant Death Syndrome (SIDS) among cocaine-exposed infants.**

   Sources: Bauchner, H., Zuckerman, B., McClain, M., Frank, D., Fried, L.E., & Kayne, H., "Risk of Sudden Infant Death Syndrome among Infants with In Utero Exposure to Cocaine," Journal of Pediatrics, 113: 831-834 (1988). (Note: Early studies reporting increased risk of SIDS did not control for socioeconomic characteristics and other unhealthy behaviors. See, e.g., Chasnoff, I.J., Hunt, C., & Kletter, R., et al., "Increased Risk of SIDS and Respiratory Pattern Abnormalities in Cocaine-Exposed Infants," Pediatric Research, 20: 425A (1986); Riley, J.G., Brodsky, N.L. & Porat, R., "Risk for SIDS in Infants with In Utero Cocaine Exposure: a Prospective Study," Pediatric Research, 23: 454A (1988)).

3. **Among the general population there has been no detectable increase in birth defects which may be associated with cocaine use during pregnancy.**

   Source: Martin, M.L., Khoury, M.J., Cordero, J.F. & Waters, G.D., "Trends in Rates of Multiple Vascular Disruption Defects, Atlanta, 1968-1989: Is There Evidence of a Cocaine Teratogenic Epidemic?" Teratology, 45: 647-653 (1992).

4. **The lack of quality prenatal care is associated with undesirable effects often attributed to cocaine exposure: prematurity, low birth weight, and fetal or infant death.**

   Sources: Klein, L., & Goldenberg, R.L., "Prenatal Care and its Effect on Pre-Term Birth and Low Birth Weight," in Merkatz, I.R. & Thompson, J.E. (eds.), New Perspectives on Prenatal Care (New York, NY: Elsevier, 1990), pp. 511-513; MacGregor, S.N., Keith, L.G., Bachicha, J.A. & Chasnoff, I.J., "Cocaine Abuse during Pregnancy: Correlation between Prenatal Care and Perinatal Outcome," Obstetrics and Gynecology, 74: 882-885 (1989).

5. **Provision of quality prenatal care to heavy cocaine users (with or without drug treatment) has been shown to significantly improve fetal health and development.**

   Source: Chazotte, C., Youchah, J., & Freda, M.C., "Cocaine Use during Pregnancy and Low Birth Weight: The Impact of Prenatal Care and Drug Treatment," Seminars in Perinatology, 19: 293-300 (1995).

Cocaine and Pregnancy ("Crack Babies")

6. Criminalizing substance abuse during pregnancy discourages substance-using or abusing women from seeking prenatal care, drug treatment, and other social services, and sometimes leads to unnecessary abortions.

Sources: Cole, H.M., "Legal Interventions During Pregnancy: Court-Ordered Medical Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," Journal of the American Medical Association, 264: 2663-2670 (1990); Polan, M.L., Dombrowski, M.P., Ager, J.W., & Sokol, R.J., "Punishing Pregnant Drug Users: Enhancing the Flight from Care," Drug and Alcohol Dependence, 31: 199-203 (1993); Koren, G., Gladstone, D. Robeson, C. & Robieux, I., "The Perception of Teratogenic Risk of Cocaine," Teratology, 46: 567-571 (1992).

7. Presented with children randomly labeled "prenatally cocaine-exposed" and "normal," child care professionals ranked the performance of the "prenatally cocaine-exposed" children below that of "normal," despite actual performance.

Source: Thurman, S.K., Brobeil, R.A., Duccette, J.P., & Hurt, H., "Prenatally Exposed to Cocaine: Does the Label Matter?" Journal of Early Intervention, 18: 119-130 (1994).

Common Sense for Drug Policy Presents The Facts:
Cocaine and Pregnancy

Corruption of Law Enforcement Officers

1. **On average, half of all police officers convicted as a result of FBI-led corruption cases between 1993 and 1997 were convicted for drug-related offenses.**

   Source: General Accounting Office, Report to the Honorable Charles B. Rangel, House of Representatives, Law Enforcement: Information on Drug-Related Police Corruption (Washington, DC: USGPO, May 1998), p. 35.

2. **The Los Angeles Police Department has recently been racked with a scandal in their Rampart Division. By the end of July 2000, the LA Times reports, "Roughly 70 officers are under investigation, suspected either of committing crimes or knowing about criminal conduct by officers and failing to report it. About 100 criminal convictions have been overturned as a result of alleged police misconduct."**

   Source: Lait, Matt and Glover, Scott, Staff Writers, "LAPD Charges 6 Officers in Rampart Case", The Los Angeles Times, July 26, 2000, p. A-1.

3. **A 1998 report by the General Accounting Office notes, "...several studies and investigations of drug-related police corruption found on-duty police officers engaged in serious criminal activities, such as (1) conducting unconstitutional searches and seizures; (2) stealing money and/or drugs from drug dealers; (3) selling stolen drugs; (4) protecting drug operations; (5) providing false testimony; and (6) submitting false crime reports."**

   Source: General Accounting Office, Report to the Honorable Charles B. Rangel, House of Representatives, Law Enforcement: Information on Drug-Related Police Corruption (Washington, DC: USGPO, May 1998), p. 8.

4. **As an example of police corruption, the GAO cites Philadelphia, where "Since 1995, 10 police officers from Philadelphia's 39th District have been charged with planting drugs on suspects, shaking down drug dealers for hundreds of thousands of dollars, and breaking into homes to steal drugs and cash."**

   Source: General Accounting Office, Report to the Honorable Charles B. Rangel, House of Representatives, Law Enforcement: Information on Drug-Related Police Corruption (Washington, DC: USGPO, May 1998), p. 37.

5. **A 1998 report by the General Accounting Office notes, "Although profit was found to be a motive common to traditional and drug-related police corruption, New York City's Mollen Commission identified power and vigilante justice as two additional motives for drug-related police corruption."**

   Source: General Accounting Office, Report to the Honorable Charles B. Rangel, House of Representatives, Law Enforcement: Information on Drug-Related Police Corruption (Washington, DC: USGPO, May 1998), p. 3.

Corruption of Law Enforcement Officers

6. In New Orleans, 11 police officers were convicted of accepting nearly $100,000 from undercover agents to protect a cocaine supply warehouse containing 286 pounds of cocaine. The undercover portion of the investigation was terminated when a witness was killed under orders from a New Orleans police officer.

Source: General Accounting Office, Report to the Honorable Charles B. Rangel, House of Representatives, Law Enforcement: Information on Drug-Related Police Corruption (Washington, DC: USGPO, May 1998), p. 36.

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7. A 1998 report by the General Accounting Office states, "The most commonly identified pattern of drug-related police corruption involved small groups of officers who protected and assisted each other in criminal activities, rather than the traditional patterns of non-drug-related police corruption that involved just a few isolated individuals or systemic corruption pervading an entire police department or precinct."

Source: General Accounting Office, Report to the Honorable Charles B. Rangel, House of Representatives, Law Enforcement: Information on Drug-Related Police Corruption (Washington, DC: USGPO, May 1998), p. 3.

8. A 1998 report by the General Accounting Office cites examples of publicly disclosed drug-related police corruption in the following cities: Atlanta, Chicago, Cleveland, Detroit, Los Angeles, Miami, New Orleans, New York, Philadelphia, Savannah, and Washington, DC.

Source: General Accounting Office, Report to the Honorable Charles B. Rangel, House of Representatives, Law Enforcement: Information on Drug-Related Police Corruption (Washington, DC: USGPO, May 1998), p. 36-37.

9. Corruption caused by the illicit trade in narcotics is especially prevalent in some foreign countries. "In 1998, DEA reported that drug-related corruption existed in all branches of the [Colombian] government, within the prison system, and in the military... In November 1998, U.S. Customs and DEA personnel searched a Colombian Air Force aircraft in Florida and found 415 kilograms of cocaine and 6 kilograms of heroin."

Source: US General Accounting Office, Drug Control: Narcotics Threat from Colombia Continues to Grow (Washington, DC: USGPO, 1999), p. 15.

10. The United Nations Drug Control Program noted the inevitable risk of drug-related police corruption in 1998, when it reported that "wherever there is a well-organized, illicit drug industry, there is also the danger of police corruption."

Source: United Nations International Drug Control Program, Technical Series Report #6: Economic and Social Consequences of Drug Abuse and Illicit Trafficking (New York, NY: UNDCP, 1998), p. 38.

Corruption of Law Enforcement Officers

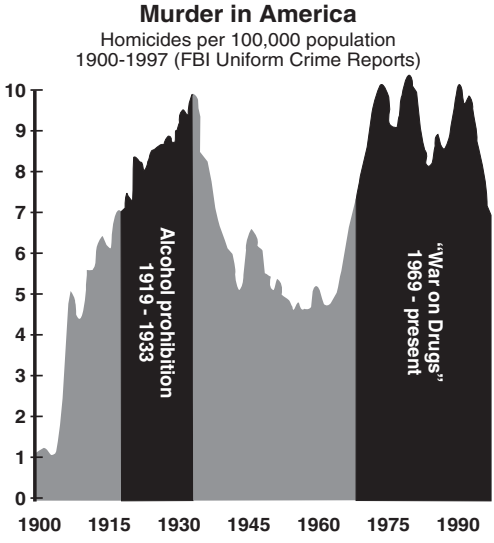
11. The difficulty of maintaining an honest government while fighting a drug war was noted by the UN Drug Control Program in 1998: "In systems where a member of the legislature or judiciary, earning only a modest income, can easily gain the equivalent of some 20 months' salary from a trafficker by making one 'favourable' decision, the dangers of corruption are obvious."

Source: United Nations International Drug Control Program, Technical Series Report #6: Economic and Social Consequences of Drug Abuse and Illicit Trafficking (New York, NY: UNDCP, 1998), p. 39.

Common Sense for Drug Policy Presents The Facts:
Official Corruption

Crime

1. **The chart at the right illustrates the homicide rate in the United States from 1900 to 1998. It is important to note that each of the most violent episodes in this century coincides with the prohibition on alcohol and the escalation of the modern-day war on drugs. In 1933 the homicide rate peaked at 9.7 per 100,000 people, which was the year that alcohol prohibition was finally repealed. In 1980, the homicide rate peaked again at 10 per 100,000.**



Source: US Census Data and FBI Uniform Crime Reports.

2. **In 1988 in New York City, 85% of crack-related crimes were caused by the market culture associated with illicit crack sales, primarily territorial disputes between rival crack dealers.**

   Source: Goldstein, P.J., Brownstein, H.H., Ryan, P.J. & Bellucci, P.A., "Crack and Homicide in New York City: A Case Study in the Epidemiology of Violence," in Reinarman, C. and Levine, H. (eds.), Crack in America: Demon Drugs and Social Justice (Berkeley, CA: University of California Press, 1997), pp. 113-130.

3. **The average "dealer" holds a low-wage job and sells part-time to obtain drugs for his or her own use.**

   Source: Reuter, P., MacCoun, R., & Murphy, P., Money from Crime: A Study of the Economics of Drug Dealing in Washington DC (Santa Monica, CA: The RAND Corporation, 1990), pp. 49-50.

4. **In 1973, there were 328,670 arrests logged in the FBI's Uniform Crime Reports (UCR) for drug law violations. In 1998, that number rose to 1,559,100 arrests for drug law violations logged in the UCR.**

   Source: FBI Uniform Crime Reports 1973. Note: 1973 data supplied by the National Criminal Justice Reference Service. Crime in America: FBI Uniform Crime Reports 1998 (Washington, DC: US Government Printing Office, 1999), p. 210.

5. **Although people may think that the Drug War targets drug smugglers and 'kingpins,' of the 1,559,100 arrests for drug law violations in 1998, 78.8% (1,228,571) were for possession of a controlled substance. Only 21.2% (330,529) were for the sale or manufacture of a drug. Simple possession of marijuana accounted for 38.4% (598,694) of the total drug arrests.**

Source: Crime in America: FBI Uniform Crime Reports 1998 (Washington, DC: US Government Printing Office, 1999), pp. 209-210.

6. A recent study by Columbia University confirms what many criminologists have long known: alcohol is associated with more violent crime than any illegal drug, including crack, cocaine, and heroin. Twenty-one percent of violent felons in state prisons committed their crimes while under the influence of alcohol alone. Only 3% were high on crack or powder cocaine alone and only 1% were using heroin alone.

Source: Califano, Joseph, Behind Bars: Substance Abuse and America's Prison Population, Forward by Joseph Califano, The National Center on Addiction and Substance Abuse at Columbia University (1998).

7. Federal statistics show that a large percentage of criminal offenders were under the influence of alcohol alone when they committed their crimes (36.3%, or a total of 1,919,251 offenders). Federal research also shows for more than 40% of convicted murderers being held in either jail or State prison, alcohol use was a factor in the crime.

Source: Greenfield, Lawrence A., Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime (Washington, DC: US Department of Justice, April 1998), pp. 20-21.

To put these numbers in perspective, see also other Factbook sections on Alcohol, Civil Rights, Prisons, Race and Prisons

Common Sense for Drug Policy Presents The Facts: Crime

Drug Courts and Treatment as an Alternative to Incarceration

In recent years, Drug Courts have become a popular, widely praised and rapidly expanding alternative approach of specialized courts that deal with drug offenders and sometimes with people charged with nonviolent crimes who are drug users. Drug Courts substitute mandatory treatment for incarceration. Because Drug Courts are new, much of the research on their effectiveness is recent, incomplete and inconclusive. Although Drug Courts have been much applauded, some concerns about their fairness and effectiveness have been expressed. These include:

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- **Providing coerced treatment at a time when the needs for voluntary treatment are not being met creates the strange circumstance of someone needing to get arrested to get treatment.**
- **People who are forced into treatment may not actually need it. They may just be people who use drugs in a non-problematic way who happened to get arrested. Arrest may not be the best way to determine who should get treatment services.**
- **Drug Courts are a much less expensive way of handling drug cases in the criminal justice system, thus they may result in more people being arrested and processed, many of whom would not have been arrested or would have been diverted. Thus, Drug Courts may be expanding the number of people hurt by the drug war.**
- **Drug Courts are creating a separate system of justice for drug offenders, a system that does not rely on the key traditions of an adversary system of justice and due process, a system where the defense, prosecution and judge work as a team to force the offender into a treatment program.**
- **Drug Courts sometimes rely on abstinence-based treatment. For example, methadone is usually unavailable to heroin addicts. In addition, they rely heavily on urine testing rather than focusing on whether the person is succeeding in employment, education or family relationships.**
- **Drug Courts also often mandate twelve-step treatment programs, which some believe to be an infringement on religious freedom.**
- **Drug Courts invade the confidentiality of patient and health-care provider. The health-care provider's client is really the court, prosecutor and probation officer, rather than the person who is getting drug treatment.**

1. **According to the nonprofit thinktank The RAND Corporation, "Subsidized by $33 million in funds disbursed pursuant to the 1994 federal crime act, over 700 drug courts are now in operation by local jurisdictions across the country."**

   Source: Drug Policy Research Center, The RAND Corporation, "What Makes Drug Courts Succeed or Fail?", DPRC Newsletter (Santa Monica, CA: RAND Corporation, June 2000), p. 4.

Drug Courts and Treatment as an Alternative to Incarceration

2. "The last decade has seen the rapid growth of specialized court forums in the states. The first drug court was created in Dade County, Florida in 1989; all but ten states followed that example within the next decade."

Source: Rottman, David, et al., Bureau of Justice Statistics, State Court Organization, 1998 (Washington, DC: US Department of Justice, June 2000), p. 207.

3. Drug courts offer court-supervised treatment as an alternative to incarceration for low-level drug offenders. Most target first-time drug offenders, while others target habitual offenders.

Source: Marc Pearce, National Center for State Courts Information Service, "Drug Courts: A Criminal Justice Revolution", Report on Trends in the State Courts 1998-1999 Final Report (Williamsburg, VA: National Center for State Courts, 1999), pp. 8-12.

4. In 1996, there were a total of 9,794,149 arrests reported to the FBI, and 7,600,241 arrestees. Of these, 66.6% — 5.01 million people - were drug users. Also in 1996, there were a total of 2,166,630 drug arrests, and 1,678,174 arrestees. Of these, 82% — 1,379,624 offenders - were estimated to be drug users.

Source: Anglin, M. Douglas, et al., National Evaluation Data and Technical Assistance Center, Drug Use Prevalence Estimates among Adult Arrestees in California, Texas, and the US: Final Report (Los Angeles, CA: UCLA Drug Abuse Research Center., June 28, 1999), pp. 39-43.

5. In an article published in the University of North Carolina Law Review in June 2000, Colorado Judge Morris B. Hoffman wrote, "Although many studies and many kinds of studies have examined drug courts, none has demonstrated with any degree of reliability that drug courts work."

Source: District Judge Morris B. Hoffman, Second Judicial District (Denver), State of Colorado, "The Drug Court Scandal", North Carolina Law Review (Chapel Hill, NC: North Carolina Law Review Association, June 2000), Vol. 78, No. 5, p. 1480.

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Recidivism Rates Compared		
City	**Traditional Court**	**Drug Court**
Denver, CO	58.0%	53.0%
Multnomah County. OR (Portland)	1.53[a]	0.59[a]
Oakland, CA	1.33[a]	0.75[a]
Riverside, CA	33.0%	13.4%
Travis County, TX (Austin)	41.0%	38.0%
Wilmington, DE	51.1%	33.3%

"[a]Expressed not as a percentage, but rather as the average number of arrests suffered during the follow-up period."

Drug Courts and Treatment as an Alternative to Incarceration

Source: Belenko, Steven & Dumanovsky, Tamara, Bureau of Justice Assistance, US Depart of Justice, "Special Drug Courts: Program Brief 2", (Washington, DC: US Department of Justice, 1993), and Granfield, Robert & Eby, Cindy, "An Evaluation of the Denver Drug Court: The Impact of a Treatment-Oriented Drug Offender System 10" (1997), as cited by District Judge Morris B. Hoffman, Second Judicial District (Denver), State of Colorado, "The Drug Court Scandal", North Carolina Law Review (Chapel Hill, NC: North Carolina Law Review Association, June 2000), Vol. 78, No. 5, p. 1496.

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7. **The State of Arizona's Drug Treatment and Education Fund "was established in January of 1997 to expand services for drug offenders and to utilize probation for non-violent drug offenders." According to a report on the first year of operation, a total of 2622 offenders were served by the program. Of that number, 932 completed their programs, of which number only 61.1% — 568 offenders - completed successfully.**

   Source: Arizona Supreme Court, Adult Services Division, Administrative Office of the Courts, Arizona, Drug Treatment and Education Fund Legislative Report Fiscal Year 1997-1998 (Arizona: Arizona Supreme Court, March 1999), p. 9.

8. **A study of Arizona's Drug Treatment and Education Fund estimates that the program saved more than $2.5 million statewide in fiscal year 1998.**

   Source: Arizona Supreme Court, Adult Services Division, Administrative Office of the Courts, Arizona, Drug Treatment and Education Fund Legislative Report Fiscal Year 1997-1998 (Arizona: Arizona Supreme Court, March 1999), p. 7.

9. **The state's study of Arizona's diversion program, offering treatment in place of incarceration, contains this important caveat: "Not enough time has elapsed since program inception for the collection of data to accurately reflect recidivism rates."**

   Source: Arizona Supreme Court, Adult Services Division, Administrative Office of the Courts, Arizona, Drug Treatment and Education Fund Legislative Report Fiscal Year 1997-1998 (Arizona: Arizona Supreme Court, March 1999), p. 6.

10. **"Even offenders who do not succeed in drug court appear to be less criminally active than they were previously. This may be due to the benefits of treatment or the supervision, sanctions, intensive surveillance, and specific deterrence of the drug court."**

    Source: Gebelein, Richard S., National Institute of Justice, "The Rebirth of Rehabilitation: Promise and Perils of Drug Courts" (Washington, DC: US Department of Justice, May 2000), p. 5.

11. **"To facilitate an individual's progress in treatment, the prosecutor and defense counsel must shed their traditional adversarial courtroom relationship and work together as a team. Once a defendant is accepted into the drug court program, the team's focus is on the participant's recovery and law-abiding behavior — not on the merits of the pending case."**

Drug Courts and Treatment as an Alternative to Incarceration

Source: National Association of Drug Court Professionals Drug Court Standards Committee, "Defining Drug Courts: The Key Components" (Washington, DC: US Department of Justice), January 1997, on the web at http://www.ojp.usdoj.gov/dcpo/Define/key2.htm, last accessed August 9, 2000.

12. Treatment options must be carefully considered by the courts. Various Federal court rulings have determined that offering only AA and NA programs, because of their religious basis, violates the establishment clause of the US Constitution. Ruling in the case of Kerr v. Farrey in the 7th Circuit Federal Court of Appeals, Judge Diane P. Wood wrote, "We find, to the contrary, that the state has impermissibly coerced inmates to participate in a religious program." Judge Wood further notes that "the Court of Appeals of New York has recently come to the same conclusion we reach today in Matter of David Griffin v. Coughlin," and that "Our conclusion is thus in harmony with that of other courts that have considered similar questions."

Source: Ruling in the United States Court of Appeals for the Seventh Circuit No. 95-1843 James W. Kerr, Plaintiff-Appellant, v. Catherine J. Farrey and Lloyd Lind, Defendants-Appellees, Judge Diane P. Wood, Decided August 27, 1996, from the web at http://www.kentlaw.edu/7circuit/1996/aug/95-1843.html, last accessed August 9, 2000.

13. It is possible that managed care will become a barrier to the success of drug courts and treatment as alternative to incarceration. The National Institute of Justice notes, "The premise of managed care, increasingly the norm, is that the least treatment required should be provided. This is at odds with research on substance abuse treatment, which has shown that the longer a person remains in treatment, the more successful treatment will be. Furthermore, managed care assumes the patient will aggressively pursue the treatment he or she deems necessary. Because most drug court clients initially prefer not to be treated, they are likely to welcome a ruling by the health care provider or the managed care insurer that treatment is not needed. Finally, drug court clients frequently encounter delays in obtaining treatment funding or must cobble together bits and pieces of various programs because the 'exhaustion' rules of health care plans limit treatment."

Source: Gebelein, Richard S., National Institute of Justice, "The Rebirth of Rehabilitation: Promise and Perils of Drug Courts" (Washington, DC: US Department of Justice, May 2000), p. 6.

14. "An individual who has an out-of-control addiction commits about 63 crimes a year. Assuming this could be reduced to 10 for someone who is in or has completed treatment, and multiplying it by the 200 offenders in Delaware's probation revocation track who comply

offenders in Delaware's probation revocation track who comply with all requirements, a single drug court may prevent more than 10,000 crimes each year."

Source: Gebelein, Richard S., National Institute of Justice, "The Rebirth of Rehabilitation: Promise and Perils of Drug Courts" (Washington, DC: US Department of Justice, May 2000), p. 5.

15. In a recent law review article, Colorado Judge Morris B. Hoffman writes, "Reductions in recidivism are so small that if they exist at all they are statistically meaningless. Net-widening is so large that, even if drug courts truly were effective in reducing recidivism, more drug defendants would continue to jam our prisons than ever before."

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Source: District Judge Morris B. Hoffman, Second Judicial District (Denver), State of Colorado, "The Drug Court Scandal", North Carolina Law Review (Chapel Hill, NC: North Carolina Law Review Association, June 2000), Vol. 78, No. 5, p. 1533-4.

16. "As the results of more sophisticated evaluations become available, preliminary success rates will not be sustained. As less tractable groups participate, rates of compliance and graduation will decline and recidivism will rise."

Source: Gebelein, Richard S., National Institute of Justice, "The Rebirth of Rehabilitation: Promise and Perils of Drug Courts" (Washington, DC: US Department of Justice, May 2000), p. 5.

17. James L. Nolan Jr., an assistant professor of sociology at Williams College, notes "Likewise, in a study conducted by W. Clinton Terry, professor of criminal justice at Florida International University, no real differences were found between the recidivism rates of those who completed and those who dropped out of Broward County's Drug Court treatment program. Only a 4 percent difference in the number of felony rearrests and a 1 percent difference in the number of misdemeanor rearrests were found between the two groups."

Source: Nolan, James L., The Therapeutic State, (New York, NY: New York University Press, 1998), p. 104.

18. James L. Nolan Jr. discusses the 1993 American Bar Association study of drug courts in his book The Therapeutic State. The study found that among offenders who were sent to the Drug Court, 20% were rearrested for a drug offense and 32% were rearrested for any felony offense within one year of the sampled arrest. Among pre-Drug Court defendants, 23% were rearrested for a narcotics offense and 33% for any felony offense within one year. He further notes, "Again, they found little difference between the samples. Drug offenders sent through the Drug Court were rearrested, on average, 324 days after their first court appearance, whereas drug offenders sentenced prior to the Drug Court were rearrested, on

offenders sentenced prior to the Drug Court were rearrested, on average, 319 days after their first court appearance."

Source: Nolan, James L., The Therapeutic State (New York, NY: New York University Press, 1998), p. 105.

19. "In identifying target populations, drug courts need to be sensitive to class and race bias. Unless care is taken, diversion courts may tend disproportionately to work with white and middle-class substance abusers."

Source: Gebelein, Richard S., National Institute of Justice, "The Rebirth of Rehabilitation: Promise and Perils of Drug Courts" (Washington, DC: US Department of Justice, May 2000), p. 5.

20. In the Arizona diversion program study, the demographics of those referred to treatment differed from the racial composition of the Arizona state corrections system.

Demographic Group	Anglo	African-American	Hispanic	Native American
Received Diversion	59.9%	9.2%	24.6%	4.6%
General Prison Population	45.7%	14.6%	33.7%	4.6%

Source: Arizona Supreme Court, Administrative Office of the Courts, Adult Services Division, "Drug Treatment and Education Fund Legislative Report, Fiscal Year 1997-1998", March 1999, p. 5; prison population stats from the Arizona Department of Corrections on the web at http://www.adc.state.az.us:81/Who.htm.

21. David Rottman of the National Center for State Courts noted in an article for the American Judges Association's Court Review, "Specialized forums like drug or domestic violence courts require a judicial temperament in interacting directly with litigants and an openness to insights from fields like mental health.

"It is unclear that legal training is the best preparation for judging in specialized contexts."

Source: Rottman, David B., "Does Effective Therapeutic Jurisprudence Require Specialized Courts (and do Specialized Courts Require Specialist Judges?)", Court Review (Williamsburg, VA: American Judges Association, Spring 2000), pp. 25-26.

22. "When a drug court judge steps down, it is not always possible to find a sufficiently motivated replacement. Without a highly motivated judge, the drug court approach simply does not work."

Source: Gebelein, Richard S., National Institute of Justice, "The Rebirth of Rehabilitation: Promise and Perils of Drug Courts" (Washington, DC: US Department of Justice, May 2000), p. 6.

23. In a recent law review article, Colorado Judge Morris B. Hoffman writes "By existing simply to appease two so diametric and irreconcilable sets of principles, drug courts are fundamentally

unprincipled. By simultaneously treating drug use as a crime and as a disease, without coming to grips with the inherent contradictions of those two approaches, drug courts are not satisfying either the legitimate and compassionate interests of the treatment community or the legitimate and rational interests of the law enforcement community. They are, instead, simply enabling our continued national schizophrenia about drugs."

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Source: District Judge Morris B. Hoffman, Second Judicial District (Denver), State of Colorado, "The Drug Court Scandal", North Carolina Law Review (Chapel Hill, NC: North Carolina Law Review Association, June 2000), Vol. 78, No. 5, p. 1477.

Common Sense for Drug Policy Presents The Facts:
Drug Courts and Treatment as an Alternative to Incarceration

Drug Testing

1. **Companies which use Factor 2000, an impairment testing system, are finding that drug and alcohol use are not the most common reasons for failure; rather, severe fatigue and illness are more common.**

   Source: Hamilton, "A Video Game That Tells if Employees Are Fit To Work," Businessweek, (June 3, 1991).

2. **A positive drug test does not indicate whether an employee was impaired or intoxicated on the job, nor does it indicate whether an employee has a drug problem or how often the employee uses the drug. Thus most tests do not provide information relevant to job performance.**

   Source: Lewis Maltby, Vice President, Drexelbrook Controls, Horsham, PA, as cited in Report of the Maine Commission to Examine Chemical Testing of Employees, (December 31, 1986).

3. **While drug testing in the workplace increased dramatically in the 1980s, in 1992 it leveled off. Much drug testing in American industry is due to government mandates requiring testing, not due to the business judgment of employers.**

   Source: American Management Association, American Management Association Survey on Workplace Drug Testing and Drug Abuse Policies (New York, NY: American Management Association, 1996).

4. **The American Management Association in its annual survey of companies on workplace surveillance and medical testing reports the following percentages of companies who conduct drug tests:**

Business Category	Testing of New Hires	Testing of All Employees
Financial Services	35.8%	18.8%
Business & Professional Services	36.0%	18.4%
Other Services	60.3%	34.7%
Wholesale & Retail	63.0%	36.8%
Manufacturing	78.5%	42.2%

   Source: American Management Association, A 2000 AMA Survey: Workplace Testing: Medical Testing: Summary of Key Findings (New York, NY: American Management Association, 2000), p. 1.

5. **The American Management Association conducts an annual survey of workplace surveillance and medical testing. In the report issued in 2000, found that employee drug testing was at its lowest level in a decade, practiced by 52% of companies surveyed in 1991, and 47% of companies surveyed in 2000.**

   Source: American Management Association, A 2000 AMA Survey: Workplace Testing: Medical Testing: Summary of Key Findings (New York, NY: American

Drug Testing

6. The Bureau of Labor Statistics noted the downward trend in drug testing after a large survey of 145,000 businesses. It found that "overall about 1 of 3 establishments that reported having a drug testing program in 1988 said they did not have one in 1990." 46% of the companies with under 50 employees dropped drug testing programs.

Source: Bureau of Labor Statistics, "Anti-Drug Programs in the Workplace: Are They Here to Stay?" Monthly Labor Review, Washington D.C.: US Bureau of Labor Statistics (April 1991), pp. 26-28.

7. In a recent study of high tech industries, researchers found that "drug testing programs do not succeed in improving productivity. Surprisingly, companies adopting drug testing programs are found to exhibit lower levels of productivity than their counterparts that do not... Both pre-employment and random testing of workers are found to be associated with lower levels of productivity."

Source: Shepard, Edward M., and Thomas J. Clifton, Drug Testing and Labor Productivity: Estimates Applying a Production Function Model, Institute of Industrial Relations, Research Paper No. 18, Le Moyne University, Syracuse, NY (1998), p. 1.

8. It is estimated that the United States spends $1 billion annually to drug test about 20 million workers.

Source: Shepard, Edward M., and Thomas J. Clifton, Drug Testing and Labor Productivity: Estimates Applying a Production Function Model, Institute of Industrial Relations, Research Paper No. 18, Le Moyne University, Syracuse, NY (1998), p. 8.

9. One reason drug testing is not used by some employers is the cost. One electronics manufacturer estimated that the cost of finding each positive result was $20,000. After testing 10,000 employees he only found 49 positive results. A Congressional committee estimated that the cost of each positive in government testing was $77,000 because the positive rate was only 0.5%.

Source: "Workplace Substance Abuse Testing, Drug Testing: Cost and Effect," Cornell/Smithers Report, Utica, New York: Cornell University (January 1992).

Common Sense for Drug Policy Presents The Facts:
Drug Testing

Drug Use Estimates

1. **87.7 million Americans aged 12 or over have used an illicit drug at least once.**

   Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Summary of Findings from the 1999 National Household Survey on Drug Abuse (Rockville, MD: SAMHSA, August 2000), p. G-5.

2. **In the past year, 26.7 million Americans aged 12 or over used an illicit drug. Of these, 19.1 million are White, 3.3 million are Black, and 2.6 million are Hispanic.**

   Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Summary of Findings from the 1999 National Household Survey on Drug Abuse (Rockville, MD: SAMHSA, August 2000), pp. G-3 & G-13.

3. **An estimated 971 thousand Americans used crack cocaine in the past year. Of those, 462 thousand are White, 324 thousand are Black, and 157 thousand are Hispanic.**

   Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, National Household Survey on Drug Abuse: Population Estimates 1998 (Washington DC: US Department of Health and Human Services, 1999), pp. 37-39.

4. **Below are the results of the National Household Survey on Drug Abuse 1999. It is important to note that the Survey finds very slight use of 'hard drugs' like cocaine, heroin and crack. The numbers for heroin are so small that frequent users (defined as 51 or more times per year) are not even tracked by the national survey.**

Substance	Ever Used	Past Year	Past Month	Frequent Users
Alcohol	179.70	138.30	104.60	44.60 million
Cigarettes	159.10	66.64	56.90	N/A
Marijuana	76.40	19.50	11.10	N/A
Cocaine	25.00	3.60	1.50	N/A
Crack	5.90	1.035	0.413	N/A
Heroin	3.05	0.403	0.208	N/A

   Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Summary of Findings from the 1999 National Household Survey on Drug Abuse (Rockville, MD: SAMHSA, August 2000), pp. G-5 & G-21.

5. **Below are results from a survey of drug use in The Netherlands published in 1999. Note the difference in drug use prevalence. For more information check out the Netherlands section of Drug War Facts.**

Drug Use Estimates

Substance	Ever Used	Past Year	Past Month	Frequent Users
Alcohol	90.2%	82.5%	73.3%	24.3% of past month users
Cigarettes	67.9%	38.1%	34.3%	N/A
Marijuana	15.6%	4.5%	2.5%	25.6% of past month users
Cocaine	2.1%	0.6%	0.2%	1.8% pf past month users
Crack	* not tracked separately			
Heroin	0.3%	0.1%	N/A	N/A

Source: University of Amsterdam, Centre for Drug Research, Licit and Illicit Drug Use in the Netherlands, 1997 (Amsterdam: University of Amsterdam, September 1999), pp. 45, 46, 47, 55

For Further Research:

An online version of the National Household Survey on Drug Abuse: Population Estimates 1998 is available at http://www.health.org/pubs/nhsda/98hhs/popest98/TOC.htm.

***Downloadable PDF versions of the Population Estimates, the Main Findings, and a Summary Report on the findings from the 1998 Survey are available at http://www.SAMHSA.gov/NHSDA.htm or to order a free copy of the Survey call the National Clearinghouse* for Alcohol and Drug Information at 1-800-729-6686.**

For a more complete perspective, also read related Drug War Facts sections on Alcohol, Comparative Dangers of Drugs, Crack, Gateway Theory, Marijuana, The Netherlands, Prison, and Race and Prison.

Common Sense for Drug Policy Presents The Facts:
Drug Use Estimates

Economics

1. **The international illicit drug business generates as much as $400 billion in trade annually according to the United Nations International Drug Control Program. That amounts to 8% of all international trade and is comparable to the annual turnover in textiles, according to the study.**

   Source: United Nations Office for Drug Control and Crime Prevention, Economic and Social Consequences of Drug Abuse and Illicit Trafficking (New York, NY: UNODCCP, 1998), p. 3.

2. **According to the United Nations, profits in illegal drugs are so inflated, that three-quarters of all drug shipments would have to be intercepted to seriously reduce the profitability of the business. Current efforts only intercept 13% of heroin shipments and 28%-40%* of cocaine shipments. (*At most; the UN Office for Drug Control and Crime Prevention notes that estimates of production and total supply are probably understated by reporting governments.)**

   Source: United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 1999 (New York, NY: UNODCCP, 1999), p. 51.

3. **According to the United Nations, illegal drugs create enormous profits — a kilogram of heroin in Pakistan costs an average of $2,720, but sells for $129,380 in the United States.**

   Source: United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 2000 (New York, NY: UNODCCP, 2000), pp. 165.

4. **According to the United nations and others, illegal drugs create enormous profits. For example, a kilogram of coca base in Columbia cost an average of only $950. In the United States, a kilogram of cocaine averaged just under $25,000 in 1997, with a "street price" of $20-90 a gram.**

   Source: United Nations Office of Drug Control and Crime Prevention, Global Illicit Drug Trends 2000 (New York, NY: UNODCCP, 2000), p. 48 and p. 167.

5. **According to a United Nations report, "Over the past decade, inflation-adjusted prices in Western Europe fell by 45% for cocaine and 60% for heroin. Comparative falls in the United States were about 50% for cocaine and 70% for heroin."**

   Source: United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 1999 (New York, NY: UNODCCP, 1999), p. 86.

6. **According to a United Nations report, "US authorities reported the mean purity level of heroin to be around 6% in 1987 but about 37% in 1997, in which year levels were even reaching 60% in New York."**

   Source: United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 1999 (New York, NY: UNODCCP, 1999), p. 86.

7. **It costs approximately $8.6 billion a year to keep drug law violators behind bars.**

   Sources: Bureau of Justice Statistics, Profile of Jail Inmates 1996 (Washington, DC: US Government Printing Office, April 1996), pp. 1 & 4; Bureau of Justice

Statistics, Prisoners in 1996 (Washington DC: US Government Printing Office, 1997), pp. 10-11; Criminal Justice Institute, Inc., The Corrections Yearbook 1997 (South Salem, NY: Criminal Justice Institute, Inc., 1997) [estimating cost of a day in jail on average to be $55.41 a day, or $20,237 a year, and the cost of prison to be on average to be about $64.49 a day, or $23,554 a year].

8. A study by the RAND Corporation found that every additional dollar invested in substance abuse treatment saves taxpayers $7.46 in societal costs.

Source: Rydell, C.P. & Everingham, S.S., Controlling Cocaine, Prepared for the Office of National Drug Control Policy and the United States Army (Santa Monica, CA: Drug Policy Research Center, RAND Corporation, 1994), p. xvi.

9. The RAND Corporation study found that additional domestic law enforcement efforts cost 15 times as much as treatment to achieve the same reduction in societal costs.

Source: Rydell, C.P. & Everingham, S.S., Controlling Cocaine, Prepared for the Office of National Drug Control Policy and the United States Army (Santa Monica, CA: Drug Policy Research Center, RAND Corporation, 1994), p. xvi.

10. A 1998 report by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated the economic costs of alcohol abuse in the United States to be $148.02 billion in 1992, 80% ($119.32 billion) of which were due to alcohol-related illness (including health care expenditures, impaired productivity and premature death). To contrast, illegal drug abuse cost a total of $97.66 billion in 1992, of which less than 40% ($38.71 billion) was due to drug-related illness or premature death. This figure includes $4.16 billion in HIV/AIDS and Hepatitis treatment costs.

Source: National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism. The Economic Costs of Alcohol and Drug Abuse in the United States, 1992 (Washington, DC: US Department of Health and Human Services, May 1998), Table 1.1, p. 1-3 and Table 4.1, p. 4-2.

11. A 1998 report by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated the economic costs of illegal drug abuse in the United States to be $97.66 billion in 1992. Sixty percent (60%) of drug costs were due to drug-related law enforcement, incarceration and crime. Only 3% of drug costs were from victims of drug-related crime.

Source: National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism. The Economic Costs of Alcohol and Drug Abuse in the United States, 1992 (Washington, DC: US Department of Health and Human Services, May 1998), Table 1.2, pp. 1-6.

Economics

12. According to the United Nations and others, illegal drugs create enormous profits. For example, a kilogram of cocaine base in Peru cost an average of only $257 in 1997. In the United States, a kilogram of cocaine averaged just under $25,000 in 1997, with a "street price" of around $66 a gram (or $66,000 per kilogram).

Source: United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 1999 (New York, NY: UNODCCP, 1999), p. 83, table 26; p. 86, and p. 89, figure 124.

13. In 1969, $65 million was spent by the Nixon administration on the drug war; in 1982 the Reagan administration spent $1.65 billion; and in 1999 the Clinton administration spent $17.7 billion.

Sources: U.S. Congress, Hearings on Federal Drug Enforcement before the Senate Committee on Investigations, 1975 and 1976 (1976); Office of National Drug Control Policy, National Drug Control Strategy, 1992: Budget Summary (Washington DC: US Government Printing Office, 1992), p. 214; Office of National Drug Control Policy, National Drug Control Strategy 2000 Annual Report (Washington DC: US Government Printing Office, 2000), p. 94, Table 4-1.

14. The ONDCP in its 2000 annual report detailed administration requests for major increases in funding to the Federal Bureau of Prisons for drug-related prison construction. These include an extra $420 Million in fiscal year 2001, and advanced appropriations of $467 Million in 2002, and an additional $316 Million in 2003—all drug-related.

Sources: Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics (Washington, DC: US Government Printing Office, 1997), p. 20; Office of National Drug Control Policy, Executive Office of the White House, National Drug Control Strategy, 1997: Budget Summary (Washington DC: US Government Printing Office, 1997), p. 111; Office of National Drug Control Policy, Executive Office of the White House, National Drug Control Strategy: Annual Report 2000 (Washington, DC: US Government Printing Office, 2000), p. 96.

15. Recent estimates indicate that Colombia repatriates $7 billion in drug profits annually, which is nearly as high as the total legitimate exports for Colombia which were $7.6 billion in 1993.

Source: Trade and Environment Database (TED), TED Case Studies: Columbia Coca Trade, Washington D.C.: American University (1997), p. 4.

16. It is estimated that Colombian narcotics cartels spend $100 million on bribes to Colombian officials each year.

Source: Trade and Environment Database (TED), TED Case Studies: Columbia Coca Trade (Washington DC: American University, 1997), p. 4.

17. In 1993, 98% of Bolivia's foreign exchange earnings from goods and services came from the coca market.

Source: US Congress, Office of Technology Assessment, Alternative Coca Reduction Strategies in the Andean Region, F-556 (Washington DC: US Government Printing Office, July 1993).

Economics

18. In a report funded by the Wisconsin Policy Research Institute, researchers concluded that drug sales in poor neighborhoods are part of a growing informal economy which has expanded and innovatively organized in response to the loss of good jobs. The report characterizes drug dealing as fundamentally a lower class response [to the information economy] by men and women with little formal education and few formal skills, and the report notes If the jobs won't be created by either the public or private sector, then poor people will have to create the jobs themselves.

Source: Hagedorn, John M., Ph.D., The Business of Drug Dealing in Milwaukee (Milwaukee, WI: Wisconsin Policy Research Institute, 1998), p. 3.

19. In a report funded by the Wisconsin Policy Research Institute, researchers concluded that drug-dealing plays a substantial role in the local economies of poorer urban neighborhoods. "At least 10% of all male Latinos and African-Americans aged 18-29 living in these two [surveyed] neighborhoods are supported to some extent by the drug economy." The report also concluded that "most drug entrepreneurs are hard working, but not super rich" and that "most drug entrepreneurs aren't particularly violent." One-fourth of all drug-dealers surveyed said they encountered no violence at all in their work, and two-thirds reported that violence occurred less than once per month.

Source: Hagedorn, John M., PhD, The Business of Drug Dealing in Milwaukee (Milwaukee, WI: Wisconsin Policy Research Institute, 1998), p. 1.

20. In its annual report for 1998-1999, the French organization Geopolitical Drug Watch writes of the US: "Inmates are even less likely to find a job after than before serving a sentence, and if nothing changes most of them are doomed to unemployment for life and are likely to go back to prison."

Source: Observatoire Geopolitique des Drogues, The World Geopolitics of Drugs 1998/1999 (Paris, France: OGD, April, 2000), p. 133.

21. The French organization OGD points out the deeper economic impact from the eventual release of American drug felons: "According to some estimates some 3.5 million prisoners will be released between now and 2010, and an additional 500,000 each year thereafter.
"Such a large-scale release of unskilled people - most of them cannot even read and write - will have a negative impact on wages, which are already low in deprived urban areas, due to a massive influx of men desperate to get a job; especially, since the reform of the welfare system in 1996 severely reduced felons' access to welfare money."

Source: Observatoire Geopolitique des Drogues, The World Geopolitics of Drugs 1998/1999 (Paris, France: OGD, April, 2000), p. 133.

Ecstasy: What the Evidence Shows

1. **Ecstasy (MDMA) is a semi-synthetic drug patented by Merck Pharmaceutical Company in 1914 and abandoned for 60 years. In the late 1970s and early 1980s psychiatrists and psychotherapists in the US used it to facilitate psychotherapy.**

   Source: Greer G and Tolbert R. A Method of Conducting Therapeutic Sessions with MDMA. in Journal of Psychoactive Drugs 30 (1998) 4:371.379. For research on the therapeutic use of MDMA see: www.maps.org

2. **Ecstasy's effects last 3 to 6 hours. It is a mood elevator that produces feelings of empathy, openness and well-being. People who take it at all night "rave" dances say they enjoy dancing and feeling close to others. It does not produce violence or physical addiction.**

   Source: Beck J and Rosenbaum M. Pursuit of Ecstasy: The MDMA Experience. Albany: State University of New York Press, 1994.

3. **According to coroner reports there were nine Ecstasy-related deaths (three of these involved Ecstasy alone) in 1998.**

   Source: Drug Abuse Warning Network, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Report of March 21, 2000. (This was a special report because the published report only includes drugs where there were over 10 deaths.)

4. **Some of these deaths are related to overheating. MDMA slightly raises body temperature. This is potentially lethal in hot environments where there is vigorous dancing and the lack of adequate fluid replacement. Many of these tragic deaths are preventable with simple harm reduction techniques such as having free water available and rooms where people can rest and relax.**

   Source: C.M. Milroy; J.C. Clark; A.R.W. Forrest, Pathology of deaths associated with "ecstasy" and "eve" misuse, Journal of Clinical Pathology Vol 49 (1996) 149-153.

5. **One of the recent risks associated with Ecstasy is the possibility of obtaining adulterated drugs that may be more toxic than MDMA. Some of the reported deaths attributed to Ecstasy are likely caused by other, more dangerous drugs.**

   Source: Laboratory Pill Analysis Program, DanceSafe. For results visit www.DanceSafe.org. See also, Byard RW et al., Amphetamine derivative fatalities in South Australia-is "Ecstasy" the culprit?, American Journal of Forensic Medical Pathology, 1998 (Sep) 19(3): 261-5.

6. **Deaths from adulterated drugs are another consequence of a zero tolerance approach. The drug should be tested for purity to minimize the risk from adulterated drugs by those who consume it.**

   Source: DanceSafe provides testing equipment and a testing service which can be used to determine what a substance is. See www.DanceSafe.org.

Ecstasy: What the Evidence Shows

7. **MDMA raises blood pressure and heart rate. Persons with known cardiovascular or heart disease should not take MDMA.**

8. **Recent studies have indicated that individuals who have used MDMA may have decreased performance in memory tests compared to nonusers. These studies are presently controversial because they involved people who used a variety of other drugs. Furthermore, it is difficult to rule out possible pre-existing differences between research subjects and controls.**

Source: E. Gouzoulis-Mayfrank; J. Daumann; F. Tuchtenhagen; S. Becker;H.J. Kunert; B. Fimm; H. Sass; Impaired cognitive performance in drug free users of recreational ecstasy (MDMA), by Journal Neurol Neurosurg Psychiatry Vol 68, June 2000, 719-725; K.I. Bolla; U.D.; McCann; G.A. Ricaurte; Memory impairment in abstinent MDMA ('Ecstasy') users, by Neurology Vol 51, Dec 1998, 1532-1537.

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Common Sense for Drug Policy Presents The Facts:
Ecstasy: What the evidence shows

Environment

1. **In order to comply with United States' demands to stop coca production, Colombia uses aerial spraying to drop herbicides on illicit crops. Since these crops are the peasants' only source of income they move into the Amazon rainforest and farm on steep hillsides. This constant push on peasants has led to the clearing of over 1.75 million acres of rainforest.**

   Source: Trade and Environment Database (TED), TED Case Studies: Columbia Coca Trade (Washington DC: American University, 1997), pp. 4-8.

2. **"Aerial spraying of a marijuana field near a Rarámuri village carried out by the Federal Attorney General's Office (Procuraduría General de la República, PGR) left 300 sick and injured and may have killed a two-year old girl according to the Chihuahua State Human Rights Office (Comisión Estatal de Derechos Humanos, CEDH)."**

   Source: Macias Medina, Silvia, "PGR Allegedly Sprays Marijuana Field, Killing Child and Injuring 300", reprinted in Frontera NorteSur, originally published in El Diaro, August 5, 2000. Available on the web at http://www.nmsu.edu/~frontera/jul_aug00/today.html, last accessed Feb. 7, 2001.

3. **In July 2000, the Colombian government agreed to work with the UN Drug Control Program on research into the use of a fungicide called fusarium oxysporum. Tests have yet to show that use of the fungus is feasible, and methods to produce the fungicide in sufficient quantities as well as a delivery mechanism have yet to be developed.**

   Source: George Gedda, Associated Press, "Colombia Tries New Drug Eradication", July 7, 2000.

4. **The US Department of Agriculture reports "A pathogenic strain of Fusarium oxysporum, causes Fusarium wilt, a disease that afflicts many crops such as watermelon, muskmelon, and basil but is a bigger problem for tomato growers."**

   Source: "USDA, Canada Collaborate on Fusarium Wilt", Methyl Bromide Alternatives Newsletter (Beltsville, MD: USDA Agricultural Research Service, April 2000), Vol. 6, No. 2.

5. **"Colombia's forests account for 10% of the entire world's biodiversity, making it the second most biodiverse country in the world in terms of species per land unit." Drug war induced deforestation in Colombia have led experts to theorize that Colombia could become another Somalia or Ethiopia within 50 years, "i.e. a fast growing population that is larger than the food production can support due to poor agricultural soils or techniques."**

   Sources: Trade and Environment Database (TED), TED Case Studies: Deforestation in Colombia, Washington DC: American University (1997); Trade and Environment Database (TED), TED Case Studies: Columbia Coca Trade, Washington DC: American University (1997).

Environment

6. When aerially sprayed, the herbicide Glyphosate can drift for up to about half of a mile. In Colombia, where the herbicide Glyphosate is sprayed from airplanes, children have lost hair and suffered diarrhea as a result of its application.

Sources: Cox, C., "Glyphosate, Part 2: Human Exposure and Ecological Effects," Journal of Pesticide Reform, Vol. 15 (Eugene, OR: Northwest Coalition for Alternatives to Pesticides, 1995); Lloyd, R., "Publisher Warns about Impacts of Drug War," World Rainforest Report 37, (Lismore, NSW: Australia, 1997); Drug Enforcement Agency, Draft Supplement to the Environmental Impact Statements for Cannabis Eradication in the Contiguous United States and Hawaii (Washington DC: U.S. Government Printing Office, April 1998).

7. Since it is illegal to manufacture cocaine, its producers must hide their facilities in the forests of South America making it impossible to properly dispose of chemical wastes. It is estimated that the unregulated manufacture of cocaine results in 10 million liters of sulfuric acid, 16 million liters of ethyl ether, 8 million liters of acetone and from 40-770 million liters of kerosene being poured directly into the ground in the Andean region, mainly Colombia.

Source: Trade and Environment Database (TED), TED Case Studies: Columbia Coca Trade (Washington DC: American University, 1997).

8. In Colombia, it is estimated that more than 200,000 tons of chemical wastes are dumped into the ground and streams each year, due to the unregulated manufacture of cocaine.

Source: Trade and Environment Database (TED), TED Case Studies: Columbia Coca Trade (Washington DC: American University, 1997).

Common Sense for Drug Policy Presents The Facts: Environment

Forfeiture

1. **According to a 1998 article published in the University of Chicago Law Review, the ability of law enforcement agencies to financially benefit from forfeited assets, and the provision of large block grants from Congress to fight the drug trade "have distorted governmental policy making and law enforcement." The authors believe that "the law enforcement agenda that targets assets rather than crime, the 80 percent of seizures that are unaccompanied by any criminal prosecution, the plea bargains that favor drug kingpins and penalize the 'mules' without assets to trade, the reverse stings that target drug buyers rather than drug sellers, the overkill in agencies involved in even minor arrests, the massive shift in resources towards federal jurisdiction over local law enforcement - is largely the unplanned by-product of this economic incentive structure."**

   Source: Blumenson, E. & and Nilsen, E., "Policing for Profit: The Drug War's Hidden Economic Agenda," University of Chicago Law Review, 65: 35-114 (1998, Winter).

2. **On April 25, 2000, HR 1658, the Civil Forfeiture Reform Act of 2000, was signed by President Clinton and became Public Law 106-185. The Act significantly reformed the Federal civil forfeiture law, including: safeguarding an innocent owner's interest in property, and placing the burden of proof on the Government to establish by a preponderance of evidence that the property is subject to forfeiture, among others.**

   Source: Text of H.R. 1658 (enrolled and sent to President) and Congressional Research Service bill summary, Library of Congress THOMAS Federal Legislative Information Service, on the web at http://thomas.loc.gov/ and the Government Printing Office website at http://www.gpo.gov/

3. **Federal forfeitures totaled approximately $730 million in 1994.**

   Source: Heilbroner, D., "The Law Goes on a Treasure Hunt," The New York Times, (1994, December 11), Section 6, p. 70, (quoting the 1992 testimony of Cary H. Copeland, then director of the Justice Department's executive-office asset forfeiture unit).

4. **During a 10-month national survey, it was discovered that 80% of people who had property forfeited were never charged with a crime.**

   Source: Schneider, A. & Flaherty, M.P., "Presumed Guilty: The Law's Victims in the War on Drugs," The Pittsburgh Press, (1991, August 11).

Common Sense for Drug Policy Presents The Facts:
Forfeiture

Gateway Theory

1. In March 1999, the Institute of Medicine issued a report on various aspects of marijuana, including the so-called, Gateway Theory (the theory that using marijuana leads people to use harder drugs like cocaine and heroin). The IOM stated, "There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs."

Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr. Division of Neuroscience and Behavioral Research, Institute of Medicine, Marijuana and Medicine: Assessing the Science Base (Washington, DC: National Academy Press, 1999).

2. The Institute of Medicine's 1999 report on marijuana explained that marijuana has been mistaken for a gateway drug in the past because "Patterns in progression of drug use from adolescence to adulthood are strikingly regular. Because it is the most widely used illicit drug, marijuana is predictably the first illicit drug most people encounter. Not surprisingly, most users of other illicit drugs have used marijuana first. In fact, most drug users begin with alcohol and nicotine before marijuana — usually before they are of legal age."

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Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr. Division of Neuroscience and Behavioral Research, Institute of Medicine, Marijuana and Medicine: Assessing the Science Base (Washington, DC: National Academy Press, 1999).

3. The 1999 federal National Household Survey of Drug Abuse provides an estimate of the age of first use of drugs. According to the Household Survey, the mean age of first use of marijuana in the US in 1997 was 17.2 years. The mean age of first use of alcohol in that year, on the other hand, was 16.1 years, and the mean age of first use of cigarettes was 15.4 years old.

Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Summary of Findings from the 1999 National Household Survey on Drug Abuse (Rockville, MD: SAMHSA, August 2000), pp. G-49, G-60 & G-61.

4. The 1999 federal National Household Survey of Drug Abuse reports, "The rate of past month illicit drug use among youths was higher among those that were currently using cigarettes or alcohol, compared with youths not using cigarettes or alcohol. In 1999, 5.6 percent of youth nonsmokers used illicit drugs, while among youths who used cigarettes, the rate of past month illicit drug use was 41.1 percent. The rate of illicit drug use was also associated with the level of alcohol use. Among youths who were heavy drinkers in 1999, 66.7 percent of also current illicit drug users. Among nondrinkers, only 5.5 percent were current illicit drug users."

Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Summary of Findings from the 1999 National Household Survey on Drug Abuse (Rockville, MD: SAMHSA, August 2000), p. 15.

Gateway Theory

5. Over 72 million Americans have used marijuana, yet for every 120 marijuana users, there is only one active, regular user of cocaine.

Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, National Household Survey on Drug Abuse: Population Estimates 1998 (Washington DC: US Department of Health and Human Services, 1999), pp. 19, 25, 31.

6. The World Health Organization's investigation into the gateway effect of marijuana stated emphatically that the theory that marijuana use by adolescents leads to heroin use is the least likely of all hypotheses.

Source: Hall, W., Room, R. & Bondy, S., WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use, August 28, 1995 (Geneva, Switzerland: World Health Organization, March 1998).

7. The World Health Organization noted the effects of prohibition in its March 1998 study, when it stated that "exposure to other drugs when purchasing cannabis on the black market, increases the opportunity to use other illicit drugs."

Source: Hall, W., Room, R. & Bondy, S., WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use, August 28, 1995 (Geneva, Switzerland: World Health Organization, March 1998).

8. According to CASA (National Center on Addiction and Substance Abuse), there is no proof that a causal relationship exists between cigarettes, alcohol, marijuana and other drugs. Basic scientific and clinical research establishing causality does not exist.

Source: Merrill, J.C. & Fox, K.S., Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use, Introduction (New York, NY: National Center on Addiction and Substance Abuse at Columbia University, October 1994).

Common Sense for Drug Policy Presents The Facts:
Gateway Theory

Hemp

1. **According to David West, PhD, "The THC levels in industrial hemp are so low that no one could ever get high from smoking it. Moreover, hemp contains a relatively high percentage of another cannabinoid, CBD, that actually blocks the marijuana high. Hemp, it turns out, is not only not marijuana; it could be called 'antimarijuana.'"**

   Source: West, David P, Hemp and Marijuana: Myths and Realities (Madison, WI: North American Industrial Hemp Council, 1998), p. 3.

2. **Although opponents of hemp production claim that hemp fields will be used to hide marijuana fields, this is unlikely because cross-pollination between hemp and marijuana plants would significantly reduce the potency of the marijuana plant. On March 12, 1998, Canada legalized hemp production and set a limit of 0.3% THC content that may be present in the plants and requires that all seeds be certified for THC content.**

   Source: West, David P, Hemp and Marijuana: Myths and Realities (Madison, WI: North American Industrial Hemp Council, 1998), pp. 4, 21.

3. **In a July 1998 study issued by the Center for Business and Economic Research at the University of Kentucky, researchers concluded that Kentucky hemp farmers could earn a net profit of $600 per acre for raising certified seeds, $320 net profit per acre for straw only or straw and grain production, and $220 net profit per acre for grain only production. The only crop found to be more profitable was tobacco.**

   Source: Tompson, Eric C., PhD, Berger, Mark C., PhD, and Allen, Steven N., Economic Impacts of Industrial Hemp in Kentucky (Lexington, KY: University of Kentucky, Center for Business and Economic Research, 1998), p. 21.

4. **In a July 1998 study issued by the Center for Business and Economic Research at the University of Kentucky, researchers estimated that if Kentucky again became the main source for industrial hemp seed (as it was in the past), the state could earn the following economic benefits:**

Scenario	Full time jobs created	Workers Earnings
Main source for certified industrial seeds only	69 jobs	$1,300,000.00
Certified seeds, plus one processing facility	303 jobs	$6,700,000.00
Certified seeds, plus two processing facilities	537 jobs	$12,000.000.00
Certified seeds, one processing facility, one industrial hemp paper-pulp plant	771 jobs	$17,600,000.00

   Source: Tompson, Eric C., PhD, Berger, Mark C., PhD, and Allen, Steven N., Economic Impacts of Industrial Hemp in Kentucky (Lexington, KY: University of Kentucky, Center for Business and Economic Research, 1998), p. iv.

Hemp

5. **"Other than Maryland, only Hawaii, North Dakota and Minnesota have laws allowing hemp production. All were passed last year. Both Minnesota and North Dakota allow farmers statewide to grow hemp."**

   Source: Montgomery, Lori, Washington Post Staff Writer, Maryland Authorizes the Production of Hemp, The Washington Post, May 19, 2000, p. B1, B5.

6. **"In Virginia, lawmakers passed a resolution last year urging federal officials to 'revise the necessary regulations' to permit experimental hemp production there."**

   Source: Montgomery, Lori, Washington Post Staff Writer, Maryland Authorizes the Production of Hemp, The Washington Post, May 19, 2000, p. B5.

Common Sense for Drug Policy Presents The Facts:
Hemp

Heroin

1. **"Heroin is processed from morphine, a naturally occurring substance extracted from the seedpod of the Asian poppy plant. Heroin usually appears as a white or brown powder. Street names for heroin include 'smack', 'H,' 'skag', and 'junk'. Other names may refer to types of heroin produced in a specific geographical area, such as 'Mexican black tar.'"'**

   Source: National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

2. **"Acute intoxication (overdose) with opioids is characterized by euphoria, flushing, itching of the skin (particularly with morphine), miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature."**

   Source: "Opioid Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195c.htm last accessed December 5, 2000.

3. **"Many complications of heroin addiction are related to the unsanitary administration of the drug. Others are due to the inherent properties of the drug, overdose, or intoxicated behavior accompanying drug use. Common complications include pulmonary disorders, hepatitis, arthritic disorders, immunologic changes, and neurologic disorders."**

   Source: "Opioid Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195c.htm last accessed December 5, 2000.

4. **"Pulmonary complications, including various types of pneumonia, may result from the poor health condition of the abuser, as well as from heroin's depressing effects on respiration. "**

   Source: National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

5. **"In addition to the effects of the drug itself, street heroin may have additives that do not readily dissolve and result in clogging the blood vessels that lead to the lungs, liver, kidneys, or brain. This can cause infection or even death of small patches of cells in vital organs."**

   Source: National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

6. **"A striking finding from the toxicological data was the relatively small number of subjects in whom morphine only was detected. Most died with more drugs than heroin alone 'on board', with alcohol detected in 45% of subjects and benzodiazepines in just over a quarter. Both of these drugs act as central nervous system depressants and can enhance and prolong the depressant effects of heroin."**

   Source: Zador, Deborah, Sunjic, Sandra, and Darke, Shane, "Heroin-related deaths in New South Wales, 1992: toxicological findings and circumstances," The

Medical Journal of Australia, published on the web at http://www.mja.com.au/public/issues/feb19/zador/zador.html last accessed on November 17, 2000.

7. **"Our findings that an ambulance was called while the subject was still alive in only 10% of cases, and that a substantial minority of heroin users died alone, strongly suggest that education campaigns should also emphasise that it is safer to inject heroin in the company of others, and important to call for an ambulance early in the event of an overdose. Consideration should also be given to trialling the distribution of the opioid antagonist naloxone to users to reduce mortality from heroin use."**

   Source: Zador, Deborah, Sunjic, Sandra, and Darke, Shane, "Heroin-related deaths in New South Wales, 1992: toxicological findings and circumstances," The Medical Journal of Australia, published on the web at http://www.mja.com.au/public/issues/feb19/zador/zador.html last accessed on November 17, 2000.

8. **"The disadvantage of continuing to describe heroin-related fatalities as 'overdoses' is that it attributes the cause of death solely to heroin and detracts attention from the contribution of other drugs to the cause of death. Heroin users need to be educated about the potentially dangerous practice of concurrent polydrug and heroin use."**

   Source: Zador, Deborah, Sunjic, Sandra, and Darke, Shane, "Heroin-related deaths in New South Wales, 1992: toxicological findings and circumstances," The Medical Journal of Australia, published on the web at http://www.mja.com.au/public/issues/feb19/zador/zador.html last accessed on November 17, 2000.

9. **"A first priority for prevention must be to reduce the frequency of drug overdoses. We should inform heroin users about the risks of combining heroin with alcohol and other depressant drugs. Not all users will act on such information, but if there are similar behavioral changes to those that occurred with needle-sharing overdose deaths could be substantially reduced. Heroin users should also be discouraged from injecting alone and thereby denying themselves assistance in the event of an overdose."**

   Source: Dr. W.D. Hall, "How can we reduce heroin 'overdose' deaths?" The Medical Journal of Australia (MJA 1996; 164:197), from the web at http://www.mja.com.au/public/issues/feb19/hall/hall.html last accessed on November 17, 2000.

10. **"Tolerance of and physical dependence on opioids (natural or synthetic) develop rapidly, therapeutic doses taken regularly over 2 to 3 days can lead to some tolerance and dependence, and when the drug is discontinued, the user may have mild withdrawal symptoms, which are scarcely noticed or are described as a case of influenza."**

    Source: "Opioid Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195c.htm last accessed December 5, 2000.

Heroin

11. **"Withdrawal, which in regular abusers may occur as early as a few hours after the last administration, produces drug craving, restlessness, muscle and bone pain, insomnia, diarrhea and vomiting, cold flashes with goose bumps ('cold turkey'), kicking movements ('kicking the habit'), and other symptoms. Major withdrawal symptoms peak between 48 and 72 hours after the last dose and subside after about a week. Sudden withdrawal by heavily dependent users who are in poor health is occasionally fatal, although heroin withdrawal is considered much less dangerous than alcohol or barbiturate withdrawal."**

    Source: National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

12. **"There is a broad range of treatment options for heroin addiction, including medications as well as behavioral therapies. Science has taught us that when medication treatment is integrated with other supportive services, patients are often able to stop heroin (or other opiate) use and return to more stable and productive lives."**

    Source: National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

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13. **"In November 1997, the National Institutes of Health (NIH) convened a Consensus Panel on Effective Medical Treatment of Heroin Addiction. The panel of national experts concluded that opiate drug addictions are diseases of the brain and medical disorders that indeed can be treated effectively. The panel strongly recommended (1) broader access to methadone maintenance treatment programs for people who are addicted to heroin or other opiate drugs; and (2) the Federal and State regulations and other barriers impeding this access be eliminated. This panel also stressed the importance of providing substance abuse counseling, psychosocial therapies, and other supportive services to enhance retention and successful outcomes in methadone maintenance treatment programs. The panel's full consensus statement is available by calling 1-888-NIH-CONSENSUS (1-888-644-2667) or by visiting the NIH Consensus Development Program Web site at http://consensus.nih.gov."**

    Source: National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

14. **"Methadone, a synthetic opiate medication that blocks the effects of heroin for about 24 hours, has a proven record of success when prescribed at a high enough dosage level for people addicted to heroin. LAAM, also a synthetic opiate medication for treating heroin addiction, can block the effects of heroin for up to 72 hours. Other approved medications are naloxone, which is used to treat**

cases of overdose, and naltrexone both of which block the effects of morphine, heroin, and other opiates. Several other medications for use in heroin treatment programs are also under study."

Source: National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

15. **"These pilot study findings showed that opiate-dependent injecting drug users with long injecting careers (most started between 1970 and 1982) and for whom opiate treatment had failed multiple times previously were attracted into and retained by therapy with injectable opiates."**

    Source: Metrebian, Nicky, Shanahan, William, Wells, Brian, and Stimson, Gerry, "Feasibility of prescribing injectable heroin and methadone to opiate-dependent drug users; associated health gains and harm reductions," The Medical Journal of Australia (MJA 1998; 168: 596-600), from the web at http://www.mja.com.au/public/issues/jun15/mtrebn/mtrebn.html last accessed on November 17, 2000.

16. **"Prescribing injectable opiates is one of many options in a range of treatments for opiate-dependent drug users. In showing that it attracts and retains long term resistant opiate-dependent drug users in treatment and that it is associated with significant and sustained reductions in drug use and improvements in health and social status, our findings endorse the view that it is a feasible option."**

    Source: Metrebian, Nicky, Shanahan, William, Wells, Brian, and Stimson, Gerry, "Feasibility of prescribing injectable heroin and methadone to opiate-dependent drug users; associated health gains and harm reductions," The Medical Journal of Australia (MJA 1998; 168: 596-600), from the web at http://www.mja.com.au/public/issues/jun15/mtrebn/mtrebn.html last accessed on November 17, 2000.

17. **"According to the 1999 MTF (Monitoring the Future Survey), rates of heroin use remained relatively stable and low since the late 1970s. After 1991, however, use began to rise among 10th- and 12th-graders and after 1993, among 8th-graders. In 1999, prevalence of heroin use was comparable for all three grade levels. Although past year prevalence rates for heroin use remained relatively low in 1999, these rates are about two to three times higher than those reported in 1991. "**

    Source: National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

18. **"The 1999 NHSDA (National Household Survey on Drug Abuse) study reports the use of illicit drugs by those people age 12 and older. The lifetime prevalence (at least one use in a persons lifetime) for heroin for those people age 12 and older was 1.4 percent. "By age category, 0.4 percent were in the 12-17 range; 1.8 percent were 18-25; and 1.4 percent were users age 26 and older."**

*Source:*National Institute on Drug Abuse, Infofax on Heroin No. 13548 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/heroin.html last accessed November 16, 2000.

Perspectives from Experts in the Field of Narcotics Treatment

19. "Unlike alcohol or tobacco, heroin causes no ongoing toxicity to the tissues or organs of the body. Apart from causing some constipation, it appears to have no side effects in most who take it. When administered safely, its use may be consistent with a long and productive life. The principal harm comes from the risk of overdose, problems with injecting, drug impurities and adverse legal or financial consequences."

Source: Byrne, Andrew, MD, "Addict in the Family: How to Cope with the Long Haul" (Redfern, NSW, Australia: Tosca Press, 1996), pp. 33-34, available on the web at http://www.csdp.org/addict/ .

20. "People rarely die from heroin overdoses - meaning pure concentrations of the drug which simply overwhelm the body's responses."

Source: Peele, Stanton, MD, "The Persistent, Dangerous Myth of Heroin Overdose," from the web at http://www.peele.net/lib/heroinoverdose.html last accessed on November 18, 2000.

21. "The majority of drug deaths in an Australian study, conducted by the National Alcohol and Drug Research Centre, involved heroin in combination with either alcohol (40 percent) or tranquilizers (30 percent)."

Source: Peele, Stanton, MD, "The Persistent, Dangerous Myth of Heroin Overdose," from the web at http://www.peele.net/lib/heroinoverdose.html last accessed on November 18, 2000.

22. "If it is not pure drugs that kill, but impure drugs and the mixture of drugs, then the myth of the heroin overdose can be dangerous. If users had a guaranteed pure supply of heroin which they relied on, there would be little more likelihood of toxic doses than occur with narcotics administered in a hospital.

Source: Peele, Stanton, MD, "The Persistent, Dangerous Myth of Heroin Overdose," from the web at http://www.peele.net/lib/heroinoverdose.html last accessed on November 18, 2000.

23. "But when people take whatever they can off the street, they have no way of knowing how the drug is adulterated. And when they decide to augment heroin's effects, possibly because they do not want to take too much heroin, they may place themselves in the greatest danger."

Source: Peele, Stanton, MD, "The Persistent, Dangerous Myth of Heroin Overdose," from the web at http://www.peele.net/lib/heroinoverdose.html last accessed on November 18, 2000.

Common Sense for Drug Policy Presents The Facts: Heroin

Impact of the Drug War on Families

1. **"In 1999 State and Federal prisons held an estimated 721,500 parents of minor children. A majority of State (55%) and Federal (63%) prisoners reported having a child under the age of 18. Forty-six percent of the parents reported living with their children prior to admission. As a result, there were an estimated 336,300 US households with minor children affected by the imprisonment of a resident parent."**

   Source: Mumola, Christopher J., US Department of Justice Bureau of Justice Statistics, Incarcerated Parents and Their Children (Washington, DC: US Department of Justice, August 2000), p. 1.

2. **The Bureau of Justice Statistics estimates that 2.8% of all children under age 18 have at least one parent in a local jail or a State or Federal prison a total of 1,941,796 kids. One in 40 have an incarcerated father, and 1 in 359 have an incarcerated mother.**

   Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), p. 8, Table 18.

3. **"A majority of parents in both State (62%) and Federal (84%) prison were held more than 100 miles from their last place of residence."**

   Source: Mumola, Christopher J., US Department of Justice Bureau of Justice Statistics, Incarcerated Parents and Their Children (Washington, DC: US Department of Justice, August 2000), p. 5.

4. **"Black children (7.0%) were nearly 9 times more likely to have a parent in prison than white children (0.8%). Hispanic children (2.6%) were 3 times as likely as white children to have an inmate parent."**

   Source: Mumola, Christopher J., US Department of Justice Bureau of Justice Statistics, Incarcerated Parents and Their Children (Washington, DC: US Department of Justice, August 2000), p. 2.

5. **Approximately 516,200 women on probation (72% of the total), 44,700 women in local jails (70% of the total), 49,200 women in State prisons (65% of the total), and 5,400 women in Federal prisons (59% of the total) have minor children.**

   Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), p. 7, Table 17.

6. **"The number of offenders under age 18 admitted to prison for drug offenses increased twelvefold (from 70 to 840) between 1985 to 1997. By 1997 drug offenders made up 11% of admissions among persons under 18 compared to 2% in 1985."**

   Source: Strom, Kevin J., US Department of Justice, Bureau of Justice Statistics, Profile of State Prisoners Under Age 18, 1985-1997 (Washington, DC: US Department of Justice, February 2000), p. 4.

7. **Fifty-eight percent of offenders under 18 years of age admitted to prison in 1997 were black and 25% were white. In 1990, African-American youth comprised 61% of admissions and whites 21%. Still, the shift from 1985 to 1990 was more dramatic: During**

this period the percentage of African-American young people put in prison increased from 53% to 62%, and the percentage of whites fell from 32% to 21%.

Source: Strom, Kevin J., US Department of Justice, Bureau of Justice Statistics, Profile of State Prisoners Under Age 18, 1985-1997 (Washington, DC: US Department of Justice, February 2000), p. 6.

8. **Despite the fact that federal spending on the drug war increased from $1.65 billion in 1982 to $17.7 billion in 1999, more than half of the students in the United States in 1999 tried an illegal drug before they graduated from high school. Additionally, 65% have tried cigarettes by 12th grade and 35% are current smokers, and 62% of twelfth graders and 25% of 8th graders in 1999 report having been drunk at least once.**

   Source: Office of National Drug Control Policy, National Drug Control Strategy: Budget Summary (Washington DC: US Government Printing Office, 1992), pp. 212-214; Office of National Drug Control Policy, National Drug Control Strategy: 2000 Annual Report (Washington, DC: US Government Printing Office, 2000), p. 97, Table 4-2; Johnston, L., Bachman, J. & O'Malley, P., Monitoring the Future: National Results on Adolescent Drug Use Overview of Key Findings 1999, (Washington, DC: NIDA, 2000), pp. 3-6.

9. **The Federal drug control budget request for FY 2001 includes $8.2 Billion for the Justice Department, $1.03 Billion for the Defense Department, and only $750 Million for the Education Department.**

   Source: Office of National Drug Control Policy, National Drug Control Strategy: 2000 Annual Report (Washington, DC: US Government Printing Office, 2000), p. 94, Table 4-1.

10. **A federal report by the U.S. Center on Substance Abuse Prevention noted that "adolescence is a period in which youth reject conventionality and traditional authority figures in an effort to establish their own independence. For a significant number of adolescents, this rejection consists of engaging in a number of 'risky' behaviors, including drug and alcohol use. Within the past few years, researchers and practitioners have begun to focus on this tendency, suggesting that drug use may be a 'default' activity engaged in when youth have few or no opportunities to assert their independence in a constructive manner."**

    Source: Maria Carmona and Kathryn Stewart, A Review of Alternative Activities and Alternatives Programs in Youth-Oriented Prevention (National Center for the Advancement of Prevention, under contract for the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention, 1996), p. 5.

11. **A federal report by the U.S. Center on Substance Abuse Prevention stated that "alternative programming appears to be most effective among those youth at greatest risk for substance abuse and related problems." According to the report, alternatives are defined as, "those that provide targeted populations with activities that are free of alcohol, tobacco, and illicit drugs."**

Source: Maria Carmona and Kathryn Stewart, A Review of Alternative Activities and Alternatives Programs in Youth-Oriented Prevention (National Center for the Advancement of Prevention, under contract for the Substance Abuse Mental Health Services Administration(SAMHSA), Center for Substance Abuse Prevention, 1996), p. 21, 3.

12. Federal research shows that the ONDCP's anti-drug media campaign is ineffective. According to NIDA's 1998 Household Survey, "exposure to prevention messages outside school, such as through the media, was fairly widespread but appeared to be unrelated to illicit drug use or being drunk". NIDA goes on to report, "Nearly 80% of youths who used illicit drugs and more than three-fourths of youths who were drunk on 51 or more days in the past year reported being exposed to prevention messages outside school."

Source: Office of Applied Studies, National Institute on Drug Abuse, National Household Survey on Drug Abuse: Main Findings 1998 (Rockville, MD: SAMHSA, US Department of Health and Human Services, March 2000), p. 174.

13. "Our results are consistent in documenting the absence of beneficial effects associated with the DARE program. This was true whether the outcome consisted of actual drug use or merely attitudes toward drug use. In addition, we examined processes that are the focus of intervention and purportedly mediate the impact of DARE (e.g., self-esteem and peer resistance), and these also failed to differentiate DARE participants from nonparticipants. Thus, consistent with the earlier Clayton et al. (1996) study, there appear to be no reliable short-term, long-term, early adolescent, or young adult positive outcomes associated with receiving the DARE intervention."

Source: Lynam, Donald R., Milich, Richard, et al., "Project DARE: No Effects at 10-Year Follow-Up", Journal of Consulting and Clinical Psychology (Washington, DC: American Psychological Association, August 1999), Vol. 67, No. 4, 590-593.

14. Public Housing Authorities (PHAs) in the US operate under a "One Strike" policy regarding drug use that is so over-reaching that even drug use by a guest can be grounds for eviction. According to the Department of Housing and Urban Development, "The 1998 amendments of the 1996 Extension Act provisions on ineligibility of illegal drug users and alcohol abusers confirm that a PHA or owner may deny admission or terminate assistance for the whole household that includes a person involved in the proscribed activity. With respect to a PHA or owner's discretion to consider rehabilitation for a household member with the offending substance abuse problem, the rule would permit a PHA or owner to hold the whole household responsible for that member's successful rehabilitation as a condition for continued occupancy and avoidance of eviction."

Source: Federal Record, Vol. 64, No. 141, Friday, July 23, 1999, p. 40266; see also Community Safety and Conservation Division, US Department of Housing and Urban Development, "One Strike and You're Out," from the web at http://www.hud.gov/pih/programs/ph/de/programs/onestr.html last accessed Nov. 7, 2000.

Impact of the Drug War on Families

15. "Research and clinical experience teach that when, as here, the personal risks of seeking medical care are raised to intolerably high levels, it is more likely that prenatal care and patient candor — and not drug use — will be what is deterred, often with tragic health consequences."

Source: American Public Health Association, along with South Carolina Medical Association, American College of Obstetricians and Gynecologists, American Nurses Association, et al., Amicus Curiae brief in support of plaintiff in case of Ferguson v. City of Charleston, et al., Docket Number 99-0936, from the web at http://supreme.lp.findlaw.com/supreme_court/briefs/99-936/99-936fo4/brief/brief01.html last accessed Nov. 7, 2000.

16. A case recently argued before the US Supreme Court (Ferguson, Crystal v. City of Charleston, et al.) involves the rights of mothers to seek medical care during pregnancy without fear of prosecution for a positive urine drug test. The Medill School of Journalism at Northwestern University reports that "because a live fetus was a 'person' under South Carolina law, a woman who used cocaine after the 24th week of pregnancy could be found guilty of the crime of distributing an illegal substance to a person under the age of 18."

Source: Northwestern University, On The Docket (Evanston, IL: Medill School of Journalism), from the web at http://www.medill.nwu.edu/docket/cases.srch?-database=docket&-layout=lasso&-response=%2fdocket%2fdetail.srch&-recID=32842&-searchlast accessed Nov. 7, 2000.

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17. Regardless of similar or equal levels of illicit drug use during pregnancy, black women are 10 times more likely than white women to be reported to child welfare agencies for prenatal drug use.

Source: Neuspiel, D.R., "Racism and Perinatal Addiction," Ethnicity and Disease, 6: 47-55 (1996); Chasnoff, I.J., Landress, H.J., & Barrett, M.E., "The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida," New England Journal of Medicine, 322: 1202-1206 (1990).

Common Sense for Drug Policy Presents The Facts:
Impact of the Drug War on Families

Interdiction

1. **The international illicit drug business generates as much as $400 billion in trade annually according to the United Nations International Drug Control Program. That amounts to 8% of all international trade and is comparable to the annual turnover in textiles, according to the study.**

   Source: United Nations Office for Drug Control and Crime Prevention, Economic and Social Consequences of Drug Abuse and Illicit Trafficking (New York, NY: UNODCCP, 1998), p. 3.

2. **Interdiction efforts intercept 10-15% of the heroin and 30% of the cocaine. Drug traffickers earn gross profit margins of up to 300%. At least 75% of international drug shipments would need to be intercepted to substantially reduce the profitability of drug trafficking.**

   Source: Associated Press, "U.N. Estimates Drug Business Equal to 8 Percent of World Trade," (June 26, 1997).

3. **"Opiate seizures represent some 8 to 15% of the estimated world production. In 1997, this interception rate was about 14%, with the South-West Asian and Near and Middle East regions together accounting for 60% of global seizure volume of opium, morphine and heroin, followed by Europe (16%) and East/South-East Asia (13%).**

   "The remaining 86% (amounting to more than 400 tonnes of heroin) of the 1997 world production is assumed to have been potentially available to global illicit markets."

   Source: United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 1999 (New York, NY: UNODCCP, 1999), p. 40.

4. **"As far as trafficking is concerned, a comparison with the interception rate of opiates in the 1998 (17%), makes the interception rate of 46% reported fro cocaine for the same year appear extremely high. Assuming a similar volume of seizures in 1999, the rate would be even higher (50%). For the reasons mentioned above, there are thus some doubts about the accuracy of the total potential cocaine production reported during the past few years (765 mt in 1999).**
   "Based on seizures and consumption estimates, UNDCP considers that production might in fact be closer to 1,000 tons."
   (In other words, government makes lowball estimates of cocaine production in order to look good.)

   Source: United Nations Internation Drug Control Programme, Global Illicit Drug Trends 2000 (New York, NY: UNODCCP, 2000), p. 32.

5. **Thirteen truck loads of cocaine is enough to satisfy U.S. demand for one year. The United States has 19,924 kilometers of shoreline, 300 ports of entry and more than 7,500 miles of border with Mexico**

and Canada. Stopping drugs at the borders is like trying to find a needle in a haystack.

Source: Frankel, G., "Federal Agencies Duplicate Efforts, Wage Costly Turf Battles," The Washington Post (June 8, 1997), p. A1; Central Intelligence Agency, World Factbook 1998, 1998.

6. **One of the major problems with supply reduction efforts (source control, interdiction, and domestic enforcement) is that "suppliers simply produce for the market what they would have produced anyway, plus enough extra to cover anticipated government seizures."**

   Source: Rydell, C.P. & Everingham, S.S., Controlling Cocaine, Prepared for the Office of National Drug Control Policy and the United States Army (Santa Monica, CA: Drug Policy Research Center, RAND, 1994), p. 6.

7. **Colombian officials "seized a record amount of coca products in 1998 - almost 57 metric tons - and had also destroyed 185 cocaine laboratories... [However] there has not been a net reduction in processing or exporting refined cocaine from Colombia or in cocaine availability within the United States."**

   Source: US General Accounting Office, Drug Control: Narcotics Threat from Colombia Continues to Grow (Washington, DC: USGPO, 1999), pp. 12, 6.

8. **"In 2000, coca production in Bolivia appears to continue the 3-year decrease started in 1997, although at a somewhat slower rate than in 1999. Production in Peru seems to be stable or possibly increasing slightly. There seems to be a further increase in the area under coca cultivation in Columbia in 2000."**

   Source: United Nations International Drug Control Programme, Global Illicit Drug Trends 2000 (New York, NY: UNDCP, 2000), p. 32.

9. **To achieve a one percent reduction in U.S. cocaine consumption, the United States could spend an additional $34 million on drug treatment programs, or 20 times more, $783 million, on efforts to eradicate the supply at the source.**

   Source: Rydell & Everingham, Controlling Cocaine (Santa Monica, CA: The RAND Corporation, 1994).

10. **"Despite 2 years of extensive herbicide spraying [source country eradication], U.S. estimates show there has not been any net reduction in [Colombian] coca cultivation - net coca cultivation actually increased 50 percent."**

    Source: US General Accounting Office, Drug Control: Narcotics Threat from Colombia Continues to Grow (Washington, DC: USGPO, 1999), pgs. 2.

11. **In spite of US expenditures of $625 million in counter narcotics operations in Colombia between 1990 and 1998, Colombia was**

able to surpass Peru and Bolivia to become the world's largest coca producer. Additionally, "there has not been a net reduction in processing or exporting refined cocaine from Colombia or in cocaine availability within the United States."

Source: US General Accounting Office, Drug Control: Narcotics Threat from Colombia Continues to Grow (Washington, DC: USGPO, 1999), pp. 3, 4, 6.

12. **"... While two major groups (the Medellin and Cali cartels) dominated drug-trafficking activities during the late 1980s and early 1990s, today there are hundreds of smaller and more decentralized organizations. These groups are now capable of producing 'black cocaine' that hinders detection and are improving their transportation capabilities by manufacturing boats capable of carrying up to 2 tons of cocaine at high speeds."**

    Source: US General Accounting Office, Drug Control: Narcotics Threat from Colombia Continues to Grow (Washington, DC: USGPO, 1999), pp. 4-5.

13. **Black cocaine is created by a new chemical process used by drug traffickers to evade detection by drug sniffing dogs and chemical tests. The traffickers add charcoal and other chemicals to cocaine, which transforms it into a black substance that has no smell and does not react when subjected to the usual chemical tests.**

    Source: US General Accounting Office, Drug Control: Narcotics Threat from Colombia Continues to Grow (Washington, DC: USGPO, 1999), p. 5.

Common Sense for Drug Policy Presents The Facts: Interdiction

International Facts and Trends: Comparing Drug Policies of Various Nations and the US

European Union:

1. **"In prosecuting drug-related offences, alternative measures to prison are favoured in all Member States if a custodial sentence is not strictly necessary. In parallel, depenalisation of drug offences is becoming increasingly common. These trends suggest a consensus that prison is not an appropriate solution for individuals with drug problems. Instead, treatment appears to be the preferred response, even when the severity of the crime makes imprisonment inevitable."[f]**
2. **"Cannabis is the most frequently used [illicit] substance in the EU. Lifetime experience (any use during a person's lifetime) in the adult population ranges from 10% in Finland to 20 or 30% in Denmark, Spain and the UK (Figure 1). Amphetamines are generally used by 1 to 4% of adults, but by up to 10% in the UK. Ecstasy has been tried by 0.5 to 4% of European adults and cocaine by 0.5 to 3%. Experience of heroin is harder to estimate because of its low prevalence and more hidden nature, but is generally reported by under 1% of adults."[f]**
3. **"Lifetime experience of cannabis increased over the decade in most countries, and levels appear to be converging. Where prevalence was low early in the decade (for example, in Greece, Finland and Sweden), increases have been proportionally greater than where initial prevalence was higher (for example, in Denmark, Germany and the UK)."[f]**
4. **"In 11 EU Member States, the judicial authorities prosecuting the possession of small quantities of heroin or similar drugs must assess whether the substance is for personal use or not. Possession solely for personal use is considered less serious than possession for other purposes and the average sentence varies from administrative sanctions - - such as confiscation of a driving license or passport - - to a fine or a custodial sentence for up to 12 months."[f]**
5. **"Treatment as an alternative to punishment is a core principle in most Member States and forms the basis of Austria's national drug policy. Probation or suspended sentences are commonly applied and successful treatment closes the case."[f]**
6. **"Spain and France include both legal and illegal drugs in their new strategies, emphasising the addictive behaviour not the substance. This tendency has been apparent, for example in German, Austrian and Swedish prevention policies, since the 1980s."[f]**
7. **"The emergence of HIV in the 1980s led to the introduction of syringe-exchange programmes which are now established in all**

Member States, although to varying degrees. Needle-sharing seems to have decreased in most countries, with more syringes being exchanged."[f]

8. **"In most countries, increased access to sterile needles and syringes, greater availability of condoms, HIV counseling and testing, and substitution treatment have all helped control HIV transmission among injectors."[f]**

Belgium:

1. **"In 1998 Belgian directive stipulated that the possession of cannabis products for personal use should be accorded the 'lowest priority' in criminal justice."[f]**

Canada:

1. **"Canada's Drug Strategy is officially one of harm reduction. However, law enforcement is followed fairly stringently with an emphasis on prohibition and high arrest rates for users."[a]**
2. **"The federal government will not appeal an Ontario court ruling that struck down marijuana laws because they don't allow for medicinal use, a Justice spokeswoman said Friday. The government made the decision Thursday, a week after Health Minister Allan Rock announced he would make changes to regulations that would allow Canadians access to marijuana for medical purposes."[n]**

Denmark:

1. **"In general, petty first-time offences - - such as possession of very small quantities for personal use - - lead to warnings, cautions and confiscation of the substance rather than more severe penalties. In Denmark, however, users possessing a single dose for their personal use may be allowed to keep it. In these cases confiscation is seen as counter-productive since a crime would probably have to be committed to pay for another dose."[f]**

France:

1. **"Similarly, a June 1999 directive of the French Minister of Justice recommended prosecutors to deliver verbal warnings and cautions rather than imprisoning drug users - - especially occasional users of cannabis — who had committed no other related offences."[f]**

Germany:

1. **"In Germany, Italy and Luxembourg, as priority has shifted from repressive policies towards prevention and care, responsibility for drug policy has moved from the Ministries of the Interior to the Ministries of Health and/or Social Affairs."[f]**

International Facts and Trends: Comparing Drug Policies of Various Nations and the US

2. **"The new elements of Germany's addiction policy, adopted in February 2000, focus on reducing drug-related harm and assisting very deprived drug users, for instance by providing a legal framework for injection rooms."[f]**

Greece:

1. **"In Greece, possession of small amounts of cannabis may in some cases be more strictly punished than possession of small amounts of heroin on the grounds that as heroin is addictive, the user is in greater physical need than the cannabis user."[f]**
2. **"In Greece, users who exchange small amounts of drugs amongst themselves proven to be exclusively for their personal use may receive a six-month prison sentence which can either be exchanged for a fine or suspended. Drug addicts involved in trafficking considerable quantities face up to eight years' imprisonment, whereas non-addicted offenders face life imprisonment."[f]**

Netherlands:

1. **Drug policy in the Netherlands is based on minimizing risk and reducing harm. That is why the use of cannabis (marijuana and hashish) is tolerated, as is the private personal cultivation of cannabis, and the sale of cannabis through coffee shops.[b]**
2. **Cannabis is not legal per se.[b,e]**
3. **Hard drugs are not tolerated at all, and trafficking of any kind can carry a stiff prison sentence.[b, e]**
4. **Drug use rates in The Netherlands are roughly equal to drug use rates for most other EU countries, and significantly lower than rates in the US, Great Britain and Ireland.[b,q]**
5. **The ratio of drug-related deaths in The Netherlands is the lowest in Europe.[h,q]**
6. **Violent crime rates in The Netherlands are much lower than in the US,[q] as is the rate of transmission of HIV/AIDS through injection drug use.[q]**
7. **The level of official corruption in The Netherlands, as reported by the watchdog group Transparency International and noted by the Dutch Ministry of Justice, is remarkably low, rating a better score in the Corruption Perception Index than the UK, Germany, and Austria, all of whom were rated as less corrupt than the US.[p,q]**
8. **"The Dutch parliament yesterday voted to decriminalize the wholesale trade in cannabis ."[d]**

International Facts and Trends: Comparing Drug Policies of Various Nations and the US

Portugal:

1. **"The Portuguese parliament voted Thursday to decriminalize the consumption of illegal drugs such as cannabis and heroin and treat drug users as people in need of medical help."[i]**
2. **"Portugal's strategy also allows for depenalising drug use or possession for personal use*, with offences incurring administrative sanctions (such as fines, confiscation of a driving licence or passport), as introduced in Spain in 1992 and Italy in 1993.**
   *** When an offence has been depenalised, penal sanctions can no longer be applied in response to it. In Portuguese, the term 'decriminalisation' ('descriminalizacao') has the same meaning as 'depenalisation' ('despenalizacao') in the sense that it is used in this report."[f]**

Spain:

1. **"It is not a crime in Spain to possess drugs for personal use but is a serious administrative offence. It is unlikely to be punished unless committed in public."[h]**
2. **" 'What should the court do with a convicted addict who, for example, is sentenced to five years in jail, agrees to treatment and is certified rehabilitated after two years?' Judge Jose Antonio Martin Pallin, one of the authors of this decision, explained to El Pais 'as long as the defendant did not commit any new crimes the remaining three years would be suspended.' "[g]**
3. **"In 1999, the Spanish Penitentiary Institution recommended that syringe exchange be available in all prisons in an attempt to lessen the dangers caused by needle sharing. 6.6% of Spain's prison population also receives anti-retroviral treatment."[f]**

Sweden:

1. **Sweden has a very strict drug policy, with a stated goal of making their country drug-free.[b]**
2. **"Between 1917 and 1955 Sweden had an alcohol rationing system, and even today embraces a comparatively restrictive alcohol policy. This tradition makes a restrictive drug policy a logical option."[b]**
3. **The Swedish authorities have recently reported that drug use in Sweden is on the rise. According to the Swedish Council for Information on Alcohol and Other Drugs, "In the 1990s, as the number of youngsters with personal experience of drug use increases, the perceived availability of drugs has also increased."[o]**

International Facts and Trends: Comparing Drug Policies of Various Nations and the US

4. **"Some drug related indicators suggest that the number of drug abusers have increased during the 1990s. The numbers of convictions against the Narcotics Drugs Act increased with 55% between 1990 and 1997, and the increase was particularly those including heroin and amphetamine. There have been more seizures of amphetamines and heroin, and street prices also suggest high availability."[o]**

Switzerland:

1. **Switzerland's approach is one of harm minimization.[a, b]**
2. **For the past few years a heroin trial has been conducted where heroin is prescribed to addicts. This program is only available to those who have failed every other sort of program.[a]**
3. **The Swiss also provide clean needles, and have the more traditional methadone maintenance programs.[a, b]**
4. **Switzerland is preparing to legalize marijuana and hashish.[m]**
5. **The Manchester Guardian reported in October 2000, "Switzerland is preparing to introduce legislation that effectively would allow the consumption of cannabis, adding to the country's pioneering but controversial record on drugs policy. The Swiss government said it would draw up legislation next year after consultation among local authorities and community associations revealed that there was widespread support for decriminalising cannabis.**

" 'Two-thirds of the organisations consulted said they were in favour of this move,' the interior minister, Ruth Dreifuss said yesterday. 'But the same groups opposed any such move on hard drugs, and officials ruled out softer laws on possessing or using such substances.' "

"Switzerland has the most liberal approach in Europe towards the treatment of heroin addicts. Since 1998 it has been providing clean needles and allowing the distribution of heroin to addicts under strict medical supervision."[c]

United Kingdom:

1. **"The United Kingdom basically follows a policy of harm minimization. Intrinsic to this approach has been the establishment of needle exchanges and structured methadone programs as well as supplying heroin to addicts in some circumstances and in specific locations. Law enforcement has been supportive of the harm minimization approach with cautioning now commonly used for selected minor offenses. Diversion schemes involving close links between police and drug treatment services are also currently being trialed."[a]**

International Facts and Trends: Comparing Drug Policies of Various Nations and the US

2. **According to Viscountess Runciman, chair of a panel of the British Police Foundation which looked into the drug laws, the UK "has a far more severe regime of control over possession offences than most other European countries".[h]**
3. **"In March 2000, the UK government announced the start of scientific trials into cannabis prescription, the results of which are expected in 2002."[f]**

United States:

1. **"The United States follows a strong law enforcement approach."[a]**
2. **"The National Drug Control Strategy proposes a ten-year conceptual framework to reduce illegal drug use and availability 50 percent by the year 2007."[l]**
3. **"In the United States, whose legislation serves as a model for international drug control agreements and which claims the leadership of the global antidrug fight, the war 'on drugs' is one of the main reasons for a rapid and dramatic increase of the prison population that started in the mid-1980s."[k]**

Sources:

a "Australian Alcohol and Illicit Drugs: Policy Issues", Australian Institute of Criminology, 1999, from the web at http://www.aic.gov.au/research/drugs/background/drugpolicies-world.html, last accessed Oct. 2, 2000.

b Boekhout van Solinge, Tim, "Dutch Drug Policy in a European Context" (Amsterdam, The Netherlands: Center for Drug Studies, University of Amsterdam, 1999), pre-publication version of an article appearing in Journal of Drug Issues 29(3), 511-528, 1999, available on the web at http://www.frw.uva.nl/cedro/library/european.pdf, last accessed June 6, 2000.

c Capella, Peter, "Swiss Ready to Legalise Cannabis," The Guardian (Manchester, England: Guardian Unlimited UK, Oct. 10, 2000.

d Cramb, Gordon, "Dutch Cannabis Vote Irks Cabinet," The Financial Times (London, England: The Financial Times Limited, June 28, 2000).

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f European Monitoring Center for Drugs and Drug Addiction, "2000 Annual Report on the State of the Drugs Problem in the European Union" (Brussells, Belgium: Office for Official Publications of the European Communities, 2000).

g Hernandez, J.A., "The Supreme Court Rules That Drug Addicts Should Be Sent To Treatment," El Pais (Madrid, Spain: El Pais, May 2, 2000), translated from the Spanish by Robert Sharpe, available in the original at http://www.elpais.es/p/d/20000502/sociedad/supremo.htm, last accessed October 13, 2000.

h Johnston, Philip, The Daily Telegraph, "International Conventions: UK Regime Among the Most Severe in Europe" (London, England: The Daily Telegraph, March 31, 2000.).

i "Lisbon Parliament Legalizes Drugs", The Washington Times (Washington, DC: News World Communications, Inc., July 7, 2000).

j Netherlands Ministry of Justice, Fact Sheet: Dutch Drugs Policy, (Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction, 1999), from the Netherlands Justice Ministry website at http://www.minjust.nl:8080/a_beleid/fact/cfact7.htm.

k Observatoire Geopolitique des Drogues, The World Geopolitics of Drugs 1998/1999, "Trends for 1998/1999: The Globalization of the Trafficking Economy" (Paris, France: OGD, April 2000).

l Office of National Drug Control Policy, "Reducing Drug Abuse in America: An Overview of Demand Reduction Initiatives", Chapter II (Washington, DC: ONDCP, January 1999), from the web at http://www.whitehousedrugpolicy.gov/drugabuse/2a.html, last accessed Oct. 4, 2000.

m Olson, Elizabeth, The New York Times, "Legalizing Marijuana" (New York, NY: Times Publishing Co., Oct. 3, 2000).

n "Ottawa Won't Appeal Ruling Striking Down Marijuana Laws: Justice," Ottawa Citizen (Ottawa, Ontario, Canada: Ottawa Citizen, Sept. 30, 2000).

o Swedish National Council for Information on Alcohol and Other Drugs (CAN), "Drug Trends in Sweden Report 1999" (Stockholm, Sweden: CAN), from the web at http://www.can.se/English/Trends.html, last accessed Oct. 12, 2000.

p "Transparency International Annual Report 2000" (Berlin, Germany: Transparency International) from the web at http://www.transparency.org/documents/annual-report/ar_2000/ti2000.html, last accessed Oct. 13, 2000.

q van Dijk, Frans, and de Waard, Jaap, "Legal Infrastructure of the Netherlands in an International Perspective: Crime Control" (The Hague, Netherlands: Ministry of Justice Directorate of Strategy Development, June 2000).

Mandatory Minimums

1. **Mandatory minimums have not actually reduced sentencing discretion. Control has merely been transferred from judges to prosecutors.**

   Source: Caulkins, J., et al., Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money? (Santa Monica, CA: RAND Corporation, 1997), p. 24.

2. **Prosecutors, not judges, have the discretion to decide whether to reduce a charge, whether to accept or deny a plea bargain, whether to reward or deny a defendant's substantial assistance or cooperation in the prosecution of someone else, and ultimately, to determine what the final sentence will be.**

   Source: Caulkins, J., et al., Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money? (Santa Monica, CA: RAND Corporation, 1997), pp. 16-18.

3. **"After eleven years, it should be obvious that the system has failed and that it cannot be fixed-even by the Supreme Court-because the criminal justice system has been distorted: the enhanced power of the prosecutor in sentencing has diminished the traditional role of the judge. The result has been even less fairness, and a huge rise in the prison population."**

   Source: Smith, Alexander, and Polack, Harriet, Curtailing the Sentencing Power of Trial Judges: The Unintended Consequences, Court Review (Williamsburg, VA: American Judges Association, Summer 1999), p. 6-7.

4. **"Most of the judges we interviewed were quite bitter about the operation of the sentencing guidelines. As one of them remarked: 'The people who drew up these guidelines never sat in a court and had to look a defendant in the eye while imposing some of these sentences.' "**

   Source: Smith, Alexander, and Polack, Harriet, Curtailing the Sentencing Power of Trial Judges: The Unintended Consequences, Court Review (Williamsburg, VA: American Judges Association, Summer 1999), p. 6.

5. **Fifty-five percent (55%) of all federal drug defendants are low-level offenders, such as mules or street-dealers. Only 11% are classified as high-level dealers.**

   Source: US Sentencing Commission, Special Report to Congress: Cocaine and Federal Sentencing Policy (Washington DC: US Sentencing Commission, February 1995), Table 18.

6. **According to the U.S. Sentencing Commission, only 5.5% of federal crack defendants are considered high-level crack dealers.**

   Source: US Sentencing Commission, Special Report to Congress: Cocaine and Federal Sentencing Policy (Washington DC: US Sentencing Commission, February 1995), Table 18.

7. **"Though it is still too early to make a final judgment, RAND found that three strikes and truth-in-sentencing laws have had little significant impact on crime and arrest rates. According to the Uniform Crime Reports, states with neither a three strikes nor a truth-in-sentencing law had the lowest rates of index crimes,**

whereas index crime rates were highest in states with both types of get-tough laws."

Source: Turner, Susan, RAND Corporation Criminal Justice Program, Justice Research & Statistics Association, Impact of Truth-in-Sentencing and Three Strikes Legislation on Crime, Crime and Justice Atlas 2000 (Washington, DC: US Dept. of Justice, June 2000), p. 10.

8. **Since the enactment of mandatory minimum sentencing for drug users, the Federal Bureau of Prisons budget increased by more than 1,350%, from $220 million in 1986 to about $3.19 billion in 1997.**

Sources: Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics (Washington, DC: US Government Printing Office, 1997), p. 20; Office of National Drug Control Policy, Executive Office of the White House, National Drug Control Strategy, 1997: Budget Summary (Washington DC: US Government Printing Office, 1997), p. 111.

9. **The ONDCP in its 2000 annual report detailed administration requests for major increases in funding to the Federal Bureau of Prisons for drug-related prison construction. These include an extra $420 Million in fiscal year 2001, and advanced appropriations of $467 Million in 2002, and an additional $316 Million in 2003 – all drug-related.**

Sources: Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics (Washington, DC: US Government Printing Office, 1997), p. 20; Office of National Drug Control Policy, Executive Office of the White House, National Drug Control Strategy, 1997: Budget Summary (Washington DC: US Government Printing Office, 1997), p. 111; Office of National Drug Control Policy, Executive Office of the White House, National Drug Control Strategy: Annual Report 2000 (Washington, DC: US Government Printing Office, 2000), p. 96.

For a more complete perspective, also read related Drug War Facts sections on Alcohol, Crack, Drug Use Estimates, Gateway Theory, Prison, Race and HIV, Race and Prison, The Netherlands, and Treatment.

Common Sense for Drug Policy Presents
The Facts: Mandatory Minimums

Marijuana

1. **In 1999, 46 percent of the 1,532,200 total arrests for drug abuse violations were for marijuana — a total of 704,812. Of those, 620,541 people were arrested for possession alone. This is an increase over 1998, when a total of 682,885 Americans were arrested for marijuana offenses, of which 598,694 were for possession alone. This increase in marijuana arrests came in spite of a decline in the total number of drug arrests from 1998 to 1999 (there were an estimated 1,559,100 drug arrests in 1998).**

Marijuana Arrests and Total Drug Arrests in the US				
Year	Total Drug Arrests	Total Marijuana Arrests	Marijuana Trafficking/ Sale Arrests	Marijuana Possession Arrests
1999	1,532,200	704,812	84,271	620,541
1998	1,559,100	682,885	84,191	598,694
1995	1,476,100	588,964	85,614	503,350
1990	1,089,500	326,850	66,460	260,390
1980	580,900	401,982	63,318	338,664

Source: Federal Bureau of Investigation, Uniform Crime Reports for the United States 1999 (Washington DC: US Government Printing Office, 2000) pp. 211-212; Federal Bureau of Investigation, Uniform Crime reports for the United States 1998 (Washington DC: US Government Printing Office, 1999), pp. 209-210; FBI, UCR for the US 1995 (Washington, DC: US Government Printing Office, 1996), pp. 207-208; FBI, UCR for the US 1990 (Washington, DC: US Government Printing Office, 1991), pp. 173-174; FBI UCR for the US 1980 (Washington, DC: US Government Printing Office, 1981), pp. 189-191.

2. **Marijuana was first federally prohibited in 1937. Today, nearly 70 million Americans admit to having tried it.**

Sources: Marihuana Tax Act of 1937; Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse: Population Estimates 1996, (Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997), p. 23, Table 3A.

3. **According to the UN's estimate, 141 million people around the world use marijuana. This represents about 2.5 percent of the world population.**

Source: United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 1999 (New York, NY: UNODCCP, 1999), p. 91.

4. **A Johns Hopkins study published in May 1999, examined marijuana's effects on cognition on 1,318 participants over a 15 year period. Researchers reported "no significant differences in cognitive decline between heavy users, light users, and nonusers of cannabis." They also found "no male-female differences in cognitive decline in relation to cannabis use." "These results ...**

seem to provide strong evidence of the absence of a long-term residual effect of cannabis use on cognition," they concluded.

Source: Constantine G. Lyketsos, Elizabeth Garrett, Kung-Yee Liang, and James C. Anthony. (1999). "Cannabis Use and Cognitive Decline in Persons under 65 Years of Age," American Journal of Epidemiology, Vol. 149, No. 9.

5. **In March 1999, the Institute of Medicine issued a report on various aspects of marijuana, including the so-called Gateway Theory (the theory that using marijuana leads people to use harder drugs like cocaine and heroin). The IOM stated, "There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs."**

   Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr., Marijuana and Medicine: Assessing the Science Base. Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999).

6. **The Institute of Medicine's 1999 report on marijuana explained that marijuana has been mistaken for a gateway drug in the past because, "Patterns in progression of drug use from adolescence to adulthood are strikingly regular. Because it is the most widely used illicit drug, marijuana is predictably the first illicit drug most people encounter. Not surprisingly, most users of other illicit drugs have used marijuana first. In fact, most drug users begin with alcohol and nicotine before marijuana? usually before they are of legal age."**

   Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr., Marijuana and Medicine: Assessing the Science Base, Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999).

7. **A 1999 report commissioned by Drug Czar Barry McCaffrey and conducted by the Institute of Medicine found that, "For most people, the primary adverse effect of acute marijuana use is diminished psychomotor performance. It is, therefore, inadvisable to operate any vehicle or potentially dangerous equipment while under the influence of marijuana, THC, or any cannabinoid drug with comparable effects."**

   Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr., Marijuana and Medicine: Assessing the Science Base, Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999).

8. **The DEA's Administrative Law Judge, Francis Young concluded: "In strict medical terms marijuana is far safer than many foods we commonly consume. For example, eating 10 raw potatoes can result in a toxic response. By comparison, it is physically impossible to eat enough marijuana to induce death. Marijuana in its natural form is one of the safest therapeutically active substances known to man. By any measure of rational analysis marijuana can be safely used within the supervised routine of medical care."**

   Source: US Department of Justice, Drug Enforcement Agency, "In the Matter of Marijuana Rescheduling Petition," [Docket #86-22], (September 6, 1988), p. 57.

Marijuana

9. Commissioned by President Nixon in 1972, the National Commission on Marihuana and Drug Abuse concluded that "Marihuana's relative potential for harm to the vast majority of individual users and its actual impact on society does not justify a social policy designed to seek out and firmly punish those who use it. This judgment is based on prevalent use patterns, on behavior exhibited by the vast majority of users and on our interpretations of existing medical and scientific data. This position also is consistent with the estimate by law enforcement personnel that the elimination of use is unattainable."

Source: Shafer, Raymond P., et al, Marihuana: A Signal of Misunderstanding, Ch. V, (Washington DC: National Commission on Marihuana and Drug Abuse, 1972).

10. When examining the relationship between marijuana use and violent crime, the National Commission on Marihuana and Drug Abuse concluded, "Rather than inducing violent or aggressive behavior through its purported effects of lowering inhibitions, weakening impulse control and heightening aggressive tendencies, marihuana was usually found to inhibit the expression of aggressive impulses by pacifying the user, interfering with muscular coordination, reducing psychomotor activities and generally producing states of drowsiness lethargy, timidity and passivity."

Source: Shafer, Raymond P., et al, Marihuana: A Signal of Misunderstanding, Ch. III, (Washington DC: National Commission on Marihuana and Drug Abuse, 1972).

11. When examining the medical affects of marijuana use, the National Commission on Marihuana and Drug Abuse concluded, "A careful search of the literature and testimony of the nation's health officials has not revealed a single human fatality in the United States proven to have resulted solely from ingestion of marihuana. Experiments with the drug in monkeys demonstrated that the dose required for overdose death was enormous and for all practical purposes unachievable by humans smoking marihuana. This is in marked contrast to other substances in common use, most notably alcohol and barbiturate sleeping pills." The WHO reached the same conclusion in 1995.

Source: Shafer, Raymond P., et al, Marihuana: A Signal of Misunderstanding, Ch. III, (Washington DC: National Commission on Marihuana and Drug Abuse, 1972); Hall, W., Room, R. & Bondy, S., WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use, August 28, 1995, (Geneva, Switzerland: World Health Organization, March 1998).

12. The World Health Organization released a study in March 1998 that states: "there are good reasons for saying that [the risks from cannabis] would be unlikely to seriously [compare to] the public health risks of alcohol and tobacco even if as many people used cannabis as now drink alcohol or smoke tobacco."

Source: Hall, W., Room, R. & Bondy, S., WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use, August 28, 1995, (contained in original version, but deleted from official version) (Geneva, Switzerland: World Health Organization, March 1998).

13. The authors of a 1998 World Health Organization report comparing marijuana, alcohol, nicotine and opiates quote the Institute of Medicine's 1982 report stating that there is no evidence that smoking marijuana "exerts a permanently deleterious effect on the normal cardiovascular system."

Source: Hall, W., Room, R. & Bondy, S., WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use, August 28, 1995 (Geneva, Switzerland: World Health Organization, March 1998).

14. Some claim that cannabis use leads to "adult amotivation." The World Health Organization report addresses the issue and states, "it is doubtful that cannabis use produces a well defined amotivational syndrome." The report also notes that the value of studies which support the "adult amotivation" theory are "limited by their small sample sizes" and lack of representative social/cultural groups.

Source: Hall, W., Room, R. & Bondy, S., WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use, August 28, 1995 (Geneva, Switzerland: World Health Organization, March 1998).

15. Australian researchers found that regions giving on-the-spot fines to marijuana users rather than harsher criminal penalties did not cause marijuana use to increase.

Source: Ali, Robert, et al., The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia: Summary Report (Canberra, Australia: Department of Health and Aged Care, 1999), p. 44.

16. Since 1969, government-appointed commissions in the United States, Canada, England, Australia, and the Netherlands concluded, after reviewing the scientific evidence, that marijuana's dangers had previously been greatly exaggerated, and urged lawmakers to drastically reduce or eliminate penalties for marijuana possession.

Source: Advisory Committee on Drug Dependence, Cannabis (London, England: Her Majesty's Stationery Office, 1969); Canadian Government Commission of Inquiry, The Non-Medical Use of Drugs (Ottawa, Canada: Information Canada, 1970); The National Commission on Marihuana and Drug Abuse, Marihuana: A Signal of Misunderstanding, (Nixon-Shafer Report) (Washington, DC: USGPO, 1972); Werkgroep Verdovende Middelen, Background and Risks of Drug Use (The Hague, The Netherlands: Staatsuigeverij, 1972); Senate Standing Committee on Social Welfare, Drug Problems in Australia-An Intoxicated Society (Canberra, Australia: Australian Government Publishing Service, 1977).

Marijuana

17. In May of 1998, the Canadian Centre on Substance Abuse, National Working Group on Addictions Policy released policy a discussion document which recommended, "The severity of punishment for a cannabis possession charge should be reduced. Specifically, cannabis possession should be converted to a civil violation under the Contraventions Act." The paper further noted that, "The available evidence indicates that removal of jail as a sentencing option would lead to considerable cost savings without leading to increases in rates of cannabis use."

Source: Single, Eric, Cannabis Control in Canada: Options Regarding Possession (Ottawa, Canada: Canadian Centre on Substance Abuse, May 1998).

18. "Our conclusion is that the present law on cannabis produces more harm than it prevents. It is very expensive of the time and resources of the criminal justice system and especially of the police. It inevitably bears more heavily on young people in the streets of inner cities, who are also more likely to be from minority ethnic communities, and as such is inimical to police-community relations. It criminalizes large numbers of otherwise law-abiding, mainly young, people to the detriment of their futures. It has become a proxy for the control of public order; and it inhibits accurate education about the relative risks of different drugs including the risks of cannabis itself."

Source: Police Foundation of the United Kingdom, "Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act of 1971", April 4, 2000. The Police Foundation, based in London, England, is a nonprofit organization presided over by Charles, Crown Prince of Wales, which promotes research, debate and publication to improve the efficiency and effectiveness of policing in the UK.

19. "There is no reason to believe that today's marijuana is stronger or more dangerous than the marijuana smoked during the 1960s and 1970s."

Source: Lynn Zimmer, Ph.D. and John P. Morgan, M.D., Marijuana Myths, Marijuana Facts (New York: The Lindesmith Center , 1997), p. 140.

(EDS. NOTE: Readers are encouraged to review chapter 19 of Marijuana Myths, Marijuana Facts where this multifaceted issue is dealt with in detail.)

Common Sense for Drug Policy Presents The Facts: Marijuana

Medical Marijuana

1. **Between 1996 and 2000, 7 states passed voter initiatives legalizing the medicinal use of cannabis (AZ, CA, ME, OR, WA, NV and AK), and one state, Hawaii, legalized medicinal use through legislation signed by Governor Caetano on June 12, 2000.**

   Source: Associated Press, "Hawaii Becomes First State to Allow Medical Marijuana Via a Bill", The New York Times, June 15, 2000.

2. **The Institute of Medicine's 1999 report on medical marijuana stated, "The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation."**

   Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr., Marijuana and Medicine: Assessing the Science Base. Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999).

3. **The Institute of Medicine's 1999 report on medical marijuana examined the question whether the medical use of marijuana would lead to an increase of marijuana use in the general population and concluded that, "At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential." The report also noted that, "this question is beyond the issues normally considered for medical uses of drugs, and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids."**

   Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr., Marijuana and Medicine: Assessing the Science Base. Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999).

4. **In the Institute of Medicine's report on medical marijuana, the researchers examined the physiological risks of using marijuana and cautioned, "Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications."**

   Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr., Marijuana and Medicine: Assessing the Science Base. Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999).

5. **The Institute of Medicine's 1999 report on medical marijuana examined the question of whether marijuana could diminish patients' immune system - an important question when considering its use by AIDS and cancer patients. The report concluded that, "the short-term immunosuppressive effects are not well established but, if they exist, are not likely great enough to preclude a legitimate medical use."**

Source: Janet E. Joy, Stanley J. Watson, Jr., and John A Benson, Jr., Marijuana and Medicine: Assessing the Science Base. Division of Neuroscience and Behavioral Research, Institute of Medicine (Washington, DC: National Academy Press, 1999).

6. **In spite of the established medical value of marijuana, doctors are presently permitted to prescribe cocaine and morphine-but not marijuana.**

   Source: The Controlled Substances Act of 1970, 21 U.S.C. §§ 801 et seq.

7. **Organizations that have endorsed medical access to marijuana include: the Institute of Medicine, the American Academy of Family Physicians; American Bar Association; American Public Health Association; American Society of Addiction Medicine; AIDS Action Council; British Medical Association; California Academy of Family Physicians; California Legislative Council for Older Americans; California Medical Association; California Nurses Association; California Pharmacists Association; California Society of Addiction Medicine; California-Pacific Annual Conference of the United Methodist Church; Colorado Nurses Association; Consumer Reports Magazine; Kaiser Permanente; Lymphoma Foundation of America; Multiple Sclerosis California Action Network; National Association of Attorneys General; National Association of People with AIDS; National Nurses Society on Addictions; New Mexico Nurses Association; New York State Nurses Association; New England Journal of Medicine; and Virginia Nurses Association.**

8. **A few of the editorial boards that have endorsed medical access to marijuana include: Boston Globe; Chicago Tribune; Miami Herald; New York Times; Orange County Register; and USA Today.**

9. **Many organizations have favorable positions (e.g., unimpeded research) on medical marijuana. These groups include: The Institute of Medicine, The American Cancer Society; American Medical Association; Australian Commonwealth Department of Human Services and Health; California Medical Association; Federation of American Scientists; Florida Medical Association; and the National Academy of Sciences.**

10. **The Controlled Substances Act of 1970 established five categories, or "schedules," into which all illicit and prescription drugs were placed. Marijuana was placed in Schedule I, which defines the substance as having a high potential for abuse, no currently accepted medical use in the United States, and a lack of accepted safety for use under medical supervision. To contrast, over 90 published reports and studies have shown marijuana has medical efficacy.**

    Sources: The Controlled Substances Act of 1970, 21 U.S.C. §§ 801 et seq.; Common Sense for Drug Policy, Compendium of Reports, Research and Articles Demonstrating the Effectiveness of Medical Marijuana, Vol. I & Vol. II (Falls Church, VA: Common Sense for Drug Policy, March 1997).

Medical Marijuana

11. The U.S. Penal Code states that any person can be imprisoned for up to one year for possession of one marijuana cigarette and imprisoned for up to five years for growing a single marijuana plant.

Source: The Controlled Substances Act of 1970, 21 U.S.C. §§ 801 et seq.

12. On September 6, 1988, the Drug Enforcement Administration's Chief Administrative Law Judge, Francis L. Young, ruled: "Marijuana, in its natural form, is one of the safest therapeutically active substances known. ...The provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II. It would be unreasonable, arbitrary and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance."

Source: US Department of Justice, Drug Enforcement Agency, "In the Matter of Marijuana Rescheduling Petition," [Docket #86-22] (September 6, 1988), p. 57.

13. The DEA's Administrative Law Judge, Francis Young concluded: "In strict medical terms marijuana is far safer than many foods we commonly consume. For example, eating 10 raw potatoes can result in a toxic response. By comparison, it is physically impossible to eat enough marijuana to induce death. Marijuana in its natural form is one of the safest therapeutically active substances known to man. By any measure of rational analysis marijuana can be safely used within the supervised routine of medical care."

Source: US Department of Justice, Drug Enforcement Agency, "In the Matter of Marijuana Rescheduling Petition," [Docket #86-22], (September 6, 1988), p. 57.

14. Between 1978 and 1997, 35 states and the District of Columbia passed legislation recognizing marijuana's medicinal value. States include: AL, AZ, AR, CA, CO, CT, FL, GA, IL, IO, LA, MA, ME, MI, MN, MO, MT, NV, NH, NJ, NM, NY, NC, OH, OK, OR, RI, SC, TN, TX, VT, VA, WA, WV, and WI.

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Common Sense for Drug Policy Presents The Facts:
Medical Marijuana

Methadone, LAAM and Buprenorphine

1. **According to the National Institutes of Health (NIH), "Methadone maintenance treatment is effective in reducing illicit opiate drug use, in reducing crime, in enhancing social productivity, and in reducing the spread of viral diseases such as AIDS and hepatitis."**

   Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 4.

2. **According to the National Institutes of Health (NIH), "All opiate-dependent persons under legal supervision should have access to methadone maintenance therapy..."**

   Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 2.

3. **"The unnecessary regulations of methadone maintenance therapy and other long- acting opiate agonist treatment programs should be reduced, and coverage for these programs should be a required benefit in public and private insurance programs."**

   Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 2.

4. **"Whatever conditions may lead to opiate exposure, opiate dependence is a brain-related disorder with the requisite characteristics of a medical illness."**

   Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 4.

5. **"The safety and efficacy of narcotic agonist (methadone) maintenance treatment has been unequivocally established."**

   Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 4.

6. **"Although a drug-free state represents an optimal treatment goal, research has demonstrated that this goal cannot be achieved or sustained by the majority of opiate-dependent people."**

   Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 5.

7. **"Of the various treatments available, Methadone Maintenance Treatment, combined with attention to medical, psychiatric and socioeconomic issues, as well as drug counseling, has the highest probability of being effective."**

   Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 7.

8. **"Twin, family, and adoption studies show that vulnerability to drug abuse may be a partially inherited condition with strong influences from environmental factors."**

   Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 8.

Methadone, LAAM and Buprenorphine

9. **"NTPs (Narcotic Treatment Programs) are the most highly regulated form of medicine practiced in the US, as they are subject to Federal, State, and local regulation. Under this regulatory burden, expansion of this system has been static for many years. This has resulted in a 'treatment gap', which is defined as the difference between the number of opiate dependent persons and those in treatment. The gap currently is over 600,000 persons and represents 75-80% of all addicts."**

   Source: "Buprenorphine Update: Questions and Answers," National Institute on Drug Abuse (Rockville, MD: National Institutes of Health), on the web at http://165.112.78.61/Bupdate.html, Last accessed on Feb. 7, 2001.

10. **"The financial costs of untreated opiate dependence to the individual, the family, and society are estimated to be approximately $20 billion per year."**

    Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 11.

11. **"Over the past two decades, clear and convincing evidence has been collected from multiple studies showing that effective treatment of opiate dependence markedly reduces the rates of criminal activity."**

    Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 12.

12. **"Methadone's half-life is approximately 24 hours and leads to a long duration of action and once-a-day dosing. This feature, coupled with its slow onset of action, blunts its euphoric effect, making it unattractive as a principal drug of abuse."**

    Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 14.

13. **"Prolonged oral treatment with this medicine [methadone] diminishes and often eliminates opiate use, reduces transmission of many infections, including HIV and hepatitis B and C, and reduces criminal activity."**

    Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 16.

14. **"Opiate-dependent persons are often perceived not as individuals with a disease but as 'other' or 'different.' Factors such as racism play a large role here but so does the popular image of dependence itself. Many people believe that dependence is self-induced or a failure of willpower and that efforts to treat it will inevitably fail. Vigorous and effective leadership is needed to inform the public that dependence is a medical disorder that can be effectively treated with significant benefits for the patient and society."**

    Source: Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 18.

Methadone, LAAM and Buprenorphine

15. "Methadone maintenance treatment (MMT) has been shown to improve life functioning and decrease heroin use; criminal behavior; drug use practices, such as needle sharing, that increase human immunodeficiency virus (HIV) risk; and HIV infection."

Source: Sees, Karen, DO, et al., "Methadone Maintenance vs. 180-Day Psychosocially Enriched Detoxification for Treatment of Opiod Dependence: A Randomized Controlled Trial", Journal of the American Medical Association, 2000, 283:1303.

16. A recent study reported in the March 8, 2000 edition of the Journal of the American Medical Association shows that traditional methadone maintenance therapy is superior to both short-term and long-term detoxification treatment as a method to treat heroin dependence.

Source: Sees, Karen, DO, et al., "Methadone Maintenance vs. 180-Day Psychosocially Enriched Detoxification for Treatment of Opioid Dependence: A Randomized Controlled Trial", Journal of the American Medical Association, 2000, 283:1303-1310.

17. "Because it is longer-acting, levomethadyl acetate (LAAM) has an advantage over methadone in that it can be administered thre times a week, rather than daily. The effectiveness of levomethadyl acetate is similar to that of methadone and, as with methadone, as sufficient dose is needed to produce an optimal effect."

Source: O'Connor, Patrick G, MD, MPH, "Treating Opioid Dependence—New data and New Opportunities," New England Journal of Medicine, Nov. 2, 2000 (Boston, MA: Massachusetts Medical Society, 2000), Vol. 343, No. 18, from the web at http://www.nejm.org/content/2000/0343/0018/1332.asp Last accessed Feb. 12 , 2001, citing Eissenberg T, Bigelow GE, Strain EC, et al. "Dose-related efficacy of levomethadyl acetate for treatment of opioid dependence: a randomized clinical trail," Journal of American Medical Association, 1997;2771945-51.

18. The National Institute on Drug Abuse notes that the DEA acknowledges the low abuse potential and relative safety of buprenorphine: "(T)he Drug Enforcement Administration has recognized the difference between burprenophine treatment products and those currently subject to 21 CFR 291." [21 CFR291: section of Federal code regarding regulations for administration and delivery of narcotic medication in the treatment of narcotic dependent persons].

Source: "Buprenorphine Update: Questions and Answers," National Institute on Drug Abuse (Rockville, MD National Institute of Health), on the web at http://165.112.78.61/Brpdate.html, Last accessed on Feb. 7, 2001.

19. "Because buprenorphine is partial opioid agonist, it is thought to have some advantages of methadone and levomethadyl acetate, including fewer withdrawal symptoms and a lower risk of overdose. Buprenorphine is as effective as methadone if a sufficeinet dose is used. Like levomethadyl acetate, buprenorphine has the advantage of being long-acting: it can be effectively administered three times per week."

Source: O'Connor, Patrick G, MD, MPH, "Treating Opioid Dependence—New data and New Opportunities," New England Journal of Medicine, Nov. 2, 2000 (Boston, MA: Massachusetts Medical Society, 2000), Vol. 343, No. 18, from the web at http://www.nejm.org/content/2000/0343/0018/1332.asp last accessed Feb. 12 ,

2001, citing Schottenfeld RS, Pakes JR, Oliveto A, Ziedonis D, Kosten TR, "Buprenorphine vs. methadone maintenance treatment for concurrent opioid dependence and cocaine abuse," Arch Gen Peychiatry 1997;54:713-20; and Schottenfeld RS, Pakes J. O'connor P, Chawarski M, Oliverto A, Kosten TR, 'Thrice-wekly versus daily buprenophine maintenance," Biol Pyschiatry 2000;1072-9.

20. A study in the March 8, 2000 Journal of the American Medical Association reviewed the Scottish model of methadone distribution to patients through doctors' offices versus the US model of methadone maintenance clinics. The study concludes: "Prescription of methadone by primary care physicians can safely increase the availability of an important treatment modality, and at the same time improve health care for this difficult-to-reach population."

Source: Weinrich, Michael, MD, and Stuart, Mary, ScD, "Provision of Methadone Treatment in Primary Care Medical Practices: Review of the Scottish Experience and Implications for US Policy", Journal of the American Medical Association, 2000, 283:1343-1348, p. 1347.

21. The Journal of the American Medical Association notes in an editorial in its March 8, 2000 edition that following the Scottish example, and allowing primary care physicians to dispense methadone, could provide a three- to five-fold increase in access, as well as reducing the cost per patient.

Source: Rounsaville, Bruce J., MD, and Kosten, Thomas R., MD, "Treatment for Opioid Dependence: Quality and Access", Journal of the American Medical Association, 2000, 283:1337:1339.

22. The Treatment Outcome Prospective Study (TOPS)-a long-term, large-scale longitudinal study of drug treatment-found that patients drastically reduced heroin use while in treatment, with 10% using heroin or other narcotics weekly or daily after just three months in treatment.

Sources: Hubbard, R.L., et al., "Treatment Outcome Prospective Study (TOPS): Client Characteristics and Behaviors before, during, and after Treatment," in Tims, F.M. & Ludford, J.P. (eds.), Drug Abuse Treatment Evaluation: Strategies, Progress and Prospects (Rockville, MD: National Institute on Drug Abuse, 1984), p. 60.

23. Methadone treatment greatly reduces criminal behavior. The decline in predatory crimes is likely in part because methadone maintenance treatment patients no longer need to finance a costly heroin addiction, and because treatment allows many patients to stabilize their lives and return to legitimate employment.

Sources: Hubbard, R.L., et al., "Treatment Outcome Prospective Study (TOPS): Client Characteristics and Behaviors before, during, and after Treatment," in Tims, F.M. & Ludford, J.P. (eds.), Drug Abuse Treatment Evaluation: Strategies, Progress and Prospects (Rockville, MD: National Institute on Drug Abuse, 1984), p. 60; Ball, J.C. & Ross, A., The Effectiveness of Methadone Maintenance Treatment, (New York, NY: Springer-Verlag, 1991), pp. 195-211; Newman, R.G. & Peyser, N., "Methadone Treatment: Experiment and Experience," Journal of Psychoactive Drugs, 23: 115-21 (1991).

Methadone, LAAM and Buprenorphine

24. In support of methadone as an effective treatment for heroin addiction, Drug Czar Barry McCaffrey issued the following statement: "Methadone is one of the longest-established, most thoroughly evaluated forms of drug treatment. The science is overwhelming in its findings about methadone treatment's effectiveness. The National Institute on Drug Abuse (NIDA) Drug Abuse Treatment Outcome Study found, for example, that methadone treatment reduced participants' heroin use by 70%, their criminal activity by 57%, and increased their full-time employment by 24%."

Source: McCaffrey, Barry, Statement of ONDCP Director Barry McCaffrey on Mayor Giuliani's Recent Comments on Methadone Therapy, (Press Release) (Washington, DC: ONDCP), July 24, 1998.

25. Methadone is cost effective. Methadone costs about $4,000 per year, while incarceration costs about $20,200 to $23,500 per year.

Sources: Institute of Medicine, Treating Drug Problems (Washington DC: National Academy Press, 1990), Vol. 1, pp. 151-52; Rosenbaum, M., Washburn, A., Knight, K., Kelley, M., & Irwin, J., "Treatment as Harm Reduction, Defunding as Harm Maximization: The Case of Methadone Maintenance," Journal of Psychoactive Drugs, 28: 241-249 (1996); Criminal Justice Institute, Inc., The Corrections Yearbook 1997 (South Salem, NY: Criminal Justice Institute, Inc., 1997) [estimating cost of a day in jail on average to be $55.41 a day, or $20,237 a year, and the cost of prison to be on average to be about $64.49 a day, or $23,554 a year].

26. Methadone does not make patients "high" or interfere with normal functioning.

Source: Lowinson, J.H., et al., (1997), "Methadone Maintenance," Substance Abuse: A Comprehensive Textbook, (3rd Ed.) (Baltimore, MD: Williams & Wilkins, 1997), pp. 405-15.

27. Methadone maintenance treatment helps clients to reduce high risk behaviors like needle sharing and unsafe sex.

Source: Rosenbaum, et al., "Treatment as Harm Reduction, Defunding as Harm Maximization: The Case of Methadone Maintenance," Journal of Psychoactive Drugs, 28: 241-249 (1996).

28. In support of methadone as an effective treatment for heroin addiction, Drug Czar Barry McCaffrey quoted Drs. Adam Yarmolinsky and Richard A. Rettig, chairman and director of a recent National Academy of Sciences study of methadone treatment, who wrote: "Methadone treatment helps heroin addicts free themselves from drug dependency, a life of crime in support of their habit and the risk of adding to the AIDS population by sharing dirty needles...[Methadone therapy] is more likely to work than any other therapy."

Source: McCaffrey, Barry, Statement of ONDCP Director Barry McCaffrey on Mayor Giuliani's Recent Comments on Methadone Therapy, (Press Release) (Washington, DC: ONDCP), July 24, 1998.

Methamphetamine

1. **"Illicit synthesis and use of methamphetamine is the chief type of amphetamine abuse in North America. Amphetamine and methamphetamine are available by prescription, but the once widespread use of amphetamine for appetite suppression has stopped. Prescribing it for other indications (eg, narcolepsy, attention-deficit hyperactivity disorder) is limited."**

   Source: "Amphetamine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195g.htm last accessed November 30, 2000.

2. **"Methamphetamine is made in illegal laboratories and has a high potential for abuse and dependence. Street methamphetamine is referred to by many names, such as 'speed,' 'meth,' and 'chalk.' Methamphetamine hydrochloride, clear chunky crystals resembling ice, which can be inhaled by smoking, is referred to as 'ice,' 'crystal,' and 'glass.'"**

   Source: National Institute on Drug Abuse, Infofax: Methamphetamine No. 13552 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/methamphetamine.html last accessed November 16, 2000.

3. **"Smokeable methamphetamine (ice) has received much publicity, although its use is largely limited to Hawaii and, to a lesser degree, California; the hydrochloride salt rather than the base is volatile. The effects are intense and persist longer than the brief 'high' of crack cocaine."**

   Source: "Amphetamine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195g.htm last accessed November 30, 2000.

4. **"Methamphetamine releases high levels of the neurotransmitter dopamine, which stimulates brain cells, enhancing mood and body movement. It also appears to have a neurotoxic effect, damaging brain cells that contain dopamine and serotonin, another neurotransmitter. Over time, methamphetamine appears to cause reduced levels of dopamine, which can result in symptoms like those of Parkinson's disease, a severe movement disorder."**

   Source: National Institute on Drug Abuse, Infofax: Methamphetamine No. 13552 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/methamphetamine.html last accessed November 16, 2000.

5. **"Methamphetamine is taken orally or intranasally (snorting the powder), by intravenous injection, and by smoking. Immediately after smoking or intravenous injection, the methamphetamine user experiences an intense sensation, called a "rush" or "flash," that lasts only a few minutes and is described as extremely pleasurable. Oral or intranasal use produces euphoria - a high, but not a rush. Users may become addicted quickly, and use it with increasing frequency and in increasing doses."**

Source: National Institute on Drug Abuse, Infofax: Methamphetamine No. 13552 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/methamphetamine.html last accessed November 16, 2000.

6. **"The psychologic effects of using amphetamine or methamphetamine are similar to those produced by cocaine. Although no stereotypical withdrawal syndrome occurs, EEG changes occur, considered by some to fulfill the physiologic criteria for dependence."**

   Source: "Amphetamine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195g.htm last accessed November 30, 2000.

7. **"Amphetamine induces tolerance that develops slowly; dose can increase progressively, so that amounts several hundredfold greater than the original therapeutic dose may eventually be ingested or injected. Tolerance to various effects develops unequally, so that tachycardia and enhanced alertness diminish but psychotoxic effects, such as hallucinations and delusions, may occur. However, even massive doses are rarely fatal. Long-term users have reportedly injected as much as 15,000 mg of amphetamine in 24 h without observable acute illness."**

   Source: "Amphetamine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195g.htm last accessed November 30, 2000.

8. **"Animal research going back more than 20 years shows that high doses of methamphetamine damage neuron cell-endings. Dopamine- and serotonin-containing neurons do not die after methamphetamine use, but their nerve endings ("terminals") are cut back and re-growth appears to be limited."**

   Source: National Institute on Drug Abuse, Infofax: Methamphetamine No. 13552 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/methamphetamine.html last accessed November 16, 2000.

9. **"The central nervous system (CNS) actions that result from taking even small amounts of methamphetamine include increased wakefulness, increased physical activity, decreased appetite, increased respiration, hyperthermia, and euphoria. Other CNS effects include irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, and aggressiveness. Hyperthermia and convulsions can result in death."**

   Source: National Institute on Drug Abuse, Infofax: Methamphetamine No. 13552 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/methamphetamine.html last accessed November 16, 2000.

Methamphetamine

10. "Abusers of amphetamine are prone to accidents because the drug produces excitation and grandiosity followed by excess fatigue and sleeplessness. Taken IV, amphetamine may lead to serious antisocial behavior and can precipitate a schizophrenic episode."

Source: "Amphetamine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195g.htm last accessed November 30, 2000.

11. "Methamphetamine causes increased heart rate and blood pressure and can cause irreversible damage to blood vessels in the brain, producing strokes. Other effects of methamphetamine include respiratory problems, irregular heartbeat, and extreme anorexia. Its use can result in cardiovascular collapse and death."

Source: National Institute on Drug Abuse, Infofax: Methamphetamine No. 13552 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/methamphetamine.html last accessed November 16, 2000.

12. "Continued high doses of methamphetamine produce anxiety reactions during which the person is fearful, tremulous, and concerned about his physical well-being, an amphetamine psychosis in which the person misinterprets others' actions, hallucinates, and becomes unrealistically suspicious; an exhaustion syndrome, involving intense fatigue and need for sleep, after the stimulation phase; and a prolonged depression, during which suicide is possible."

Source: "Amphetamine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195g.htm last accessed November 30, 2000.

13. "Persons who use high IV doses usually accept that sooner or later they will experience paranoia and often do not act on it. Nevertheless, with very intense drug use or near the end of weeks of use, awareness may fail and the user may respond to the delusions. Recovery from even prolonged amphetamine psychosis is usual. Thoroughly disorganized and paranoid users recover slowly but completely. The more florid symptoms fade within a few days or weeks, but some confusion, memory loss, and delusional ideas commonly persist for months."

Source: "Amphetamine Dependence", The Merck Manual of Diagnosis and Therapy, Section 15.Psychiatric Disorders, Chapter 195.Drug Use and Dependence, Merck & Co. Inc., from the web at http://www.merck.com/pubs/mmanual/section15/chapter195/195g.htm last accessed November 30, 2000.

14. "In 1997, 4.4 percent of high school seniors had used crystal methamphetamine at least once in their lifetimes - an increase from 2.7 percent in 1990. Data show that 2.3 percent of seniors reported past year use of crystal methamphetamine in 1997 - an increase from 1.3 percent in 1990."

Source: National Institute on Drug Abuse, Infofax: Methamphetamine No. 13552 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/methamphetamine.html last accessed November 16, 2000.

15. "According to the 1996 NHSDA, 4.9 million people (aged 12 and older) had tried methamphetamine at least once in their lifetimes (2.3 percent of population). This is not a statistically significant increase from 4.7 million people (2.2 percent) who reported using methamphetamine at least once in their lifetime in the 1995 NHSDA."

Source: National Institute on Drug Abuse, Infofax: Methamphetamine No. 13552 (Rockville, MD: US Department of Health and Human Services), from the web at http://www.nida.nih.gov/Infofax/methamphetamine.html last accessed November 16, 2000.

Common Sense for Drug Policy Presents The Facts: Methamphetamine

Militarization of the Drug War

Brief Chronology of Domestic Military Involvement

*** 1878-The Posse Comitatus Act makes it illegal for the military to act as police on U.S. territory or waters.**

*** 1981-Posse Comitatus Act is amended to allow limited military involvement in policing.**

*** 1991-Posse Comitatus Act is amended to allow counter-drug training of civilian police by the military.**

*** 1995-Joint Task Force 6, under direction of the Defense Secretary, is expanded to the entire continental United States. It has 700 troops, including 125 combat-ready troops on the U.S.-Mexican border. (Houston Chronicle, 1997, June 22)**

*** May 1997-Esequiel Hernandez becomes the first U.S. citizen shot and killed by JTF-6 troops.**

*** July 2000-US Congress approves $1.3 Billion in military aid to Colombia to fight their drug war as part of "Plan Colombia". An additional 60 combat helicopters are approved for use in Colombia, and the cap on US military personnel assisting in the Colombian conflict is doubled to 500.**

1. **Senator Robert Byrd (D-WV) detailed the escalation of US military involvement in the Colombia drug war authorized by Plan Colombia: "We doubled the cap on U.S. military personnel to 500, as requested by the Pentagon, and tripled the allowable number of U.S. civilian contractors to 300." In addition, Congress authorized the provision of 18 additional Black Hawk helicopters and 42 more UH-1H "Huey" helicopters to Colombia, which are legally restricted to anti-narcotics operations and not for use against guerrillas.**

   Source: Senator Robert Byrd, speech before Senate June 30, 2000, on final conference version of legislation authorizing "Plan Colombia", from Congressional Record (Washington, DC: USGPO), p. S6228.

2. **In July 2000, Representative Benjamin Gilman wrote Secretary of State Madeleine Albright calling for a change in the rules of engagement for US troops in Colombia to allow use of US-controlled helicopters against guerrillas. This came less than a month after approval of "Plan Colombia", which re-affirmed the restriction against use of American military aid for counter-insurgency operations.**

   Source: Tamayo, Juan O., "Attacks in Colombia Spur Call for US Helicopters", Miami Herald, July 25, 2000, from the web at http://www.miamiherald.com.

3. **The National Guard currently has more counter-narcotics officers than the DEA has special agents on duty. Each day it is involved in 1,300 counterdrug operations and has 4,000 troops on duty.**

   Source: Munger, M., "The Drug Threat: Getting Priorities Straight," Parameters, (Summer 1997).

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Militarization of the Drug War

4. **Eighty-nine percent (89%) of police departments have paramilitary units, and 46% have been trained by active duty armed forces. The most common use of paramilitary units is serving drug-related search warrants (usually no-knock entries into private homes). Twenty percent (20%) of police departments use paramilitary units to patrol urban areas.**

   Source: Kraska, P. & Kappeler, V., "Militarizing American Police: The Rise and Normalization of Paramilitary Units," Social Problems, Vol. 44, No. 1 (February 1997).

5. **In 1996 "Drug Czar" Retired General Barry McCaffrey said of the Drug War, "It makes us all very uncomfortable to see uniformed military units getting heavily involved."**

   Source: McGee, J., "Military Seeks Balance in Delicate Mission: The Drug War," Washington Post, (November 29, 1996).

6. **On February 15, 2000, before the House Subcommittee on Criminal Justice, Drug Policy, and Human Resources, Gen. McCaffrey testified about sending military aid to Colombia to fight their drug war: "Military support will be required to provide a sufficient level of security for the CNP (Colombian National Police) to perform their law enforcement mission. The proposed assistance package would enable the Colombian Army to operate jointly with the CNP as they move into the dangerous drug production sanctuaries in southern Colombian by providing funds to stand up two additional Army Counternarcotics Battalions. The first Army Counternarcotics Battalion, which was trained and equipped by the US, was brought on line in late 1999."**

   Source: Testimony of ONDCP Director McCaffrey from ONDCP website at www.whitehousedrugpolicy.gov/news/testimony/021500/index.html

Common Sense for Drug Policy Presents The Facts:
Militarization of Drug Enforcement

Prison

1. **All major Western European nations' incarceration rates are about or below 100 per 100,000. In the United States, in 1999, the incarceration rate for African-American women was 212 per 100,000, and for African-American men 3,408 per 100,000. The rate of incarceration for Hispanic women is 87 per 100,000, and for Hispanic men the rate is 1,335 per 100,000. The rate of incarceration for white women is 27 per 100,000, and for white men the rate is 417 per 100,000.**

   Sources: Currie, E., Crime and Punishment in America, New York, NY: Metropolitan Books, Henry Holt and Company, Inc. (1998), p. 15; Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1999 (Washington DC: US Department of Justice, August 2000), p. 9, table 14.

2. **In 1985, our incarceration rate was 313 per 100,000 population. Now it is 645 per 100,000, which is three to 10 times higher than rates of the other modern democratic societies. The largest single factor contributing to this imprisonment wave is an eight-fold rise in drug arrests. In 1980, when illicit drug use was peaking, there were about 50,000 men and women in prison for violating drug laws. Last year, there were about 400,000.**

   Source: Reinarman, C. & Levine, H.G., Casualties of War, San Jose Mercury News, (letter), (March 1, 1998), Sect. C, p. 1.

3. **The overall U.S. incarceration rate is six times that of its nearest Western competitors.**

   Source: Currie, E., Crime and Punishment in America (New York, NY: Metropolitan Books, Henry Holt and Company, Inc., 1998), p. 61.

4. **As of year end 1999, the US had 2,026,596 persons incarcerated. This total represents persons held in:**

   Federal and State Prisons – 1,284,894
   Local Jails – 605,943
   Juvenile Facilities – 105,790 (as of October 29, 1997)
   Territorial Prisons – 18,394
   INS Facilities – 7,675
   Military Facilities – 2,279
   Jails in Indian Country – 1,621

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   This means that at the end of 1999 one in every 137 residents in the United States and its Territories were incarcerated.

   Source: Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1999 (Washington DC: US Department of Justice, August 2000), p. 1.

5. **The U.S. nonviolent prisoner population is larger than the combined populations of Wyoming and Alaska.**

   Source: John Irwin, Ph. D., Vincent Schiraldi, and Jason Ziedenberg, America's One Million Nonviolent Prisoners (Washington, DC: Justice Policy Institute, 1999), pg. 4.

Prison

6. Since year end 1990, the total inmate population has risen by 711,818 people, the equivalent of 1,607 inmates each week.

Source: Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prison and Jail Inmates at Midyear 1999 (Washington DC: US Department of Justice, April 2000), p. 2.

7. The incarceration rate in prison and jail in 1990 was 458 per 100,000 US residents. In 1999, the rate was 690 inmates per 100,000 population.

Source: Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1999 (Washington DC: US Department of Justice, August 2000), p. 2, Table 1.

8. At the end of 1999, 1 in every 137 US residents were incarcerated.

Source: Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1999 (Washington DC: US Department of Justice, August 2000), p. 1.

9. There were 5.9 million adults in the 'correctional population' by the end of 1998. This means that 2.9% of the U.S. adult population — 1 in every 34 — was incarcerated, on probation or on parole.

Source: Bonczar, Thomas & Glaze, Lauren, US Department of Justice, Bureau of Justice Statistics, Probation and Parole in the United States (Washington DC: US Department of Justice, August 1999), p. 1.

10. In 1990, of the 739,960 sentenced prisoners in Federal and State prisons, 370,400 were African-American. By 1999 the number of African-Americans had grown to 558,700 out of a total of 1,222,799 sentenced prisoners.

Source: Beck, Allen J., Ph.D., and Christopher Mumola, US Department of Justice, Bureau of Justice Statistics, Prisoners in 1998 (Washington, DC: US Department of Justice, August 1999), p. 9, and Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1999 (Washington, DC: US Department of Justice, August 2000), p. 1.

11. Assuming recent incarceration rates remain unchanged, an estimated 1 of every 20 Americans (5%) can be expected to serve time in prison during their lifetime. For African-American men, the number is greater than 1 in 4 (28.5%).

Source: Bonczar, T.P. & Beck, Allen J., US Department of Justice, Bureau of Justice Statistics, Lifetime Likelihood of Going to State or Federal Prison (Washington DC: US Department of Justice, March 1997), p. 1.

12. The Bureau of Justice Statistics reports that in 1995, the nation spent $112,868,448,000 on the Federal, State and Local justice systems. In that year, the United States had 1,585,586 adult jail and prison inmates. Based on this information the cost per inmate year was:
— Corrections spending alone: $25,071 per inmate
— Corrections, judicial and legal costs: $40,504 per inmate
— Corrections, judicial, legal and police costs: $71,184 per inmate

Source: Gifford, Lea S., US Department of Justice, Bureau of Justice Statistics, Justice Expenditure and Employment in the United States, 1995 (Washington, DC: US Department of Justice, November 1999), p.1.Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prison and Jail Inmates at Midyear 1999 (Washington, DC: US Department of Justice, April 2000), p.2.

13. "Prisoners sentenced for drug offenses constitute the largest group of Federal inmates (58%) in 1998, up from 53% in 1990 (table 21). On September 30, 1998, the date of the latest available data, Federal prisons held 63,011 sentenced drug offenders, compared to 30,470 at year end 1990."

Source: Beck, Allen J., PhD, US Department of Justice, Bureau of Justice Statistics, Prisoners in 1999 (Washington, DC: US Department of Justice, August 2000), p. 12.

14. Over 80% of the increase in the federal prison population from 1985 to 1995 was due to drug convictions.

Source: US Department of Justice, Bureau of Justice Statistics, Prisoners in 1996 (Washington DC: US Department of Justice, 1997).

15. In 1998, drug law violators comprised 21% of all adults serving time in State prisons - 236,800 out of 1,141,700 State inmates.

Source: Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1999 (Washington, DC: US Department of Justice, August 2000), p. 10 and Table 15.

16. Eighty-four percent (84%) of the increase in state and federal prison admissions since 1980 was accounted for by nonviolent offenders.

Source: Ambrosio, T. & Schiraldi, V., Executive Summary-February 1997 (Washington DC: The Justice Policy Institute, 1997).

17. "Department of corrections data show that about a fourth of those initially imprisoned for nonviolent crimes are sentenced for a second time for committing a violent offense. Whatever else it reflects, this pattern highlights the possibility that prison serves to transmit violent habits and values rather than to reduce them."

Source: Craig Haney, Ph.D., and Philip Zimbardo, Ph.D., The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment, American Psychologist, Vol. 53, No. 7 (July 1998), p. 720.

18. The United States operates the biggest prison system on the planet.

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Source: Currie, E., Crime and Punishment in America (New York, NY: Metropolitan Books, Henry Holt and Company, Inc., 1998), p. 3.

19. The federal Bureau of Justice Statistics reports that in 1990 there were 1,148,702 inmates in custody in jails, federal and state prisons, for an incarceration rate in the US of 458 per 100,000 population. By June 30, 1999, that number had climbed to 1,860,520, for an incarceration rate of 682 inmates per 100,000 population.

Source: Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prison and Jail Inmates at Midyear 1999 (Washington DC: US Department of Justice, April 2000), p. 2.

Prison

20. If one compares 1996 to 1984, the crime index is 13 points higher. This dramatic increase occurred during an era of mandatory minimum sentencing and three strikes you're out.

Source: Federal Bureau of Investigation, Uniform Crime Reports 1996 (Washington DC: US Department of Justice, 1997), p. 62, Table 1.

21. "We must have law enforcement authorities address the issue because if we do not, prevention, education, and treatment messages will not work very well. But having said that, I also believe that we have created an American gulag."

Source: Gen. Barry R. McCaffrey (USA, Ret.), Director, ONDCP, Keynote Address, Opening Plenary Session, National Conference on Drug Abuse Prevention Research, National Institute on Drug Abuse, September 19, 1996, Washington, DC, on the web at http://165.112.78.61/MeetSum/CODA/Keynote2.html

22. According to the Department of Justice, studies of recidivism report that "the amount of time inmates serve in prison does not increase or decrease the likelihood of recidivism, whether recidivism is measured as parole revocation, re-arrest, reconviction, or return to prison."

Source: An Analysis of Non-Violent Drug Offenders with Minimal Criminal Histories, Washington D.C.: U.S. Department of Justice (1994, February), p. 41.

23. The table below shows the average time (mean and median) served by Federal prisoners for various offenses.

Average Time Served in Federal Prison

Offense	Mean	Median
Murder/manslaughter	61.7 months	40.1 months
Drug Trafficking	43.2 months	40.1 months
Drugs	42.5 months	40.0 months
Rape	unavailable	unavailable
Robbery	59.9 months	50.5 months
Burglary	20.4 months	15.7 months
Assault	28.2 months	18.3 months
Auto Theft	19.1 months	15.7 months

Source: Urban Institute, US Department of Justice, Bureau of Justice Statistics, Compendium of Federal Justice Statistics, 1997 (Washington, DC: US Department of Justice, October 1999), p. 88.

24. States spent $32.5 billion on Corrections in 1997 alone. To compare, states only spent $22.2 billion on cash assistance to the poor.

Source: National Association of State Budget Officers (NASBO), 1999 State Expenditure Report (Washington, DC: NASBO, June 2000), pp. 38, 68.

Prison

25. Since the enactment of mandatory minimum sentencing for drug users, the Federal Bureau of Prisons budget has increased by 1,350%. Its budget has jumped from $220 million in 1986 to $3.19 billion in 1997.

Sources: US Department of Justice, Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics 1996 (Washington DC: US Department of Justice, 1997), p. 20; Office of National Drug Control Policy, Executive Office of the White House, National Drug Control Strategy 1997, Budget Summary (Washington DC: US Government Printing Office, 1997), p. 111.

26. The ONDCP in its 2000 annual report detailed administration requests for major increases in funding to the Federal Bureau of Prisons for drug-related prison construction. These include an extra $420 Million in fiscal year 2001, and advanced appropriations of $467 Million in 2002, and an additional $316 Million in 2003 — all drug-related.

Sources: Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics (Washington, DC: US Government Printing Office, 1997), p. 20; Office of National Drug Control Policy, Executive Office of the White House, National Drug Control Strategy, 1997: Budget Summary (Washington DC: US Government Printing Office, 1997), p. 111; Office of National Drug Control Policy, Executive Office of the White House, National Drug Control Strategy: Annual Report 2000 (Washington, DC: US Government Printing Office, 2000), p. 96.

27. From 1984 to 1996, California built 21 new prisons, and only one new university.

Source: Ambrosio, T. & Schiraldi, V., Trends in State Spending, 1987-1995, Executive Summary-February 1997 (Washington DC: The Justice Policy Institute, 1997).

28. California state government expenditures on prisons increased 30% from 1987 to 1995, while spending on higher education decreased by 18%.

Source: National Association of State Budget Officers, 1995 State Expenditures Report (Washington DC: National Association of State Budget Officers, 1996).

For a more complete perspective, read Drug War Facts sections on Alcohol, Crack, Drug Use Estimates, Gateway Theory, Race and Prison, and Women.

Common Sense for Drug Policy Presents The Facts: Prison

Race, HIV and AIDS

1. **AIDS is now the number two cause of death among African American men between the ages of 25 and 44 and the number three cause of death among African-American women ages of 25 and 44.**

   Source: Murphy, Sherry L., Centers for Disease Control, "Deaths: Final Data for 1998", National Vital Statistics Reports (Hyattsville, MD: National Center for Health Statistics, July 24, 2000), Vol. 48, No. 11, pp. 34, 36, Table 8.

2. **More than 110,000 African Americans had injection-related AIDS or had already died from it by the end of 1997.**

   Source: Dawn Day, Ph.D., Health Emergency 1999: The Spread of Drug-Related AIDS and other Deadly Diseases Among African Americans and Latinos (The Dogwood Center, 1998), p. i.

3. **By year-end 1999, African-Americans accounted for 272,881 - 37 percent - of the 733,374 reported cases of AIDS in the US. Of these, 112,545 were reported to be injection-related.**

   Source: Centers for Disease Control, HIV/AIDS Surveillance Report (1999 Year-End Edition, December 1999), Vol. 11, No. 2, Table 7, page 16; Table 9, Page 18; and Table 11, page 20; available online at http://www.cdc.gov/hiv/stats/hasr1102/table7.htm and http://www.cdc.gov/hiv/stats/hasr1102/table13.htm.

4. **AIDS is now the fourth leading cause of death among Latinos aged 25 to 44. Nearly half of these deaths (minimum 44%) are injection-related.**

   Source: Murphy, Sherry L., Centers for Disease Control, "Deaths: Final Data for 1998", National Vital Statistics Reports (Hyattsville, MD: National Center for Health Statistics, July 24, 2000), Vol. 48, No. 11, p. 37, Table 9. Centers for Disease Control, HIV/AIDS Surveillance Report (1999 Year-End Edition, December 1999), Vol. 11, No. 2, Table 9, page 18, and Table 11, page 20, available online at http://www.cdc.gov/hiv/stats/hasr1102/table7.htm and http://www.cdc.gov/hiv/stats/hasr1102/ table11.htm.

5. **More than 54,000 Latinos had injection-related AIDS or had already died from it by the end of 1997.**

   Source: Dawn Day, Ph.D., Health Emergency 1999: The Spread of Drug-Related AIDS and other Deadly Diseases Among African Americans and Latinos (The Dogwood Center, 1998), p. i.

6. **The Hispanic community has been disproportionately affected by HIV/AIDS. Although Hispanic persons only represent 12% of the U.S. population, they represent 18.2% of all reported AIDS cases.**

   Source: National Coalition of Hispanic Health and Human Services Organizations. HIV/AIDS: The Impact on Minorities (Washington, DC: National Coalition of Hispanic Health and Human Services Organizations, 1998), Figure 1, pg. 11; Centers for Disease Control, HIV/AIDS Surveillance Report (1999 Year-End Edition, December 1999), Vol. 11, No. 2, Table 7, page 16, available online at http://www.cdc.gov/hiv/stats/hasr1102/table7.htm.

Common Sense for Drug Policy Presents The Facts:
Race, HIV and AIDS

Race, Prison and the Drug Laws

1. **"The racially disproportionate nature of the war on drugs is not just devastating to black Americans. It contradicts faith in the principles of justice and equal protection of the laws that should be the bedrock of any constitutional democracy; it exposes and deepens the racial fault lines that continue to weaken the country and belies its promise as a land of equal opportunity; and it undermines faith among all races in the fairness and efficacy of the criminal justice system. Urgent action is needed, at both the state and federal level, to address this crisis for the American nation."**

   Source: Key Recommendations from Punishment and Prejudice: Racial Disparities in the War on Drugs (Washington, DC: Human Rights Watch, June 2000), from the web at http://www.hrw.org/campaigns/drugs/war/key-reco.htm.

2. **"Our criminal laws, while facially neutral, are enforced in a manner that is massively and pervasively biased. The injustices of the criminal justice system threaten to render irrelevant fifty years of hard-fought civil rights progress."**

   Source: Welch, Ronald H. and Angulo, Carlos T., Justice On Trial: Racial Disparities in the American Criminal Justice System (Washington, DC: Leadership Conference on Civil Rights/Leadership Conference Education Fund, May 2000), p. v.

3. **On June 30, 1999, an estimated 11% of black males, 4% of Hispanic males, and 1.5% of white males in their twenties and early thirties were in prison or jail.**

   Source: US Department of Justice, Bureau of Justice Statistics, Prisoners and Jail Inmates at Midyear 1999 (Washington DC: US Department of Justice, April 2000), p. 1.

4. **"Among the nearly 1.9 million offenders incarcerated on June 30, 1999, more than 560,000 were black males between the ages of 20 and 39 (table 12). Expressed in terms of percentages, 12.3% of black non-Hispanic males age 25 to 29 were in prison or jail, compared to 4.2% of Hispanic males and about 1.5% of white males in the same age group (table 13). Although incarceration rates drop with age, the percentage of black males age 45 to 54 in prison or jail in 1999 was still nearly 3.4% — twice the highest rate (1.7%) among white males (age 30 to 34)."**

   Source: US Department of Justice, Bureau of Justice Statistics, Prisoners and Jail Inmates at Midyear 1999 (Washington DC: US Department of Justice, April 2000), p. 10.

5. **According to the US Census Bureau, the estimated US population by July 1, 1999, was 272,691,000. Of that, 196,600,000, or 71.5%, were white; 33,443,000, or 12.2%, were black; and 32,345,000, or 11.8%, were of Hispanic origin. Additionally, 2,048,000 or 0.7% were Native American, and 10,476,000, or 3.8%, were Asian or Pacific Islanders.**

   Source: US Census Bureau, Department of Commerce, "Resident Population Estimates of the United States by Sex, Race, and Hispanic Origin: April 1, 1990 to July 1, 1999, with short-term projection to June 1, 2000, from the web at http://www.census.gov/population/estimates/nation/intfile3-1.txt

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6. **"Between 1990 and 1997 the number of black inmates serving time for drug offenses increased by 60%, while the number of white inmates increased by 46% and the number of Hispanic inmates by 32%. The number of violent offenders also rose more sharply among black inmates (up 69%) and Hispanic inmates (up 86%) than among white inmates (up 47%)."**

   Source: Beck, Allen J., Ph.D., and Mumola, Christopher J., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1998 (Washington, DC: US Department of Justice, August 1999), pg. 11.

7. **According to the federal Household Survey, "most current illicit drug users are white. There were an estimated 9.9 million whites (72 percent of all users), 2.0 million blacks (15 percent), and 1.4 million Hispanics (10 percent) who were current illicit drug users in 1998." And yet, blacks constitute 36.8% of those arrested for drug violations, over 42% of those in federal prisons for drug violations. African-Americans comprise almost 60% of those in state prisons for drug felonies; Hispanics account for 22.5%.**

   Sources: Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse: Summary Report 1998 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999), p. 13; US Department of Justice, Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics 1998 (Washington DC: US Department of Justice, Bureau of Justice Statistics, August 1999), p. 343, Table 4.10, p. 435, Table 5.48, and p. 505, Table 6.52; Beck, Allen J., Ph.D. and Mumola, Christopher J., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1998 (Washington DC: US Department of Justice, Bureau of Justice Statistics, August 1999), p. 10, Table 16.

8. **Among persons convicted of drug felonies in state courts, whites were less likely than African-Americans to be sent to prison. Thirty-two percent (32%) of convicted white defendants received a prison sentence, while 46% of African-American defendants received prison sentences. It should also be noted that Hispanic felons are included in both demographic groups rather than being tracked separately so no separate statistic is available.**

   Source: Levin, David J., Langan, Patrick A., and Brown, Jodi M., US Department of Justice, Bureau of Justice Statistics, State Court Sentencing of Convicted Felons, 1996 (Washington DC: US Department of Justice, February 2000), p. 8.

9. **All major Western European nations' incarceration rates are about or below 100 per 100,000. In the United States, in 1999, the incarceration rate for African-American women was 375 per 100,000, and for African-American men 4,617 per 100,000. The rate of incarceration for Hispanic women is 142 per 100,000, and for Hispanic men the rate is 1,802 per 100,000. The rate of incarceration for white women is 53 per 100,000, and for white men the rate is 630 per 100,000.**

Source: Currie, E., Crime and Punishment in America (New York, NY: Metropolitan Books, Henry Holt and Company, Inc., 1998), p. 15; Beck, Allen J., Ph.D., US Department of Justice, Bureau of Justice Statistics, Prison and Jail Inmates at Midyear 1999 (Washington DC: US Department of Justice, April 2000), p. 10.

10. The United States incarcerates African-American men at a rate that is approximately four times the rate of incarceration of Black men in South Africa.

Source: Craig Haney, Ph.D., and Philip Zimbardo, Ph.D., "The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment," American Psychologist, Vol. 53, No. 7 (July 1998), p. 714.

11. At the start of the 1990s, the U.S. had more Black men (between the ages of 20 and 29) under the control of the nation's criminal justice system than the total number in college. This and other factors have led some scholars to conclude that, "crime control policies are a major contributor to the disruption of the family, the prevalence of single parent families, and children raised without a father in the ghetto, and the inability of people to get the jobs still available."'

Source: Craig Haney, Ph.D., and Philip Zimbardo, Ph.D., "The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment," American Psychologist, Vol. 53, No. 7 (July 1998), p. 716.

12. The rate of imprisonment for black women is more than eight times the rate of imprisonment of white women; the rate of imprisonment of Hispanic women is nearly four times the rate of imprisonment of white women.

Source: Amnesty International, "Not Part of My Sentence: Violations of the Human Rights of Women in Custody" (Washington, DC: Amnesty International, March 1999), p. 19.

13. 1.46 million black men out of a total voting population of 10.4 million have lost their right to vote due to felony convictions.

Source: Thomas, P., "Study Suggests Black Male Prison Rate Impinges on Political Process," The Washington Post (January 30, 1997), p. A3.

14. "Thirteen percent of all adult black men — 1.4 million — are disenfranchised, representing one-third of the total disenfranchised population and reflecting a rate of disenfranchisement that is seven times the national average. Election voting statistics offer an approximation of the political importance of black disenfranchisement: 1.4 million black men are disenfranchised compared to 4.6 million black men who voted in 1996."

Source: Jamie Fellner and Mark Mauer, Losing the Vote: The Impact of Felony Disenfranchisement Laws in the United States (Washington, DC: Human Rights Watch & The Sentencing Project, 1998), p. 8. Election data cited comes from the US Census Bureau, Voting and Registration in the Election of November 1996 (P20-504) (Washington, DC: US Census Bureau, July 1998).

Race, Prison and the Drug Laws

15. One in three black men between the ages of 20 and 29 years old is under correctional supervision or control.

Source: Mauer, M. & Huling, T., Young Black Americans and the Criminal Justice System: Five Years Later (Washington DC: The Sentencing Project, 1995).

16. At current levels of incarceration, newborn Black males in this country have a greater than 1 in 4 chance of going to prison during their lifetimes, while Latin-American males have a 1 in 6 chance, and white males have a 1 in 23 chance of serving time.

Source: Bonczar, T.P. & Beck, Allen J., US Department of Justice, Bureau of Justice Statistics, Lifetime Likelihood of Going to State or Federal Prison (Washington DC: US Department of Justice, March 1997).

17. In 1986, before mandatory minimums for crack offenses became effective, the average federal drug offense sentence for blacks was 11% higher than for whites. Four years later following the implementation of harsher drug sentencing laws, the average federal drug offense sentence was 49% higher for blacks.

Source: Meierhoefer, B. S., The General Effect of Mandatory Minimum Prison Terms: A Longitudinal Study of Federal Sentences Imposed (Washington DC: Federal Judicial Center, 1992), p. 20.

18. Regardless of similar or equal levels of illicit drug use during pregnancy, black women are 10 times more likely than white women to be reported to child welfare agencies for prenatal drug use.

Source: Neuspiel, D.R., "Racism and Perinatal Addiction," Ethnicity and Disease, 6: 47-55 (1996); Chasnoff, I.J., Landress, H.J., & Barrett, M.E., "The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida," New England Journal of Medicine, 322: 1202-1206 (1990).

19. Due to harsh new sentencing guidelines, such as 'three-strikes, you're out,' "a disproportionate number of young Black and Hispanic men are likely to be imprisoned for life under scenarios in which they are guilty of little more than a history of untreated addiction and several prior drug-related offenses States will absorb the staggering cost of not only constructing additional prisons to accommodate increasing numbers of prisoners who will never be released but also warehousing them into old age."

Source: Craig Haney, Ph.D., and Philip Zimbardo, Ph.D., "The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment," American Psychologist, Vol. 53, No. 7 (July 1998), p. 718.

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Common Sense for Drug Policy presents The Facts:
Race, Prison and the Drug Laws

Syringe Exchange

1. **"After reviewing all of the research to date, the senior scientists of the Department and I have unanimously agreed that there is conclusive scientific evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs."**

   Source: US Surgeon General Dr. David Satcher, Department of Health and Human Services, Evidence-Based Findings on the Efficacy of Syringe Exchange Programs: An Analysis from the Assistant Secretary for Health and Surgeon General of the Scientific Research Completed Since April 1998 (Washington, DC: Dept. of Health and Human Services, 2000), from the website of the Harm Reduction Coalition at http://www.harmreduction.org/surgreview.html.

2. **According to Dr. Harold Varmus, Director of the National Institutes of Health, "An exhaustive review of the science in this area indicates that needle exchange programs can be an effective component in the global effort to end the epidemic of HIV disease."**

   Source: Varmus, Harold, MD, Director of the National Institutes of Health, Press release from Department of Health and Human Services, (April 20, 1998).

3. **According to a study in 1996, "Drug paraphernalia laws in 47 U.S. states make it illegal for injection drug users (IDUs) to possess syringes." The study concludes, "decriminalizing syringes and needles would likely result in reductions in the behaviors that expose IDUs to blood borne viruses."**

   Source: Bluthenthal, Ricky N., Kral, Alex H., Erringer, Elizabeth A., and Edlin, Brian R., "Drug paraphernalia laws and injection-related infectious disease risk among drug injectors", Journal of Drug Issues, 1999;29(1):1-16. Abstract available on the web at http://www.nasen.org/NASEN_II/research1.htm.

4. **In 1998, HIV infection became the number five leading cause of death among persons aged 25 to 44 years.**

   Source: Murphy, Sherry L., Centers for Disease Control, "Deaths: Final Data for 1998", National Vital Statistics Reports (Hyattsville, MD: National Center for Health Statistics, July 24, 2000), Vol. 48, No. 11, p. 26, Table 8.

5. **According to the Centers for Disease Control, by year-end 1999 there were a total of 733,374 reported cases of AIDS in the US. Of these, 263,789 - 35% — are linked to injection drug use.**

   Source: Based on the number of AIDS cases for which the method of exposure is known. Centers for Disease Control, HIV/AIDS Surveillance Report (1999 Year-End Edition, December 1999), Vol. 11, No. 2, Table 5, p. 14, available online at http://www.cdc.gov/hiv/stats/hasr1102/table5.htm.

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6. **In 1999, 37% of all new AIDS cases among women in the US were injection-related, that is, the woman became infected because she herself used an HIV-infected needle or because her husband or significant other did so (based on the number of HIV infections for which the cause was reported).**

Source: Based on the number of new AIDS cases among women for which the method of exposure is known. Centers for Disease Control, HIV/AIDS Surveillance Report (1999 Year-End Edition, December 1999), Vol. 11, No. 2, Table 5, p. 14, available online at http://www.cdc.gov/hiv/stats/hasr1102/table5.htm.

7. In 1999, 37.6% of the 263 new AIDS cases reported among children under age 13 were injection-related.

Source: Based on the number of new AIDS cases among children for which the method of exposure is known. Centers for Disease Control, HIV/AIDS Surveillance Report (1999 Year-End Edition, December 1999), Vol. 11, No. 2, Table 5, p. 14, available online at http://www.cdc.gov/hiv/stats/hasr1102/table5.htm.

8. Donna Shalala, the Secretary of Health and Human Services: "A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs."

Source: Shalala, D.E., Secretary, Department of Health and Human Services, Press release from Department of Health and Human Services (April 20, 1998).

9. The estimated lifetime cost of treating an HIV positive person is $195,188.

Source: Holtgrave, DR, Pinkerton, SD. "Updates of Cost of Illness and Quality of Life Estimates for Use in Economic Evaluations of HIV Prevention Programs." Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, Vol. 16, pp. 54-62 (1997).

10. In 1991, there were an estimated 18,500 children 18 and younger who lost their mothers to AIDS.

Source: Michaels, D. & Levine, C., "Estimates of the Number of Motherless Youth Orphaned by AIDS in the United States", Journal of the American Medical Association, 268: 3456-3461 (1992).

11. In 1997, Dr. Ernest Drucker wrote in The Lancet that if current U.S. policies limiting clean needle programs were not changed, an additional 5,150 to 11,329 preventable HIV infections could occur by the year 2000. In 1999 alone, the CDC reports there were at least 2,946 new injection-related HIV infections.

Source: Lurie, P. & Drucker, E., "An Opportunity Lost: HIV Infections Associated with Lack of a National Needle-Exchange Programme in the U.S.A.", Lancet, 349: 604-08 (1997); Centers for Disease Control, HIV/AIDS Surveillance Report (1999 Year-End Edition, December 1999), Vol. 11, No. 2, Table 6, p. 15, available online at http://www.cdc.gov/hiv/stats/hasr1102/table3.htm.

12. Between 1991 and 1997, the U.S. Government funded seven reports on clean needle programs for persons who inject drugs. The reports are unanimous in their conclusions that clean needle programs reduce HIV transmission, and none find that clean needle programs cause rates of drug use to increase.

Syringe Exchange

Sources: National Commission on AIDS, The Twin Epidemics of Substance Abuse and HIV (Washington DC: National Commission on AIDS, 1991); General Accounting Office, Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy (Washington DC: US Government Printing Office, 1993); Lurie, P. & Reingold, A.L., et al., The Public Health Impact of Needle Exchange Programs in the United States and Abroad (San Francisco, CA: University of California, 1993); Satcher, David, MD, (Note to Jo Ivey Bouffard), The Clinton Administration's Internal Reviews of Research on Needle Exchange Programs (Atlanta, GA: Centers for Disease Control, December 10, 1993); National Research Council and Institute of Medicine, Normand, J., Vlahov, D. & Moses, L. (eds.), Preventing HIV Transmission: The Role of Sterile Needles and Bleach (Washington DC: National Academy Press, 1995); Office of Technology Assessment of the U.S. Congress, The Effectiveness of AIDS Prevention Efforts (Springfield, VA: National Technology Information Service, 1995); National Institutes of Health Consensus Panel, Interventions to Prevent HIV Risk Behaviors (Kensington, MD: National Institutes of Health Consensus Program Information Center, February 1997).

13. Drug Czar Barry McCaffrey misinterpreted results of two Canadian needle exchange studies when he suggested in testimony to Congress that the studies showed needle exchange efforts have failed to reduce the spread of HIV and may have worsened the problem. In a clarification published in The New York Times, the authors of the studies corrected him, pointing out that among other factors, in Canada syringes can be purchased legally while they could only be purchased with prescriptions in the United States. Therefore, unlike in the USA studies, the populations in the Canadian studies were less likely to include the more affluent and better functioning addicts who could purchase their own needles and who were less likely to engage in the riskiest activities. Thus, it was not surprising that participants in the study had higher rates of HIV than those who did not - they were in different risk categories.

Source: Bruneau, J. & Schechter, M.T., "Opinion: The Politics of Needles and AIDS," The New York Times (April 9, 1998); Federal Information Systems Corporation Federal News Service, "Hearing of the National Security, International Affairs and Criminal Justice Subcommittee of the House Government Reform and Oversight Committee subject: Office of National Drug Control Policy chaired by: Representative Dennis Hastert (R-IL) Barry R. Mccaffrey, Director, Office of National Drug Control Policy." (March 26, 1998)

14. NIH also states that, "individuals in areas with needle exchange programs have an increased likelihood of entering drug treatment programs."

*Source:*National Institutes of Health Consensus Panel, Interventions to Prevent HIV Risk Behaviors (Kensington, MD: NIH Consensus Program Information Center, February 1997), p. 6.

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15. Needle exchange programs can "prevent significant numbers of [HIV] infections among clients of the programs, their drug and sex partners and their offspring. In almost all cases, the cost per HIV infection averted is far below the $119,000 lifetime cost of treating an HIV infected person."

Source: Lurie, P. & Reingold, A.L., et al., The Public Health Impact of Needle Exchange Programs in the United States and Abroad (San Francisco, CA: University of California, 1993), Vol. 1, Executive Summary, pp. iii-v.

16. In the 96 largest metropolitan areas in the United States, there are 1,256,300 uninfected persons who inject drugs and are thus at risk for HIV infection.

Source: Holmberg, S., "The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas," American Journal of Public Health, 86: 642-54, Table 2 (1996).

17. "Estimates of the annual number of syringes required to meet the single-use standard run in the range of 1 billion. The most recent estimate of the number of syringes distributed by needle exchange programs in the United States (1997) was 17.5 million."

Source: Burris, Scott, JD, Lurie, Peter, MD, et al., "Physician Prescribing of Sterile Injection Equipment to Prevent HIV Infection: Time for Action", Annals of Internal Medicine (Philadelphia, PA: American College of Physicians, August 1, 2000), Vol. 133, No. 3, from the web at http://www.annals.org/issues/v133n3/full/200008010-00015.html last accessed September 12, 2000, citing Lurie P, Jones TS, Foley J. A sterile syringe for every drug user injection: how many injections take place annually, and how might pharmacists contribute to syringe distribution? J Acquir Immune Defic Syndr Hum Retrovirol 1998;18(Suppl 1):S45-51, and Update: syringe exchange programs — United States, 1997. MMWR Morb Mortal Wkly Rep. 1998;47:652-55.

18. Injecting drug use is the single largest route of exposure to HIV for Hispanics. As of June 1997, 37.2% of all AIDS cases among Hispanics were linked to IDU.

Source: National Coalition of Hispanic Health and Human Services Organizations, HIV/AIDS: The Impact on Minorities (Washington, DC: National Coalition of Hispanic Health and Human Services Organizations, 1998), Figure 5, p. 15.

Common Sense for Drug Policy Presents The Facts:
Syringe Exchange

The Netherlands and the United States:

1. **The Netherlands follows a policy of separating the market for illicit drugs. Cannabis is primarily purchased through coffee shops. Coffee shops offer no or few possibilities for purchasing illicit drugs other than cannabis. Thus The Netherlands achieve a separation of the soft drug market from the hard drugs market - and separation of the 'acceptable risk' drug user from the 'unacceptable risk' drug user.**

   Source: Abraham, Manja D., University of Amsterdam, Centre for Drug Research, Places of Drug Purchase in The Netherlands (Amsterdam: University of Amsterdam, September 1999), pp. 1-5.

2. **Comparing Important Drug and Violence Indicators**

Social Indicator	Year of Estimate (US vs. Neth.)	USA	Netherlands
Lifetime prevalence of marijuana use (ages 12+)	1998 vs. 1997	33%[1]	15.6%[2]
Past month prevalence of marijuana use (ages 12+)	1998 vs. 1997	5%[3]	2.5%[4]
Lifetime prevalence of heroin use (ages 12+)	1998 vs. 1997	1.1%[5]	0.3%[6]
Incarceration Rate per 100,000 population	1998 vs. 1996	645[7]	77.3[8]
Per capita spending on drug related law enforcement	1997 vs. 1995	$81[9]	$27[10]
Homicide rate per 100,000 population	1995 vs. 1995	8[11]	1.8[12]

Source #1: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse: Main Findings 1998 (Washington, DC: US Department of Health and Human Services, March 2000), pp. 18, 24

Source #2: Abraham, Manja D., Cohen, Peter D.A., van Til, Roelf-Jan, and de Winter, Marielle A.L., University of Amsterdam, Centre for Drug Research, Licit and Illicit Drug Use in the Netherlands, 1997 (Amsterdam: University of Amsterdam, September 1999), pp. 39, 45.

Source #3: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse: Main Findings 1998 (Washington, DC: US Department of Health and Human Services, March 2000), pp. 18, 24.

Source #4: Abraham, Manja D., Cohen, Peter D.A., van Til, Roelf-Jan, and de Winter, Marielle A.L., University of Amsterdam, Centre for Drug Research, Licit and Illicit Drug Use in the Netherlands, 1997 (Amsterdam: University of Amsterdam, September 1999), pp. 39, 47.

Source #5: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse: Main Findings 1998 (Washington, DC: US Department of Health and Human Services, March 2000), pp. 24, 62.

Source #6: Abraham, Manja D., Cohen, Peter D.A., van Til, Roelf-Jan, and de Winter, Marielle A.L., University of Amsterdam, Centre for Drug Research, Licit and Illicit Drug Use in the Netherlands, 1997 (Amsterdam: University of Amsterdam, September 1999), pp. 40, 45.

Source #7: Bureau of Justice Statistics; Based on total U.S. population in 1997 of 267,636,000 as per the U.S. Census Bureau.

Source #8: According to the Dutch Bureau of Statistics, CBS Voorburg, as of September 30, 1996 the Netherlands had 11,931 prisoners with an approximate population of 15,424,122. This data was provided by a statistician at CBS Voorburg and obtained from Statistics Netherlands: Statistical Yearbook 1998, p. 434, table 53.

Source #9: Office of National Drug Control Policy, National Drug Control Strategy, 1997: Budget Summary, Washington DC: U.S. Government Printing Office (1997); MacCoun, R. & Reuter, P., "Interpreting Dutch Cannabis Policy: Reasoning by Analogy in the Legalization Debate," Science, 278: 47 (1997); Based on total U.S. population in 1997 of 267,636,000 as per U.S. Census Bureau.

Source #10: Drug-related law enforcement spending in the Netherlands in 1995 is estimated at 640 million Dutch gilders according to the Dutch Justice Department.

Source #11: The FBI reported that the homicide rate in 1995 was 8 per 100,000 people, for a total of 21,597 homicides. (Uniform Crime Reports: Dept. of Justice Press Release, 10/13/96).

Source #12: In both 1995 and 1996, the Netherlands recorded 273 homicides, which is a homicide rate of 1.8 persons per 100,000 inhabitants. (Registered Murders in the Netherlands, Press Release, CBS Voorburg - Statistics Netherlands, 7/14/98).

3. **"There were 2.4 drug-related deaths per million inhabitants in the Netherlands in 1995. In France this figure was 9.5, in Germany 20, in Sweden 23.5 and in Spain 27.1. According to the 1995 report of the European Monitoring Centre for Drugs and Drug Addiction in Lisbon, the Dutch figures are the lowest in Europe. The Dutch AIDS prevention programme was equally successful. Europe-wide, an average of 39.2% of AIDS victims are intravenous drug-users. In the Netherlands, this percentage is as low as 10.5%."**

   Source: Netherlands Ministry of Justice, Fact Sheet: Dutch Drugs Policy, (Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction, 1999), from the Netherlands Justice Ministry website at http://www.minjust.nl:8080/a_beleid/fact/cfact7.htm.

4. **"The number of addicts in the Netherlands has been stable - at 25,000 - for many years. Expressed as a percentage of the population, this number is approximately the same as in Germany, Sweden and Belgium. There are very few young heroin addicts in the Netherlands, largely thanks to the policy of separating the users markets for hard and soft drugs. The average age of heroin addicts is now 36."**

Source: Netherlands Ministry of Justice, Fact Sheet: Dutch Drugs Policy, (Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction, 1999), from the Netherlands Justice Ministry website at http://www.minjust.nl:8080/a_beleid/fact/cfact7.htm.

5. **"Cannabis use among young people has also increased in most Western European countries and in the US. The rate of (cannabis) use among young people in the US is much higher than in the Netherlands, and Great Britain and Ireland also have relatively larger numbers of school students who use cannabis."**

   Source: Netherlands Ministry of Health, Welfare and Sport, Drug Policy in the Netherlands: Progress Report September 1997-September 1999, (The Hague: Ministry of Health, Welfare and Sport, November 1999), p. 7.

6. **"The figures for cannabis use among the general population reveal the same pictures. The Netherlands does not differ greatly from other European countries. In contrast, a comparison with the US shows a striking difference in this area: 32.9% of Americans aged 12 and above have experience with cannabis and 5.1% have used in the past month. These figures are twice as high as those in the Netherlands."**

   Source: Netherlands Ministry of Health, Welfare and Sport, Drug Policy in the Netherlands: Progress Report September 1997-September 1999, (The Hague: Ministry of Health, Welfare and Sport, November 1999), pp. 7-8.

7. **"The prevalence figures for cocaine use in the Netherlands do not differ greatly from those for other European countries. However, the discrepancy with the United States is very large. The percentage of the general population who have used cocaine at some point is 10.5% in the US, five times higher than in the Netherlands. The percentage who have used cocaine in the past month is 0.7% in the US, compared with 0.2% in the Netherlands.*"**

   Source: Netherlands Ministry of Health, Welfare and Sport, Drug Policy in the Netherlands: Progress Report September 1997-September 1999, (The Hague: Ministry of Health, Welfare and Sport, November 1999), p. 6. The report notes "*The figures quoted in this paragraph for drug use in the US are taken from the National Household Survey 1997, SAMSHA, Office of Applied Studies, Washington, DC".

Common Sense for Drug Policy Presents The Facts:
The Netherlands

Treatment

1. **Treatment is 10 times more cost effective than interdiction in reducing the use of cocaine in the United States.**

   Source: Rydell, C.P. & Everingham, S.S., Controlling Cocaine, Prepared for the Office of National Drug Control Policy and the United States Army (Santa Monica, CA: Drug Policy Research Center, RAND Corporation, 1994).

2. **A study by the RAND Corporation found that every additional dollar invested in substance abuse treatment saves taxpayers $7.46 in societal costs.**

   Source: Rydell, C.P. & Everingham, S.S., Controlling Cocaine, Prepared for the Office of National Drug Control Policy and the United States Army (Santa Monica, CA: Drug Policy Research Center, RAND Corporation, 1994), p. xvi.

3. **The RAND Corporation study found that additional domestic law enforcement efforts cost 15 times as much as treatment to achieve the same reduction in societal costs.**

   Source: Rydell, C.P. & Everingham, S.S., Controlling Cocaine, Prepared for the Office of National Drug Control Policy and the United States Army (Santa Monica, CA: Drug Policy Research Center, RAND Corporation, 1994), p. xvi.

4. **When analyzing options to reduce societal costs of cocaine use RAND found the following relationship:**
   For every additional $1.00 Spent On: Societal Benefits Are:

Source-Country Control	A LOSS of 85 cents
Interdiction	A LOSS of 68 cents
Domestic Enforcement	A LOSS of 48 cents
Treatment	A GAIN of $7.46

   Note: Societal costs include crime, violence and loss of productivity, etc.

   Source: Rydell, C.P. & Everingham, S.S., Controlling Cocaine, Prepared for the Office of National Drug Control Policy and the United States Army (Santa Monica, CA: Drug Policy Research Center, RAND Corporation, 1994), p. xvii.

5. **In 1996, voters in Arizona passed an initiative which mandated drug treatment instead of prison for non-violent drug offenders. At the end of the first year of implementation, Arizona's Supreme Court issued a report which found:**
   A) Arizona taxpayers saved $2.6 million in one year;
   B) 77.5% of drug possession probationers tested negative for drug use after the program;
   The Court stated, "The Drug Medicalization, Prevention and Control Act of 1996 has allowed the judicial branch to build an effective probation model to treat and supervise substance abusing offenders... resulting in safer communities and more substance abusing probationers in recovery."

   Source: State of Arizona Supreme Court, Drug Treatment and Education Fund: Implementation Full Year Report: Fiscal Year 1997-1998, 1999.

Treatment

6. In 1992, the U.S. government spent only 7% of its drug-control budget on treatment, the remaining 93% of its budget went to ineffective programs of source control, interdiction and law-enforcement.

Source: Rydell, C.P. & Everingham, S.S., , Controlling Cocaine, Prepared for the Office of National Drug Control Policy and the United States Army (Santa Monica, CA: Drug Policy Research Center, RAND Corporation, 1994), p. 5.

7. According to ONDCP Director Barry McCaffrey, "America is suffering from a significant treatment gap - defined as the difference between individuals who would benefit from treatment and those receiving it. . . . (A)pproximately five million drug users needed immediate treatment in 1998 while only 2.1 million received it." Further, he notes "Limited funding is a major factor in the availability of treatment."

Source: Gen. Barry R. McCaffrey (USA, Ret.), Director, ONDCP, Final Remarks, American Methadone Treatment Association Conference, "Treatment: Our Vision for the Future", San Francisco, CA, April 12, 2000, from the web at http://www.whitehousedrugpolicy.gov/news/speeches/041200/index.html.

8. The National Treatment Improvement Evaluation Study (NTIES) found that with treatment: drug selling decreased by 78%, shoplifting declined by almost 82%, and assaults (defined as 'beating someone up') declined by 78%. Furthermore, there was a 64% decrease in arrests for any crime, and the percentage of people who largely supported themselves through illegal activity dropped by nearly half - decreasing more than 48 percent.

Source: Center for Substance Abuse and Treatment, National Treatment Improvement Evaluation Study 1997 Highlights, from the web at http://www.health.org/nties97/crime.htm.

9. The 1997 National Treatment Improvement Evaluation Study (NTIES) stated, "Treatment appears to be cost effective, particularly when compared to incarceration, which is often the alternative. Treatment costs ranged from a low of $1,800 per client to a high of approximately $6,800 per client." To contrast, the average cost of incarceration in 1993 (the most recent year available) was $23,406 per inmate per year.

Source: Center for Substance Abuse and Treatment, National Treatment Improvement Evaluation Study 1997 Highlights, from the web at http://www.health.org/nties97/costs.htm; Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics 1996 (Washington DC: US Department of Justice, 1997), p. 4, 502. (Average cost is based on an adult jail and prison population of 1,364,881, and total corrections expenditures of $31,946,667,000 for 1993.)

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10. A recent study by researchers at Substance Abuse Mental Health Services Administration has indicated that 48% of the need for

drug treatment, not including alcohol abuse, is unmet in the United States.

Source: Woodward, A., Epstein, J., Gfroerer, J., Melnick, D., Thoreson, R., and Wilson, D., "The Drug Abuse Treatment Gap: Recent Estimates," Health Care Financing Review, 18: 5-17 (1997).

11. Treatment decreased welfare use by 10.7% and increased employment by 18.7% after one year, according to the 1996 National Treatment Improvement Evaluation Study.

Source: Center for Substance Abuse and Treatment, National Treatment Improvement Evaluation Study (Washington DC: US Government Printing Office, 1996), p. 11.

12. A recently concluded study of heroin maintenance in Switzerland for the World Health Organization concluded:

(a) The health of participants improved.
(b) Illicit cocaine and heroin use declined greatly.
(c) Housing situation improved and stabilized - most importantly there were no longer any more homeless participants.
(d) Fitness for work improved considerably, those with permanent employment more than doubled from 14% to 32%.
(e) The number of unemployed fell by half (from 44% to 20%)
(f) A third of the patients that were on welfare, left the welfare rolls. But, others went on to welfare to compensate for their lost income from sales of drugs.
(g) Income from illegal and semi-legal activities decreased significantly, from 69% of participants to 10%.
(h) The number of offenders and offenses decreased by about 60% during the first 6 months of treatment.
(i) The retention rate was average for treatment programs. 89% over 6 months, and 69% over 18 months.
(j) More than half of the dropouts did so to switch to another form of treatment. 83 of the participants did so to switch to an abstinence-based treatment, and it is expected that this number will grow as the duration of individual treatment increases.
(k) There were no overdoses from drugs prescribed by the program.

Source: Robert Ali, et al, Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts (New York, NY: The World Health Organization, April 1999).

13. According to CASA (National Center on Addiction and Substance Abuse), the cost of proven treatment for inmates, accompanied by education, job training and health care, would average about $6,500 per inmate. For each inmate that becomes a law-abiding, tax-paying citizen, the economic benefit is $68,800. Even if only one

in 10 inmates became a law-abiding citizen after this investment, there would still be a net social gain of $3,800.

Source: National Center on Addiction and Substance Abuse at Columbia University, Behind Bars: Substance Abuse and America's Prison Population, (New York, NY: National Center on Addiction and Substance Abuse at Columbia University, January 8, 1998), Foreword by Joseph Califano.

14. Treatment availability for drug and alcohol addicted prison inmates has declined over the last decade:
Among those prisoners who had been using drugs in the month before their offense, 15% of both State and Federal inmates said they had received drug abuse treatment during their current prison term, down from a third of such offenders in 1991.
Among those who were using drugs at the time of offense, about 18% of both State and Federal prisoners reported participation in drug treatment since admission, compared to about 40% in 1991.

Source: Bureau of Justice Statistics, Substance Abuse and Treatment, State and Federal Prisoners, 1997 (Bureau of Justice Statistics, Washington, DC: US Department of Justice, January 1999), p. 10.

Common Sense for Drug Policy Presents The Facts:
Treatment

Women

1. **At midyear in 1999, at least 149,200 women were behind bars — an incarceration rate of 106 per 100,000 population.**

   Source: Beck, Allen J., PhD, Prison and Jail Inmates at Midyear, 1999 (Washington DC: US Department of Justice, April 2000), p. 10, Tables 12 and 13.

2. **The number of women incarcerated in prisons and jails in the USA is approximately 10 times more than the number of women incarcerated in Western European countries, even though Western Europe's combined female population is about the same size as that of the USA.**

   Source: Amnesty International, Not Part of My Sentence: Violations of the Human Rights of Women in Custody (Washington, DC: Amnesty International, March 1999), p. 15.

3. **Women are the fastest growing and least violent segment of prison and jail populations. 85.1% of female jail inmates are behind bars for nonviolent offenses.**

   Source: John Irwin, Ph. D., Vincent Schiraldi, and Jason Ziedenberg, America's One Million Nonviolent Prisoners (Washington, DC: Justice Policy Institute, March 1999), pgs. 6-7.

4. **From 1986 (the year mandatory sentencing was enacted) to 1996, the number of women sentenced to state prison for drug crimes increased ten fold (from around 2,370 to 23,700) and has been the main element in the overall increase in the imprisonment of women.**

   Source: Amnesty International, Not Part of My Sentence: Violations of the Human Rights of Women in Custody (Washington, DC: Amnesty International, March 1999), p. 26.

5. **From 1985 to 1996, female drug arrests increased by 95%, while male drug arrests increased by 55.1%.**

   Sources: Federal Bureau of Investigation, Uniform Crime Reports 1985 (Washington DC, US Government Printing Office, 1986), p. 181, Table 37; Federal Bureau of Investigation, 1997 Uniform Crime Report (Washington DC: US Government Printing Office, 1998), p. 231, Table 42.

6. **In 1998, there were an estimated 3,170,520 arrests of women, of which 272,073 were for drug offenses-18% of the total drug arrests that year.**

   Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), p. 5, Table 10.

7. **Between 1990 and 1996, the number of women convicted of drug felonies increased by 37% (from 43,000 in 1990 to 59,536 in 1996). The number of convictions for simple possession increased 41% over that period, from 18,438 in 1990 to 26,022 in 1996.**

   Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), p. 5, Table 11.

Women

8. The most serious offense for 72% of women in federal prisons and 34% of women in state prisons is violation of drug laws.

Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), p. 6, Table 15.

9. The rate of imprisonment for African-American women is at least eight times the rate of imprisonment of white women; the rate of imprisonment of Hispanic women is nearly four times the rate of imprisonment of white women.

Source: Beck, Allen J., PhD, and Mumola, Christopher J., US Department of Justice, Bureau of Justice Statistics, Prisoners in 1998 (Washington, DC: US Department of Justice, August 1999), p. 10, Table 15.

10. Approximately 516,200 women on probation (72% of the total), 44,700 women in local jails (70% of the total), 49,200 women in State prisons (65% of the total), and 5,400 women in Federal prisons (59% of the total) have minor children.

Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), p. 7, Table 17.

11. In 1997 an estimated 2.8% of all children under age 18 had at least one parent in a local jail or a State or Federal prison. About 1 in 359 children have an incarcerated mother for a total of 194,504 children with their mothers behind bars.

Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), pp. 7-8, Tables 17 and 18.

12. Forty-four percent of women under correctional authority, including 57% of the women in State prisons, reported that they were physically or sexually abused at some point in their lives. Sixty-nine percent of women reporting an assault said that it had occurred before age 18.

Source: Greenfield, Lawrence A., and Snell, Tracy L., US Department of Justice, Bureau of Justice Statistics, Women Offenders (Washington, DC: US Department of Justice, December 1999), p. 8, Table 20.

13. Many women in prisons and jails in the USA are victims of sexual abuse by staff, including male staff touching inmates' breasts and genitals when conducting searches; male staff watching inmates while they are naked; and rape.

Source: Amnesty International, Not Part of My Sentence: Violations of the Human Rights of Women in Custody (Washington, DC: Amnesty International, March 1999), p. 38.

17. As of June 1997, two-thirds of the AIDS cases in Hispanic women were directly linked to injecting drug use: 42.8% of Hispanic

Women

15. As of June 1997, two-thirds of the AIDS cases in Hispanic women were directly linked to injecting drug use: 42.8% of Hispanic women contracted AIDS by injecting drugs, and an additional 23.2% contracted the disease through sexual intercourse with male injecting drug users.

Source: National Coalition of Hispanic Health and Human Services Organizations, HIV/AIDS: The Impact on Minorities (Washington, DC: National Coalition of Hispanic Health and Human Services Organizations, 1998), Figure 6, pg. 16.

16. African American women accounted for over 50 percent of all injection-related AIDS cases among women in 1997, although they made up only 12 percent of the female population. Similarly, Latina women accounted for almost 25 percent of all injection-related AIDS cases among women in 1997, although they made up only 10 percent of the female population.

Source: Dawn Day, Ph.D., Health Emergency 1999: The Spread of Drug-Related AIDS and other Deadly Diseases Among African Americans and Latinos (The Dogwood Center, 1998), p. i.

Common Sense for Drug Policy Presents The Facts: Women

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