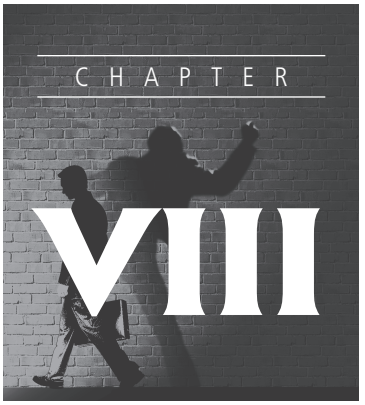

From "Just Say No!" to "Well, Maybe"—The War on Drugs and Sensible Alternatives

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As compared to other Western countries, the United States places a great deal of emphasis on criminal justice responses to illegal drug use[1]. With the most recent "War on Drugs" that began in the mid-1980s, the criminal justice system emphasis became even more pronounced: arrests for drug offenses increased, the sentences for drug offenses were lengthened significantly, and the number of people incarcerated for the commission of drug crimes similarly increased. These policies were apparently implemented with the goal of preventing drug use and drug-related harm, but after 30 years and billions of dollars in criminal justice system expenditures, it is clear that these policies have failed to achieve these goals.

In this chapter, we critically examine these policies, focusing on their effectiveness (or more appropriately, the lack thereof), their economic and social costs, and several unintended consequences that result from them. We begin with a brief discussion of the history of drug legislation in the United States followed by a description of a variety of potential approaches to drug regulation. We then examine trends in arrests and incarcerations for drug offenses and discuss social class and racial inequality in the application of drug laws. We proceed to a discussion of ***mandatory minimum sentencing*** policies, which have a disproportionately negative impact on the poor and members of minority groups. We also discuss ancillary policies, such as the denial of welfare and student aid to individuals who are convicted of drug offenses; these policies similarly have a negative impact on the poor and members of minority groups. The next section of the chapter discusses alternative approaches to drug regulation that were implemented in other Western countries. We conclude the chapter with a discussion of recent changes in the response to illegal drugs in the United States at the state and federal levels.

[1] In this chapter, we address policies related to drugs that are currently illegal in the United States. It is important to note, however, that considerably more harm, including deaths, is associated with legal drugs, such as alcohol, tobacco, and prescription/pharmaceutical drugs.

The Back Story: The History of Drug Laws in the United States

In the 19th century, consciousness-altering substances were sold openly in the United States. Medicine, which lacked the scientific basis it would eventually develop in the 20th century, relied extensively on painkillers to "treat" patients—many of these products contained various derivatives of opium. In 1910, morphine was the most frequently used medical drug, while alcohol was the fifth most commonly used medical drug. The Bayer chemical company successfully synthesized heroin in 1898 and sold the drug over the counter. Cocaine was aggressively marketed and advertised as a cure for hay fever and sinus problems; it was also used as a food additive and was an ingredient in soft drinks, such as Coca-Cola (Mosher & Akins, 2007).

In the early 20th century in the United States, addiction to drugs was fairly common, facilitated by a mass production of drugs and advertising of the products and by physicians and pharmacists who supplied opiate drugs to addicts. Estimates of the number of drug addicts in 1915 ranged from 200,000 to 275,000, with concentrations in the south and among members of the middle and upper classes (Brecher, 1972). However, consistent with subsequent drug laws in the United States (see Table 8.1), the first state and local government efforts to restrict the non-medical use of drugs was not aimed at middle and upper-class users, but instead at the immigrant Chinese population who were associated with opiate use.

Table 8.1 United States Drug Policy Timeline

United States Drug Policy		
1906	Pure Food & Drug Act	Established the Food & Drug Administration (FDA). Labeling of drugs now required over concerns of unlabeled use of animal products, addictive, or harmful substances. Drug could contain these, so long as labeled. Resulted in appreciable drop in addiction in U.S.
1909	Opium Exclusion Act	Banned imported, non-medicinal opium smoking
1914	Harrison Narcotics Tax Act	Opium and cocaine distributors must register and pay tax. Act is a tax only—opiates and narcotics still available through prescriptions. Addiction viewed as a medical issue, not criminal justice issue.
1919	18th Amendment (Volstead Act)	Established the federal prohibition of alcohol in the U.S. Federal enforcement of alcohol prohibition began in 1920.
1922	Narcotic Drug Import & Export Act	Use of narcotics limited to medical use.
1924	Heroin Act	Heroin manufacture illegal
1926	Rolleston Committee in UK	Established medical, not criminal justice, response to addiction in UK. Prompted court cases in U.S., in which medical authority lost to criminal justice interest on issues of addiction

Table 8.1 (Continued)

United States Drug Policy		
1933	21st Amendment	Overturned 18th Amendment
1937	Marihuana Tax Act	Control of marijuana similar to narcotics: through tax on grower, distributor, seller, buyer. Superseded by Controlled Substance Act of 1970
1938	Food, Drug, and Cosmetic Act	FDA authority over drug safety established, extended beyond mere labeling. Drugs defined, established drugs administered by prescription vs. non-prescription
1942	Opium Poppy Control Act	Established that growers must have license to grow opium poppies
1951	Durham-Humphrey Amendment	Established guidelines for prescription drugs
1951	Boggs Amendment to Harrison Narcotic Act	Established first mandatory sentences for narcotics violations
1956	Narcotics Control Act	Imposed severe penalties for drug violation
1962	Kafauver-Harris Amendments	Essentially established the FDA as agency responsible for testing and approving drugs. Drugs must be effective and approved before human trials can begin
1963	Methadone Maintenance	Methadone introduced in U.S. as alternative to heroin for heroin addicts
1965	Drug Abuse Control Amendments	Regulation of amphetamines and barbiturates as "dangerous drugs," established ongoing regulation of other drugs in future. First federal prohibition of particular substances
1966	Narcotic Addict Rehabilitation Act	Allowed treatment in lieu of jail for drug offenders
1968	The Drug Abuse Control Amendments (DACA) Amendments	Suspended sentence & expungement for offenders with no repeat drug violation within 1 year
1969–1970	Methadone treatment became standard practice in Washington, DC	Methadone treatment for heroin addicts began in Washington, DC, jails. When Nixon expanded funding throughout Washington, DC, burglaries decreased 41%
1970	Comprehensive Drug Abuse Prevention and Control Act (Controlled Substances Act)	Updated all narcotic laws in U.S. First effort to control all drugs through enforcement (Department of Justice), not just through taxation (Treasury). Established Justice oversight for most controlled substances, separate commission to study marijuana
1971	Nixon declared "War On Drugs"	Nixon declared War on Drugs in June 1971 speech, declaring drugs "public enemy number 1." Despite tough rhetoric, Nixon spent more money on treatment than enforcement

(Continued)

Table 8.1 (Continued)

United States Drug Policy		
1972	Drug Abuse Office and Treatment Act	Established federal funds for drug prevention and treatment
1973	Methadone Control Act	Act established the regulations for methadone dispensation and licensing
1973	Heroin Trafficking Act	Increased penalties for heroin
1973	Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) established	Former Agencies consolidated: National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), and National Institute on Alcohol Abuse and Alcoholism (NIAAA)
1973	Drug Enforcement Administration (DEA)	Bureau of Narcotics and Dangerous Drugs reorganized into DEA, the "super-agency" to handle all aspects of illegal drug issue in U.S., including enforcement, customs, and school education. U.S. policy criticized internationally for demonization of addiction over harm reduction
1976	Carter moved to decriminalize cannabis	Candidate Jimmy Carter campaigned for presidency on decriminalization of cannabis campaign
1978	Alcohol and Drug Abuse Education Amendments	Responsibility for drug education became part of Department of Education
1980	Drug Abuse, Prevention, Treatment, and Rehabilitation Amendments	Extended prevention, education, and treatment efforts for drug abuse and addiction
1984	Just Say No	First Lady Nancy Reagan introduced "Just Say No" campaign. Birth of Drug Abuse Resistance Education (DARE)
1984	Drug Analogue (Designer Drug) Act	Made designer drugs with similar effects & structure subject to same law as existing drugs
1985	Crack as a social problem	Crack emerged as a social problem during the 1980's
1986	Anti-Drug Abuse Act of 1986	Increased penalties for drug trafficking, established mandatory minimums for drugs 100:1 sentence disparity between powdered/crack cocaine, leading to racial disparities in sentencing
1988	Senator John Kerry, U.S. Senate Committee on Foreign Relations	Senate report alleged CIA involved with cocaine sales, used proceeds to fund arms purchases
1988	Anti-Drug Abuse Act of 1988	Established office of National Drug Control Policy
1988	Omnibus Drug Act (Chemical Diversion and Trafficking Act)	Increased penalties for drug users and traffickers. Addressed money laundering and weapons in drug markets; allowed seizure of vehicles and assets used in drug trade

Table 8.1 (Continued)

United States Drug Policy		
1990	Bush escalated "War On Drugs"	President Bush administration approved 50% spending increase for War on Drugs. Spending increase earmarked for enforcement, not prevention or treatment
1992	Clinton on cannabis	President Clinton admitted to smoking cannabis, but not inhaling
1992	Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) reorganized	Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) reorganization: National Institute on Drug Abuse (NIDA), National Institute on Mental Health (NIMA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) moved to National Institute of Health; programs moved to Substance Abuse and Mental Health Services Administration (SAMHSA)
1994	Violent Crime Control and Law Enforcement Act	Largest crime bill in U.S. history. In addition to weapon and violent crime provisions, mandated drug testing for federal parolees
1995	U.S. Sentencing Commission recommended revisions on mandatory minimum sentences	U.S. Sentencing Commission sought to address sentencing disparity in federal sentencing guidelines. Congress rejected recommendations of the very Commission charged with making specific recommendations to Congress
1996	Comprehensive Methamphetamine Control Act	Limited access to equipment and chemicals used in production of methamphetamines
2005	Combat Methamphetamine Act	Pseudophedrine (active ingredient in Sudafed) classified as Schedule V substance; ID required for purchase. Methamphetamine production decreased in U.S.
2010	Fair Sentencing Act	Sentencing disparity between crack and powdered cocaine reduced from 100:1 to 18:1

Source: Adapted from Mallicoat & Ireland (2013).

The first federal law regulating drugs in the United States—the Pure Food and Drug Act—was passed in 1906. This law did not make the use of narcotic and other drugs illegal, but required manufacturers of such products to list the ingredients, including the quantity of alcohol and other drugs. Specific regulation of drugs by the U.S. federal government began in 1914 with the passage of the Harrison Narcotics Act. Racial issues played a major role in the passage of this legislation, particularly with respect to the inclusion of cocaine as one of the regulated drugs. Cocaine was portrayed as a drug that was disproportionately used by Blacks, which gave them superhuman strength and contributed to assaults on Whites, particularly sexual assaults against white women (Mitchell, 2009). The Marihuana Tax Act of 1937, the first federal law banning marijuana, was similarly influenced by racial fears. The drug was portrayed

as one that was disproportionately used by Mexican immigrants and black jazz musicians, who were also alleged to be involved in distributing the substance to young people (Mosher, 1999).

The Current State of Drug Policies in the United States

"***Drug Policy***" refers to the laws and procedures implemented by governments to deal with drug use and problems related to such use. The language used to describe drug policy is often vague and inconsistent, and the "drug policy" for any given country typically involves dozens of individual policies enacted (where relevant) at the federal, state, and local levels that are aimed at the control of psychoactive drug consumption, and harm related to the use of drugs.

The most restrictive form of drug policy is drug ***criminalization*** (or drug prohibition), under which the production, manufacture, sale, and/or possession/consumption of certain drugs are violations of one or more criminal statutes. In practical terms, this means that drug problems are largely handled through the criminal justice system, although the severity of sanctions related to violations of the laws, and the level of discretion exercised by criminal justice system agents, may vary substantially based on the behavior in question (e.g., possession vs. dealing), the particular substance, the amount of the substance involved, and a host of other factors. As is documented in more detail below, drug criminalization is the approach that dominates (for certain drugs) in the United States. Critics of the criminalization approach point out that it is very expensive, has little or no deterrent effect on drug use, and comes with a number of other often negative consequences, which are described in detail below.

The next most restrictive form of drug policy is ***de facto legalization***. This approach to drug offenses might be more appropriately termed "drug procedure" rather than "drug policy," as de facto legalization does not represent any formal policy, but rather the informal yet systematic practice of not enforcing drug laws (typically marijuana possession) by law enforcement.

Decriminalization is the process of removing some form of conduct, previously defined as criminal, from the jurisdiction of criminal justice agencies. Many have noted that while the policy is referred to as decriminalization, it is better termed ***depenalization*** (MacCoun & Reuter, 1997) as the offense in question, although still illegal, cannot result in incarceration of the offender. Offenders are still processed and punished for violations of the law, but in a limited way (often equivalent to a traffic ticket).

The most permissive form of drug regulation policy is drug ***legalization***. The general understanding of drug legalization is that some or all drugs become "legal" in the sense that, under certain circumstances, they can be purchased from government approved vendors and consumed. All criminal and civil penalties associated with use of the substance are removed—thus the substance(s) in question become regulated in much the same way that alcohol is currently regulated in the United States. Importantly, however, even under drug legalization policies, ancillary behaviors associated with drug use (i.e., driving under the influence of drugs) may be criminalized.

An additional set of policies and strategies aimed at reducing the harms caused by drug use and the policies designed to regulate drugs is known as ***harm reduction*** (also known as harm minimization). These policies do not focus on the attempted elimination of drug use and addiction—advocates of harm reduction strategies typically view the pursuit of a "drug-free world" as a completely unrealistic objective. By necessity, the policy approaches suggested by harm reduction advocates vary with respect to the particular drug and the drug-related behavior in question. The general message is that policy should not make firm distinctions between drug users and those who produce and sell drugs; that "soft" and "hard"

drugs should not be treated similarly as they pose substantially different risks to users; and that ideology should never take precedence over practicality in attempts to minimize drug-related harm (Goode, 1997). President Jimmy Carter made a harm reduction-based appeal to Congress in his 1977 testimony, commenting, "Penalties against drug use should not be more damaging to an individual than the use of the drug itself. Nowhere is this clearer than in the laws against possession of marijuana for personal use" (Carter, 1977).

With respect to the approach to dealing with harder drugs (e.g., amphetamines, cocaine, heroin) the message from supporters of harm reduction approaches is somewhat more ambiguous. Proposals for the outright legalization of these substances are not the norm among harm reduction advocates, but strict criminal justice sanctions, such as lengthy prison sentences for possession/use of these substances, are typically seen as misguided, ineffective, and counterproductive. In the context of these harder drugs (which pose completely different addiction risks as compared to marijuana, for example), harm reduction advocates tend to view drug use and addiction as primarily health, and not criminal justice system, issues. They are thus more likely to promote some form of decriminalization and/or policy that uses the law as a tool to mandate treatment for users, instead of imposing the law as a mechanism to incarcerate large numbers of drug users. Needle exchange programs and clean needle distribution are also commonly advocated (and effective) approaches to reduce the harm associated with heroin or other illicit opiate injection—in particular the spread of HIV, hepatitis, and other blood-borne diseases (Ferrini, 2000).

Another common, albeit slightly more controversial, harm reduction strategy for the treatment of heroin (and other opiate) addiction is opiate replacement therapy. Opiate replacement therapy involves the substitution of one type of opiate for another, either temporarily or on a long-term basis, in the belief that the substituted drug is less problematic in some way(s). Several drugs are used in this manner, including buprenorphine and slow-release oral morphine, but the most well-known drug used for opiate replacement therapy is methadone. Methadone is a synthetic opiate that is cross-tolerant with other drugs in the opiate category, meaning that taking methadone provides tolerance for all drugs in the category (e.g., heroin) (O'Brien, 1997).

Methadone maintenance typically involves the addict taking an orally administered and standardized dose of methadone, the effects of which last for 12 to 24 hours, with accompanying reductions in the intense cravings commonly associated with opiate addiction (Gahlinger, 2001). When methadone is taken orally and at stable doses, it does not provide any euphoria or "high," and cognition, alertness, and higher mental functions are not impaired (Nadelmann, 1996; O'Brien, 1997). However, this form of drug treatment is more controversial than some others because, by definition, methadone maintenance involves substance dependency—it is precisely because the individual develops an adequate level of tolerance to methadone that the drug "works" in the prevention of heroin use. Critics of methadone maintenance programs also point out that addicts may horde and/or sell prescribed methadone or combine it with a drug like Xanax to obtain a heroin-like high (Negroponte, 2005). Despite these criticisms, methadone maintenance has been found to be effective in the treatment of chronic heroin and other opiate addiction, reducing heroin use, behaviors associated with high HIV risk, crime related to substance use, and levels of unemployment (Leshner, 1999; Marsch, 1998). It is one of the few harm reduction strategies currently embraced by the U.S. federal government's Office of National Drug Control Policy (ONDCP, 2000).

It is important to note that in the United States, harm reduction is an approach that disproportionately relies on dealing with the problems created by *legal* drug use, especially alcohol, and is much less likely to be employed to address problems stemming from the use of currently illegal substances. For example, alcohol consumption is allowed (even to the point of intoxication), but is regulated in a variety of ways

intended to reduce the harms that may result from its use. As such, there are policies designed to control access to alcohol: (a) legal age restrictions; (b) consumption/possession regulations; (c) hours of sale and zoning restrictions on establishments selling the drug; (d) regulations on the advertising of alcohol products; (e) regulations on the purity and potency of alcohol products; and (f) provisions of extensive treatment options for those who become dependent on alcohol. The United States also penalizes the harmful consequences associated with the use of alcohol—for example, laws against drunk driving and public intoxication—but not use of the substance itself. As is addressed in more detail later, harm reduction advocates propose that similar policies should be adopted to reduce the harm associated with some, or all, currently illegal drugs.

As noted, the dominant drug regulation policy in the United States for approximately the last 100 years has been criminalization. The passage of the 1914 Harrison Narcotics Control Act launched a policy of arresting and incarcerating increasingly large numbers of users and traffickers in illicit drugs (Brecher, 1972; Musto, 1999) with a disproportional impact on members of minority groups and the poor. Contemporary policies toward illegal drugs in the United States are consistent with principles established early in the 20th century, with a particular focus on a law enforcement approach to the drug problem and stringent penalties attached to violations of drug laws. In 2009, there were 1,663,582 arrests for drug offenses in the United States comprising approximately 12% of the total arrests in that year, and constituting about the same number of arrests as for murder, rape, robbery, burglary, and theft combined (Bureau of Justice Statistics, 2010). And, despite the rhetoric on the part of government and law enforcement officials that the War on Drugs is focused on those who traffic in these substances, arrests for possession of drugs were about four times greater than those for trafficking. Although the rhetoric states that the War on Drugs is also focused on "hard drugs," in 2009, 51.6% of all drug arrests involved marijuana (Bureau of Justice Statistics, 2010), and of the 858,408 arrests for marijuana in that year, 88.4% were for simple possession of the substance.

Given the tremendous number of arrests for drug offenses and the severe penalties that result from convictions for such offenses, the drug war also contributed to unprecedented levels of imprisonment in the United States (Austin & Irwin, 2012). At the end of 2010, there were 2,266,800 adults incarcerated in the United States (Bureau of Justice Statistics, 2011), translating to an incarceration rate of more than 700 per 100,000/population. On December 31, 2011, there were 197,050 prisoners under federal jurisdiction, and of these, 94,600, or 48%, were serving time for drug offenses. At the state level, 237,000 prisoners were serving time for drug offenses, representing 17% of the total number of adults incarcerated in state prisons. And as of the mid-2000s, the United States had 100,000 more people incarcerated for drug offenses than the European Union had for all offenses combined, despite the fact that the European Union had 100 million more inhabitants (Wood, Tyndal, Zhang, Montaner, & Kerr, 2003).

Specific (and Ancillary) Drug Policies

Mandatory Minimum Sentences

Mandatory minimum sentencing policies have been a component of criminal laws in the United States since 1790 (Schulhofer, 1993) but had their greatest impact in the last three decades. Interestingly, in the 1979 Comprehensive Drug Abuse and Control Act, the U.S. Congress concluded that mandatory minimum sentences had not realized their intended purpose of deterring drug offenders, and most mandatory minimum sentencing policies were repealed at that time. However, prompted at least in part by the "crack cocaine epidemic" of the mid-1980s, the federal government and several state governments enacted mandatory minimum penalties for drug offenses in the 1980s (some states, such as New York, enacted

such statutes in the 1970s). As of 2012, there were 171 mandatory minimum sentencing statutes in the United States, and approximately 80% were for drug law violations (Tabichnick, 2012).

Most relevant in the context of issues addressed in this chapter, at the federal level, the 1988 Anti-Drug Abuse[2] Act created a host of mandatory minimum penalties for drug offenses, with the most important being a distinction between crack and powder cocaine. Under this legislation, a first-time offender convicted of possession of 5.01 grams of crack cocaine was subject to a mandatory minimum penalty of five years imprisonment. If the individual possessed only 5.0 grams of cocaine or less, they were subject to a maximum sentence of one year imprisonment (Wilkins, Newton, & Steer, 1993). In contrast, for powder cocaine, the five-year mandatory minimum sentence did not apply until the individual possessed more than 500 grams of the substance. In passing this legislation, apparently in response to an alleged crack cocaine "epidemic" in the United States (Reinarman & Levine, 1997), Congress ignored the fact that crack and powder cocaine are essentially the same drugs pharmacologically and have the same effects and consequences (Hatsukami & Fischman, 1996). Congress also failed to offer any rationale for the selection of the 100 to 1 ratio in amounts of powder versus crack cocaine that triggered the mandatory minimum penalties (Sklansky, 1995).

Related to the points regarding racial disparities in the application of drug laws, it is important to note that African Americans (and, to a lesser extent, Hispanics) were far more likely to be arrested and prosecuted under federal crack cocaine statutes than were Whites. A United States Sentencing Commission study in 1992 found that in 16 states, including states with large populations, such as Connecticut, New Jersey, and Illinois, not a single white person had been prosecuted under federal crack laws (Gelacak, 1997). Another study by the Sentencing Commission found that in 1994, Blacks accounted for over 90% of federal prosecutions for crack offenses (Gelacak, 1997).

These racial differences in prosecutions and sentencing under the federal crack laws must be considered in light of data on racial differences in the use of drugs in general and crack cocaine in particular. Although it is true that hardcore drug use and the negative consequences associated with such use are more common in inner-city areas where minorities tend to be concentrated, overall drug use figures for 1990 reported by the National Institute on Drug Abuse (NIDA) indicated that Whites comprised 77% of the estimated 1.3 million users of illegal drugs in the United States, while Blacks comprised 15%. The United States Sentencing Commission acknowledged the racial disparities in sentencing that resulted from the crack/powder cocaine distinction, and while not willing to admit that the law was racially discriminatory in its intent, the Commission commented; "If the impact of the law is discriminatory, the problem is no less regardless of the intent. The problem is particularly acute because the disparate impact arises from a penalty structure for two different forms of the same substance" (Gelacak, 1997, p. 2).

The federal Anti-Drug Abuse Act of 1998 also provided enhanced mandatory minimum penalties for individuals convicted of selling drugs within 1,000 feet of playgrounds, youth centers, swimming pools, video arcades, and other locations where young people are believed to congregate (Gray, 2001)—a number of individual states enacted similar laws. Although many of these laws have since been repealed, it is worth considering how they were applied in particular states. In Massachusetts, legislation provided a two-year mandatory minimum penalty for selling drugs within 1,000 feet of a primary, secondary, or vocational school. A study on the application of these laws in the city of New Bedford found that 84% of all drug trafficking cases within the city limits occurred within school zones. However, a review of the case files revealed that only one of the 443 transactions that occurred involved the actual sale of drugs to children,

[2] Earlier, the 1986 Anti-Drug Abuse Act also created the same distinction between crack and powder cocaine trafficking.

and more than 70% of the cases occurred when school was not in session. The authors of this study concluded that the outcome of the legislation did not result in better protection of children from exposure to drugs, but instead, resulted in an escalation of the severity of penalties for violations of drug laws (Brownsberger & Aromaa, 2003).

A similar study focusing on the application of school zone laws in the state of New Jersey found that African Americans and Hispanics, who comprised 27% of the state's population, constituted 96% of all prison inmates in the state whose most serious offense was a school zone violation (New Jersey Commission to Review Criminal Sentencing, 2005). Of 90 reported school zone cases studied in detail by the Commission, not one involved the selling of drugs to minors, and only two of the cases actually occurred on school property. The Commission concluded that the school zone policies were racially discriminatory and recommended significant changes in the laws; however, it was not until 2010 that mandatory minimum penalties for individuals convicted of selling drugs in school zones were eliminated in the state of New Jersey.

Medical Marijuana Laws

A significant development in the drug policy arena is related to the passage of medical marijuana laws in several states. Marijuana has been used for medicinal purposes for at least 300 years, and more than 100 articles on the therapeutic uses of the substance were published in scientific journals between 1840 and 1900. Cannabis was listed in the *United States Pharmacopeia* as a recognized medicine from 1850 until 1942 and could be purchased in local pharmacies in some states until the mid-1920s (Davenport-Hines, 2001). While there is certainly not a consensus on the medical utility of marijuana, a number of prominent organizations and individuals support use of the drug for medicinal purposes. Reports by the National Institutes of Health and the Institute of Medicine noted that cannabis and its constituents may have some medical utility (National Institutes of Health, 1997), and in a publication from the National Academy Press it was noted that "accumulated data indicate a therapeutic potential for cannabinoid drugs, particularly for symptoms, such as pain relief, control of nausea and vomiting, and appetite stimulation" (Joy, Watson, & Benson, 1999, p. 3). This report also pointed out that, with the exception of the harms associated with administering marijuana through smoking, the adverse effects of the drug "are within the range of effects tolerated for other medications" (1999, p. 4). Other organizations in favor of allowing the use of medical marijuana include the American Public Health Association, the Federation of American Scientists, the Physicians' Association for AIDS Care, the Lymphoma Association of America, and the National Association of Prosecutors and Criminal Defense Attorneys (Zimmer & Morgan, 1997). The *New England Journal of Medicine* and the *Journal of the American Medical Association* have also taken editorial stances in favor of medical marijuana.

In 1988, Francis L. Young, the Chief Administrative Law Judge of the Drug Enforcement Administration, recommended that marijuana be removed from Schedule I of the Controlled Substances Act so that it could be used for medical purposes. Young noted that cannabis fulfilled the legal requirement of currently accepted medical use in treatment and noted that it was "one of the safest therapeutically active substances known to man" (as quoted in Grinspoon & Bakalar, 1995, p. 1875). However, the federal government's Drug Enforcement Administration (DEA) ignored this recommendation, and since then, DEA agents and other federal government officials have actively engaged in a campaign of pursuing medical marijuana users and providers in states where medical marijuana legislation has been enacted.

As of April 2013, 19 states and the District of Columbia passed legislation allowing marijuana use for medicinal purposes. Although it would appear on the surface that these state laws allow marijuana to be

used for medical purposes, they are in conflict with federal legislation, which continues to list marijuana as a Schedule I drug, and also with Article IV of the Constitution, which holds that federal law shall be the "law of the land" and hence prevail over state laws.

In response to medical marijuana initiatives passed in Arizona and California in the 1990s, President Clinton's drug czar Barry McCaffrey, threatened to arrest any doctor who merely *mentioned* to a patient that marijuana might help them (Boyd & Hitt, 2002) and at one point referred to medical marijuana as "Cheech and Chong medicine" (as quoted in Forbes, 2000). President George W. Bush's drug czar John Walters was even more strident in his opposition to medical marijuana laws, at one point referring to medical marijuana as "medicinal crack" (as quoted in Drug Policy Alliance, 2003). In what some have argued was a violation of the 1939 Hatch Act (which prevents federal government officials from using their authority to affect the outcome of an election), Walters actively campaigned against a marijuana decriminalization ballot initiative in the state of Nevada in 2000, arguing, among other things, that passage of the law would make Nevada a "vacation spot for drug traffickers" (as quoted in Janofsky, 2002). Walters also campaigned against a proposed medical marijuana law in Maryland in 2002, but Maryland Governor Robert Ehrlich eventually approved the legislation, marking the first time a Republican governor had done so (Drug Policy Alliance, 2003).

Proposed medical marijuana legislation was also blocked by federal authorities in Washington, DC, where in September of 2002, a federal appeals court overturned (without providing any rationale), a previous court ruling that had cleared the way for a medical marijuana ballot initiative to be considered by voters in the District of Columbia (Santana, 2002). This was the second time the measure had been blocked in the District of Columbia—in 1998, voters approved a medical marijuana initiative by a vote of 69% to 31%, but Congress prevented the law from going into effect.

As a presidential candidate as well as after taking office, President Obama indicated that his administration would take a "hands-off" approach to medical marijuana (Egelko, 2011). This stance was reflected in a 2009 statement by federal Justice Department officials which indicated that, as a general rule, prosecutors should not focus their resources on "individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana" (as cited in Baker, 2011). However, a 2011 Justice Department memo seemed to partially contradict the previous statement, in stating "we maintain the authority to enforce [federal law] vigorously against individuals and organizations that participate in unlawful manufacturing and distribution activity involving marijuana, even if such activities are permitted under state law" (as cited in Baker, 2011). In addition, the 2011 National Drug Control Strategy claimed that marijuana was "addictive and unsafe," and devoted a full five pages to attacking marijuana legalization and medical marijuana.

Under the Obama administration, there have been at least 200 raids and 70 indictments against medical marijuana providers in six states (Martin, 2012). Although some of these raids focused on medical marijuana dispensaries that were located close to schools, one legislator from Washington state (which had recently allowed for the sale of liquor in grocery stores) questioned why marijuana dispensaries were seemingly more dangerous to young people than were grocers (Martin, 2012).

As Ethan Nadlemann, Director of the Drug Policy Alliance pointed out in a *New York Times* editorial (Nadelmann, 2011) in addition to the hundreds of raids of medical marijuana dispensaries that have been conducted by the Drug Enforcement Administration, pressures are also being exerted on medical marijuana businesses by other federal government agencies. Nadelmann notes, for example, that the Treasury Department has forced banks to close the accounts of medical marijuana businesses that are operating legally under state laws; that the Internal Revenue Service has required dispensary owners to pay punitive

taxes that are not imposed on any other businesses; and that the Bureau of Alcohol, Tobacco, and Firearms ruled that medical marijuana patients cannot legally purchase firearms. Importantly, Nadelmann notes that these federal efforts will not be successful in stopping the trade in marijuana, but instead serve only to push it back underground, resulting in potentially higher levels of violence and other social harms.

Marijuana Legalization Measures

Despite the federal government's stance on marijuana, in recent years, some states have included marijuana legalization measures on voters' ballots. Rivas (2010) argues that three factors are driving the momentum behind these measures: (a) demographic factors—baby boomers who consumed marijuana in their youth, and do not share previous generations' fear of the drug; (b) economic factors that have reduced criminal justice system budgets (and, more generally, the budgets of state governments), forcing states to seek alternative revenue sources; and (c) the level of drug-related violence in Mexico.

In the fall of 2010, a marijuana legalization measure, Proposition 19 (the "Regulate, Control, and Tax Cannabis Act") was included on the ballot in the state of California (McKinley, 2010). Some political opinion polls indicated that this measure had a fairly good chance of being approved by voters, and in an interesting preemptive move, Governor Arnold Schwarzenegger signed a law just prior to the vote that made the penalty for marijuana possession in the state of California equivalent to a traffic ticket—a $100 fine and no provision for jail time. Schwarzenegger's strategy was important, because one of the primary arguments of supporters of Proposition 19 was that the state's marijuana laws were too costly to enforce and prosecute (Lagos, 2010). In opposition to this law, there were pronouncements by law enforcement officials, such as the police chief in Pleasant Hill, California, who argued "if the price drops [as was predicted if the legislation passed] more people are going to buy it. Low income people are going to buy marijuana instead of buying food, which happens with substance abusers" (as quoted in Wohlsen, 2010). Interestingly, one of the largest financial contributors to the campaign against marijuana legalization in California was the state's beer and beverage distributors, who likely believed their profits would suffer if marijuana was legalized and Californians chose marijuana (instead of alcohol) as their recreational drug. Although Proposition 19 was ultimately defeated by a margin of 56.5% opposed versus 43.5% in favor, younger voters were much more likely to support the measure, and 65% of voters in San Francisco approved it (Proposition 19, 2010).

More recently, in the fall 2012 elections, the states of Colorado, Oregon, and Washington included marijuana legalization measures on their ballots. Colorado's measure, known as Amendment 64, permitted retail stores to sell marijuana, and taxed and regulated the substance in a fashion similar to alcohol. Among the supporters of the Colorado legislation was Bruce Madison, former associate medical director at the University of Colorado School of Medicine who noted that Colorado's marijuana laws "waste millions of dollars by ruining thousands of lives by unnecessary arrest and incarceration, and [cause] the deaths of hundreds of people killed in black market criminal activities" (as quoted in Horwitz, 2012).

In the state of Washington, prior to the inclusion of the marijuana legalization measure on the 2012 ballot, Governor Christine Gregoire (as well as Rhode Island Governor Lincoln Chafee) petitioned the Drug Enforcement Administration to reclassify marijuana as a Schedule II drug, thereby recognizing its medicinal value (Martin, 2011). Washington's measure made it legal for individuals 21 years of age and older to possess up to one ounce of marijuana, and it was estimated that the state would receive approximately $500 million in taxes and licensing fees per year (Carson, 2012).

Among the supporters of the Washington legislation were several prominent politicians in the state, former federal prosecutor John McKay, Seattle's City Attorney, and its mayor and city council

(Garber & Miletich, 2011). King County Sheriff Steve Strachan, himself a former Drug Abuse Resistance Education Officer, also supported the legalization campaign, commenting, "with alcohol being highly regulated, we're able to have a more reasonable conversation about it" (as quoted in Westneat, 2012). The legalization campaign also had considerable financial backing from the Drug Policy Alliance, international travel guide Rick Steves, and Progressive Insurance founder Peter Lewis.

Although the marijuana legalization measure in the state of Oregon did not pass, voters in Colorado and Washington approved the measures (with approximately 55% in favor in both states). While President Obama, in an interview with Barbara Walters of ABC News suggested that his administration had "bigger fish to fry," and that it "would not make sense for us to see a top priority as going after recreational [marijuana] users in states that have determined that it's legal" (as quoted in Weiner, 2012), it remains to be seen how marijuana legalization is handled in the two states. There is also considerable ambiguity regarding how the laws are interpreted by state and local law enforcement and criminal justice system officials; there are also questions surrounding laws related to driving under the influence of marijuana, and drug-testing of employees, among others.

Drug Courts

An alternative to mass incarceration of drug offenders which has become increasingly popular over the last three decades, and which might be construed as consistent with harm reduction policies, is drug courts. The first ***drug court*** was established in Miami, Florida, in 1989, and as of 2011, over 2,600 drug courts exist in the United States (National Drug Court Resource Center, 2012).

Although there is considerable variation across drug court programs with respect to who is eligible and how programs are administered, compared to the traditional legal model of dealing with drug offenders, these courts are based on a "restorative justice" or "therapeutic jurisprudence" paradigm. This means that the process is less about assigning blame and punishment and more about achieving positive change in the life of the offender (Jensen & Mosher, 2006). Offenders enrolled in these courts are expected to participate in drug treatment as a condition of avoiding prison, with the understanding that sanctions (including the possibility of incarceration) may result if they do not comply with the requirements of the treatment program. Drug courts use the threat of sanctions in combination with rewards for compliance in order to keep offenders motivated to participate in treatment.

Generally, offenders in drug court programs appear more frequently in front of judges and are required to enter into an intensive treatment program; undergo frequent, random urinalysis; receive sanctions for failure to comply with program requirements; encouraged to become drug-free; and urged to develop vocational and other skills to promote reentry into the community. Most studies assessing the effectiveness of drug courts found them to be reasonably effective in reducing drug use and recidivism among those who complete the program, at least in the short term (Bahr, Harris, Strobel, & Taylor, 2012; Belenko, 2001; Shaffer, 2011). Perhaps more importantly, many studies lauded drug courts for producing substantial cost savings when compared to incarceration (Downey & Roman, 2010; Washington State Institute for Public Policy, 2002).

Despite ongoing support from many criminal justice system officials and researchers, drug courts are under increased criticism in recent years. While few doubt that drug courts represent significant improvement over strictly punitive responses to drug law violations, among other things, critics asserted that the reported high success rates of these courts is inflated and also that drug courts may serve to perpetuate existing racial and ethnic inequalities in the criminal justice system. With respect to the first issue and relying only on methodologically sound studies, two separate meta-analyses of drug court outcomes found

reductions in recidivism of drug court completers, but the reductions were only 9% (Shaffer, 2011) and 12% (Mitchell, Wilson, Eggers, & Mackenzie, 2012) respectively. Clearly, this is much less than the 75% reduction in recidivism claimed by the National Association of Drug Court Professionals (www.NADCP.org).

In addition, there is mounting evidence of class, gender, and racial/ethnic biases becoming further institutionalized as a result of inequities found in drug courts. Research suggests that these programs may reproduce class stratification, as individuals who are unemployed or undereducated are less likely to complete drug court programs (Brown, 2010), and individuals with already limited financial resources and employment opportunities are further burdened by the intensive reporting and transportation requirements (Drug Policy Alliance, 2011). Racial and ethnic disparities have also been reported. African Americans are less likely to complete drug court programs (Brown, Zuelsdorff, & Gassman, 2009; McKean & Warren-Gordon, 2011), and non-White graduates of juvenile drug courts do not experience the same recidivism benefits as Whites (Carter & Barker, 2011). A shortage of culturally sensitive programming for people of color has also been noted (Justice Policy Institute, 2011a), as well as a reduced likelihood of being admitted to drug courts and evidence of more severe sanctioning of minorities for rule violations (McKean & Warren-Gordon, 2011).

Critics of drug courts also examined their larger impacts in terms of "net-widening" and "mesh-tightening." ***Net-widening*** refers to the broadening of criminal justice system influence as an increasing number of individuals are brought into the system. According to some researchers, the benevolent intentions attached to the belief that all drug users need treatment has contributed to a growth in drug arrests and drug prosecutions (Gardiner, 2008; Hoffman, 1999). A ***mesh-tightening*** effect may also be created by the increased formality and intensive monitoring of drug court clients, making it more difficult for them to exit the criminal justice system once they are enrolled in a drug court program. Drug court clients are more closely scrutinized than traditional probationers (particularly with respect to frequent drug testing), leading officials to discover and sanction minor offenses that may have previously gone unnoticed, or were ignored. In short, while it is once again important to emphasize that drug courts generally represent a less costly and more humane approach to dealing with drug offenders than incarceration, they do not appear to be the panacea that some credited.

Race, Gender, and Class Implications of Drug Policies in the United States

The consequences of U.S. drug policies extend beyond the incarceration of hundreds of thousands of individuals—these policies also contribute to, and often exacerbate, existing racial/ethnic and social inequalities. For example, members of racial/ethnic minority groups constitute more than 75% of federal drug inmates (Bureau of Prisons Quick Facts, 2010) and more than 80% at the state level (Mauer, 2009). African Americans are the most disproportionately incarcerated group, representing 49% of those incarcerated for drug offenses in 2010, but only 13% of the total population (Guerino, Harrison, & Sabol, 2011). African Americans are disproportionately incarcerated for drug offenses in 97% of the largest counties (Beatty, Petteruti, & Ziedenberg, 2007) and compared to Whites are at least twice as likely to receive a sentence of incarceration for drug convictions in every state.

Although the disproportions are not as great, Hispanic Americans comprise 16% of the U.S. population, but 21.6% of those incarcerated for drug offenses (Guerino et al., 2011). Although limited data exist to make such comparisons, Native Americans are imprisoned for drug offenses at rates higher than Whites

in states where they comprise a significant proportion of the population, such as Washington state (Lee & Vukich, 2001) and Montana (Ross, 1998), and this is also true of the native Hawaiians in Hawaii (Thompson, 2010).

Data on class biases in incarceration for drug offenses are more difficult to obtain, but it is notable that as drug incarceration rates peaked in the mid-1990s, more than half of state and federal prisoners had annual incomes of less than $10,000 and one-fifth made less than $3,000 (Reiman, 1998). States with higher poverty rates tend to have higher incarceration rates (Beckett & Western, 2001), and counties with higher rates of unemployment and poverty were found to imprison drug offenders at higher rates (Beatty et al., 2007).

While the majority of imprisoned drug offenders are male, the growth in incarceration for drug offenses is also unevenly felt by women. During the most recent war on drugs, the relative growth in the number of women in prison for drug offenses was even greater than for males (Mauer & King, 2007)—as of 2005, 29% of incarcerated women had committed drug offenses, compared with 19% of men (Harrison & Beck, 2005). Additionally, two-thirds of women imprisoned for drug crimes have children under the age of 18 (Mumola, 2000).

Particularly affected have been women of color, who have much higher rates of incarceration for drug offenses than White women (Lapidus et al., 2005). In the state of New York, for example, women of minority backgrounds comprise 91% of those incarcerated for drug offenses, but only 32% of the population (Lapidus et al., 2005). Similarly, in California, women of color represent 54% of drug prisoners and 38% of the population. There are also intersections of class and race—37% of women in prison for drug offenses in the late 1990s earned less than $600 per month, and 30% received public assistance (Greenfield & Snell, 2000).

Although Mauer (2009) noted that as of the mid-2000s, racial disparities in incarceration for drug law violations were declining and he concluded, "While these trends are welcome as a possible indication of a change in policy and practice, they need to be tempered by an assessment of the overall scale of imprisonment and punishment" (p. 19). He also speculated that because so many African Americans have already been incarcerated, there are fewer Blacks on the streets to arrest (Fears, 2009). Race, class, and gender implications are further explored below as unintended consequences of our drug criminalization policies.

Unintended Consequences of U.S. Drug Criminalization Policies

A number of additional federal and state policies containing drug-offense penalties and restrictions were enacted over the past 20 years that extend the impacts of the drug war into other social realms. Such policies have not only led to unintended consequences for society in general, but these effects further exacerbated racial and social class disparities. In 1996, welfare reform legislation (the Personal Responsibility and Work Opportunities Reconciliation Act), denied, for life, federal welfare benefits to any individual convicted of a felony drug offense, including access to food stamps and temporary aid to needy families (Schwartz, 2002). It is important to note that this provision does not apply to individuals who commit murder, rape, and other serious crimes. The law also allowed states to require drug and alcohol testing of anyone seeking welfare. As of 2002, more than 92,000 women were denied access to welfare as a result of felony drug convictions (Kirkorian, 2002) and the legislation resulted in even more deleterious effects on women of color (Allard, 2002). While it is encouraging to note that a number of states recognize

the problems associated with this policy and use the option to not enforce these Welfare Reform Act provisions, the fact that these laws are in place at the federal level and that close to half the states continue to enforce them is cause for concern. Additionally, as of 2011, 31 states and Congress were considering legislation to require ongoing drug testing of welfare and food stamp recipients, despite evidence that testing does not deter drug use (Office of the Assistant Secretary for Planning and Evaluation, 2011).

Public housing eligibility is also impacted by drug war legislation. Under the 1988 Anti-Drug Abuse Act, public housing agencies were required to evict tenants if the tenant, a member of their own family, or guests were involved in "drug-related crimes"—these laws potentially affect the more than three million residents of federally funded housing in the United States. Similarly, under the "One-Strike" initiative within the 1996 federal welfare reform legislation, local public housing authorities were given access to background checks on applicants, and were able to deny housing or evict tenants for any involvement in illegal drug use or sales. Clearly, these public housing policies target poor (and often minority) urban individuals and contribute to the discriminatory impacts of the drug war.

Under provisions of the 1998 Higher Education Act, individuals applying for federal financial aid are required to answer a question regarding their prior drug convictions. If applicants indicate they have a conviction for a drug offense, or if they refuse to answer the question, they are sent a follow-up questionnaire that asks them to provide information on the type and number of drug convictions they have, as well as the date the convictions occurred (Students for Sensible Drug Policy, 2006). Individuals who indicate they have a conviction for a drug offense, including possession of marijuana, or who refuse to answer the question can be denied federal student aid.

Students for Sensible Drug Policy (2006) estimated that since the drug conviction question was added to federal student aid applications in the 2001–2002 school year, 189,065 applicants (approximately one in every 400) had their requests for financial aid denied because of their answers to this question. Davenport-Hines (2001) notes that this law, similar to other drug legislation in the United States, has a disproportionately negative impact on the poor and members of minority groups. Similarly, a *New York Times* editorial commented, "By narrowing access to affordable education, the federal government further diminishes the prospects of young people who are already at risk of becoming lifetime burdens to society. . . . It doesn't take a genius to see that barring young offenders from college leads to more crime, not less" (Cutting College Aid, 2005).

Collectively, the drug-related welfare, public housing, and education laws (among others) provide for lifelong penalties that amplify the impacts of drug convictions. Both the welfare and student aid laws ultimately serve to further reduce employment opportunities (that are already severely limited) for ex-offenders, increasing the likelihood that they will be forced into the secondary labor market or illicit employment. As a result of these laws, ex-offenders (and particularly people of color) experience difficulties in finding affordable housing. By indirectly penalizing family members of those convicted of nonviolent drug offenses, future generations are also negatively impacted due to the connection between stable family environments and children's future educational attainment (Allard, 2002).

As of 2010, 12 states also had disenfranchisement statutes that disqualify individuals convicted of (drug and other) felony offenses from voting, even after such individuals served their sentences (Sentencing Project, 2010). With a significant proportion of felony convictions in recent decades stemming from the drug war, the concentration of drug convictions in poor and minority communities further exacerbates existing disadvantages by reducing the opportunity to effect political change. Estimates suggest that 1.4 million African American males (13%) are currently disenfranchised, and it is projected that 30% of African American males will lose voting rights at some point in their life, and 40% will lose these rights permanently in certain states (Sentencing Project, 2010).

The discussion of specific drug and ancillary legislation above leaves little doubt that in the United States, the criminalization approach to drugs and the attendant drug war has a significant impact for both the criminal justice system as well as society as a whole. There is also virtually no scientific evidence to suggest that these laws have been effective in their apparent goals of reducing drug use in American society. What we do know is that these laws have disproportionately impacted the poor and members of minority groups in ways that were never intended.

What Research Has Taught Us: Outcomes Associated With Less Punitive Drug Policies

Several other countries (and a handful of states in the United States) adopted drug control policies that diverge from a strict criminalization model. Although care must be taken when making cross-national comparisons, research on these "policy experiments" can inform us about what works and what does not work in drug policy. In general, in countries following a shift to less punitive forms of drug policy (the "sky did not fall" approach),the rates of drug use did not substantially increase, and in some cases drug use even declined (see, for example, EMCDDA, European Monitoring Centre for Drugs and Drug Addiction, 2011). Next, we provide a short summary of some of the most notable "drug policy experiments" and the research related to these policies.

Among the most well-known examples of a country with more permissive drug policies is the Netherlands. Since 1976, the Dutch have employed a policy of de facto legalization for marijuana (there is a misconception that marijuana is legalized in the Netherlands, but this is not the case). The Dutch legislation is based on the principle of the separation of markets for soft (cannabis) and hard (heroin, cocaine, amphetamines, etc.) drugs in order to prevent users from entering the criminal underworld (EMCDDA, 2009). As of the early 2000s, estimates suggested that there were between 1,200 and 1,500 "coffee shops" (about one per 1,200 inhabitants) in the Netherlands that sold cannabis products. Most of these establishments offer a variety of marijuana and hashish with varying potency levels, and the typical coffee shop menu lists from five to 20 different varieties of cannabis, as well as coffee, teas, and baked goods that contain the substance (Reid, 2002). Thus, marijuana consumption is tolerated, provided that coffee shop proprietors abide by a number of regulations. These include that sales must be limited to five grams of marijuana per person, per visit; that no hard drugs are sold in the establishments; that the coffee shops do not advertise drugs; that there is no community nuisance created by their presence; that the shops sell marijuana only to adults; and that the coffee shops do not stock more than 500 grams of cannabis (Netherlands Ministry of Health, 2003). Growing or importing marijuana remains illegal in the Netherlands, so coffee shop proprietors risk legal sanctions when obtaining the drugs (this is the so-called "front door, back door problem"—that is, what happens at the front door is legal, what happens at the back door is not).

It is notable that rates of current marijuana use in the Netherlands remain below marijuana use rates in the United States, and below use rates of many other European countries, including those with more punitive cannabis policies. Rates of marijuana consumption in the Netherlands are comparable to those of adjacent countries, such as Belgium and Germany, and are considerably lower than in Britain, France, and Spain (Blickman & Jelsma, 2009). It is important to note, however, that despite perceptions that they are ubiquitous in the Netherlands, the number of coffee shops selling cannabis has steadily declined from a peak of approximately 1,500 in the mid-1990s to 702 in 2008 (Blickman & Jelsma, 2009). And, in December of 2008 (and despite the fact that 80% of Dutch citizens were opposed (Treble, 2008), Dutch

officials announced that at least one-fifth of the remaining marijuana cafes in the country would be forced to close. The legislation forced the coffee shops to become members-only clubs and to close those that were located near schools (Pignal, 2010).

Perhaps more importantly, given allegations that marijuana is a "***gateway drug,***" by definition a drug that opens the door to the use of other, harder drugs, the Netherlands has comparatively lower rates of cocaine, heroin, and amphetamine use (MacCoun, 2011). Dutch officials claim that this is at least partially attributable to their practice of allowing quasi-legal access to marijuana (by far, the most commonly used illegal drug) and thus creating a social barrier between the cannabis and hard drug markets (Zimmer & Morgan, 1997).

While certainly known for their liberal policies on marijuana, the Dutch have also adopted harm reduction approaches for other substances. They offer support and assistance to heroin users in the country, with the result that the average age of heroin users increased from approximately 25 in the late 1970s to 36 in the late 1990s (Gray, 1999). Over the same period, the average age of heroin users in the United States declined from 25 to 19. The Dutch have also taken steps to reduce the harm associated with ecstasy (MDMA) use. Although MDMA is still illegal and classified as a hard drug in the Netherlands, ecstasy users can take their pills to drug treatment centers to have the chemical contents analyzed (Richburg, 2001). This program provides ecstasy users with information regarding the effects they can expect from consuming the substance and has the additional advantage of providing public health officials with current information regarding what types of ecstasy are on the market and a profile of users (Cumming, 2004).

Over the past decade, several other European countries loosened penalties on illegal drugs and several decriminalized a wide range of substances. The most sweeping reforms were made in Portugal, which in 2001 decriminalized not just marijuana possession, but possession of *all* drugs for personal use. In 1999, Portugal had the highest rate of drug-related deaths in the European Union, and approximately 100,000 people (nearly one percent of the population) were heroin addicts (Specter, 2011). Under the 2001 legislation, the use and possession of drugs do not constitute criminal offenses, but instead are treated as "administrative offenses" (van het Loo, van Beusekom, & Kahan, 2002). In Portugal, individuals found possessing small quantities of drugs and who the police believe are not involved in more serious offenses like drug trafficking appear before a panel consisting of a doctor, social worker, and lawyer. While these commissions can impose sanctions on users, the main objective is to "explore the need for treatment and to promote healthy recovery" (EMCDDA, 2004).

Treatment and prevention methods became the primary focus of drug policy in Portugal, expanding and incorporating evidence-based practices. In addition, safe injection facilities and needle exchanges were established in many areas where drug problems were concentrated; methadone substitution therapy became the norm for those with opiate addiction; doctors and pharmacies began providing safe access to methadone and heroin maintenance doses; and healthcare professionals were employed to make regular visits to problem areas.

Evaluations of the Portuguese approach to drug regulation have generally been positive, indicating that the country is experiencing reductions in drug use (problematic and otherwise), crime, and drug-related deaths. The most comprehensive analysis of the Portuguese experiment is provided by a report written in 2009 by Glenn Greenwald for the CATO Institute, a Washington-based think tank. Greenwald notes, "judged by virtually every metric, the Portuguese decriminalization framework has been a resounding success" (p. 1). In 2001, Portugal experienced close to 400 drug-related deaths, the majority of these from opiate overdoses (Hughes & Stevens, 2012). However, in 2009, there were only 54 drug-related deaths

in the country (EMCDDA, 2011). In addition, the rate of Hepatitis-C among intravenous drug users was 29% in 2009, among the lowest rates in all of Europe (United Nations Office on Drugs and Crime (UNODC), 2011); the number of new HIV cases dropped from nearly 1,400 in 2000 to fewer than 400 in 2006 (Greenwald, 2009), and the number of people seeking drug treatment more than doubled (Szalavitz, 2009).

Perhaps most importantly in the context of evaluating the Portuguese approach, several studies have found that, despite predictions to the contrary, there is little evidence to suggest that drug use in Portugal has increased (Greenwald 2009; Hughes & Stevens, 2012). Although data on past-year drug use indicate that the percentage of Portuguese citizens using drugs increased slightly (from 3.4% in 2001 to 3.7% in 2007 (Hughes & Stevens, 2010), only 16% of Portuguese students reported lifetime use of marijuana in a 2007 survey (European School Survey Project on Alcohol and Other Drugs (ESPAD), 2011). Also, lifetime use of heroin declined from 2.6% to 1.8% between 2001 and 2006 (Hughes & Stevens, 2012).

An additional example of successful harm reduction drug control strategies comes from Canada. Although, similar to the United States, Canada has a long history of stringent drug policies with a criminal justice focus (in fact, Canada's first drug legislation, the Opium and Narcotic Drug Act, was passed in 1908, predating the U.S. Harrison Narcotics Act by six years (Mosher, 1999)), although in the early 2000s, there were indications that Canada was moving toward policies based on harm reduction principles. For example, regulations that came into effect in Canada in 2001 allowed certain individuals access to medical marijuana; a special committee of the Canadian Senate recommended the legalization of cannabis possession and use in 2002 (Canada, 2002); and there were also indications in the early 2000s that in some jurisdictions, at least, marijuana had been de facto decriminalized (i.e., law enforcement officials tolerated and did not arrest users of the substance) (Mosher & Akins 2007).

In addition to the developments surrounding marijuana, some Canadian jurisdictions adopted harm reduction policies in order to address problems related to intravenous drug use. In the early 2000s, the city of Vancouver, British Columbia, had an estimated 12,000 intravenous drug users in a population of 1.3 million, and more than 4,500 of these users lived in a 12-block section of the city known as the downtown eastside. This area had a drug overdose rate that was five times higher than any other Canadian city, and the highest HIV infection rate of any jurisdiction in the Western world. More than 1,000 drug users died in this area over the course of a decade, with 416 overdose deaths in 1998 alone (Glionna, 2003). In response to this situation, Vancouver implemented a "four pillars" approach to drug issues—focusing on treatment, prevention, enforcement, and harm reduction—and established a safe drug injection facility (known as "Insite") for intravenous drug users (Mulgrew, 2007).

An evaluation of the first year of operation of this facility revealed that there were approximately 600 visits a day, and although there were more than 1,000 overdose cases, none were fatal. This study also found that the site led to reductions in the number of people injecting drugs in public in the downtown eastside of Vancouver, as well as fewer discarded syringes and less injection-related litter in the area (British Columbia Center for Excellence in HIV/AIDS, 2004; see also Wood et al., 2007). Participation in the safe injection facility was also associated with a 30% increase of entry into drug detoxification programs (Strathdee & Pollini, 2007), and a study published in the *Canadian Medical Journal* (Bayoumi & Zaric, 2008) estimated that Insite would save the province of British Columbia $14 million and prevent 1,000 HIV infections over a 10-year period. Several other more recent evaluations of this safe injection facility reported similarly positive results (Beyrer, 2011; Marshall, Milloy, Wood, Montaner, & Kerr, 2011; Pinkerton, 2010).

In addition to the Vancouver safe injection site, a special Canadian House of Commons committee on drug issues supported the creation of federally approved safe injection sites for hardcore users of heroin

or cocaine, the expansion of methadone maintenance programs, and needle exchange programs (MacCharles, 2002). In response to the recommendations of this House of Commons report, Canada initiated a heroin maintenance study in 2003, the first of its kind implemented in North America. Under this program, which was initiated in the major metropolitan cities of Vancouver, Toronto, and Montreal, 80 heroin addicts in each city received free heroin and were able to inject the drug up to three times per day at a drug treatment center. Addicts also received counseling at the end of the first year and were to be weaned off heroin, or offered methadone withdrawal and counseling for an additional year (Carey, 2003). Evaluations of this program found that participating addicts experienced improved physical and mental health, and committed fewer crimes (Smith, 2009)[3].

Although space restrictions do not permit a complete accounting of these developments, drug policy discussions in several other European countries, including Britain, Germany, Spain, and in Australia and New Zealand emphasized harm reduction approaches, and several of these countries adopted certain aspects of the larger harm reduction philosophies. The harm reduction dialogue is also becoming increasingly prominent in Central and South American countries. For example, in 2009, the Latin American Commission on Drugs and Democracy, led by former Brazilian president Fernando Henrique Cardoso (and including former presidents Ernesto Zedillo of Mexico and Cesar Gaviria of Colombia) published a report which referred to the drug war led by the United States as a "failed war" and recommended that governments consider alternatives, including the decriminalization of marijuana (de Cordoba, 2009). Cardoso, Gaviria, and Zedillo also published an editorial in the *Wall Street Journal* in which they argued:

> In order to drastically reduce the harm caused by narcotics, the long-term solution is to reduce the demand for drugs in the main consumer countries . . . We must start by changing the status of addicts from drug buyers in the illegal market to patients cared for by the public health system. . . . By treating consumption as a matter of public health, we will enable police to focus their efforts on the critical issue: the fight against organized crime. (February 23, 2009)

More recently, the 2011 Global Commission on Drugs, whose members included the former presidents of Mexico, Brazil, and Columbia, the Prime Minister of Greece, former United Nations Secretary Kofi Annan, former U.S. Secretary of State George Schultz, and British billionaire Richard Branson, among others, called for radical changes in drug policy. The commission noted that its starting point was a recognition that the global drug problem is "a set of interlinked health and social problems to be managed rather than a war to be won" (2011, p. 4). The Commission report argued that drug policies should be guided by the following principles: (a) drug policies should be based on solid empirical and scientific evidence, and (b) drug policies must be based on human rights and public health principles.

Data from the drug policy experiments and developments discussed above (and those in other nations) suggest that less punitive drug control policy is a viable alternative to a strict criminalization model. Patterns of drug use do not appear to increase significantly following a shift to a less punitive approach, and may even decrease, particularly for hard drugs. There are also a number of ancillary benefits to users' health status, treatment participation, and reduced law enforcement and criminal justice system expenditures.

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[3] While the developments described above indicate a move toward harm reduction drug policies in Canada, it is important to note that there is by no means consensus that drug policies in Canada should be softened. In particular, the current Canadian conservative federal government has attempted to shut down (unsuccessfully) the Insite safe injection facility and has proposed more severe penalties for some drug and drug-related crimes (MacQueen, 2010).

How Do We Fix It: Recent Developments in United States Drug Policies

A study by the National Center on Addiction and Substance Abuse (2009) estimated that in 2005, federal, state, and local governments spent at least $467.7 billion (combined) responding to substance abuse and addiction, which represents close to 11% of their (combined) $4.4 trillion budgets. The study also estimated that of every dollar spent by federal and state governments in 2005, only 1.9 cents was spent on prevention and treatment, 1.4 cents on taxation and regulation, 0.7 cents on interdiction of drugs, and 0.4 cents on drug-related research. The remaining funds were devoted to "shoveling up the wreckage", with health care costs totaling $207.2 billion and $47 billion on criminal justice system expenditures. The report noted that "the federal government spends more than 30 times as much to cope with the health consequences of addiction as it spends on prevention, treatment, and research" (p. 3). The key question is, how can we move beyond our costly, ineffective, and harmful policies toward drugs?

Bruce Alexander (1990) noted that one of the primary reasons drug policies are ineffective, and in many cases counterproductive, is that they are typically determined by national/federal law. He argued that one possible avenue to more rational and progressive drug regulations is for such laws to be "as local as possible" (p. 293). The policies allowing for medical use of marijuana in 19 states and the District of Columbia and recent developments in several states toward the legalization of marijuana suggest that many states are rethinking their severe policies toward drugs. While part of the impetus for these changes is related to a growing recognition that drug treatment can be effective, a number of states moved to relax their policies as a result of the costs associated with incarcerating large numbers of drug offenders.

Treatment in Lieu of Incarceration Laws

The state of California, which passed Proposition 215 (The Compassionate Use Act) allowing for the use of medical marijuana in 1996, also passed Proposition 36 (The Substance Use and Crime Prevention Act) in 2000. This legislation allowed individuals convicted of their first and second nonviolent drug possession offenses the option of participating in drug treatment instead of being incarcerated. The law also allowed offenders on probation or parole for certain offenses and after violations of drug-related provisions of their probation or parole to receive treatment in lieu of incarceration (Uelmen, Abrahamson, Appel, Cox, & Taylor, 2002). Individuals convicted of drug trafficking or other felony offenses were not eligible for this program. Although there have been some negative consequences associated with this legislation, in its first year of operation, Proposition 36 was estimated to have saved the state of California $275 million (Haake, 2003).

Sentencing Reductions

In recent years, there has been progress in reducing or eliminating some of the "tough on crime" sentencing practices that dominated the criminal justice system and resulted in significant changes to sentencing practices. In 2002, the state of Washington passed legislation that reduced by six months the 21- to 27-month mandatory minimum sentence for first-time convictions for trafficking in heroin and cocaine, and also eliminated the "triple-scoring" sentences for nonviolent drug offenders. This law was projected to save Washington state $45 million per year, with the money saved as a result of reductions in the length of sentences being devoted to funding drug courts in the state.

Also in Seattle, Washington, a 2003 ballot initiative required police to make marijuana possession their lowest law enforcement priority. Although (then) federal drug czar John Walters expressed opposition to this law, (then) Seattle Police Chief (and current drug czar in the Obama administration) Gil Kerlikowske, commented:

> The one thing that is pretty clear here is that there's strong recognition that the drug issues and the drug problem are not just a law enforcement or criminal justice problem . . . Just arresting the same people, putting handcuffs on the same people, makes no sense. (as quoted in Pope, 2003)

In 1973, the state of New York enacted legislation (known as the Rockefeller drug laws) that created mandatory minimum sentences of 15 years to life for possession of four ounces of drugs (this penalty was equivalent to the penalty for second degree murder in the state of New York). Similar to the federal drug legislation discussed above, these laws disproportionately affected African Americans (and to a lesser extent, Hispanics) and led to high levels of incarceration in the state of New York. After considerable opposition to these laws in the late 1990s and 2000s, New York Governor David Paterson in 2009 admitted that the laws were counterproductive and revised them. Under the revisions, mandatory minimum sentences for drug laws were removed, and judges were allowed to sentence drug offenders to shorter terms of incarceration, and also to order substance abusers to enter drug treatment programs in lieu of prison (Davis, 2012). Importantly, the changes in the New York legislation were retroactive, allowing more than 1,000 prisoners to apply to be resentenced (Canfield, 2009). It was estimated that the repeal of the Rockefeller drug laws would save the state of New York approximately $250 million per year, primarily in reduced incarceration costs (Hastings, 2009).

In 1995, the Sentencing Commission unanimously recommended to Congress that the 100 to 1 ratio between powder and crack cocaine for the purposes of sentencing be reduced to one to one. However, these recommendations were rejected by Congress and President Clinton. It wasn't until 2010 under the Obama administration that the ***Fair Sentencing Act*** was passed. Under this legislation, the gap between crack and powder cocaine sentencing ratios were narrowed from 100 to 1 to 18 to 1 (Douglas, 2010). Prior to the passage of this legislation, former Republican Congressman J. C. Watts and former Congressman and former head of the Drug Enforcement Administration Asa Hutchinson wrote an editorial in the *Washington Post* calling for the attorney general to change the law; earlier, Hutchinson implied that changing the federal crack cocaine law would flood the streets of the United States with violent felons. Watts and Hutchinson argued, "The truth is that for years our legal system has enforced an unfair approach to sentencing federal crack offenders. . . . it makes no sense that somebody arrested for a crack cocaine offense should receive a substantially longer prison term than somebody who is convicted of a powder cocaine offense" (Watts & Hutchinson, 2008). In defending the eventual change in this legislation, and acknowledging the harm done by the crack/powder cocaine distinction, Attorney General Eric Holder concurred with Watts and Hutchinson and commented, "There is simply no logical reason why their [crack cocaine users/traffickers] sentences should be more severe than those of other cocaine offenders" (as quoted in Serrano, Savage, & Williams, 2011). Under the change in this legislation, an estimated 12,000 federal prisoners, the vast majority of whom were from racial minority groups, were eligible for sentence reductions, with an average reduction of approximately three years (Schwartz, 2011). While this change should be viewed as a positive development in the larger context of drug policy, a federal appeals court judge in Chicago, noting that the disparity between crack and powder cocaine had not been completely eliminated, commented that the Act was misnamed, suggesting that instead it should have been called "the not quite as fair as it could be sentencing act" (as quoted in Liptak, 2011).

And, as Michelle Alexander (2010) comments, "merely reducing sentence length, by itself, does not disturb the basic architecture of the new Jim Crow" (p.14).

Conclusion

While, as noted above, many Western nations address drug use as primarily public health issues and have implemented harm reduction policies to address substance use and abuse, the United States has a long history of dealing with drug problems through the criminal justice system. There is little evidence to suggest that criminal justice system responses to drug use are effective in reducing such use, and these policies simultaneously create a number of social and economic problems. The most problematic consequences of these policies are that they contribute significantly to unprecedented levels of incarceration in the United States and disproportionately impact members of minority groups and the lower social classes.

A 1997 publication from the Office of National Drug Control Policy asserted "the foremost objective of the Office of National Drug Control Policy is to create a national drug control strategy based on science rather than ideology" (p. 1). Similar sentiment was echoed in the 2012 National Drug Control Policy statement, which noted that the federal government's strategy to reduce drug use and its consequences would be based on a "collaborative, balanced, and science-based approach" (ONDCP, 2012, p. 1). In light of the policies and activities of the federal government with respect to drugs as reviewed above, this assertion needs to be questioned.

For many countries, the shift to a set of drug policies based on harm reduction principles transpired in recognition of the substantial challenges and costs, both social and financial, that accompany drug criminalization and their stringent enforcement. Throughout this chapter, we emphasized the challenges facing countries that adopted such policies. Conversely, harm reduction advocates emphasize policies that consider and attempt to balance the damage done by the *response* to drug use against the harms of drug use *per se*. As an analogy, Hunt (2005) urges us to consider the regulation of automobile use. He notes that although there are many hazards associated with driving—including considerable environmental damage, injuries, and deaths—elimination of driving is clearly not a realistic strategy. Instead, countries have enacted laws on speed limits, the control of vehicle emissions, and seat belt and other safety devices as harm reduction strategies to reduce the risks associated with the use of automobiles. Harm reduction policies involve similar goals for drug use.

Finally, while the passage of laws allowing for the medical use of marijuana, marijuana legalization measures, and the more general softening of drug policies in individual states may portend larger changes in drug policies in the United States, it appears as though the federal government feels as though such policies represent a threat to federal hegemony in the drug policy arena.

KEY TERMS

Criminalization
Decriminalization
De facto legalization
Depenalization
Drug court
Drug policy
Fair Sentencing Act
Gateway drug
Harm reduction
Legalization
Mandatory minimum sentencing
Mesh-tightening
Net-widening

DISCUSSION QUESTIONS

1. Discuss the key distinctions between forms of drug policy (criminalization, de facto legalization, decriminalization, legalization, harm reduction). What is the dominant form of drug policy in the United States?
2. Discuss racial disparities in the application/enforcement of drug laws in the United States. Why do these disparities exist (and persist)?
3. There are indications that U.S. drug policies may be "softening." Discuss the reasons for this, and examine recent developments in drug policies in your state.

WEBSITES FOR ADDITIONAL RESEARCH

Office of National Drug Policy: http://www.whitehouse.gov/ondcp

National Institute on Drug Abuse: http://www.drugabuse.gov/related-topics/criminal-justice-drug-abuse

UCLA Integrated Substance Abuse Programs: http://www.uclaisap.org/

Drug Policy Alliance: http://www.drugpolicy.org/

Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov/

RAND Drug Policy Research Center: http://www.rand.org/multi/dprc.html

Bureau of Alcohol, Tobacco, Firearms and Explosives: http://www.atf.gov/

National Drug Research Institute (Australia): http://ndri.curtin.edu.au/

UK Drug Policy Commission (UK): http://www.ukdpc.org.uk/

Alcohol and Drug Findings (UK): http://findings.org.uk/aboutDAF.htm