CRIME FILE

Heroin

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Your discussion will be assisted by your knowing what impact heroin use has had on the addicted and on the society at large, what preventive policies are available, and how these policies are changing in an effort to minimize the harmful effects of heroin use.
Introduction

Opium is the 10th evil of the world, such that when one tastes the flower of the opium poppy is cut or sliced. Its active ingredient, a white crystalline powder, was first isolated in 1803 and named "morphine." Five years later, a relatively simple chemical manipulation produced from opium, heroin, which was about 20 times a half and times as strong on a weight basis.

Although heroin can be smoked or eaten, injection into a vein is the preferred method by which addicts in the United States take the drug. This is the most efficient method since none of the drug is destroyed by fire or by gastric juices. Moreover, injection minimizes the time lag between the administration of the drug and the feeling of its effect. Many heroin addicts particularly value the "rush" that the injected drug gives them to 10 times effect since the rush.

Effects of Heroin

Heroin has many effects, but for our purposes only a few are relevant. First, it is a stimulant, and thus it is very desirable and is an addiction. After taking one high, a relatively few addicts become addicted physically to the drug. After a period of withdrawal, the administration of the drug gives rise to time lot of addicts, and the time of consumption is the "rush" and the "high" that many addicts experience. The drug can be administered through various means, but the most common is an injection into the vein. A period of abstinence or moderate use, however, does not prevent the addicts from experiencing the "rush" and the "high.

Suggested Policy Changes

Various policies have been advocated to lower the impact of heroin addiction on our society.

1. Legalization: One possible policy is to treat heroin addicts like alcoholics, making it possible for them to monitor their use and prevent it from escalating. After all, while some addicts do not come across the drug in their daily lives and thus are unable to obtain it, others do so through social contacts or acquaintances. Whatever the reason, heroin addiction, like alcoholism, is a condition that can be treated in various ways by maintaining the same period of abstinence or moderate use to periods of compulsive use.

2. Incapacitation of offenders: A primary reason for concern about heroin addiction in the United States today is that the heroin addict is a compulsive offender. The heroin addict needs to both obtain the drug and to sell it to support his habit. There is some dispute about the total amount of money that heroin addicts must obtain through criminal means, but the research indicates that the total number of addicts may be as high as 1 million. There is also evidence that a long drug user's daily consumption of heroin is a cost of about $50 per day. The best estimates indicate that the annual cost of this roughly $15 billion per year sustained from criminal sources, such as prostitution, robberies, and burglaries, and occasional work. Most of the money is used for the purchase of heroin, and the remaining money is used for the support of the property crime.

Precipitously small within the United States, we have already invested heavily in prevention of sale within the United States, and prevention of heroin distribution into the United States. However, our efforts have been closely monitored by many other countries, particularly the United States. Because of this close monitoring, the heroin distribution into the United States has been effectively blocked.

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other in vain. After some years under this system, the British clinics gradually stopped prescribing heroin for the great majority of their clients. They have now switched over to methadone—a synthetic opiate developed in Germany during World War II—as a maintenance drug.

4. Methadone maintenance. Methadone is pharmacologically similar to heroin and hence blocks heroin withdrawal and prevents heroin use from becoming compulsive. Methadone, however, differs from heroin in important ways. First, it is far safer, far more easy to use than heroin. Second, it is much easier for doctors to prepare it so that it can only be taken orally. Third, it is effective for at least 24 hours—about four times as long as that of heroin. As a result, methadone, though equally addictive, is easier for the addict to take a short time before a dispensing clinic than to inject every four hours. Moreover, few addicts are addicted on methadone, they can be permitted to take several doses, supply the drug home with much less fear that they will be able to sell it illegally—if at all—than at a price comparable to that of heroin.

Even though methadone is less euphoric than heroin, and methadone is less appealing because it is impractical to inject, it still has value for addicts in staying off withdrawal symptoms.

Conclusion as to the efficacy of methadone maintenance under American conditions are still tentative. Treatment programs, which exist in almost all sizable cities, vary greatly. Some give all addicts methadone and provide virtually no other services. Others give methadone merely as a method of “hooking” addicts so that they may be treated for their underlying psychological problems—both those unaltering and those caused by their addiction. Finally, there are sizable variations in the reliability of data among reports on programs.

A number of general statements may be made which seem to apply to all of the methadone programs. Methadone maintenance works for about 50 to 80 percent of the addicts who undergo treatment. Moreover, the arrest rate of addicts drops dramatically when they enter methadone treatment. For instance, in one program where the addicts were arrested on average once per year before admission, the overall arrest rate of those who entered the program was reduced to about one-fifth of this figure, while among those who remained in the program the arrest rate was reduced to less than one-fifth the previous rate.

One may ask then, why we cannot do better than this. As I have written elsewhere: There is no doubt, however, that methadone is not perfect. Entirely apart from its inability to affect the addict's use of heroin, methadone maintenance suffers from another, more serious disadvantage. Typically, the patient with an infection has only that wrong with him if he is cured. He is well again. The heroin addict, on the other hand, may suffer from many anemia, and other diseases caused by his use of heroin. And in the absence of a work record or any legitimate occupational skills, and the inability to receive help from any friends in a better position than his own. Whether or not these obstacles are traceable to his heroin addiction, they will remain after he ceases his heroin use.

References


Discussion Questions

1. Why are there so many heroin addicts in the United States?

2. Would legalizing heroin use substantially reduce the number of other crimes committed by addicts? What would be the consequences of such a move?

3. Should heroin, which is an especially effective painkiller, be made available for terminally ill patients for whom no legal painkiller is as effective?

4. Of the various policies advocated to combat heroin addiction, which do you prefer—legalization, more law enforcement, the "two-market approach," or increased treatment efforts?

This study guide and the ideographs, Heroin, is one of 22 in the CRIMEFILE series. For information on how to obtain programs, or other criminal justice issues in the series, contact CRIMEFILE, National Institute of Justice, NCJRS, Box 6000, Rockville, MD 20850 or call 800-651-3420 (301-251-3300 from Metropolitan Washington, D.C., and Maryland).