

11. Rose, D., and O'Reilly, K. *The ESRC Review of Government Classification*. London: Office for National Statistics, 1998.
12. National Statistics (UK). *The National Statistics Socio-economic Classification (NS-SEC): Introduction*. (2002). Accessed on July 2, 2003, at: http://www.statistics.gov.uk/methods_quality/ns_sec/default.asp
13. Wright, E.O. *Class Counts: Comparative Studies In Class Analysis*. New York: Cambridge University Press, 1997.
14. Krieger, N. Women and social class: a methodological study comparing individual, household, and census measures as predictors of black/white differences in reproductive history. *J. Epidemiol. Community Health* 45 (1991): 35-42.
15. Muntaner, C., and Parsons, P.E. Income, social stratification, class and private health insurance: a study of the Baltimore metropolitan area. *Int. J. Health Services* 26 (1996): 655-671.
16. Wohlfarth, T., and van den Brink, W. Social class and substance use disorders: the value of social class as distinct from socioeconomic status. *Soc. Sci. Med.* 47 (1998): 51-58.
17. Soderfelt, B., Danermark, B., and Larsson, S. Social class and sickness absences. A comparative study of four ways to measure class. *Scand. J. Soc. Med.* 15 (1987); 211-217.
18. Rose, D., and Pevalin, D.J. (eds.) *A Researcher's Guide to the National Statistics Socio-economic Classification*. London: Sage Publications, 2003.
19. Krieger, N. Theories for social epidemiology in the 21st century: an ecosocial perspective. *Int. J. Epidemiol* 30 (2001): 668-677.
20. National Statistics (UK). *Household level NS-SEC*. (2002). Accessed on July 2, 2003, at: http://www.statistics.gov.uk/methods_quality/ns_sec/household_level.asp



Robert J. MacCoun and Peter Reuter. **Drug War Heresies: Learning from Other Vices, Times, and Places**. Cambridge University Press, (2001). \$28.00 paper, \$75.00 hardcover.

The authors of this text are both professors of public policy who have made important contributions to the debate over America's drug policy. Peter Reuter headed the RAND Corporation's influential Drug Policy Research Center before taking his current position at the University of Maryland at College Park. Robert MacCoun of the University of California at Berkeley is the author of numerous influential

publications on drug policy, including “Drugs and the Law: A Psychological Analysis of Drug Prohibition,” a paper that has changed the mind of many a believer in the war on drugs. The authors bring considerable analytic skill to examining the evidence regarding the impact of the war on drugs and its alternatives. Regrettably, they are able to make less of the admittedly limited data than I had hoped for when I picked up this book.

The authors identify three standards that could be the basis for current drug policies’ reevaluation and revision. The first is the philosophical standard, which asks whether the state has sufficient justification to infringe on the liberty of its citizens to control drug use. While MacCoun and Reuter seem to acknowledge that current policies cannot meet this standard, they assert that “Only libertarians believe this to be the applicable standard.”

The second is the political standard. Here they conclude that public opinion and “the almost complete absence of drug reform rhetoric among elected officials” shows that policy change cannot be readily based on this standard. However, the book was written before some of the recent referenda on drug policy. Changes emerging from policy discussions in various states suggest that reform may actually be closer to meeting their political standard than the authors suggest.

Third is what the authors term “the policy analytic standard.” They argue that this is an intermediate standard—one might say a *tertium quid*—that may be useful in resolving the conflict between the first two standards. They define this standard as follows:

a change in laws is justified if (a) theory and available evidence provide reasonable confidence that the change would yield (b) a net reduction in total drug-related harm (c) across all but the most extreme weightings of types of harm (morbidity vs. crime vs. lost liberty) and bearers (users vs. nonusers, the middle class vs. the urban poor). (p. 13)

Your guess is as good as mine what they mean by morbidity *versus* crime *versus* lost liberty or why mortality isn’t included as a harm worth reducing. Nor do I have any idea why they include the totally inappropriate “(a),” “(b)” and “(c)” in a sentence that is not a series. Such quibbles aside, those are constructs that most public health policy-makers will feel at home with.

The bulk of the book is devoted to applying the policy analytic standard, with occasional reference to the political standard. Part I of the book provides an overview of America's current "highly punitive prohibition" drug policy. Part II is a fairly even-handed discussion of current drug policy arguments against drug prohibition, along with an examination of the evidence as to whether prohibition actually suppresses drug use.

Throughout this section and the rest of the book, however, the authors seem unwilling to consider drug use as being anything other than inherently "reckless or irresponsible." Even when they acknowledge that "many if not most drug users never do wrongful harm to others as a result of their using careers," they nonetheless compare drug use to running red lights or driving while intoxicated. A fairer comparison might be to riding a bicycle or being a deerhunter (p. 61). They offer a section on "the benefits of drug use" (pp. 70–71) but make no serious attempt to address the positive benefits that most illicit drug users report experiencing.

Another quibble with one of the authors' minor, but repeated, points. They write that

depenalization (often confusingly called decriminalization) refers to a substantial reduction of penalties for possession of modest quantities of prohibited psychotropic drugs. (p. 74)

It is MacCoun and Reuter who seem to be confused about depenalization and decriminalization. The term "decriminalization" is well established and quite accurately used in the general literature of drug policy reform. It refers to a reduction in penalties from the level of a crime—a felony or misdemeanor—to that of an offense. Offenses are not punishable by imprisonment, and conviction for an offense does not constitute a criminal conviction. "Depenalization," on the other hand, refers to the elimination of *all* penalties. In the 1970's, several states decriminalized possession of small amounts of marijuana, making persons convicted of possession subject to a fine, whereas the Netherlands, for example, depenalized possession of small amounts of marijuana, eliminating any penalty.

In Part III the authors apply their evidence for application of "policy analytic standard" to U.S. drug policy. They begin by examining analogous experiences with "other vices" (gambling and prostitution)

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and other drugs (alcohol and tobacco), offering a historical view of the American experience of legal heroin and cocaine prior to the Harrison Act.

They finish with an examination of recent European experiences with alternative policies and practices. Not surprisingly, the authors' examination of "other vices" is as tainted by *a priori* judgments of the inherent immorality of the activities as is their judgment of drug use. They write, for instance, about "the moral debasement of state governments" in sponsoring lotteries. While acknowledging that their assertions about changes in the prevalence of gambling behavior "are merely plausible conjectures," they proceed to draw conclusions as if their conjectures were facts. They assume that the increase in gambling that they conjecture has occurred must have produced an increase in pathological gambling, when it is at least equally plausible that those prone to pathological gambling were least likely to be affected by anti-gambling laws. Their examination of prostitution shows an even greater paucity of real data to support their conclusions.

The discussion of Prohibition—that is, prohibition of alcohol in the 1920s—is also seriously deficient. They assert that "it came after a period of modest decline in alcohol consumption." Prohibition was actually preceded by the greatest decline in alcohol consumption in U.S. history, both greater and more sustained than the decline associated with Prohibition. I have criticized elsewhere the naïve acceptance that enactment of Prohibition resulted in an apparently instantaneous drop in cirrhosis death rates, rather than their being due to the decade of decline in alcohol use that preceded Prohibition (Duncan, 1997). MacCoun and Reuter, on the other hand, are quick to accept such "voodoo epidemiology," and as quick to write off as only "occasional" the significant increase in mortality owing to alcohol poisoning that accompanied Prohibition. They do note that the 50,000 cases of paralysis from a single famous incident (Morgan, 1982) dwarf the numbers effected by any instances of heroin contamination.

The book provides an interesting discussion of the period from the early 1880's through 1905, when there was no prohibition of cocaine or heroin. There also was, of course, no drug prohibition before 1880, but cocaine had not yet been isolated, nor heroin synthesized. Coca, which contains cocaine, and heroin, which contains opiates that have all the same effects as heroin, however, were available and unregulated. Unfortunately, the authors predicate a good deal of their analy-

sis on the *a priori* assumption that non-medical drug use is always bad and thus may merit prohibition. Despite documenting that this era of unrestricted availability of cocaine and heroin produced low levels of dependence and little if any causal connection between drug use and crime or violence, they see no clear basis for a policy analytic conclusion of that experience.

In my judgment, one of the best parts of the book is the three-chapter review of European experiences with drug policy alternatives. It includes one of the few discussions available in English of Italy's depenalization of drug use in 1975, its repenalization in 1990, and its re-depenalization in 1993. The discussion of the Dutch experience with a national policy of canalization and harm reduction is also generally good. They conclude that *de facto* depenalization of marijuana did not in itself result in any increase in use, but argue that commercialization following the former did. While this seems plausible, I find their evidence less than convincing. They argue that use among youths has increased, citing four national surveys of students aged 16–17 that seem to show a remarkable increase. However, they also cite from three surveys of youths 16–19 in Amsterdam showing no sign of any such increase. Is it plausible that commercialization had no impact on youths in the city where commercialization of cannabis was greatest, but had a major impact on youths exposed to less of it? Could not those findings reflect greater willingness to admit to use in a society less uptight about cannabis, rather than reflecting changes in actual use?

The same chapter also contains one of a number of minor errors in the book's descriptions of the actual drug substances. The authors write about "a high-potency domestic *sinsemilla* (seedless) strain." There of course cannot be a seedless "strain" of cannabis, since it could not reproduce itself. Marijuana that is seedless ("*sinsemilla*" in Spanish) is simply a female plant of any strain that has not been pollinated and therefore remains at its peak level of THC production.

Some of us who have been practicing harm reduction here in the U.S. for more than thirty years would differ with the statement that begins Chapter 12: "Western Europe is the original home of the harm reduction movement." Beyond this, their discussion of harm reduction in Europe impresses me as being a mix of the relevant, the irrelevant and the dubious.

In Part IV the authors offer their assessment of the alternatives. Given my disappointment with much of Part III, my expectations for this

part were not high. Much of it strikes me as dubious conclusions based on dubious data. There are, however, parts that I recommend more favorably. Their discussion of “the Spectrum of Regimes” describes three overlapping regimes—regulatory, prescriptive, and prohibitory—that are reflected in eight policy models ranging from a free market to pure prohibition. This usefully makes their point (as I argue elsewhere) that the policy debate need not be set solely in terms of prohibition versus legalization (Duncan, 1994).

Of even greater value is the authors’ attempt to explicate the elements of harm which may be attributable to drug use. This is a truly valuable contribution, one that I hope will be followed up by the authors and others interested in drug policy. Their model of harm, however, suffers from their failure to specify how likely those harms are to occur or whether they will occur with varying drugs and forms of drug use. Also missing from their attempt to project the consequences of alternative policies is an examination of the harms due to the policies themselves. The authors’ final conclusion regarding drug policy reform is that “the desirability of major reform has a reasonable empirical and ethical basis.” They do warn, however, that increased drug use is a predictable result of the commercialization that will inevitably result should any of the currently illegal drugs be legalized. Critics of this approach have argued that it is doubtful that society would ever tolerate outright commercialization of “hard” drugs or “hard” forms of drugs (such as crack or injectable opiates). Because most Americans have very negative conceptions of drugs like heroin and cocaine, ingrained through a lifetime of exposure to propaganda and media depictions, they would be unlikely to significantly escalate use by commercial promotion. And David Borden of the Drug Reform Coordination Network has suggested that commercialization of marijuana may actually be a good thing, if it competes with and hence reduces use of alcohol or other more dangerous drugs.

To me, the more important question is whether policy reform would increase or decrease drug *abuse*. The National Association for Public Health Policy (1999) has taken the position that the proper goal of drug policy should be prevention and treatment of drug abuse and the amelioration of its negative consequences. Drug use and drug abuse do not necessarily vary together; for instance, cocaine use has been declining in recent years, but it appears that cocaine dependence has been increasing. Policies that suppress drug use may actually increase

drug abuse and vice versa. This perspective is often missing in discussions of drug policy issues, even heretical ones such Drug War Heresies.

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REFERENCES

Duncan, D. F. (1994). Editorial: Rethinking drug policy options—Getting beyond prohibition versus legalization. *Substance Abuse*, 15, 197–198.

Duncan, D. F. (1997). Uses and misuses of epidemiology in shaping and assessing drug policy. *Journal of Primary Prevention*, 17, 375–382.

MacCoun, R. (1998). Toward a psychology of harm reduction. *American Psychologist*, 53, 1199–1208.

MacCoun, R. J. (1993). Drugs and the law: A psychological analysis of drug prohibition. *Psychological Bulletin*, 113, 497–512.

Morgan, J. P. (1982). The Jamaica ginger paralysis. *Journal of the American Medical Association*, 15, 1864–1867.

National Association for Public Health Policy (1999). A public health approach to mitigating the negative consequences of illicit drug abuse. *Journal of Public Health Policy*, 20, 268–281.



Barbara Seaman. **The Greatest Experiment Ever Performed on Women: Exploding the Estrogen Myth.** New York: Hyperion Books, 2003. xv+332 pp. \$24.95 cloth.

Little more than a year ago, a post-menopausal woman visiting her internist would more than likely have been strongly advised to go on hormone replacement therapy (HRT). Women who expressed skepticism about the new hormone regime, prescribed mainly as a preventive regimen, were looked upon as medical Luddites. Advertisements, magazines, and drug company communications to physicians described estrogen replacement as a way to treat hot flashes, to prevent osteoporosis, dementia, Alzheimer's and heart diseases, and in general to protect women from the natural effects of aging. How could women refuse HRT intervention in the face of all the medical evidence?