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# CASUALTIES OF THE DRUG WAR

By

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**ABSTRACT**

The “War on Drugs” started with the Controlled Substances Act and expanded with the Sentencing Reform Act and Anti-Drug Abuse Acts. Mostly they have provided tertiary measures that have done little to eradicate drugs or drug addiction. Instead, the U.S. remains the number one nation in the world in drug use. In addition, there is an ever-growing prison population that has surpassed unsustainable levels. Many of the people behind bars are there for drug related crimes. It is time to examine drug policies, particularly those that send people to prison, and to consider establishing more programs that help people overcome challenges of substance abuse. This thesis will critically examine these policies and make recommendations for policy makers to consider.

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## **OVERVIEW**

This is an analysis of the major policies that comprise the United States' "War on Drugs." The War on Drugs is an ad hoc collection of various drug laws that were intended to treat the problem of illicit drug demand in the United States. Perhaps the cornerstone of the War on Drugs is the Controlled Substances Act, part of the larger legislation called the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Substance use or dependence affects all people, regardless of race, class, gender, sexual orientation, ethnicity, culture, religion and spirituality, socioeconomic status, disability, or any other factors. Alcohol, tobacco, and other drug problems have consequences for all members of a family, especially children. (Social Work Speaks: National Association of Social Workers policy statements, 2012, p.29) Substance Use Disorder (SUD) is a disease that is treatable, with potential for full recovery. The severity of drug demand came into the national spotlight more than ever in the 1960s and 1970s. Unfortunately, the laws written to address the problem in large part haven't worked and in many ways have been detrimental to individuals, communities, and society as a whole.

## **HISTORICAL ANALYSIS**

The use of drugs and alcohol for medicinal and/or mind altering qualities has been in existence throughout history. Historical accounts of substance use, including alcohol, opium, and marijuana, date back thousands of years. Substance abuse, in modern context, dates back to the late 1800s. (History, 2007)

Some of the first attempts to control a growing demand for drugs in the United States occurred in the late 19<sup>th</sup> and early 20<sup>th</sup> century. Each law was rather specific to individual types of drugs. Local municipalities and states were some of the first to attempt some form of control. For example, in the late 1800s there was a growing opium demand with the opium originating from China. With that came one of the first anti-opium laws, passed in San Francisco in 1875. Later came a discriminatory law, the 1882 Chinese Exclusion Act, which banned immigration from China for 10 years in an attempt to prevent the importation of opium. (Courtwright, 2004) This was just one example in a list of succeeding discriminatory laws that targeted specific populations.

The first federally implemented laws were the 1906 Pure Food and Drug Act and then the 1914 Harrison Act. The Pure Food and Drug Act eventually led to the creation of the Food and Drug administration. Both laws focused on opiates and cocaine. These laws formed the basis of drug laws leading into the mid 20<sup>th</sup> century. The Harrison Act in particular was very influential in shaping drug policy throughout the first half of the century. Also, in 1920 both the 18<sup>th</sup> amendment and the Volstead Act prohibited alcohol sale and distribution. Alcohol consumption dropped in this period, but organized crime flourished. In 1933 the 21<sup>st</sup> amendment reversed the prohibition of alcohol by ratifying the 18<sup>th</sup> amendment. Ad Hoc legislation for drug control continued, creating an unstable regulatory system of controls, treatments, fines, and sentences. What was needed was a comprehensive reform effort. (Courtwright, 2004)

**DESCRIPTION OF THE POLICIES**

The first influential law that dictated how drug abuse would be dealt with in the first half of the 20<sup>th</sup> century was the 1914 Harrison Act.

On its surface, the Harrison Act appeared only to regulate the production and distribution of opium and coca derivatives, but in practice it was interpreted to preclude doctors from prescribing drugs to maintain addiction, and it ushered in a half-century of increasingly punitive antidrug laws. The act itself increased the maximum penalty specified in federal narcotics laws to five years from two. But by the end of the 1950s, federal and some state antinarcotics laws included life imprisonment and the death penalty and imposed mandatory minimum sentences for certain drug offenses. Still, the scale of enforcement was minor, as was drug use. (Boyum, D., & Reuter, P., 2005, p. 5)

One of the first attempts to regulate the drug problem (especially heroin) with a different emphasis than the punitive system that had been established throughout the 1950s was the Comprehensive Drug Abuse Prevention and Control Act of 1970 (CDAPCA). This policy was established by President Richard Nixon and was the beginning of what is known as “The War on Drugs.” The CDAPCA was divided into three parts. Prevention and Treatment efforts were expanded in Title I of the CDAPCA. Differentiation between legal and illegal drugs was codified in Title II of the CDAPCA, known as the Controlled Substances Act. Title III of CDAPCA was known as the Controlled Substances Import and Export Act. It set penalties for importation and exportation of controlled substances. This policy has been said to be a high point in progressive drug policy. (Courtwright, 2004)

Title I of the Comprehensive Drug Abuse Prevention and Control Act (1970) provided funding for prevention, treatment, and research. It broadened the language of the Community Mental Health Centers Act (CMHCA) to include substance abuse and



addiction. Also, it significantly increased funding for the CMHCA, doubling funding for the 1973 fiscal year. In addition, Title I set up grants for state and local private and nonprofit agencies for education. The National Institute for Mental Health was made the focal point for drug education and training of professionals. It provided funding for “Special projects for narcotic addicts and drug dependent persons” and “broader treatment authority in public health service hospitals for persons with drug abuse and other drug dependence problems.” Title I also amended the Public Health Services Act by broadening its language to include “drug abusers and dependents,” expanded protection of privacy for research regarding drug addiction, and expanded availability of research grants. (Comprehensive Drug Abuse Prevention and Control Act, 1970)

Section (4) “provided that the Secretary of Health, Education, and Welfare, after consultation with the attorney general and with national organizations representative of persons with knowledge and experience in the treatment of narcotic addicts, shall determine the appropriate methods of professional practice in the medical treatment of the narcotic addiction of various classes of narcotic addicts, and shall report thereon from time to time to congress (CDAPCA, 1970).”

Title I was the final step in reform started in the 1966 Narcotic Addict Rehabilitation Act. It provided federal funding for inpatient and outpatient treatment programs provided by state and local agencies, including Methadone maintenance for heroin addiction. This reflected the progressive wisdom of the time that treatment was more effective than past remedies of incarceration. (Courtwright, 2004)

Title II of CDAPCA, known as the Controlled Substances Act (CSA), states that, “many of the drugs included within this title have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.” Second, drug importation is detrimental to health and welfare of American people. Third, much of the traffic comes through interstate and foreign commerce. CSA establishes a legal precedence for drug control under the commerce clause (Courtwright, 2004).

The signature role of CSA was to provide drug scheduling. Schedules I-V provided categories or schedules for drugs according to potential for addiction and medical use. Schedule I included drugs judged to be most dangerous and addictive, with little or no medical use. This included Marijuana, Heroin, and LSD. Schedule II included drugs with some medical value, but were also highly addictive such as morphine. Schedules III-V contained other prescription drugs, with the most accessible being in schedule V. Title II also provided a framework for scheduling new drugs. The original intention was to provide flexibility in fine-tuning the law in the future. (Courtwright, 2004)

Title II (CSA) was also intended to provide relief from the minimum sentencing provided by earlier laws, such as the 1956 Narcotic Control Act. The original CSA contained no minimum sentencing guidelines. The Bureau of Narcotics and Dangerous Drug’s director John Ingersoll, said the new guidelines would make the system fairer. He said it would also preserve distinctions between casual users, addicts, and traffickers, with the heaviest sentences for the latter. (Courtwright, 2004)

The CSA was not entirely socially progressive. It provided funding for additional enforcement agents. In addition, it provided a legal benchmark for “no-knock” search warrants processed on suspected dealers (Courtwright, 2004). Not long after the introduction of the War on Drugs and the CSA, policy makers started passing more legislation, much of it taking the country back to a punitive and interdictory approach from just a few years prior. This approach was similar to that set in place by first the Harrison Act of 1914 and then later the Narcotic Control Act of 1956. One of these efforts took place in 1973, with the formation of Drug Enforcement Agency (DEA) as part of the Department of Justice. The DEA was empowered to enforce federal drug laws. This signaled a move towards treating the problem with the power of the judicial system.

In 1974, the National Institute on Drug Abuse (NIDA) was established and became the leader in the fight against substance abuse through research and establishing community-based treatment programs (Social work speaks: NASW policy statements, 2012, p. 29). By the late 1970’s treatment funding diminished, and federal involvement waned until the 1980’s. Nancy Reagan started the “Just Say No” campaign popular during the 1980’s and new policy reflected the socially conservative values of the time.

In 1984, the Sentencing Reform Act was passed. In 1986 and 1988 the Anti-Drug Abuse Acts (ADA) were passed. These laws established minimum sentencing guidelines in response to a growing crack cocaine epidemic. The ADA also established what is known as the drug czar, or the Office of National Drug Control Policy, which coordinates both supply and demand reduction efforts for the President’s administration. The stated

purpose of the ADA was to address the continuing problems of substance abuse and the so-called “war on drugs” (Rowe, 2006, p.43).

The ADA policies established harsher penalties for possession and an extreme discrepancy in sentencing for powder cocaine vs. crack cocaine possession (the sentence for 1 gram of crack cocaine equaled that of the sentence for 100 grams of powder cocaine). ADA also established our current minimum sentencing guidelines (Rowe, 2006, p.43). One of the most detrimental outcomes of these minimum sentencing guidelines is the limitation it puts on judiciary discretion and additional influence given to prosecutors. (Rowe, 2006, p. 45). In other words, judges are forced to give minimum sentences regardless of the individual merits of the case and prosecutors can use the threat of minimum sentences to force plea bargains. ADA also affected funding and although there is still funding for treatment and education, it pales in comparison to funding for interdiction and incarceration (Rowe, 2006).

## **SOCIAL ANALYSIS**

According to the National Institute on Drug Abuse (NIDA), “addiction is a chronic, often relapsing brain disease that causes compulsive drug seeking and use, despite harmful consequences to the addicted individual and to those around him or her. Although the initial decision to take drugs is voluntary for most people, the brain changes that occur over time challenge an addicted person’s self control and hamper his or her ability to resist intense impulses to take drugs.” (National Institute on Drug Abuse, n.d.)

Fortunately, empirical data suggests addiction is treatable with the right combination of treatment approaches. The needs of the person must be taken into account

and the treatment approach molded to fit those needs. If managed properly, recovery can be maintained much like other chronic and recurring diseases such as diabetes and heart disease. (NIDA, n.d.)

The treatment community, including the American Psychiatric Association and the National Association of Social Workers, considers substance abuse a major problem in society and considers addiction a disease (Melemis, 2011) In the past addiction was not considered a disease. It is now widely accepted to be a disease, although some still see it as a moral impairment. The United States government also considers substance abuse a problem and started passing legislation in 1906, essentially the beginning of the regulation of recreational and medicinal drug use in the United States (Rowe, 2006, p.14).

Society has conflicting views on how to deal with the substance abuse problem in America, with many agreeing with our current tertiary approach of incarceration as a means of controlling the growing drug problem. Many believe that substance abuse is purely a personal choice. This view spearheads the methodology of incarceration as a solution to the problem. The medical community has come to a consensus that substance abuse is a disease that requires treatment. Empirical data suggests that personal choice, environment, socio-cultural circumstances, genetics, and mental health are all contributing factors that cause substance use to become abuse and later dependence/addiction (addiction-rehabilitation.com, 2006). The most effective solutions to the problems associated with substance abuse are education and treatment (Rowe, 2006).

The use of illegal drugs and alcohol is not a new social concern. However, federal involvement has increased over time in response to shifts in public attitudes. Legislation has attempted various approaches on stabilizing substance abuse through three dimensions of control: regulation, taxes, and sanctions. There has been an incrementalization of policy shaping our current legislation, some replacing or incorporating others. There are in essence two approaches to address the drug problem; one is to reduce the supply and the other to reduce the demand. At times policy has focused more on the demand through prevention and treatment, but for the most part the lion's share of funding has gone to reducing the supply through law enforcement and interdiction.

### **THE NEED FOR POLICY**

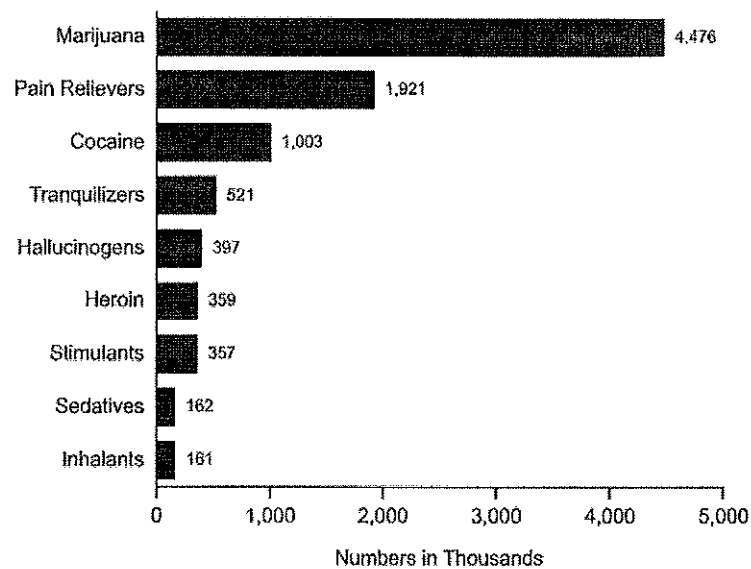
Drug addiction numbers remained relatively stable from the late 1800s through the mid 1900's. At the time that the Controlled Substances Act was passed in 1970, drug abuse was becoming a major public health issue. (Courtwright, 2004). President Nixon said, "[drugs] are destroying the lives of hundreds of thousands of young people all over America" (Peters, G., n.d.). In the 1980s cocaine addiction was a major problem and, by the mid 1980s, the crack cocaine abuse had become an epidemic. Empirical data suggests there is still a tremendous problem with substance abuse and addiction. After Alcohol and Marijuana, the most abused drugs are opiates and cocaine.

According to the National Institute on Drug Abuse:

In 2010 17.9 million Americans (7.0 percent of the population) were dependent on alcohol or had problems related to their use of alcohol (abuse). This number is basically unchanged since 2002. After alcohol,

marijuana has the highest rate of dependence or abuse among all drugs. In 2010, 4.5 million Americans met clinical criteria for dependence or abuse of marijuana in the past year—more than twice the number for dependence/abuse of pain relievers (1.9 million) and four times the number for dependence/abuse of cocaine (1 million). There continues to be a large “treatment gap” in this country. In 2010, an estimated 23.1 million Americans (9.1 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.6 million people (1 percent) received treatment. About 60 percent of admissions were White, 21 percent were African-American, and 14 percent were Hispanic or Latino. Another 2.3 percent were American Indian or Alaska Native, and 1 percent was Asian/Pacific Islander.

Dependence/Abuse and Treatment



[NIDA, 2010]

African Americans, Hispanics, Native Americans, and Asian/Pacific Islanders, who represent 25 percent of the U.S. population, face numerous health disparities. These include shorter life expectancy and higher rates of diabetes, cancer, heart disease, stroke, substance abuse, infant mortality, and low birth weight. Scientists postulate that these health disparities result from intertwined factors such as biology, the environment, and specific behaviors that are significantly impacted by a shortage of racial and ethnic

minority health professionals, discrimination, and inequities in income, education, and access to health care. (NIDA, n.d.) These health disparities contribute to enhanced likelihood of substance abuse and addiction.

In the past, men have always surpassed women with substance abuse issues, but that gap is slowly closing. A study at Columbia University found that women use drugs for different reasons than men, such as depression, eating disorders, sexual abuse, and early puberty. The study also found that the high-risk situations women face that make them vulnerable to substance abuse are different than with men. Statistically women become addicted faster and suffer more damage to their bodies. (National Center on Addiction and Substance Abuse at Columbia University, 2003)

Children are especially vulnerable to the impact of addiction. Children of addicted parents who are not in treatment are often neglected. More than one in ten children live with a parent or other adult who uses illicit drugs. Many never receive therapy. Substance use among youth is a continuing problem as well. While numbers are down, 28 percent of high school students reported heavy drinking in 2003 along with 23 percent reporting marijuana use. Among the heavy drinkers, 65.5 percent are also using illicit drugs.

(Social work speaks: NASW policy statements, 2012, p. 29)

## **POLICY ANALYSIS**

Socially constructed views at the time these policies were enacted played a role in their passage and implementation. The passage of the CSA in 1970 was a reflection of the progressive times after the Civil Rights Era, but still reflected the incoming Conservative



values of the Nixon Era. For the first time, some emphasis was made on the need for greater treatment efforts. A distinction was being made between medical need and street use. In addition, the need for medication-assisted drug treatment was realized and promoted. This progressive ideology was short lived, as the DEA was formed shortly after the enactment of the CSA and provided much of the enforcement for the drug laws of the War on Drugs. This quickly shifted the emphasis away from public health and into a judicial arena.

The U.S. has generally been a society that believes that everyone gets what he or she aspires to. If the person fails, it is generally viewed to be his/her fault. Society also has a predisposition to hold racial stereotypes. The paradigm of social construction of the 1980s viewed the world through the lens of the suburban white male. As a consequence, laws were passed that are unfair to racial minorities and less harsh on whites. The laws do not take into account various socioeconomic factors that attribute to choices people make and their eventual outcomes. (Segal, 2010, p. 66-67)

Like previous substance abuse related legislation, the Anti-Drug Abuse Acts were intended to reduce the prevalence of substance abuse in society. The intent was to prevent or reduce the availability of drugs, effectively the supply side of the equation. The laws were also in response to concern that some penalties were not harsh enough. Unfortunately some penalties, specifically those that have most affected African-Americans, were too harsh (Cohen, 2004, p.207). Also, most of the funding was directed at interdiction efforts, rather than prevention and treatment (Rowe, 2006, p.43).

The 1988 version of the act was meant to address the growing crack cocaine problem (Rowe, 2006, p.43). A 100:1 ratio of sentencing was established, meaning that the penalty for crack possession resulted in a sentence of 100 times the amount of cocaine (Brown, 2011). The act has provided the taxpayers with a huge tax bill for drug enforcement agencies and the prison-industrial complex and has provided addicts and communities with very little relief. In fact, it has been devastating to urban communities.

The War on Drugs is enforced by the judicial system, various law enforcement agencies, and several health service agencies. The ASA established the Office of National Drug Control Policy (ONDCP), commonly referred to as the “drug czar,” whom advises the President on current drug policy. The Substance Abuse and Mental Health Services Administration (SAMHSA) was formed later in 1992 to oversee the treatment initiatives and consists of several agencies. The implementation of the drug policy takes place on the local level with local law enforcement, and domestic and international interdiction by agencies such as the Coast Guard and the Drug Enforcement Agency. Courts at all levels, local, state and federal, carry out the sentencing according to the acts’ guidelines. (Rowe, 2006, p. 59-60)

Rowe (2006) found:

The difficulty with the sentencing guidelines is that they remove a great deal of judicial discretion...by using this system, we tie the hands of those people who should be in the best position to actually adjudicate what penalty should be meted out...This gives prosecutors leverage to gain cooperation from the accused, but it also means the same crime will not necessarily produce the same sentence even when the guidelines are applied. (Rowe, 2006, p. 45)

The sentences for privileged populations are typically more lenient than those for disenfranchised populations. The costs of interdiction are alarming as well. They are

essentially fighting the supply side of the equation rather than concentrating on the demand. The problem with this approach is that it costs too much money and the government does not have unlimited funds for law enforcement. Incarceration is not working either. The prison population keeps growing and the substance abuse problem continues to grow as well. (Rowe, 2006, p.86-87)

A 2006 professional analysis conducted by the American Civil Liberties Union illustrates one of the detrimental outcomes of the Anti-Drug Abuse Act of 1986:

The report details discriminatory effects of the drug law that devastated African American and low-income communities...One of the report's key findings indicates that sentencing policies, particularly the mandatory minimum for low-level crack offenses, subject people who are low-level participants to the same or harsher sentences as major dealers. As law enforcement focused its efforts on crack offenses, a dramatic shift occurred in the incarceration trends for African Americans, relative to the rest of the nation. This trend effectively transformed federal prisons into institutions increasingly dedicated to incarcerating African Americans. The report also explains that there is no rational medical reason for the 100-to-1 disparity between crack and powder cocaine, and instead causes an unjustified racial disparity in our penal system...Because of its relative low cost, crack cocaine is more accessible to poor people, many of whom are African Americans. Conversely, powder cocaine is much more expensive and tends to be used by more affluent white Americans. The report includes recent data that indicates that African Americans make up 15 percent of the country's drug users, yet they make up 37 percent of those arrested for drug violations, 59 percent of those convicted, and 74 percent of those sentenced to prison for a drug offense. More than 80 percent of the defendants sentenced for crack offenses are African American, despite the fact that more than 66 percent of crack users are white or Hispanic. (McCurdy, 2006)

In addition, as of 2000, Latinos constituted 12.5% of the US population, but 43.4% of all federal drug offenders, further illustrating the racial disparities in sentencing law enforcement (National Council of La Raza, 2002).

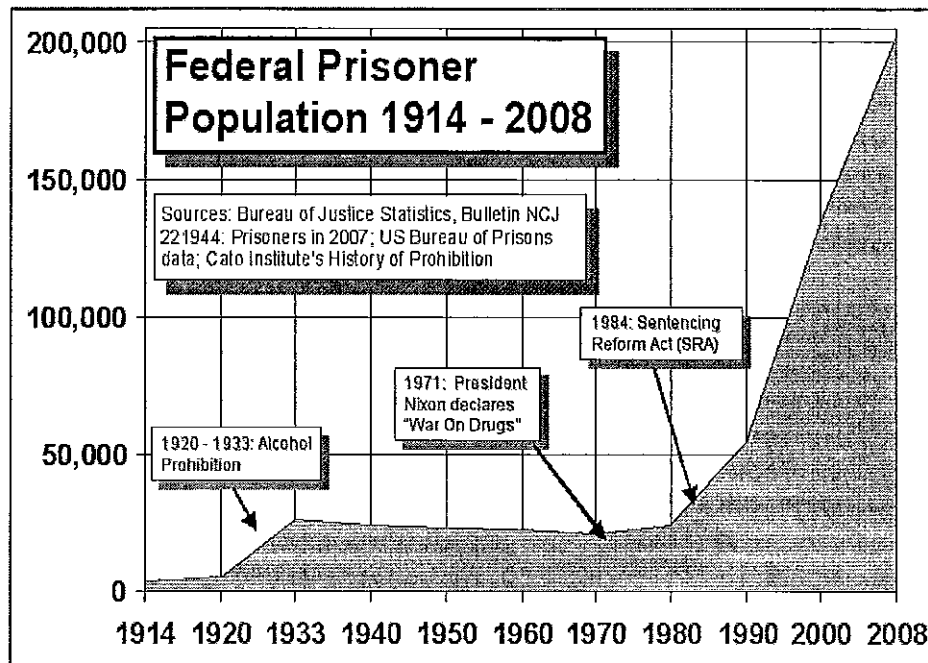
In addition to the immediate consequences of incarceration as a method of

treatment, there are lasting consequences of a felony criminal record to the individual which create barriers to recovery:

- 1 in 40 Americans cannot vote. (1/4 of those are African Americans)
- Half as many job positions are available
- Any landlord can deny rental housing.
- Certain offenses allow a judge to revoke a driver's license.
- Public assistance can be denied.
- Universities can deny admission.
- College aid and loans can be denied.
- Military service can be denied.
- Loss of gun rights.
- Restricted foreign travel.
- Difficulties adopting children.
- Potential loss of parental rights.
- Social stigma.
- Expunging a record is expensive and often impossible.

## **ECONOMIC ANALYSIS**

The total per-inmate cost averages \$31,286 and ranges from \$14,603 in Kentucky to \$60,076 in New York. (The Price of Prisons: What Incarceration Costs Taxpayers | Vera Institute of Justice, n.d.) With the number of prisoners growing exponentially, in large part due to the policies of the war on drugs, there is a massive economic impact to communities, states, and the country as a whole.



(November Coalition - War on Drugs Statistics: Graphs and Fact Sheets, n.d.)

It is difficult to estimate the actual amount these policies cost. There are various policies that supply different agencies with funding with multiple complex factors to consider. According to a May, 2009 New York Times article:

Government spending related to smoking and the abuse of alcohol and illegal drugs reached \$468 billion in 2005, accounting for more than one-tenth of combined federal, state and local expenditures for all purposes, according to a new study. Most abuse-related spending went toward direct health care costs for lung disease, cirrhosis and overdoses, for example, or for law enforcement expenses including incarceration, according to the report released by the National Center on Addiction and Substance Abuse, a private group at Columbia University. Just over 2 percent of the total went to prevention, treatment and addiction research. The study is the first to calculate abuse-related spending by all three levels of government. (Eckholm, 2009)

NIDA estimates this cost to be as much as \$600 billion annually, with the illicit drug portion close to \$200 billion. "Drug abuse and addiction have negative consequences for individuals and for society. As staggering as these numbers are, they do not fully describe the breadth of destructive public health and safety implications of drug abuse and

addiction, such as family disintegration, loss of employment, failure in school, domestic violence, and child abuse.” (NIDA, n.d.)

These policies did not go far enough in expanding treatment and prevention measures. Historically, less than 40% of the drug control budget is spent on prevention, treatment, and research (Office of National Drug Control Policy, 2012). This is unfortunate in light of the fact that the best treatment centers pay for themselves twelve times over in comparison to tertiary funding (Eckholm, 2009). Therefore, the cost keeps mounting while the addiction rate changes very little.

With already stressed budgets in local municipality police departments, relying on them for the drug control problem is unsustainable. Many local treatment centers function with little help from the government. Dawn Farms, a treatment agency in Washtenaw County, Michigan, operates with less than twenty-five percent of its budget coming from government grants, forcing them to rely on unpredictable donations. (J. Balmer, Personal Communication, December 5, 2012).

## **RECOMMENDATIONS**

Based on the foregoing analyses, the following are recommendations for policy makers to consider for better addressing issues of substance abuse and addiction. Policy revisions should . . .

- Give less emphasis on law enforcement and more funding for prevention, treatment, and research. A large portion of the funds allocated for tertiary measures and interdiction should be reapportioned to prevention and treatment.

Most data indicates primary and secondary methods of prevention to be more cost effective. With annual incarceration costs as high as \$60,000 per inmate, the current system is beyond unsustainable.

- Provide adequate treatment inside prison. The Justice Policy Institute, (2009) indicated that over fifty percent of prisoners meet the criteria for substance abuse or dependence. For the most part, so-called “substance abuse treatment” that takes place inside the walls of prisons is highly inadequate and is often done with non-professionals.
- Provide an emphasis on drug courts. Some success has been found with the use of drug courts as an alternative to traditional court. With drug court there is an opportunity to attend rehabilitation services. There can often be higher success rates due to the “incentive” of staying out of jail.
- Eliminate minimum sentencing. Minimum sentencing has more than doubled the length of stay for incarcerated individuals. Minimum sentencing has removed the judicial discretion of judges to tailor sentencing to an individual’s unique circumstances.
- Eliminate 18:1 (previously 100:1) crack/powder cocaine sentencing discrepancies. These discrepancies unfairly target minorities in poor neighborhoods where crack cocaine is a cheaper alternative to powder cocaine, more traditionally used by drug users with more money.
- Eliminate “Truth in Sentencing” laws. These laws eliminate the incentive of “good-time,” which in the past was a way to get out of prison sooner based on good behavior and completing educational and treatment programs.

- Initiate research to address treatment and prevention strategies of all populations. An often-overlooked aspect of drug policy is the vulnerabilities and needs of individuals with regard to gender, sexual orientation, ethnicity, culture, religion and spirituality, socioeconomic status, disability, and other factors. (Social work speaks: NASW policy statements, 2012, p. 29)
- Initiate advertising campaigns to educate the public about addiction, as both a preventative and as a method of stigma reduction. “People first” language is preferable to language such as “substance abuser” or “drug addict.”

## CONCLUSION

The War on Drugs started in 1970 by President Nixon, while well intentioned, has led to a series of unfair policies. Although substance abuse is a major problem, incarceration is not the answer. Empirical data suggests that the best approach is to focus on education and treatment. There is indication that drug courts can be a successful alternative to traditional courts, especially considering the lasting implications of a felony record and the barriers this creates to a person in recovery. The most important changes are to fully fund treatment, education, prevention, research and for policy makers and the public to recognize that addiction is a disease that is treatable and has the potential for a full recovery given the proper support systems.

In addition, the progress that has been made in reformation with legal drugs like tobacco is a good indicator of the value of education and prevention since tobacco use has been declining in recent years. Another approach is decriminalization of certain drugs. Several states have now legalized Marijuana for



both medical purposes and recreational use. Although this step away from incarceration is good, legalization of all drugs is certainly not the answer. The answer likely lies somewhere in-between.

The drug czar under President Obama's administration, Gil Kerlikowske, has expressed that the administration prefers what they call a "third way" approach. They are recommending an expansion of prevention and treatment efforts as well as a reform of the criminal justice system's approach, such as expanding drug court utilization. (JAMA Network, n.d.) While this sounds like a breath of fresh air, the proof is yet to come.

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