

## **The Pacific Drug Policy Institute and Research Findings that Led to Its Founding**

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### *Summary*

The failure of currently employed drug control measures is caused by what I call the “drug/crime subsidy”. Because the drug/crime subsidy is caused by our government’s \$17 billion investment (per annum) in drug control measures. Apologists for the war on drugs argue that the illegal drug could be controlled, if we would just enforce the drug laws. As well as being the primary victims of the drug/crime epidemic, drug users are also major carriers in the contagions of drug use and addiction. Experts estimate that addicts consume 80% of illegal drugs. An estimated 20% of illegal drugs is consumed by recreational or casual drug users. We could eliminate 20% of the drug/crime subsidy by serving the drug-related needs of these users.

Key words: drug/crime subsidy - illegal drug - drug control -  
public health strategy - black market

### **Origin and Mission of the Institute**

PDPI’s mission is to improve the quality of public information relating to the drug/crime epidemic and its control. This is to be done by engaging researchers, educators, and practitioners in the further development of a new interdisciplinary field of drug/crime studies. To expedite the work, PDPI plans to: 1) conduct and fund research on topics necessary to rational policy formation, 2) conduct conferences and seminars, 3) publish monographs on research findings, 4) publish a Journal of Drug/Crime Studies, and 5) manage public dissemination of the information product. Improvement of drug policy is one expected effect of the Institute’s work. The research findings that led to the founding of PDPI are set forth in comparatively weighty writings, referred to below as “the literature”. They are available in hard copy and at the PDPI web-site. This paper provides a quick overview of only the most important findings.

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### **Principal Findings Re Drug/Crime Epidemic**

Surprisingly, the literature includes the first attempt at a comprehensive analysis of the social dynamics of the “drug/crime epidemic” (defined below). The analysis relies heavily on the work of other observers for many details, but it also contains many new insights, and important myths are exploded. The integration of details is unique in the drug policy literature. The findings support two conclusions of major importance: first, that the war on drugs has failed and cannot be fixed, and, second, that the entire epidemic is vulnerable to control by tested, proved and inexpensive public health measures, without legalizing private enterprise in drug manufacturing and distribution. The failure of currently employed drug control measures is caused by what I call the “drug/crime subsidy”. This is defined as the super-profit reward to black-market entrepreneurs for producing and bringing drugs to the consumer market and for promoting drug consumption. Why call profit a subsidy? Because the drug/crime subsidy is caused by our government’s \$17 billion investment (per annum) in drug control measures. These measures induce the scarcity that causes drug prices to range from 70 to 170 times real economic value. The latter numbers mean that the estimated \$70 billion annual drug sales figure consists almost entirely of a subsidy to the crime syndicates. With \$70 billion at their command, the criminals can readily purchase the failure of law enforcement. In fact, in their eager efforts to harvest the drug/crime subsidy, black-market drug suppliers have made drugs readily available everywhere in our society – including our jails and prisons. Apologists for the war on drugs argue that the illegal drug could be controlled, if we would just enforce the drug laws. On the contrary, the failure of drug control in jails and prisons demonstrates that the drug/crime subsidy has made the drug laws unenforceable – even under totalitarian conditions.

The drug/crime subsidy is also the energy source that drives all of the currently rampant pathologies of the “drug/crime syndrome”. The latter is the increase in pathologies that is caused by ongoing drug use under the conditions of war on drugs. The syndrome includes the extraordinary prevalence of all of the following pathologies: drug use and addiction; blood-borne diseases; over-dosing; emergency admissions; school dropouts; educational failure; youth rebellion; prostitution; teen pregnancy; domestic violence; absenteeism; accidents; prenatal injury; gangsterism; gang violence; criminalization of youth; incarceration; husbandlessness; fatherlessness; homelessness; dependency; money laundering; corruption of the criminal justice system, politics and business; and still more. These pathologies complete a vast positive feedback loop\*. They stimulate public demand for drug war measures to “keep drugs out”. As we have seen above, the real effect of these measures is to magnify the economic reward for bringing drugs in and promoting their use.

The drug/crime epidemic, then, is defined as the evolving social catastrophe that embraces 1) the social pathologies of the drug/crime syndrome, plus 2) the causal connections linking these pathologies, plus 3) the entire positive feedback loop that is

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\* A positive feedback loop in an array of events in which each event in the series causes or stimulates its successor, and the last event in the series causes or stimulates the first.

completed by public demand for intensified war on drugs, plus 4) the energy source that drives the loop – the drug/crime subsidy.

### **The General Nature of the Public Health Remedy**

I use the phrase “public health measures” with the same very narrow meaning that the phrase had when first coined: public health measures control diseases by interrupting their contagious processes. In contrast, medical practice treats diseased individuals. Public health measures are also “systemic” – again, in relation to the contagious process, rather than in relation to a disease process in an individual. The pioneers of public health discovered that, to interrupt a contagious process, one must first properly understand the relationships between its three key elements: the agent of the disease, the carrier, and the host (or victim). In yellow fever, a classic example, the disease agent is a virus that inhabits the carrier, a mosquito. The latter transmits the disease to the victim’s blood while feeding on it. Understanding these relationships empowered public health officials to control the contagion by draining mosquito swamps. Similarly, a public health strategy to control addiction must be founded on a proper understanding of the relationships between the disease agent (drugs and the drug culture), the carrier (the black-market drug supply system), and that system’s victims (drug users). As well as being the primary victims of the drug/crime epidemic, drug users are also major carriers in the contagions of drug use and addiction. For this reason, treatment and harm-reduction measures for addicts and drug users act as systemic controls against the contagious processes of all the disorders in the drug/crime syndrome. (We will see how below.) Consequently, the countries that use treatment and harm-reduction measures reap benefits across the board; this shows up in all of their health and social statistics. Our drug warriors make little or no use of these measures, and it shows in our deplorable statistics. On the surface, typical drug war measures may look systemic in relation to the contagion of drug use and addiction. That is, drug interdiction, drug crop destruction, crop substitution, and drug busts do target drugs and their sources. These measures are not systemic. They are based upon a misconception of the epidemic’s real processes, and, as a result, they fail. The misconceptions most responsible for the failure relate to two key relationships: 1) that between the addict and the drug, and 2) that between the addict and the drug supplier. As to the first relationship, drug warriors see addiction as a moral fault, so they prescribe punishment. Punishment fosters addiction: it forces drug use under ground, ruling out early interventions that could nip addiction in the bud; it dooms the addict to repeated jail terms that do not fix the disease. Rather than address the real relationship between the addict and the drug, drug-war policies exclude most addicts from treatment: 1) with long waiting lists, 2) with arbitrarily high admission thresholds, 3) by punishing relapse with expulsion from therapy, and 4) with treatment regimens many addicts find worse than the disease. In contrast, experience elsewhere proves that we get far better results by understanding addiction as a physiologically based, recurrent disease and making treatment readily available. Contrary to the drug-war myth, addicts want and seek treatment. They do use it when it is available. Why not?

It helps them to recover and lead normal, productive lives. Treatment is also much less costly than jail, and it reduces all related pathologies.

As to the relationship between addicts and their drug suppliers, our present massive failure to treat addicts leaves them as the captive money-cows of black-market drug suppliers. The obscene profits gained from exploiting their money-cows motivate drug suppliers to seduce still more victims. Untreated, many addicts are unemployable and must earn the cost of maintaining their addiction (\$10,000 plus per year) through the characteristic crimes of addicts: robbery, theft, prostitution, drug-pushing, and seducing new drug users. These crimes further enrich the criminal syndicates. Experts estimate that addicts consume 80% of illegal drugs. If so, by defining addiction as a disease and providing acceptable treatment on demand, we could: 1) relieve addicts of their worst suffering, 2) eliminate 80% of the \$70 billion drug/crime subsidy, 3) eliminate well over 80% of the related pathologies of the drug/crime syndrome, and 4) cut social costs. Instead, war on drugs fertilizes the mosquito swamp. An estimated 20% of illegal drugs is consumed by recreational or casual drug users. We could eliminate 20% of the drug/crime subsidy by serving the drug-related needs of these users. Overdosing from drugs of uncertain potency would be ended, as well as sickness caused by adulterated black-market drugs.

In face-to-face and day-to-day contact with drug users, an agency empowered to serve their needs would be well positioned to steer them toward less dangerous drugs, to teach self-protective measures, to refer troubled drug users to counselling and therapy, and to encourage early quitting. Instead, we wage war against these primary victims of the drug/crime epidemic, so fertilizing the mosquito swamp. Up to this point, we have looked only at treatment and harm-reduction measures. Still another class of devices for substance control is the governmental (or governmentally-authorized) public health monopoly.

For the first example, let's consider the "state alcohol monopolies". These are used to supply existing demand and prevent private profiteering in drink. All of the Scandinavian countries have extensive experience with this general type of monopoly. So does 1/3 of the United States. Sweden is a good example. Prior to joining the European common market, Sweden prohibited private enterprise in alcohol distribution. That prohibition generated no black-market gangsterism, such as the U.S.A. experienced in the 1920's. The state alcohol monopoly (the Systembolaget) prevented black-market sales by supplying existing demand. In doing so, it also eliminated the economic incentive for the creation of new demand. As a result, Sweden's indices for alcohol-related pathologies ranked with the lowest in the industrial world. Another example: the pharmacy system that is common in the U.S. is a state-authorized public health monopoly. For the protection of public health, the right to engage in sales of pharmaceuticals is restricted by statute to pharmacies under state control. Purchase requires a prescription. The interesting point to us here is that, even though some medicinal drugs have a potential for recreational use, their sale by pharmacies – at normal prices – satisfies existing demand for these controlled substances and eliminates

profit opportunities in black-market sales. The result is that there are virtually none. Pharmacy sales at normal prices also explode the prominent drug-war myth that high prices for the illegal drugs keep them out of the hands of children. If high prices had that effect, kids would be using less. Looking at the long-term trend, they are using more. The obvious explanation is that high prices excite sales efforts enough to overcome the deterrent to demand.

The information presented above is evidence that a new public health strategy is feasible. The agent of this strategy is a monopoly empowered to serve all the drug-related needs of all drug users. The monopoly uses treatment and harm-reduction measures of the sort generally described above to eliminate the drug/crime subsidy and control all the contagious processes of the drug/crime epidemic. The name I have given to this strategy is “market interposition” (MI). I chose this name to call attention to the key characteristic that makes for its success: The agency for drug market interposition (ADMI) is designed and empowered to interpose itself between the supply and demand sides of the market and prevent their mutual stimulation. The interposition is effective when the agency satisfies demand. Under this condition: 1) drug gangsters cannot make enough sales to stay in their dirty business, so they abandon it; 2) there is no economic incentive to seducing new drug users, so that too stops; and 3) in face-to-face contact with drug users, the agency provides or facilitates treatment and harm-reduction measures.

If they are to be prevented from resorting to black-market sources, drug users must prefer the services and products of the agency, so the agency must defeat the black-marketeers in competition for customer loyalty. The literature identifies many ways this can be done, while advancing all relevant public health interests. There is no mystery here: both the alcohol monopolies and the pharmacy system defeat black-market commerce competitively, and they do it with less powerful tools than those proposed here. To illustrate the enhanced competitive power of the ADMI, let us consider the following. The drug supply industry includes a long series of industrial processes. The series starts with the planting of drug crops; it includes harvesting, purification, transport, storage, cutting, packaging, distribution and promotion, and ends with sale to the user. The changes of ownership that take place along the way make up the “drug commerce ladder”. At every stage or rung of this ladder, the respective trafficker must defray extraordinarily high operating costs that are consequent on the condition of illegality. The literature defines these extraordinary costs as “super-costs”, and seven separate categories of such super-costs are described. Not the least of these is “super-profit”. In this context, super-profit is defined as profit in excess of the normal rate, that each black-market entrepreneur on the commercial ladder requires to compensate him for assuming the extraordinary risks of conducting business under the condition of illegality. To sustain the necessary motivation in the entire system, the retail price to the final user must cover the sum of these super-profits and all other super-costs. To strangle the black market, all the ADMI must do is undercut the black market price enough to eliminate the marginal increment of profit that attracts black-market participation. The

ADMI can both do that and generate a positive cash flow because it operates legally, with only ordinary and necessary costs, and without distributing profit. Clearly, surplus revenue would be generated by supplying the needs of casual drug users. The surplus could be used to serve the needs of indigent addicts without cost to them. The analysis has not yet been done to test this point, but the entire program might be self-sustaining! By no stretch of the imagination could net cost remotely approach the \$17 billion now being spent on the drug war. The power to eliminate profit opportunities in illegal commerce makes MI an inherently effective strategy for substance control. Furthermore, since the ADMI has the capability to strangle black market commerce, its managers can be held accountable for any failure to do so. In contrast, drug warriors are never held accountable for the ongoing defeat of drug-war measures: wily and unscrupulous criminals take the blame for that, not the drug-war measures that now indirectly subsidize illegal commerce in drugs. It might be inferred that MI is a more appropriate strategy for use in control of the less dangerous substances. The opposite is true. The more dangerous the substance, the more urgent the need to prevent its unauthorized distribution, and the more compelling is the need to serve such demand as might otherwise make illegal commerce profitable. Not the least of its virtues is that MI works without compulsion and without punishment; it works simply by changing the incentives that influence the behaviour of drug users and suppliers. When we implement MI, illegal drugs will virtually disappear. They will remain available only through the authorized agency, only for licensed use by the initiated, and only under restricted circumstances designed to prevent contagion and to minimize harm. The public health monopolies prove it. Finally, the literature gives some attention to considerations in the design of the ADMI – in particular, to factors affecting choice as to its place in the institutional structure of our society, its powers, its mode of governance, and the MI planning process. At this early stage, there is no fixed recommendation on these matters. Indeed, there is no narrow prescription for any aspect of implementation. One task of PDPI will be to conduct research to support choice in these matters.

### **The Interpositionist Critique of Legalization**

The awful cost and continuing failure of the war on drugs mean that drug policy may be approaching political crisis. MI is not yet recognized as a policy option, so the danger implicit in this crisis is that the public may dump drug war for the visible alternative – legalization. Some free market economists and libertarians mistakenly read the failure of war on drugs to mean that all governmental measures for drug control must fail and breed social disorder. They would cut government out of drug control altogether and allow the drug supply industry to market its wares on exactly the same basis as merchants of ordinary economic goods. On the other hand, not even Milton Friedman, free market economist par excellence, wants to do that. He wants “legalization with controls”. That concedes a role for government. The question becomes “What role?”. Alcohol and tobacco have given us both recent and contemporary experience with “legalization with controls”. In the case of alcohol, two-thirds of our states use alcohol

control boards (ACB's) to regulate alcohol. The history of the ACB's suggests what we might expect, if we were to employ a similar institution to regulate a legalized commerce in drugs. Over time: 1) liquor licenses become very valuable; 2) the licensing process is corrupted; 3) the "regulated" alcohol industry co-opts the ACB; 4) the latter is gradually degraded into an agency merely for alcohol tax collection; 5) impoverished inner city neighborhoods (lacking political clout to defend themselves) are swamped with licensed liquor stores and liquor ads; 6) high rates of alcoholism, alcohol-related social pathologies and cirrhosis intensify the problems of urban poverty and blight, and 7) these sorry results give the government-haters fresh evidence of the inevitability of government ineffectiveness. In the meantime, the Systembolaget does better! No, "legalization with controls" is a formula for government failure. Where profit wars with public health, profit wins.

Legalization would decriminalize drug use and addiction, but do nothing to arrest them. It would end black-market drug commerce (and related evils), but it would let loose a profit-motivated drug supply industry. Legalized drug pushers could not be prevented from promoting and advertising their wares to the young and the gullible, just as today's merchants of alcohol and tobacco do. As in the cases of alcohol and tobacco, high rates of addiction would follow. Drug-induced psychosis, related violence, related spousal and child abuse, accidents from drug-induced incompetence, absenteeism, damage to health, and shortened life – all would at least continue, and maybe increase under the influence of legalized drug-pushing for profit. More, we would have continuing political struggle over minor drug control issues and measures. In all such struggles, the political clout of the drug industrialist would be added to that of the tobacco and alcohol industries.

### **How Interposition Is (and Is Not) Likely To Be Adopted, and Why**

My studies have also addressed how MI might come to be adopted as public policy. My purpose in this study area has been to develop a general plan for the least costly route to policy change, considering major pertinent factors. The evidence to support the resulting plan came from three sources: 1) the standard model that political scientists use to describe the way our society typically processes public policy issues; 2) the history of political struggle and policy change relating to alcohol, tobacco and the currently illegal drugs; and 3) my own experience promoting MI. If correct, the resulting plan will focus effort for MI where it is most likely to be productive, bringing change sooner. As with any guide to action, the test of this plan is pragmatic, and it is subject to change on the basis of new evidence and experience. Abbreviated and shorn of most of the supporting evidence, the key observations or tenets of this plan are as follows.

1) Government forms policy pursuant to the demands of politically dominant constituencies. Therefore, policy change is dependent on changing the dominant constituencies, changing what they want, or both.

2) MI is the reform policy option most capable of uniting a politically dominant coalition for reform: the coalition would ally those who deplore drug war and its effects

with those who want effective means to bar hucksters of stupefying, addicting, and health-endangering products. Policy change can come only when the key constituencies for war on drugs (parent, teacher and employer groups) enter this coalition.

3) For information to rely and act upon, the key constituencies now have the leading ideologues of war on drugs and professionals with career interests in war on drugs. Policy change depends on creating a new source of expert information and policy leadership. To be credible to the key constituencies, the new source must be composed of prominent researchers, academics and professionals from criminal justice, health, economics, pharmacology, treatment, prevention, etc.

4) This new leadership can most quickly come into being through the research, educational, and organizing programme that PDPI has been created to conduct.

5) Very wealthy individuals can greatly expedite the change process by funding the agents of change – PDPI and political action groups motivated by PDPI’s information product. With suitable resources supporting the change agents, policy change can come quickly. (For example, in 1930, John D. Rockefeller II switched sides, denounced alcohol prohibition, and launched the movement for the state alcohol monopolies. In two years the job was done.)

6) Appeals to “insiders” or “persons of power and influence” are not realistic alternatives to persuading the key constituencies in the manner described above. On the contrary, until the new information begins to reach the dominant constituencies, only few individuals will be positioned to make any use of either MI or the new critique of drug policy. A few examples point up some real obstacles to this illusory alternative: neither politicians nor drug war bureaucrats are likely to use MI. Politicians must wage war on drugs because the dominant constituencies want it. Bureaucrats are hired to implement adopted policy, not to change or oppose it. Foundations may be unlikely contributors: experience to date suggests that none is presently authorized to support PDPI in its intended role. If this is true, for a foundation to support PDPI, its authorization would have to be revised. Researchers in the drug policy and crime policy areas may not use it; they must serve the established funders, seeking answers to the problems the latter are authorized to pursue. Most academics and workers in drug-related professions will not use it; MI has little application to existing professions. Many may oppose it as contrary to their career ambitions. Others will be reluctant to support an idea that might offend persons in a position to obstruct their future career opportunities. The media are not likely to use it: MI and its potential will remain only a wish among many (and not news) until PDPI is funded to perform its role.

Impediments of the sort just described are not unique to MI. On the contrary, impediments of the same sort obstruct change in all public policy areas. Obversely, in all public policy areas, when change comes quickly, it is in the generic manner described in the first five tenets above.

7) Now, the top priority task in the shortest and least costly route to policy change is building PDPI and its related political action committee, gaining adherents where

possible, and recruiting funders. Whatever their skills, interested volunteers can play roles essential to both of these tasks.

### **An End Note**

Before a thing happens, it looks impossible. Afterwards, it seems to have been inevitable. It is simply harder to foresee the relevant causal processes and how they will shape the future, than it is to reconstruct how we arrived where we are. The reality is that society constantly invents new, and shucks worn-out institutions. Every social institution comes into existence in consequence of some foresight, act of invention and overt action. Just as we are the inheritors of the world built by earlier generations, so will we leave, as our legacy to future generations, the world as our acts will have reshaped it.

Contrary to what the government haters claim, drug war and the failure of drug control are not the fault of government; the buck stops with the electorate. We the people are responsible for the doings of our government. A bygone electorate made a mistake and institutionalized machinery they thought would work for drug control. We can see now how the machinery they created defies their good intentions and breeds social catastrophe. It falls to us in our time to fix it. Happily, we still have the tools that the founding fathers placed at our disposal – the institutions of a self-governing society. The rules of the self-government game require that we choose a plan that provides maximum benefits and minimum detriments for us and our values. Then, if we want to advance our interests and values, we have to act to persuade the majority that our plan serves their real interests too. When we fail to play the game, we betray our responsibility as citizens, and our failure endangers our democratic institutions and the future right of our progeny to govern themselves.

If we fail to fix the drug/crime epidemic, who will fix it, and when? The history of the last seventy years shows that the drug/crime epidemic becomes ever more menacing of social welfare over time – bringing an ever-greater threat of criminal rule. If we fail, will the next generation have a chance to succeed? We must not fail.

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