War on drugs a losing battle

In 1968, President Richard Nixon initiated the War on Drugs when American soldiers were coming home from the Vietnam War addicted to heroin. More than a decade later, President Ronald Reagan launches the South Florida Drug Task force, headed by then Vice-President George Bush, in response to the city of Miami's demand for help. In 1981, Miami was the financial and import central for cocaine and marijuana, and the residents were fed up. Thanks to the task force, drug arrests went up by 27%, and drug seizures went up by 50%.

With that, the need for prosecutors and judges also rose. Despite these increased arrests and seizures, marijuana and cocaine still poured into south Florida. At this stage, the root of the problem, the Colombian Cartels, was not attacked. The DEA soon realized that they needed to crack down on the cartels. In 1982 the DEA went to Colombia to eradicate fields of marijuana and coca plants.

These fields were located and burned. The hard part now, was finding the labs used to turn the coca leaves into cocaine. These labs were in very remote locations, to avoid surveillance.

The DEA suspected that the cocaine labs were very large, but the Colombians kept eluding them. Finally the DEA was able to track down the chemicals used in the processing of cocaine to one of the labs, and the DEA scored their first major bust.

On March 10, 1984 twelve tons of cocaine were seized from a very remote lab. The DEA thinks they made an impact, but amazingly the cocaine availability on American streets remained the same. The DEA is shocked, and

realizes just how big the drug problem in the United States was. Because the Cartel leaders had money, they also began to acquire power.

The dealers run for political office and win. Drug dollars poured into Colombia, building cities. The United States respond to the rise in the drug lords' power by pressuring Colombia to extradite narcotics traffickers to the U. S. The Colombians, who want no Colombians in American Jails, oppose this. The drug dealers both respected and feared extradition, and recognized the threat.

When the Colombian Justice Minister openly supported extradition, he was assassinated. Still, the U. S. pressures the extradition issue. In 1985, anti-Government Guerillas, mainly composed of the drug dealers, attack the Colombian Supreme Court. The extradition requests were destroyed, and eleven Supreme Court Justices were killed.

In total, over 200 people lost their lives. At this point, the drug lords are using terrorism to force the Colombian government to back off the extradition issue. During the 1980s, it appeared that Central America was awash in drugs, and drug money. The violence continues today, through drug related gang violence, to botched drug raids. Drug dealers often carry weapons, some illegal, to defend themselves and their drugs. The drugs themselves do not cause violence; it is the fact that they are illegal that causes the violence.

If two drug dealers have a dispute, they have no legal way for it to be settled. The only option for them is violence. At this time, the Parent's Movement is focusing its attentions on marijuana and children.

Nancy Reagan makes her famous “ Just say No!” speech and President Reagan makes marijuana a top priority. Upon 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.” When also 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 World Health Organization reached the same conclusion in 1995. The World Health Organization released a study in March 1998 stating: “ 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.

” Marijuana was seen as a gateway to other drugs, giving birth to the Gateway Theory. Unfortunately, the Gateway Theory is flawed in many ways. In 1937 Harry Anslinger, then head of the Federal Bureau of Narcotics testified before Congress, saying that there was no connection between the use of marijuana and the use of harder drugs, and in fact, the users of different drugs typically did not associate with one another. It also does not seem logical that the use of one drug would cause a craving for another drug, never used before.

Many drug users say that the first drugs they ever used were the two socially sanctioned drugs, alcohol and tobacco. These drugs are both harmful and legal.

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.” 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.”

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. The same survey 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 that were heavy drinkers in 1999, 66. 7 percent were also current illicit drug users. Among nondrinkers, only 5. 5 percent were current illicit drug users."

Over 72 million Americans have used marijuana, yet for every 120 people who have ever tried marijuana, there is only one active, regular user of cocaine. Marijuana is also thought by many people to have medicinal properties, and people do use it for medicine.

However, marijuana is illegal, turning the people who use it as medicine into criminals. In spite of the established medical value of marijuana, doctors are presently permitted to prescribe cocaine and morphine – but not marijuana. In the 1970s, cannabis was " re-discovered" as a medical substance. Controlled studies have revealed its therapeutic utility in the treatment of

cancer chemotherapy side effects, glaucoma, and spasticity ailments. Federal regulations continue to make research with the drug very difficult, however, and many promising areas of therapeutic application have received little or no attention. These include: asthma, AIDS, epilepsy, analgesic action, tumor retardation, nervous disorders, glaucoma and mental illness.

The Marijuana Tax Act of 1937, intended to prohibit marijuana’s social use, was most effective in prohibiting medical use of the drug. Strict regulations governing cultivation of the plant made its production impractical. New synthetic drugs caught the fancy of physicians and marijuana was used less frequently, Finally, in 1942, the Federal Bureau of Narcotics convinced the U. S. Pharmacopeia to remove the drug from its listing.

The Controlled Substances Act of 1970 established five categories, or “ schedules,” into which 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. 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.”

The most profound activist for marijuana’s use as a medicine is Dr. Lester Grinspoon, author of Marihuana: The Forbidden Medicine.

According to Grinspoon, “ The only well-confirmed negative effect of marijuana is caused by the smoke, which contains three times more tars and five times more carbon monoxide than tobacco. Nevertheless, even the heaviest marijuana smokers rarely use as much as an average tobacco smoker. And, of course, many prefer to eat it.” His book includes personal accounts of how prescribed marijuana alleviated epilepsy, weight loss of aids, nausea of chemotherapy, menstrual pains, and the severe effects of multiple sclerosis. The illness with the most documentation and harmony among doctors which marijuana has successfully treated is MS.

Grinspoon believes for MS sufferers, “ Cannabis is the drug of necessity.” One patient of his, 51 year old Elizabeth MacRory, says “ It has completely changed my life…It has helped with muscle spasms, allowed me to sleep properly, and helped control my bladder.

” Marijuana also proved to be effective in the treatment of glaucoma because its use lowers pressure on the eye.

Glaucoma is an eye disease that afflicts more than four million Americans and is the leading cause of blindness in the United States. According to the National Society for Prevention of Blindness, there are 178, 000 new cases of glaucoma diagnosed each year. Glaucoma can strike people of all ages but is

most often found among those over 65. The most common form of glaucoma is chronic or open-angle glaucoma.

It is characterized by increased pressure within the eye (intraocular pressure or IOP) which can cause damage to the optic nerve if not controlled effectively. Other types of glaucoma include narrow-angle and secondary. Treatment of narrow-angle glaucoma is primarily surgical. In approximately 90% of the open-angle and secondary glaucoma topical (eyedrop), preparations along with some oral medications can effectively control the disease, but at least 10% of all cases fail to be completely controlled by available prescriptive drugs. In some instances, available glaucoma medications can cause side effects such as headaches, kidney stones, burning of the eyes, blurred vision, cardiac arrhythmias, insomnia, and nervous anxiety.

These side effects may become so severe that the patient must discontinue use.

Scientists have been working to develop a marijuana eyedrop for several years. Until recently, they concentrated on delta-9-THC, marijuana’s psychoactive ingredient. Some researchers, however, have begun to wonder if other constituents in the cannabis plant might be more effective in reducing IOP. The few glaucoma patients who have continued, legal access to marijuana bolster this theory. In these cases, synthetic THC is only effective for a short period of time.

Natural marijuana, however, consistently lowers IOP. Marijuana is the best natural expectorant to clear the human lungs of smog, dust and the phlegm

associated with tobacco use. Marijuana smoke is a natural bronchial dilator, effectively dilating the airways of the lungs, the bronchi, opening them to allow more oxygen into the lungs. That makes marijuana the best overall bronchial dilator for 80% of the population (the remaining 20% sometimes show minor negative reactions.)

Statistical evidence – showing up consistently as anomalies in matched populations – indicates that people who smoke tobacco cigarettes are usually better off and will live longer if they smoke cannabis moderately, too.

Dr. Donald Tashkin, UCLA Pulmonary Studies, stated, “ Taking a hit of marijuana has been known to stop a full blown asthma attack.” 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.

…[T]he 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.” The Institute of Medicine’s 1999 report on medical marijuana summarized the medical value of marijuana saying: “ The accumulated data suggest a variety of indications, particularly for pain relief, antiemesis, and appetite stimulation.

For patients, such as those with AIDS or undergoing chemotherapy, who suffer simultaneously from severe pain, nausea, and appetite loss,

cannabinoid drugs might thus offer broad spectrum relief not found in any other single medication. The data are weaker for muscle spasticity, but moderately promising. The least promising categories are movement disorders, epilepsy, and glaucoma. Animal data are moderately supportive of a potential for cannabinoids in the treatment of movement disorders and might eventually yield stronger encouragement.

” Drug Czar Barry McCaffrey’s assertion in his Scripps-Howard News Service column that no clinical evidence demonstrates that smoked marijuana is good medicine, is inconsistent with the facts. Whether this is an intentional deception, as part of the federal government’s stated public relations offensive against medical marijuana, or whether it is based on ignorance does not matter. The reality is General McCaffrey’s statements are not consistent with the facts. In the early 1980s the DEA focus was mainly cocaine and marijuana.

However, a new problem was on the rise, crack. Crack was distributed to the U. S. through the Bahamas. The Bahamas were ideal because of the islands and waterways, and the fact that Florida was only 90 minutes by air.

At this point the drug smugglers have the advantage over the DEA. The smugglers were always just a few steps ahead of the law. The DEA tried using helicopters to catch the smugglers’ boats, but by the time the helicopters got close enough to make the grab; they would have to turn back because they were close to running out of gas. The DEA was seen as a dog trying to catch rabbits; the dog would catch one or two, but most of the time the rabbits get away. Crack really began as a problem in Harlem, New York.

The spread of crack moved like fire through dry brush in the New York Tri-State area. This drug hit the Black and Latino communities the hardest. Crack became more popular in inner cities because it was cheap compared to cocaine. Cocaine was seen as a drug for the rich, and crack was for the poor. Crack was also more addictive than cocaine, since smoking it made it more concentrated.

Before the onset of crack, women were not statistically addicts.

When women started using crack, it brought about a total disintegration of the family. Babies born to mothers who used crack were addicted themselves. Heroin has been an abused drug since it’s conception in the late nineteenth century as a patent medicine. Today there are treatments available to heroin addicts, however users are still stigmatized and because of that stigma of being a “ junkie”, many do not seek help. The health problems brought on by using heroin are usually associated with the use of needles.

Hepatitis C and HIV are two of the biggest heath problems that IV heroin users face. Users that snort heroin or smoke it (referred to as “ chasing the dragon”) have very few of these problems. There are different opinions on how to stop America’s drug problem. Two of those opinions are education and treatment, and prison.

D. A. R. E. is a popular education tool for teaching children how to avoid the subtle pressure to do drugs, and how to manage stress and conflict without drugs and violence.

D. A. R. E. is very popular, and one of the reasons is because it puts the local police in the “ good guy” position. Having a policeman come into a classroom can be an effective way to teach important survival skills, such as traffic rules, and bicycle safely, and resisting predatory strangers.

In recent years, newspapers have published several accounts where children credited D. A. R. E. with helping them thwart an improper approach by a stranger.

D. A. R. E. is especially popular among the children themselves. Most D.

A. R. E. officers are friendly, affable officers, and develop good rapport with the kids, who are charmed by tales of adventure in law enforcement.

Police departments like D. A. R. E.

because it provides additional revenue and a useful opportunity to engage in community relations. D. A. R. E. officers are frequently personable, attractive officers who make an excellent impression on children and present a positive image of police in general.

However, informal surveys have found that D. A. R. E.

is no more effective than any other drug education program.

“ The D. A. R. E.

program’s limited effect on adolescent drug use contrasts with the program’s popularity and prevalence. An important implication is that D. A. R.

E. could be taking the place of other, more beneficial drug education programs that kids could be receiving.” Because of attempting to prevent all drug experimentation and/or use, D. A.

R. E.’s objectives are not only unrealistic but also possible counter-productive because they are obviously unattainable. As an example, some studies have shown that adolescents who have experimented with illicit drugs (especially marijuana) are better adjusted than either abstainers or frequent users and were more socially skilled with higher levels of self-esteem than abstainers. Some people say that drug addiction is a disease, and addicts should be treated as people needing medical help.

“ Whatever conditions may lead to opiate exposure, opiate dependence is a brain-related disorder with the requisite characteristics of a medical illness.” There are a few different methods of treatment, but for the sake of simplicity, this paper will cover methadone and narcotic antagonists. Methadone is a synthetic narcotic analgesic that was developed in Germany during World War II due to the lack of opiate based pain medication.

Methadone prevents often-excruciating withdrawal symptoms, yet blocks the pleasurable effects of heroin. For a heroin addict, he is either “ straight” (feeling normal), “ high”, or “ sick”. He wakes up sick, shoots up, and gets high.

That lasts for a few hours maybe, and he shoots up again if he can, to avoid getting sick. In this viscous cycle, it is easy to see how holding a job or living normally is out of the question. “ 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.” 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.” “ All opiate-dependent persons under legal supervision should have access to methadone maintenance therapy.

..” Methadone maintenance is long-term, if not permanent. However, the methadone is given in a controlled environment; patients must come to the clinic once or twice a day for their dose. This way the patients were not given a narcotic that they could sell on the street.

A daily appearance at the clinics and the opportunities for counseling is cited as one of the major reasons for the success of the methadone program.

“ 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.” Narcotic antagonists, such as the drug naltrexone, work by blocking the effects of narcotics such as heroin. Naltrexone works only if the addict has already been detoxed, and is motivated to take the drug. Narcotic antagonists work best for those addicts that tend to relapse impulsively. “ The unnecessary regulations of methadone maintenance therapy and other long-acting opiate antagonist treatment programs should be reduced, and coverage for these programs should be a required benefit in public and private insurance programs.

” 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.

Another way of thinking is that drug addicts are criminals and should be punished. Certainly, this is one of the objectives of the War on Drugs, to put the drug traffickers in prison. However, how many millions of people do you think we have to put in prison to have the best results? Under current laws, most users also fall under the category of dealers, due to either the amount carried, or the way the drugs are packaged. Potentially forty million people would have to be imprisoned under these laws, and that is just impossible.

Although people may think that the War on Drugs targets drug smugglers and ‘ King Pins,’ 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) was for the sale or manufacture of a drug. Simple possession of marijuana accounted for 38.

4% (598, 694) of the total arrests. Even if only ten percent of the drug dealers were put in prison, the U. S. would have to build four prisons for every one we have now. How many people need to be in prison for drug offenses to effectively control the drug problem? The government has asked the taxpayers to write a blank check for prisons to jail non-violent offenders.

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. 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. 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.

For a single drug user to be put in prison, it costs taxpayers about a half million dollars. That includes $150, 000 for arrest and prosecution, $150, 000 for a new cell, and approximately $30, 000 a year for the next five years. In the same respect, that amount of money could provide education and treatment for one hundred people. Which do you think is the better option? In California, and in a few other states, schools, libraries, and medical facilities are being closed in order to build more prisons.

The money is being taken from education and treatment in order to build more prisons. Is this planning for our children’s future? 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 yearend 1990.”

Table 21 notes there were 56, 989 Federal prisoners in 1990, compared to 108, 925 in 1998. : Over 80% of the increase in the federal prison population from 1985 to 1995 were due to drug convictions. In 1998, drug law violators comprised 21% of all adults serving time in State prisons – 236, 800 out of 1, 141, 700 State inmates.

Nonviolent offenders accounted for Eighty-four percent (84%) of the increase in state and federal prison admissions since 1980. 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. It seems that no matter how hard the government tries to fight drugs, it will always lose.

Government’s solution is spending more money, imprison more people but that does not keep people from using drugs. In this final part of the paper, I will discuss legalization and decriminalization to effectively end the War on Drugs. “ Prohibition…

goes beyond the bounds of reason in that it attempts to control a man’s appetite by legislation and makes a crime out of things that are not crimes.

A prohibition law strikes a blow at the very principles upon which our government was founded.”—Abraham Lincoln December, 1840 As the drug war hysteria begins to subside, it becomes increasingly obvious that there must be a serious re-examination of the laws prohibiting “ soft drugs”, such as marijuana. The decriminalization of “ soft drugs” has emerged as an active political issue in many European countries, including Switzerland, Holland, and Germany.

The policies being considered range from decriminalization, or repeal of criminal penalties for private use and cultivation of cannabis, to full legalization, in which marijuana is commercially sold like alcohol and tobacco. 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.

Decriminalization involves the removal of criminal penalties for possession of marijuana for personal use. Small fines may be issued (similar to traffic tickets) but there is no arrest, incarceration, or criminal record. Marijuana is presently decriminalized in 10 states—California, Colorado, Maine, Minnesota, Mississippi, Nebraska, New York, North Carolina, Ohio, and Oregon. In these states, cultivation and distribution remain criminal offenses. We already have some evidence that legalization works.

In the U. S. states that have briefly decriminalized marijuana in the 1970s, the number of users stayed about the same. In the Netherlands, legal tolerance of marijuana has led to a significant decline in consumption and has successfully prevented kids from experimenting with hard drugs. Eleven times as many U.

S. high school seniors smoked pot daily in 1983 as did students the same age in the Netherlands. The Dutch discovered that making the purchase of small amounts of marijuana freely available to anyone over 16 cuts the drug dealer out; as a result, there is virtually no crime associated with the use of marijuana.

Treatment for addiction to hard drugs is widely available there; 75 percent of the heroin addicts in Amsterdam are on methadone maintenance, living relatively normal, crime-free lives. All this still falls short of legalization, and problems still abound, but the experience of the Netherlands clearly points in the right direction.

The Dutch see illicit drug use as a health problem, not as a criminal problem. Drug legalization is neither a simple nor singular public policy proposal. For example, drug legalization could at one extreme involve a return to wide-open access to all drugs for all people as. Partial legalization could entail such changes in drug policy as making currently illegal drugs available in their crude forms to certain types of medical patients. It might include the maintenance of addicts on heroin or their drug of choice, handouts of needles to addicts without the requirement of cessation of drug use, or marked softening in sentencing guidelines for drug-related offenses short of

frank legalization. Right now, a marijuana smoker is arrested every forty-five seconds.

When we define all marijuana smoking as criminal, including that which involves adults smoking in the privacy of their own homes, we are wasting police and prosecutorial resources, clogging courts, filling costly and scarce jail and prison space, and needlessly wrecking the lives and careers of genuinely good citizens. Millions of Americans use marijuana; few abuse it. The government should limit its involvement in this issue solely to address and sanction irresponsible marijuana and other drug use. Responsible marijuana use causes no harm to society and should be of no interest to the federal government.

In conclusion, it appears that however well intentioned the War on Drugs was, it is now a losing battle that Americans keep pouring their tax dollars into. It all boils down to supply and demand. If there is a demand for illegal drugs, there will always be a supply. The drug war is over, and we lost. We merely repeated the mistake of Prohibition. The harder we tried to stamp out drugs, the more lucrative we made them, and the more they spread.

I hope that it will only be a matter of time before the drug laws are thoroughly reexamined, and the government can admit that the War on Drugs was a failure.

Bibliography:

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

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). 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).

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). 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). 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. 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. 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.

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

The Controlled Substances Act of 1970, 21 U. S. C. 801 et seq. US Department of Justice, Drug Enforcement Agency, “ In the Matter of Marijuana Rescheduling Petition,” [Docket #86-22], (September 6, 1988), p.

57. Hepler, R. S. & Frank, I. “ Marijuana Smoking and Intraocular Pressure,” Journal of the American Medical Association, 217, 1392 (1971).

US Department of Justice, Drug Enforcement Agency, “ In the Matter of Marijuana Rescheduling Petition,” [Docket #86-22] (September 6, 1988), p. 57. “ How Effective is D. A. R. E.

?” American Journal of Public Health, September 1994, p. 1399. “ Truth and D. A.

R. E.: Tracking Drug Education to Graduation and as Symbolic Politics," by E. Wysong and R.

Aniskiewicz (Indiana University), D. Wright (Wichita State University), Social Problems Vol. 41 No. 3, August, 1994 Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov.

17-19; 15(6): 4. Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 5. Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov.

17-19; 15(6): 4. Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov. 17-19; 15(6): 2. Effective Medical Treatment of Opiate Addiction. NIH Consensus Statement 1997 Nov.

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

Center for Substance Abuse and Treatment, National Treatment Improvement Evaluation Study 1997 Crime in America: FBI Uniform Crime Reports 1998 (Washington, DC: US Government Printing Office, 1999), pp. 209-210. 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.

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.

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.

12 and Table 21. US Department of Justice, Bureau of Justice Statistics, Prisoners in 1996 (Washington DC: US Department of Justice, 1997 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. Ambrosio, T. & Schiraldi, V., Executive Summary-February 1997 (Washington DC: The Justice Policy Institute, 1997). 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 Abraham, Manja D., University of Amsterdam, Centre for Drug Research, Places of Drug Purchase in The Netherlands (Amsterdam: University of Amsterdam, September 1999), and pp.

1-5. www. NORML. org Other sources consulted: www. drcnet. org www. pbs. org www. erowid. org www. masscann. org The Emperor Wears No Clothes The Authoritative Historical Record of the Cannabis Plant, Hemp Prohibition, and How Marijuana Can Still Save the World By : Jack Herer Pages : 182 (New Edition : 330) Pub Date : 1990 (New Edition : 1996) Publisher : Hemp Publishing (New Edition : Quick American Archives) ISBN : 0-88706-541-4