

Effective Drug Control: Toward A New Legal Framework

***State-Level Regulation as a
Workable Alternative to the “War on Drugs”***

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Drug Policy Project**

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- 1) Should young persons be legally prohibited from possessing and consuming psychoactive substances?**
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RESOLUTION

State Regulation and Control of Psychoactive Substances

The King County Bar Association, together with a coalition of professional and civic organizations, has been examining a public health approach to the chronic societal problem of substance abuse and encouraging public investment in research, education, prevention and treatment as a more effective alternative to the use of criminal sanctions.

The King County Bar Association has concluded, in consideration of the findings enumerated below, that the establishment of a new legal framework of state-level regulatory control over psychoactive substances, intended to render the illegal markets for such substances unprofitable, to restrict access to psychoactive substances by young persons and to provide prompt health care and essential services to persons suffering from chemical dependency and addiction, will better serve the objectives of reducing crime, improving public order, enhancing public health, protecting children and wisely using scarce public resources, than current drug policies.

Therefore, the King County Bar Association resolves that:

The Washington State Legislature should establish a special consultative body, composed of experts in pharmacology, education, medicine, public health, law and law enforcement, as well as public officials and civic leaders, including delegates from the leadership of each caucus in the House and Senate, to provide specific recommendations for legislation to establish regulatory systems and structures for the State of Washington to control psychoactive substances that are currently produced and distributed exclusively through illegal markets, including the regulation of manufacturing, transportation, storage, purity and product safety, limitations on sale and other transfer, labeling, pricing and taxation, requirements of medical supervision, limits on advertising, and the civil and criminal enforcement of such regulations, as set forth more fully below.

The King County Bar Association transmits this resolution to the Washington State Legislature, urging the establishment of a special consultative body as provided and for the purposes stated in this resolution.

ADOPTED this 19th day of January, 2005.

The Coalition and Its Task Forces and Committees

The coalition includes the King County Medical Society, the Church Council of Greater Seattle, the Loren Miller Bar Association, the Municipal League of King County, the Seattle League of Women Voters, the Washington Academy of Family Physicians, the Washington Association of Addiction Programs, the Washington Osteopathic Medical Association, Washington Physicians for Social Responsibility, the Washington Society of Addiction Medicine, the Washington State Bar Association, the Washington State Medical Association, the Washington State Pharmacy Association, the Washington State Psychiatric Association, the Washington State Psychological Association and the Washington State Public Health Association.

The coalition has established over a dozen task forces and committees comprising hundreds of participants, including lawyers, judges, doctors, pharmacists, law enforcement officers, elected and appointed public officials, health care professionals, drug treatment specialists, scholars, educators, leaders of civic organizations and others who, together with full-time professional staff, have spent thousands of hours over three years investigating and analyzing the problems arising from the prohibited use and sale of certain psychoactive substances, especially the problems arising from the operation of the illegal markets in which such substances are exclusively produced and distributed.

Findings and Conclusions

The task forces and committees have concluded that current drug control policies are fundamentally flawed and that the unrelenting demand for prohibited psychoactive substances has fostered and strengthened highly profitable illegal markets for the production and distribution of such substances; and that the operation of such illegal markets is a proximate cause of devastating societal impacts, including:

1. Rates of prohibited substance use and of crime related to prohibited substances that have failed to decline or have actually increased during the current period of intensified law enforcement and incarceration, including children experimenting with more dangerous substances at younger ages;
2. Soaring public costs on the federal, state and local levels arising from the continued use of harsh criminal sanctions related to prohibited psychoactive substances, contributing to the overcrowding of jails and prisons and draining public coffers of the resources needed for investment in local communities and for the provision of essential services;

3. Impaired administration of justice from the continuous flow of drug cases clogging the courts and causing undue and sometimes prejudicial delays in the investigation and prosecution of non-drug-related criminal matters and in the processing of civil matters;
4. Undermining of public health, including the transmission of blood-borne diseases, the uncontrolled distribution of impure and hazardous substances, and the development of high-potency, synthetic substances that are more easily concealed but are more harmful to health, as well as the inhibition of users of prohibited substances from seeking medical attention for chemical dependency and addiction;
5. Disproportionate arrest and incarceration of ethnic minorities and the poor, causing the disruption of families and the interference with or denial of educational, employment and housing opportunities, and exacerbating the social conditions that are associated with chemical dependency and addiction;
6. Compromises in the protection of citizens' constitutional rights as a result of stepped-up law enforcement and penalties related to prohibited substances, impinging upon individual privacy rights and depriving persons convicted of drug offenses of the right to vote and other civil rights; and
7. Loss of respect for the law arising from public sentiments that the dangers of certain prohibited substances are overstated, that drug-related penalties are unjust and that coercing abstinence through the use of criminal sanctions is a futile public objective.

Subjects to Be Considered by Consultative Body

1. The prohibition of and sanctions for the unlicensed manufacture of state-controlled psychoactive substances;
2. The prohibition of and sanctions for the distribution or delivery of state-controlled psychoactive substances by or to unauthorized persons;
3. The establishment of age-related restrictions on availability;
4. The determination of the degree to which state-controlled substances may be made available to authorized recipients and in what forms, concentrations and quantities;
5. The determination of the degree to which medical supervision or other restrictions may be necessary to minimize the harm associated with the misuse of such substances;

6. The regulation of state-licensed facilities for state-controlled substances to eliminate incentives to promote the use of such substances or to divert them into an illegal market;
7. The prohibition or limitation of the display and use of state-controlled substances in some or all public places;
8. The prohibition or strict limitation of any commercial advertising or promotion of state-controlled substances, to the extent permitted by the First Amendment, and the promotion of publicly sponsored counter-advertisement to educate the public about the risks and potential harms from the use of such substances;
9. The provision of current, scientifically-based information to recipients of state-controlled substances, including counseling about the particular risks and adverse effects of the use of any such substance and about the availability of treatment for chemical dependency or addiction;
10. The dedication of net proceeds from the sale of state-controlled substances, and of net proceeds from the collection of civil and criminal penalties, for use by the State of Washington to invest in substance abuse prevention, treatment, research and education programs;
11. Pricing structures for state-controlled substances that compensate the state for the administration of the regulatory framework and that maximize funding for prevention, treatment, research and education, while maintaining price levels low enough to render any illegal markets for such substances unprofitable but high enough to deter consumption, especially by young persons; and
12. Provisions for ongoing regulatory oversight, civil and criminal enforcement, and legislative advice by the state agency or agencies charged with regulating state-controlled substances.

– END –

INTRODUCTION

The King County Bar Association, through its Drug Policy Project, has been promoting a public health approach to the chronic societal problem of substance abuse, stressing the need to shift resources into research, education, prevention and treatment as an alternative to the continued use of criminal sanctions, which has proven to be a relatively expensive, ineffective and inhumane approach to reduce the harms of psychoactive drug use. The principal objectives of this effort have been:

- 1) reductions in crime and public disorder;
- 2) improvement of the public health;
- 3) better protection of children; and
- 4) wiser use of scarce public resources.

By any measure, current drug control policies have failed to achieve those objectives.

In 2001 the King County Bar Association adopted a comprehensive statement on drug policy, asserting that the current “War on Drugs” is fundamentally flawed and is associated with numerous negative societal consequences, including:

- the failure to reduce problematic drug use, particularly among children;
- dramatic increases in crime related to prohibited drugs, including economic crimes related to addiction and the fostering of efficient and violent criminal enterprises that have occupied the unregulated and immensely profitable commercial market made possible by drug prohibition;
- skyrocketing public costs arising from both increased drug abuse and increased crime;
- erosion of public health from the spread of disease, from the concealment and inadequate treatment of addiction and from undue restrictions on proper medical treatment of pain;
- the abridgement of civil rights through summary forfeitures of property, invasions of privacy and violations of due process;
- disproportionately adverse effects of drug law enforcement on the poor and persons of color;
- the clogging of the courts and compromises in the effective administration of justice, as well as a loss of respect for the law.

Based on these findings, the King County Bar Association concluded that, rather than criminally punish persons for drug use *per se*, any state sanction or remedy should be aimed at reducing the harm directly caused to others by persons using drugs, and that unmitigated criminal sanctions should continue to be imposed upon persons who commit theft, burglary, fraud, forgery and all other criminal offenses, but such offenders should have the opportunity to receive drug treatment if their crimes are related to drug addiction.

Further, the King County Bar Association recognized the breadth of federal drug law as a major impediment to any fundamental and meaningful drug policy reform and asserted that federal law should permit the states to develop their own drug control strategies and structures, using the following principles to guide such state-level efforts:

- 1) Any public policy toward drug use should seek to result in no more harm than the use of the drugs themselves;
- 2) Any public policy toward drug use should address the underlying causes and the resulting harms of drug abuse instead of attempting to discourage drug use through the imposition of criminal sanctions;
- 3) The state should regulate the use of drugs in a manner that recognizes citizens' individual liberties while answering the need to preserve public health, public safety and public order, especially providing compassionate treatment to those in need; and
- 4) The state should regulate the use of drugs in a manner that uses scarce public resources as efficiently as possible.

The King County Bar Association has established a growing coalition of legal, medical, civic and religious groups supporting drug policy reform, engaging over a dozen task forces and working groups composed of scores of participants, including lawyers, judges, doctors, pharmacists, law enforcement officers, health care professionals, drug treatment specialists, scholars and educators. A principal effort for more than three years was developing the parameters of an alternative legal framework for drug control to address more effectively the problems arising from the sale and use of prohibited psychoactive substances, especially the problems arising from the operation of the illegal markets in which such substances are exclusively produced and distributed.

As a result of its intensive study, the King County Bar Association recommended the consideration of a state-level system of regulatory control over those psychoactive substances that are currently produced and distributed exclusively in illegal markets. The main purposes of such a state-level regulatory system would be:

- 1) to render the illegal markets for psychoactive substances unprofitable, thereby eliminating the incentives for criminal enterprises to engage in the violent, illegal drug trade;
- 2) to restrict access to psychoactive substances by young persons much more effectively than the current drug control scheme; and
- 3) to open many new gateways to treatment so as to provide prompt health care and essential services to persons suffering from drug addiction.

These goals conform to the principal objectives established at the outset of the King County Bar Association's overall examination of drug policy – reducing crime, improving health, protecting children and saving public resources.

The King County Bar Association and its coalition partners did not propose specific statutory changes and did not presume to set forth every detail of a state-level regulatory system for controlling psychoactive substances. Rather, the coalition called on the Washington State Legislature to authorize a special consultative body, composed of

experts in pharmacology, medicine, public health, education, law and law enforcement, as well as public officials and civic leaders, to provide specific recommendations for legislative action to establish such a state-level system of regulatory control. The Board of Trustees of the King County Bar Association adopted a resolution on January 19, 2005, published herein, calling for the establishment of such a consultative body

This report is the product the Legal Frameworks Group of the King County Bar Association Drug Policy Project, which included the participation of more than two dozen attorneys and other professionals, as well as scholars, public health experts, state and local legislative staff, current and former law enforcement representatives and current and former elected officials. The Legal Frameworks Group moved beyond the mere criticism of the current drug control regime and set out to lay the foundation for the development of a new, state-level regulatory system to control psychoactive substances more effectively.

This report is divided into the following major sections:

Part I surveys the history of drug use and drug control efforts, especially in the United States, and also reflects on the cultural context of drugs and drug use in America, with the intent of informing the development of a politically tenable drug control model.

Part II reports on innovative developments around the world in approaches to the problems of drug abuse and drug-related crime, searching for appropriate models to replicate or adapt in the United States.

Part III describes the current system for attempting to control prohibited psychoactive substances at the federal and state levels and identifies specific proposals for fundamental drug law reform that have been put forward over the years, including scholarly papers and other state-level legislative proposals.

Part IV presents that argument that federal law should yield to the primacy of the states, permitting the states to develop their own drug control systems and restoring the balance that allows states to be the laboratories to change and improve laws and public policy.

Part V outlines the parameters of a state-level system for controlling psychoactive substances that are currently produced and distributed exclusively in illegal markets, including consideration of a host of complex practical questions around manufacturing, purity and safety, labeling, distribution, medical supervision, licensing, prescriptions, advertising and counter-advertising, criminal enforcement, third-party liability and other issues.

I. DRUGS AND THE DRUG LAWS: HISTORICAL AND CULTURAL CONTEXTS

Americans are expected to be “drug-free” in a society in which both legal and illegal drugs are used to remarkable excess. While hundreds of thousands of American citizens are routinely arrested and incarcerated each year for possessing and using certain prohibited, psychoactive substances, the American commercial marketplace is flooded with attractive media images aggressively promoting other mind-altering or pleasure-inducing substances to treat various new “disorders” and “syndromes” and to satisfy the American appetite for instant gratification.

Any critical examination of current drug policies, as well as any recommendations for meaningful reform, must reflect an understanding of this paradox of drug use in America, a nation that purportedly eschews drugs yet consumes them with abandon. Crafting more effective policies to address the chronic problem of substance abuse requires an exploration of the historical and cultural contexts of the use of psychoactive substances in human societies and a review of the modern attempts to control such use, particularly in the United States.

A NATURAL PROPENSITY

Archaeological evidence from across the world has revealed a human inclination to seek altered states of consciousness through the use of psychoactive substances.¹ Stone Age peoples are thought to have consumed hallucinogenic mushrooms more than 12,000 years ago.² Sumerian tablets refer to the opium poppy through a word that means “to enjoy.”³ The earliest historical evidence of the domestication and eating of poppy seeds come from the lake dwellers of Switzerland 4,500 years ago.⁴ In the ensuing Bronze Age, opium was used widely as a balm for the pains of childbirth and of disease and an opium trade traversed Europe and the Middle East to Asia.⁵ The cultivation of cannabis, or hemp, began in China and also in Neolithic Europe almost 4,500 years ago.⁶ Indian lore from before that time recognized the intoxicating properties of cannabis, which, in the Brahman tradition, believed that it “grew at the spot where drops of divine ambrosia fell from heaven . . . [making] the mind agile while granting long life and sexual prowess.”⁷ The use of coca and other stimulants in South America can also be traced back to primordial times.⁸

Our human ancestors consumed psychoactive substances not only to seek altered mental states, but also for survival, suggesting an evolutionary purpose for drug-taking. Having to endure harsh environmental conditions, hunter-gatherers sought out plants rich in alkaloids, including opium and coca, as important sources of nutrition and energy.⁹ Lower animals are also known to be attracted to fermented fruits and a host of roots and berries for their intoxicating effects, suggesting that the urge to alter consciousness extends even deeper into our evolutionary past.¹⁰ This evidence supports the proposition that intoxication is a universal human need, or what has been called the “fourth drive.”¹¹

PROHIBITIONS OF THE PAST

Mind-altering substances used throughout the ages for various religious and medicinal purposes were generally controlled carefully through rituals that often acknowledged the substances as sacred.¹² However, personal and social problems associated with psychoactive substances have also been recognized since ancient times.¹³ In the modern age in particular, beginning with colonization in the 16th century and the Great Enlightenment, Europeans took those substances sacred to the indigenous peoples in the colonies and brought them home for recreational use, which spurred efforts to proscribe them. For substances in common use today, including coffee, chocolate and tobacco, there were strict prohibitions often enforced by harsh punishment.

Tobacco smokers returning from the Americas to Spain in the 16th century were subject to the tortures of the Great Inquisition.¹⁴ In 17th century England, King James I despised tobacco use by his subjects because he disliked seeing them emulate the “savage” Indians in America, while in Russia, Czar Michael Federovitch executed anyone on whom tobacco was found.¹⁵ Tobacco use was prohibited in the 17th century in Bavaria, Saxony, Zurich, Transylvania, Sweden and numerous other areas of Europe, and many Eastern Mediterranean rulers at that time imposed the death penalty on anyone smoking tobacco,¹⁶ and also on anyone owning or visiting a coffee house.¹⁷ Despite these prohibitions and the extreme sanctions imposed, both tobacco and coffee consumption continued and increased and were eventually normalized in European and Near Eastern societies.¹⁸

The motivating impulses behind drug prohibitions have often been unrelated to concerns over the effects of the drugs themselves. For example, the coffee prohibition in the Middle East had less to do with concern about health risks of caffeine than with the official view of the coffee house as a lurid meeting place for political and religious dissidents.¹⁹ The Spanish Conquistadors in the New World consumed and marketed coca liberally and used it to increase the productivity of their enslaved indigenous workers but, on the other hand, the chewing of the sacred coca leaves by those native peoples in their religious practice was strictly forbidden by the Catholic Church, which condemned such “idolatry” and considered it a hindrance to the conversion to Christianity.²⁰ In China, the 18th century opium ban, which punished keepers of opium shops with strangulation, also served purposes unrelated to the drug – discouraging Chinese citizens from co-mingling with “barbaric” Europeans, who were the drug’s primary merchants, and also attempting to protect the Chinese economy by stemming the outflow of silver sent overseas in exchange for opium.²¹

As prohibitionist sentiments have historically been in response to the clash of social and cultural traditions, the use of particular drugs has been associated with alternative subcultures, hated minority groups and foreign enemies.²² An “us versus them” mentality frames the public debate, eventually singling out certain psychoactive substances more for their perceived relationship to unpopular social groups than for any deleterious effects of the drugs themselves.²³ Thus, drug prohibition has been a means through which dominant cultural or social groups act to preserve their own prestige and lifestyle against threats to the established social order.²⁴ The cultural clash that inspired

prohibitions such as England's Gin Act of 1736, for example, which was aimed at the lower social classes, foreshadowed the American movement for alcohol prohibition.²⁵

Millions of Americans today suffer from the misery associated with substance abuse and it is important not to underestimate the earnestness and legitimacy of many governmental efforts to address very real societal dangers linked to substance abuse. It is equally important, however, to recognize that societies' historical reactions to drugs and drug-related activity have arisen from a mix of cultural, religious, political and economic factors rather than from the mere concern over certain chemical or pharmacological actions. Such an understanding should inform more effective public policies to address the chronic problem of substance abuse in the United States.

GROUNDWORK FOR DRUG PROHIBITION IN AMERICA

As with human consumption of psychoactive substances in all parts of the world, drugs have been used in the United States since its earliest days as a nation. Even one of the first events leading to the American Revolution – the Boston Tea Party of 1773 – was a public outcry over excessive taxation of a drug.²⁶ Peoples native to the continent introduced the world to tobacco, which eventually financed America's early development as a nation.²⁷ Coffee, tea, alcohol, hemp and the opiates, which had been known for centuries, were brought to America by European and Asian settlers. Until the late 19th century these drugs were used legally in the United States with much public indifference and very little government interference.²⁸ Indeed, taxes on psychoactive substances provided a significant part of government revenue for most modern nations prior to the advent of income taxation.²⁹

The 19th Century: A Rudimentary Pharmacopoeia

Prior to 1800, opium was widely available in the United States, and throughout the world, as an ingredient in numerous products and “multidrug prescriptions.”³⁰ It was hailed by doctors and peddlers of patent medicines for its “calming and soporific effects” and was often recommended to patients as a treatment for whatever condition ailed them.³¹ Opium use by women was particularly widespread because of its favored status as a physician's treatment for “female troubles” related to menstrual and menopausal disorders.³² Although physicians were generally aware of the potentially harmful effects of uncontrolled opium use, for most of the century such a danger was rarely thought to outweigh the drug's medicinal value.³³

Morphine, a derivative of opium, was first discovered in 1804 and appeared later in the 19th century in many patent medicines readily available to American consumers.³⁴ Morphine was manufactured legally in the U.S. from both imported and domestically grown poppies and its popularity as a painkiller further expanded the American use of opiates. Morphine use increased substantially in the 1870s following the invention of the hypodermic syringe, the rapid spread of patent medicines and the broad acceptance of morphine in medical practice during and after the Civil War.³⁵

Heroin, an opiate derived from morphine through chemical processes, was a later addition to the American pharmacopoeia. It was “discovered” in 1874 but first came to

market in 1898 when Bayer Pharmaceuticals introduced it as “The Sedative for Coughs.” Heroin was first thought to be a cure for morphine dependency and was used briefly to relieve morphine withdrawal symptoms,³⁶ but it was mostly in great demand for treating patients suffering from tuberculosis, pneumonia and other common respiratory conditions of the time. Named for its tendency to make the user feel “heroisch” (“powerful” in German),³⁷ heroin’s own propensity to foster dependency was debated but did not initially arouse much concern.³⁸ Heroin was widely prescribed by doctors into the 1920s.

Coca has been used in South America for thousands of years for its effects as a stimulant and for religious and mystical purposes. The active element of coca, cocaine, was first isolated from the coca plant in 1844 and became popular in Europe and North America as a drink additive. French Wine of Coca, Ideal Tonic, was registered under the trademark “Coca-Cola” in 1885; due to the “dry laws” at the time, alcohol was replaced by cola nuts in 1886.³⁹ Originally advertised as a medicinal beverage, Coca-Cola contained both coca and caffeine until the coca was removed in 1903.⁴⁰ Cocaine was made famous by Sigmund Freud for its “exhilarating” effect on the body and as a treatment for depression and morphine addiction.⁴¹ The medical use of cocaine was also publicly endorsed by the Surgeon-General of the United States Army.⁴² Between 1890 and 1905 cocaine’s popularity surged as a treatment for fatigue and respiratory ailments and as an ingredient in various tonics, ointments and sprays.⁴³

The Puritan and the Progressive: Confluence of Cultural Strains

In early America many drugs now considered illicit were widely and often used. George Washington and Thomas Jefferson, in fact, documented their cultivation and use of hemp for pain relief and other purposes.⁴⁴ Drug use was not without its critics and was certainly attended by numerous personal and family problems, but the vast majority of drug users were able to lead productive lives and their drug use or dependency did not prevent them from being fully functioning contributors to American society.⁴⁵ Drug use in the 19th century generally lacked the stigma of today and indeed was just as prevalent in high society as it was in the nation’s ghettos and slums, as President William McKinley, Queen Victoria and other European royalty celebrated and entertained with coca wine, for example.⁴⁶

The 19th century featured Western imperialism, growing international commerce, the industrial revolution and waves of immigration, bringing about massive social and cultural changes in the United States. The nation’s economy began moving away from its agricultural roots and cities grew in size and importance, as factory work increased and traditional living conditions and lifestyles changed dramatically. Substances such as opium, tobacco, tea and coffee had become more easily obtainable through foreign trade and alcoholic beverages became industrial commodities that were available year round. Heavy use of substances that had once been available only to the wealthy was becoming increasingly common in the lower classes and popular understanding of drug usage began to change.⁴⁷ While the use of many different drugs was both legal and widespread in 19th century America, it was not universally accepted and doctors, religious leaders and government officials warned against excess and advocated for moderation or restriction. Arguments for prohibition began to gain political traction as the social and economic upheavals helped bring the issue to mainstream America.

Alcohol was the earliest and most prominent target of social crusaders in the 1800s.⁴⁸ The temperance movement first became active at the state and local levels and the first national anti-alcohol association, the American Society for the Promotion of Temperance, was founded in 1826. Protestant church leaders of the temperance charge were largely motivated by old-world Puritan notions of a Christian social order and concern that overindulgence in alcohol “seriously interfered with their soul saving mission because it destroyed man’s health, impaired his reason and distracted him from the love of God.”⁴⁹ Traditional Puritan doctrine did not actually advocate total abstinence from alcohol, however, but moderate and careful use.⁵⁰ Therefore, while the temperance movement represented Puritan values of self-control and pious reverence, the rising influence and motivations of anti-alcohol crusaders in the early 19th century were also attributed to other factors.

The early temperance movement had strong social and political overtones, particularly reflecting the rising importance of the “common man” in the United States.⁵¹ The emerging new “middle class” was increasingly active in the nation’s economic, political and social life – and also heavily used psychoactive substances – and exhibited a certain moral independence that shunned traditional church teachings and rejected the social standards and political power of the old American “aristocracy.” In this sense, temperance can be viewed as an attempt by a declining ruling class to cling to traditional values and institutions and to stake out its moral superiority by demonizing the common man’s indulgence in drink.⁵²

As the temperance movement grew in popularity it eventually lost its association with aristocratic dominance and was ironically co-opted by the middle and lower classes against which it had originally been aimed. Over time, “temperance became a sign of middle-class respectability and a symbol of egalitarianism” and was a key tenet of the emerging popular movement toward self-improvement and the “perfectability” of man.⁵³ By the early 1900s this sentiment converged with the Progressive movement and thus became a powerful political influence.

Until the 20th century the federal government had traditionally been very weak, playing a minimal role in people’s daily lives. As urban life became a major hardship for millions of people, however, citizens grew restless with political corruption and local governments’ inability to respond to crises. Economic depression in the 1890s had led to dissatisfaction with the government, while railroads, trusts and holding companies and industrial monopolies wielded considerable political influence. The rich consolidated their economic power, but the poor and middle class also agitated for change and from this discontent the Progressive movement emerged.

Progressivism was based on the concept that human nature is basically good and that government should be the tool for improving and perfecting society to create a better world.⁵⁴ As a middle-class movement, Progressivism sought to “preserve economic opportunity and restore social and political democracy so that all American’s might continue to prosper.”⁵⁵ For all its concern about social justice, however, the Progressive movement was markedly racist and xenophobic. Progressives sought to protect their own social status by attempting to assimilate poor immigrants and racial minorities into their

ideal of a homogeneous American lifestyle. As part of their zeal to reform government, to curb big business and to improve people's lives, Progressives took up the cause of the temperance movement and quickly adopted a strong stance against alcohol.⁵⁶

Progressives were concerned about the consequences of drinking among the lower classes and the potential for civil discord: "Fearful of the growing unrest from below, the middle classes became deeply concerned lest the sale of liquor increase this discontent."⁵⁷ Saloons attracted the lower classes and were regarded as dens of debauchery that fostered un-Americanism and prevented assimilation into American society, breeding lawlessness and violence and conjuring up fears of rebellion by poor immigrants and laborers.⁵⁸ As the 20th century unfolded, similar fears were aroused in the public campaigns against heroin, cocaine and other drugs.

Old Puritan values of piety, frugality and industriousness framed a new Progressive agenda to achieve middle-class utopia through democracy and strong government controls. The Progressives' fervor against alcohol did not extend to heroin, cocaine, cannabis or other drugs, however, which were thought to be benign compared with alcohol and its tendency to lead men to social and moral ruin.⁵⁹ Thus, the anti-narcotics movement and the anti-alcohol movement actually arose quite independently from one other. Nevertheless, as David Musto explains:

the interrelation between the battles against alcohol and against narcotics is an important one. The anti-alcohol crusade helped establish the attitude that there could be no compromise with the forces of evil, that 'moderation' was a false concept..." and that prohibition was the only logical or moral policy when dealing with such a great national problem.⁶⁰

By 1905, in fact, Senator Henry W. Blair (R-NH) declared that "the temperance movement must include all poisonous substances which create unnatural appetite, and international prohibition is the goal."⁶¹

Patterns of Drug Prohibition and Race

Concern about drug use in America arose from distinct associations of certain drugs with unpopular and vulnerable societal sub-groups – of opium with the Chinese, of cocaine with "Negroes," of alcohol with urban Catholic immigrants, of heroin with urban immigrants and of marijuana with Mexicans – and from the claim that a myriad of foreign enemies were using these drugs against the United States.⁶² Propaganda often contributed to popular understanding of drugs more than factual or scientific accounts.

Throughout the 1800s Chinese exclusionary laws were commonplace, especially in the American West, and anti-Chinese hostility intensified when Chinese workers became a scapegoat for bad economic conditions. After the economic depression of the 1870s the California legislature began studying the "moral" aspects of its Chinese inhabitants, with specific attention paid to the problem of "vice" in Chinese communities.⁶³ Anti-Chinese sentiment in the U.S. thereby created strong negative perceptions about opium.

While opium use was common among all classes and races, opium smoking was a distinctly Chinese practice that became an exclusive target of the public and of state legislatures. This was particularly so once the public consciousness was awakened to the “special problem” of white men and women who “began to ‘contaminate’ themselves by frequenting the dens in Chinatown.”⁶⁴ As the Progressive Era commenced, middle class America struck against this threat to morality and social order.

Associating Chinese opium use with corruption of American values and female chastity was an easily alluring explanation for social problems of the day and it became an influential point of view.⁶⁵ Smoking opium, like the Chinamen who introduced the habit, became a despicable practice to Progressive reformers. All the while, opium in its various other forms, including morphine and laudanum, continued for many years to be freely dispensed by pharmacists, doctors, and purveyors of patent medicines.⁶⁶

Changing perceptions of cocaine at the turn of the 20th century were also linked to race. In the late 1800s poor black laborers in South took to the habit of snorting cocaine to help them endure strenuous conditions. Sniffing was the quickest and cheapest way to ingest cocaine and, as a crude method of use, clearly distinguished common people from the upper and professional class users who preferred injecting it with a needle.⁶⁷ Plantation owners and other employers soon found great value in cocaine as a means of improving productivity and controlling workers, and some even began supplying it to their black crews.⁶⁸ Poor blacks and cocaine became firmly linked in the public mind.

Racial tensions in the South soon transformed the image of black cocaine use into a source of white fear. Fantasized stories stirred panic about “cocainized” blacks leaving plantations and construction sites on sexual rampages having their way with white women.⁶⁹ Medical publications supported this myth with stories of how cocaine could transform law-abiding Negroes into menacing predators with increased and perverted sexual desire.⁷⁰ Also appealing to anti-Semitic sentiments, newspapers reported that there was “little doubt that every Jew peddler in the South carries the stuff.”⁷¹ Other popular legends attributed cocaine to giving blacks superhuman strength and that southern police departments switched from .32 caliber to .38 caliber revolvers because cocaine made crazed blacks impervious to the smaller rounds.⁷²

Thus, the anticipation that blacks might “rise up” above their place in society gave rise to considerable white alarm.⁷³ The racist roots of this image are further exposed by the fact that blacks were not the predominant users of cocaine in the early 20th century.⁷⁴ Cocaine sniffing was more popular with whites and was especially associated with the criminal cultures of prostitutes, pimps, gamblers and other white “urban hoodlums.”⁷⁵

The national prohibition of alcohol sales in the 1920s stimulated an increase in cannabis smoking, called “marihuana” by the Mexican immigrants who brought it with them for recreational and medicinal use.⁷⁶ In the 1930s marijuana use was found to be widespread from schools to neighborhood bridge parties.⁷⁷ Despite such common usage, however, public concern about marijuana was aroused through its association with Mexicans; and fear of marijuana in the United States was most intense in areas with high concentrations of Mexican immigrants.⁷⁸

Like the Chinese before them, Mexican immigrants were a targeted scapegoat for high unemployment rates in the 1930s and their association with marijuana helped raise public alarm.⁷⁹ The medical community also appealed to public prejudices, suggesting that marijuana “releases inhibitions and restraints imposed by society” and “acts as a sexual stimulant” that particularly affects “overt homosexuals.”⁸⁰

Fast-forwarding to the 1980s and 1990s, the national panic over “crack” cocaine has fostered the perception of the drug’s predominance in poor, black urban settings and yet, according to the U.S. Sentencing Commission, “nearly 90 percent of the offenders convicted in federal court for crack cocaine distribution are African-American while the majority of crack cocaine users are white.”⁸¹ The disproportionately adverse effect of drug law enforcement on the poor and racial minorities now spans more than a century.

A close examination of the legislative history of America’s drug laws reveals a host of uncharitable sentiments that have helped shape public perceptions of disfavored social subgroups and their practices. Any meaningful effort to reform drug policy in the United States must acknowledge this uncomfortable historical nexus between racial animus and American public attitudes towards certain drugs.

LEGISLATIVE BEGINNINGS IN THE STATES

There was no national drug control policy in the United States during the 19th century as state and local governments promulgated the earliest drug laws, and even those laws were limited to regulation of alcohol distribution, local restrictions on smoking tobacco and regulation of pharmacies.⁸² During that time “statutory vocabulary was simple and direct: arsenic, tobacco, alcohol, morphine, and other opium alkaloids were all ‘poisons’” and, when they were regulated at all the law put the onus on the health professions to police their distribution.⁸³

Early state and local drug laws varied immensely in scope and effect. In 1860 Pennsylvania enacted an early anti-morphine law. In 1875 San Francisco passed an anti-opium law that is widely considered the first of its kind, targeting only the smoking of opium, which was common among Chinese immigrants, and not affecting the myriad other forms of opium use favored by most Americans. The California state legislature enacted a similar law in 1881 that focused only on opium smoking dens.⁸⁴ Virginia City, Nevada had passed a similar anti-opium ordinance in 1876 and this law was expanded and adopted statewide a year later. Other cities and states across the nation soon followed suit. These laws were all different and, for the most part, full of so many loopholes and exceptions that they were largely ineffective in actually preventing or limiting opium smoking.

Almost none of the early drug laws imposed a blanket prohibition on any substance. “A typical law would provide for the sale of narcotized proprietaries without restriction, but would confine provision of pure drugs to pharmacists and physicians, requiring a prescription that would be retained by the pharmacist for inspection for a period of time.”⁸⁵ Some of these laws were so complicated that compliance was impossible, while others were practically nugatory due to exceptions for patent medicines and domestic remedies.⁸⁶ Despite the relative laxity of the laws, they were enforced to

varying degrees against targeted or guileless violators. Passage of these laws marked the first time in United States history when people began getting arrested for possession of drugs, and punishments were frequently “prompt and thorough.”⁸⁷

THE FIRST FEDERAL DRUG LAWS

Federal involvement in regulating drugs first emerged to bolster state efforts and reflected a similar concern about social groups using certain drugs rather than the drugs themselves. In 1883 Congress raised the import tariff on smoking opium, leaving opium imported for other purposes unaffected.⁸⁸ In 1887 Congress prohibited the import of opium into the United States by any subject of China; the law did not apply to non-Chinese and importation from Canada remained legal.⁸⁹ In 1890 a new federal law permitted only American citizens to manufacture opium for smoking.⁹⁰

The early federal opium laws produced mixed results. They were effective to the extent they were intended to marginalize the Chinese and to clarify social distinctions; indeed, maltreatment of the Chinese in the United States was so prevalent that it raised the ire of the Chinese government and threatened to destabilize trade and international relations.⁹¹ However, from the viewpoint of actually improving the nation’s health and safety and reducing use of drugs these laws did very little. Opium and other drugs continued to be legally available in many forms, and they were used for various purposes in all strata of American society.

Government officials were aware of the opium laws’ failures and of their consequences. The U.S. Treasury reported in 1888 that the effect of federal efforts had been “to stimulate smuggling...by systematic organizations on the Pacific coast” and that “although all possible efforts have been made by this Department to suppress the traffic, it is found practically impossible to do so.”⁹² These early difficulties, however, did not prevent the Congress from promulgating even more stringent measures in the future.

The Pure Food and Drug Act

A new chapter in the history of U.S. drug regulation began with the passage of the federal Pure Food and Drug Act of 1906, which required foods and medicines to be properly labeled as to their ingredients and contents. The Pure Food and Drug Act did not impose prohibitions on any substance; rather, it required only that certain products containing dangerous or potentially habit-forming drugs include appropriate notices to the public. The measure was the most prominent example of federal consumer protection legislation that emerged from the American Progressive movement.

At the turn of the 20th century Americans read stories of graft and greed and the works of famous “muckraking” journalists such as Upton Sinclair were popular favorites, and public sentiment supported congressional action to regulate the food and drug industries. A principal target of the muckrakers was the patent medicine industry, portrayed as peddling adulterated, mislabeled products in a reckless manner. “Poisonous substances provided an issue on which prohibitionists, social reformers and proponents of federal intervention combined with enduring results.”⁹³ Public officials responded by

targeting patent medicine-makers with regulation, all for the sake of “purification” and to “protect the children.”⁹⁴

The Pure Food and Drug Act marked a significant change in the conception of the constitutional power of the federal government. Matters of public health and safety were long considered the exclusive realm of the states and the federal government had no ability to exercise a general police power. This was especially true in an area that affected business interests, so Congress had to be creative in the drafting the Pure Food and Drug Act as a criminal statute, ultimately relying on the Commerce Clause for its authority.⁹⁵

Although the Pure Food and Drug Act did not impose any prohibitions, it had a historically demonstrable effect on reducing opiate addiction.⁹⁶ New purity and labeling requirements markedly improved the safety of medicines and drugs available to the public. This record of success was interrupted, however, by the passage of the Harrison Narcotic Act of 1914, which essentially cut off access to the legal, well-regulated supply of opiates and enabled the growth of an illicit market in adulterated, misbranded and contaminated drugs of all kinds.⁹⁷

The national “anti-drug” movement in the United States was only in its infancy at the time of the Pure Food and Drug Act, whereas alcohol had been the primary target of moral and social crusaders for quite some time. The Anti-Saloon League and the influential alcohol prohibition movement had overshadowed “anti-drug” forces, which lacked any strong central organization. It is peculiar, therefore, that the nation’s first major “anti-drug” law, the Harrison Narcotics Act of 1914, was adopted a full five years before National Alcohol Prohibition.⁹⁸ This historical anomaly stems directly from the efforts of a few charismatic, driven and influential individuals and from America’s changing role in world politics at the dawn of the 20th century.

Opium and U.S. Occupation of the Philippines

Victory in the Spanish-American War in 1899 turned the United States into a world power, which acquired Puerto Rico, Guam, Cuba and the Philippines, embracing its moral duty to uplift the inferior peoples in these territories.⁹⁹ The Filipinos were less enthusiastic about U.S. domination, however, and they rose up against the American occupiers in a prolonged insurrection. Upon suppressing this uprising, the United States took over governance of the Philippines and William Howard Taft was appointed civil governor. One of the first major problems he had to face was how to deal with island’s “opium problem.”

Opium use in the Philippines was very common and the Spanish had previously operated an opium monopoly on the islands that entailed licensing narcotics addicts and legally supplying them with their requirements of the drug.¹⁰⁰ Despite Governor Taft’s support for continuing this practice, the notion was extremely offensive to two influential American religious leaders in the Philippines, Reverend Wilbur Crafts, a Roosevelt administration official and leader of the International Reform Bureau, and the Reverend Charles H. Brent, the Episcopal Bishop of the Philippines. Both of these men strongly opposed, on moral grounds, American involvement in supporting such a vice as opium

taking, especially in providing it to our foreign charges.¹⁰¹ The vocal opposition of Bishop Brent and Wilbur Crafts proved to be decisive in preventing the U.S. from reinstating the Spanish opium monopoly in the Philippines.

In 1905 Congress ordered that all Filipinos be prohibited from obtaining opium for any non-medical purpose and that all legal sales of the drug would be prohibited by 1908.¹⁰² This policy set a powerful precedent and had long-term implications. Even though American officials acknowledged that “prohibition of opium smoking in the Philippines does not in fact prohibit,”¹⁰³ Congress was nevertheless disposed to support outright prohibition and the United States established itself as the world leader in the area of international narcotics control.¹⁰⁴

Opium and Tension With China

By 1900 China was outwardly expressing deep concern about foreign interference and about opium use by its people, culminating in the Boxer Rebellion, which was the strongest manifestation of Chinese nationalism and anti-imperialism to date.¹⁰⁵ President Roosevelt even considered deploying troops to China to protect American investments.¹⁰⁶ However, this international crisis provided a unique window of opportunity that was seized upon by the fledgling American anti-drug movement.

Bishop Brent urged President Roosevelt to help China in its battle against opium.¹⁰⁷ U.S. efforts in the Philippines had been considered a success and inspired hope that it may serve as a successful model elsewhere. Bishop Brent and Reverend Crafts called for an international meeting between the United States, Japan and the other powerful nations with interests in the Far East, and President Roosevelt agreed with this approach, eventually convening the Conference of the International Opium Commission in Shanghai in 1909.¹⁰⁸

Along with Bishop Brent and Reverend Wilbur Crafts, the third major seminal figure in the development of American drug policy was an ambitious, Washington, D.C. doctor named Hamilton Wright, who had some knowledge about opium and “Oriental” cultures. The State Department had appointed Wright to the American delegation to the Shanghai Opium Conference. Dr. Wright began many years of tireless work that eventually earned him the informal title of “father of American narcotic laws.”

By calling and convening an international meeting on the Chinese opium trade, the United States was again holding itself out as a world leader on the issue of drug policy, and Hamilton Wright believed the U.S. should serve as a model for other nations by enacting its own “exemplary” opium laws.¹⁰⁹ Ironically, the U.S. itself had no laws limiting the use, sale or manufacture of products containing opium and coca, so to save face in advance of the international opium conference, Wright worked with Secretary of State Elihu Root and others to remedy this situation before the meeting, helping to secure the enactment of national opium prohibition.¹¹⁰

The 1909 Opium Exclusion Act

The Opium Exclusion Act was the first federal drug prohibition law, passed quickly just as the Shanghai Opium Conference was convening as a message of U.S.

intolerance toward recreational drug use. Constitutional concerns led the State Department to recommend that Congress impose a prohibition through a national ban on imported, non-medicinal smoking opium.¹¹¹ Section 11 of the Pure Food and Drug Act had already authorized the federal government to ban any imported drug deemed dangerous to the public's health, but Congress went ahead and approved the Opium Exclusion Act in any event, on February 9, 1909.¹¹²

The Foster Antinarcotics Bill: Prelude to the Harrison Act

Upon his immediate return from Shanghai, Hamilton Wright sought sweeping federal anti-drug legislation, to be founded upon Congress' constitutionally granted taxing power, and he drafted just such a proposal. Representative David Foster of Vermont, chairman of the House Committee on Foreign Affairs, introduced Wright's legislation in 1910. Known as the Foster Antinarcotics Bill, it called for a federal tax on all drug transactions in the nation and would have required all sellers of drugs to register with the government and to record and report all of their transactions.

Supporters of the Foster Antinarcotics Bill appealed to popular fears and myths about racial minorities.¹¹³ The interests opposed to the bill, however, including the nation's drug manufacturers and retailers, opposed the bill for its cumbersome record-keeping and reporting requirements and, since the public was not enthusiastically driving a national anti-narcotic movement, the arguments of business and industry carried their weight in Congress. Despite calls from Hamilton Wright and President Taft that the United States had to show the world that it "had its house in order" before the second International Opium Conference in the Hague in 1912,¹¹⁴ the measure failed.

The Harrison Narcotic Act of 1914 and its Interpretation

Still resolved to see domestic drug prohibition enacted, Hamilton Wright had his legislation introduced in the next session. This time, Representative Francis Burton Harrison (D-NY), who himself had been Governor General of the Philippines from 1913 to 1921, agreed to shepherd it through the House. The bill met again with strong opposition, especially from the American Medical Association, so the bill's proponents reluctantly agreed to modify its record-keeping provisions, to reduce the penalties and to continue to allow the sale of patent medicines with small amounts of narcotics in them.¹¹⁵ After the grudging compromise of all parties, the result was the Harrison Narcotic Act of 1914, a major watershed in the federal effort to regulate drugs.¹¹⁶

The Harrison Act required all manufacturers and purveyors of narcotics to register their activity with the federal government, to keep records of their sales and to pay a tax on each transaction.¹¹⁷ Although ostensibly only a tax measure, the practical effect of the Harrison Act was to severely limit the availability of opium and cocaine for non-medical, recreational purposes. The bill was not presented as a prohibitionist measure in reaction to domestic morality concerns; rather, the congressional debate focused on comportsing with international treaty obligations imposed by the Hague Opium Convention of 1912.¹¹⁸ In only a few short years, however, the Harrison Act was transformed from a relatively innocuous revenue measure into a powerful tool for federal authorities to regulate, and ultimately prohibit, a wide range of narcotics-related activity.

Linking the Harrison Act to The Hague Opium Convention was a clever means to circumvent constitutional concerns at the time. The power of Congress to regulate interstate commerce and to raise revenue was considered to be very limited in 1914 and the prevailing view was that the power to regulate “local” affairs was reserved to the states by the Tenth Amendment.¹¹⁹ Therefore, federal control of narcotics and medical prescriptions was thought to be unconstitutional.¹²⁰ However, Hamilton Wright and his cohorts had purposefully engineered the Hague Opium Convention in order to establish a mandatory international legal foundation on which U.S. drug laws would be built.¹²¹

To the U.S. medical community the Harrison Narcotic Act was seen mostly as “a law for the orderly marketing of opium, morphine, heroin, and other drugs—in small quantities over the counter and in larger quantities on a physician’s prescription.”¹²² Doctors and pharmacists felt protected by the language of the statute, which they had a hand in drafting, specifically shielding them from government interference in their medical practices.¹²³ However, instead of protecting doctors, the language of the Act was subject to multiple interpretations and it was not long before undercover U.S. Treasury agents – the original “narcs” – began arresting thousands of doctors and pharmacists for prescribing and administering drugs to narcotics addicts.¹²⁴

Although the Harrison Act was vague about what it meant for physicians to act only “in pursuit of their professional practice,” the U.S. Treasury Department took initiative to promulgate rules forbidding doctors from providing drugs for addiction maintenance in cases where addiction was deemed unrelated to medical issues.¹²⁵ The question of whether Congress had the power to regulate doctors and to punish the mere possession of drugs quickly became a contentious legal issue and the Treasury Department’s efforts to enforce the Harrison Act as a prohibitionist law against doctors and their patients were initially rebuffed by the courts.¹²⁶

The *Doremus* and *Webb* Decisions

Undaunted by adverse court rulings, the Treasury Department continued attempts to regulate the prescription practices of doctors and pharmacists under the guise of tax law enforcement. Finally, in the 1919 case of *United States v. Doremus*, the Supreme Court explicitly upheld the Harrison Narcotic Act as a legitimate revenue measure, confirming federal authority to control the manner in which physicians could dispense drugs.¹²⁷ In the companion case of *Webb v. United States*, decided on the same day as *Doremus*, the Supreme Court held that the legitimate practice of medicine could not include prescribing drugs to patients simply to maintain their addiction with no intent to cure them.¹²⁸ The Treasury Department used this decision to support its enforcement against physicians who were distributing drugs to patients “for the purpose of gratifying his appetite for the drug.”¹²⁹

A New Political Climate

During the brief period when the Supreme Court expanded its interpretation of the permissible scope of the Harrison Narcotic Act, dramatic events around the world and at home profoundly affected Americans’ sense of purpose and security. Between 1914 and

1919 the First World War raged in Europe, ratification of the 18th Amendment imposed national alcohol prohibition in the United States and the Progressive Era of middle-class egalitarianism quickly faded into history. It was a time when “the liberalizing movements of LaFollette, Theodore Roosevelt and Woodrow Wilson had declined into a fervent and intolerant nationalism” and America was gripped with fear of anarchy and communism following the Bolshevik Revolution.¹³⁰

By 1919 Americans were in no mood to take a soft stance on any perceived national threat. The use of narcotics was being demonized as antisocial and personally degenerating and the public willingly opposed any suggestion of maintaining such a vice at that time.¹³¹ Prohibitionist sentiments ran high and not just in regard to alcohol and narcotics; tobacco was also gaining critics and by 1921 cigarettes would be prohibited in fourteen states, with 92 other anti-cigarette bills under consideration in another 28 state legislatures.¹³²

The *Behrman* and *Linder* Decisions

The Treasury Department continued to pursue its prohibitionist agenda before the Supreme Court, and in 1922 the case of *United States v. Behrman* expanded upon prior court decisions. The *Behrman* decision specifically upheld the Treasury Department’s rule that made it illegal for doctors to prescribe drugs to addicts whose only ailment was addiction itself. The 6-3 decision affirmed the Treasury’s position that a narcotics prescription for an addict was a *de facto* criminal act, regardless of the intent or “good faith” of the physician.¹³³

In Europe the medical establishment did not generally question the necessity of giving maintenance prescriptions as part of the consistent medical management of narcotics addicts:

A medical man has no right to inflict untold suffering on a patient on the ground that the great suffering endured will act as a deterrent against further lapses....The physician’s duty is not only to heal the sick, but to alleviate pain, and in no sense to employ a punitive method.¹³⁴

In sharp contrast to European practice, by the 1920s physicians and pharmacists in the United States had lost all discretion in this area of medicine, whereby addiction was “demedicalized” and criminalized through the enforcement of the Harrison Narcotic Act, despite many voices of protest.¹³⁵ From the mid-1920s, there were almost no resources available to treat narcotics addicts and this inevitably gave rise to a vibrant black market to satisfy demand.¹³⁶ Criminalization brought the usual risks, as well, so unless they were affluent enough to gain entry into private hospitals, opiate addicts typically suffered through withdrawal in jail cells.¹³⁷

In 1925 the Supreme Court drew back somewhat from the *Behrman* holding in *Linder v. United States*, unanimously declaring that:

“[t]he opinion cannot be accepted as authority for holding that a physician, who acts *bona fide* and according to fair medical standards, may never give an addict moderate amounts of drugs for self-administration in order to

relieve conditions incident to addiction. Enforcement of the tax demands no such drastic rule, and if the Act had such scope it would certainly encounter grave constitutional difficulties.”¹³⁸

The Court also expressed its view that drug addiction is a disease and that relieving the “conditions incident to the addiction” may be medically appropriate.¹³⁹

In the short span between the *Behrman* and *Linder* decisions, however, the die had been cast and the Court’s reversal had little effect on national drug enforcement policy. The Treasury Department’s punitive enforcement practices were so firmly established by 1925 that “few were willing to challenge Treasury’s actions politically or in court, and the ruling had little real impact.”¹⁴⁰ The *Linder* decision’s irrelevance is evidence of how embedded the “anti-drug” sentiment had become in American politics in such a short period; the changing social and political climate allowed Congress to expand its police powers to calm the passions of the time, laying a firm foundation for an era of drug prohibition that continues to the present day.

DRUG PROHIBITION AND BUREAUCRATIC ENTRENCHMENT

Concerns about the constitutionality and wisdom of the Harrison Narcotic Act continued throughout the 1920s. In 1928, however, the Supreme Court partly settled the issue by specifically upholding the constitutionality of the Act.¹⁴¹ By that time there was a widespread national debate about alcohol prohibition, but apart from the continuing controversy between the medical community and the federal government, there was comparatively little national discussion about the Harrison Act.

Heavy enforcement of the Harrison Narcotic Act led to prison overcrowding, however, and to calls for alternatives to imprisonment. By the late 1920s more federal prisoners were being housed for Harrison Act violations than for any other class of offense.¹⁴² Representative Stephen G. Porter (R-PA), chair of the House Committee on Foreign Affairs, who had emerged as a new leader in the fight against narcotics, took up the idea of creating “federal narcotics farms” where drug addicts convicted under the Harrison Act could be housed and treated for their addiction. President Coolidge signed into law the Porter Narcotic Farm Act in 1929, which established one farm in Lexington, Kentucky and another in Fort Worth, Texas.¹⁴³

The Porter Act of 1930

Following the success of his Narcotic Farm bill, Rep. Porter turned his attention to the creation of a new government agency to take up enforcement of the Harrison Act. It was Porter’s desire to have a separate drug enforcement agency both to streamline the bureaucracy and to represent the United States at foreign conferences. In 1930 Congress thereby established the Bureau of Narcotics, to be housed in the Treasury Department, and Treasury Secretary Andrew Mellon appointed his nephew-in-law Harry J. Anslinger as its first commissioner.¹⁴⁴ Although not fully realized at the time, Anslinger’s appointment was an extremely significant event, as he would go on to become one of the most prominent and influential figures in the history of American drug control policy.

“Reefer Madness”

Marijuana became the next major target of U.S. anti-drug efforts, which was a curious development given the fact that for several years the Bureau of Narcotics had consistently minimized the dangers of the drug.¹⁴⁵ Only a decade earlier, the U.S. Agriculture Department had published pamphlets urging Americans to grow marijuana (cannabis) as a profitable undertaking.¹⁴⁶ Narcotics Commissioner Harry Anslinger had stated that heroin was a much greater danger, that marijuana was only a “problem” in areas with large Mexican populations and that marijuana legislation would be most effective at the state level.¹⁴⁷

A closer look at the behind-the-scenes intrigue involving certain influential Americans in the 1930s reveals how the sudden federal campaign against marijuana was more likely related to economic factors and to commercial interests more than to any legitimate fears over the drug itself. In the 1920s the Du Pont Company had developed and patented numerous petroleum-based products, including fuel additives, chemical processes for the manufacture of paper from wood pulp and numerous synthetic products such as nylon, cellophane and other plastics. At the same time other firms were developing synthetic products from renewable biomass resources, especially from hemp (cannabis). By 1935 raw cellulose from hemp had become a viable option for fuel, fabric and plastics and paper – a cheaper, cleaner and renewable raw material compared to petroleum. Faced with this competition, Lammont DuPont lobbied the U.S. Treasury Department to seek the prohibition of hemp.¹⁴⁸

Business interests of William Randolph Hearst, the newspaper magnate, were also threatened by hemp, as his timber holdings and his joint enterprises with DuPont for wood-based pulp papermaking would have been rendered uncompetitive.¹⁴⁹ Hearst used his chain of newspapers to aggravate racial tensions, portraying Mexicans in particular as lazy, degenerate and violent and as job stealers and smokers of “marihuana” – a word brought into the common parlance due in part to frequent mentions in Hearst’s publications.¹⁵⁰ The aggressive efforts to demonize cannabis were effective, as the sheer number of newspapers, tabloids, magazines and film reels under Hearst’s control enabled him to inundate American media with propaganda. Americans readily accepted the stories of crazed crimes incited by marijuana use, and official accounts of the “evils” of marijuana continue to color popular opinion of the drug today.

The Marihuana Tax Act of 1937

Under pressure to take a stand against marijuana, Harry Anslinger and the Bureau of Narcotics readily changed the agency’s position and sought a means by which to bring the drug under federal control. Passage of a marijuana bill under the treaty power was not feasible since Mexico declined to support a trilateral marijuana pact with the United States and Canada, and it was also unlikely that a revenue measure could provide adequate government control.¹⁵¹ Therefore, the Bureau conceived the idea of regulating marijuana with a transfer tax, an approach taken in the National Firearms Act, which levied a tax on transfers of machine guns and which had been recently upheld by the Supreme Court.¹⁵²

Anslinger and the Bureau of Narcotics drafted the Marihuana Tax Act of 1937 and also worked through the media to create the marijuana “problem,” arguing principally that marijuana use produced insanity and led to violent crime.¹⁵³ The Senate report accompanying the bill described the danger as follows:

Under the influence of this drug marihuana the will is destroyed and all power of directing and controlling thought is lost. Inhibitions are released. As a result of these effects, many violent crimes have been committed under the influence of this drug [M]arihuana is being placed in the hands of high school children...by unscrupulous peddlers. Its continued use results many times in impotency and insanity.¹⁵⁴

Despite opposition by the American Medical Association and other moderate voices, the Marihuana Tax Act passed without a recorded vote and after only two hours of debate and was signed into law on October 1, 1937. The measure did not actually prohibit possession or sale of marijuana; rather, any person importing, selling or otherwise handling cannabis was required to register with the government and pay a transfer tax on each transaction. Those without the fiscal transfer stamp could be fined and jailed for up to twenty years.¹⁵⁵

Passage of the Marihuana Tax Act cemented the power of Harry Anslinger over the direction of U.S. drug policy and further entrenched the federal government’s authority to regulate “illicit” drugs by any means. Anslinger deflected skepticism and concern about the wisdom of the hard-line policy on marijuana and pressed on for decades with an effective public relations campaign and with vigorous criminal enforcement under the growing arsenal of federal drug laws.¹⁵⁶

The Boggs Act of 1951

During the Second World War the U.S. experienced a relative decline in levels of use of opiates, cocaine and marijuana.¹⁵⁷ Some of the decline was due to an acute shortage in opiate supplies, where shipments from opium-producing countries were either cut off or impaired by military actions.¹⁵⁸ The opiate shortage meant, however, that persistent narcotics addicts could no longer easily obtain illicit opiates through medical supply channels as they had before and, where scarcity increased the “street” price, the huge profits in narcotics began to attract criminal enterprises in a burgeoning black market, especially for heroin.¹⁵⁹

In the years immediately following the World War II levels of illicit drug use began to rise steadily once again.¹⁶⁰ This caused concern in the Bureau of Narcotics and resulted in modification in the penalties associated with Harrison Act violations. The Boggs Act, named after Representative Hale Boggs (D-LA), was passed in 1951 and imposed the nation’s first mandatory minimum sentences for drug-related convictions.¹⁶¹

Criticism from the Professions

The federal government’s continued punitive emphasis began to attract many critics, including the American Bar Association, which succeeded in getting a

congressional subcommittee to reexamine the nation's narcotic problem. The American Medical Association joined forces with the ABA in questioning America's drug policies. In response, Senator Price Daniel (D-TX) called for a study of the U.S. approach to the drug problem. The Daniel hearings were held across the country but there were signs that Harry Anslinger and the Bureau of Narcotics were integral in shaping the content and conclusions of those hearings.¹⁶²

There was little surprise in 1956 when Daniel's committee concluded that America's drug problem was severe and that drastic punitive measures were justified. In a nine-page report the committee "accused the Supreme Court of permitting major dope traffickers to escape trial by its too-liberal interpretation of constitutional safeguards; it found the Narcotics Bureau could not fight the traffic effectively without being freed to tap telephones; the allowance of bail in narcotics cases was intensifying the flow of drugs into the country; and Bureau agents ought to have statutory authority to carry weapons."¹⁶³ It further condemned the notion of drug treatment clinics, and called for increased penalties for drug offenses, including the death penalty for smuggling and heroin sales.¹⁶⁴

The Narcotic Control (Daniel) Act of 1956

The end result of Senator Daniel's work was the Narcotic Control Act of 1956, which passed with very few questions and little dissent. The measure increased both prison terms and fines for violations of narcotics laws and established new mandatory minimum sentences by eliminating suspended sentences, probation and parole. In addition, a provision for imposing the death penalty was added, applying to anyone over eighteen years of age who provided heroin to anyone under eighteen years of age.¹⁶⁵ This outcome was not likely what the American Bar Association had intended when it called for a reexamination of the drug laws. Despite these severe measures, illicit drug use increased dramatically into the 1960s.

Drug Abuse Control Act of 1965

America's drug scene changed dramatically in the 1960s. Baby-boomers entered their formative years and the nation was experiencing previously unparalleled economic prosperity, but at the same time the social fabric of America was being torn apart by the conflict in Vietnam. Drugs such as marijuana and heroin once again surged in popularity along with the use of newer drugs such as barbiturates, amphetamines and LSD. Young people were encouraged to "question authority" and the prevailing culture and drug use was a "symbol of rejection of traditional values and patriotism."¹⁶⁶ Drug policy was deeply ingrained as a major issue of national political concern and even had President Kennedy's attention.¹⁶⁷ A report by a Presidential advisory commission in 1963 focused on the dangers of drugs and called for new repressive legislation to fight their spread.¹⁶⁸

The Drug Abuse Control Amendments of 1965 charted a new course in federal drug laws. Under this Act, the Bureau of Drug Abuse Control was established within the Food and Drug Administration (FDA). The FDA assumed responsibility for enforcement of this new law, which in its limited scope covered stimulants and depressants and which "imposed a registration, inspection and record-keeping pattern, covering everyone

concerned with the controlled traffic, which closely paralleled the Harrison [Act] requirements.”¹⁶⁹

Despite being hailed as a new front in America’s campaign against illicit psychoactive substances, the 1965 Amendments failed to curb the nation’s appetite for them. In fact, regulations promulgated under the law led to quotas on the number of pharmaceutical methamphetamine tablets that could be produced, thereby limiting supply and spawning a black market in “speed,” marketed at first by the Hell’s Angels motorcycle gang in the 1960s and later by other criminal organizations.¹⁷⁰ The “meth lab” problem plaguing Washington and other western states today is a haunting reenactment of the “speed lab” problem in California in the 1960s, each brought about by the severe restrictions placed on pharmaceutical amphetamines almost 40 years ago.

In 1968 a merger of the FDA’s relatively new Bureau of Drug Abuse Control with Treasury’s old Bureau of Narcotics created a new agency named the Bureau of Narcotics and Dangerous Drugs, housed in the Department of Justice. That same year, Congress made further amendments and modifications to the Harrison Act and, once again, increased penalties for federal law violations.¹⁷¹

International efforts to control drugs intensified during the 1960s. The black market and trafficking of illicit drugs was taking on added importance in the United States by the end of the decade when “a torrent of Mexican and, to a lesser degree, Colombian marijuana flooded the country.”¹⁷² Heroin was smuggled from Turkey in massive quantities and by 1970 the United States saw unprecedented levels of heroin use. Drugs were becoming one of the nation’s most prominent issues of social concern.

Even with the raft of federal anti-drug laws and agencies to enforce them, such enforcement efforts did not stem the tide of drug use and drug-related crime; and yet there was also a certain perverse, bureaucratic imperative that worked to perpetuate the vigilant fight against drug use and drug trafficking, as Gore Vidal observed in 1970:

The bureaucratic machine has a vested interest in playing cops and robbers... want[ing] strong laws against the sale and use of drugs because if drugs are sold at cost there would be no money in it for anyone. If drug were cheaply available, addicts would not commit crimes to pay for the next fix, but if there was no money in it, the Bureau of Narcotics would wither away, something they are not about to do without a struggle.¹⁷³

THE MODERN “WAR ON DRUGS”

Under President Nixon’s command the U.S. embarked on a new era of drug control. Shortly after assuming office in 1969, President Nixon announced a global campaign to stamp out drugs and drug traffickers. He launched “Operation Intercept” and ordered the closure of 2,500 miles of the Mexican border and searches of hundreds of thousands of people and vehicles.¹⁷⁴ In 1970 Nixon created the National Commission on Marijuana and Drug Abuse and in 1971 he declared drugs to be “public enemy number one.” These actions marked the initiation of the national and international “War on Drugs.”

The Comprehensive Drug Abuse Prevention and Control Act of 1970

The Controlled Substances Act of 1970 was another historic turning point in America's attitude and approach to regulating illicit drugs.¹⁷⁵ This Act completely replaced the Harrison Narcotic Act as the federal government's primary vehicle of domestic drug control. It reformed all previously existing drug laws under the federal power to regulate interstate commerce and introduced a system by which drugs were divided into categories depending upon their potential for abuse. One immediate impact of this act was to "effectively destroy the Federal-State relationship that existed between the Harrison Act and the Uniform Narcotic Drug Act."¹⁷⁶ To restore this balance the Commissioners on Uniform State Laws created the Uniform Controlled Substances Act.¹⁷⁷ This scheme of complementary federal and state drug control laws soon became the national standard.

The "War on Drugs" came of age in the 1970s as President Nixon declared "total war...on all fronts against an enemy with many faces,"¹⁷⁸ a thinly-veiled reference to counter-culture protesters and racial minorities.¹⁷⁹ Nixon exhibited personal anger toward drug users in America and "as a puritan and as a man perennially frustrated with his circumstances ...detested the hedonism and easy gratification of many young people."¹⁸⁰ This sentiment was reflected in some of the heavy-handed drug policies the Nixon administration pursued, although there was also a major thrust at the time to address the heroin addiction problem through treatment.¹⁸¹ The federal bureaucratic mechanism for drug control was strengthened under Nixon as Congress consolidated all anti-drug activities under the new Drug Enforcement Agency in 1973.

The federal approach toward illegal drugs took on a slightly different tenor during the brief administration President Ford, who expressed some pragmatism about drug use. While Ford did continue to press for stronger anti-drug measures, he did so from a perspective that drug abuse was always going to be a problem and that hopes of completely eliminating it were illusory.¹⁸² This new attitude was also reflected during the Carter administration, as President Carter expressed concerns about current drug policies and even suggested that marijuana should be decriminalized.¹⁸³ This suggestion never made its way into federal law, however, and before long, any perceived softening of attitudes towards drug use quickly dissipated.

Out of the maelstrom of Vietnam, Watergate, oil embargoes and "stagflation" in the late 1970s, popular fears rose once again to dictate national drug policy as the political center of gravity was moving back to the right. The infamous drug cartels from Colombia were becoming a fixture in international politics and trade, and parents were becoming more concerned about drug use by their pre-teen and teenage children. President Ronald Reagan came to office with an attitude toward illicit drugs that was reminiscent of the Nixon years. Nancy Reagan's "Just Say No" campaign swept the nation in the 1980s and was very popular with parents, schools and the media. Reagan also supported a strong law enforcement approach to drug control and even replicated some of the tactics used earlier during the Nixon administration.¹⁸⁴

The Comprehensive Crime Control Act of 1984

In 1984 Congress amended the Controlled Substances Act in various ways, including providing for scheduling of certain “designer drugs,” for government seizure of profits derived from criminal acts and for temporary placement of substances into Schedule I of the CSA without the usual procedural requirements when required to avoid an imminent public safety hazard.¹⁸⁵ By this time, a new “menace” was emerging on the national scene in the form of crack cocaine. Images of street gangs, inner city violence and the growing threat of a deadly new disease called AIDS were creating fear across all across the nation and having a profound influence on public perceptions of drugs. In 1986 a college basketball star, Len Bias, died suddenly from a suspected cocaine overdose and the furor over cocaine and other drugs became front-page news.

The Anti-Drug Abuse Act of 1986

In 1986 President Reagan signed the Anti-Drug Abuse Act of 1986¹⁸⁶ and intensified the federal government’s campaign against drugs and the bipartisan support for tough new penalties for drug law violators was partly a reaction to the overdose death of Len Bias. Passed with a nearly unanimous vote, the Act instituted five- and ten-year mandatory minimum sentences and also the possibility of the death penalty for certain drug offenses.

The Anti-Drug Abuse Act of 1988

The White House Office of National Drug Control Policy (ONDCP), an Executive branch office, was created with passage of the Anti-Drug Abuse Act of 1988.¹⁸⁷ This measure was directed toward preventing the manufacture of scheduled drugs and included increased penalties to further discourage drug use. In passing this legislation, Congress avowed that, “the legalization of illegal drugs, on the Federal or State level, is unconscionable surrender in a war in which...there can be no substitute for total victory,” and that “it is the declared policy of the United States Government to create a drug-free America by 1995.”¹⁸⁸ Despite billions of dollars in spending and the incarceration of tens of thousands of drug offenders, this goal was never attained.

The “War on Drugs” into the 21st Century

Drug-related law enforcement activity and the increasing incarceration of drug offenders did not slack off during the 1990s, when “illicit” drug use was on the rise again. In fact, the last decade of the 20th century saw unprecedented law enforcement activity related to illegal drugs. Unfortunately, the increasing arrest and incarceration of drug offenders and the lengthening of prison sentences during the 1990s failed to reduce the prevalence of drug use, the problem of drug abuse, the incidence of drug offenses and drug-related crime and the related public costs.¹⁸⁹

Recent rehabilitative options for drug offenders have largely been a reaction to the perceived ineffectiveness of criminal sanctions. Some encouraging reports have come from the nation’s new “drug courts,” which have been shown to reduce recidivism and prohibited drug use among their participants.¹⁹⁰ Meanwhile, the vast majority of drug offenders at the state and federal levels continue to serve long prison terms, most without

any rehabilitative component to their sentences, as taxpayers continue to spend hundreds of millions of dollars annually to confine repeatedly a class of non-violent offenders who have the highest recidivism rate because of their drug dependence.

The Legacy of Drug Prohibition

The unfortunate legacy of the recent federal drug laws includes a five-fold increase in federal drug convictions since the 1970s and over 67,000 sentenced drug offenders in federal prison in 2001, up from only 3,400 in 1970, where drug offenders now comprise over 55% of the federal prison population.¹⁹¹ In the states, the number behind bars for violating the drug laws has increased eleven-fold since 1980, from fewer than 42,000 at that time to almost 500,000 today.¹⁹² As the “War on Drugs” has intensified in the past 25 years, the number of incarcerated drug offenders has grown by over 1,000 percent, nearly 40 times greater than the growth rate of the U.S. population overall.¹⁹³

The tragedy of mass incarceration of drug law violators in the U.S. has been compounded by the lack of progress in reducing access to and use of drugs, especially the use of “hard” drugs by young persons. Heroin is reported to be easier for high school student to obtain today than it was in the 1970s and 1980s and one in three high school seniors say that it is now easy to get cocaine, crack or LSD.¹⁹⁴ Cocaine use among teens has risen recently and the average age at first use, particularly of crack cocaine and heroin, has declined significantly in the last dozen years.¹⁹⁵ In addition, high school seniors report that marijuana is easier to get now than it was during most of the 1980s and 1990s and more high school students currently use marijuana than tobacco.¹⁹⁶

The White House drug control office stresses the importance of supply reduction efforts “to make drugs more expensive, less potent, and less available.”¹⁹⁷ However, despite federal expenditures of over \$45 billion since 1980 on such efforts,¹⁹⁸ the White House itself has reported that cocaine and heroin “street” prices have fallen to historic lows while purity levels have risen and remained stable, signs that the criminal enterprises trafficking in drugs are becoming more efficient, selling a better product for less.¹⁹⁹ Meanwhile, law enforcement agencies across the U.S. continue to report that illegal drugs are “readily available” in urban, suburban and rural areas.²⁰⁰ The abject failure of current U.S. drug policy has finally led to calls for fundamental reform.

II. INTERNATIONAL TRENDS IN DRUG POLICY: LESSONS LEARNED FROM ABROAD

Nations across the world face the continual challenge of drug abuse and drug-related crime within their own borders and, like the United States, they struggle with the costly ineffectiveness of their current drug policies. Just as many American states are beginning to depart from the harshly punitive approach through innovations such as drug courts, several nations, particularly in Europe, have devised methods under the rubric of “harm reduction” that have been shown to address the problem of drug addiction more effectively than strict criminal law enforcement. Meanwhile, in other regions of the world, particularly in Asia, states have been turning to ever harsher measures, including summary executions, but with no success in reducing drug use or its attendant harms. The following survey of the most recent international trends in drug policy should provide useful guidance in the effort to improve drug policies in the United States:

INTERNATIONAL LEGAL FRAMEWORK

The current drug control regime is global in scope, under a series of international conventions adopted by United Nations member nations.²⁰¹ Most nations are signatories to those treaties, which prohibit the use and sale of the same drugs that are prohibited in the United States.²⁰² The U.N. conventions are part of the large body of international law that is not “enforceable” in the traditional sense, but signatories to the drug control treaties are subject to enormous diplomatic pressure, particularly from the United States, not to enact national laws that depart from the prohibition framework.²⁰³ The International Narcotics Control Board (INCB), an independent body within the United Nations, serves more as a panel to monitor adherence to the U.N. conventions rather than as an enforcement agency, but it often voices support for or objection to drug policy developments around the world, consistent with prevailing U.S. domestic and foreign drug policy interests.²⁰⁴

Within the framework of international drug prohibition, a number of countries, especially in Europe, now employ less punitive measures to address drug use and dependence without endangering their international legal or diplomatic standing – despite occasional public scolding from the United Nations.²⁰⁵ Within the European Union, however, fundamental opposition to prohibitionist drug policies has begun to surface among parliamentarians. In 2003 a group of 108 members of European parliaments from seven political groups and 13 European Union member states recommended reform of the United Nations drug control conventions, denouncing prohibitionist policy as the cause of harm “because it is an obstacle to prevention, only leads to blind repression and causes rising profits to organized crime.”²⁰⁶ Among European leaders there is certainly no consensus about the wisest approach to drug policy, but there is a desire to reconcile differing views on the matter. Greek Prime Minister George Papandreou, the European Union President in 2003, called for an open and frank discussion of international drug laws to deal with the disparate nature of its members' treatment of the subject.²⁰⁷

STRICT PROHIBITION MODEL

The strict prohibition model of drug control is reflected in the current policy of the United States, codified under the federal Controlled Substances Act and complementary executive policies and state and local laws. Under the paradigm of strict prohibition, proscribed drugs and their use are subject to control by the criminal justice system and only complete abstinence is permissible under the law. The primary objective of the strict prohibition model is “use reduction” or “prevalence reduction,” with the eventual goal of eliminating all illegal drug use.²⁰⁸ The possession of “soft” drugs, such as marijuana, is either a criminal or a serious civil offense and possession of “hard” drugs, such as heroin or cocaine, is always a criminal offense.²⁰⁹ Distribution and manufacturing are always punished even more severely.

American drug control interests extend worldwide, particularly to the countries supplying the drugs that meet U.S. demand. Most of the “source” countries are economically vulnerable and comply with U.S. policies and practices, often employing drug-related punishments more harsh than in the U.S. Southeast Asia is the latest region of the world to be inundated by illegal drugs and the associated criminal enterprises and states such as Thailand have imposed severe, military measures in response, not only inviting criticism from human rights groups, but also failing to abate continued drug abuse problems.²¹⁰ Besides drug trafficking, many countries still punish simple drug possession harshly, not only in Asia but even in Bulgaria, which has re-criminalized the possession of small amounts of drugs, punishable by three to fifteen years in prison.²¹¹

“Source Control”

The United States remains committed to a vigorous interdiction effort, arguably the most militaristic aspect of the “War on Drugs,” despite decades of failing to stem the plentiful supply of illegal drugs across the border.²¹² In the months before the terrorist attacks of September 11, 2001, the top priority for American intelligence agencies was illegal drug interdiction and twice as many agents were assigned to drug enforcement than to counterterrorism.²¹³ Despite that effort, the street prices of heroin and cocaine are at a 20-year low.²¹⁴ Currently, the U.S. military remains deeply involved in drug interdiction efforts, particularly at the Mexican border and in South America.

In 2000 the U.S. Congress, with Clinton administration support, provided a \$1.3 billion package for Colombia to combat the illegal drug trade and rebel forces.²¹⁵ The failure of “Plan Colombia” was evident early, as the area of Colombia planted with coca actually increased by over 25 percent during the first two years of the military operation and Colombia continued to supply over 80 percent of the cocaine shipped into the U.S.²¹⁶ Domestic opposition to “Plan Colombia” continued to mount, and two weeks before the terrorist attacks on the U.S. in 2001, a bipartisan group of legislative leaders in Colombia introduced bills to decriminalize and legalize the drug trade, as former President Ernesto Samper commented: “The problem is that the law of the marketplace is overtaking the law of the state. We have to ask, is legalization a way out of this?”²¹⁷

Since September 11, 2001, however the Colombian government has resumed a hard-line stance and has cooperated extensively with the Bush Administration, which has continued to seek increases in the number of military troops and advisors and civilian contractors participating in “Plan Colombia.”²¹⁸ After almost four years and \$4 billion invested, even the Director of the White House Office of National Drug Control Policy, John Walters, admitted that the U.S.-sponsored South American anti-drug campaign has failed to dent the flow of Latin American cocaine onto American streets, acknowledging that “we have not yet seen in all these efforts what we're hoping for on the supply side, which is a reduction in availability.”²¹⁹

Although the U.S. government points to a decrease in coca cultivation in Colombia as a success, the market is nevertheless robust, as the amount being produced more than satisfies U.S. demand for cocaine, and the trade has adapted by developing new markets outside of the U.S.²²⁰ In addition, drug traffickers have produced a genetically engineered strain of “super coca” that is resistant to the defoliating chemicals being sprayed on the coca fields. The potent plant can grow more than twelve feet tall, compared to the regular plant which grows only five feet, and yields four times more cocaine than existing plants, allowing growers to plant smaller fields.²²¹

Latin American farmers growing coca have organized resistance to the American-led drug eradication efforts, destabilizing their own governments in the process.²²² In Bolivia, coca-growing peasants were instrumental in bringing down the presidency of Gonzalo Sanchez de Lozada, who resigned after weeks of violent protests that virtually paralyzed the nation, and Bolivia subsequently softened its stance in support of coca crop eradication efforts.²²³

Elsewhere in Latin America, the Brazilian government has authorized the military to shoot down any planes it believes is involved in drug trafficking.²²⁴ This type of interdiction strategy has not been popular since a plane carrying innocent civilians was shot down in 2001 by the Peruvian military in conjunction with U.S. intelligence. Colombia resumed their shoot-down program in 2003 and had shot down almost a dozen planes in the first half of 2004 with the backing of the United States.²²⁵ Since the election of President Vicente Fox, Mexico has been a strong partner with the United States in the “War on Drugs,” but the lure of profit in the drug trade still corrupts police forces across Mexico. All the detectives on one of Mexico’s state police forces were suspended recently after two top officers were arrested on federal drug trafficking charges.²²⁶ Furthermore, despite the Mexican government’s fumigation efforts, opium poppy production increased 78% in 2003 after a 70% increase in 2002.²²⁷

In Central Asia, the United States has not been able to stop the growth of opium poppies despite its military presence in Afghanistan, which produced 89 percent of the world’s opium at the end of 2004.²²⁸ Almost two million poppy farmers, or seven percent of Afghanistan’s population, are attracted to the high profits. The price of opium has dropped with so many farmers producing poppies, while the price of cucumbers, okra and tomatoes has soared with the shortage of vegetable crops.²²⁹ Opium traffickers and their supporters are even among officials in the Afghan government.²³⁰ The opium and heroin leaving Afghanistan travels mainly through Iran, which has led to an increase in heroin use in Iran, angering officials who are frustrated at the United States’ failure to take

responsibility for fighting drugs in Afghanistan.²³¹ As of 2002, there were an estimated 2 million drug addicts in Iran, giving it one of the highest addiction rates in the world.²³² On the other hand, just as the U.S. military began direct operations against the opium producers, Afghan President Hamid Karzai protested, not wanting to antagonize the regional warlords during the period before the first national election.²³³ Nevertheless, only six months later, suspicions of U.S. aerial spraying of poppy crops began to arise.²³⁴

Illegal drug markets flourish elsewhere in the world, even in the South Pacific, where interdiction efforts have been just as unsuccessful as in Latin America and Asia. Australian and Fijian police have been attempting to intercept the large amounts of methamphetamine that is being produced in Fiji for distribution in the United States, Europe, Australia and New Zealand. Countries in the South Pacific are considered vulnerable to exploitation by drug traffickers and manufacturers.²³⁵

Death Penalties and Death Squads

The strictest enforcement practices of the drug prohibition model are found in East Asia and Southeast Asia and on the Arabian Peninsula and have attracted attention from human rights monitors. In one example, Thailand's Prime Minister Thaksin Shinawatra declared victory in the country's "war on drugs" in late 2003, purportedly fulfilling King Bhumibol Adulyadej's 2002 birthday wish that he hoped the country would be free of drugs by his next birthday. During 2003 thousands of suspected drug dealers were allegedly murdered by Thai police in order to carry out that goal.²³⁶ Another side-effect of Thailand's drug war has been an increase in alcoholism and homeless children; the number of alcoholics seeking treatment has risen 30% since the major offensive began in early 2003 as former amphetamine users take up alcohol as a replacement.²³⁷

In the Philippines, death squads popularly linked to police, businessmen and local officials have been operating with impunity since the late 1990s in Davao City and the surrounding region, slaying dozens of people. No death squad member has been arrested despite years of killings. Those killed are almost always on lists of persons "wanted" by the Philippines Drug Enforcement Agency (PDEA). Davao City Mayor Rodrigo Duterte has warned drug dealers to "start swimming" as far as Indonesia if they want to survive and has called critics of the death squads "reactive idiots." The killings have support, especially among law enforcement and the business community, who feel more confident to operate "free from criminals, drug syndicates and terrorists."²³⁸

Many drug-related offenses are subject to the death penalty in Vietnam, Singapore, Malaysia, China, Iran and Saudi Arabia, as hundreds, if not thousands of drug law violators are executed each year. In Singapore the law imposes a mandatory death sentence for at least 20 different drug-related crimes.²³⁹ For instance, anyone caught with slightly more than a pound of marijuana or more than a half ounce of heroin is considered a drug trafficker, where the only penalty is death by hanging.²⁴⁰ In 2004 the interim president of Iraq, Ayad Allawi, announced that Iraq was also to resume the death penalty for drug traffickers.²⁴¹

On June 26, 2004, to mark the United Nations' International Day Against Drug Abuse and Illicit Trafficking, China tried, sentenced and executed dozens of people convicted of drug trafficking. Twenty-eight people were executed in China on that day alone and at least 50 others were executed in the week leading up to Anti-Drugs Day.²⁴² Despite the public executions, levels of drug use and abuse and drug-related crime in China are rising.²⁴³ While China has 1.05 million registered drug addicts, 75% of whom are under age 35, experts believe the actual number of addicts is over 4 million.²⁴⁴

Citizenship Revocation and Deportation

In addition to summary executions and the incarceration of large numbers of people, Thailand is also considering stripping the citizenship of those people whom it believes are involved in trafficking. The new edict also would strip the citizenship of that person's family members.²⁴⁵ In The United States, in the wake of the September 11 attacks, federal immigration authorities have taken a hard-line approach by deporting non-citizens convicted of even minor drug offenses, irrespective of how long they have lived away from their country of origin or whether it is currently safe for them to return to their country of origin.²⁴⁶

Mass Incarceration

The strict prohibition model of drug control has strained the limits of the criminal justice system. By the end of 2003, the incarceration rate in the United States was at an all-time high, with over two million people behind bars. Nearly seven million people, or one of every 32 adults, were under some form of correctional supervision.²⁴⁷ According to the U.S. Justice Department, drug offenders "represent the largest source of jail population growth," as the number of people in jail for drug crimes increased 37% from 1996 to 2002 and thirteen percent of those jailed for drug crimes were there for their first offense.²⁴⁸ With 1.4 million people in federal and state prisons, the numbers are likely to increase, with relatively long mandatory minimum sentences, and even life sentences for drug offenses.²⁴⁹ Along with the high incarceration rates is the deterioration of prisons across the country, including in California, the largest state prison system, which was called "dysfunctional" in a recent report commissioned by Governor Schwarzenegger.²⁵⁰

Prisons in East Asia are also filling up with drug offenders. The Philippines has launched a campaign to rid the islands of drugs by 2010, resulting in crammed jails and a paralyzed justice system.²⁵¹ As of 2004, the country had 3.4 million drug users.²⁵² Although Vietnam sentences people to death or life in prison if caught possessing or trafficking 600 grams of heroin or 20 kilograms of opium, the country reported having 169,000 drug addicts in late 2003, up 22,000 from the previous year.²⁵³

INNOVATIONS WITHIN THE PROHIBITION MODEL

Despite the global reach of drug prohibition, many countries are finding room to apply different means to address the problems of drug addiction and drug-related crime. In Canada, Australia, New Zealand and Western Europe, and in some corners of the United States, the law treats the offenses of drug possession and use very differently from offenses involving the distribution or manufacturing of drugs, reflecting an understanding of the counterproductive effect of punishing drug users who possess small amounts of drugs for their personal use. Even the former chief of Interpol, Raymond Kendall, has admitted that drug prohibition has failed and has actually worsened conditions, and that the only effective solution is harm reduction, suggesting that drugs be medicalized rather than criminalized.²⁵⁴

Across Europe there is significant variety in national drug control policies.²⁵⁵ In Scandinavia, for example, Sweden and Norway favor the American-style approach and base their drug policies on moral grounds, applying harsh sanctions for drug use and eschewing measures to reduce the harm from illegal drugs.²⁵⁶ By contrast, other European nations are more pragmatic in their approach, including Switzerland, the Netherlands, Italy, Spain and Portugal, which have largely decriminalized or “depenalized” personal drug possession and use and have sought to employ measures to reduce the harm from drug use rather than merely attempting to reduce drug use *per se*. Expressing this pragmatic view, the president of the Swiss Confederation recently acknowledged the permanence of drug use in modern life, stating that Switzerland is facing up to “social reality.”²⁵⁷

Harm Reduction – A Guiding Principle

The principal objective of the strict prohibition model is “use reduction” but an alternative core concept driving drug policy reforms in Europe and in other wealthy countries is “harm reduction.”²⁵⁸ The harm reduction concept has already been embraced in other policy domains, including mandated safety standards for motor vehicles, toys, sports equipment, food and pharmaceuticals, the distribution of condoms in schools, social welfare supports for the homeless and the unemployed and the promotion of the “designated driver” in situations where alcohol consumption raises the risk of traffic-related injury or death.²⁵⁹ The practice of harm reduction acknowledges drug use as part of the human world, for better or worse, and measures the quality of individual and community life and well-being rather than drug use *per se*. The principles guiding the practice of harm reduction dictate a non-judgmental and non-coercive approach, rendering services to assist drug users in reducing the attendant harm from drug use and often in reducing drug use itself.²⁶⁰

Critics of the harm reduction approach – defenders of the strict prohibition model – assert that any tolerance of drug use “sends the wrong message” and is tantamount to an endorsement of drug use, leading to greater use and greater harm. However, a service provider practicing harm reduction would likely deliver the following message:

We view drug use as harmful, we discourage drug use and we are eager to help you stop using drugs. If you will not stop using drugs,

however, we can help you reduce the harm from your drug use.

Rather than an “endorsement” of drug use, the social message of harm reduction is that certain acts are socially unacceptable but the actor can still repair the damage.²⁶¹

It is important to note that harm reduction is not necessarily antithetical to drug prohibition, illustrated by the recent proliferation of harm reduction programs in Europe. Just as harm reduction measures seek to reduce the harmful effects of drug use, they also seek to reduce the harshness of the punitive drug prohibition regime without necessarily challenging the regime itself.²⁶²

In North America, the city of Vancouver, British Columbia, is boldly establishing harm reduction as one the “four-pillars” of its drug policy, along with prevention, treatment and law enforcement.²⁶³ The harm reduction pillar is described as:

a pragmatic approach that focuses on decreasing the negative consequences of drug use for communities and individuals. It recognizes that abstinence-based approaches are limited in dealing with a street-entrenched open drug scene and that the protection of communities and individuals is the primary goal of programs to tackle substance misuse.²⁶⁴

Vancouver’s harm reduction programs currently include a supervised safe injection site, needle exchanges and community health services.²⁶⁵ Elsewhere in Canada, the city of Winnipeg has begun distributing crack smoking kits filled with glass-tube pipes, matches and lip balm, hoping to reduce harms to crack users and develop relationships between the users and outreach workers.²⁶⁶

Scotland has started providing clean needles, with no questions asked, in its prisons in order to combat the spread of deadly diseases such as Hepatitis C and HIV/AIDS, acknowledging the reality of drug use within the prisons.²⁶⁷

Harm reduction principles in Europe support policies that segregate illegal drug markets, whereby distinctions in the treatment of “hard” and “soft” drug markets reduce the likelihood that people acquiring soft drugs will be exposed to dealers trafficking in hard drugs. Profit margins for hard drugs are much higher, giving a seller of hard drugs an incentive to try to sell hard drugs to someone who is only interested in a soft drug like marijuana. Cannabis “normalization” is thus another part of an overall harm reduction strategy.²⁶⁸

Diversions and Drug Treatment

Some nations, and currently some states and local governments in the United States, have chosen to divert drug law violators from prison or jail into compulsory treatment. In California, Proposition 36, a ballot initiative enacted in 2000, gives non-violent drug possession offenders the right to receive drug treatment instead of incarceration.²⁶⁹ In the first two years of the law’s enactment, 66,000 arrestees were diverted.²⁷⁰ Across the United States, court-supervised drug treatment programs, most often federally-supported “drug courts,” are proliferating rapidly, offering defendants alternatives to incarceration and offering local jurisdictions the opportunity to save court

and detention costs.²⁷¹ The diversion of drug offenders into treatment, although it is considered an “innovation” in drug policy, still falls squarely into the strict prohibition model, whereby individuals are subject to the control of the criminal justice system and total abstinence from drug use is the only permissible outcome.

A number of European nations also divert minor drug law violators into compulsory treatment, including France, Germany, Switzerland, Norway and Italy.²⁷² Sweden maintains the most intrusive and paternalistic policy in this regard, allowing local authorities to impose compulsory treatment on any individual suspected of being a drug abuser, *even without any arrest or conviction*.²⁷³ In Western Australia, people caught with a personal amount of drugs, besides marijuana, can choose to enter counseling as long as they are first-time offenders, admit to the crime and are only charged with the drug crime.²⁷⁴ In the state of Victoria, first time offenders are cautioned and referred to a drug education service.²⁷⁵

In a few nations beyond Europe and America, drug addiction is regarded as a health problem rather than as a criminal problem. In Nigeria, for instance, the National Drug Law Enforcement Agency (NDLEA) describes drug addicts as “victims” rather than as “offenders” and those arrested for drug possession are given counseling and released, unless the addiction is deemed to be so damaging to the individual that it requires treatment and rehabilitation with a plan for reintegration into society.²⁷⁶ Even on the Arabian Peninsula, the United Arab Emirates is likewise considering shifting its drug policy toward treating drug users like patients instead of criminals, as “victims” that should be treated and reintegrated into society.²⁷⁷

Decriminalization

Many nations have pushed the bounds of the strict prohibition model by decriminalizing the possession of small amounts of drugs for personal use. Spanish law has not imposed criminal sanctions for possession of small amounts of drugs since 1983; Italy decriminalized drug possession from 1975 to 1990, re-criminalized drug possession again from 1990 to 1993 and then returned once again to decriminalization.²⁷⁸ More recently, the Belgian Parliament modified its drug laws to establish a new scheme that increases criminal sanctions for illegal drug production, continues to criminalize possession and cultivation of drugs, but separates cannabis from all other drugs, allowing for civil fines for possession or cultivation of cannabis for personal use for the first and second offense. Individuals can be sent to treatment in any phase of the legal process if there is evidence of problematic use.²⁷⁹

In Portugal, a new law took effect in July 2001 that eliminated all criminal penalties for possession or use of small amounts of any illegal drug. Instead of arrest, anyone caught using or possessing small amounts of illegal drugs is reported to a special commission set up by local authorities to ensure that users seek treatment. Although sale and trafficking of drugs are still criminally punished, the sale of drugs to support one’s own drug habit is considered a mitigating circumstance. As Portuguese drug policy has turned away from the punitive approach, individuals with drug problems have been voluntarily appearing at government offices and asking for treatment, no longer fearing punishment by the state.²⁸⁰

Russian President Vladimir Putin signed a bill into law in early 2004 allowing persons to escape criminal liability for possession of small amounts of drugs. The amendment to the Criminal Code stipulated that possession of no more than ten times the amount of a single dose is considered an administrative infraction rather than a criminal offense.²⁸¹ This is considered a much-needed positive step in a country with an outdated drug policy scheme that is fueling Russia's HIV-infection rate to epidemic proportions.²⁸²

The Dutch government has instituted *de facto* decriminalization even for some drug trafficking activities, having quietly stopped prosecuting the smuggling of small amounts of cocaine coming into Amsterdam's international airport. The policy may soon be expanded to other "hard" drugs.²⁸³

In Latin America, domestic social concerns and increasing annoyance with U.S. interference in local politics has led some countries to reform their punitive drug laws, or at least to attempt such reform, while at the same time often retaining harsh laws for drug trafficking. The Venezuelan government proposed decriminalizing possession of up to a ten-day supply of drugs and increased penalties for trafficking.²⁸⁴ In Ecuador, people caught with a small amount of drugs who are deemed to have an addiction can be released.²⁸⁵ Existing law in Colombia allows the possession of "personal dosages" of cocaine, hashish and marijuana and some Colombian legislators would like to halt the prosecution of peasants who cultivate less than seven acres of coca or opium plants.²⁸⁶ A proposal in the National Congress of Brazil would subject drug users and addicts to educational measures instead of prison terms. Treatment would not be compulsory but freely available to those who elect it. At the same time, minimum penalties for drug traffickers would be raised.²⁸⁷ In the Caribbean, Jamaica's National Commission on Ganja, established by the government to consider the issue, recommended decriminalizing the possession of marijuana for personal use.²⁸⁸

Decriminalization of cannabis has even reached Sri Lanka, where the government is considering legalizing cannabis as an herbal medicine for ayurvedic practitioners.²⁸⁹

Cannabis Normalization

The Netherlands has long been a pioneer in implementing pragmatic and innovative drug policies. A key tenet of Dutch drug policy is "normalization," fostering the integration of drug users and drug addicts into the community rather than their marginalization, which helps to discourage antisocial behavior and facilitates treatment and rehabilitation.²⁹⁰ The policy of "normalization" applies most readily to cannabis, or marijuana.

In the late 1960s and early 1970s, the Dutch established two national commissions to review what was perceived as the growing problem of cannabis use by Dutch youth.²⁹¹ The first commission, known as the Hulsman Commission, acknowledged the limits of criminal law enforcement in the attempt to control illegal drug markets and drug use:

Police forces will have to be constantly enlarged to keep pace with the never ending escalation. If we opt for criminal law as the central

means for opposing drug use, this option is inadequate and therefore also extremely dangerous. Time after time it will show that the means will fall short, upon which those who favor punishment will plead for increase of law enforcement, until it will be amplified a hundred fold from the present situation...This will boost polarization between different parts of our society and can result in increased violence.²⁹²

The second commission, known as the Baan Commission, issued a landmark report in 1976 evaluating the risks associated with the use of drugs, including tobacco and alcohol, dividing those risks into physical damage, psychological damage and social damage. The report described the social aspects of drug use and small drug trade in the Netherlands, revealing the special characteristics of a youth culture and sub-culture that were important determinants of the functions of drug use. The Baan report concluded that stigmatizing “deviant” behavior, such as drug use, through the use of punitive measures would likely increase the probability that such behavior would intensify, initiating a downward spiral that would impede the return of the stigmatized drug user to a socially accepted life style. Further, the Baan report countered hypotheses that drug use stemmed primarily from social misery or pathology.²⁹³

Examining the epidemiology of drug use in the Netherlands and the demographic characteristic of drug users, the Baan report found that most drug use is short-lasting experimentation by young persons and also that cannabis use does not lead directly to other drug use. However, the report concluded that laws declaring cannabis illegal promote contacts between cannabis users and those who use “harder” psychoactive substances, increasing the likelihood of multiple drug use. Like the Hulsman report before it, the Baan report embraced this social scientific perspective and proposed separating the drug-using subcultures.²⁹⁴

The legal and policy reforms coming out of the Dutch commission reports evolved into the current Dutch approach, which officially separates the market for cannabis from the market for other drugs. In 1976, the Dutch adopted a written policy of non-enforcement for violations involving possession or sale of up to 30 grams of cannabis, a threshold that was reduced to five grams in 1995. The written policy regulates the technically illicit sale of such small amounts in commercial establishments called “coffee shops,” of which there are up to 1,500 nationwide. The regulations are strictly enforced and prohibit advertising, hard drug sales, transactions over the small quantity threshold and public disturbances. In the meanwhile, Dutch law enforcement agencies move aggressively against any large-scale cannabis growers or distributors.²⁹⁵

Because drug use and other consensual activities have been “normalized” in the Netherlands, central Amsterdam may impress the uninformed or moralistic observer as rife with vice. A closer look at the prevalence of psychoactive drug use in the Netherlands reveals, however, that heroin use has not risen in the more than 25 years since the adoption of the two-market strategy, as addicts have grown older and fewer young people have initiated heroin use. Cannabis and heroin use in general is lower in the Netherlands than in the United States²⁹⁶ and cannabis use among Dutch teens remains less than half the rate in the United States and much lower than in Britain.²⁹⁷ A recent study comparing marijuana use in the United States and the Netherlands found no

evidence that decriminalization of cannabis leads to increased drug use, putting in to question the notion that strict penalties are the way to inhibit use. There was also no proof that having a regulated legal cannabis market provides a “gateway” to other illicit drug use, when cannabis users in the U.S. were far more likely to have used other illicit drugs.²⁹⁸

In Switzerland, the Public Health Commission of the State Council favors the legalization of cannabis, but the Swiss Parliament narrowly defeated a bill in 2003 that would have decriminalized cannabis. The Swiss are likely to continue efforts to normalize cannabis use.²⁹⁹ Elsewhere in Europe, a movement is afoot to decriminalize cannabis possession in the Czech Republic, where possession of small amounts for personal use has been tolerated since 1999.³⁰⁰ The law is not specific as to the definition of “small amount,” but police and judges have a great deal of discretion, routinely throwing cases out of court. A recent Czech government study concluded that cannabis is no more of a health risk than alcohol or tobacco. Police officials oppose a move toward decriminalization, however, fearing an increase in crime and the use of hard drugs.³⁰¹

The British public and public officials have warmed to the notion of cannabis normalization as the British Parliament took a first step in 2003 by reclassifying and downgrading cannabis from a Class B drug to a Class C drug, reducing fines and possible jail time. This classification puts cannabis on a par with steroids and anti-depressants.³⁰² The reclassification did not legalize or even decriminalize cannabis, but police now have wide discretion to deal with the individual offense. Aggravating factors are now needed to justify arrest, such as using cannabis in front of young people. As for trafficking in cannabis, however, the maximum penalty for trafficking in cannabis was increased, to 14 years.³⁰³

Elsewhere in the English-speaking world cannabis laws are being relaxed, including parts of Australia, where minor possession and growing of cannabis is decriminalized and brings only a fine.³⁰⁴ The most far-reaching proposal has come from Canada, where former Prime Minister Jean Chretien and current Prime Minister Paul Martin have supported the Canadian Parliament’s intention to decriminalize, and eventually legalize cannabis. Even the Royal Canadian Mounted Police Commissioner endorsed legislation to decriminalize small amounts of cannabis for personal use.³⁰⁵ In 2002 Canada's Senate Special Committee on Illegal Drugs released a 600-page report detailing the results of a two-year study on cannabis and its use, recommending legalization with criminal sanctions applying only to “behaviour causing demonstrable harm to others,” including illegal trafficking, selling to minors (16 and under) and driving while intoxicated.³⁰⁶ The fundamental premise underlying the report:

In a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy insofar as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development

and can recognize the presence, difference and equivalence of others.³⁰⁷

In its report the committee identified guiding principles for the roles of the state, criminal law, science and ethics in developing public policy on cannabis, concluding that:

Public policy on illegal drugs, specifically cannabis, ought to be based on an ethic of reciprocal autonomy and a resolve to foster human action. It ought to defer to criminal law only where the behaviour involved poses a significant direct danger to others. It ought to promote the development of knowledge conducive to guiding and fostering reflection and action.³⁰⁸

Canada's move toward relaxing its cannabis laws has infuriated the United States government. The director of the White House drug control office, John Walters, has gone on a campaign claiming that the United States is being inundated with high potency cannabis from British Columbia, even insinuating that it is responsible for sending increasing numbers of Americans to the emergency room.³⁰⁹ However, according to a recent U.S. Department of Justice report, the vast majority of imported cannabis found in the U.S. comes from Mexico, and the number of cannabis "mentions" in emergency rooms was less than 10% of all drug mentions. Despite 98% of state and local law enforcement agencies describing cannabis availability as high or moderate, only 13% of those agencies identified cannabis as their greatest drug threat.³¹⁰

Safe Administration of "Hard" Drugs

The trend toward cannabis normalization is pushing the global drug prohibition model to its limit, leading the United Nations International Narcotics Control Board (INCB) to warn of the "undermining" of the international drug control scheme.³¹¹ Even more controversial, however, is the development of government-sanctioned locations for the safe administration of "hard" drugs, mostly for the safe injection of heroin, but also for the use of stimulants such as crack cocaine. In Europe there are currently almost 50 of these medically-supervised facilities that are available to drug users for administering their own drugs in a safer and non-public space, with the possibility of referrals to social and health services.³¹²

The INCB issued a report in 2003 harshly criticizing safe injection facilities as "violating the provisions of the international drug control conventions."³¹³ However, the treaties provide exceptions for the use of controlled substances if it is for a "medical or scientific purpose."³¹⁴ One week after the INCB's report, the European Union's drug monitoring agency, the European Monitoring Center for Drugs and Drug Addiction, released a report concluding that such sites are largely achieving their intended objectives, including:

- helping to establish contact with hard-to-reach drug-using populations;
- providing a safe and hygienic environment for drug consumption;
- reducing mortality and morbidity associated with drug use resulting from overdose, transmission of HIV and hepatitis and bacterial infections;
- promoting access to social, health and drug treatment services; and
- reducing public drug use and its associated nuisance.³¹⁵

In Germany, the Consumption and Injecting Room (CIR) in Munster reported the following findings for the year 2002:

The CIR has reached the target group of drug users from the visible public drug scene. Feared effects like congregation of drug users and dealers in front of the facility, nuisance of the public, drug dealing in the CIR or honey pot effects were avoided because of the professional work of our staff and density of control In the CIR, the pre-obtained drugs can be used under relatively safe and hygienic conditions, the likelihood of rescue in cases of overdoses increases, infection-prophylaxis can be provided and concentration of problems in the public, including visible drug use and dealing, inappropriately discarded injecting equipment and congregation of a drug scene, is considerably reduced.³¹⁶

Such consumption rooms are also available in Frankfurt and Hamburg, where they are integrated in a drug help center with other services such as counseling, medical help and a shelter.³¹⁷ The German government attributes its steady decrease in drug deaths to its harm reduction policies.³¹⁸

The Netherlands also has a network of facilities for the safe injecting and smoking of prohibited drugs. Registered users can also get a shower, hot food and a “respite from the rigors of the street.”³¹⁹ The facilities provide access to rehabilitation programs and job training, allowing social services and police to establish constructive relationships with drug addicts, which helps to reduce public disorder related to drug use. The most common crimes committed by drug addicts, including burglary, robbery, shoplifting and theft from cars, are considerably less prevalent in the Netherlands than in Britain, for example.³²⁰ The Dutch have also opened a retirement home for addicts and are planning more.³²¹

Harm reduction measures are also being applied in the Americas. The government of Brazilian President Lula da Silva took steps toward the end of 2004 to redefine its national drug policy as a public health problem rather than a criminal problem. While Brazil will still combat drug trafficking, it is moving toward harm reduction for drug users, placing the problem of drug use under the jurisdiction of the Health Ministry. The goal is to create 250 “drug use centers” around the country in 2005 and expand the network of treatment for drug users.³²²

The Canadian government approved a three-year trial of supervised injection for intravenous drug users, beginning in Vancouver in 2004.³²³ At “safe injection” sites, addicts are to be given clean needles, tourniquets, water and cotton balls, nurses supervise the activity and referrals are given for detox centers and homeless shelters. Authorities also hope to increase contact between the state's health agencies and drug addicts. The Canadian government is requiring scientific research to determine the effectiveness of such sites, assessing whether supervised injection reduces the harm associated with intravenous drug use.³²⁴ A study conducted one year after the safe injection site first opened reported that the clinic saves lives, helps heroin addicts improve their lives, and refers two to four clients per day to addiction treatment programs.³²⁵ There is also evidence of an improvement in public order in the community surrounding the clinic.³²⁶

The mayor of Vancouver is interested in adding an “inhalation” room to the safe injection site so that people who smoke drugs such as crack and heroin can benefit from the services provided at the site.³²⁷ Another site is being considered for Victoria, British Columbia.³²⁸

Drug Prescription

Supervised injection facilities do not fit comfortably within the strict prohibition model, but an even more controversial development is the medical prescription of prohibited drugs to drug users, currently being tried with heroin in a number of European countries and in Australia and Canada. Closely supervised provision of injectable, pharmaceutical-grade heroin or other, short-acting opiates, has been shown to be more effective than the use of opiate substitutes such as methadone in recruiting, retaining and benefiting chronic, opiate-dependent, injection drug users who are resistant to current standard treatment options.

The longest-running heroin prescription programs are underway across Switzerland, where chronic heroin addicts receive controlled, daily doses of soluble heroin (diamorphine) under supervised care, along with psychosocial treatment, at injection centers across the country. Oral doses (long-acting or short-acting) are also available. Stabilized patients who have been in the program for several months may eventually take home oral doses of either heroin or methadone to counter withdrawal symptoms.³²⁹

Participants in the Swiss heroin maintenance programs have experienced marked improvement in their physical and mental health, longer stays in treatment, reduction, and sometimes elimination of their drug use, improved social functioning and an enormous reduction in criminal behavior, particularly property-related crimes committed to support the high cost of drug dependency.³³⁰ The favorable outcomes from the limited trials in the mid-1990s led the Swiss Government to enact the Ordinance Concerning the Medical Prescription of Heroin in 1999, enabling high-quality, standardized treatment to be provided throughout Switzerland. By 2003, there were 1,232 recognized addicts who received daily treatment in 21 outpatient treatment centers and two prisons.³³¹

Swiss health insurers must pay 75 percent of the cost of heroin prescriptions, or about \$10 million annually. The patients pay the remaining cost, unless they are indigent, in which case the local government subsidizes the amount. Both outpatient and residential treatment, along with counseling and services, are available in centers located in rural areas and in mid-size and large towns. Abstinence is the eventual goal for all patients but short-term goals are emphasized, which is consistent with the principles of harm reduction.³³²

A growing number of European countries are following the Swiss lead, instituting heroin prescription trials of their own.³³³ In the Netherlands, a successful pilot program providing free heroin to 300 participants has been expanded to treat thousands of heroin users. According to the Dutch agency managing the heroin prescription trial, all participants in the pilot program had better mental and physical health after one year in the program, while the number of days addicts engaged in crime to “score” heroin

dropped from 14 to two per month.³³⁴ The changing political climate in the Netherlands has cast uncertainty over the future of heroin prescription, however. In 2002 heroin was to be submitted for registration as a medicine in the Netherlands, but since the election of the present center-right coalition government there has been opposition to heroin-assisted treatment and the plans for further expansion of the program and for the registration of heroin as a medicine were rejected by Parliament, leaving only the projects already underway to be continued.³³⁵

Germany launched a three-year, clinical trial in 2002 for 1,120 opiate addicts, with half being prescribed heroin and the other half methadone. Comparable to the Swiss approach, the German project is designed to benefit dependent drug users who have fallen through the net of existing support programs. The clinical evaluation of the trial is comparing the heroin treatment group with the methadone treatment group, measuring health improvements and reductions in drug-related crime and addiction.³³⁶ Supported by the Federal Health Ministry and numerous German states, and overseen by the German Medical Association, opiate prescription centers are currently located in Hamburg, Hanover, Cologne, Frankfurt, Karlsruhe, Munich and Bonn. According to reports published in the press, the initial experience with heroin prescription in Germany has been positive.³³⁷

Spain has also had success with its clinical trials of heroin prescriptions. Compared to the control group prescribed with only methadone, those who received maintenance doses of heroin markedly improved their physical and mental, they were four times less likely to contract HIV, and the likelihood of their engaging in criminal activity was reduced by double.³³⁸

In Britain, heroin has long been recognized as a medicine, but the British experience with heroin prescription has been controversial. Heroin maintenance programs were used by general practitioners throughout the early 1900s, supported by the Dangerous Drugs Regulations of 1921, which authorized "any duly qualified medical practitioner ... so far as is necessary for the practice of his profession or employment in such capacity to be in possession of and supply the drugs."³³⁹ There were less than 100 known heroin addicts from the 1930s through 1960s taking advantage of the treatment through general practitioners.³⁴⁰ Heroin use in Britain sharply increased in the 1960s, however, attributed to both Canadian and American addicts moving to London and an "American-style" response by Britain to the modest rise in the number of addicts.³⁴¹ In response to the increase in addicts, the ability of doctors to prescribe heroin was curtailed with the 1971 Misuse of Drugs Act, after which a dramatic increase in heroin addiction ensued as the unregulated "black market" provided an ample supply. The number of heroin users in Britain increased from less than 2,000 in 1971 to over 300,000 today.³⁴² Faced with such a high prevalence of heroin use, and observing the positive outcomes from heroin prescription programs in Switzerland and elsewhere, the British government has once again shown interest in expanding the allowance of doctors who can prescribe heroin. Approximately 450 opiate-dependent patients were being prescribed heroin in 2003, and the British Home Office declared its support for the expansion of heroin prescription.³⁴³

A recent study of British heroin addicts found that injectable opiate treatment allows patients to receive a safe supply of the drug, improve family relationships and avoid contact with the police. Even if quitting is not the main goal of the participant, the program was still considered a viable option, leading to reduced criminality and reduced health risks.³⁴⁴ Otherwise, the high cost of a heroin habit drives many addicts into welfare fraud, selling small amounts of drugs, frequent thefts and prostitution.³⁴⁵ Britain's recent drug policy shift reflects the willingness to find more effective means to address the unreasonable public and economic costs of drug addiction, health care, criminal justice and lost productivity.

Heroin prescription has also come to North America, as the Canadian government has approved pilot projects in Vancouver, Toronto and Montreal, involving 470 subjects with one-third in each trial site. The participants will be randomly assigned to three different groups: the control group who will receive strictly methadone maintenance treatment; the group who will receive prescription heroin in addition to methadone maintenance therapy; and a small subgroup who will receive hydromorphone (also known as laudanum), which is a medically available opioid.³⁴⁶ Addiction medicine physician specialists will monitor individual prescriptions and social workers will assist with access to community resources, including addiction treatment, housing and job training. Clinic staff will guide all those ready towards treatments which get them off drugs altogether. After 12 months, participants will be aided through a transition period, and then monitored by the research team for up to two years to determine the study's longer-term outcomes.³⁴⁷ The North American Opiate Medication Initiative (NAOMI) began recruitment of heroin users in February 2005. The recruitment period is expected to take six to nine months.³⁴⁸

Given the previous reactions of the United States and the United Nations to Canada's approval of cannabis decriminalization and of supervised drug injection facilities,³⁴⁹ the advent of heroin prescription to North America could further chill Canadian-American relations.

Legalization and Regulation

As outlined above, many industrialized nations have developed pragmatic policies that challenge the bounds of drug prohibition, from the official non-enforcement of cannabis laws to state-sanctioned supervised injection facilities and heroin prescription programs. Nowhere in the world, however, has any state dared to defy the global prohibition regime at its core by asserting regulatory control over the production and distribution of currently prohibited drugs as a means of eliminating the "black" market and its attendant social harms.

To a very limited extent, a few countries have established regulated supplies of cannabis for medical purposes. The Netherlands already provides government-contracted supplies of cannabis to pharmacies to ensure that a safe, controlled and reliable source of the plant is available.³⁵⁰ Pilot programs for medical cannabis availability in pharmacies have also begun in Canada³⁵¹ and in Spain.³⁵² In addition, the Israeli government is trying an experimental program that administers cannabis to Israeli soldiers, traumatized by war with the Palestinians, to treat post-traumatic stress disorder.³⁵³ Even the heroin

prescription programs in Europe and Canada, however, are made possible through specific, carefully circumscribed *exemptions* from the prohibition-based legal framework and not through any fundamental change of that framework.

LESSONS LEARNED: THE LIMITS OF THE PROHIBITION MODEL

The global scope of the drug prohibition regime, secured in international law and “enforced” through the political process, has inhibited innovation, but rising political pressure brought on by the cost of unabated social and economic problems related to prohibited drugs has inspired pragmatic policy shifts. A survey of recent international trends in drug policy yields the following general conclusions that may offer instructive guidance for improving drug policies in the United States:

1) The operation of the **strict prohibition model** of drug control, which seeks to reduce and eventually eliminate of all drug use, has required the primacy of the criminal justice system to enforce laws that require total abstinence and has featured:

a) “**Source control**” strategies to interrupt drug production in countries such as Colombia and Afghanistan, a tactic that has not only completely failed to limit adequate supply of cocaine and heroin to meet U.S. and world demand but has also destabilized foreign governments, poisoned the subsistence crops of peasant farmers and stimulated innovation by the criminal enterprises, such as the production of a new, inhalable form of heroin coming from Colombia and the development of a potent, resilient “super coca” plant;

b) **Death penalties** and **death squads**, particularly in East Asia, where executions, some with due process and some without, have failed to stem the growing use of and addiction to hard drugs in China, Vietnam, the Philippines and Thailand, among other countries; and

c) **Incarceration** of drug users as well as drug sellers, resulting in overcrowded prisons, which is happening in the United States to the greatest degree, with the highest number of its citizens behind bars than any other nation – without having achieved any meaningful reductions in drug use or drug-related crime.

2) The principle of “**harm reduction**” guides the policies of a number of countries that have reformed their drug laws further than the United States. Harm reduction measures aim to reduce the harm from drug use rather than attempting to reduce drug use *per se* and the harm reduction approach is non-judgmental and non-coercive, assisting drug users in reducing the attendant harm from drug use and usually in reducing drug use itself.

Harm reduction measures are unable to address the fundamental problem of the “black” market and the attendant ready access of illegal drugs to young people. So it is important to understand that **harm reduction is not a new paradigm of drug control**, but only an innovative approach within the prohibition model, whereby certain measures are employed to reduce the harmful effects of drug use as well as the harshness of the

punitive global drug prohibition regime. The most prominent examples of the harm reduction approach in drug policy include:

a) **Diversion** of drug offenders into treatment, the first step in the shift toward a public health approach, is beginning to take hold in the United States, reducing recidivism and illegal drug use among participants. Such treatment programs are “abstinence-only,” however, unable to help reduce the harm to drug users who are unwilling to quit;

b) **Decriminalization** of drug use is common in Europe, from Russia to Italy to Belgium to Portugal, where anyone caught with small amounts of illegal drugs are reported to local commissions to ensure that users seek treatment. Individuals with drug problems in Portugal have been voluntarily appearing at government offices and asking for treatment, no longer fearing criminal punishment by the state.

c) **Depenalization** of certain drugs is a step further than decriminalization, particularly the Dutch policy of cannabis normalization, where the market for “hard” drugs has been separated from cannabis, for which there is an official “non-enforcement” policy. The rate of cannabis use in the Netherlands remains less than half of the U.S. rate and since the “hard” and “soft” drug markets were separated there has been no increase in the number of heroin addicts in the Netherlands, with youth initiation of the drug having been suppressed.

d) Numerous countries, including Germany and Canada, have started to provide supervised locations for the **safe administration** of illegal drugs, a practice that has resulted in reductions in the transmission of disease, accidental deaths and public disorder. This approach is testing the limits of the strict prohibition regime and has come under sharp criticism, despite its effectiveness.

3) **Medicalization** of drug addiction is once again becoming a viable option in Europe, as Switzerland, Germany, the Netherlands and Britain, and recently Canada, have instituted opiate prescription programs in which hard-core drug addicts are brought indoors into medically-supervised facilities and stabilized with controlled doses that are free of charge. These programs have brought about very promising outcomes, including:

- reductions in overdose deaths;
- reductions in the transmission of disease;
- reductions in economic crimes related to addiction;
- reductions in levels of public disorder;
- reductions in the quantity of drugs used;
- elimination of drug habits altogether for 20% of participants;
- stabilization of the health of participants;
- increased employment rates of participants;
- law enforcement support; and
- a changed culture where addictive drugs like heroin lose their cachet and are considered more like medication for sick people, resulting in declining rates of first-time use of such drugs.

The opiate prescription programs in Europe and Canada are made possible only through specific, carefully circumscribed *exemptions* from the prohibition-based legal framework and not through any fundamental change of that framework.

4) **Other policies** in Europe have helped to reduce the harm associated with drug use, including alcohol, especially in connection with motor vehicle operation. Numerous countries maintain a zero-tolerance policy for driving with *any* amount of alcohol in the bloodstream and those countries are tough on impaired driving in general. For the protection of young people, most European countries have delayed the driving age to 18 or above, while setting the drinking age at 16 or even below (such as Denmark).

Despite having challenged the bounds of the strict prohibition model with seemingly “bold” policy developments on the international front, no nation has yet defied the global prohibition regime at its core by asserting full regulatory control over the production and distribution of currently prohibited drugs as a means of eliminating the “black” market and its attendant social harms.

III. CONTROLLING PSYCHOACTIVE SUBSTANCES: THE CURRENT SYSTEM AND ALTERNATIVE MODELS

THE CURRENT SYSTEM OF DRUG CONTROL

The current legal framework for drug control is composed of three legal tiers: international treaties; federal statutes and regulations; and state statutes and regulations. The laws at each level function as an interlocking system intended to limit certain medical uses of drugs, to prevent the diversion of certain drugs for “non-medical” uses and to enforce the absolute prohibition of the use and sale of certain other drugs.

International Treaties

The United States is a party to three international treaties that provide the basic legal framework for a worldwide system to control drugs that have been determined to have a high potential for abuse.³⁵⁴ The purpose of the treaties is to limit the use of drugs to medical and scientific purposes only.³⁵⁵

Most nations are signatories to the U.N. Conventions, which prohibit the use and sale of the same drugs that are prohibited in the United States.³⁵⁶ The U.N. conventions are part of the large body of international law that is not “enforceable” in the traditional sense, but signatories to the drug control treaties are subject to enormous diplomatic pressure, particularly from the United States, not to enact national laws that depart from the prohibition framework. The International Narcotics Control Board (INCB), an independent body within the United Nations, serves more as a panel to monitor adherence to the U.N. conventions rather than as an enforcement agency, but it often voices support for or objection to drug policy developments around the world, consistent with prevailing U.S. domestic and foreign drug policy interests.³⁵⁷

U.S. Drug Control – Federal Preemption

The federal government regulates psychoactive substances under a series of statutory schemes, mainly under Title 21 of the United States Code. These include the Controlled Substances Act, the Federal Food, Drug and Cosmetic Act and the enabling acts authorizing the Office of National Drug Control Policy and the Drug Enforcement Administration. Other miscellaneous federal initiatives found throughout the U.S. Code address drug use as it relates to other areas of law regulated by the federal government, including enhanced penalties for use of prohibited drugs in federal prison³⁵⁸ and federal aid for state drug courts.

Controlled Substances Act

The Controlled Substances Act (CSA)³⁵⁹ begins with congressional findings that many drugs being controlled have a legitimate medical purpose, but that the illegal importation, manufacture, distribution and possession and improper use have “a substantial and detrimental effect on the health and general welfare of the American people.”³⁶⁰ The CSA authorizes the Attorney General to place controlled substances on a

rank of schedules³⁶¹ and sets forth standards to guide the scheduling of substances, such as potential for abuse, pharmacological effect, degree of addictiveness and whether the U.S. is treaty-bound to control a drug.³⁶² The CSA prescribes five schedules and assigns certain substances to each of the schedules.³⁶³ All substances listed under Schedule I are stated to have “a high potential for abuse, ... no currently accepted medical use in treatment in the United States, and ... a lack of accepted safety for use of the drug or other substance under medical supervision” and are strictly prohibited for any sale or use.³⁶⁴ Some common examples of the hundreds of controlled substances under the various schedules include:

- Schedule I – Heroin, marihuana, LSD, other prohibited substances
- Schedule II – Morphine, Oxycodone (Percodan, Percocet, OxyContin), codeine, cocaine, meperidine (Demerol), Ritalin, amphetamines, secobarbital, pentobarbital
- Schedule III – Codeine combinations (Tylenol with codeine), hydrocodone combinations (Vicodin, Lortabs), Marinol
- Schedule IV – Phenobarbital, benzodiazepines (Librium, Valium), Propoxyphene (Darvon), Talwin
- Schedule V – Codeine cough syrups, antidiarrheals

The CSA includes registration requirements for persons who manufacture or dilute a controlled substance,³⁶⁵ as well as labeling and packaging requirements as required by regulation of the Attorney General,³⁶⁶ and authorizes the Attorney General to set production quotas.³⁶⁷ The Act requires every registrant to keep records of inventory, deliveries, *etc.*,³⁶⁸ and requires order forms to be used, copies of which go to various authorities,³⁶⁹ including prescriptions.³⁷⁰

The CSA makes it a crime to manufacture, distribute or possess a controlled substance with such intent unless authorized by the Act³⁷¹ or to conspire to do the same.³⁷² There are specific sentencing guidelines depending on the substances and quantities involved,³⁷³ as well as to fail to register or operate beyond the scope of such registration,³⁷⁴ as outside one’s quota,³⁷⁵ or to simply possess a controlled substance unless pursuant to a prescription,³⁷⁶ which subjects someone to one year in prison and a “minimum” fine of \$1000 for a first offense, except for cocaine base which has a sentence of five to 20 years, regardless of amount, with a five-year mandatory minimum sentence. The Act also authorizes civil penalties for “small amounts” of certain controlled substances with fines up to \$10,000 to be assessed by the Attorney General, with a right to a trial *de novo*.³⁷⁷

Federal Food, Drug and Cosmetic Act

The Federal Food, Drug and Cosmetic Act³⁷⁸ defines the term “drug” in part as:

- (A) articles recognized in the official United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; and (B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (C) articles (other than food) intended to affect the structure or any

function of the body of man or other animals; and (D) articles intended for use as a component of any article specified in clause (A), (B), or (C).³⁷⁹

The Act authorizes the Secretary of Health and Human Services to promulgate regulations³⁸⁰ and conduct examinations and investigations,³⁸¹ and establishes the Food and Drug Administration (FDA) within the Department of Health and Human Services.³⁸² The Secretary is authorized to cooperate with “associations and scientific societies” in the revision of the U.S. Pharmacopoeia necessary to carry out the work of the Food and Drug Administration.³⁸³

Federal Agencies

The Office of National Drug Control Policy (ONDCP)³⁸⁴ and the Drug Enforcement Administration (DEA)³⁸⁵ are both authorized under Title 21 of the U.S. Code. The ONDCP, part of the Executive Office of the President, was established by the Anti-Drug Abuse Act of 1988. The purpose of the agency is to establish policies, priorities and objectives for drug control in the nation. Its stated goals are “to reduce illicit drug use, manufacturing, and trafficking, drug-related crime and violence, and drug-related health consequences.” The agency releases an annual National Drug Control Strategy that establishes a program, budget and guidelines for anti-drug efforts at the national, state and local levels.³⁸⁶

The DEA is an arm of the U.S. Department of Justice. Its mission is:

to enforce the controlled substances laws and regulations of the United States and bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations, involved in the growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the United States; and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.³⁸⁷

Alcohol Exemption under the 21st Amendment

The 21st Amendment to the U.S. Constitution repealed the 18th Amendment, a national prohibition on the sale of alcohol. Section 2 of the 21st Amendment has been interpreted to give the individual states the right to make their own laws governing the manufacture, distribution and sale of alcohol within their borders.³⁸⁸ The federal government does regulate the importation and interstate transportation of intoxicating liquors under the Federal Alcohol Administration Act of 1935, and it has the sole power to regulate liquor sales in the District of Columbia, on government owned military reservations and on tribal reservations.³⁸⁹

A pending decision from the U.S. Supreme Court in 2005 could redefine the reach of federal commerce power against the 21st Amendment, with internet-based winemakers seeking direct shipments nationwide arguing that the states’ regulation of alcohol is an impediment to interstate commerce.³⁹⁰

What the Current System Allows

The drug control system under the federal Controlled Substances Act can be said to operate fairly effectively with regard to substances whose manufacture and distribution are closely regulated, although there have been some persistent problems of diversion of certain regulated substances to street markets, such as Oxycontin. In general, however, the regulation of the scheduled drugs abides by the principle of controlling substances to a degree that is commensurate with their known propensity for harm and problematic use. There is one critical and enormous exception to this principle – the absolute prohibition of substances in Schedule I, which has ironically resulted in the ceding of control of those so-called “controlled substances” to the black market, effectively leaving their production and distribution exclusively in the hands of criminal enterprises.

On a global scale the regime of drug prohibition has wrought devastating consequences, as powerful gangs threaten stability and corrupt governments in the poorer “source” countries, people and the land are poisoned by drug eradication efforts and terrorist networks tap into the big business of prohibited drugs to fund their operations. In the United States and Europe the poor are also drawn to the fleeting profits of the drug trade and end up in jails and prisons in grossly disproportionate numbers.³⁹¹

U.S. efforts to suppress drug production from “source” countries have repeatedly resulted in more efficient production within those countries and in the displacement of production to other countries. Despite the destruction and seizure of hundreds of metric tons of prohibited drugs each year, the supply “keeps flowing in at prices that ... are still low enough to retain a mass market... [and] making U.S. borders impermeable to heroin and cocaine has proven impossible.”³⁹² Data from the White House drug office itself show that the U.S. drug interdiction strategy has been an abysmal failure, as prices for cocaine and heroin remain at or near their all-time lows, while the purity levels are at their all-time highs.³⁹³

The prohibition of alcohol in the early 20th century in the United States was a failed experiment that revealed how such “a ban could distort or corrupt law enforcement, encourage the emergence of gangs and the spread of crime, erode civil liberties, and endanger public health by making it impossible to regulate the quality of a widely consumed product.”³⁹⁴ Drug prohibition has given rise to the same effects and is now prosecuted on an international scale.

The Business of Dealing Drugs

History has shown that high profits are assured to those who provide through the “black market” a prohibited product for which there is an unrelenting demand. Without any regulation, this black market regulates itself through such illegal means as violence and money laundering. The so-called “profit paradox” has been highlighted as one of the fundamental flaws in the prohibitionist drug control strategy, whereby the high street-level cost of prohibited drugs leads to higher profits, which, in turn, create stronger incentives for criminal enterprises to continue doing business in prohibited drugs.³⁹⁵

The black market in psychoactive substances runs rampant in urban, suburban and rural areas alike throughout the United States, and on a global scale the trade in prohibited drugs generates over \$400 billion a year,³⁹⁶ with as much as \$500 million laundered through the U.S. financial system each year.³⁹⁷ What are essentially small, illegal corporations are sprouting up in an increasingly sophisticated black market, with salaries, *per diem* and meal allowances, manufacturing setups and inventory. These clever operations go to great lengths to avoid detection.³⁹⁸

The trade in marijuana, a substance known for its pacifying qualities, has grown more violent as highly organized, well-armed groups that once focused on cocaine and heroin are now dealing in marijuana, as well. The increase in price due to higher potency, varieties grown indoors domestically has made dealing in the drug more attractive to gangs who use violence to maintain control of their markets.³⁹⁹

Drug dealers are increasingly moving into rural areas, where crime rates are rising in comparison with most cities. Rural areas with incomes below the poverty level and few job opportunities are ripe for the prohibited drug trade and limited law enforcement resources in poor counties allow drug dealers to maintain flourishing business. Junior high and high school students in rural areas are using more crack cocaine and even more methamphetamine, with heroin use rising to comparable levels among young people in metropolitan areas.⁴⁰⁰

Towns along the U.S. border with Mexico are being taken over by violence arising from the drug trade, as the powerful Mexican cartels have “turned the streets into battlefields and plazas overtaken by gunmen firing grenades and assault weapons.”⁴⁰¹ The murder of a journalist from Nuevo Laredo had a chilling effect on news organizations along the border, as the editor of one newspaper admitted, “We censor ourselves. The drug war is lost. We are alone. And I don’t want to put anyone else at risk for a reality that is never going to change.”⁴⁰²

Mexican drug dealers are taking advantage of the high rates of Mexican immigration to factory and farming towns in the United States, using those towns as distribution centers for methamphetamine, heroin, cocaine and other drugs. The dealers use the cover of working immigrants to blend into the community and recruit drug couriers from the immigrants who cannot find jobs or have lost theirs.⁴⁰³ Mexican cartels have largely taken over marijuana production in the U.S., concentrating their cultivation efforts in California rather than trying to smuggle it from Mexico. Mexican cartels are known to be growing marijuana on Forest Service lands throughout the West.⁴⁰⁴

With such high profit margins, corruption is rife among underpaid government officials and police. It is estimated that Mexican drug gangs make \$3 billion to \$30 billion annually by smuggling cocaine across the U.S. border. The gangs are believed to have police, politicians and judges on their payrolls. This was evident when the entire police force of the state of Morelos was suspended after the chief of detectives was arrested on federal drug trafficking charges.⁴⁰⁵ Drug gangs also put pressure on law enforcement either to accept kickbacks or risk retribution.⁴⁰⁶

The black market in prohibited drugs has even caused a surge of violence in Britain, as London saw its murder rate double in 2003, fueled by an increase in the use of guns, primarily in the drug trade.⁴⁰⁷ The United Kingdom is also experiencing a dramatic influx of “drug mules” from Jamaica.⁴⁰⁸ Drug mules often carry 2 pounds of drugs in their bodies, in up to 25 drug-stuffed condoms or latex gloves.⁴⁰⁹ Considered expendable by the drug barons, drug mules risk arrest and even death if one of the pellets of drugs inside their bodies burst and they are often poor women willing to take the desperate measure of ingesting drugs in order to make some money.⁴¹⁰

The black market in prohibited drugs has become deeply entrenched in poor countries, where government officials find themselves unable to resist the immense profits. Since the late 1970s, for example, the North Korean government has reportedly been encouraging North Korean farmers to produce opium poppies and government-subsidized factories then process the poppies into heroin. It is suspected that methamphetamine found in Japan and China also comes from North Korea.⁴¹¹ The illegal opium trade is now seen as a bigger threat to democracy in Afghanistan than al Qaeda or the Taliban, as local government officials and those running for office are often involved in the drug trade.⁴¹²

Financing Terrorism

Known terrorist organizations are tapping into the prohibited drug trade to finance their operations. As Antonio Maria Costa, the Executive Director of the United Nations Office on Drugs and Crime, explained:

“It has become more and more difficult to distinguish clearly between terrorist groups and organized crime units, since their tactics increasingly overlap. The world is seeing the birth of a new hybrid of ‘organized crime – terrorist organizations’ and it is imperative to sever the connection between crime, drugs and terrorism now.”⁴¹³

According to Mr. Costa, “Without a doubt, the greatest single threat today to global development, democracy and peace is transnational organized crime and the drug trafficking monopoly that keeps this sinister enterprise rolling.”⁴¹⁴

The prohibited drug trade now actively funds the Taliban and al-Qaeda in Afghanistan.⁴¹⁵ Moroccan drug gangs trafficking in hashish have been linked to al-Qaeda sleeper cells in several countries in Europe, including the terrorists who attacked commuter trains in Spain.⁴¹⁶ The trade in prohibited drugs also provides funding for Hezbollah and Hamas, tied to a methamphetamine trafficking organization.⁴¹⁷

Environmental Harms

In an attempt to fight prohibited drugs at the source, the U.S. is fumigating crops in Colombia with a strong herbicide. While the principal target is coca, the fumigation has had detrimental side effects, saturating the land and seeping into tributaries, affecting the health of Colombian farmers and their children. The concentration of glyphosate, or Roundup®, in the herbicide being sprayed in Colombia is 26%, compared with the 1%

the Environmental Protection Agency recommends for use in the U.S. Health officials have found widespread health problems in Colombia's fumigated regions, including chronic headaches, fevers, skin ulcers, sores, flu, diarrhea and abdominal pain.⁴¹⁸

Despite human attempts to control the natural environment to combat drugs, the plant world has a way of adapting, as a new strain of coca plant has been identified in Colombia. First reports were that the powerful drug cartels had genetically modified coca plants to produce a strain that is resistant to glyphosate. However, testing of the plant revealed no evidence of genetic modification, leaving the explanation to selective breeding. Cuttings were made and distributed to dealers and farmers eager for a plant that could withstand the fumigation. Because all other vegetation competing for nutrients around these resistant coca plants has been killed off by the spraying, the coca plants have become more productive.

Unfortunately, in order to combat this new strain, the U.S. government is considering switching from Roundup to *Fusarium oxysporum*, a plant-killing fungus that is known to attack coca. Because it is a fungus, it can live on in the soil with the potential for mutating and attacking subsistence crops, such as corn and tomatoes. Florida's Department of Environmental Protection rejected the use of the fungus after finding that it was "difficult, if not impossible, to control [Fusarium's] spread." Nevertheless, the U.S. is still trying to convince the Colombian government to make the switch.⁴¹⁹

Harsh Punishment and Racial Disparities

In the United States the response to prohibited drug use calls for harsh criminal sanctions, distinguishing the U.S. with the highest incarceration rate in the world. In 2003, nearly 1.7 million people in the U.S. were arrested for a drug offense, more than for any other criminal offense.⁴²⁰ Eighty-one percent of those arrests were for possession of prohibited drugs.⁴²¹ At least three-quarters of the roughly \$40 billion the U.S. spends each year to control drug abuse is to apprehend and punish drug law violators rather than providing prevention and treatment services.⁴²²

Although whites use prohibited drugs at a rate roughly equal to that of African-Americans and Latinos,⁴²³ three-quarters of those incarcerated for drug law violations are non-white.⁴²⁴ African Americans make up about 13% of regular (monthly) drug users; 35% of those arrested for possessing drugs; 55% of those convicted; and 74% of those sentenced to prison. There are now more young black men in jails and prisons than there are in colleges and universities.⁴²⁵ Full of rage from having learned a set of survival skills in prison, young black men may also have picked up a drug habit, including the injection of drugs with shared needles, putting them at risk for HIV and other blood-borne illnesses that they then take back to the community. These men also have a reduced chance of employment and of receiving benefits like food stamps, housing and student financial aid. Poor, minority communities are filled with young men whose futures are bleak, leading many to re-offend.⁴²⁶

Impaired Administration of Justice and Civil Rights

The effect of drug prohibition on crime has compromised the total administration of justice in American society, sapping resources from the civil and family courts in order to process the huge number of drug-related cases in the criminal courts. In addition, the large number of arrestees for drug law violations overloads the police, giving rise to irregular procedures to cope with the work pressures. The difficulties of enforcing laws against consensual activity such as the sale and use of prohibited drugs has led to extensive use of informants, wiretapping and “bugging” and often to entrapment, to arrests and searches prior to obtaining proper warrants and even to the offering of drugs to physiologically-dependent addicts in order to get information.⁴²⁷

The clogging of the courts with petty drug cases has often led to hasty bargaining to clear the dockets, resulting in penalties that bear little consistent relationship to the actual conduct in question and that are more related “to the social status of the accused and his retention of an astute lawyer.”⁴²⁸ Largely due to the disproportionately adverse effect of drug law enforcement on racial minorities and the poor, many in those segments of the public have come to disrespect law enforcement and the courts and have further acquired attitudes conducive to the violation of laws and to non-cooperation with law enforcement.⁴²⁹

The “War on Drugs” has also had the effect of militarizing the police. Over 90% of cities with populations over 50,000, and 70% of smaller cities, have paramilitary units in their police departments, sometimes equipped with tanks, grenade launchers and helicopters.⁴³⁰

The federal Controlled Substances Act and most of the complementary state statutes, as well, have general forfeiture provisions with respect to any property used to violate the drug laws.⁴³¹ Seizure is authorized prior to conviction upon the issuance of a warrant.⁴³² The police department may often keep the property seized, creating an ethical dilemma and a conflict of interest.

Curbs on Legitimate Medical Practice

Federal laws restricting the prescription of regulated pharmaceutical drugs have limited appropriate medical treatment, especially for patients with chronic and severe pain who rely on opioid analgesics. Patients suffering from severe pain caused by conditions such as cancer, degenerative arthritis and nerve damage have usually tried surgery and other medications like codeine before turning to stronger opiates such as hydrocodone (Vicodin), oxycodone (OxyContin), morphine or methadone.⁴³³ With the increased diversion of these drugs, federal and state local authorities have increased their scrutiny of doctors who prescribe pain medications. Twenty-one states have prescription drug monitoring programs.⁴³⁴ Unfortunately, the signs the authorities are looking for – prescribing high volumes of narcotic painkillers for extended periods, prescribing potentially lethal doses or prescribing several different drugs – could also be signs that a doctor is responsibly treating someone with intractable pain. A patient visiting several pharmacies, what could be considered “doctor shopping” by the authorities, may be an attempt to attain an adequate level of pain control. The pressure on the doctors have left

many to stay away from the practice of pain management altogether, making it difficult for patients with severe pain to get the relief they need.

Doctors treating chronic pain are desperate for official guidance so that they may responsibly treat their patients with as much medication as needed without the fear of arrest. The Drug Enforcement Administration issued pain management guidelines in August 2004, prominently displayed on their website as “frequently asked questions.” These guidelines were negotiated by the DEA and pain management specialists in order to end the controversy over the arrests of hundreds of pain specialists who prescribe powerful opiates. However, less than two months after the guidelines were published they were removed from the DEA website, replaced by the explanation that the document “contained misstatements” and “was not approved as an official statement of the agency.” The move came after the legal defense team of Dr. William Hurwitz, a physician accused of drug trafficking, sought to use the guidelines as evidence.⁴³⁵

Increases in Drug-Related Harms

Drug prohibition has brought with it impurity of substances, imprecise dosages and extreme modes of ingestion.⁴³⁶ Without regulation, the substances are produced by people who are trying to turn a profit and are often “cut” with other drugs or substances in order to increase the amount of product. People who use the drugs also tend to use the highest dosage possible because of the inflated price and the risk they took to get the drug. A similar phenomenon occurred during alcohol prohibition in the 1920s, as “hard” liquor was more popular to sell than beer because it could turn a higher profit due to alcohol content-determined price, it could be hidden and transported easier and it could be preserved indefinitely whereas beer spoiled easily.⁴³⁷

With the prohibition on drugs also comes an increase in blood-borne illnesses such as HIV and Hepatitis A, B and C as a result of needle sharing by drug users. It is further exacerbated by the large numbers of prisoners with these diseases in overcrowded facilities. This has also led to a resurgence of tuberculosis in jails and prisons. In 1988 the rate of TB in the general population was 13.7 per 100,000, whereas. In correctional facilities the case rates have been as high as 400 to 500 per 100,000.⁴³⁸ When these prisoners are released, they bring these diseases with them back to the community.

State Administration of the Current Drug Control System

Uniform Controlled Substances Act.

Most of the state controlled substances laws in effect today are based on the 1970 model law called the Uniform Controlled Substances Act (UCSA).⁴³⁹ The UCSA follows the same approach as federal law, seeking to enforce drug prohibition through the use of criminal sanctions. Facing enormous budget pressures, however, many states have made innovations within the federal framework of drug prohibition and criminal enforcement to find alternatives to the expensive use of incarceration.

Drug Courts and Treatment Alternatives

There have been numerous well-publicized efforts around the country to move drug policy away from a purely punitive purpose, although all such efforts have remained within the confines of the criminal justice system.⁴⁴⁰ These reforms have had positive outcomes for participants and have ameliorated some negative impacts of current drug policy, but none have been able to resolve the problems arising from criminalization.

“Drug courts” are the most prominent drug policy innovation recently, having helped states and localities to realize cost savings and having reduced rates of recidivism and prohibited drug use among participants, at least in the short term.⁴⁴¹ The drug court model, however, while stressing rehabilitation over retribution, still does not represent a fundamental departure from the federal legal framework. The use and sale of selected psychoactive substances, which are prohibited and punished under federal law, continue to be uniformly prohibited and punished in all of the states, and the federally-subsidized drug courts use the threat of criminal sanctions to coerce abstinence, sanctions which are often imposed; many, if not most, drug court participants are still confined to jail or prison for failure to complete treatment requirements.⁴⁴²

If insightfully and compassionately administered, drug courts can make a large contribution to rehabilitation of addicts, reduction of crime, and avoid the economic and societal costs of unnecessary imprisonments. However, drug courts are not a panacea and do present some real dangers to the participants and the general public:

- 1) People who are forced into treatment may not actually need it; they may just be people who use drugs in a non-problematic way who happened to get arrested.
- 2) Providing coerced treatment, at a time when the needs for voluntary treatments are not being met, creates the strange circumstance of someone needing to get arrested to get treatment.
- 3) Some drug courts rely on abstinence-based treatment. For example, methadone may not be allowed to heroin addicts. In addition, some may rely heavily on urine testing rather than focus on whether the person is succeeding in employment, education or family relationships.
- 4) Drug courts often mandate twelve-step treatment programs that some believe to be an infringement on religious freedom.

- 5) Drug courts invade the confidentiality of patient and health care provider. The health care provider's client is really the court, prosecutor and probation officer, rather than the person who is receiving drug treatment.
- 6) Drug courts are creating a separate system of justice for drug offenders not based on the time honored adversarial roles of defense attorney, prosecutor and judge. Therefore, a relapsed patient may end up with much harsher penalties than from a regular court.

The intent to emphasize treatment is commendable, as long as the approach also mitigates potential harm.

Even if all drug courts were to avoid such pitfalls, such programs are currently available only to a few defendants, although court-supervised treatment programs are now proliferating rapidly across the country.⁴⁴³ Nevertheless, even if such programs were widely available, drug courts are still powerless to rein in the illegal markets for the prohibited psychoactive substances, markets that are left unregulated and in the hands of criminal enterprises that reap enormous profits and that often control their interests through violence.

Numerous states have enacted measures to provide drug treatment in lieu of incarceration, most prominently in California, where voters passed Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, which allows first and second time non-violent, simple drug possession offenders the opportunity to receive substance abuse treatment instead of incarceration.⁴⁴⁴ In the first two years of the law's enactment, 66,000 drug offenders were diverted, many receiving treatment for the first time.⁴⁴⁵ Across the United States, court-supervised drug treatment programs have spread quickly, offering defendants alternatives to incarceration and offering local jurisdictions the opportunity to save court and detention costs.⁴⁴⁶

It is important to note that the diversion of drug offenders into treatment, although considered an "innovation" in drug policy, still falls squarely into the strict prohibition model, whereby individuals are subject to the control of the criminal justice system and total abstinence from drug use is the only permissible outcome.

De-policing

The "de-policing" concept is being employed to mandate that police officers refrain from actively targeting certain crimes involving non-violent drug offenses so that they may have more time to pursue crimes the public deems more serious to their safety. In 2003, voters in Seattle, Washington passed Initiative 75, which instructs police to turn a blind eye to possession or use of small amounts of cannabis by adults.⁴⁴⁷ As a result the number of people arrested for cannabis fell, with 18 arrests in the first half of 2004, compared with 70 arrests in the same time period one year prior. At the same time, there has been no evidence of widespread public consumption of cannabis as a result of the measure.⁴⁴⁸

CURRENT STATE-LEVEL MODELS FOR REGULATING DRUGS

As stated above and by legions of commentators, the current, prohibition-based system of “regulating” psychoactive substances has lent itself to criminal activity, erosion of public health, skyrocketing public costs, compromises in civil rights and the excessive punishment of the poor, among other adverse effects. However, there exist systems of regulation for certain other substances that could serve as potential models for regulating those substances now subject to absolute prohibition. There is also a range of legal remedies other than criminal sanctions that could be considered when addressing the harms associated with the use of psychoactive substances.

Regulatory Mechanisms for Currently Legal Substances

The most well-known regulatory systems for other psychoactive substances are for alcohol, tobacco and pharmaceuticals. These substances are each regulated in different manners so that they may only be obtained by certain individuals in certain ways, according to how the government deems it most appropriate for the particular substance.

Alcohol

From 1920 to 1933 the 18th Amendment to the U.S. Constitution prohibited the manufacture, transportation and sale of alcohol. After prohibition proved to be a failure, the 18th Amendment was repealed and gave the states the right to make their own laws regarding alcohol. Today every state, and the District of Columbia, has its own liquor control board that regulates alcohol within each state.⁴⁴⁹ The federal agency, the Bureau of Alcohol, Tobacco, Firearms and Explosives, serves as the law enforcement agency for the trafficking of illegal tobacco and alcohol by criminal and terrorist organizations, and to assist local, state and other federal law enforcement and tax agencies with investigations of interstate trafficking of tobacco and alcohol.⁴⁵⁰

States license alcohol manufacturers, distributors and retailers and enforce liquor laws and rules. The state liquor control boards regulate the manufacture, distribution and sale of alcohol. Eighteen states are “control states,” a model in which the state is directly involved in the distribution and/or sale of liquor. The original purpose of establishing a control model was so the state could control the availability of alcohol through factors such as restricted number of outlets, no advertising and using state employees to sell spirits who have no financial incentive to sell or promote sales.

Some laws for alcohol vary even within states, as counties may have their own regulations. For example, the state of Texas has a patchwork of wet and dry counties, and counties that are a confusing mixture of both. At some restaurants in those dry counties patrons must become “members” in order to purchase alcohol, leading to high administrative costs for the restaurants. Supermarkets are also losing alcohol revenues, so the state is in the process of trying to ease those restrictions that are hurting businesses financially. Texas is not alone in having a confusing scheme of alcohol laws.⁴⁵¹

Washington State Liquor Control Board

Washington is considered to be one of the strictest “control” states in the country, a system overseen by the Washington State Liquor Control Board.⁴⁵² is run by a three member Board appointed by the Governor for six-year terms. There are nine divisions covering the agency’s three primary functions: licensing, enforcement and retail services.

The Licensing Division licenses distributors and retail outlets, *e.g.*, restaurants, taverns, grocery stores and breweries, and regulates non-retail licensees such as manufacturers, distributors and importers. The Licensing Division also advises manufacturers, distributors and retailers on advertising and promotion laws and rules, and approves labels for all beer and wine sold in the state. Finally, the division manages the permit program for bartenders and alcohol servers.

The Enforcement and Education Division has 74 liquor and tobacco enforcement agents throughout the state of Washington, who visit restaurants and bars to ensure that minors are not being served and to prevent over-service. The agents also check grocery and convenience stores to ensure they do not sell to minors, and the agents also educate licensees on liquor and tobacco laws and rules.

Retail services of the Washington State Liquor Control Board include purchasing, distribution and retail stores. The Purchasing Division recommends new product listings and de-listings, places orders with suppliers, fills special orders, and negotiates military contracts and tribal vendor agreements. The Liquor Control Board is the sole wholesaler of spirits in the state and runs a distribution center. Liquor is shipped to stores by independent carriers that operate on a bailment system (the supplier owns the product until it leaves the distribution center). The Retail Services Division manages the operation of 157 state-run stores in larger communities and 155 contract liquor stores in smaller communities. State-run stores account for approximately 83% of the total sales. Contract store managers are paid on commission.

The Liquor Control Board sets the marked-up price for spirits sold in state and contract liquor stores. Profits from the sale of spirits and state excise tax on beer, wine and spirits are distributed to the State General Fund; city, county and border areas; health services; education and prevention; and research.

Tobacco

Tobacco production, advertising, packaging, sale and distribution is regulated by the federal government but states may impose taxes and enact laws restricting use by minors and setting limits on places where tobacco may be smoked. The Federal Trade Commission regulates tobacco advertising and warning labels, and the Department of Agriculture regulates the farming of tobacco. The Bureau of Alcohol, Tobacco, Firearms and Explosives under the U.S. Department of Justice enforces the regulations in association with other federal, state, local and international law enforcement entities. In Washington State, the Liquor Control Board’s Enforcement and Education Division enforces tobacco regulations in addition to alcohol, provides education on tobacco laws, and deters the sale of untaxed cigarettes. There are no laws requiring the disclosure of ingredients in tobacco products and no requirement to warn of carcinogens.⁴⁵³

Tobacco products and advertising were on the verge of being regulated by the Food and Drug Administration after the U.S. Senate passed a bill in mid-2004, but the leadership in the U.S. House of Representatives blocked the action. Health care advocates are pushing for FDA oversight of tobacco after an adverse U.S. Supreme Court decision in 2000 declaring the agency's earlier claim of authority over tobacco unconstitutional.⁴⁵⁴ If approved, the bill would have allowed the FDA to regulate the sale, distribution, labeling and advertising of cigarettes and smokeless tobacco, as well as the ability to require manufacturers to better disclose the contents and consequences of their products in new, stronger warning labels on packages.⁴⁵⁵

Pharmaceuticals and the “Gray Market”

Pharmaceuticals are regulated federally by the Drug Enforcement Administration (DEA), the Food and Drug Administration (FDA), the Consumer Products Safety Commission (CPSC), the Centers for Medicare and Medicaid Services (CMS) and the Occupational Safety and Health Administration (OSHA). Also operating on the national level is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a non-profit organization that evaluates and accredits health care organizations and programs in the U.S. In the state of Washington pharmaceuticals are regulated by the Board of Pharmacy, the Department of Social and Health Services, the Department of Ecology, and the Department of Labor and Industries.

The DEA regulates the manufacture, distribution, possession, storage and disposal of pharmaceuticals. The regulation of pharmaceuticals is a closed system where everyone must register with the DEA, including manufacturers, distributors, prescribers and pharmacies, and records, prescriptions and order forms are all required. In the state of Washington there is a Board of Pharmacy that oversees pharmaceuticals in the state under the Legend Drug Act⁴⁵⁶ and the Uniform Controlled Substances Act,⁴⁵⁷ and there are professional boards that oversee professionals who work with and around pharmaceuticals.

Drugs are classified as over the counter (OTC), prescription (legend drugs), or controlled substances. There is no supervision for provision of OTC drugs, while prescription drugs can only be used under authorization by a physician under federal law. Controlled substances are classified into five schedules under the Controlled Substance Act according to potential for abuse. The DEA issues licenses to physicians to prescribe controlled substances. While the prohibited substances under Schedule I cannot be prescribed, as they have no approved medical use, substances under Schedule II can be prescribed with non-refillable written prescriptions. Substances in the lower schedules are less strictly controlled, with some Schedule V substances available over the counter.

Prescription authority must be authorized under state law, which is governed by the Legend Drug Act, Food Drug and Cosmetic Act, Uniform Controlled Substances Act, Profession's Practice Act, and rules adopted under these laws. Physicians with the degrees of M.D. and D.O. (osteopaths) have no restrictions on their prescribing authority, while dentists, nurse practitioners, nurse anesthetists, physician assistants, optometrists, naturopaths and veterinarians all have restrictions on their prescribing authority. Drugs

are used or stored by pharmacies, drug wholesalers, hospitals, outpatient surgery centers, doctors' offices or clinics, nursing homes and adult family homes and boarding homes.

The FDA regulates the initial approval of a drug and the manufacture and distribution. The decision whether or not to make a drug prescription or over the counter is not always based strictly on science. Advisory committees to the FDA recommend whether or not to allow a prescription drug to be sold over the counter before the FDA's commissioner decides to accept or reject the finding, but such a decision involves more than science or patient safety, as influences like marketing and financial considerations, politics, doctors' concerns and consumer psychology may also contribute. Doctors often prefer prescriptions for drugs that are generally safe enough to be over the counter because they would like the ability to monitor their patients' use of the drugs and they are vocal about this concern whenever a drug comes up for consideration as an over-the-counter option. Although it is reasonable for doctors to be concerned for their patients' safety, some are concerned that it could prevent people from having easier access to medicines they need.⁴⁵⁸

The "gray market" is the term used to describe the market in diverted legal prescription drugs. These drugs are diverted not only by drug abusers but by licensed health care professionals and others at any site where the drugs are stored, administered, prescribed or dispensed. The manners in which drugs are diverted include theft, armed robbery, burglary, record alteration, prescription forgery, "wastage" and substitution. For example, from January through February of 2003, drug thefts from pharmacies in the state of Washington included four armed robberies, four burglaries, eight employee thefts and four lost-in-transits, totaling 28,925 dosage units at a cost of \$20,893. The main drug implicated was Oxycontin. In 2002, the Washington State Pharmacy Board investigated 130 nurses, 6 pharmacists, 13 pharmacy techs and one pharmacy intern for diversion. These investigations may lead to criminal charges or, at the very least, administrative proceedings by their respective professional boards, but the Pharmacy Board prefers to employ the "medical model" rather than the "criminal model." The boards send violators to treatment, withhold their licenses until required follow-ups with aftercare and meetings, and monitor them for up to five years with urinalysis.⁴⁵⁹

Existing Legal Remedies – Civil and Other Non-Criminal Sanctions

Civil Proceedings: The Other "Drug Courts"

Courts hearing certain types of civil cases already operate as a parallel system of "drug courts." The civil courts are concerned with assessing and addressing conduct that adversely affects others – particularly children – and such conduct is often associated with substance abuse. Compared with the criminal courts, the civil courts are charged with evaluating harm and finding remedies, rather than determining guilt and meting out punishment, and are therefore more remedial and therapeutic in nature.⁴⁶⁰

Civil courts are regularly called upon to evaluate and remedy the impacts of drug use in family law cases involving divorce, child custody, child support, and child welfare. Drug use might be addressed in the course of a tort claim, employment law case or civil commitment proceeding. The following is a partial list of civil proceedings in which

drug use is already being addressed outside of the criminal justice system: Involuntary Commitment,⁴⁶¹ Civil Commitment,⁴⁶² Domestic Relations,⁴⁶³ Child Welfare,⁴⁶⁴ Child Dependency (order to substance abuse treatment),⁴⁶⁵ Child Dependency (violation of substance abuse treatment order,⁴⁶⁶ and the Uniform Controlled Substances Act involving a tort cause of action by a parent for sale or transfer of controlled substances to a minor.⁴⁶⁷

Existing law even protects drug users from unintentionally entering into a marriage under the influence of alcohol and/or other mind-altering substances.⁴⁶⁸ In Alaska, a drug dealer is strictly liable to the recipient of the drugs or another person if the recipient causes civil damages while under the influence of the drugs.⁴⁶⁹

Civil Contempt and Remedial Sanctions: Coercion With a Purpose

Proponents of the current, criminal justice-based approach to substance abuse argue that the threat of jail or prison is necessary to coerce people into treatment. It is important to acknowledge, however, that contact with the criminal justice system also results in the assignment of a criminal record, the denial of a host of services, voting disqualification and other prejudicial effects, all of which are counterproductive to the goals of drug treatment. The proper venue for the state to address these questions is in the *civil* context – and orders in civil proceedings are ultimately enforced by the court’s power to find a party in contempt. Civil courts have inherent power to coerce compliance – the so-called “hammer” – and impose sanctions as punitive or remedial measures.⁴⁷⁰

Professional Sanctions

Professional organizations have their own punishment for members who are not performing to the standards of their professions. For example, attorneys must follow the Rules of Professional Conduct as enforced by the Washington State Bar Association and the Washington State Medical Association has the Principles of Medical Ethics. Failure to abide by these ethics rules subjects the professional to sanctions governed by their respective associations.

ALTERNATIVE MODELS OF DRUG CONTROL

The public debate around drug “legalization” has generally assumed that there are only two policy options: criminalization or legalization. However, there is a wide spectrum of options available for systems of regulation beyond mere criminalization. Many ideas have been already been proposed for alternative models to the current system of drug control. Some are simply general frameworks of how drugs should be regulated or provided in an effort to undercut the black market. Others have been proposed in the form of legislation. Some countries have already implemented some alternatives to prohibition in the attempt to combat more effectively the harms linked to drug abuse.

General Frameworks

Leading drug policy researchers, Peter Reuter and Robert MacCoun, have outlined the spectrum of possible drug control regimes.⁴⁷¹ Such regimes include pure prohibition, prohibitory prescription, maintenance, regulatory prescription, positive license, negative license, adult market, and the free market:

The Spectrum of Drug Control Regimes⁴⁷²

REGIME		MODEL	? DECREASING RESTRICTIVENESS
PROHIBITORY	PRESCRIPTION	Pure Prohibition: Full prohibition, with no allowed use for any purpose whatever (e.g., heroin, marijuana).	
		Prohibitory Prescription: Prohibited except for narrow therapeutic purposes unrelated to addiction; administered by a doctor or other health professional (e.g., cocaine).	
		Maintenance: Prescribed for relief of addiction; otherwise prohibited (e.g., methadone). Administered by an authorized agent, or for some patients, self-administered under tight supervision.	
	REGULATORY	Regulatory Prescription: Self-administered, under prescription, for relief of psychiatric problems (e.g., anxiety, depression); otherwise prohibited (e.g., current U.S. regime for Valium, Prozac).	
		Positive License: Available for any reason to any adult in possession of an appropriate license, gained by demonstrated capacity for safe use (theoretical regime).	
		Negative License: Available for any reason to any adult who has not forfeited the right by violating conditions of eligibility (theoretical regime).	
		Adult Market: Available to any adult (e.g., alcohol).	
		Free Market: Available to any individual (e.g., caffeine).	

Report from Britain– *After the War on Drugs: Options for Control*

Transform, a drug policy think tank in the United Kingdom, released a report in October 2004 setting forth models for a new drug control regime.⁴⁷³ The report, which was released with the support of former police officers and Members of Parliament,⁴⁷⁴ calls for the control and regulation of drugs and lays out a suggested legal framework based on an examination of the existing models in Britain under which drugs are produced, existing ways in which drugs are supplied and new drug supply options.

The Transform report breaks down the existing options for drug production into: 1) pharmaceutical drugs; 2) non-pharmaceutical drugs; and 3) unlicensed production. One example of a pharmaceutical drug is diamorphine, or heroin, which is still a pharmaceutical drug in the United Kingdom, the production of which is licensed and regulated.⁴⁷⁵ More than half of the global opium poppy production is for the legal medical market.

Non-pharmaceutical drugs include alcohol, tobacco and caffeine. In Britain alcohol and tobacco are produced and imported under domestic and international licensing agreements and policed and taxed by Customs and Excise. Unlike tobacco, alcohol is a food/beverage besides being a drug and is therefore subject to various standards legislation. While home production of alcohol is not licensed, tobacco could be licensed and taxed for personal production but rarely is, thus making it *de facto* unlicensed.

Caffeine is unlicensed, subject only to food and drink regulations. Other psychoactive substances, such as psychedelic mushrooms, khat, “herbal remedies” and “food supplements” are available in Britain but produced without any regulation or control.

The **supply** of drugs occurs through prescription, pharmacy sales, licensed sales, licensed premises for consumption and unlicensed sales. In the prescription model, drugs are prescribed by a licensed doctor and dispensed by a licensed pharmacist. Further restrictions to the prescription model allow injectable diamorphine (heroin) to be prescribed only by a doctor with a specialized license, the occasional requirement that methadone be consumed in the pharmacy and the dispensing and injecting of diamorphine under medical supervision in a specialized venue, as occurs in Switzerland.

In the pharmacy sales model, pharmacists make sales behind the counter with the responsibility to make restrictions according to age, quantity and concerns regarding misuse. The pharmacist is qualified to offer advice and health and safety information.

Licensed sales include drugs such as alcohol and tobacco where licensed sellers are restricted to whom they can sell based on age and the hours in which they may sell, and licensing authorities oversee the regulations of these drugs. A step beyond this is licensed premises for sale and consumption, where the drug, mostly alcohol, is consumed at the sale site, and there is the added restriction of intoxication of the purchaser.

The final existing supply option is unlicensed sales, where there are no existing controls at point of purchase for some intoxicants. Mushroom vendors are starting to get

a second look by police and Customs and Excise, and some vendors voluntarily have restrictions on the basis of age. Also, sales of certain solvents and inhalants are prohibited to children.

The Transform report suggests the establishment of new supply options, built on existing models, including specialized pharmacists and licensed users with membership based licensed premises. Specialized pharmacists would be a combination of pharmacist and “drugs worker,” licensed to vend certain drugs to “recreational” users, and trained to recognize problematic use, provide safety information and make referrals to social services. Membership-based licensed premises are similar to the licensed premises for consumption already existing in many countries, with the *caveat* that drug purchase and consumption would require a membership with various conditions and restrictions.

Regulatory Options

Mark Haden, clinical supervisor of Addiction Services at the Vancouver Coastal Health Authority, has examined the various ways in which drugs could be regulated:

1. **“Free market” legalization.** Drugs are sold in the “free market.” Promotion, advertising and finding ways to promote sales and use of the substances would be allowed.
2. **Legalization with “product” restrictions.** Restrictions on manufacturers, packagers, distributors, wholesalers and retailers.
3. **Market Regulation.** Restrictions on the product and purchaser, discussed in further detail below.
4. Allow drugs to be available on **prescription.** All physicians could be allowed to prescribe currently illicit substances for medical or maintenance purposes.
5. **Decriminalization.** The removal of criminal sanctions for personal use only. This does not provide for legal options for how to obtain drugs, so there is still unregulated access to drugs of unknown purity and potency.
6. **De facto decriminalization or de facto legalization.** Collectively agreeing to ignore existing laws without changing them – an option for establishing a transitional period when testing out which policy options to consider.
7. **Depenalization.** Penalties for possession are significantly reduced and would include discharges, diversion to treatment instead of jail for possession of large amounts and trafficking, and “parking ticket” status for possession of small amounts for personal consumption.
8. **Criminalization.** Continuing to enforce all existing laws prohibiting certain drugs through the use of criminal sanctions.⁴⁷⁶

The “Market Regulation” model, in which access to substances would be regulated by placing restrictions on the purchaser or the consumer, is particularly instructive. This model includes 14 different regulatory mechanisms, which are not necessarily mutually exclusive:

1. **Age of purchaser.** There are currently restrictions to access of alcohol and tobacco based on age, but there is no control of the age when illegal drugs can be purchased. Drug dealers today do not ask their customers for age identification.

2. **Degree of intoxication of purchaser.** In Canada the sale of alcohol is restricted based on the degree of intoxication of the purchaser. Sellers can refuse to sell to a customer whom they perceive to be engaging in high-risk substance using behavior.
3. **Volume rationing.** Quantities would be limited to a certain amount deemed appropriate for personal consumption so that purchasers would not be selling the product on the black market or using an unsafe amount.
4. **Proof of dependence prior to purchase.** Purchaser must have been assessed by a health worker to be dependent and then allowed to use the rationed amount in a designated space.
5. **Proof of “need” in order to purchase.** Beyond those drugs on which people are dependent, other drugs such as LSD and Ecstasy, which have been shown to have potential psychotherapeutic benefits when used in controlled therapeutic environments, could be used with registered and trained psychiatrists and psychologists.
6. **Required training for purchasers.** Training programs could provide information to drug users about addiction, treatment services and other public health issues, like sexually transmitted diseases and blood-borne illnesses. The programs could provide the knowledge and skills aimed at discouraging drug use, reducing the amount of drug use, and reducing the harm of drug use. Program graduates would receive a certificate they would be required to show prior to purchase.
7. **Registrations of purchasers.** This would allow the purchasers to be tracked for “engagement” and health education. It might also discourage individuals from wanting to participate.
8. **Licensing of users.** Like licenses for new motor vehicle drivers that restricts where and when they drive and who they are permitted to drive with, these licenses would control time, place and associations for new substance users. This would be a graduated program with demonstrated responsible, non-harmful drug use. The license could be given demerit points or suspended based on infractions such as providing substances to non-licensed users, driving under influence or public intoxication. The licenses could also specify different levels of access to various substances based on levels of training and experience. People in some professions, like airplane pilots or taxi drivers, could be restricted from obtaining licenses to purchase long-acting drugs that impair motor skills.
9. **Proof of residency with purchase.** Some societies have gone through a process of developing “culturally specific social controlling mechanisms” that form over time a certain amount of relatively healthy, unproblematic relationships with substances. “Drug tourists” who have not been integrated into this culture may behave in problematic ways that do not adhere to the local restraining social practices. Therefore, purchasers may be restricted to residents of a country, state/province, city or neighborhood.
10. **Limitations in allowed locations for use.** Alcohol is often restricted for public consumption and some public locations do not allow tobacco consumption. Locations for substance use could vary based on the potential for harm. Options of locations include supervised injection rooms for injected drugs, supervised

consumption rooms for the smoking of heroin and cocaine, and home use for weaker drugs of known purity and quantity.

11. **Need to pass a test of knowledge prior to purchase.** A short test could be administered at the distribution point to demonstrate to the staff that the purchaser has the required knowledge of safe use of the substance that is likely to minimize harm.
12. **Tracking of consumption habits.** Registered purchasers would have the volume and frequency of purchasing tracked. This could be used to instigate “health interventions” by health professionals who could register their concerns with the user and offer assistance if a problem is identified. The tracking may be a deterrent to use, as well as a possible increase in price of the substance once the user has passed a certain volume threshold.
13. **Required membership in group prior to purchase.** Drug users can belong to advocacy or union groups that would act similar to existing professional regulatory bodies that provide practice guidelines for their members. If the user acts outside of the norms of the discipline, the group can refuse membership. The norms are enforced through a variety of peer processes and education.
14. **Shared responsibility between the provider and the consumer.** Sellers could be partially responsible for the behaviors of the consumers. To that end, the sellers would monitor the environment where the drug is used and restrict sales based on the behavior of the consumers. Proprietors could be held responsible through fines or license revocations for automobile accidents or other socially destructive incidents for a specified period of time after the drug is consumed. The consumer would not be absolved of responsibility but a balance would be established where the consumer and seller were both liable.⁴⁷⁷

A Variety of Ideas

The Economist published its “survey of illegal drugs” in its July 28, 2001 issue. In the section entitled, “Set it free,” the Editors write that “the best answer is to move slowly but firmly to dismantle the edifice of enforcement.” This could be achieved through government distribution, like alcohol in Scandinavia, or through the private sector with tough bans on advertising and full legal liability. Sales could be made through pharmacies or mail-order, and individual states could decide whether to allow public sale. The result would arguably be the ability to regulate drug quality, treat the health of users and only punish drug users who commit crimes against people or property.⁴⁷⁸

John P. Morgan, M.D., a physician and professor of pharmacology at the City University of New York Medical School, advocated legalizing cannabis in his essay, “Prohibition is Perverse Policy,” with the requirement that “a cigarette weighing 500mg to 1.0 gram of marijuana would deliver 12 to 20mg of delta-9-THC.” Dr. Morgan would also set the purchase age at 18, have strict penalties for driving under the influence of cannabis, and “encourage development of other delivery systems so combustion and inhalation were unnecessary.”⁴⁷⁹

Todd Austin Brenner, a managing partner at the law firm Brenner, Brown, Golian and McCaffrey Co. in Ohio, supports phased legalization, cannabis first, in a manner very similar to alcohol regulation, proceeding then to all narcotics. Some drugs such as heroin and crack would be banned from sale but available free of charge at clinics where registered addicts could obtain them. Brenner speculates that more education and emphasis on health-consciousness and value of personal choice will reduce problematic drug use.⁴⁸⁰

Taylor Branch, a national authority on America's civil rights movement, also espouses taxing and regulating drugs. His plan would license private distributors carefully and tax the drugs as heavily as possible, ideally to the point just short of creating a criminal black market. There would be no prescription requirement and a ban on commercial advertising for harmful drugs, even though their sale would be legal. Police powers would be concentrated on two tasks: prohibiting sales to children and enforcing strict sanctions against those who cause injury to others while under the influence. Branch feels that people do not believe government warnings about psychoactive drugs, and getting the public to trust such warnings would be an important step toward reducing use. For example, the rate of tobacco smoking has dropped dramatically because people came to accept the health warnings.⁴⁸¹

Richard B. Karel, in his "Model Legalization Proposal," argues that crack cocaine should not be legalized, hoping that its use will be substituted by other available forms of cocaine, including a cocaine chewing gum similar to nicotine gum used to help smokers to quit. He also sees the benefit of distributing cocaine in a clinical setting, but also allowing an ATM-type system where users would need to acquire a card that only allowed them to acquire the drug every 48 to 72 hours. He mentions that while opium was used in the late nineteenth and early twentieth centuries to treat alcoholics, U.S. drug policy of banning opium smoking has now led to dangerous forms of opiate use, such as intravenous heroin. Therefore, Karel believes that smokable opium should be made available in a similar fashion as the cocaine gum with ATM cards. PCP should remain illegal, hopefully substituted by other drugs that are available. Pyschedelics should be available to whoever can demonstrate the knowledge as to their effects, through such methods as a written examination, screening test and interview.⁴⁸²

Arnold Trebach, Professor Emeritus at the American University in Washington, D.C. and former president of the Drug Policy Foundation (now Drug Policy Alliance), advocates for the immediate repeal of drug prohibition, much in the way alcohol prohibition ended in the 1930s. Trebach believes that all currently illicit drugs should be treated the way alcohol is treated and wishes to turn back the clock to before opium smoking was outlawed, with sensible regulations regarding purity, labeling, places and hours of sale, and age limits for purchasers.⁴⁸³

Ethan Nadelmann, the executive director of the Drug Policy Alliance, has spent decades writing about alternatives to drug prohibition, and proposed a model whereby the government would distribute drugs through a mail-order system, also known as the "right of access" model. Local jurisdictions could still prohibit the sale and public consumption of drugs but would have to acknowledge the right of access for all adults. He believes this system would make it difficult for people to obtain the drugs despite their legal

availability, would be easy to transition to from prohibition, and would avoid the principal problem of the “supermarket model” – the potential for a substantial increase in amount and diversity of psychoactive drug consumption.⁴⁸⁴

Specific Models

Safe Administration and Prescription of “Hard” Drugs

A model now in effect in Canada, Switzerland and many other countries in Europe is the safe administration of “hard” drugs, particularly heroin.⁴⁸⁵ While some worry about the diversion of drugs from the clinics, it has been shown that illegally distributed methadone has come from its use as a prescription painkiller, not diversion from opioid treatment programs, programs comparable to the heroin maintenance programs.⁴⁸⁶

Numerous countries have also instituted opiate prescription programs in which hard-core drug addicts are brought indoors into medically-supervised facilities and stabilized with controlled doses that are free of charge. These programs have brought about very promising outcomes, including: reductions in overdose deaths; reductions in the transmission of disease; reductions in economic crimes related to addiction; reductions in levels of public disorder; reductions in the quantity of drugs used; elimination of drug habits altogether for 20% of participants; stabilization of the health of participants; increased employment rates of participants; law enforcement support; and a changed culture in which addictive drugs like heroin lose their cachet and are considered to be medication for the sick, resulting in declining rates of first-time use of such drugs.⁴⁸⁷

The opiate prescription programs in Europe and Canada are made possible only through specific, carefully circumscribed *exemptions* from the prohibition-based legal framework and not through any fundamental change of that framework.

Past Proposed Legislation

There has already been legislation proposed, or at least drafted, in Congress and in state legislatures. While some have only addressed cannabis, the scope of other bills has extended to all currently prohibited drugs. One of the first bills to begin addressing legalization was introduced in the New York senate in 1971 by Senator Franz Leichter.⁴⁸⁸ The bill established a Marijuana Control Authority to license and regulate commerce in cannabis, similar to alcohol regulation but forbidding advertising. The bill was introduced throughout the 1970s and attracted a number of co-sponsors. One co-sponsor, Senator Joseph L. Galiber, introduced his own bill in 1989, expanding the scope of the Leichter bill to include all drugs. The bill was entitled, “A Bill to Make All Illegal Drugs as Legal as Alcohol.”⁴⁸⁹ Under the Galiber bill, a State Controlled Substances Authority would be authorized to make all necessary rules for drug production, distribution and sales. Doctors and pharmacists would be licensed to sell all controlled substances. Senator Galiber, disturbed by the harsh ineffectiveness of the so-called “Rockefeller drug laws” in New York, continued to introduce versions of his bill throughout the 1990s until his death.

The Cannabis Revenue and Education Act was introduced in 1981 in Massachusetts to regulate the commercial production and distribution of cannabis.⁴⁹⁰ The Act would impose a tax based on THC content, with half of the net tax proceeds going toward a Cannabis Education Trust, set up to educate the public about marijuana abuse.

The Cannabis Revenue Act (CRA), drafted in the U.S. Congress in 1982, was the only bill at the federal level to regulate and tax cannabis. The bill would have allowed each state to choose one of three options for legalizing cannabis: 1) retaining prohibition; 2) be part of the federal regulation and taxation scheme with only laws to handle driving under the influence and distribution to minors; or 3) enact its own regulation and taxation scheme in addition to the federal one.⁴⁹¹

Bills modeled on the federal CRA proposal were introduced in Oregon and Pennsylvania in 1983. The Oregon bill called for state-operated stores with the revenue earmarked for local school districts and law enforcement.⁴⁹² The Pennsylvania bill would have put the regulation of the commercial cannabis industry under the Department of Agriculture with retail sales at state-owned liquor outlets, and personal cultivation and possession would allowed up to 2.2 pounds.⁴⁹³

A bill was introduced in the Missouri legislature in 1990 to license the production, distribution and sale of all drugs with strict limits on where drugs could be used, prohibiting drug use in bars, restaurants, offices, or cars, and in the presence of a minor under age 18, including in a private residence.⁴⁹⁴

An organization called Washington Citizens for Drug Policy Reform sponsored an initiative in 1993 to regulate cannabis in the state of Washington. Under Initiative 595, adults would have been allowed to grow and possess up to a “personal use quantity,” as determined by the courts, while cultivating, transporting and selling more than a personal use quantity would have required a license obtained from a cannabis control authority. There would be a \$15 tax per ounce of cannabis “at standard cured moisture content.”⁴⁹⁵ The initiative allowed the retail sale of “cannabis products” made from the cannabis plant, opening the possibility of a wide variety of cannabis-based products like sodas, candy and teas. The initiative also made sure to mention federal intervention:

Sec. 21. State agencies shall refrain from enforcing any provision of United States criminal law not consistent with the purposes of this act, to avoid a waste of resources.⁴⁹⁶

Two drug regulation initiatives were put forward in Oregon in 1997. The Oregon Drug Control Amendment would have amended the state constitution to require that laws regulating controlled substances be passed and to prohibit laws prohibiting adult possession of controlled substances.⁴⁹⁷ The amendment included a section that prohibited the state from making a “net profit from the manufacture or sale of controlled substances.”⁴⁹⁸ The Oregon legislature was to enact a regulatory scheme to address the following issues:

- a. A minimum legal age of not greater than 21 years;
- b. Reasonable limits on adult personal possession;

- c. Adequate public health and consumer safeguards;
- d. Adequate manufacturing, price, import and export controls;
- e. Penalties for violations, provisions for enforcement;
- f. Exceptions for controlled scientific research;
- g. Exceptions under medical and/or parental supervision;
- h. Exceptions for traditional, spiritual practices;
- i. A defined legal level of impairment;
- j. Promotion of temperance, moderation and safety;
- k. On-demand substance abuse and harm reduction programs.⁴⁹⁹

The other Oregon initiative in 1997, the Oregon Cannabis Tax Act (OCTA), would have renamed the Oregon Liquor Control Commission the “Oregon Intoxicant Control Commission” and would have charged the agency with licensing the cultivation and processing of cannabis. Licensees would only sell their crop to the Commission, who would sell it in OICC stores at a price that will “generate profits for revenue to be applied to the purposes [of the statute] and to minimize incentives to purchase cannabis elsewhere, to purchase cannabis for resale or for removal to other states.”⁵⁰⁰

The OCTA specified the distribution of profits from the sale of cannabis and issuance of licenses after administrative and enforcement costs: 90 percent to the general fund, 8 percent to the Department of Human Resources for treatment on demand programs, 1 percent “to create and fund an agricultural state committee for the promotion of Oregon hemp fiber, protein and oil crops and associated industries” and 1 percent to the school districts for drug education programs.⁵⁰¹ The initiative list requirements for the curriculum of the drug education programs:

1. Emphasize a citizen’s rights and duties under our social compact and to explain to students how drug abusers might injure the rights of others by failing to fulfill such duties;
2. Persuade students to decline to consume intoxicants by providing them with accurate information about the threat intoxicants pose to their mental and physical developments; and
3. Persuade students that if, as adults, they choose to consume intoxicants, they must nevertheless responsibly fulfill all duties they owe others.⁵⁰²

As with Initiative 595 in Washington, the OCTA initiative also included a section addressing the problem of federal preemption:

Section 474.315. As funded by [this law], the Attorney General shall vigorously defend any person prosecuted for acts licensed under this chapter, propose a federal act to remove impediments to this chapter, deliver the proposed federal act to each member of Congress and urge adoption of the proposed federal act through all legal and appropriate means.⁵⁰³

IV. STATES' RIGHTS: TOWARD A FEDERALIST DRUG POLICY

State leaders across the country are bristling at expanding federal mandates and preemptions in areas from tort law to environmental protection to education.⁵⁰⁴ A growing fissure is also developing between federal and state authorities over the general direction of criminal law enforcement, as federal prosecutors have been directed to seek long prison terms for “child predators, criminal bosses, drug kingpins and violent gun criminals” while, at the state level, many legislatures and governors facing fiscal constraints are eagerly seeking to reduce prison sentences and to expand rehabilitative alternatives to incarceration.⁵⁰⁵ States are particularly beginning to depart from the more draconian federal approach to drug law enforcement, recognizing that most drug law violators are nonviolent and pose little or no threat to community safety.⁵⁰⁶

Within the federal legal framework of drug prohibition, states and localities enjoy some discretion to employ different methods for controlling drug abuse and drug-related crime, but such discretion is limited. The “drug court” is currently the most popular innovation at the local level, a new tool for the justice system in its struggle to rein in court costs and to reduce persistently high recidivism rates among drug law violators.⁵⁰⁷ The drug court model, however, fully conforms to the federal framework, employing the threat of criminal sanctions to coerce abstinence and often imposing such sanctions on those who fail to comply with court-imposed conditions. Drug courts are valuable and effective in reducing public costs and in reducing rates of recidivism and substance abuse among their participants, but they cannot abate the illegal markets for psychoactive drugs, as incentives remain strong for criminal enterprises to engage in the illegal drug trade.

Every state in the United States still prohibits and punishes the use and sale of the same psychoactive substances that are prohibited and punished under federal law. No state has yet proposed or enacted a state-level regulatory system as an alternative model to control more effectively those psychoactive substances that are now produced and distributed exclusively in illegal markets. The extent to which the state of Washington or any other state could promulgate such a system, diverging so fundamentally from the federal legal framework, remains a critical open question.

POWERS RESERVED TO THE STATES

States purportedly enjoy sovereign powers exclusive of federal interference. Accordingly, federal authority is supposed to be restricted only to powers specifically enumerated in the U.S. Constitution or otherwise delegated to the federal government by the people.⁵⁰⁸ The framers of the Constitution designed the American federal system of government “for the very purpose of rejecting the idea that the will of the people in all instances is expressed by the central power, the one most remote from their control.”⁵⁰⁹

Police Power and State Sovereignty

The notion of limited federal authority with generalized police powers reserved to the states is “deeply ingrained in our constitutional history.”⁵¹⁰ States are supposed to

have exclusive authority to exercise their police powers, commonly understood as the protection of “health, welfare, safety and morals,” defined by a Washington court as:

[an] attribute of sovereignty and an essential element of a state’s power to govern, which cannot be surrendered, in the exercise of which a state may prescribe laws intended to promote health, peace, morals, education, good order and the welfare of the people, and the only limitation upon which is that it must reasonably tend to correct some evil or promote some interest of the state.⁵¹¹

In the federal system, states’ police powers give them primary authority for defining and enforcing the criminal law in particular.⁵¹² States not only have the authority to protect the health, welfare and safety of their citizens pursuant to their police powers, but also the constitutional *obligation* to do so.⁵¹³

Until the early 20th century the Tenth Amendment was frequently invoked to curtail powers expressly granted to Congress, including the power to regulate commerce and to lay and collect taxes.⁵¹⁴ The modern recognition of federal power under the Commerce Clause, however, has rendered the Tenth Amendment merely a truism and little more than a quaint notion of constitutional history. The U.S. Supreme Court under Chief Justice Rehnquist has attempted to revive the “states’ rights” doctrine as embodied in the Tenth Amendment, but only tentatively and in selected cases.⁵¹⁵

FEDERAL ENCROACHMENT ON STATES’ RIGHTS

There is a growing body of federal criminal law, which most prominently includes drug-related crimes, some of which are capital offenses. No general police power is supposed to exist on the federal level, but the courts have long recognized that law enforcement activity by federal agents may look like the exercise of police power.⁵¹⁶ The authority to “regulate” such criminal conduct on the federal level is founded on other constitutional provisions, especially the Commerce Clause today.

Federal Commerce Power

The U.S. Constitution grants the Congress “the power to ... regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.”⁵¹⁷ Federal commerce power was initially understood by the courts simply as the authority to reduce barriers to free trade between the states.⁵¹⁸ In the early 20th century, however, the interpretation of federal commerce power began to expand, allowing congressional intervention in activities that had only a “substantial economic effect” or “close and substantial relation” to interstate commerce,⁵¹⁹ and to activities that were part of the “stream of commerce.”⁵²⁰

With the New Deal in the 1930s came a vast expansion of federal authority and the courts’ validation of that authority, particularly through broader interpretations of federal commerce power.⁵²¹ By the 1940s, activities that, in their “cumulative effects,” would affect interstate commerce were deemed within federal jurisdiction, even trivial

intrastate instances of such activities.⁵²² Invoked to legitimate the civil rights legislation of the 1960s, federal commerce power widened to encompass social welfare objectives.⁵²³

The U.S. Supreme Court has recently acknowledged that federal commerce power is still subject to “outer limits.”⁵²⁴ Legal scholars have squelched predictions, however, that the Court would ever reign in congressional power under the Commerce Clause to impose federal criminal laws that overlap with state authority.⁵²⁵

Prohibition and “Regulation” of Illicit Commerce

The Commerce Clause arguably gives Congress authority over “regular” commerce but not over *illicit* commerce, where the only means to “regulate” illicit commerce is through the use of police power, which is traditionally reserved to the states. However, long-established case law recognizes that federal authority to regulate commerce among the states extends even to illicit commerce, as Congress may prohibit interstate transport of articles that “are injurious to public morals,” and such “regulation” may even look like police power.⁵²⁶ The power to regulate commerce extends to the prohibition of shipments in such commerce, and such power “is complete in itself, may be exercised to its utmost extent and acknowledges no limitations, other than are prescribed in the Constitution.”⁵²⁷

THE PREEMPTIVE EFFECT OF FEDERAL DRUG LAWS

Unlike the prohibition of alcohol in the 1920s, which was achieved by means of a constitutional amendment, the basis for the legitimacy of the federal drug laws under the Constitution continued to evolve during the 20th century.⁵²⁸ In the early 1900s federal authority to regulate the possession and sale of narcotics was founded on the express taxing power of Congress, through the Harrison Act of 1914 and its aggressive enforcement against doctors and pharmacists. Early federal authority over drug policy also relied on the implied foreign affairs power, first through the enactment of the Narcotic Drugs Import and Export Act of 1922, which set strict quotas on the quantity of drugs that could be imported into the United States.⁵²⁹ That measure allowed possession of narcotics without a prescription to become presumptive evidence of having illegally imported drugs.⁵³⁰ The Porter Act of 1930, which established the powerful federal Bureau of Narcotics, the Marijuana Tax Act of 1937, and subsequent federal laws that stiffened penalties in the 1950s and 1960s were all based on federal taxing power.⁵³¹

The Controlled Substances Act

Not until 1970, with the passage of the Comprehensive Drug Abuse Prevention and Control Act, or the “Controlled Substances Act,”⁵³² was federal preemptive authority over drug policy firmly grounded in federal commerce power. What had begun rather innocuously in the early 20th century as a federal system of medically-related registration and taxation became a blanket prohibition of the use and sale of particular drugs. While members of Congress in the early 20th century expressed concern that the new federal role in this area was an unconstitutional exercise of police power infringing on the rights of states, by the end of that century Congress took such federal preemptive power for granted.

To bolster its primacy over drug control policy through the Controlled Substances Act, Congress found that "[t]he illegal importation, manufacture, distribution, and possession and improper use of controlled substances have a substantial and detrimental effect on the health and general welfare of the American people" and in particular, Congress made the following express findings:

A major portion of the traffic in controlled substances flows through interstate and foreign commerce. Incidents of the traffic which are not an integral part of the interstate or foreign flow, such as manufacture, local distribution, and possession, nonetheless have a substantial and direct effect upon interstate commerce because:

- (A) after manufacture, many controlled substances are transported in interstate commerce;
- (B) controlled substances distributed locally usually have been transported in interstate commerce immediately before their distribution; and
- (C) controlled substances possessed commonly flow through interstate commerce immediately prior to such possession.

Local distribution and possession of controlled substances contribute to swelling the interstate traffic in such substances....Controlled substances manufactured and distributed intrastate cannot be differentiated from controlled substances manufactured and distributed interstate. Thus, it is not feasible to distinguish, in terms of controls, between controlled substances manufactured and distributed interstate and controlled substances manufactured and distributed intrastate....Federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic.⁵³³

Almost every state has enacted the Uniform Controlled Substances Act, intended to provide a foundation for a coordinated, federal-state system of drug control.⁵³⁴ This system allows for some state discretion in prescribing fines and sentences, and some case law has interpreted the federal Controlled Substances Act as not preempting the states' role in drug control.⁵³⁵ Closer scrutiny of the Act, however, reveals a clear congressional intent to preempt state laws that conflict with the federal law. Section 903 of the Act reads:

"No provision of this subchapter shall be construed as indicating an intent on the part of Congress to occupy the field in which that provision operates, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, *unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.*"⁵³⁶

This provision precludes any state from promulgating laws that might diverge from the federal model of drug prohibition, although no state has yet enacted any such laws.

Growing Federal Commerce Power – Pending Supreme Court Decisions

Decisions in two separate matters argued before the U.S. Supreme Court in the 2004-05 term will further define the scope of federal commerce power in the area of drug control. In *Ashcroft v. Raich*⁵³⁷, individuals permitted under California law to use marijuana for medical purposes either grow their own or are given free supplies, an arrangement that arguably constitutes entirely non-commercial, intrastate activity beyond the reach of Congress. Whether the Court agrees with this argument remains to be seen; a Court ruling against the California respondents in this case would enlarge federal commerce power to an historic level.⁵³⁸

The other relevant matter pending before the Court involves out-of-state wineries and their interest in boosting internet sales by being allowed to ship directly into states that have more restrictive alcohol control laws.⁵³⁹ These consolidated cases pit federal commerce power against the 21st Amendment, with winemakers arguing that the Commerce Clause, which prohibits states from limiting interstate commerce, takes precedence over the 21st Amendment, which gives states the right to regulate alcohol. Numerous conflicting decisions on this issue in the lower courts across the country necessitated U.S. Supreme Court action.⁵⁴⁰ A decision in the winemakers' favor would further erode the states' purportedly exclusive control over alcohol regulation.⁵⁴¹

THE COMMERCE CLAUSE TURNED ON ITS HEAD

In the early days of American legal history, the Commerce Clause was interpreted to embody a national policy of free trade, implying that states may not discriminate against one another and that Congress may act to reduce discriminatory barriers to commerce between the states. After a century of expanded interpretation, however, the Commerce Clause has not so much served to reduce barriers to free trade between the states as it has served to permit federal intervention in matters that once were the sole province of the states.

In the drug policy arena, broad federal commerce power has arguably stifled innovation on the state level and limited the states' discretion to exercise their inherent police powers. Although states currently comply willingly with the framework of federal preemption over drug policy, dissent is growing, not only regarding the continued federal prohibition of the use of marijuana for medical purposes, but also in reaction to federal intervention in the medical profession regarding the treatment of chronic pain.⁵⁴² However, if Washington or any other state were to depart fundamentally from the federal model of drug prohibition and attempt to establish an alternative regulatory system to control psychoactive substances, such efforts might run headlong into a century of case law supporting federal preemption.

Tests for State Police Power – A Drug Policy Scenario

To test a hypothetical scenario in which the state of Washington were to establish its own regulatory framework for drug control as an alternative to prohibition, certain key principles from landmark cases interpreting the reach of federal commerce power may help to guide whether such state action would be permissible:

Anti-discrimination. The fundamental principle underlying the Commerce Clause is that a state may use its police powers to protect public health in a way that incidentally affects interstate commerce *as long as the act is not discriminatory toward interstate commerce*.⁵⁴³ Accordingly, if Washington chose to use its police powers to protect public health by regulating and controlling psychoactive substances, rather than leaving them in the hands of criminal enterprises, such action might not be upheld where Washington is intentionally “discriminating” against interstate commerce. Albeit, the commerce is illicit, but the Commerce Clause has long been interpreted to give Congress the power to regulate even illicit commerce through means that resemble police power.⁵⁴⁴

Local nature of problems. Under the “Cooley Doctrine,” states are free to regulate things of a local nature that require different treatment from state to state and may not regulate things that require a uniform national treatment.⁵⁴⁵ The diversion and misuse of controlled substances has been declared by Congress to be a national problem requiring a national solution, justifying federal preemption in this policy area. However, the U.S. Supreme Court has held in other cases that “simply because Congress may conclude that a particular activity substantially affects interstate commerce does not necessarily make it so” and that “the Constitution requires a distinction between what is truly national and what is truly local.”⁵⁴⁶ The Court has not yet considered whether the Controlled Substances Act improperly prevents states from effectively regulating the “local nature” of their respective drug abuse problems.⁵⁴⁷

Rational means to legitimate ends. Any state action affecting interstate commerce requires a legitimate state end and a rational means to that end.⁵⁴⁸ Under this balancing test, the state of Washington’s new regulatory framework for controlling psychoactive substances should satisfy the requirement that the local benefit outweigh the burden on commerce, where the commerce that is “burdened” is illicit commerce controlled by criminal enterprises.

Some discrimination allowed. When there is a legitimate local interest and no nondiscriminatory means to achieve it, a discriminatory means may be used to limit interstate commerce.⁵⁴⁹ By establishing its own, intrastate system of psychoactive drug control in order to render the violent black market unprofitable, to restrict access by young persons to drugs and to open new gateways to treat hard-to-reach populations, the state of Washington could clearly demonstrate a “legitimate local interest,” and with no non-discriminatory means to achieve it, where the “competition” is organized crime.

The principles above are used to test state action only in the *absence* of federal legislation – the notion of the “Dormant Commerce Clause.”⁵⁵⁰ Nevertheless, even though Congress has “spoken” definitively in the area of drug control, applying these federalist principles to current drug policy reveals the perverse outcomes that have arisen from federal preemption in this area of the law. Federal drug prohibition has not only guaranteed a thriving illicit market controlled by criminal enterprises, it has also put that illicit market beyond the reach of the police powers of states that might elect to address their societal drug abuse problems through means other than drug prohibition.

STEPS TOWARD A FEDERALIST DRUG POLICY

The debate over the balance of power between the federal government and the several states is as old as the Republic.⁵⁵¹ Over the course of the last century, enhanced federal authority in almost every realm of the law has marginalized the importance of “states’ rights,” despite some resurgence of the principle embodied in the Tenth Amendment invoked by the Rehnquist Court.⁵⁵² Nevertheless, states’ efforts to find more effective drug policies will inevitably challenge the current federal balance of power as states begin to depart from the federal drug control scheme.

States as Laboratories

Justice Brandeis famously declared that “denial of the right to experiment may be fraught with serious consequences to the nation” and that states should be encouraged to “serve as a laboratory” in the trial of “novel social and economic experiments” because by so doing knowledge and perspective could be gained “without risk to the rest of the country.”⁵⁵³ This concept was reiterated recently in a drug policy case, as Justice Stevens emphasized “the importance of showing respect for the sovereign States that comprise our Federal Union, [which] imposes a duty on federal courts, whenever possible, to avoid or minimize conflict between federal and state law, particularly in situations in which the citizens of a State have chosen to try a different approach.”⁵⁵⁴

Certain states have been more “progressive” or “liberal” than the federal government in areas of social policy, providing, for example, constitutional and statutory protection against discrimination on the basis of sexual orientation and protection of physician-assisted suicide, welfare rights and freedom of expression.⁵⁵⁵ In other areas of the law, states have fallen victim to federal “homogenization” by Congress, whether through direct regulation, conditional federal spending or, in the case of drug policy, through preemption.⁵⁵⁶ Such overbroad federal authority forecloses opportunities for the states, especially where there is compelling evidence that policymaking decentralized to the state level leads to more innovative and cost effective policy measures and that the states as laboratories provide useful demonstrations for other jurisdictions.⁵⁵⁷

Federal drug control policy is also grounded in a particular moral perspective – that the use of certain prohibited substances is “wrong.”⁵⁵⁸ Federal preemption in the area of drug policy thus extends beyond mere statutory or practical limitations on the states; federal authority is used to impose a centralized morality on the states.⁵⁵⁹ Even the fervent federalist, Alexander Hamilton, argued at the dawn of the Republic that any national attempt to impose morality or to dictate civic virtue to the states would be “as troublesome as it would be nugatory,” further justifying how local administration of justice is “the most powerful, most universal and most attractive source of popular obedience and attachment.”⁵⁶⁰ In short, “federalism is good for the soul as well as the body.”⁵⁶¹

Key Amendments to Federal Drug Law

As a first step in the decentralization of national drug policy, certain amendments to federal law would help spur the “laboratories of democracy” among the states, allowing them to develop reforms more compatible with their local political climates. One simple amendment to Section 903 of the Controlled Substances Act, the “positive conflict” clause,⁵⁶² would arguably be sufficient to restore the federal-state balance in drug policy, whereby preeminence would be given to state law instead of federal law whenever conflicts arose between the two.⁵⁶³

Another simple regulatory change – the removal of marijuana from the federal list of Schedule I (prohibited) substances – which could be promulgated by the U.S. Attorney General, would create enormous opportunities for state and local governments to realize significant cost savings in law enforcement, prosecution and incarceration, without necessarily compromising community health and safety. States and localities would be responsible not only for their respective policies toward marijuana control but also for their budgets for drug enforcement, which would force a “candid conversation” in the local political arena about the wisest use of scarce public resources and about the best means to protect public health and safety.⁵⁶⁴

Some perverse incentives have been created by federal dominance in drug policy, which have had the effect of boosting intensified law enforcement activity, prosecution and incarceration. The most notable policy incentives of this sort are drug-related asset forfeiture and mandatory minimum sentences, each of which would be ripe for reform in a more federalist drug policy environment.⁵⁶⁵

CURRENT OPTIONS AVAILABLE TO THE STATES

Through enactment of the Uniform Controlled Substances Act, Washington and the states have *voluntarily* integrated their drug control laws into the federal scheme. Could a state, therefore, voluntarily diverge from the federal scheme just as easily? Even without any amendment to the federal Controlled Substances Act, could a state enact its own regulatory system for controlling those psychoactive substances that are currently produced and distributed exclusively in illegal markets? May the state of Washington establish its own system and structures for drug control in an attempt to find a more workable alternative to federal drug prohibition?

Reassertion of Inherent Police Powers

There is a strong argument that states’ exercise of police powers should be respected at the federal level, especially regarding a public health issue such as drug abuse. Drug problems vary significantly from state to state and between regions, which should allow state and local jurisdictions wider discretion to develop more creative policy responses. The power of states to control drugs exists independent of federal legislation; case law from Washington, in fact, affords the state the maximum permissible authority to fight the drug abuse problem, in view of the “dangerous nature and injurious effect of unregulated drug use.”⁵⁶⁶

Assuming that the U.S. Supreme Court would not second-guess a legislative policy decision made in Washington, or in any other state, pursuant to its police powers to protect health, welfare and safety, Washington could confidently establish its own state-level regulatory system to control those psychoactive substances currently produced and distributed exclusively in illegal markets. Whether or not the state were to create its own regulatory system, Washington may still decline to enforce or provide appropriations for its share of the enforcement of federal drug laws, which many states did during national prohibition of alcohol in the 1920s.⁵⁶⁷ A long line of cases supports the principle that the federal government may not “commandeer” states,⁵⁶⁸ nor may it compel state and local law enforcement officers to enforce federal laws.⁵⁶⁹ The state legislature may even prohibit state law enforcement officers from cooperating with federal agents, which has already happened in California localities in connection with its medical marijuana laws.

Exclusive Regulation of Medical Practice

Recent case law has limited federal authority to meddle in the states’ regulation of medical practice, particularly limiting the use of the federal Controlled Substances Act to override a state’s decisions concerning what constitutes “legitimate” medical practice.⁵⁷⁰ Drafters of the Uniform Controlled Substances Act acknowledged that the federal focus on controlling drug use might chill the legitimate practice of medicine, especially regarding the prescription of narcotics.⁵⁷¹ However, Congress never intended, through the Controlled Substances Act or other federal laws, to grant blanket authority to the U.S. Attorney General or to the federal Drug Enforcement Agency to define, as a matter of federal policy, what constitutes the legitimate practice of medicine.

Despite questioning by the courts, federal authorities are pressing ahead to regulate doctors’ use of drugs, particularly for the purpose of treating chronic pain. As a result, the antipathy of medical practitioners toward the federal bureaucracy is reaching the boiling point.⁵⁷²

States’ broad police powers are supposed to preclude the federal exercise of authority in matters of medical practice.⁵⁷³ The regulation of the medical field has historically come under the primary control of the individual states, including the power to regulate the administration of drugs by health professionals.⁵⁷⁴ Accordingly, to the extent that the regulation of drugs is a medical issue, a state could authorize the creation of medical prescription programs as a new addiction treatment modality, along the model of the successful prescription programs now operating in Europe and Canada.⁵⁷⁵

State as “Market Participant”

When a state functions like a commercial enterprise it may “discriminate” in favor of its own residents and, as a business proprietor (or “market participant”), it is free of Commerce Clause limitations and the reach of federal commerce power.⁵⁷⁶ Accordingly, if the state of Washington or any other state sought to undercut the illicit market in psychoactive substances by becoming the exclusive purveyor of such substances to qualified state residents, it might be allowed to set restrictive rules that “discriminate” against out-of-state residents and that impose burdens on interstate commerce that would otherwise not be permitted.⁵⁷⁷

CONTINUED FEDERAL INTERFERENCE?

Even if a state were to enact statutes and promulgate regulations to establish a new, state-level regulatory system to control “black market” psychoactive substances, the federal government might still intervene in the state’s affairs under the following authorities:

Federal Police Power

Federal agents might continue to arrest, prosecute and punish individuals for violating federal drug laws, justifying their broad authority on the weight of the modern case law supporting federal drug control authority under the Commerce Clause. In practical terms, federal agents would likely continue to pursue larger-scale illicit producers and traffickers, as they do today. However, if a state were to establish a regulatory system, including state-controlled drug prescription clinics and state-controlled production of cannabis, the extent of any large-scale, illicit production and distribution would be very limited, where the “black market” demand will have been significantly reduced. A flourishing “gray market” in legally produced substances would likely continue, however.

Nevertheless, if a state were to establish its own regulatory system for drug control, the U.S. Justice Department might seek injunctive action against the state. In such a case, the limits of states’ rights to exercise their police powers to control drugs would be put to the ultimate test. If the U.S. Supreme Court were to validate a state-level regulatory framework that diverged from the federal law, federal jurisdiction over the psychoactive substances controlled by a state would attach only in limited circumstances, not based on the Commerce Clause but on the federal criminal law, involving only matters involving the actual interstate transport of federally-prohibited substances and any activity conducted on federal property.

Taxing and Spending Powers

Congress’ spending power is not limited to supporting other enumerated powers, it is an enumerated power itself and may be used directly to support the “general welfare.”⁵⁷⁸ The federal government broadly uses its spending power to coax states into compliance with federal regulations.⁵⁷⁹ In the drug policy context, enormous federal outlays to the states serve as strong financial incentives to continue the prosecution of federal drug control imperatives – a practice that could be regarded as “back-door commandeering” of the states to enforce federal drug policy. A state might pause at the prospect of losing millions of dollars for law enforcement, prosecution and incarceration, fearing “punishment” by the federal government for having diverged from the prohibition model. However, if the state-level regulatory system were to achieve its objectives, the need for criminal justice resources would significantly diminish.

Implied Foreign Affairs Power

Federal authority over drug policy was secured early in the 20th century through the implied foreign affairs power of the federal government.⁵⁸⁰ Two years before the passage of the Harrison Narcotic Act, the United States purposefully engineered the Hague Opium Convention of 1912 in order to establish a mandatory international legal foundation on which U.S. drug laws would be built.⁵⁸¹ Current U.S. drug laws continue to be founded partly on federal treaty power, under a series of United Nations conventions sponsored by the U.S. to buttress its domestic drug laws.⁵⁸²

There are no real limits on the treaty power of the federal government, and the Tenth Amendment does not prohibit the federal government from going beyond the Constitution to enforce treaty obligations at the state level.⁵⁸³ To the extent that a treaty violates a specific constitutional provision, however, it is void.⁵⁸⁴ Barring such violations, the federal government could conceivably use its treaty power to quash state and local drug policy reforms. Unfortunately, the U.S. has an interest in maintaining the current model of drug prohibition, as its “unwavering commitment to abide by the international agreements it engineered as long as four decades ago freezes drug policy in time and is ...a commitment to ignorance since it discards new evidence in favor of past prejudice.”⁵⁸⁵

SUMMARY

Despite the case law validating the federal Controlled Substances Act under the Commerce Clause, the federalist tradition still regards the federal government as one of enumerated powers and Congress as possessing only those powers specifically delegated to it under the U.S. Constitution. In view of the potential harms of unregulated drug use, states still retain the inherent power to protect their own citizens by controlling drugs and combating drug abuse locally, independent of any congressional legislation or statement that drug abuse is a “national problem.” Any federal challenge to the state of Washington or any other state that might establish a new regulatory system to control psychoactive substances that are currently produced and distributed exclusively in illegal markets should yield to the state's legitimate exercise of its police powers, which would take place through the state's own political processes, whether through legislative action and/or the passage of ballot initiatives.

V. PARAMETERS OF A NEW LEGAL FRAMEWORK FOR PSYCHOACTIVE SUBSTANCE CONTROL

Treating drug use as a criminal matter rather than a social and medical issue has not been successful in reducing drug use, nor the harms arising from drug use.⁵⁸⁶ For over three decades the state has been seeking new tools to fight the persistent crime problem that has inevitably arisen from the policy of drug prohibition, meanwhile distracting both the state and society at large from effectively addressing the problem of drug addiction itself.

Persuasive and voluminous research indicates that a public health approach to drug abuse – stressing research, education, prevention and treatment – is far more effective than the use of criminal sanctions. However, the policy of drug prohibition, which has spawned a range of intractable problems, from a flourishing “black market” to the spread of blood-borne diseases to official corruption, has been a major impediment to employing such a public health approach.

PRINCIPLES AND OBJECTIVES

The following principles were set forth by the King County Bar Association in 2001 to guide reform of drug control policies and practices:

- 1) Any public policy toward drug use should seek to result in no more harm than the use of the drugs themselves;
- 2) Any public policy toward drug use should address the underlying causes and the resulting harms of drug abuse instead of attempting to discourage drug use through the imposition of criminal sanctions;
- 3) The state should regulate drugs in a manner that recognizes citizens’ individual liberties while answering the need to preserve public health, public safety and public order, especially providing compassionate treatment to those in need; and
- 4) The state should regulate the use of drugs in a manner that uses scarce public resources as efficiently as possible.⁵⁸⁷

Using these principles as a guide, a critical step toward improving society’s response to drug abuse would be to establish a state-level regulatory system to control those psychoactive substances that are currently produced and distributed exclusively in illegal markets, where those substances are now controlled by criminal gangs and are readily available to children.

The principle objectives of the King County Bar Association’s broad drug policy reform efforts have been: to reduce crime and public disorder; to improve public health; to protect children more effectively; and to make wiser use of scarce public resources. In accordance with those objectives, the purposes of any new regulatory system to control

psychoactive substances that are currently produced and distributed exclusively in illegal markets would be:

- 1) to render the illegal markets for psychoactive substances unprofitable, thereby eliminating the incentives for criminal enterprises to engage in the violent, illegal drug trade;
- 2) to restrict access to psychoactive substances by young persons much more effectively than the current drug control scheme; and
- 3) to open many new gateways to treatment so as to provide prompt health care and essential services to persons suffering from drug addiction.

The King County Bar Association does not presume to set forth every detail of a state-level regulatory system for controlling psychoactive substances, nor any specific, statutory changes required for that purpose. Rather, the Association, along with a broad coalition of other professional and civic groups, has called on the Washington State Legislature to authorize a special consultative body, comprised of experts in pharmacology, medicine, public health, education, law and law enforcement, as well as public officials and civic leaders, to provide specific recommendations for legislative action to establish such a state-level system of regulatory control.⁵⁸⁸ The following outline of key issues to be addressed may serve as a sketch of the parameters of such a regulatory system:

REGULATION AND CONTROL – ESSENTIAL COMPONENTS

Controversial Terminology

The politically charged term “legalization” is insufficient to describe how the state would control psychoactive substances that are now exclusively produced and distributed through illegal markets. The concept of *strict regulation and control* of psychoactive drugs is a more accurate and useful concept and this must be very carefully distinguished from the idea of *commercialization* of such drugs.

To some, the notion of “legalization” suggests that addictive psychoactive substances might be available over the counter and more easily accessible by children; that today’s drug dealers would continue to do business but simply be unencumbered by law enforcement; or that the criminal enterprises now controlling the drug trade would become legitimate or that pharmaceutical, alcohol and tobacco companies would “take over the business” and aggressively promote the sale of their psychoactive drugs in the commercial marketplace. That is not a responsible vision for a system of effective drug control. The notion of state-level regulation and control contemplates a more effective means to *reduce* access to and use of psychoactive drugs by young persons, the prohibition of the private sale of such drugs, the prohibition of advertising and the medical prescription of some or most drugs as a proven means to reduce harm and drug abuse in hard-to-reach populations of addicted persons.

Substances Subject to State Regulation and Control

State regulation and control is needed to control psychoactive substances that are *exclusively produced and distributed in illegal markets*. The most troublesome examples of such illegal markets include those for cannabis and heroin, the use and sale of which are absolutely prohibited under federal law and are deemed to have no medical value, and for methamphetamine and cocaine, for which the law allows medical use only in extremely limited circumstances. Other prohibited substances, such as phencyclidine (PCP, or “angel dust”), are used by so few people that a black market could not be sustained for that substance alone. Where the objectives of the regulatory system are to undercut the black market, to restrict access by young persons and to open gateways to treatment, the most widely used substances, for which black markets continue to flourish, would be the principal targets of regulation.

The Importance of State Control

In order to maintain strict supervision over production and distribution, currently-prohibited psychoactive substances would most prudently be controlled by state-owned or state-controlled facilities. This is especially true of the “hard” drugs that pose serious risks of harm, which might only be provided to medically certified addicts as part of addiction treatment in state-licensed clinics and/or from private doctors’ offices. The recent track record of such facilities in Europe is encouraging, as prescription drug maintenance programs have brought about meaningful reductions in overdose deaths, reductions in the transmission of disease, reductions in economic crimes related to addiction, reductions in levels of public disorder, reductions in youth initiation rates, reductions in quantity of drug use and even elimination of use altogether for a sizable number of addicts.⁵⁸⁹ Such “win-win” results should also help to reduce the burden on law enforcement, which strongly supports such programs in Europe.

Sources of Production

The state would not have to smuggle or purchase heroin, methamphetamine or cocaine from Latin American or Asian criminal gangs, nor would in-state cultivation of opium, coca or ephedra be necessary to obtain needed supplies. Cocaine and methamphetamine are actually legal drugs under federal law, so the state could obtain a pharmaceutically pure supply for special treatment facilities for registered addicts, accomplished by the state pursuant to its exclusive power to regulate medical practice. Rather than heroin (diamorphine), comparable short-acting opiates that are medically available, such as laudanum (hydromorphone) could be provided, as Canadian clinics are currently doing.⁵⁹⁰

If the state were to regulate the production and distribution of cannabis, it could obtain a controlled supply of cannabis from licensed producers or cooperatives of producers entirely within the state of Washington, following the example of the British Home Office and the Dutch government, which have already licensed private producers of cannabis for research purposes. Before entering into contracts with the state the producers would be thoroughly screened and their operations would be closely monitored and audited, subject to criminal sanctions for engaging in unauthorized distribution

outside the state system, especially to young persons. Disincentives would remain very strong for producers not to violate these terms, as their livelihoods and their personal liberty would be at stake. Further, there would be few incentives for qualified adults to obtain cannabis outside the state system, as a reliable product would be available at a price at, or just below the “black market” price.

Effects on Current Drug Prescription Regime

No changes would be needed to the current federal-state regulatory system for prescription medications. Instead, some of the currently prohibited drugs, or effective substitutes that are not prohibited, might be made available by prescription as part of addiction treatment regimes aimed at reducing the quantity of use and eventually the elimination of use – the approach now proven effective in Europe. Currently prohibited substances might also be approved for other medically proven purposes, such as for pain relief or for the treatment of mental health conditions such as depression and post-traumatic stress disorder.

Purity, Labeling and Health Warnings

A significant advantage of a regulatory system for psychoactive substances would be better guarantees of purity and safety of those substances under state control. Just as with other prescription medications, accurate labeling and comprehensive information about dosages and contraindications would be provided for those substances administered to addicted persons through state-controlled medical facilities, hopefully more comprehensive than the information provided to consumers at a pharmacy.

Limits on Access to Psychoactive Substances

Currently there are no effective limitations on access to prohibited psychoactive drugs. In fact, young persons today often have greater access to such drugs than adults do.⁵⁹¹ A regulatory system would establish more effective limits on such access, although no system can be completely fool-proof. Under a regulatory system, there would be differing degrees of control for each substance, depending on their known potential for harm and problematic use. It is possible, therefore, that only registered addicts would have access to the more addictive drugs such as heroin, cocaine and methamphetamine for the purpose of addiction treatment, and only through state-licensed or state-controlled medical treatment facilities. By contrast, cannabis might be regulated less strictly, perhaps in a similar manner as distilled spirits are controlled in Washington State.

A wide spectrum of regulatory mechanisms could be employed to limit access to state-regulated psychoactive substances,⁵⁹² including:

Proof of dependence. Under this requirement, an individual seeking to obtain a substance must be assessed by a health worker to be dependent and then allowed to use a carefully rationed amount in a designated space.

Proof of “need.” Beyond the substances on which people are physiologically dependent, other drugs such as LSD and Ecstasy, which have been shown to have

potential psychotherapeutic benefits when used in controlled therapeutic environments, could be used with registered and trained psychiatrists and psychologists.

Required training. Training programs could provide information about addiction, treatment services and other public health issues, such as sexually transmitted diseases and blood-borne illnesses. The programs could provide the knowledge and skills aimed at discouraging drug use, reducing the amount of drug use, and reducing the harm of drug use. Program graduates would receive a certificate that would be required to be shown prior to obtaining a substance.

Required test of knowledge. A short test could be administered at the point of distribution of state-controlled substances to demonstrate to the staff that the individual obtaining the substance has the required knowledge of safe use that is likely to minimize harm.

Registration. This would allow those who obtain substances to be tracked for “engagement” and health education. It might also discourage individuals from substance use as well as reducing problematic use.

Licensing. As with licenses for new motor vehicle drivers that restrict the place and time of driving and who they are permitted to drive with, a licensing scheme could also help to control the time and place of substance use and the associations of new substance users. This would be a graduated program requiring a demonstration of responsible, non-harmful substance use. The licensee could be given demerit points or have the license suspended based on infractions, such as providing substances to non-licensed users, driving under influence or public intoxication. Such licenses could also specify different levels of access to various substances based on levels of training and experience. People in some professions, like airplane pilots or taxi drivers, could be restricted from obtaining licenses to purchase long-acting drugs that impair motor skills.

Proof of residency. Some societies have gone through a process of developing “culturally specific social controlling mechanisms” that form over time a certain amount of relatively healthy, unproblematic relationships with substances. “Drug tourists” who have not been integrated into such a culture may behave in problematic ways that do not adhere to the local restraining social practices. Therefore, those allowed to obtain substances could be restricted to residents of a particular jurisdiction. The state of Washington would not become a drug haven for “riff-raff” from other states and countries if only Washington state residents would be eligible to receive substances through the state regulated system.

Degree of intoxication. In many jurisdictions the sale of alcohol is restricted based on the degree of intoxication of the purchaser. Similarly, with other intoxicants the state could refuse to provide substances to individuals perceived to be engaging in high-risk, substance-using behavior.

Volume rationing. Quantities may be limited to a certain amount deemed appropriate for personal consumption so that users would not sell the substances on the black market or use an unsafe amount. Such limits currently exist in those European countries that have normalized cannabis use. As for the addictive drugs provided through

medical facilities, carefully controlled doses would be provided by medical professionals, presumably reduced over the course of time, to optimize the treatment objectives of harm reduction, quantity-of-use reduction and eventual abstinence.

Tracking of consumption habits. Registered purchasers would have the volume and frequency of purchasing tracked. This could be used to instigate “health interventions” by health professionals who could register their concerns with the user and offer assistance if a problem is identified. The tracking may be a deterrent to use, as well as a possible trigger for increases in the cost of the substance once the user surpasses certain volume thresholds.

Required membership in group. Users of certain substances may belong to advocacy or union groups that would act similar to existing professional regulatory bodies that provide practice guidelines for their members. If the user acts outside of the norms of the discipline, the group can refuse membership. The norms would be enforced through a variety of peer processes and education.

Private Production and Consumption of Cannabis

As an easy-to-grow weed, cannabis will inevitably be produced to some extent by private citizens on private property. A state-supervised system of home production (not dissimilar to home brewing) and non-commercial exchanges (“gifting”) might actually satisfy the demand for cannabis, thereby reducing the potential harm from excessive availability. The state legislature would need to consider the nature and scope of state regulation of such home production and non-commercial exchanges and, depending on the degree to which that approach would satisfy demand and eliminate the illegal market, would determine whether establishing state-controlled outlets would even be necessary.

The Moral Authority of the State

The state might face an ethical dilemma if it were to become the purveyor of mind-altering substances for profit. It is instructive to note, however, that the Washington State Liquor Control Board, which does an effective job of limiting access by minors to distilled spirits, still brings in about \$100 million each year to help balance the state’s budget!

It is important to consider once again the main objectives of the proposal to assert state regulatory control over currently prohibited substances:

- 1) to undercut the violent, illegal markets that spawn disease, crime, corruption, mayhem and death, not to mention reducing the wasteful public expenditures devoted to continually chasing these problems but never effectively address them;
- 2) to reduce access by young persons to psychoactive drugs and to provide them better education and prevention services; and
- 3) to open new gateways to treatment, particularly finding the hard-to-reach population of addicted persons who consume the bulk volume of drugs, drying up black market demand for

those drugs and thereby reducing public disorder, economic crimes related to addiction, transmission of disease, accidental death, quantities of drugs consumed, initiation of use by young persons and drug addiction itself, as well as criminal justice, public health and social welfare costs.

A policy to achieve these objectives could only enhance the moral authority of the state.

PROTECTING YOUNG PERSONS FROM THE HARMS OF DRUGS

Among the public policy objectives to be served by any drug control strategy, the protection of children is arguably the most important. To satisfy this objective, any regulatory system designed to undercut illegal drug markets and to reduce the harm from psychoactive drugs must distinguish between the rights and interests of adults and those of children.

We often hear about “the message we send to children.” Unfortunately, young people today receive many mixed messages, including, “Take a pill to feel better,” “Drink beer and get drunk” and “just say no, except when you’re 21 you can drink.” In a society that purportedly aims to be “drug-free,” young people witness excessive use of both legal and illegal drugs by adults and are bombarded by commercial advertisements promoting a wide variety of mind-altering, pleasure-inducing substances. The most troublesome mixed message we now send to young people is that drugs are bad and dangerous, but we still leave control of drugs up to criminal gangs rather than take control over them ourselves, as with all other hazardous substances.

The attempt to fashion the appropriate parameters of a regulatory system for drug control must address the following threshold issues:

1) Should young persons be legally prohibited from possessing and consuming psychoactive substances?

Recent scientific findings have reformed previous notions about the early development of the human brain and validate a public policy that seeks to prevent the use of psychoactive substances that may impair the development of children and teenagers. Some recent evidence suggests that the use of psychoactive substances before age fifteen may be related to neurological problems, as compared with the initiation of use after age nineteen.⁵⁹³ Other recent evidence indicates that *legally prescribed* psychoactive drugs present undue risks of harm to persons under age eighteen.⁵⁹⁴

Whether or not drugs directly affect the developing brain, children’s limited ability to make informed judgments renders them especially vulnerable to the adverse consequences of drug use and preventing or delaying such allows for the development of social competence and resilience to risk.⁵⁹⁵ Therefore, where young persons’ vulnerability unreasonably exposes them to the potential harms from psychoactive drug use, it is desirable and reasonable that young persons be legally prohibited from possessing and using such drugs.⁵⁹⁶

As with any form of prohibition, a drug control policy that restricts young persons from possessing or using psychoactive substances should be limited to the reduction of actual harm, as balanced against the often dangerous conditions and counterproductive effects brought about by prohibition itself. For example, it is worth noting that, in our society, young persons are permitted, and often encouraged to use certain psychoactive drugs, such as caffeine and sugar. These substances have been scientifically proven to have deleterious effects on children, but the negative effect of prohibiting their consumption would be viewed as too great to justify prohibition.⁵⁹⁷

2) Should young persons be criminally punished for possessing and consuming psychoactive substances?

The legal prohibition of young persons' possession and use of psychoactive drugs justifies a state sanction for such possession and use. The law should authorize the seizure of psychoactive drugs found in young persons' possession, but the state sanction need not be a criminal sanction.

Voluminous literature supports the notion that criminal punishment for the possession and use of drugs, whether for adults or children, is counterproductive and inappropriate and has brought about severe societal consequences.⁵⁹⁸ Criminal punishment of drug possession and use has not resulted in decreased substance abuse among young persons; in fact, more young persons are now experimenting with more dangerous psychoactive substances, and at even younger ages.⁵⁹⁹

Possession and use of psychoactive drugs by young persons should not be subject to criminal punishment. However, any young person who, while under the influence of a prohibited psychoactive substance, causes harm to other persons or to property, should be held accountable under current laws prohibiting those acts. In such cases, acts causing harm to others and to property are the trigger for the criminal sanction, not the actor's use of drugs nor the actor's intoxication.

Any state response to drug use by young persons should directly address the underlying causes of the young person's drug use. A family-oriented and community-oriented approach, stressing the young person's rehabilitation and restoration, would be most appropriate and most effective.⁶⁰⁰ A reasonable policy, in the case of a young person found possessing or using drugs, would be a referral to the appropriate local or state agency for evaluation of the young person's needs and provision of services and assistance to meet those needs. Drug use by young persons should be addressed using sound, evidence-based social work practices, not through criminal punishment and stigmatization.⁶⁰¹

The remedial measures used to address a young person's psychoactive drug use should depend on each particular situation and should directly address the causes, the degree and the negative effects of the drug use, not merely the drug use *per se*. The use of drug testing, for instance, may be useful as a guide to clinical intervention but drug test results should not be used as proof of guilt or innocence or as justification for punishment. Recent evidence gathered from surveying over 75,000 American school children persuasively suggests that drug testing of young persons in schools, for instance,

does not result in any decrease in drug use.⁶⁰² By contrast, evidence-based prevention programs and clinical intervention and treatment have been shown to be much more effective in preventing and delaying initiation of drug use by young persons.

3) Should young persons be criminally punished for selling or otherwise providing psychoactive substances to others?

The demonstrated risks and harms to young persons from the use of psychoactive drugs, as outlined above, dictates that any sale or other transfer of psychoactive drugs by *adults* to young persons should subject such adults to criminal punishment. Providing potentially dangerous substances to an individual who lacks mature discretion can reasonably be viewed as a nonconsensual act that threatens public safety and, therefore, should be treated as a criminal act. Washington state law already provides for criminal punishment in the case of furnishing liquor to minors,⁶⁰³ and this provision may serve as a useful corollary to establishing similar punishment of adults in connection with furnishing other psychoactive substances to minors.

Circumstances in which adults furnish drugs to young persons should be carefully distinguished from situations where young persons sell or otherwise provide drugs to other young persons. Such young persons are most often in peer relationships and in those situations, the underage provider would be more appropriately subject to the same type of state-sanctioned assessment, intervention and provision of services described in (2) above. In most cases, young persons are presumed to lack the adequate knowledge and discretion to assess the various consequences of drug use, so they should not be criminally punished for providing drugs to their peers, except when the provider is significantly older than the user. Statutory rape laws covering consensual sex between minors provides a useful model.

4) What measures should be promoted to reduce the harm from and to discourage the use of psychoactive substances by young persons?

A report by the U.S. Center on Substance Abuse Prevention noted that:

Adolescence is a period in which youth reject conventionality and traditional authority figures in an effort to establish their own independence. For a significant number of adolescents, this rejection consists of engaging in a number of 'risky' behaviors, including drug and alcohol use. Within the past few years, researchers and practitioners have begun to focus on this tendency, suggesting that drug use may be a 'default' activity engaged in when youth have few or no opportunities to assert their independence in a constructive manner.'⁶⁰⁴

Unfortunately, studies have shown that many, if not most, drug education programs for youth are not effective.⁶⁰⁵ A recent study revealed that illegal drug use by suburban and urban public school students is virtually identical and that well over a third of all students, and over four of ten twelfth graders, have used illegal drugs. The study found that almost one of every seven students in both urban and suburban schools, that about one of every six twelfth graders, have been high on drugs at school and that about

one in ten suburban students, and about one in fourteen urban students, have driven while high; and about one in five suburban twelfth graders have done so.⁶⁰⁶

Many programs that solely advocate complete abstinence, or are based on the assumptions that drugs are not a common part of our culture, that drug use is the same as drug abuse, that marijuana is the gateway to drugs such as heroin and cocaine, or that exaggerating risks will deter youths from experimentation, are not effective and, in fact, are often counterproductive to the goal of reducing drug use by young people.⁶⁰⁷

Providing activities that keep young people interested in and connected to society is more likely to accomplish the delaying of, or abstinence from, drug use than is the fear of stigmatization or criminal punishment.⁶⁰⁸ Examples of such activities include:

- Participation in engaging activities, such as music, art, performing arts and sports;
- Attention to and direction in academic pursuits;
- Involvement with school, religious, community and other organizations;
- Communication with parents and friends; and
- Science based drug education programs in school and the community.

Schools, churches, civic organizations and government all have a legitimate role in helping families teach young persons about the effects and risks of psychoactive substance use. There is an abundance of data indicating that certain types of prevention programs are effective in reducing harmful behaviors that are associated with substance abuse. The current challenge is getting such programs implemented with fidelity.⁶⁰⁹

5) What measures are needed to limit the illegal market for psychoactive substances that targets young persons?

Experience with the regulation of adult use of alcohol supports the conclusion that prohibiting psychoactive drugs to a very limited portion of the population (minors) is not likely to support the formation of a substantial illicit market targeting that population. If Washington were to adopt a regulatory system for the control and distribution of psychoactive substances to undercut the illegal markets for those substances, albeit with a prohibition as to young persons, and if the regulatory scheme also encompassed programs for preventive education and, especially, strict limitations on promotional advertising, there would be little incentive for a “black market” directed solely at young persons.

Under the current, unregulated scheme whereby possession and use of psychoactive substances are criminalization for both adults and young persons, there has been an increase in availability of psychoactive substances to young persons. As long as a profitable illegal market in psychoactive substances exists for adults, there will be no reasonable means to limit how such substances are supplied to young persons.

History has shown that prohibition creates a supply of products at an inflated price and, therefore, a strong financial incentive for criminals to provide drugs to anyone willing to pay, including young persons.⁶¹⁰ When products are not prohibited generally - where there is no economic incentive for an illegal market for adults - young persons have less opportunity and pressure to obtain drugs and, therefore, legitimate suppliers have a disincentive to supply drugs to young persons.

CURBING DEMAND FOR DRUGS: LIMITING PROMOTION

One of the most important components of any new system to control psychoactive substances would be severe limits on advertising and promotion, as strict as the law would allow within the constitutional protections of free speech. Any system of regulation and control would have to be designed so as not to foster a commercial market, especially in the manner that alcohol and tobacco have been commercialized. There is compelling evidence that advertising and promotion are more highly associated with increases in consumption of drugs than the mere legal status of the drugs themselves.⁶¹¹

The Harms of Unfettered Promotion

Current “vices” are all aggressively promoted in American society, as alcohol, tobacco, pharmaceuticals and gambling are advertised on television, at sports events, on billboards and in publications. Where advertising is proven to have an effect on consumption, the potential for harm is not remote. Reports have shown, for example, that junk food advertising has been shown to increase obesity in children,⁶¹² and alcohol advertising has led to increased alcohol consumption that, in turn, has led to increased motor vehicle fatalities.⁶¹³

Prescription drug advertising has grown 150 percent since 1997, the year the Food and Drug Administration revised its guidelines to permit more advertisements.⁶¹⁴ Pharmaceutical companies are making billions of dollars from their well-advertised products, even when similar products that are cheaper and available over-the-counter may work just as well. Some politicians see the need to limit the advertising because they believe it is driving the spending on expensive drugs that contributes to the inflation of the nation’s health care costs. The FDA has no plans to change the rules, however, and is even studying a proposal to loosen the rules more.⁶¹⁵ To boost profits, pharmaceutical companies are investing in marginal improvements of their existing drugs rather than invest in riskier, breakthrough drugs.⁶¹⁶ The large profits that are allegedly for research and development also go toward forms of “education” about the drugs for doctors and all manner of incentives for them to prescribe those certain drugs. According to Dr. Marcia Angell, former editor in chief of *The New England Journal of Medicine*, “Once upon a time, drug companies promoted drugs to treat diseases. Now it is often the opposite. They promote diseases to fit their drugs.”⁶¹⁷

Tobacco is another substance with heavy advertising and promotion and a strong lobby. Broad restrictions on the convenience of smoking, such as workplace bans, educational programs and pressure from physicians, have worked to increase the stigmatization of smoking, and tobacco use has decreased in recent years. There have also been more regulations placing restrictions on tobacco advertising and increased taxes, but the tobacco industry has used great influence and legal pressure to make sure that the restrictions and taxes have been limited. Local municipalities have had the most success putting restrictions on where smoking can occur.⁶¹⁸

Gambling, while not as heavily promoted as alcohol and pharmaceuticals, is still an advertised “vice.” States promote their own form of gambling – the state lottery – with commercials but often without any counter-advertising on the harms of gambling. The states have evolved from regulators of gambling to promoters of gambling.⁶¹⁹ There are now approximately five million pathological and problem gamblers in the U.S.,⁶²⁰ and the uneasiness of some state legislators with the promoting of gambling has led some states to restrict their own advertising, including Massachusetts, which lowered its state lottery budget from \$12 million to \$400,000.⁶²¹

First Amendment Issues

The weakness of most alternatives to prohibition is that commercial interests generate advertising and other forms of promotion that produce undesirable consequences. The challenge is to combat the “black market” with some form of controlled availability that does not give any commercial interest an incentive for promotion.

Washington State attempted such a program 70 years ago when it legalized alcohol and set up state liquor stores. The theory was that the state government would be the only party legally authorized to buy alcoholic beverages from manufacturers. It would then provide the beverages in state liquor stores run by salaried state government employees who have no incentive to promote sales. However, they forgot to account for the effect of trademarks. Because the state liquor stores resell products marked with trademarks supplied by the manufacturers, the manufacturers are able to advertise directly to consumers and thereby promote their products.

One alternative to prohibition would be a system whereby salaried state government employees purchase only generic products that cannot be identified for promotion as to source by their inherent characteristics, resell them in packaging that gives no indication of the original source that could be used for promotion, and make purchases from a large number of suppliers who contractually agree to refrain from advertising or other promotion and agree to refrain from engaging in cooperative actions so that there is no promotion by a group such as the “Dairy Farmers of Washington.”

The prohibition against advertising and other promotion would face no constitutional problem because it would be agreed to by contract. The state would have the leverage to make such a system work because the state would be the sole licensing authority, custodian and purveyor of the substances in question.

In the United States advertising, or commercial speech, is protected as free speech under the Constitution.⁶²² However, not all commercial speech is protected. There are times when the government has a legitimate reason to put restrictions on the commercial speech. For instance, the commercial speech must concern lawful activity and not be misleading. But if the government does regulate the speech, there must be a substantial government interest. If so, the regulation must directly advance the governmental interest asserted and must do so in a way that is not more extensive than is necessary to serve that interest.⁶²³

The U.S. Supreme Court struck down a Massachusetts law banning tobacco billboards from within 1000 feet of schools and requiring tobacco ads at point of sale to be 5 feet off the ground if children under the age of 18 were admitted into the store. The Court held that the statutes were more extensive than necessary.⁶²⁴ The Supreme Court also struck down a Rhode Island statute prohibiting billboard advertising by liquor stores as a violation of the First Amendment,⁶²⁵ as was a Pennsylvania law banning advertisements for alcohol in college newspapers. The judge in that case cited the state's heavy burden when restricting free speech, saying the government had not proven that by banning the ads in the school newspapers, underage drinking would diminish, especially when students are exposed to so many other advertisements for alcohol on television, the radio and other non-college newspapers.⁶²⁶

One way to prohibit advertising is by the state to include in the contracts with its suppliers that they will have no claim of trademark of its product and cannot advertise or promote its product. The supplier would have to agree to these provisions in order to enter into business with the state.⁶²⁷ Under the Constitution, for the state to place any limitations on advertising, it must serve a legitimate public interest in order to comply with the First Amendment. In addition, under Washington State law, the state can prohibit a trademark on a good or service which "consists of or comprises immoral, deceptive, or scandalous matter."⁶²⁸

The Importance of Counter-Advertising

Just as important as state restrictions on advertising would be aggressive, state-sponsored counter-advertising. As an essential part of a public health strategy, state-funded education, public service messages and other forms of communication would foster the normative changes needed to reduce problematic substance use. The very best example of such normative change through public service counter-advertisement is the recent success in drastically reducing tobacco consumption over the course of the last three decades in the United States, accomplished without having incarcerating anyone.

The success of counter-advertising regarding tobacco has depended on many factors:

- adequate, long-term funding;
- ability to administer the campaign free from political interference (including prohibiting the tobacco industry from being involved in the planning or administration of the campaign);
- a broad-based focus rather than one exclusively targeting children; and
- ability of the campaign to be complementary of other tobacco control activities conducted at the federal, state and local levels (*e.g.* support for indoor smoking regulations).⁶²⁹

The Washington State Liquor Control Board is considering a legislative proposal to promote the counter-advertising of alcohol. The legislation would create an alcohol education advisory council separate from the Liquor Control Board to develop, implement and support statewide public education programs aimed at reducing alcohol misuse and abuse among youth and adults in Washington State.⁶³⁰

CURRENT SYSTEMS LEFT UNTOUCHED

A new legal framework to control psychoactive substances that are currently produced and distributed exclusively in illegal markets would not require the invention of an entirely new system – only the need to address the problems arising from drug prohibition. The regulation and control of those substances could generally fall within the purview of current systems, including the drug prescription system, although a new state regulatory agency might have to be established.

The Courts and the Justice System

While bringing psychoactive substances that are now controlled by criminal enterprises into a regulatory framework, the law would continue to operate as it does today to regulate *human conduct* that causes harm to others and their property, whether or not individuals are abusing drugs or under their influence at the time.

Holding People Accountable

The civil courts already address conduct that adversely affects others – particularly children. Civil courts are regularly called upon to evaluate and remedy the impacts of drug use in family law cases involving divorce, child custody, child support, and child welfare. Drug use might be addressed in the course of a tort claim, employment law case or civil commitment proceeding. Civil proceedings could adequately deal with the problems arising from substance abuse through the involuntary commitment statute,⁶³¹ the civil commitment statute,⁶³² the domestic relations statute,⁶³³ the child welfare statute,⁶³⁴ the child dependency statute providing for orders into substance abuse treatment,⁶³⁵ the child dependency statute sanctioning violations of substance abuse treatment orders⁶³⁶ and the Uniform Controlled Substances Act involving a tort cause of action by a parent for sale or transfer of controlled substances to a minor.⁶³⁷

Continued Utility of Drug Courts

Drug courts are the most promising short-term option, generating cost savings and reducing recidivism and prohibited drug use among their participants. If insightfully and compassionately administered, drug courts can help rehabilitate addicts and reduce crime and help avoid some of the economic and societal costs of unnecessary imprisonment.

However, drug courts are fully consistent with the legal framework of drug prohibition, so they embody a difficult conflict between compassion and coercion; there is always the potential for more harm, despite the therapeutic intent. Drug courts may reduce public costs and recidivism and substance abuse among their participants, but they are powerless to abate illegal markets for psychoactive drugs, as incentives remain strong for violent, criminal enterprises to engage in the drug trade. Drug courts are also unable to reduce the easy access by young persons to psychoactive substances, a problem inherent in drug prohibition. Finally, drug courts are not serving the hard-to-reach population of addicted persons who refuse treatment, a population that has responded well in Europe to the type of medical prescription programs that are currently prohibited under U.S. law.

Under a new legal framework to regulate and control psychoactive substances, drug courts would still play a vital role, holding defendants accountable for their *behavior that harms others*, such as theft and crimes against persons, where chemical dependency would be deemed to be linked to such crimes. Many drug courts already receive this type of clientele and would continue to be very useful in regulating human conduct, but not the mere use of certain psychoactive substances *per se*.

Driving Under the Influence

Where sanctions related to drugs should be aimed at reducing the harm directly caused to others by persons using drugs rather than for the mere use of drugs *per se*, driving while intoxicated and doing harm to persons or property while intoxicated would continue to be punished criminally, although with treatment options available.

Drug Use by Professionals

As for the professions and drug use, effective assistance programs are already in place for lawyers, doctors, pharmacists and others, and those programs already embrace the medical model rather than the criminal model. As self-regulating entities, professional associations take disciplinary actions against their members for many causes, including conduct related to drug use or drug addiction.

ADDRESSING PERSISTENT PROBLEMS

The Gray Market

The current proposal for a new legal framework does *not* address the increasingly vexing problem of diversion of legally-regulated pharmaceuticals, such as methadone, Oxycontin, ketamine, Ritalin and benzodiazepines, into the illicit, GRAY market, a problem that law enforcement increasingly finds itself battling. Gray markets, however, are relatively easier to control than black markets, where all production and distribution is illegal. Gray markets also do not spawn the kinds of violence, disorder, disease and death that arise from the operation of black markets; thus, it is important to distinguish between the two. Nevertheless, law enforcement, prosecutors and the courts will continue to play a critical role in reining in the problem of the gray markets in psychoactive drugs.

The Black Market

The vast bulk of “hard” drugs are consumed by a relatively small number of addicted users.⁶³⁸ Certifying and registering as many of those users as possible and bringing them into state-controlled medical treatment facilities would arguably dry up the black market to a great extent in each local area. Other potential users who might want to experiment with such substances would have to obtain them from the “gray” market, which currently exists for other pharmaceuticals and is easier to control, as mentioned above.

The street prices for prohibited drugs are at historic lows – another indication of the failure of current drug policy – yet such prices are still artificially and astronomically

above their actual value in terms of their chemical composition and production cost.⁶³⁹ Pricing structures for state-controlled substances could slightly undercut black market prices, or in some cases the substances would be provided free of charge or at very low cost (along a sliding scale) to registered addicts at the state-controlled medical treatment facilities. Any revenue to the state would support the administration of the regulatory framework and would provide funding for prevention, treatment, research and education, while maintaining price levels low enough to render illegal markets for such substances unprofitable but high enough to deter consumption, especially by young persons.

The greatest concern is to protect young people from the potential harms of psychoactive drug use. Regarding cannabis, most students report that cannabis is widely available and easier to obtain than beer.⁶⁴⁰ If cannabis were regulated like distilled spirits, therefore, it would be less accessible to young people than beer is today. Unscrupulous outlets might try sell to young people, but looking at the Washington Liquor Control Board model, its age restriction compliance rate is about 95% at its outlets.⁶⁴¹

Furthermore, the economic laws of prohibition illustrate how a black market could not thrive on the relatively limited demand of minors alone – another lesson learned from the repeal of alcohol prohibition in the 1930s. A gray market would likely arise, however, where adults would illegally divert drugs to young people, which would be criminally punished. In the civil courts, as well, adults would be held accountable, as they are today, for negligent or reckless parental/custodial supervision of minors.

Alcohol and Cannabis: The Substitution Effect

Alcohol is associated with more societal problems than any other substance and is linked with many hospital admissions, violent crimes and accidental deaths. Under the new legal framework for controlling currently prohibited psychoactive substances, most such substances would become *less* available than they are today and certainly less available than alcohol, especially to young persons. The only exception is for cannabis, which might become more available to adults. Compelling research from many countries indicates, however, that cannabis availability brings about a “substitution effect,” which dampens the use of alcohol and tobacco, as well as of other, more dangerous drugs.⁶⁴² Provided that young persons are adequately protected, cannabis availability to adults may actually reduce the health, social and crime problems associated with alcohol. It is also important to remember that this proposal, by seeking to undercut the black market, would help to reduce the health, social and crime problems associated with drug prohibition.

Preventing Increases in Drug Addiction

A system of unfettered availability of all drugs to all adults at local drug stores would certainly lead to increased use and addiction. That is not the system of drug control that is contemplated. Rather, where pure and safe forms of “hard” drugs would be available to addicts through prescribed maintenance regimes aimed at reducing harm, drug use and drug addiction, the medical nature of this approach would not likely encourage many new users to try such drugs for the first time when the drugs are perceived more as medicine for sick people than as a way to have fun. That is what is now happening in Europe.⁶⁴³

Preventing Increases in Crime and Violence

Compared with the pharmacological effects of alcohol giving rise to violent behavior, illegal drugs and violence are linked primarily to illegal drug marketing: disputes among rival distributors, arguments and robberies involving buyers and sellers and crimes committed to finance expensive drug habits. The proposal for a new legal framework to control drugs aims to undercut illegal drug markets; thus, levels of violence associated with such markets would dramatically decline or even disappear, which was the result of the repeal of alcohol prohibition in the 1930s.

Some drugs, especially stimulants such as cocaine and methamphetamine, are associated with unpredictable and sometimes violent behavior, but cannabis and tobacco have little association with violence and opiates have an anesthetizing effect, making violence less likely – although withdrawal from opiate addiction can lead to aggressive behavior. Where the proposal for a new legal framework would seek to reduce the harm from and addiction to dangerous drugs such as cocaine and methamphetamine, levels of violence would decrease to the extent that the system achieves its objectives.

Costs and Cost Savings

The new legal framework for psychoactive substance control would not only pay for itself, but would provide the state with additional funds for effective education about the dangers of psychoactive drugs and for medical treatment for those harmed by drug use. Recent research in Washington State has shown how generous investments in prevention and treatment yield significant savings from avoided costs in medical care, social welfare and criminal justice.⁶⁴⁴ The current proposal would allow for enhanced prevention and treatment to be financed from massive savings that would arise from reduced use of the criminal justice system.

The current approach of drug prohibition and criminalization is costing the taxpayers a fortune, draining state and local coffers as ever-rising criminal justice costs are driving many counties close to bankruptcy. Meanwhile, the addicted cannot get the treatment they need, families are torn apart because of incarceration and non-violent drug law violators cannot rebuild their lives due to the prejudicial effects of criminal convictions, among many other negative effects of the current policy.

IMPLEMENTING A NEW FRAMEWORK

Any statutory and regulatory changes to implement a new legal framework to control psychoactive substances more effectively will have to take place incrementally, first through clinical trials and then integrated into the public health system. Separate consideration would be given to each substance, probably beginning with cannabis and the opiates (heroin). Meaningful outcome measurements would be established for improvements in public order, public health and public costs and rigorous evaluation would determine the new system's effectiveness, leading to amendment or repeal. Sunset provisions in any legislation could ensure a return to the criminal enforcement model if the regulation-and-control model was demonstrably less effective.

ENDNOTES

PART I

DRUGS AND THE DRUG LAWS: HISTORICAL AND CULTURAL CONTEXTS

¹ Aldous Huxley wrote: "All the vegetables sedatives and narcotics, all the euphorics that grow on trees, the hallucinogens that ripen in berries or can be squeezed from roots – all, without exception, have been known and systematically used by human beings from time immemorial." Quoted in Daniel Kunitz (2001), "On Drugs: Gateways to Gnosis, or Bags of Glue?" *Harper's Magazine*, October 2001, p. 92. William L. White refers to "the promised pleasure (and masked pain) imbedded within the human species' unremitting attraction to intoxicants." William L. White (1998), *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, Bloomington: Chestnut Health Systems, p. xiii.

² Terence McKenna (1992), *Food of the Gods: The Search for the Original Tree of Knowledge*, New York: Bantam, p. 47.

³ Alfred Lindesmith (1947), *Addiction and Opiates*, Chicago: Aldine, p. 207.

⁴ Richard Rudgley (1993), *Essential Substances: A Cultural History of Intoxicants in Society*, New York: Kodansha, pp. 24-26; Ashley Montagu (1966), "The Long Search for Euphoria," *Reflections*, v.1, pp. 62-69.

⁵ Norman Imlah (1970), *Drugs in Modern Society*, London: Geoffrey Chapman, p. 5; Alfred Lindesmith (1965), *The Addict and the Law*, New York: Vintage, p. 194. The earliest undisputed reference to the use of poppy juice was recorded by Theophrastus (371-287 B.C.), a Greek naturalist and philosopher, around 300 B.C. See Thomas Szasz (1974), *Ceremonial Chemistry*, New York: Doubleday/Anchor, p. 184.

⁶ Richard Rudgley (1993), *op. cit.*, p. 29.

⁷ Antonio Escohotado (1996), *A Brief History of Drugs: From the Stone Age to the Stoned Age*, Rochester, VT: Park Street Press, p. 9

⁸ Richard Davenport-Hines (2002), *The Pursuit of Oblivion: A Global History of Narcotics*, New York: W.W. Norton, p. 26.

⁹ Abbie Thomas (2002), "Survival of the Druggies," *New Scientist*, 30 March 2002, p.11

¹⁰ Almost all psychoactive plants were "discovered by animals, whose familiarity with the plant world protected them against poisoning and also allowed for altered "perception," among which the koala bear's use of eucalyptus is most celebrated. See Ronald K. Siegel (1989), *Intoxication: Life in Pursuit of Artificial Paradise*, New York: E.P. Dutton., pp. 19-146; Carol Kaesuk Yoon (2004), "Of Drunken Elephants, Topsy Fish and Scotch With a Twist," *The New York Times*, March 23, 2004, p. D5.

¹¹ Ronald K. Siegel (1989), *op. cit.*, p. 10; See also Andrew Weil (1972), *The Natural Mind: A New Way of Looking at Drugs and the Higher Consciousness*, Boston: Houghton Mifflin; and most recently Helen Phillips and Graham Lawton (2004), "The Intoxication Instinct," and the entire issue of *New Scientist*, v.184, n. 2473, 13 November, 2004.

¹² See, e.g., R. Gordon Wasson (1980), *The Wondrous Mushroom: Mycolatry in Mesoamerica*, New York: McGraw-Hill; R. Gordon Wasson, A. Hoffmann and Carl A. P. Ruck (1978), *The Road to Eleusis*, New York: Harcourt Brace; P. T. Furst, ed. (1976), *Flesh of the Gods: The Ritual Use of Hallucinogens*, New York: Praeger.

¹³ Robin Room (2003), "Addiction Concepts and International Control," *Global Drug Policy: Building a New Framework, Contributions to the Lisbon International Symposium on Global Drug Policy*, October 2003, p. 16, citing references to negative outcomes associated to alcohol use that appear in the Jewish Bible and in classic Chinese poetry; Rev. Wilbur F. Crafts *et al.* (1909), *Intoxicating Drinks and Drugs in All Lands and Times*, cites the earliest prohibitionist teaching, by an Egyptian priest, who writes to his pupil: "I, thy superior, forbid thee to go to the taverns. Thou art degraded like beasts." at p. 5. See <http://www.kingkong.demon.co.uk/ngcoba/cr.htm>

¹⁴ The first Inquisition processes for tobacco habits charged that "only Satan can confer upon human beings the power to exhale smoke through the mouth." Antonio Escohotado (1996), *op. cit.*, p. 56.

¹⁵ Griffith Edwards (1972), "Psychoactive Substances," *The Listener*, March 23, 1972, p. 361.

¹⁶ Around the year 1650 Sultan Murad IV of the Ottoman Empire decreed the death penalty for smoking tobacco: "Wherever there Sultan went on his travels or on a military expedition his halting-places were always distinguished by a terrible rise in executions. Even on the battlefield he was fond of surprising men in the act of smoking, when he would punish them by beheading, hanging, quartering or crushing their hands and feet . . . Nevertheless, in spite of all the horrors and persecution . . . the passion for smoking still persisted." Edward M. Brecher and the editors of *Consumer Reports* (1972), *Licit and Illicit Drugs. The Consumers Union Report on Narcotics, Stimulants Depressants, Inhalants, Hallucinogens, and Marijuana – including Caffeine, Nicotine, and Alcohol*, Boston; Little, Brown and Co., p. 212.

¹⁷ Richard H. Blum *et al.* (1969), *Society and Drugs*, San Francisco: Jossey-Bass, p. 12.

¹⁸ Coffee use in particular was eventually authorized by Arab sultans, who were coffee addicts themselves and encouraged its use to prevent fatigue during long readings of sacred scriptures. Antonio Escotado (1996), *op. cit.*, p. 32. Tobacco was eventually regulated and taxed in Europe by the end of the 17th century. *Id.* at 57.

¹⁹ Richard H. Blum *et al.* (1969), *op. cit.*, p. 11.

²⁰ Richard Davenport-Hines (2002), *op. cit.*, p. 47; Antonio Escotado (1996), *op. cit.*, pp. 53-54; Richard Rudgley (1993), *op. cit.*, p. 133.

²¹ Richard Davenport-Hines (2002), *op. cit.*, p. 46.

²² William L. White, "Themes in Chemical Prohibition," in William E. Link *et al.*, *Drugs in Perspective* (1979), Washington, D.C.: National Institute on Drug Abuse, p. 171. *See also* David F. Musto (1991), "Opium, Cocaine, and Marijuana in American History," *Scientific American*, July 1991, pp. 20-27.

²³ William L. White has identified the following eight dominant themes in the development of chemical prohibitionist movements:

1. The drug is associated with a hated subgroup of the society or a foreign enemy;
2. The drug is identified as solely responsible for many problems in the culture, *i.e.*, crime, violence, and insanity;
3. The survival of the culture is pictured as being dependent on the prohibition of the drug;
4. The concept of "controlled" usage is destroyed and replaced by a "domino theory" of chemical progression;
5. The drug is associated with the corruption of young children, particularly their sexual corruption;
6. Both the user and supplier of the drug are defined as fiends, always in search of new victims; usage of the drug is considered "contagious;"
7. Policy options are presented as total prohibition or total access; and
8. Anyone questioning any of the above assumptions is bitterly attacked and characterized as part of the problem that needs to be eliminated. *See* William L. White (1979), *op. cit.*

²⁴ Joseph Gusfield (1986), *Symbolic Crusade: Status Politics and the American Temperance Movement*, Urbana and Chicago: University of Illinois Press, p. 3.

²⁵ The Gin Act of 1736 had the stated purpose of making spirits "come so dear to the consumer that the poor will not be able to launch into excessive use of them." As with all prohibitions, however, the effort was unsuccessful and resulted in general lawbreaking and a failure to halt the steady rise in the consumption of even legally produced liquor. In 1742 the Gin Act was revised to set reasonable excise levels, establishing the basis for liquor control to this day. *See* George E.G. Catlin (1931), *Liquor Control*, London: Thornton Butterworth, Home University Library, p. 15.

²⁶ The British Coercive Acts, passed in response to colonial resistance to the tax on tea, led to the formation of the First Continental Congress, which, in turn, led to the War of Independence. *See* Alexander T. Shulgin (1988), *Controlled Substances: A Chemical and Legal Guide to the Federal Drug Laws*, Berkeley: Ronin Publishing, p. 243, discussing taxation as the primary means of drug control. Even after the American Revolution, during the Whisky Rebellion of 1792, riotous protests by farmers in western Pennsylvania against a federal tax on liquor had to be put down by overwhelming force sent to the area by George Washington.

²⁷ *See* Iain Gately (2001), *Tobacco: A Cultural History of How an Exotic Plant Seduced Civilization*, NY: Grove Press.

²⁸ The National Commission on Marijuana and Drug Abuse reported to Congress in 1973, "Drug policy as we know it today is a creature of the 20th Century. Until the last third of the 19th Century, America's total legal policy regarding drugs was limited to regulation of alcohol distribution, localized restrictions on

tobacco smoking, and the laws of the various states regulating pharmacies and restricting the distribution of 'poisons.'" See "Drug Use in America: Problem in Perspective," *Second Report of the National Commission on Marijuana and Drug Abuse*, p. 14 (1973).

²⁹ Robin Room (2003), *op. cit.*, p. 15.

³⁰ David F. Musto (1999), *The American Disease: Origins of Narcotic Control*, 3rd ed., New York: Oxford University Press, p. 1.

³¹ *Id.* at 70.

³² Edward M. Brecher *et al.* (1972), *op. cit.*, p. 17.

³³ Dr. George Wood, a professor of the theory and practice of medicine at the University of Pennsylvania, president of the American Philosophical Society, and the author of the leading American text, *Treatise on Therapeutics*, wrote in 1868 of the pharmacological effects of opium: "A sensation of fullness is felt in the head, soon to be followed by a universal feeling of delicious ease and comfort, with an elevation and expansion of the whole moral and intellectual nature, which is, I think, the most characteristic of its effects. . . . It seems to make the individual, for the time, a better and greater man. . . . The hallucinations, the delirious imaginations of alcoholic intoxication, are, in general, quite wanting. Along with this emotional and intellectual elevation, there is also increased muscular energy; and the capacity to act, and to bear fatigue, is greatly augmented." in David F. Musto (1999), *op. cit.*, pp. 71-72.

³⁴ David F. Musto (1999), *op. cit.*, p. 72; Friedrich Wilhelm Adam Serturner, a German chemist, first isolated and described morphine and by 1826 the Merck Company was producing morphine in substantial quantities. In the 1830's pharmaceutical manufacturers in Philadelphia became the major source of morphine for Americans. See Thomas Szasz (1974), *op. cit.*, p. 189.

³⁵ Edward M. Brecher *et al.* (1972), *op. cit.*, p. 3.

³⁶ David T. Courtwright, "The Roads to H: The Emergence of the American Heroin Complex, 1989-1956," in David F. Musto, ed. (2002), *One Hundred Years of Heroin*, Westport, CT: Auburn House, p. 3.

³⁷ Daniel Patrick Moynihan, "One Hundred Years of Heroics," in David F. Musto, ed. (2002), *op. cit.*, p. 23.

³⁸ Heroin was widely lauded as a "safe preparation free from addiction-forming properties." Ashley Montagu (1966), *op. cit.*, p. 68; James R. L. Daly declared in 1900 in the *Boston Medical and Surgical Journal* that heroin "possesses many advantages over morphine. . . . It is not hypnotic; and there is no danger of acquiring the habit. . . ." Quoted in Henry H. Lennard *et al.* (1973), "Methadone Treatment," *Science*, v.179, p. 1079, March 16, 1973.

³⁹ Antonio Escototado (1996), *op. cit.*, p. 71.

⁴⁰ David F. Musto (1999), *op. cit.*, p. 43.

⁴¹ E. M. Thornton (1983), *Freud and Cocaine: The Freudian Fallacy*, London: Blond and Briggs, p. 46; Freud was considered the world's authority on cocaine and was thought to have used it daily for almost a decade. Advertising both for the Parke-Davis and Merck pharmaceutical companies, Freud was quoted as claiming that cocaine would allow "doing away with all asylums for alcoholics." See also Ernest Jones (1953), *The Life and Work of Sigmund Freud*, New York: Basic Books, v.1, p. 82.

⁴² Jill Jonnes (1996), *Hep-Cats, Narcs, and Pipe Dreams: A History of America's Romance with Illegal Drugs*, New York: Scribner, p. 22.

⁴³ David F. Musto (1999), *op. cit.*, p. 7.

⁴⁴ Ernest Abel (1980), *Marijuana: The First 12,000 Years*, New York: Plenum Press, quoting from the diaries of Jefferson and Washington and from Jefferson's Farm Books.

⁴⁵ Edward M. Brecher *et al.* (1972), *op. cit.*, pp. 6-7, 33-41.

⁴⁶ *Id.*; See also E.G. Eberle *et al.* (1903), "Report of Committee on the Acquisition of Drug Habits," *Proceedings of the American Pharmaceutical Association*, v. 51, pp. 477, 481, in *American Journal of Pharmacy*, Oct. 1903.

⁴⁷ *Id.*

⁴⁸ The clergyman Benjamin Parsons declared in 1840: ". . . alcohol stands preeminent as a destroyer. . . . I never knew a person become insane who was not in the habit of taking a portion of alcohol every day." Parsons listed forty-two distinct diseases caused by alcohol, among them inflammation of the brain, scrofula, mania, dropsy, nephritis and gout. Quoted in Burton Roueche (1960), *The Neutral Spirit: A Portrait of Alcohol*, Boston: Little, Brown & Co., pp. 87-88.

⁴⁹ David E. Kyvig (1979), *Repealing National Prohibition*, Chicago: University of Chicago Press, p. 8.

⁵⁰ Joseph R. Gusfield (1986), *Symbolic Crusade Status Politics and the American Temperance Movement*, Urbana and Chicago: University of Illinois Press, p. 36. With no concept of addiction, early temperance advocates encouraged moderation, such as substituting wine and beer for distilled spirits. William L. White (1998), *op. cit.*, p. 5

⁵¹ Joseph R. Gusfield (1986), *op. cit.*, p. 36.

⁵² *Id.* at 5.

⁵³ *Id.* at 44.

⁵⁴ Lewis L. Gould (2001), *America in the Progressive Era, 1890-1914*, Harlow: Pearson Education, p. 22.

⁵⁵ James H. Timberlake (1963), *Prohibition and the Progressive Movement 1900-1920*, Cambridge: Harvard University Press, p. 101. Progressivism has been described as a melding of "Calvinistic Protestantism, Scientific Materialism and Uninhibited Capitalism." See Henry Steele Commager (1950), *The American Mind: An Interpretation of American Thought and Character Since the 1880's*, New Haven: Yale University Press; See generally George E. Mowry (1958), *The Era of Theodore Roosevelt and the Birth of the Modern America 1900-1912*, New York: Harper & Row; Richard Hofstadter (1966), *The Age of Reform: From Bryan to F. D. R.*, New York: Alfred A. Knopf; and Merle Curti (1964), *The Growth of American Thought*, 3rd ed., New York: Harper & Row.

⁵⁶ James H. Timberlake (1963), *op. cit.*, p. 102.

⁵⁷ *Id.* at 115.

⁵⁸ *Id.*; The Progressive's battle against alcohol also served as a gateway for women to enter the national political scene. Saloons were notorious for drawing men away from their wives and children and toward prostitution, gambling and laziness, raising concern for women who were charged with maintaining the nation's home life. The movement for universal suffrage was also gaining momentum in the late 1800s and the alcohol industry had used its political power to oppose women's rights to the vote. Campaigning against alcohol gave women a relevant cause upon which to begin asserting political influence, and the Women's Christian Temperance Union joined with the Anti-Saloon League to become a powerful political force. See Norman H. Clark (1976), *Deliver Us From Evil: An Interpretation of American Prohibition*, New York: W.W. Norton & Company, p. 4.

⁵⁹ James H. Timberlake (1963), *op. cit.*, p. 219. In contrast to alcohol, opiates "had never been associated with the comportment of social irresponsibility, lust, or violence." *Id.*

⁶⁰ See summary by David F. Musto of David T. Courtwright's *Dark Paradise: Opiate Addiction in America Before 1940*, Cambridge: Harvard University Press (1982), in "The History of Legislative Control Over Opium, Cocaine, and Their Derivatives," in R. Hamowy, ed. (1987), *Dealing with Drugs*, San Francisco: Pacific Institute for Research on Public Policy, pp. 36-37.

⁶¹ Quoted in Rev. Wilbur F. Crafts *et al.* (1909), *op. cit.*, p. 230.

⁶² William L. White (1979), *op. cit.*

⁶³ Patricia A. Morgan (1978), "The Legislation of Drug Law: Economic Crisis and Social Control," *Journal of Drug Issues*, v.8, no.1, p. 56. This strategy served to help "maintain an ideology, developing during this time, which transferred onus from the business class as cause of economic problems to a moral attack against a race that could be perceived as the cause of a wide range of problems." *Id.* at 57.

⁶⁴ *Id.* at 58.

⁶⁵ In 1878 the San Francisco police department reported that, while visiting these opium dens they "found white women and Chinamen side by side under the effects of this drug—a humiliating sight to anyone who has anything left of manhood." Testimony of the San Francisco Police Department recorded in California State Senate Committee, *Chinese Immigration, Its Social, Moral and Political Effects*, Sacramento, CA: State Publishing Office, 1878. At the same time, the *San Francisco Post* railed against the Chinese for having "impoverished our country, degraded our free labor and hoodlumized our children. He is now destroying our young men with opium."

⁶⁶ Richard Davenport-Hines (2002), *op. cit.*, pp. 83-88.

⁶⁷ Charles E. de M. Sajous (1902), *Analytical Cyclopaedia of Practical Medicine, III*, Philadelphia: F.A. Davis, p. 506.

⁶⁸ Richard Davenport-Hines (2002), *op. cit.*, p. 200.

⁶⁹ *Id.* Dr. Edward H. Williams cited Dr. Christopher Kochs: "Most of the attacks upon white women of the South are the direct result of the cocaine crazed Negro brain" and Dr. Williams concluded that "Negro cocaine fiends are now a known Southern menace." "Negro Cocaine 'Fiends' Are A New Southern Menace," *The New York Times*, Feb. 8, 1914, IV, p 12.

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- ⁷⁰ Joseph F. Spillane (2000), *Cocaine: From Medical Marvel to Modern Menace in the United States, 1884-1920*, Baltimore: Johns Hopkins University Press, pp. 92-93.
- ⁷¹ William L. White (1979), *op. cit.*
- ⁷² David F. Musto (1999), *op. cit.*, p. 7.
- ⁷³ David F. Musto (1999), *op. cit.*, p. 7.
- ⁷⁴ William O. Walker, III (1981), *op. cit.*, p. 14.
- ⁷⁵ Richard Davenport-Hines (2002), *op. cit.*, p. 200.
- ⁷⁶ Ronald K. Siegel (1989), *op. cit.*, p. 273.
- ⁷⁷ William O. Walker, III (1981), *op. cit.*, p. 102; Marijuana "tea pads," reminiscent of opium dens of days gone by, began to appear in New Orleans and other southern port cities and by 1930 they were all over the United States, with 500 or so in New York City alone. Ronald K. Siegel, *op. cit.*, p. 273.
- ⁷⁸ David F. Musto (1999), *op. cit.*, p. 219. The Federal Bureau of Narcotics contributed to public fears over marijuana by promulgating official statements about police estimates that "fifty percent of the violent crimes committed in districts occupied by Mexicans, Spaniards, Latin Americans, Greeks or Negroes may be traced to this evil" of marijuana. Richard J. Bonnie & Charles H. Whitebread II (1974), *The Marijuana Conviction*, Charlottesville: University Press of Virginia, p. 100, citing a statement from Will S. Wood to Aaron W. Uris.
- ⁷⁹ C.M Goethe of the American Coalition stated that, "marijuana, perhaps now the most insidious of our narcotics, is a direct by-product of unrestricted Mexican immigration." He added that, "Mexican peddlers have been caught distributing sample marijuana cigarets [sic] to school children" and concluded by saying "our nation has more than enough laborers." *The New York Times*, September 15, 1935, IV, p. 9; A Texas police captain summed up the Mexican marijuana problem, describing how it made Mexicans "very violent, especially when they become angry.... They seem to have no fear, I have also noted that under the influence of this weed they have enormous strength and that it will take several men to handle one man while under ordinary circumstances one man could handle him with ease." Ernest L. Abel (1980), *op. cit.*, p. 207.
- ⁸⁰ David F. Musto (1999), *op. cit.*, p. 220, quoting a leading researcher's presentation to the American Psychiatric Association in 1934.
- ⁸¹ U.S. Sentencing Commission (1997), *Special Report to the Congress: Cocaine and Federal Sentencing Policy*, Washington, D.C.: U.S. Sentencing Commission, April 1997, p. 8.
- ⁸² "Drug Use in America: Problem in Perspective" (1973), *Second Report of the National Commission on Marijuana and Drug Abuse*, p. 14.
- ⁸³ *Id.*
- ⁸⁴ Smoking opium alone or with friends in a private residence was not covered by the California legislation. See Elaine Casey (1978), *History of Drug Users and Drug Use in the United States*, Facts About Drug Abuse Participant Manual, The National Drug Abuse Center for Training Resource and Development, U.S. Govt. Publication No. 79-FADA-041P.
- ⁸⁵ David F. Musto (1999), *op. cit.*, p. 91.
- ⁸⁶ *Id.*
- ⁸⁷ Edward M. Brecher *et al.* (1972), *op. cit.*, p. 43.
- ⁸⁸ Charles E. Terry and Mildred Pellens (1928), *The Opium Problem*, New York: Committee on Drug Addictions, Bureau of Social Hygiene, p. 747.
- ⁸⁹ Alexander T. Shulgin (1988), *Controlled Substances: A Chemical and Legal Guide to the Federal Drug Laws*, Berkeley: Ronin Publishing, p. 244.
- ⁹⁰ Edward M. Brecher *et al.* (1972), *op. cit.*, p. 44.
- ⁹¹ David F. Musto (1982), "The History of Legislative Control Over Opium, Cocaine, and Their Derivatives," *op. cit.*, summarizing David T. Courtwright (1982), *op. cit.*
- ⁹² *Id.*
- ⁹³ Richard Davenport-Hines (2002), *op. cit.*, p. 212.
- ⁹⁴ *Id.*
- ⁹⁵ At the time of its passage, some members of Congress expressed deep concern that the Pure Food and Drug Act represented an illegal exertion of power not expressly delegated to it by the Constitution. Nevertheless, the law was enacted and subsequently upheld as a valid exercise of Congress' constitutional power to regulate commerce between the states. See *United States v. Seventy-Four Cases of Grape Juice*, 181 F. 629 (W.D.N.Y. 1910); See also *Shawnee Milling Co. v. Temple*, 179 F. 517 (S.D. Iowa 1910). See

also the discussion of evolving federal commerce power in King County Bar Association (2005), "States Rights: Toward a Federalist Drug Policy." *Report of the Legal Frameworks group to the King County Bar Association Board of Trustees*, 2005.

⁹⁶ See Lawrence Kolb and A.G. Du Mez (1924), *The Prevalence and Trend of Drug Addiction in the United States and Factors Influencing It*, Treasury Department, US Public Health Service, Reprint No. 924, Washington D.C.: US Government Printing Office, p. 14.

⁹⁷ *Id.*

⁹⁸ Since the late 1800s the Anti-Saloon League presented a powerful political front against alcohol and the liquor industry. Its power grew and was manifested in the rising popularity of the Prohibition Party, which influenced presidential politics, culminating in 1919 with passage of the 18th Amendment prohibiting the sale of alcohol in the United States.

⁹⁹ H.U. Faulkner (1959), *Politics, Reform, and Expansion, 1890-1900*, New York: Harper and Row, p. 239.

¹⁰⁰ Richard Davenport-Hines (2002), *op. cit.*, pp. 202-203.

¹⁰¹ Reverend Crafts was a well-known advocate for an "international civilizing crusade against alcohol and drugs" and he supported "a policy of prohibition in all indigenous races, in the interest of commerce as well as conscience." Antonio Escohotado (1996), *op. cit.*, p. 77. Bishop Brent worked closely with the United States War Department in managing the Philippines and was dedicated to freeing Asia from opium and was an international leader in the anti-opium movement. *Id.*; See also David F. Musto (1999), *op. cit.*, pp. 25-26. The influence of Reverend Craft and Bishop Brent largely shaped America's international and national drug policy for decades to come.

¹⁰² *Id.*; See Philippine Tariff Revision Act, 3 March 1905, 33 *Stat. L.* 944.

¹⁰³ Richard Davenport-Hines (2002), *op. cit.*, p. 205.

¹⁰⁴ David F. Musto, "The History of Legislative Control Over Opium, Cocaine, and Their Derivatives," *op. cit.*, summarizing David T. Courtwright (1982), *op. cit.*

¹⁰⁵ David F. Musto (1999), *op. cit.*, p. 29.

¹⁰⁶ Antonio Escohotado (1996), *op. cit.*, p. 78.

¹⁰⁷ *Id.*

¹⁰⁸ The 1909 Shanghai Opium Conference produced mixed results. Delegates from thirteen nations were present, but they were unable to reach any binding agreements or accords. They did, however, air "the issue of international control and looked ahead to subsequent meetings." William O. Walker, III (1981), *op. cit.*, p. 15. Most of the attendees expressed little interest in taking efforts to prohibit drugs, and there was not even agreement about the evil or immorality of non-medicinal drug use. David F. Musto (1999), *op. cit.*, p. 36.

¹⁰⁹ David F. Musto (1999), *op. cit.*, p. 33.

¹¹⁰ See Edward Marshall (1911), "Uncle Sam is the Worst Drug Fiend in the World," *The New York Times*, March 12, 1911, V, p. 12.

¹¹¹ David F. Musto (1999), *op. cit.*, p. 34.

¹¹² *Id.* at 34-35.

¹¹³ With continuing regard to opium, Wright noted that "one of the most unfortunate phases of the habit" was a "large number of women who have become involved and were living as common-law wives or cohabiting with Chinese in the Chinatowns of our various cities." Hamilton Wright (1910), *Report on the International Opium Commission and on the Opium Problem as Seen within the United States and Its Possessions*, Opium Problem: Message from the President of the United States, Senate Doc. No. 377, 61st Cong., 2nd Sess., 21 Feb. 1910, p. 45. Speaking of the danger of cocaine Wright reported that "it has been authoritatively stated that cocaine is often the direct incentive to the crime of rape by the Negroes of the South and other sections of the country." *Id.* at 48-49.

¹¹⁴ *Id.* at 45.

¹¹⁵ David F. Musto, "The History of Legislative Control Over Opium, Cocaine, and Their Derivatives," *op. cit.*, summarizing David T. Courtwright (1982), *op. cit.*

¹¹⁶ Signed into law on December 17, 1914, the official title of the Harrison Act was: "An Act to provide for the registration of, with collectors of internal revenue and to impose a special tax upon all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves, their salts, derivatives or preparations, and for other purposes." United States Statutes at Large, v.36, 63 Cong., 3 Sess., Part I, pp. 785-90.

¹¹⁷ Eva Bertram, Morris Blachman, Kenneth Sharpe, & Peter Andreas (1996), *Drug War Politics: The Price of Denial*, Berkeley: University of California Press, p. 68.

¹¹⁸ The Hague Opium Convention of 1912 was the result of Hamilton Wright's efforts to achieve international consensus on narcotics control. The treaty urged signatories "to use best endeavors" to suppress the illicit drug trade. William O. Walker, III (1981), *op. cit.*, p. 16.

¹¹⁹ Richard J. Bonnie & Charles H. Whitebread II (1974), *op. cit.*, p. 16. See King County Bar Association (2005) "States Rights: Toward a Federalist Drug Policy," *op. cit.*

¹²⁰ Eva Bertram *et al.* (1996), *op. cit.*, p. 9.

¹²¹ Article VI of the U.S. Constitution makes international treaties the supreme law of the land and presenting the Harrison Act as necessary to comply with The Hague Convention lent the Act constitutional legitimacy. William O. Walker, III (1981), *op. cit.*, p. 16.

¹²² Edward M. Brecher *et al.* (1972), *op. cit.*, p. 48.

¹²³ The Harrison Act stated, in relevant part: "Nothing contained in this section shall apply to the dispensing or distribution of any of the aforesaid drugs to a patient by a physician, dentist, or veterinary surgeon registered under this Act in the course of his professional practice only." Public Law No. 223, 63rd Cong., approved December 17, 1914.

¹²⁴ Richard Davenport-Hines (2002), *op. cit.*, p. 230; Eva Bertram *et al.* (1996), *op. cit.*, p. 69. The federal crackdown on doctors was also generally justified by reports discrediting the medical profession, especially the Carnegie Foundation's Flexner Report of 1910, which revealed defective medical training and shoddy medical research practices. As a result, not only was drug addiction criminalized, but scientific research on psychoactive drugs was virtually halted. See Norman E. Zinberg and John A. Robertson (1969), *Drugs and the Public*, New York: Simon and Schuster, pp. 69-69.

¹²⁵ This vagueness in the statute may have been intentional on the part of Congress: "The manifest lack of federal power to regulate medical practice as well as the need to unify professional support of the Harrison Act may have required these vague phrases." David F. Musto (1999), *op. cit.*, p. 125.

¹²⁶ The first major legal challenge to the constitutionality of the Harrison Narcotic Act came in 1916 when the Supreme Court limited the scope of the Act in the case of *United States v. Jin Fuey Moy*, 241 U.S. 394 (1916), denying the U.S. Treasury Department's attempt to prosecute a doctor for prescribing drugs to an addict and to criminalize the addict's possession of an illicit drug. The Court recognized that an act of Congress is only valid if carried out pursuant to an expressly granted constitutional power and, in so doing, held that the Harrison Act was not required under international treaty and, therefore, where the Act was passed under Congress' taxing power, it could only be valid for raising revenue. The Court then found that both preventing a doctor from exercising professional judgment to prescribe drugs and prohibiting mere possession of drugs were actions unrelated to revenue collection and that the federal government could not use the Harrison Act to prosecute doctors who prescribe drugs or to prosecute individuals who possess drugs. *United States v. Jin Fuey Moy*, *supra*, at 401.

¹²⁷ Justice Day wrote that, "[i]f the legislation enacted has some reasonable relation to the exercise of the taxing authority conferred by the Constitution, it cannot be invalidated because of the supposed motives which induced it...The act may not be declared unconstitutional because its effect may be to accomplish another purpose as well as the raising of revenue." *United States v. Doremus*, 249 U.S. 86, 93, 94 (1919).

¹²⁸ The *Webb* case arose from a factual scenario in which a doctor was arrested and prosecuted for selling thousands of prescriptions to addicts. The Court's majority opinion summarily concluded that, to call "such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required." *Webb v. United States*, 249 U.S. 96 (1919).

¹²⁹ Eva Bertram *et al.* (1996), *op. cit.*, p. 74.

¹³⁰ David F. Musto (1999), *op. cit.*, p. 132.

¹³¹ *Id.* at 134.

¹³² Elaine Casey (1978), *op. cit.*

¹³³ *United States v. Behrman*, 258 U.S. 280, 289 (1922).

¹³⁴ Richard Davenport-Hines (2002), *op. cit.*, p. 229, quoting English physiologist Arthur Gamgee (1908).

¹³⁵ William L. White, "Trick or Treat: A Century of American Responses to Heroin Addiction," in David F. Musto, ed. (2002), *op. cit.*, p. 136.

¹³⁶ Legendary figures such as Arnold Rothstein and Charles "Lucky" Luciano first capitalized on opiate and cocaine prohibition, beginning in 1925, by importing drugs from Europe and distributing throughout the

U.S. through gang connections, and such gang-related drug distribution systems continue to operate today. Richard Davenport-Hines (2002), *op. cit.*, p. 232.

¹³⁷ William L. White, "Trick or Treat: A Century of American Responses to Heroin Addiction," in David F. Musto, ed. (2002), *op. cit.*, p. 136.

¹³⁸ *Linder v. United States*, 168 U.S. 5, 22 (1925)

¹³⁹ Eva Bertram, *et al.* (1996), note 3, at p. 75.

¹⁴⁰ *Id.*

¹⁴¹ *Nigro v. U.S.*, 276 U.S. 332 (1928).

¹⁴² *Id.* at 204.

¹⁴³ 21 U.S.C. §§ 221-237 (1934) (repealed 1944).

¹⁴⁴ Alexander T. Shulgin (1988), *op. cit.*, p. 245.

¹⁴⁵ With regard to popular accounts of a marijuana threat, the Bureau wrote: "This publicity tends to magnify the extent of the evil and lends color to an inference that there is an alarming spread of the improper use of the drug, whereas the actual increase in such use may not have been inordinately large." Federal Bureau of Narcotics (1932), *Report by the Government of the United States of America for the Calendar Year Ended December 31, 1931: On the Traffic in Opium and Other Dangerous Drugs*, Government Printing Office, p. 51.

¹⁴⁶ David F. Musto (1973), "An historical perspective on legal and medical responses to substance abuse," *Villanova L. Rev.*, v.18, May 1973, p. 816.

¹⁴⁷ William O. Walker, III (1981), *op. cit.*, p. 103.

¹⁴⁸ See John Craig Lupien (1995), *Unraveling an American Dilemma: The Demonization of Marihuana*, thesis presented to the Faculty of the Graduate School, Pepperdine University, with exhaustive summary and analysis of Record Group 170, Accession Number: W 170-74-005, Boxes 1-5, the "Marihuana Tax Act of 1937" files from the Washington National Research Center, National Archives. See also Chris Conrad (1993), *Hemp: Lifeline to the Future*, Los Angeles: Creative Xpressions Publications; Jack Herer (1991), *The Emperor Wears No Clothes*, Van Nuys: Hemp Publishing; James B. Slaughter (1988), "Marijuana Prohibition in the United States: History and Analysis of a Failed Policy," *Columbia Journal of Law and Social Problems*, v.21, n.4, pp. 417-474; and Michael Schaller (1970), "The Federal Prohibition of Marihuana," *Journal of Social History*, v.4, no.1, Fall 1970, pp. 61-74.

¹⁴⁹ In the 1930s a new technique for using hemp pulp for papermaking was developed by the Department of Agriculture, in conjunction with the patenting of the hemp "decorticator," a revolutionary new technology for harvesting hemp. See "The New Billion Dollar Crop," *Popular Mechanics*, v.69, February 1938, pp. 238-239; and R. S. Kellogg (1936), *The Story of News Print Paper*, New York: Newsprint Service Bureau, pp. 48-49.

¹⁵⁰ Jack Herer (1991), *op. cit.*, pp. 24-25.

¹⁵¹ William O. Walker, III (1981), *op. cit.*, p. 103.

¹⁵² David F. Musto (1999), *op. cit.*, p. 222.

¹⁵³ Norman E. Zinberg and John A. Robertson (1969), *op. cit.*, p. 178.

¹⁵⁴ *Id.* at 178-179, quoting the U.S. Senate report accompanying the Marijuana Tax Act of 1937.

¹⁵⁵ Alexander T. Shulgin (1988), *op. cit.*, p. 245.

¹⁵⁶ Within a year after passage of the Marijuana Tax Act, Harry Anslinger had to rebut New York Mayor Fiorello La Guardia, who had commissioned a team of distinguished scientists to study the effects of marijuana. His concern stemmed from the abundance of sensationalistic newspaper accounts that New York's youth was "teetering on the brink of an orgy of marihuana-induced crime and sex." Ernest L. Abel (1980) *op. cit.*, p. 249. To Anslinger's dismay, the findings of the La Guardia Commission contradicted the arguments which the Bureau had presented during its final assault against marihuana. Specifically, the report stated that:

"Marihuana is used extensively in the Borough of Manhattan but the problem is not as acute as it is reported to be in other sections of the United States;

"The distribution and use of marihuana is centered in Harlem;

"The majority of marihuana smokers are Negroes and Latin Americans;

"The practice of smoking marihuana does not lead to addiction in the medical sense of the word;

“The sale and distribution of marihuana is not under the control of any single organized group;

“The use of marihuana does not lead to morphine or heroin or cocaine addiction and no effort is made to create a market for these narcotics by stimulating the practice of marihuana smoking;

“Marihuana is not the determining factor in the commission of major crimes;

“Marihuana smoking is not widespread among school children; and

“Juvenile delinquency is not associated with the practice of smoking marihuana.

“The publicity concerning the catastrophic effects of marihuana smoking in New York City is unfounded.” La Guardia Commission (1973 reprint), *The Marihuana Problem in the City of New York*, Metuchen: Scarecrow Reprint Corp., pp. 24-25.

¹⁵⁷ William O. Walker, III (1981), *op. cit.*, pp. 170-171.

¹⁵⁸ Daniel Glaser, “Interlocking Dualities in Drug Use, Drug Control and Crime,” in James A. Inciardi and Carl D. Chambers, eds. (1974), *Drugs and the Criminal Justice System*, Beverly Hills: Sage, p. 46.

¹⁵⁹ *Id.*

¹⁶⁰ H.J. Anslinger (1951), “The Federal Narcotic Laws,” *Food, Drug, and Cosmetic Law Journal*, v.6, pp. 743-748.

¹⁶¹ Public Law No. 255, 82nd Cong., approved 2 Nov. 1951. Under the Boggs Act, first convictions carried a mandatory minimum penalty of two years in jail and second or subsequent convictions could not be reduced by suspensions or probation.

¹⁶² Rufus King (1972), *The Drug Hang-Up, America’s Fifty Year Folly*, Springfield: Bannerstone House, ch. 14.

¹⁶³ *Id.* at ch. 16.

¹⁶⁴ *Id.*

¹⁶⁵ Alexander T. Shulgin (1988), *op. cit.*, p. 246.

¹⁶⁶ David F. Musto (1999), *op. cit.*, p. 248.

¹⁶⁷ In 1962 President John F. Kennedy, speaking on the issue of consumer protection legislation, remarked that “one problem meriting special attention deals with the growing abuse of non-narcotic drugs, including barbiturates and amphetamines. Society’s gains will be illusory if we reduce the incidence of one kind of drug dependence, only to have new kinds of drugs substituted. The use of these drugs is increasing problems of abnormal and social behavior, highway accidents, juvenile delinquency and broken homes.”

¹⁶⁸ Rufus King (1972), *The Drug Hang-Up, America’s Fifty Year Folly*, Springfield: Bannerstone House, Ch. 26.

¹⁶⁹ Rufus King (1972), *The Drug Hang-Up, America’s Fifty Year Folly*, Springfield: Bannerstone House, Ch. 26.

¹⁷⁰ The record-keeping requirements and restrictions on amphetamine production created shortages that drove up the “street” price high enough to attract criminal organizations to profit from the traffic, as was the case with opiates in the 1940s and 1950s and with alcohol in the 1920s. Richard Davenport-Hines (2002), *op. cit.*, pp. 312-313.

¹⁷¹ Alexander T. Shulgin (1988), *op. cit.*, p. 247.

¹⁷² *Id.*

¹⁷³ Richard Davenport-Hines (2002), *op. cit.*, p. 424.

¹⁷⁴ Richard Davenport-Hines (2002), *op. cit.*, p. 422.

¹⁷⁵ Pub.L. 91-513, Oct. 27, 1970, 84 Stat. 1236.

¹⁷⁶ Alexander T. Shulgin (1988), *op. cit.*, p. 247.

¹⁷⁷ *Id.*

¹⁷⁸ Richard Davenport-Hines (2002), *op. cit.*, p. 421.

¹⁷⁹ See Dan Baum (1996), *Smoke and Mirrors: The War on Drugs and the Politics of Failure*, New York: Little Brown and Co.

¹⁸⁰ *Id.*

¹⁸¹ See Jerome H. Jaffe, “One Bite of the Apple: Establishing the Special Action Office for Drug Abuse Prevention,” in David F. Musto, ed. (2002), *op. cit.*, pp. 43-53.

¹⁸² David F. Musto (1999), *op. cit.*, p. 257. It was during the Ford administration that the Domestic Council Drug Abuse Task Force released its *White Paper on Drug Abuse*, which recognized that governmental actions could only hope to contain the problem of drug abuse and that total elimination was an unlikely prospect. See Domestic Council Drug Abuse Task Force, *White Paper*, September 1975, p. 97-98.

¹⁸³ In a message to Congress, President Carter stated that “penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself; and where they are, they should be changed.” Quoted in David F. Musto (1999), *op. cit.*, p. 261.

¹⁸⁴ In 1982 the White House launched a coordinated effort in South Florida to fight illegal drugs entering the state. The government spent millions to seize over 30 tons of cocaine and 1500 tons of marijuana between 1983 and 1985. Richard Davenport-Hines (2002), *op. cit.*, p. 437. Despite this massive interdiction, drug use was estimated by the DEA to have increased substantially during that time. Yet, while more money was appropriated for law enforcement, funding for treatment and research declined. David F. Musto (1999), *op. cit.*, p. 267.

¹⁸⁵ See Pub. L. No. 98-473, Oct. 12, 1984, 98 Stat. 1976; Alexander T. Shulgin (1988), *op. cit.*, p. 250.

¹⁸⁶ Pub. L. No. 99-570, Oct. 27, 1987, 100 Stat. 3207.

¹⁸⁷ Pub. L. No. 100-690, Nov. 18, 1988, 102 Stat. 4181.

¹⁸⁸ Alexander T. Shulgin (1988), *op. cit.*, p. 250.

¹⁸⁹ See King County Bar Association (2001), *Is It Time to End the War on Drugs?*, *op. cit.*, pp. 59-65.

¹⁹⁰ See discussion of drug courts in King County Bar Association (2005), “Controlling Psychoactive Substances; The Current System and Alternative Models,” *Report of the Legal Frameworks Group to the King County Bar Association Board of Trustees*, pp. 13-14.

¹⁹¹ *Sourcebook of Criminal Justice Statistics* (1997), Bureau of Justice Statistics, Washington: Department of Justice, table 5.37 p. 414; *Sourcebook of Criminal Justice Statistics* (2001), Bureau of Justice Statistics, Washington: Department of Justice, table 5.19, p. 416, and table 6.51, p. 512.

¹⁹² Jonathan Caulkins and Sara Chandler, “Long-Run Trends in Incarceration of Drug Offenders in the United States,” cited in John M. Walsh (2004), *Are We There Yet? Measuring Progress in the U.S. War on Drugs in Latin America*, Washington, D.C.: Washington Office on Latin America, p. 7.

¹⁹³ John M. Walsh (2004), *op. cit.*, p. 7, citing U.S. Census Bureau, *Statistical Abstract of the United States, 2003*.

¹⁹⁴ Lloyd D. Johnston *et al.* (2003), *Monitoring the Future National Survey Results on Drug Use, 1975-2002*, NIH Publication No. 03-5375, Bethesda: National Institute on Drug Abuse, v. I, table 13.

¹⁹⁵ John M. Walsh (2004), *op. cit.*, p. 5, citing National Survey on Drug Use and Health, 2003.

¹⁹⁶ Lloyd D. Johnston *et al.* (2003), *op. cit.*

¹⁹⁷ Office of National Drug Control Policy (2004), *National Drug Control Strategy*, March 2004.

¹⁹⁸ *Id.*, FY2005 Budget Summary.

¹⁹⁹ Office of National Drug Control Policy (2004), *The Price and Purity of Illicit Drugs: 1981 Through the Second Quarter of 2003*, Washington, D.C.: Executive Office of the President (Publication Number NCJ 207768), November 2004.

²⁰⁰ U.S. Department of Justice (2004), *National Drug Threat Assessment 2004*, Washington, D.C.: National Drug Intelligence Center (NDIC), April 2004.

PART II

INTERNATIONAL TRENDS IN DRUG POLICY: LESSONS LEARNED FROM ABROAD

²⁰¹ U.N. ECON. & SOC. COUNCIL, SINGLE CONVENTION ON NARCOTIC DRUGS, 1961, U.N. Doc. UNE/CN.7/GP/1, U.N. Sales No. 62.XI.1 (1961); U.N. ECON. & SOC. COUNCIL, CONVENTION ON PSYCHOTROPIC SUBSTANCES, 1971, U.N. Sales No. E.78.XI.3 (1977); and U.N., CONVENTION AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES, 1988 (1988).

²⁰² Robert J. MacCoun and Peter Reuter (2001), *Drug War Heresies*, Cambridge University Press, p. 206.

²⁰³ Peter Andreas from Harvard University’s Center for International Affairs describes the political pressure on nations not to withdraw from global drug prohibition: “Open defection from the drug prohibition regime would...have severe consequences, placing the defecting country in the category of a pariah “narcostate,” generating material repercussions in the form of economic sanctions and aid cutoffs and damaging the

country's moral standing in the international community." Richard Friman and Peter Andreas, eds. (1999), *The Global Economy and State Power*, New York: Roman and Littlefield, pp. 127-8. Dutch scholar Peter Cohen expresses it more dramatically: "The international drug treaties are among the holiest texts of the Drug Prohibition Church. At the Church's meetings, wherever they are held, you will find people kneeling in ridiculous postures before them, because for them the texts contain the sacred words of the Divine. A reformist perspective on the Treaties or a refusal to kneel before the texts, are very dangerous actions now for countries, as the growing hegemony of the U.S. has consequences that push towards extremism and orthodoxy. The more the U.S. Caesars exploit their hegemony, the more the U.N. Drug Conventions symbolize their desire to define and control Humankind, the same way as their gulag state, armies and armada of aircraft carriers are its material expression." Peter Cohen (2003), "The drug prohibition church and the adventure of reformation," *International Journal of Drug Policy*, V.14, no.2, April 2003, pp. 213-215. See also Harry G. Levine (2002), "The Secret of Worldwide Drug Prohibition," *The Independent Review*, v.VII, no.2, pp. 165-180; and Hans-Jorg Albrecht, "The International System of Drug Control: Developments and Trends," in Jurg Gerber and Eric L. Jensen, eds. (2001), *Drug War, American Style: The Internationalization of Failed Policy*, New York: Garland, p. 49.

²⁰⁴ For example, the INCB recently warned of "threats to middle-class Americans" by drug traffickers of a new, inhalable form of heroin coming from Colombia. Karl Peter Kirk, "U.N.: Drug Producers Target Middle Class," *Associated Press*, March 2, 2004. More recently, the U.N. had to back down on its program of providing clean needles to heroin users as part of a campaign to reduce AIDS infection because of U.S. opposition to any program deemed to appear to condone drug use and not to require strict abstinence. "U.S. cash threats to Aids war," *The Observer* (UK), February 6, 2005.

²⁰⁵ The INCB has strenuously warned Canada and other nations that are straying too far from the strict prohibition model of dire international legal consequences. See, e.g., Chad Skelton, "U.N. Needles City Over Injection Site," *Vancouver Sun*, March 3, 2004, page B1.

²⁰⁶ In their joint appeal, the European parliamentarians maintained, *inter alia*, that "the drug prohibition policy stemming from the UN Conventions of 1961, 1971 and 1988 is the actual cause of the increasing damage which the production, trafficking, sale and consumption of illegal substances inflict on entire sections of society, the economy as well as public institutions, thus undermining health, freedom and individuals' lives." See http://www.radicalparty.org/lia_paa_appeal/.

²⁰⁷ "Greek Foreign Minister says international debate necessary to tackle problems with illicit drugs," *Athens News Agency*, October 6, 2003.

²⁰⁸ Robert J. MacCoun (1998), "Toward a Psychology of Harm Reduction," *American Psychologist*, v.53, pp.1199-1208.

²⁰⁹ Although the drug control schemes on the federal and state levels predominantly impose criminal sanctions related to illegal drugs, a closer look at some U.S. states and cities reveals a tolerant approach to the possession of small amounts of marijuana. At least twelve of the United States have loosened penalties in recent years. Donna Leinwand, "Canada's plan to allow pot possession causes U.S. rift," *USAToday.com*, May 8, 2003, at http://www.usatoday.com/news/world/2003-05-07-canadapot-usat_x.htm. In Seattle the recently-enacted Initiative 75 instructs police effectively to turn a blind eye to possession or use of small amounts of marijuana by adults. Beth Kaiman, "Seattle voters favor measure on marijuana," *The Seattle Times*, September 17, 2003, page A4.

²¹⁰ U.S. Department of State (2003), *Human Rights Report*, <http://www.state.gov/g/drl/rls/hrrpt/2003/>; Human Rights Watch (2004), "Timeline of Thailand's War on Drugs," August 17, 2004.

²¹¹ Brian Bernbaum, "Bulgarian lawmakers get marijuana letters," *CBS News Online*, April 29, 2004. The passing of the law was met with protests in Bulgaria, including journalists of a trendy Bulgarian magazine placing small amounts of marijuana in legislators' mailboxes.

²¹² While 10-15% of heroin and 30% of cocaine is intercepted internationally, it is estimated that 75% would have to be intercepted to substantially reduce the profitability of drug trafficking. "U.N. Estimates Drug Business Equal to 8 Percent of World Trade," *Associated Press*, June 26, 1997. Efforts to intercept drugs at the source are also not cost effective. To achieve a one percent reduction in U.S. cocaine consumption, the United States could spend an additional \$34 million on drug treatment programs, or 23 times as much -- \$783 million -- on efforts to eradicate the supply at the source. C. P. Rydell and Susan S. Everingham (1994), *Controlling Cocaine*, Santa Monica: RAND Corporation.

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- ²¹³ National Commission on Terrorist Attacks Upon the United States (2004), *The 9/11 Commission Report: Final Report of the National Commission on Terrorist Attacks Upon the United States*, W.W. Norton & Co., pp. 74, 76 and 77.
- ²¹⁴ According to the Office of National Drug Control Policy (ONDCP), cocaine at the wholesale level has continually declined in price from an average of \$125.43 per gram in 1981 to \$38.00 per gram in 1989 and down to \$26.03 per gram in 2000. Office of National Drug Control Policy (2001), *The Price of Illicit Drugs: 1981 through the Second Quarter of 2000*, ONDCP Office of Programs, Budget, Research and Evaluations, prepared by: Abt Associates, Inc., October 2001. Table 1, pp. 28-30. Its recent update of price and purity reveals a continuation of the same trends. Office of National Drug Control Policy (2004), *The Price and Purity of Illicit Drugs: 1981 Through the Second Quarter of 2003*, Washington, D.C.: Executive Office of the President (Pub. No. NCJ 207768), prepared by: RAND Corporation, November 2004.
- ²¹⁵ "U.S. drug czar to meet Colombia's president, review aid program," *CNN.com*, August 9, 2000, at <http://www.cnn.com/2000/WORLD/americas/08/09/colombia.mccaffrey/>.
- ²¹⁶ "Colombia's Coca Up, U.S. Says," *The New York Times*, March 9, 2002, p.A5.
- ²¹⁷ "Colombians consider decriminalizing drug trade," *Dallas Morning News*, September 10, 2001, p. A3.
- ²¹⁸ "Bush: Add troops in Colombia," Bloomberg Newswire, *New York Daily News*, March 23, 2004.
- ²¹⁹ "US Anti-Drug Campaign 'Failing,'" *BBC News*, Aug. 6, 2004, at: <http://news.bbc.co.uk/2/hi/americas/3540686.stm>. Curiously, a few days later Mr. Walters seemed to contradict his previous statements, touting American-backed efforts as having brought about a 30 percent decline in the production of coca and a sharp reduction in the flow of cocaine into the U.S. "'Big Decline' in Colombian Cocaine," *BBC News*, Aug. 11, 2004, at <http://news.bbc.co.uk/2/hi/americas/3556464.stm>.
- ²²⁰ Juan Forero, "Hide-and-Seek Among the Coca Leaves," *The New York Times*, June 9, 2004, page A4.
- ²²¹ Jeremy McDermott, "New super strain of coca plant stuns anti-drug officials," *The Scotsman* (Scotland), August 27, 2004.
- ²²² In Peru, the National Confederation of Coca Growers of Peru (CONPACCP) marched to Lima in 2004 demanding the end of eradication of coca crops, shutting down the Peruvian drug agency and recognizing coca as a traditional crop. Hugo Cabieses, "Peru's cocaleros on the march," *Report on the Americas*, North American Congress on Latin America, v.38, no.1, July/August 2004.
- ²²³ "Bolivia's president resigns, U.S. troops to assess situation after month of violent clashes," *CNN.com*, October 17, 2003, at <http://www.cnn.com/2003/WORLD/americas/10/17/bolivia.president/>.
- ²²⁴ "Critics take aim at Brazil's drug plane law," *CNN.com*, *AP*, July 20, 2004, at <http://www.cnn.com/2004/WORLD/americas/07/20/brazil.planes.ap/>.
- ²²⁵ "Brazil to Shoot Down Drug Planes," *BBC News*, June 23, 2004, at <http://news.bbc.co.uk/2/hi/americas/3833695.stm>.
- ²²⁶ "Mexican State Sacks Entire Police," *BBC News*, April 13, 2004, at <http://news.bbc.co.uk/2/hi/americas/3621073.stm>.
- ²²⁷ James Blears, "Mexico Produces Bumper Crop of Opium Poppies," *Voice of America News*, April 16, 2004, at <http://www.voanews.com/article.cfm?ObjectID=56D7E481-1B90-4D36-A58FAFFBA0A6F2EA&Title=Mexico%20Produces%20Bumper%20Crop%20of%20Opium%20Poppies&db=voa>.
- ²²⁸ Nat Ives, "Karzai Plans to Destroy Poppy Fields in 2 Years," *The New York Times*, December 13, 2004, p. A12.
- ²²⁹ David Rohde, *The New York Times*, Thursday, July 1, 2004, page A13.
- ²³⁰ "Kabul government concedes officials assist drug trafficking," *The Washington Times*, May 14, 2004.
- ²³¹ "What the Taliban Banned: With the Taliban toppled, Afghan opium is flooding Iran," *The Economist*, March 14, 2002, p. 68.
- ²³² Jim Muir, "Iran's Battle With Heroin," *BBC News*, June 7, 2004, at http://news.bbc.co.uk/1/hi/world/middle_east/2031624.stm.
- ²³³ Rowan Scarborough, "DEA official to monitor Afghan anti-drug plan," *The Washington Times*, August 18, 2004.
- ²³⁴ Carlotta Gall, "Afghans Accuse U.S. of Secret Spraying to Kill Poppies," *The New York Times*, February 27, 2005, p. 3.
- ²³⁵ "Fiji: Record drug haul," Reuters, *The New York Times*, June 10, 2004, p. A8.
- ²³⁶ "Thaksin hails death of 'bad people'," Associated Press Bangkok, *Taipei Times*, December 4, 2003, p. 5. Thailand's National Human Rights Commission and Amnesty International have been looking into the

situation, reporting that more than 90,000 people have been arrested on drug charges and another 329,000 have been blacklisted. Napanisa Kaewmorakot, "Compensate families of those killed, says NHRC," *The Nation* (Thailand), December 15, 2003.

²³⁷ "War on drugs increases the number of alcoholics," *Pattaya Mail* (Thailand), Vol. XII No. 27, Friday July 2 - 8, 2004. With thousands of people arrested, their children are left homeless and, with no adults to care for them, many of the children start sniffing glue and are recruited by drug dealers to deliver drugs. "Drug trade flourishes in Klong Toei," *The Nation* (Thailand), April 12, 2004.

²³⁸ Anthony S. Allada, "Swim no, drug peddlers told," *Mindanao Times*, August 13, 2004.

²³⁹ Amnesty International (2004), *Singapore: High Execution Rate Shrouded in Secrecy*, available at <http://www.amnestyusa.org/countries/singapore/document.do?id=80256DD400782B8480256E1A005B789>

²⁴⁰ Singapore Central Narcotics Bureau (2004), *Laws Against Drug Abuse*, available at <http://www.cnb.gov.sg/enforcement/index.asp?page=9>.

²⁴¹ "The going gets tough and so does Allawi," *The Daily Telegraph* (UK), August 10, 2004, p. 19.

²⁴² Amnesty International (2004), *China: Annual execution spree looms on UN anti-drugs day*, available at <http://www.amnestyusa.org/countries/china/document.do?id=80256DD400782B8480256EB30057A2DA>.

²⁴³ *Id.*

²⁴⁴ "Rising drug addiction costing China billions," *Associated Press*, February 12, 2004.

²⁴⁵ "Human Rights: Drug kin to lose citizenship," *The Nation* (Thailand), September 5, 2003.

²⁴⁶ One man from Ohio, adopted from Brazil when he was eight years old, was sent back to Brazil at age 22 after a small marijuana sale when he was eighteen. While there, living in poverty as an English teacher, he was shot to death four years later. Marilyn Miller and Gina Mace along with Knight Ridder correspondent Kevin Hall, "Deported Man Shot to Death in Brazil," *Akron Beacon Journal*, July 27, 2004, p. A1.

²⁴⁷ "Probation and Parole in the United States, 2003," <http://www.ojp.usdoj.gov/bjs/abstract/ppus03.htm>.

²⁴⁸ "Profile of Jail Inmates, 2002," available at <http://www.ojp.usdoj.gov/bjs/abstract/pji02.htm>.

²⁴⁹ See, e.g., John Sharp, "Man Gets Life Sentence for Producing Meth," *Peoria Journal Star*, May 14, 2004. Proposed federal legislation would increase penalties to ten years to life for some marijuana sales. See "Defending America's Most Vulnerable: Safe Access to Drug Treatment and Child Protection Act of 2004" (H.R. 4547).

²⁵⁰ "Reforming California's Youth and Adult Correctional System," California Performance Review, Corrections Independent Review Panel, available at <http://www.report.cpr.ca.gov/indrpt/corr/index.htm> (August 18, 2004); Jim Wasserman, "Schwarzenegger panel suggests reforms for troubled California prison system," *North County Times* (CA), July 1, 2004.

²⁵¹ Non Alquitran and Christina Mendez, "A Banner Year in War on Drugs," *Philippine Star*, December 25, 2003.

²⁵² "Philippine drug users numbered at 3.4 million," *Xinhua News Agency* (China), September 15, 2004, at http://news.xinhuanet.com/english/2004-09/15/content_1986360.htm.

²⁵³ "Three Vietnamese drug traffickers receive death sentences," *Xinhua News Agency* (China), July 27, 2004.

²⁵⁴ Raymond Kendall, "Drogues: guerre perdue, nouveaux combats (Drugs: lost war, new combat)," *Le Monde* (France), Oct. 26, 2004, p. 22.

²⁵⁵ For an exhaustive and comprehensive survey of legislative approaches to illicit drug use in Europe, see European Monitoring Centre for Drugs and Drug Addiction (2005), *Illicit Drug Use in the EU: Legislative Approaches*, EMCDDA Thematic Paper, Lisbon, available at <http://www.emcdda.eu.int/?nnodeid=7079>.

²⁵⁶ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, p. 209.

²⁵⁷ Andrew Osborn, "Spliffs in the park and a shop selling hemp," *The Guardian*, August 3, 2001, page 4. Similarly, the city of Zurich, having seen its harm reduction strategy begin to bear fruit, now expresses its drug policy objectives differently, treating addicts the same regardless if their drug is legal or illegal. In the past the officials focused on the open drug scene to the neglect of other aspects of addiction. "Zurich revises its drugs strategy," *Swissinfo*, August 12, 2004.

²⁵⁸ The seminal work on harm reduction is credited to University of Washington scholar G. Alan Marlatt. See G. Alan Marlatt (1998), *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*, Guilford Press, New York; see also G. Alan Marlatt (1999), *Using Harm Reduction in Treating Addictive Behaviors*, University of Washington.

²⁵⁹ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, pp. 388-89.

²⁶⁰ “Principles of Harm Reduction,” Harm Reduction Coalition, New York (2001). According to the Harm Reduction Coalition’s Principles of Harm Reduction, harm reduction:

- accepts, for better or for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them;
- understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others;
- establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies;
- calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm;
- ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them;
- affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use;
- recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm;
- does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

²⁶¹ Robert J. MacCoun and Peter Reuter, *op. cit.*, pp. 391-92, citing J. Braithwaite, *Crime, Shame and Reintegration*, Cambridge (UK): Cambridge University Press, 1989.

²⁶² Harry G. Levine (2002), *op. cit.*, p. 173.

²⁶³ Donald MacPherson (2001), *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*, City of Vancouver, Four Pillars Drug Strategy, April 24, 2001, available at http://www.city.vancouver.bc.ca/fourpillars/pdf/Framework_REVISED.pdf.

²⁶⁴ *Id.* at 4.

²⁶⁵ City of Vancouver, Four Pillars Drug Strategy, Harm Reduction Fact Sheet, last updated July 1, 2004, available at http://www.city.vancouver.bc.ca/fourpillars/pdf/Factsheet_harmreduction.pdf.

²⁶⁶ “Clean pipes for crack addicts,” *Edmonton Journal*, August 27, 2004, p. A8.

²⁶⁷ Kate Foster, “Heroin kits on demand for Scots prisoners,” *The Scotsman*, October 17, 2004.

²⁶⁸ Czech Deputy Prime Minister Petr Mares has stated that “what [we’re] trying to do is to build a barrier between those who are experimenting with marijuana and those who are offering hard drugs. I don’t like our kids to get in contact with drug dealers and I believe that, well...let them have an opportunity to raise two or three marijuana plants and smoke them. It’s better than to try to buy it on the streets.” Brian Whitmore, “With a velvet approach, Czechs look to revamp vice laws,” *Boston Globe*, July 6, 2003, p. A5.

²⁶⁹ The Substance Abuse and Crime Prevention Act of 2000, <http://www.prop36.org/about.html>.

²⁷⁰ Douglas Longshore, Ph.D., Darren Urada, Ph.D., Elizabeth Evans, M.A., Yih -Ing Hser, Ph.D., Michael Prendergast, Ph.D., Angela Hawken, Ph.D., Travis Bunch, and Susan Ettner, Ph.D. (2004), *Evaluation of the Substance Abuse and Crime Prevention Act: 2003 Report*, Department of Alcohol and Drug Programs, California Health and Human Services Agency, September 23, 2004.

²⁷¹ The latest survey of U.S. drug courts is found in C. West Huddleston, III, Karen Freeman-Wilson and Donna L. Boone (2004), *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States*, Alexandria: National Drug Court Institute.

²⁷² Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, p. 209.

²⁷³ *Id.* at 298.

²⁷⁴ Wendy Pryer, “Secret Soft Turn on Hard Drugs,” *The West Australian*, July 26, 2004.

²⁷⁵ Australian Institute of Criminology (2004), *Illicit Drugs and Alcohol*, available at: <http://www.aic.gov.au/research/drugs/types/cannabis.html>.

²⁷⁶ Okey Ndiribe, “Lagos and the Hard Drugs Menace,” *The Vanguard* (Nigeria), August 11, 2004.

²⁷⁷ Muawia E. Ibrahim, “Drug Abusers to be Treated as Patients,” *Khaleej Times* (UAE), June 28, 2004.

²⁷⁸ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, pp. 213, 235.

²⁷⁹ “Belgium: New package of drug laws enter into force,” European Legal Database on Drugs, February 6, 2003, available at

http://eldd.emcdda.eu.int/databases/eldd_news_detail.cfm?id=02/06/2003BELGIUM:%20New%20package%20of%20drug%20laws%20enter%20into%20force.

²⁸⁰ Giles Tremlett, "Lisbon takes drug use off the charge sheet," *The Guardian* (UK), July 20, 2001, p. 20.

²⁸¹ "No More Jail Terms for Drug Possession," *The Moscow Times*, May 14, 2004.

²⁸² Although an estimated 80% of the HIV-AIDS cases in Russia are drug related, the treatment budget is too small to serve the country's four million or so intravenous drug users. With Soviet-era curbs on nearly all controlled substances including methadone, a common treatment for heroin addicts in the U.S., it is hard to give addicts substitution therapy, and nearly 20% of the AIDS cases are in the prison population, making the disease hard to treat and further fueling its spread. Bill Nichols, "Russian AIDS workers wage battle on edge of epidemic," *USA Today*, April 20, 2004, p. A13.

²⁸³ In 2003 Dutch customs officers arrested 2,176 smugglers from the Caribbean, an average of more than five per day; now the Dutch government has decided that prosecuting them is a waste of resources. A Dutch Justice Ministry spokesman stated, "Locking up thousands of smugglers doesn't solve the problem - there will always be more of them. We've been honest enough to admit that we only manage to stop fifteen percent of the drugs coming in, so we are trying something new." Justice Sparks, "Dutch law could unleash cocaine flood in Britain," *The Sunday Times* (UK), Feb. 2004, p. 24.

²⁸⁴ Irma Alvarez, "Penas hasta de 20 años y multas contra tráfico de drogas (Up to 20 years and fines for drug trafficking)" *El Universal* (Venezuela), January 13, 2004, available at: http://www.eluniversal.com/2004/01/13/pol_art_13105A.shtml.

²⁸⁵ Sandra G. Edwards (2003), "Illicit Drug Control Policies and Prisons: The Human Cost," Special Update: Ecuador, Washington Office on Latin America, November 2003, available at: http://www.wola.org/publications/ddhr_ecuador_memo4.pdf.

²⁸⁶ "Colombians consider decriminalizing drug trade," *Dallas Morning News*, September 10, 2001, p. A3.

²⁸⁷ General Paulo Roberto Yog de Miranda Uchôa, National Antidrug Secretary, Federative Republic of Brazil, "The Brazilian National Drug Policy Legislation," Speech at the Senlis Council 2004 Vienna International Symposium, (March 16, 2004), available at: http://www.senliscouncil.net/modules/events/vienna_2004/uchoa_speech.

²⁸⁸ "Ministry studying ganja commission proposals," *The Jamaica Gleaner*, August 23, 2001, p. A9.

²⁸⁹ Kaminie Jayanthi Liyanage, "Cannabis cultivation: Relaxing the strong arm of the law," *Sunday Observer* (Sri Lanka), May 23, 2004, at: <http://www.sundayobserver.lk/2004/05/23/fea11.html>

²⁹⁰ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, p. 239.

²⁹¹ The Hulsman Commission, established by the National Federation of Mental Health Organizations, set out to "clarify factors that are associated with the use of drugs, to give insight into the phenomenon as a whole, and to suggest proposals for a rational policy." Louk Hulsman (1971), 'Ruimte in het drugbeleid.' *Boom Meppel*, p. 5. The Baan Commission, chaired by Pieter Bann, Chief of Mental Health, was asked to "investigate causes of increasing drug use, how to confront irresponsible use of drugs, and to propose a treatment system for those who developed dependence on these drugs." "Achtergronden en risico's van druggebruik (Backgrounds and Risks of Drug Use)," Staatsuitgeverij Den Haag, 1972, p. vii.

²⁹² Louk Hulsman (1971), *op. cit.*, pp. 49, 51.

²⁹³ Peter Cohen (1994), *The case of the two Dutch drug policy commissions. An exercise in harm reduction 1968-1976*. Paper presented at the 5th International Conference on the Reduction of Drug Related Harm, 7-11 March, 1994, Toronto: Addiction Research Foundation, Revised in 1996, pp. 26, 27.

²⁹⁴ *Id.* at 4-6.

²⁹⁵ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, pp. 240-41, citing Ministry of Foreign Affairs *et al.* (1995), *Drugs Policy in the Netherlands: Continuity and Change*, Rijswijk, The Netherlands.

²⁹⁶ For U.S. figures see U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse: Volume I. Summary of National Findings (Washington, DC: HHS, August 2002), p. 109, Table H.1; for figures from the Netherlands see Trimbos Institute (2002), *Report to the EMCDDA by the Reitox National Focal Point, The Netherlands Drug Situation 2002*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction, Nov. 2002, p. 28, Table 2.1.

²⁹⁷ The most recent study of Dutch school children showed that 20 percent of 15-to-16 year-olds had tried cannabis and five percent smoked it regularly, compared with a lifetime use rate of about 35 to 40 percent in the U.S. and in Britain. In addition, only one of every 1,000 Dutch teens have tried heroin, compared

with one of every 100 in the U.S. and one of every 50 in Britain. David Rose (2002), "The Dutch Lesson," *The Observer* (UK), February 24, 2002, p. 10.

²⁹⁸ Craig Reinerman, Peter D. A. Cohen and Hendrien L. Kaal (2004), "The Limited Relevance of Drug Policy: Cannabis in Amsterdam and in San Francisco," *American Journal of Public Health*, v.94, no.5, May 2004, pp. 836-842.

²⁹⁹ Gordana Mijuk, "Swiss parliament blocks moves to decriminalize cannabis," Associated Press, AP Worldstream, September 25, 2003.

³⁰⁰ Prevalence of cannabis use in the Czech Republic is relatively high; recent surveys estimate that 60 to 80 percent of 18-year olds have used cannabis. See note 66, *supra* (Brian Whitmore, "With a velvet approach, Czechs look to revamp vice laws," *Boston Globe*, July 6, 2003, p. A5).

³⁰¹ *Id.*

³⁰² Warren Hoge, "Britain to Stop Arresting Most Private Users of Marijuana," *The New York Times*, July 11, 2002, p. A3.

³⁰³ Q&A: Cannabis Guidelines," BBC News, January 22, 2004, at <http://news.bbc.co.uk/1/hi/uk/3103416.stm>

³⁰⁴ See note 73, *supra* ("Illicit Drugs and Alcohol," Australian Institute of Criminology, at <http://www.aic.gov.au/research/drugs/types/cannabis.html>).

³⁰⁵ Lisa Schmidt, "Majority of MPs support decriminalizing marijuana, says Keith Martin," *Canadian Press*, November 8, 2001, at http://www.canoe.ca/Health0111/08_martin-cp.html.

³⁰⁶ The Special Senate Committee on Illegal Drugs (2002), Senate Committee Recommends Legalization of Cannabis, news release, Ottawa, September 4, 2002.

³⁰⁷ *Id.* at 3-4.

³⁰⁸ *Id.* at 49.

³⁰⁹ Colin McDonald, "U.S. Drug Czar Warns of Potent Pot Here," *The Seattle Post-Intelligencer*, July 20, 2004, p. B2.

³¹⁰ "National Drug Threat Assessment 2004," U.S. Department of Justice, National Drug Intelligence Center, 2004-Q0317-002, April 2004.

³¹¹ International Narcotics Control Board (2004), *Report of the INCB for 2003*, United Nations, available at http://www.incb.org/e/ind_ar.htm.

³¹² "Vancouver's Heroin Users Get Safe-Injection Site," *CBC News*, Sept. 15, 2003, http://www.cbc.ca/stories/2003/09/15/safe_injection030915.

³¹³ International Narcotics Control Board (2004), *op. cit.*, p. 37.

³¹⁴ See Chad Skelton, "U.N. Needles City Over Injection Site," *Vancouver Sun*, March 3, 2004, p. B1., *supra*.

³¹⁵ Dagmar Hedrich (2004), *European Report on Drug Consumption Rooms*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), February 2004, p. 83. Report available at <http://www.emcdda.eu.int/?nnodeid=1327>. The report's conclusion was that "safe consumption rooms" reach a population of long-term problem drug users with various health and social problems and they provide a hygienic environment for drug use and, for regular users, decreased exposure to risks of infectious diseases and increased access for hard-to-reach target populations of drug users to health, welfare and drug treatment services. The report found that safe injection facilities provide immediate emergency help in case of overdose and can make a contribution to the reduction of overdose deaths at community level, given sufficient capacity and coverage in terms of location and opening hours, as well as consultation with residents and police, consumption rooms can reduce the level of drug use in public places and help to reduce public nuisance.... There is no evidence that consumption rooms encourage increased drug use or initiate new users. There is little evidence that by providing better conditions for drug consumption they perpetuate drug use in clients who would otherwise discontinue consuming drugs such as heroin or cocaine, nor that they undermine treatment goals. When managed in consultation with local authorities and police, they do not increase public order problems by increasing local drug scenes or attracting drug users and dealers from other areas.

³¹⁶ Ralf Gerlach and Wolfgang Schneider, *Annual Report 2002 of the Consumption and Injecting Room (CIR) at INDRÖ, Munster, Germany*.

³¹⁷ C. Haasen & M. Prinzleve (2001), *Support Needs for Cocaine and Crack Users in Europe*, (COCINEU) Centre for Interdisciplinary Addiction Research, University of Hamburg, Contract number: QL4-CT-2001-02301, Deliverable N° 2: Evaluation of research situation in Europe.

³¹⁸ “Drug-related deaths have fallen again,” *Die Bundesregierung* (Federal Government), April 30, 2003, available at <http://www.bundesregierung.de/en/artikel-,10001.482122/Drug-related-deaths-have-falle.htm>. See also “Weiterer Rückgang bei den Drogentodesfällen im 1. Halbjahr 2004 (Further decrease in drug deaths in the first half of 2004),” news release, German Ministry of Health and Social Security, September 2, 2004, available at http://www.bmgs.bund.de/deu/gra/aktuelles/pm/d04/BMGS_104_5864.cfm.

³¹⁹ David Rose (2002), *op. cit.*

³²⁰ *Id.*, citing the 2000 International Crime Victims Survey.

³²¹ Seniorenpannd, located in Rotterdam, allows its residents to use drugs they buy off the street while encouraging the residents to consume less. The main goal is to help addicts live their final years in comfort and dignity. According to the home’s manager, some people’s addiction is irreversible, and the home allows those people to have some stability and quality of life at the end of their lives. Carl Honore, “Home where the old folk snort heroin,” *The Scotsman* (UK), Dec. 20, 2004.

³²² Luciano Constantino and Iuri Dantas, “Policy proposal considers drug consumption as a public health problem, and no longer one for the police,” *Folha de São Paulo* (Brazil), Nov. 15, 2004.

³²³ A few “safe injection” sites have already been operating illegally in Vancouver, but the operation of the sites is tolerated by local law enforcement, which supports the activity. The Canadian government must grant special exemptions to such sites, allowing them to have illegal narcotics on their premises. Joel Baglole, “Vancouver’s Heroin ‘Fix,’” *The Wall Street Journal*, April 1, 2003, p. D8.

³²⁴ *Id.*

³²⁵ “Safe injection site saving lives: report,” *CBC News British Columbia*, September 23, 2004, available at http://vancouver.cbc.ca/regional/servlet/View?filename=bc_sis_study20040923. See also British Columbia Centre for Excellence in HIV/AIDS (2004), *Evaluation of Supervised Injection Site: Year One Summary*, Vancouver Coastal Health Authority, available at http://www.vch.ca/sis/Docs/esis_year_one_sept16_042.pdf.

³²⁶ British Columbia Centre for Excellence in HIV/AIDS (2004), “Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users,” Vancouver Coastal Health Authority, available at <http://www.cmaj.ca/cgi/content/abstract/171/7/731>.

³²⁷ Larry Campbell, “A different way to help drug users,” opinion, *National Post*, October 5, 2004, p. A17.

³²⁸ “Victoria needs safe injection site, says mayor,” *CBC News British Columbia*, March 19, 2004, at http://vancouver.cbc.ca/regional/servlet/View?filename=bc_sis20040319.

³²⁹ Individual heroin prescription centers in Switzerland have significant autonomy but must comply with national legal guidelines. The 1999 Ordinance states that the objectives for the patient are: 1) sustained commitment to treatment; 2) improvement in physical and mental health status; 3) improvement in social integration (fitness for work, reduced contact with the drug scene, decrease in criminal behavior); and 4) permanent abstinence from opiate consumption as a long-term goal. Swiss Federal Office of Public Health, *Heroin-assisted Treatment (HAT)*, August 28, 2001.

³³⁰ A six-year study of the Swiss heroin prescription program found “a significant decrease in the use of illegal substances, illegal income and most other variables concerning social conditions.” Franziska Güttinger, Patrick Gschwend, Bernd Schulte, Jürgen Rehm and Ambros Uchtenhagen (2003), *Evaluating Long-Term Effects of Heroin-Assisted Treatment: The Results of a 6-Year Follow-Up*, Zurich: Addiction Research Institute. Other research and published studies related to the Swiss opiate prescription experiment include: Cornelia Brehmer, Peter X. Iten (2001), “Medical prescription of heroin to chronic heroin addicts in Switzerland—a review,” *Forensic Science International*, v.121, pp. 23-26; Jürgen Rehm, Patrick Gschwend, Thomas Steffen, *et al.* (2001), “Feasibility, safety and efficacy of injectable heroin prescription for refractory opioid addicts: a follow-up study,” *The Lancet*, v.358, October 27, 2001; Robert B. Haemmig, “Koda 1 in Bern: Medical Aspects,” in Gabrielle Bammer, ed. (1999), *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*; Martin Killias and Juan Rabasa (1997), “Less Crime in the Cities Through Heroin Prescription? Preliminary Results from the Evaluation of the Swiss Heroin Prescription Projects,” *The Howard Journal*, v.35, no.4, November 1997; and A. Uchtenhagen, “Summary of the Synthesis Report,” in A. Uchtenhagen, F. Gutzwiller and A. Dobler-Mikola, eds. (1997), *Programme for a Medical Prescription of Narcotics: Final Report of the Research Representatives*, Zurich: Institute for Social and Preventative Medicine, University of Zurich.

³³¹ Franziska Güttinger *et al.* (2003), *op. cit.*

³³² Samantha Tonkin, "Health insurers to foot bill for heroin," *Swissinfo*, June 12, 2002, at <http://www.swissinfo.org/sen/Swissinfo.html?siteSect=111&sid=1188746>.

³³³ Research on heroin-assisted treatment has already begun or scientific trials will be starting shortly in several European countries and Australia. In **Spain**, the regions of Catalonia and Andalusia are initiating heroin-assisted treatment trials. The Andalusian project involving injectable heroin has been approved by the Spanish Medicines Agency for about 250 subjects. The Catalanian trial will involve the prescription of oral heroin exclusively. In **Luxembourg**, the adoption of the revised Narcotics Law in March 2001 created the legal basis for heroin prescription and the Health Ministry has scheduled a trial to begin in 2004. **Belgium** is developing a protocol for heroin-assisted treatment research and a study is to be conducted in the cities of Liège, Brussels and Antwerp. In **France**, the Health Ministry announced in 2001 that it supported in principle the initiation of a research project on heroin prescription and it established a working party to prepare for trials. A victory for Gaullists in the June 2002 elections caused a shift in the French government's priorities and a heroin prescription trial is not expected to begin in the near future. Swiss Federal Office of Public Health 2000 (2001), *Heroin-assisted treatment in 2000* (abridged version), available at <http://www.suchtund aids.bag.admin.ch/imperia/md/content/drogen/hegebe/22.pdf>.

³³⁴ "Experiment heroïne in meer steden (Experimenting heroin in more cities)," *de Volkskrant* (NL), March 5, 2004; see report by the Central Committee on the Treatment of Heroin Addicts (2002), *Medical Co-Prescription of Heroin, Two Randomized Controlled Trials*, Presented to the Minister of Health, Welfare and Sports, the Netherlands, February 2002.

³³⁵ Swiss Federal Office of Public Health 2000 (2001), *op. cit.*

³³⁶ European Legal Database on Drugs (2004), Germany, available at http://eldd.emcdda.eu.int/databases/eldd_country_profiles.cfm?country=DE.

³³⁷ Swiss Federal Office of Public Health 2000 (2001), *op. cit.*

³³⁸ Manuel Altozano, "El primer ensayo español con heroína culmina con éxito y supera a la metadona (The first Spanish test with heroin culminates successfully and surpasses methadone)," *el Pais* (Spain), Dec. 9, 2004. See also Rafael Méndez, "Los adictos del ensayo de heroína mejoran su salud cuatro veces más que con metadona (Study reports addicts given heroin improve their health four times more than with methadone)," *el Pais* (Spain), March 17, 2004, p. 56.

³³⁹ According to H.B. Spear, former Chief Inspector of the Home Office Drugs Branch, the "cardinal" belief of the British medical profession is that "even if only a few doctors are convinced of the therapeutic benefits of a particular drug, that drug should be available for their use." It is this belief system, otherwise known as the "British system," that has led to the continued opposition by the British medical profession to the U.S. attempts to prohibit all legitimate manufacture and use of heroin. H.B. Spear (1997), "Heroin and the 'British System,'" *International Perspectives on the Prescription of Heroin to Dependent Users: A collection of papers from the United Kingdom, Switzerland, the Netherlands and Australia*, Feasibility Research into the Controlled Availability of Opioids Stage 2 Working Paper Number 14 NCEPH Working Paper 52, Gabriele Bammer (ed.) National Centre for Epidemiology and Population Health, The Australian National University, Australian Institute of Criminology, January 1997, pp. 12-13.

³⁴⁰ *Id.* Philip M Fleming, "Prescription Heroin as Treatment for Dependence – Current UK Situation."

³⁴¹ Edward M. Brecher and the editors of Consumer Reports (1972), *Licit and Illicit Drugs. The Consumers Union Report on Narcotics, Stimulants Depressants, Inhalants, Hallucinogens, and Marijuana -- including Caffeine, Nicotine, and Alcohol*, Boston; Little, Brown and Co.

³⁴² Michael White, "Legalise heroin, says former police chief," *The Guardian* (UK), November 7, 2001, p.2.

³⁴³ "Doubts over heroin prescriptions," *BBC News*, September 12, 2003, at <http://news.bbc.co.uk/1/hi/health/3094750.stm>.

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- ³⁵⁰ Keith B. Richburg, “For Dutch in Pain, Drugstores Offer Pot by Prescription,” *The Washington Post*, February 11, 2004. p. A22. See Amendment to Opium Act, 2 October 2002, No. 02.004519, Opium Act, as after enforcement of the Act of 13 July, 2002, to amend the Opium Act (Staatsblad [Bulletin of Acts and Decrees] 2002, 520), and the Decree to actualise the Lists I and II of the Opium Act (Staatsblad 2002, 623), which Decree will be enacted simultaneously with the aforementioned Act Law of 12 May 1928, containing regulations concerning opium and other narcotic substances (Opium Act), available at <http://www.cannabisbureau.nl/eng/index.html>.
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- ³⁵² “La efectividad terapéutica del cannabis exige la estabilidad de su principio activo (The therapeutic effectiveness of cannabis demands the stability of its active principle),” *Diario Medico*, April 1, 2004, available at <http://www.diariomedico.com/edicion/noticia/0,2458,465993,00.html>.
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PART III

CONTROLLING PSYCHOACTIVE SUBSTANCES: THE CURRENT SYSTEM AND ALTERNATIVE MODELS

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- ³⁵⁷ See discussion of the U.S. role in international drug policy enforcement, King County Bar Association (2005), “International Trends in Drug Policy: Lessons Learned from Abroad,” *Report of the Legal Frameworks Group to the King County Bar Association Board of Trustees*, pp. 2-3.
- ³⁵⁸ 42 U.S.C. § 14052(a) – (c).
- ³⁵⁹ 21 U.S.C. §§ 801 *et seq.* (1999).
- ³⁶⁰ *Id.* § 801(1).
- ³⁶¹ *Id.* § 811(b).
- ³⁶² *Id.* §§ 811(c) and (d).
- ³⁶³ *Id.* § 812.
- ³⁶⁴ *Id.* § 812(b)(1).
- ³⁶⁵ *Id.* § 822-23.
- ³⁶⁶ *Id.* § 825.
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- ³⁶⁸ *Id.* § 827.
- ³⁶⁹ *Id.* § 828.
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- ³⁷⁵ *Id.* § 842(b).
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- ³⁷⁹ *Id.* § 321(g)(1).
- ³⁸⁰ *Id.* § 371.
- ³⁸¹ *Id.* § 372.
- ³⁸² *Id.* § 3393.
- ³⁸³ *Id.* § 377.
- ³⁸⁴ *Id.* §§ 1701-1713.
- ³⁸⁵ The DEA is authorized to act to enforce the drug laws pursuant to administrative Reorganization Plan No. 2 sent to Congress July 6, 1977, effective July 1, 1973. It resulted from the merger of the Offices of Drug Abuse Law Enforcement and Natural Narcotics Intelligence.
- ³⁸⁶ <http://www.whitehousedrugpolicy.gov/index.html>
- ³⁸⁷ <http://www.usdoj.gov/dea/>
- ³⁸⁸ U.S. CONST. amend. XXI § 2.
- ³⁸⁹ 27 USC §§ 201 *et seq.*
- ³⁹⁰ *Granholm v. Heald*, Docket No. 03-1116, appealed from Sixth Circuit (Aug. 28, 2003) and *Swedenburg v. Kelly*, Docket No. 03-1274, appealed from the Second Circuit (Feb. 12, 2004). See further discussion in King County Bar Association (2005) “States’ Rights: Toward a Federalist Drug Policy,” *Report of the Legal Frameworks Group to the King County Bar Association Board of Trustees*, p. 8.
- ³⁹¹ “Drugs policy in the United States is ...breeding a generation of men and women from disadvantaged backgrounds whose main training for life has been in the violence of prison.” Editors, “The case for legalization: Time for a puff of sanity,” *The Economist*, July 28, 2001, p. 11.
- ³⁹² Jonathan P. Caulkins *et al.*, “Lessons of the ‘War’ on Drugs for the ‘War’ on Terror,” in Arnold M. Howitt and Robin Pangl, eds. (2003), *Countering Terrorism: Dimensions of Preparedness*, Cambridge: MIT Press.
- ³⁹³ Office of National Drug Control Policy (2004), *The Price and Purity of Illicit Drugs: 1981 Through the Second Quarter of 2003*, Washington, D.C.: Executive Office of the President (Pub. No. NCJ 207768), November 2004.
- ³⁹⁴ “A Survey of Illegal Drugs: Stopping it,” *The Economist*, July 28, 2001, special section, p.10.
- ³⁹⁵ See Eva Bertram, Morris Blachman *et al.* (1996), *Drug War Politics: The Price of Denial*, Berkeley: University of California Press, pp. 11-31.
- ³⁹⁶ Estimates according to U.S. Treasury officials and independent analysts. Tod Robberson, “Investigators hope money trail is path to stopping drug flow,” *The Dallas Morning News*, October 21, 2001, p. 1A.
- ³⁹⁷ Estimates according to congressional investigators. Mark Schapiro, “Drug War on Trial,” *The Nation*, Sept. 17-24, 2004, p. 25.
- ³⁹⁸ Shaila K. Dewan, “Drug Ring, Called an Efficiently Run Business, Is Broken Up,” *The New York Times*, April 1, 2003, p. A17.
- ³⁹⁹ Kevin Flynn, “Violent Crimes Undercut Marijuana’s Mellow Image,” *The New York Times*, May 19, 2001, p. A1.
- ⁴⁰⁰ Fox Butterfield, “As Drug Use Drops in Big Cities, Small Towns Confront Upsurges,” *The New York Times*, Feb. 11, 2003, p. A1.
- ⁴⁰¹ Ginger Thompson, “Sleepy Mexican Border Towns Awake to Drug Violence,” *The New York Times*, January 23, 2005, p. 3.
- ⁴⁰² *Id.*
- ⁴⁰³ Tim Golden, “Mexican Drug Dealers Turning U.S. Towns into Major Depots,” *The New York Times*, November 16, 2002, p. A1.
- ⁴⁰⁴ Nick Madigan, “Marijuana Found Thriving in Forests,” *The New York Times*, Nov. 16, 2002, p. A12.
- ⁴⁰⁵ Ioan Grillo, “Mexican state governor suspends 552 detectives,” *The Houston Chronicle*, April 13, 2004.
- ⁴⁰⁶ “A Survey of Illegal Drugs: Stopping it,” *The Economist*, July 28, 2001, special section, p. 11.
- ⁴⁰⁷ David Bamber and Mark Foxwell, “Guns and drugs fuel sudden rise in London’s murder rate,” *The Sunday Telegraph* (UK), March 21, 2004, p. 13.
- ⁴⁰⁸ The Deputy British High Commissioner in Jamaica asserted that estimates by the media that 1 out of every 10 passengers from Jamaica was a drug mule was probably on the low side. “Jamaican drug mules ‘flooding’ UK,” *BBC News*, Jan. 3, 2002, available at <http://news.bbc.co.uk/1/hi/uk/1739808.stm>
- ⁴⁰⁹ Carmen Sesin, “Caring for ‘drug mules’ who perish on the job,” *NBC News*, May 25, 2004, available at <http://www.msnbc.msn.com/id/5050399/>.

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- ⁴¹⁰ Nearly all of the Jamaican women currently imprisoned in the UK for smuggling drugs are single mothers. Some claimed they were forced to transport drugs, while others admit doing so out of desperation. “Jamaica battles UK drug ‘mules,’” *BBC News*, Jan. 4, 2002, available at http://news.bbc.co.uk/2/hi/uk_news/1741283.stm. The United States also has its own problem with drug mules, as seizures of heroin at JFK Airport alone amounted to 237 pounds in 2003, and seizures of cocaine amounted to 63 pounds. Carmen Sesin (2004), *op cit.*
- ⁴¹¹ Victor Cha, “North Korea’s Drug Habit,” *The New York Times*, June 3, 2004, p. A27.
- ⁴¹² Anne Barnard and Farah Stockman, “US weighs role in heroin war in Afghanistan,” *The Boston Globe*, October 20, 2004, p. A1.
- ⁴¹³ United Nations, “U.N. Warns About Nexus Between Drugs, Crime and Terrorism,” Press Release SOC/CP/311, October 1, 2004.
- ⁴¹⁴ Mr. Costa continued, “Organized crime continues to rely on billions of narco-dollars to fund a host of heinous enterprises – from child trafficking to prostitution to arms smuggling, and wholesale efforts to sabotage legal institutions and democratic governments across the world via invasive, systemic corruption.” United Nations, “UNODC and European Commission Agree Drugs, Crime Terrorism Inextricably Linked: Bilateral Solutions Needed to Combat New Threats,” Press Release, January 18, 2005.
- ⁴¹⁵ Rory Callinan, “Taliban back in business of drugs and terror,” *The Australian*, May 31, 2004, p. 11.
- ⁴¹⁶ Jose Maria Irujo, “La policía alerta sobre la financiación del terrorismo islamista con el tráfico de hachís (Police are on the alert to financing of Islamic terrorists by hashish traffickers),” *El Pais* (Spain), May 16, 2004, p. 22.
- ⁴¹⁷ “U.S. Drug Ring Tied to Aid for Hezbollah,” *The New York Times*, September 3, 2002, p. A16.
- ⁴¹⁸ Lucine Eusani and Alan Grostephan, “Poison Rain,” Resource Center of the Americas, November 2002, at http://www.americas.org/item_90.
- ⁴¹⁹ Joshua Davis, “The Mystery of the Coca Plant that Wouldn’t Die,” *Wired Magazine*, November 2004.
- ⁴²⁰ Federal Bureau of Investigation, *Crime in the United States 2003*, p. 270, Table 29.
- ⁴²¹ *Id.* at 269, Table 4.1.
- ⁴²² “A Survey of Illegal Drugs: Collateral Damage,” *The Economist*, July 28, 2001, special section, p. 13.
- ⁴²³ Substance Abuse and Mental Health Services Administration (2003), *National Survey on Drug Use and Health*, Washington: U.S. Department of Health and Human Services, p. 18.
- ⁴²⁴ U.S. Sentencing Commission (2002), *Sourcebook of Federal Sentencing Statistics*, Table 4.
- ⁴²⁵ “A Survey of Illegal Drugs: Collateral Damage,” *The Economist*, July 28, 2001, special section p.13.
- ⁴²⁶ Jerome Miller states, “Those who spend time in correctional facilities are compelled to adopt the values and violent tactics necessary to survive in these facilities. They then bring these antisocial survival tactics out to the streets.” Andrew A. Skolnic k, “‘Collateral Casualties’ Climb in Drug War,” *Journal of the American Medical Association*, June 1, 1994, pp. 1636, 1639.
- ⁴²⁷ Searches and arrests are routinely justified by courts if they occur in a “drug-prone neighborhood.” See, e.g., *People v. Jones*, New York Appellate Division, *New York Law Journal*, June 13, 1996. Police officers need only to see money changing hands in one of these neighborhoods, without specific evidence of a drug transaction, in order to make an arrest. James Ostrowski, “Drug Prohibition Muddles Along: How a Failure of Persuasion Has Left Us with a Failed Policy,” in Jefferson M. Fish, ed. (1998), *How to Legalize Drugs*, Northvale, NJ: Jason Aronson, Inc., pp.357-8.
- ⁴²⁸ Daniel Glaser, “Interlocking Dualities in Drug Use, Drug Control, and Crime” in James A. Inciardi and Carl D. Chambers, eds. (1974), *Drugs and the Criminal Justice System*, Beverly Hills: Sage, p. 50.
- ⁴²⁹ *Id.*
- ⁴³⁰ “A Survey of Illegal Drugs: Collateral Damage,” *The Economist*, July 28, 2001, special section, p. 12.
- ⁴³¹ 21 U.S.C. § 853 (1999).
- ⁴³² *Id.* § 853(f).
- ⁴³³ Sally Satel, “Doctors Behind Bars: Treating Pain Is Now Risky Business,” *The New York Times*, October 19, 2004, p. F6.
- ⁴³⁴ Office of National Drug Control Policy, *National Drug Control Strategy*, Washington, D.C.: Executive Office of the President, March 2004, p. 28.
- ⁴³⁵ Marc Kaufman, “DEA Withdraws its Support of Guidelines on Painkillers,” *The Washington Post*, October 21, 2004, p. A3.
- ⁴³⁶ Harry G. Levine and Craig Reinerman, “The Transition from Prohibition to Regulation: Lessons from Alcohol Policy for Drug Policy,” in Jefferson M. Fish, ed. (1998), *op. cit.*, p. 278.

⁴³⁷ *Id.* at 268.

⁴³⁸ Andrew A. Skolnick (1994), *op. cit.*, pp.1638-1639.

⁴³⁹ The Uniform Controlled Substances Act, drafted in 1970 by the National Conference of Commissioners on Uniform State Laws, was adopted by the state of Washington on May 21, 1971. 1st Ex. Sess., c. 308, Laws of 1971; codified in chapter 69.50 R.C.W.

⁴⁴⁰ Fifteen years ago, the first drug court was established in Florida, with the King County Drug Court becoming Washington's first in 1994. Arizona voters passed Proposition 2000 in 1996 and California voters passed Proposition 36 in 2000, requiring first and second time offenders arrested for simple possession to be given drug treatment instead of jail. At the law enforcement level, some communities have called on their law enforcement agencies to reallocated resources away from drug arrests and prosecution, most recently and dramatically involving the disbanding of a Texas regional drug task force in response to the Tulia scandal and the passage of Initiative 75 in Seattle in 2003.

⁴⁴¹ C. West Huddleston, III, Karen Freeman-Wilson and Donna L. Boone (2004), *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States*. Washington, D.C.: Bureau of Justice Assistance, U.S. Department of Justice, National Drug Court Institute, White House Office of Drug Control Policy; Michael Rempel, Dana Fox-Kralstein *et al.* (2003), *The New York State Adult Drug Court Evaluation: Policies, Participants and Impacts*, New York: Center for Court Innovation, p. 7; Jonathan E. Fielding, M.D. *et al.* (2002), "Los Angeles Drug Court Programs: Initial Results," *Journal of Substance Abuse Treatment*, v.23, pp. 217-224; Steven Belenko, (2001, 1999, 1998), "Research on Drug Courts: A Critical Review," *National Drug Court Inst. Rev.*, v.1, pp. 1-42; v.2(2), pp. 1-58; Reginald Fluellen (2000), "Do Drug Courts Save Jail and Prison Beds?" *Issues in Brief*, New York: Vera Institute of Justice; Steve Aos (1999), *Can Drug Courts Save Money for Washington State Taxpayers?*, Olympia, WA: Washington State Institute for Public Policy, January, 1999. The extent of drug courts' effectiveness is still open to debate, however. See Morris B. Hoffman (2002), "The Rehabilitative Ideal and the Drug Court Reality," *Federal Sentencing Reporter*, v.14, no.1, p. 172; and Douglas B. Marlowe, David S. Dematteo and David S. Festinger (2003), "A Sober Assessment of Drug Courts," *Federal Sentencing Reporter*, v.16, no.1, pp. 113-128. Even the data on drug courts collected by the Justice Department has been found to be inadequate for evaluating drug court effectiveness. U.S. General Accounting Office (2002), *Drug Courts: Better DOJ Data Collection and Evaluation Efforts Needed To Measure Impact of Drug Court Programs*, Washington, D.C.: Government Printing Office, GAO-02-434, April 2002, pp. 12-13.

⁴⁴² Retention and completion rates differ widely for court-supervised treatment programs around the United States because of the variety of eligibility and performance criteria. Some courts "cream" or "cherry pick" participants to ensure favorable outcomes, whereas others, such as King County's Drug Diversion Court, admit more socially-handicapped participants, risking some political unpopularity from relatively low "success" rates in the attempt to ameliorate public disorder and to assist hard-to-reach populations. Out of 3,071 defendants opting into King County's drug court program, only 622 participants have "graduated" and only 350 participants are currently active. See <http://www.metrokc.gov/kcscd/drugcourt/>.

⁴⁴³ C. West Huddleston, III, Karen Freeman-Wilson and Donna L. Boone (2004), *op. cit.*

⁴⁴⁴ California's Proposition 36, "The Substance Abuse and Crime Prevention Act of 2000," amended California Penal Code § 8.

⁴⁴⁵ Douglas Longshore, Ph.D., Darren Urada, Ph.D., Elizabeth Evans, M.A., Yih-Ing Hser, Ph.D., Michael Prendergast, Ph.D., Angela Hawken, Ph.D., Travis Bunch, and Susan Ettner, Ph.D., "Evaluation of the Substance Abuse and Crime Prevention Act: 2003 Report," prepared for the Department of Alcohol and Drug Programs, California Health and Human Services Agency, September 23, 2004.

⁴⁴⁶ The latest survey of U.S. drug courts is found in C. West Huddleston, III, Karen Freeman-Wilson and Donna L. Boone (2004), *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States*, National Drug Court Institute, Alexandria, VA. Robert J. MacCoun and Peter Reuter, *op. cit.*, p. 209.

⁴⁴⁷ Beth Kaiman, "Seattle voters favor measure on marijuana," *The Seattle Times*, September 17, 2003, p.A4.

⁴⁴⁸ Bob Young, "Marijuana measure called effective by supporters and foes," *The Seattle Times*, August 18, 2004, p. B1.

⁴⁴⁹ A list of links to all of the state liquor control boards can be found on the Bureau of Alcohol, Tobacco, Firearms and Explosives website at <http://www.atf.gov/alcohol/info/faq/subpages/lcb.htm>

⁴⁵⁰ Bureau of Alcohol, Tobacco, Firearms and Explosives, "Alcohol and Tobacco Diversion," ATFOnline, available at <http://www.atf.gov/antdiversion.htm>

⁴⁵¹ Ralph Blumenthal, "Can't Get a Drink in Texas? Try the Next County Over (Or Maybe Next Door)," *The New York Times*, October 1, 2003, p. A12.

⁴⁵² All information provided by Merritt Long, Chair, and Rick Garza, Deputy Administrative Director, Washington State Liquor Control Board, presentation to the King County Bar Association Legal Frameworks Group, February 11, 2003.

⁴⁵³ American Heart Association, *Federal Regulation Of Tobacco*, available at: <http://www.americanheart.org/presenter.jhtml?identifier=11223>.

⁴⁵⁴ Dan Morgan and Helen Dewar, "House Blocks FDA Oversight of Tobacco," *The Washington Post*, October 12, 2004, p. A4.

⁴⁵⁵ Carl Hulse, "Senate Approves Tobacco Buyout and New Curbs," *The New York Times*, July 16, 2004, p.A1.

⁴⁵⁶ RCW 69.41.

⁴⁵⁷ RCW 69.50.

⁴⁵⁸ Gina Kolata, "There's a Blurry Line Between Rx and O.T.C.," *The New York Times*, Dec. 21, 2003, p.A3.

⁴⁵⁹ Don Williams, Executive Director, Washington State Board of Pharmacy, "Introduction to Pharmacy & Licit Drug Regulation," presentation to King County Bar Association Legal Frameworks Group, March 27, 2003.

⁴⁶⁰ The King County Bar Association stated in 2001 that any state sanction or remedy related to drug use should be aimed at reducing the harm directly caused to others by persons using drugs, rather than criminally punish persons for drug use *per se*, and that civil remedies, supported by a court's contempt power, are already available to be imposed on persons who use drugs to the detriment of others. King County Bar Association (2001), *Is It Time to End the War on Drugs?*, Seattle, Washington, p. 24.

⁴⁶¹ RCW 70.96A.140(1): When a designated chemical dependency specialist receives information alleging that a person presents a likelihood of serious harm or is gravely disabled as a result of chemical dependency, the designated chemical dependency specialist, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of the information, may file a petition for commitment of such person with the superior court, district court, or in another court permitted by court rule.

⁴⁶² RCW 71.05.040: Persons who are developmentally disabled, impaired by chronic alcoholism or drug abuse ... shall not be detained for evaluation and treatment or judicially committed solely by reason of that condition unless such condition causes a person to be gravely disabled or as a result of a mental disorder such condition exists that constitutes a likelihood of serious harm: Provided however, That persons who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering from dementia and who otherwise meet the criteria for detention or judicial commitment are not ineligible for detention or commitment based on this condition alone... The legislative intent statement for RCW 71.05 (mental illness) would be a good starting point for reforming Washington's policy toward drug users:

The provisions of this chapter are intended by the legislature:

(1) To prevent inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment;

(2) To provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders;

(3) To safeguard individual rights;

(4) To provide continuity of care for persons with serious mental disorders;

(5) To encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures;

(6) To encourage, whenever appropriate, that services be provided within the community;

(7) To protect the public safety.

RCW 71.05.010.

⁴⁶³ RCW 26.09.191(3) (Restrictions in temporary or permanent parenting plans): A parent's involvement or conduct may have an adverse effect on the child's best interests, and the court may preclude or limit any provisions of the parenting plan, if any of the following factors exist: ... (c) A long-term impairment

resulting from drug, alcohol, or other substance abuse that interferes with the performance of parenting functions.

⁴⁶⁴ RCW 26.44.170(3) (abuse and neglect): If a determination is made under subsection (1) of this section that there is probable cause to believe abuse of alcohol or controlled substances has contributed to the child abuse or neglect, the department shall, within available funds, cause a comprehensive chemical dependency evaluation to be made of the person or persons so identified. The evaluation shall be conducted by a physician or persons certified under rules adopted by the department to make such evaluation. The department shall perform the duties assigned under this section within existing personnel resources.

⁴⁶⁵ RCW 13.34.174 (order of alcohol or substance abuse diagnostic investigation and evaluation, treatment plan, breach of plan, reports):

(1) The provisions of this section shall apply when a court orders a party to undergo an alcohol or substance abuse diagnostic investigation and evaluation.

(2) The facility conducting the investigation and evaluation shall make a written report to the court stating its findings and recommendations including family-based services or treatment when appropriate. If its findings and recommendations support treatment, it shall also recommend a treatment plan setting out:

- (a) Type of treatment;
- (b) Nature of treatment;
- (c) Length of treatment;
- (d) A treatment time schedule; and
- (e) Approximate cost of the treatment.

The affected person shall be included in developing the appropriate treatment plan. The treatment plan must be signed by the treatment provider and the affected person. The initial written progress report based on the treatment plan shall be sent to the appropriate persons six weeks after initiation of treatment. Subsequent progress reports shall be provided after three months, six months, twelve months, and thereafter every six months if treatment exceeds twelve months. Reports are to be filed with the court in a timely manner. Close-out of the treatment record must include summary of pretreatment and posttreatment, with final outcome and disposition. The report shall also include recommendations for ongoing stability and decrease in destructive behavior.

Each report shall also be filed with the court and a copy given to the person evaluated and the person's counsel. A copy of the treatment plan shall also be given to the department's caseworker and to the guardian ad litem. Any program for chemical dependency shall meet the program requirements contained in chapter 70.96A RCW.

(3) If the court has ordered treatment pursuant to a dependency proceeding it shall also require the treatment program to provide, in the reports required by subsection (2) of this section, status reports to the court, the department, the supervising child-placing agency if any, and the person or person's counsel regarding the person's cooperation with the treatment plan proposed and the person's progress in treatment.

(4) If a person subject to this section fails or neglects to carry out and fulfill any term or condition of the treatment plan, the program or agency administering the treatment shall report such breach to the court, the department, the guardian ad litem, the supervising child-placing agency if any, and the person or person's counsel, within twenty-four hours, together with its recommendation. These reports shall be made as a declaration by the person who is personally responsible for providing the treatment.

(5) Nothing in this chapter may be construed as allowing the court to require the department to pay for the cost of any alcohol or substance abuse evaluation or treatment program.

⁴⁶⁶ RCW 13.34.176 (violation of alcohol or substance abuse treatment conditions, hearing, notice, modification of order): (1) The court, upon receiving a report under RCW 13.34.174(4) or at the department's request, may schedule a show cause hearing to determine whether the person is in violation of the treatment conditions. All parties shall be given notice of the hearing. The court shall hold the hearing within ten days of the request for a hearing. At the hearing, testimony, declarations, reports, or other relevant information may be presented on the person's alleged failure to comply with the treatment plan and the person shall have the right to present similar information on his or her own behalf.

(2) If the court finds that there has been a violation of the treatment conditions it shall modify the dependency order, as necessary, to ensure the safety of the child. The modified order shall remain in effect until the party is in full compliance with the treatment requirements.

⁴⁶⁷ RCW 69.50.414 (tort action for sale or transfer of controlled substance to minor, cause of action by parent, damages): The parent or legal guardian of any minor to whom a controlled substance, as defined in

RCW 69.50.101, is sold or transferred, shall have a cause of action against the person who sold or transferred the controlled substance for all damages to the minor or his or her parent or legal guardian caused by such sale or transfer. Damages shall include: (a) Actual damages, including the cost for treatment or rehabilitation of the minor child's drug dependency, (b) forfeiture to the parent or legal guardian of the cash value of any proceeds received from such sale or transfer of a controlled substance, and (c) reasonable attorney fees.

⁴⁶⁸ If a court finds that “[A] marriage should not have been contracted because ... a party lacked capacity to consent to the marriage, either because of mental incapacity or because of the influence of alcohol or other incapacitating substances ... and that the parties have not ratified their marriage by voluntarily cohabiting ... after attaining capacity to consent, [the court] shall declare the marriage invalid as of the date it was purportedly contracted.” RCW 26.09.040(4)(b)(i).

⁴⁶⁹ ALASKA STAT. 09.65.205 (1997).

⁴⁷⁰ Contempt Power, RCW 7.21.030 (remedial sanctions, payment for losses): (1) The court may initiate a proceeding to impose a remedial sanction on its own motion or on the motion of a person aggrieved by a contempt of court in the proceeding to which the contempt is related. Except as provided in RCW 7.21.050 [contempt committed within the courtroom], the court, after notice and hearing, may impose a remedial sanction authorized by this chapter.

(2) If the court finds that the person has failed or refused to perform an act that is yet within the person's power to perform, the court may find the person in contempt of court and impose one or more of the following remedial sanctions:

(a) Imprisonment if the contempt of court is of a type defined in RCW 7.21.010(1)(b) through (d). [] The imprisonment may extend only so long as it serves a coercive purpose.

(b) A forfeiture not to exceed two thousand dollars for each day the contempt of court continues.

(c) An order designed to ensure compliance with a prior order of the court.

(d) Any other remedial sanction other than the sanctions specified in (a) through (c) of this subsection if the court expressly finds that those sanctions would be ineffectual to terminate a continuing contempt of court.

(e) In cases under chapters 13.32A [Family Reconciliation Act], 13.34 [dependency and termination of parent-child relationship], and 28A.225 RCW [compulsory school attendance and admission], commitment to juvenile detention for a period of time not to exceed seven days. This sanction may be imposed in addition to, or as an alternative to, any other remedial sanction authorized by this chapter. This remedy is specifically determined to be a remedial sanction.

(3) The court may, in addition to the remedial sanctions set forth in subsection (2) of this section, order a person found in contempt of court to pay a party for any losses suffered by the party as a result of the contempt and any costs incurred in connection with the contempt proceeding, including reasonable attorney's fees.

(4) If the court finds that a person under the age of eighteen years has willfully disobeyed the terms of an order issued under chapter 10.14 RCW [harassment], the court may find the person in contempt of court and may, as a sole sanction for such contempt, commit the person to juvenile detention for a period of time not to exceed seven days.

⁴⁷¹ Robert J. MacCoun and Peter Reuter (2001), *op. cit.*, p. 310.

⁴⁷² *Id.* at 311.

⁴⁷³ Steve Rolles and Danny Kushlick (2004), *After the War on Drugs: Options for Control*, London: Transform Drug Policy Foundation.

⁴⁷⁴ Alan Travis, “MPs back legalisation 'road map',” *The Guardian* (UK), October 13, 2004.

⁴⁷⁵ In the UK, the licensing and regulation of heroin is overseen by the Medicines and Healthcare products Regulatory Agency (MHRA) and the UK Licensing Authority. Rolles and Kushlick (2004), p. 17.

⁴⁷⁶ Mark Haden, M.S.W. “Illicit IV Drugs: A Public Health Approach,” *Canadian Journal of Public Health*, v.93, n.6, Nov./Dec. 2002.

⁴⁷⁷ Mark Haden, “Regulation of Illegal Drugs: An Exploration of Public Health Tools,” *The International Journal of Drug Policy*, v.15, 2004, pp. 225-230.

⁴⁷⁸ “A Survey of Illegal Drugs: Set It Free,” *The Economist*, July 28, 2001, special section p.16.

⁴⁷⁹ Krauss, Melvyn B. & Lazfar, Edward P. eds, *Searching for Alternatives: Drug-Control Policy in the United States*, Hoover Institution Press, 1991.

⁴⁸⁰ Brenner, Todd Austin. “The Legalization of Drugs: Why Prolong the Inevitable?” *Capital U Law Rev.* 18:237-255, 1989.

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- ⁴⁸¹ Taylor Branch, "Let Koop Do It: A Prescription for the Drug War." *The New Republic*, October 24, 1988, pp. 22-26.
- ⁴⁸² Richard B. Karel. "A Model Legalization Proposal," in James A. Inciardi, ed. (1991), *The Drug Legalization Debate*, SAGE Publications: Studies in Crime, Law and Justice v.7.
- ⁴⁸³ James A. Inciardi and Arnold S. Trebach (1993), *Legalize It? Debating American Drug Policy*, Washington, D.C.: American University Press, pp. 79-80.
- ⁴⁸⁴ Ethan Nadelmann (1992) "Thinking Seriously About Alternatives to Drug Prohibition," *Journal of the American Academy of Arts and Sciences*, v.121, no.3, p. 85..
- ⁴⁸⁵ For more information about such programs in other countries, see King County Bar Association (2005) "International Trends in Drug Policy," *Report of the Legal Frameworks Group to the King County Bar Association Board of Trustees*.
- ⁴⁸⁶ Substance Abuse and Mental Health Services Administration (2004), "Methadone-Associated Mortality: Report of a National Assessment," U.S. Department of Health and Human Services, Pub. No. 04-3904, p.19.
- ⁴⁸⁷ See King County Bar Association (2005) "International Trends in Drug Policy," *op. cit.*, pp. 22-26.
- ⁴⁸⁸ Senate Bill No. 4944, February 16, 1971, 1971-72 session; Senate No. 3980, Assembly No. 6025, March 15, 1979, 1979-80 session.
- ⁴⁸⁹ S. 1918, 1989-90 Regular Session of the New York Senate.
- ⁴⁹⁰ House No. 1737, 1981 Session.
- ⁴⁹¹ Richard M. Evans, Esq., *Report of the National Task Force on Cannabis Regulation*, December 1982.
- ⁴⁹² Oregon State Senate, Bill No. 497, 1983 regular session.
- ⁴⁹³ Commonwealth of Pennsylvania, The Pennsylvania Marijuana Cultivation Control Act of 1983, introduced by Sen. T. Milton Street.
- ⁴⁹⁴ State of Missouri, House Bill No. 1820, 85th General Assembly, introduced by Rep. Elbert Walton.
- ⁴⁹⁵ Initiative Measure 595 (1993, Section 10(1)), State of Washington.
- ⁴⁹⁶ Initiative Measure 595 (1993, Section 21), State of Washington.
- ⁴⁹⁷ The Oregon Drugs Control Amendment, Section 1 (1997).
- ⁴⁹⁸ *Id.*, Section 6.
- ⁴⁹⁹ *Id.*, Section 3.
- ⁵⁰⁰ Oregon Cannabis Tax Act, Section 474.055.
- ⁵⁰¹ *Id.*, Section 474.075(3).
- ⁵⁰² *Id.*, Section 474.055(d).
- ⁵⁰³ *Id.*, Section 474.315.

PART IV

STATES' RIGHTS: TOWARD A FEDERALIST DRUG POLICY

- ⁵⁰⁴ James Dao (2005), "Rebellion of the States: Red, Blue and Angry All Over," *The New York Times*, January 16, 2005, p. WK1.
- ⁵⁰⁵ Paul von Zielbauer (2003), "The American Agenda for Fighting Crime: More Prison Time ... and Less," *The New York Times*, September 28, 2003, p. 25. Despite federal concerns over violent and dangerous criminals, a careful look at the federal prison population shows that it is comprised mostly of non-violent offenders, as murderers and sex offenders account for only five percent and major drug traffickers make up only one percent of all federal prisoners. *Id.*
- ⁵⁰⁶ The Western Governors Association asserted in 2000 that "states, rather than the federal government, are in a better position to understand the substance abuse problem confronting them. The federal government needs to work closely with the states to provide the resources necessary to meet the individual and unique needs of each state rather than approaching the issue in a one-size-fits-all manner." Western Governors' Association (2000), *Drug Policy in the West*, Governors' Policy Statement, Denver, Colorado, p. 2. In the last few years a number of states have enacted reforms providing for mandatory drug treatment in lieu of incarceration, including Arizona, California and Hawaii, and other states, including Washington, Michigan, Kansas, Delaware, Maryland and Pennsylvania, have amended their criminal codes to reduce

sentences for drug crimes, to allow for greater judicial discretion in drug cases and to express the preference for treatment in lieu of incarceration.

⁵⁰⁷ See King County Bar Association (2005) “Controlling Psychoactive Substances: The Current System and Alternative Models,” *Legal Frameworks Group Report to the King County Bar Association Board of Trustees*, pp. 13-14, surveying research showing drug courts’ effectiveness.

⁵⁰⁸ “The powers not delegated to the United States by the Constitution, nor prohibited to it by the States, are reserved to the States respectively, or to the people.” U.S. CONST. amend. X.

⁵⁰⁹ *Alden v. Maine*, 527 U.S. 706, 759 (1999). In 1788 James Madison stated in *The Federalist* No. 45: “The powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite.” Edward Mead Earle, intro. (1937), *The Federalist*, New York: Random House, p. 303.

⁵¹⁰ *New York v. United States*, 505 U.S. 144, 155 (1992).

⁵¹¹ *Peden v. City of Seattle*, 510 P.2d 1169, 9 Wash.App. 106, review denied 82 Wash.2d 1010 (1973).

⁵¹² *Engle v. Issac*, 456 U.S. 107, 128 (1982); *Screws v. United States*, 325 U.S. 91, 109 (1945).

⁵¹³ “No state may...excuse its failure to perform a public duty.” *Champion v. Ames*, 188 U.S. 321 (1903), citing *Stone v. Mississippi*, 101 U.S. 874 (1879). Even if a state wanted to allow Congress to exceed its constitutional authority, it could not do so: “State officials cannot consent to the enlargement of the powers of Congress beyond those enumerated in the Constitution.” *New York v. United States*, supra, at 168-69 (1992).

⁵¹⁴ See, e.g., *Hammer v. Dagenhart*, 247 U.S. 251 (1918); and *United States v. E.C. Knight Co.*, 156 U.S. 1 (1895).

⁵¹⁵ See, e.g., *United States v. Morrison*, 529 U.S. 598 (2000); *Printz v. United States*, 521 U.S. 898 (1997); and *United States v. Lopez*, 514 U.S. 549 (1995). It is important to note, however, that the Rehnquist Court has invoked the Tenth Amendment to limit the reach of federal criminal law under the Commerce Clause, upon which current federal drug laws principally rely for their legitimacy. See Linda Greenhouse (2003), “For a Supreme Court Graybeard, States’ Rights Can Do No Wrong,” *The New York Times*, March 16, 2003, p.WK5.

⁵¹⁶ *Champion v. Ames*, 188 U.S. 321 (1903); *Hoke v. United States*, 277 U.S. 308 (1913). In *Hamilton v. Kentucky Distilleries Co.*, 251 U.S. 146 (1919), the Court stated: “That the United States lacks the police power, and that this is reserved to the States by the Tenth Amendment, is true. But it is nonetheless true that when the...United States exerts any of the powers conferred on it by the Constitution, no valid objection can be based upon the fact that such exercise may be attended by the same incidents which attend the exercise by a State of its police power.” at 151.

⁵¹⁷ U.S. CONST. Art. I, sec. 8[3]

⁵¹⁸ *Gibbons v. Ogden*, 22 U.S. 1 (1824), firmly established Congress’ broad power to regulate interstate commerce but such commerce was not deemed to include business activities solely within any state. See, e.g., *Paul v. Virginia*, 8 Wall. 180 (1869); and *Kidd v. Pearson*, 128 U.S. 1 (1888).

⁵¹⁹ *Interstate Commerce Commission v. Atchison Topeka & Santa Fe Railroad Co.*, 234 U.S. 294 (1914).

⁵²⁰ *Stafford v. Wallace*, 258 U.S. 495 (1922), relying on *Swift v. United States*, 196 U.S. 375 (1905).

⁵²¹ See, e.g., *National Labor Relations Board v. Jones & Laughlin Steel*, 301 U.S. 1 (1937), recognizing federal commerce power over local manufacturing; and *United States v. Darby*, 312 U.S. 100 (1941), justifying any reasonable means to achieve federal ends. Even before the 1930s, the U.S. Supreme Court upheld federal powers in areas that had traditionally been seen as states’ responsibilities. See, e.g., *Hamilton v. Kentucky Distilleries Co.*, 251 U.S. 146 (1919).

⁵²² *Wickard v. Filburn*, 317 U.S. 111 (1942); *Perez v. United States*, 402 U.S. 146 (1970).

⁵²³ *Heart of Atlanta Motel v. United States*, 379 U.S. 241 (1964); *Katzenbach v. McClung*, 379 U.S. 294 (1964); *Daniel v. Paul* (lake club snack bar) (1969).

⁵²⁴ Congress may regulate: (1) the channels of commerce; (2) the instrumentalities of commerce; and (3) those activities that substantially affect interstate commerce. *U.S. v. Lopez*, 514 U.S. 549, 556-557 (1995).

⁵²⁵ David G. Savage (2004), “Finite Federalism,” *American Bar Association Journal*, July 2004, p. 22

⁵²⁶ *Reid v. Colorado*, 187 U.S. 137, 23 S.Ct. 92 (1902); and *Champion v. Ames*, 188 U.S. 321 (1903). The *Champion* case also held, however, that “interstate commerce does not comprehend activities that take place entirely within a state’s borders.” at 346.

⁵²⁷ *Gibbons v. Ogden*, supra, 9 Wheat, 1, 196; see also *Reid v. Colorado*, 187 U.S. 137, 23 S.Ct. 92 (1902); *United States v. Delaware & Hudson Co.*, 213 U.S. 366 (1909); *James Clark Distilling Co. v. Western*

Maryland Railroad Co., 242 U.S. 311 (1917); *United States v. Hill*, 248 U.S. 420, 39 S.Ct. 143 (1919); and *McCormick & Co., Inc. v. Brown*, 286 U.S. 131, 52 S.Ct. 522, 87 A.L.R. 448 (1932).

⁵²⁸ See King County Bar Association (2005), "Drugs and the Drug Laws: Historical and Cultural Contexts," *Report of the Legal Frameworks Group to the KCBA Board of Trustees*, discussion of the strengthening of federal authority over drug control through judicial interpretation of the Harrison Act of 1914, pp. 19-21.

⁵²⁹ Daniel K. Benjamin & Roger Leroy Miller (1991) *Undoing Drugs: Beyond Legalization*, New York: Basic Books, p. 266.

⁵³⁰ Richard J. Bonnie & Charles H. Whitebread II (1974), *The Marijuana Conviction*, Charlottesville: University Press of Virginia, p. 61.

⁵³¹ King County Bar Association (2005), "Drugs and the Drug Laws: Historical and Cultural Contexts," *op. cit.*, pp. 22-26.

⁵³² Pub.L. 91-513, October 27, 1970, 84 Stat. 1236.

⁵³³ 21 U.S.C. §§ 801(2)-(6).

⁵³⁴ The Uniform Controlled Substances Act, drafted in 1970 by the National Conference of Commissioners on Uniform State Laws, was adopted by the state of Washington on May 21, 1971. 1st Ex. Sess., c. 308, Laws of 1971; codified in chapter 69.50 R.C.W.

⁵³⁵ See, e.g., *Nichols v. Board of Pharmacy*, 61 Or. App. 274, 657 P.2d 216 (1983), Sup.Ct. *review denied*.

⁵³⁶ Pub. L. 91-513, title II, s 708, Oct. 27, 1970, 84 Stat. 1284 (emphasis added), cited in Daniel K. Benjamin & Roger Leroy Miller (1991), *op. cit.*, p. 264.

⁵³⁷ Docket No. 03-1454, appealed from Ninth Circuit Court of Appeals (Dec. 16, 2003).

⁵³⁸ Linda Greenhouse (2004), "States' Rights Defense Falters in Medical Marijuana Case," *The New York Times*, November 30, 2004, p. A18.

⁵³⁹ The consolidated wine cases are *Granholt v. Heald*, Docket No. 03-1116, appealed from Sixth Circuit Court of Appeals (Aug. 28, 2003) and *Swedenburg v. Kelly*, Docket No. 03-1274, appealed from the Second Circuit Court of Appeals (Feb. 12, 2004). Winemakers are banned in about 24 states from directly shipping their products to consumers. Meanwhile, other states allow online and telephone sales of wine that consumers cannot find in their home states, for shipments to their home address.

⁵⁴⁰ See, e.g., *Beskind v. Easley*, 325 F.3d 506 (4th Cir.2003) and *Bainbridge v. Turner*, 311 F.3d 1104 (11th Cir.2002), each finding discrimination against interstate commerce that could not be "saved" by the 21st Amendment; and *Bridenbaugh v. Freeman-Wilson*, 227 F.3d 848 (7th Cir.2000), validating state power under the 21st Amendment because the state is empowered "to control alcohol in ways that it cannot control cheese." at 851.

⁵⁴¹ See Linda Greenhouse (2004), "Justices Question Ban on Wine Sales From Out of State," *The New York Times*, December 8, 2004, p. 1.

⁵⁴² See note 69, *infra*.

⁵⁴³ *Willson v. Blackbird Creek Marsh Co.* (1829), *supra*; *Baldwin v. G. A. F. Seelig, Inc.*, 294 U.S. 511 (1935).

⁵⁴⁴ *Champion v. Ames*, 188 U.S. 321, *supra*.

⁵⁴⁵ *Cooley v. Board of Wardens of Port of Philadelphia*, 52 U.S. 299 (1851).

⁵⁴⁶ *United States v. Morrison*, 529 U.S. 598, *supra*, at 614, 617-618; see also *United States v. Lopez*, 514 U.S. 549, *supra*.

⁵⁴⁷ See John C. Haaga & Peter Reuter (1990), "The Limits of the Czar's Ukase: Drug Policy at the Local Level," 8 *YALE L. & POL'Y REV.* 36.

⁵⁴⁸ *Pike v. Bruce Church, Inc.*, 397 U.S. 137 (1970).

⁵⁴⁹ *Maine v. Taylor*, 477 U.S. 131 (1986).

⁵⁵⁰ The tests in the context of the Dormant Commerce Clause allow certain state and local laws to be found unduly burdensome on interstate commerce even if Congress has not legislated in the area. First articulated by Justice Marshall in *Willson v. Blackbird Creek Marsh Co.*, 27 U.S. 245 (1829).

⁵⁵¹ See, e.g. James Madison (1788), "The Federalist No. 46: An Examination of the Comparative Means of Influence of the Federal and State Governments," in *The Federalist*, Edward Mead Earle, intro. (1937), *op. cit.*, pp. 304-312. Early congressional debate also reflected concern over the specter of a centralized federal government: "Interference with the power of the States is no constitutional criterion of the power of Congress. If the power was not given, Congress may not exercise it; if given, they might exercise it, although it should interfere with the laws, or even the Constitutions of the States." 5 *Annals of Congress* 1897 (1791).

⁵⁵² Where the term “states’ rights” has commonly conjured up associations with reactionary and racist positions of the past, many current attempts to revive federalist doctrine involve politically “liberal” states departing from social policies established by a “conservative” federal government. See, e.g., Ernest A Young (2004), “Marijuana and Federalism: Let Homegrowers Be,” *National Law Journal*, December 13, 2004, p. 23; and Jim Holt (2004), “A States’ Rights Left?,” *The New York Times Magazine*, November 21, 2004, p. 27

⁵⁵³ *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (dissenting).

⁵⁵⁴ Despite his acknowledgment of the need for a healthy federal balance of power, Justice Stevens offered his statement as part of his concurring opinion in *U.S. v. Oakland Cannabis Buyers’ Coop*, 532 U.S. 483, 495 (2001), in which the Court upheld a federal injunction against a cooperative organization permitted under California law to distribute marijuana to medically certified patients.

⁵⁵⁵ Lynn Baker (2002), “Should Liberals Fear Federalism?” 2001 William Howard Taft Lecture on Constitutional Law, 70 *U. CINN. L. REV.* 433.

⁵⁵⁶ *Id.*

⁵⁵⁷ See David Osborne (1990), *Laboratories of Democracy*, Cambridge: Harvard Business School Press. Beyond merely allowing states more latitude in drug policy, “it might be feasible for different jurisdictions to set up some natural experiments by adopting different specific regulations within a broad pattern of liberalization. In that way, we could soon anticipate quasi-scientific evaluation of the outcomes, valuable information that could eventually serve as substantive data for making more confident choices among alternatives in terms of public health and social welfare, as well as efficiency and efficacy.” Dwight B. Heath (1992), “U.S. Drug Control Policy: A Cultural Perspective,” in *Political Pharmacology: Thinking About Drugs*, Cambridge, MA: Proceedings of the American Academy of Arts and Sciences, v.121, no.3, p. 288.

⁵⁵⁸ See Erich Goode (2005), *Drugs in American Society*, 6th ed., New York: McGraw-Hill, Ch. 4.

⁵⁵⁹ See Editors (2003), “Steamroller Ashcroft,” *The Economist*, May 3, 2003.

⁵⁶⁰ Alexander Hamilton (1788), “The Federalist No. 17,” in *The Federalist*, Edward Mead Earle, intro. (1937), *op. cit.*, p. 103.

⁵⁶¹ David Marion, Director of the Wilson Center for Leadership in the Public Interest at Hampden-Sydney College, argues, “A persuasive ‘quality of life’ argument can be made for reserving a major role for the states in our constitutional system. Leaving important responsibilities with the states provides the American people with many opportunities to become ‘big fish in little ponds.’ In addition to promoting good civic virtues, decentralized decision-making improves the likelihood governmental decisions will address the real (not just perceived) needs of the people. David Marion, (2005), “Body and Soul of Federalism,” *Washington Times*, January 16, 2005.

⁵⁶² Pub. L. 91-513, title II, s 708, Oct. 27, 1970, 84 Stat. 1284, section fully cited, *supra*, at p. 7.

⁵⁶³ Daniel K. Benjamin & Roger Leroy Miller (1991), *op. cit.*, p. 266.

⁵⁶⁴ David W. Rasmussen & Bruce L. Benson (2003), “Rationalizing Drug Policy Under Federalism,” 30 *FLA. ST. U. L. REV.* 728-29.

⁵⁶⁵ *Id.* at pp. 730-32.

⁵⁶⁶ Daniel K. Benjamin & Roger Leroy Miller (1991), *op. cit.*, p. 265. See *State v. Lee*, 382 P.Ed. 491, 62 Wash.2d 228 (1963); and *City of Seattle v. Ross*, 344 P.2d 216, 54 Wash.2d 655 (1959).

⁵⁶⁷ By 1927, after a little more than seven years of alcohol prohibition, only eighteen U.S. states were still funding their share of the enforcement of the Volstead Act and the Eighteenth Amendment. David L. Teasley (1992), “Drug Legalization and the ‘lessons’ of Prohibition,” *Contemporary Drug Problems*, Spring 1992, p. 34, citing the historian J.C. Burnham.

⁵⁶⁸ *New York v. United States*, 505 U.S. 144, 166 (1992). Where Congress has authority under the U.S. Constitution to pass laws requiring or prohibiting certain acts, it lacks the power directly to compel the states to require or prohibit those acts. *Reno v. Condon*, 528 U.S. 141, 149 (2000).

⁵⁶⁹ *Printz v. United States*, 521 U.S. 98 (1997).

⁵⁷⁰ In *Oregon v. Ashcroft*, 192 F.Supp.2d 1077 (D.Or. 2002), the Ninth Circuit enjoined the U.S. Justice Department from attempting to use the Controlled Substances Act to halt the implementation of Oregon’s “Death with Dignity Act.” The U.S. Supreme Court granted a writ of *certiorari* on February 22, 2005 on the federal challenge to the lower court decision and will hear arguments in *Gonzales v. Oregon*, No. 04-623, in the upcoming term.

⁵⁷¹ See Prefatory Note to the Uniform Controlled Substances Act (1970), U.L.A. vol. 9, part IV, p. 645.

⁵⁷² The Association of American Physicians and Surgeons' counsel stated: "The war on drugs has turned into a war on doctors ... and the suffering patients who need to drugs to attempt anything approaching a normal life Physicians are being threatened, de-licensed and imprisoned for prescribing in good faith with the intention of relieving pain." quoted in Joe Cantlupe and David Hasemyer (2004), "Painful remedy? Patients, advocates and government spar over tighter controls on painkillers," *San Diego Union-Tribune*, September 28, 2004.

⁵⁷³ The concept of states' authority over medical practice, articulated in *Linder v. U.S.*, 268 U.S. 5, 18 (1925), which limited federal power under the Harrison Narcotic Act of 1914, is still a valid legal principle.

⁵⁷⁴ *Whalen v. Roe*, 429 U.S. 589 (1977); *See also Maryland v. Wirtz*, 392 U.S. 183, 193. (1968).

⁵⁷⁵ *See* summary of drug prescription programs in King County Bar Association (2005), "International Trends in Drug Policy: Lessons Learned from Abroad," *Report of the Legal Frameworks Group to the King County Bar Association Board of Trustees*, pp. 22-26.

⁵⁷⁶ *Reeves v. William Stake*, 447 U.S. 429 (1980); and *South-Central Timber v. Alaska*, 467 U.S. 82 (1984). Even if a state acts as a "market participant," the federal government may still directly regulate state activity, burdening the state not as a sovereign power but only in its "enterprise" capacity. *See Brown v. Environmental Protection Agency*, 566 F.2d 665, 672 (9th Cir. 1977).

⁵⁷⁷ The "market participant" exception to federal commerce power is only applicable in the context of the "Dormant Commerce Clause," when Congress has left a vacuum in the law and states attempt to fill it. In the instant case, Congress has arguably left a vacuum in the law by failing to regulate the many aspects of production and distribution of the psychoactive substances it has prohibited. Alternatively, where Congress has practically occupied the field of psychoactive drug control through its policy of prohibition, the "market participant" exception might not apply. It is instructive to acknowledge this exception, however, to help guide state efforts to exercise their police powers in the effort to address their drug abuse problems.

⁵⁷⁸ U.S. CONST. Art. I, sec. 8[3].

⁵⁷⁹ *See, e.g., South Dakota v. Dole*, 483 U.S. 203 (1987). The spending power may be used when only a national power "can serve the interests of all," however. *Helvering v. Davis*, 301 U.S. 619 (1937).

⁵⁸⁰ The implied foreign affairs power exclusive to the federal government is founded on the "necessary and proper" clause of Article 1, Section 8 of the Constitution, a phrase that "has been construed as permitting any measures which are 'appropriate,' not merely those which are essential or indispensable." Daniel K. Benjamin and Roger Leroy Miller (1991), *op. cit.*, p. 285, n. 17.

⁵⁸¹ *See* King County Bar Association (2005) "Drugs and the Drug Laws: Historical and Cultural Contexts," *op. cit.*, pp. 18-20.

⁵⁸² U.N. ECON. & SOC. COUNCIL, SINGLE CONVENTION ON NARCOTIC DRUGS, 1961, U.N. Doc. UNE/CN.7/GP/1, U.N. Sales No. 62.XI.1 (1961); U.N. ECON. & SOC. COUNCIL, CONVENTION ON PSYCHOTROPIC SUBSTANCES, 1971, U.N. Sales No. E.78.XI.3 (1977); and U.N., CONVENTION AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES, 1988 (1988).

⁵⁸³ *Missouri v. Holland*, 252 U.S. 416 (1920).

⁵⁸⁴ *Reid v. Covert*, 354 U.S. 1 (1957).

⁵⁸⁵ David W. Rasmussen & Bruce L. Benson (2003), *op. cit.*, p. 727.

PART V

PARAMETERS OF A NEW LEGAL FRAMEWORK FOR PSYCHOACTIVE SUBSTANCE CONTROL

⁵⁸⁶ *See* King County Bar Association (2001), *Is It Time To End the War on Drugs?*, Seattle: King County Bar Association, pp. 59-70; *See also* King County Bar Association (2005) "Drugs and the Drug Laws: Historical and Cultural Contexts," *Legal Frameworks Group Report to the King County Bar Association Board of Trustees*, Seattle: King County Bar Association, p. 32.

⁵⁸⁷ King County Bar Association (2001), *op. cit.*, p. 15.

⁵⁸⁸ *See* King County Bar Association (2005), *Resolution on State Regulation and Control of Psychoactive Substances*, adopted by the King County Bar Association Board of Trustees on January 19, 2005.

⁵⁸⁹ See review of recent data from European drug prescription programs in King County Bar Association (2005), "International Trends in Drug Policy: Lessons Learned from Abroad," *Report of the Legal Frameworks Group to the King County Bar Association Board of Trustees*, pp. 22-26.

⁵⁹⁰ See North American Opiate Medication Initiative, *Project Backgrounder*, August 24, 2004.

⁵⁹¹ Most high school students report that illegal drugs are "easy to obtain," including "hard" drugs such as heroin and crack cocaine, and more high school students now use marijuana than tobacco. Lloyd D. Johnston *et al.* (2003), *Monitoring the Future National Survey Results on Drug Use, 1975-2002*, NIH Publication No. 03-5375, Bethesda: National Institute on Drug Abuse, v. I, table 13.

⁵⁹² See Mark Haden (2004), "Regulation of Illegal Drugs: An Exploration of Public Health Tools." *The International Journal of Drug Policy*, v.15, pp. 225-230.

⁵⁹³ R. Andrew Chambers, M.D., Jane M. Taylor, Ph.D, and Marc N. Potenza, M.D., Ph.D. (2003), "Developmental Neurocircuitry of Motivation in Adolescence: A Critical Period of Addiction Vulnerability," *American Journal of Psychiatry*, June 2003. Neuroscientists have documented different kinds of development in the adolescent brain, including: a small surge in brain cell development in the hippocampus and amygdala around the time of puberty, after which no new brain cells are formed; the progressive sheathing of neurons, or "myelination," which occurs throughout adolescence to about age 25 and is thought to be associated with speed and efficiency of nerve cell transmissions; and a synaptic "pruning" and reformation throughout childhood, into adolescence and into adult life. The myelination of neurons appears to correlate with improved judgment in emotionally tense situations. The novelty seeking, "throwing judgment to the wind" nature of adolescent behavior clearly correlates with incomplete myelination of the frontal lobe neurons, although it is important not to presume that alcohol, cannabis or other drugs retard the myelination process or negatively affect brain development in a direct way. See, e.g., Ronald E. Dahl, M.D. and Linda Patia Spear, M.D. (2004), *Adolescent Brain Development: Vulnerabilities and Opportunities*, New York Academy of Sciences; powerpoint presentation available at <http://www.wccf.org/pdf/dahl.pdf>.

⁵⁹⁴ A number of recent teenage suicides have been associated with the use of prescribed anti-depressant medications, giving rise to significant concerns in the medical community and within regulatory agencies about the safety of using such drugs to treat childhood depression. See Erica Goode, "Stronger Warning Is Urged on Antidepressants for Teenagers," *New York Times*, February 3, 2004, p. A12; Erica Goode, "British Warning on Antidepressant Use for Youth," *New York Times*, December 11, 2003, p. A1; Erica Goode, "Leading Drugs for Psychosis Come Under New Scrutiny," *New York Times*, May 20, 2003, p. A1.

⁵⁹⁵ Although no cause-effect relationship can be established, the heightened risks associated with early drug use by children is well documented, revealing that early initiation of alcohol, tobacco and marijuana is linked with low academic achievement and school dropout, early pregnancy and parenthood, stealing and other delinquent behavior and the use of predatory and domestic violence. See, e.g., Nels Ericson, *Substance Abuse: The Nation's Number One Health Problem*, U.S. Department of Justice, Washington, D.C. (2001); Bridget Grant and Deborah Dawson, "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence," *Journal of Substance Abuse*, 9 (1997); Phyllis Ellickson *et al.*, "Does Early Use Increase the Risk of Dropping Out of High School?" in *Journal of Drug Issues*, v. 28, no.2 (1998).

⁵⁹⁶ Defining "young persons" in this context and determining the appropriate age limits for prohibiting the possession and use of psychoactive drugs requires the consideration of a number of factors. For example, the brains of children and teenagers between the ages of eleven and about seventeen or eighteen are undergoing striking changes in many areas, including the frontal cortex, the hippocampus, the corpus callosum and Wernicke's area. See, e.g., Paul M. Thompson *et al.* (2000), *Nature*, v.404, pp. 90-3; J.N. Giedd *et al.* (1999), *Nature Neurosciences*, v.2, n.10, pp. 861-3; and F.M. Benes *et al.* (1994), *Archives of General Psychiatry*, 51, June 1994. These changes in the brain are associated with changes in emotional reactions, risk-taking and judgment, especially with the extensive reshaping of the frontal cortex. See, e.g., Scott D. Lane & Don R. Cherek (2001), *Experimental and Clinical Psychopharmacology*, v.9, n.1, pp. 74-82; Linda Patia Spear (2000), *Current Directions in Psychological Science*, v.9, n.4; Abigail A. Baird *et al.* (1999), *Journal of the American Academy of Child and Adolescent Psychiatry*, v.38, n.2, pp. 3195-9; and J.N. Giedd *et al.*, *op cit.*

⁵⁹⁷ Conversely, some existing regulatory models should be reviewed in light of the King County Bar Association's core principle that the state's sanction or response to drug use should result in less harm than the use of the drug itself. For example, eighteen-year-olds are legally permitted to use tobacco products, despite the overwhelming evidence that tobacco is more addictive and potentially physically harmful to the user than alcohol (although less intoxicating with each use). This policy reflects the perception that alcohol

use has a greater impact on public safety than tobacco. However, there are a number of currently prohibited drugs, for which the mere possession and use is criminally punished, that may have a similarly lesser impact on public safety than alcohol, and even less of an impact on personal health than tobacco.

⁵⁹⁸ See, e.g., the report of the Bar Association of the City of New York (1994), "A Wiser Course: Ending Drug Prohibition," *The Record*, vol. 49, no. 5.; and the Joint Committee of the American Bar Association and the American Medical Association on Narcotic Drugs (1961), *Drug Addiction: Crime or Disease?*, Interim and Final Reports, University of Indiana Press, Bloomington, IN.

⁵⁹⁹ John M. Walsh (2004), *Are We There Yet? Measuring Progress in the U.S. War on Drugs in Latin America*, Washington, D.C.: Washington Office on Latin America, p. 5, citing National Survey on Drug Use and Health, 2003

⁶⁰⁰ One of the nation's premier remedial programs for youth is the Reclaiming Futures project, supported by the Robert Wood Johnson Foundation, which is a new approach to helping teenagers caught in the cycle of drugs, alcohol and crime. The Reclaiming Futures project, which has invested heavily in the Seattle - King County area, embraces the notion of "wrap-around," bringing communities together to improve drug and alcohol treatment, to expand and coordinate services and to find jobs and volunteer work for young people in trouble with the law. See <http://www.reclaimingfutures.org/index.asp>.

⁶⁰¹ Recent studies show conclusively that "get tough" programs for youths do not prevent criminal behavior and may even exacerbate such problems, including the DARE program. See National Institute of Health, *Preventing Violence and Related Health-Risking Social Behaviors in Adolescents*, National Institute of Health State-of-the-Science Conference, October 13-15, 2004, Bethesda, Maryland; transcripts posted at <http://consensus.nih.gov/ta/023/preventviolenceintro.html>

⁶⁰² Ryoko Yamaguchi, Lloyd D. Johnston and Patrick M. O'Malley (2003), "Relationship Between Student Illicit Drug use and School Testing Policies," *Journal of School Health*, v.73, no.4, pp. 159-164.

⁶⁰³ See RCW 66.44.270.

⁶⁰⁴ Maria Carmona and Kathryn Stewart (1996), *A Review of Alternative Activities and Alternatives Programs in Youth-Oriented Prevention*, National Center for the Advancement of Prevention, Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention, p. 5.

⁶⁰⁵ See, e.g., Donald R. Lynam, Richard Milich, et al. (1999), "Project DARE: No Effects at 10-Year Follow-Up", *Journal of Consulting and Clinical Psychology*, American Psychological Assoc., v. 67, n. 4, pp. 590-93; Dennis Rosenbaum (1998), *Assessing the Effects of School-based Drug Education: A Six Year Multilevel analysis of Project DARE*, Abstract (April 6, 1998).

⁶⁰⁶ Jay P. Green, Ph.D, and Greg Forster, Ph.D (2004), *Sex, Drugs, and Delinquency in Urban and Suburban Public Schools*, New York: Manhattan Institute for Policy Research.

⁶⁰⁷ Nancy S. Tobler, Michael R. Roona et al. (2000), "School-Based Adolescent Drug Prevention Programs: 1998 Meta-Analysis," *Journal of Primary Prevention*, v.20, n.4.

⁶⁰⁸ Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Dep't of Health and Human Services (1999), *Risk and Protective Factors for Adolescent Drug Use: Findings from the 1997 National Household Survey on Drug Abuse*; See also, Carmona and Stewart, *supra*, at pp. 5, 21.

⁶⁰⁹ The Prevention Working Group of the King County Bar Association Drug Policy Project is examining ways to implement more effective prevention methods in Washington's schools and communities.

⁶¹⁰ See, e.g., Mark Thornton (1991), *The Economics of Prohibition*, University of Utah Press, 1991.

⁶¹¹ Robert J. MacCoun and Peter Reuter (2001), *Drug War Heresies*, Cambridge University Press, pp.240-1.

⁶¹² Kaiser Family Foundation (2004), *The Role of Media in Childhood Obesity*, report, February 2004.

⁶¹³ Henry Saffer (1997), "Alcohol advertising and motor vehicle fatalities," *The Review of Economics and Statistics*, 79 (3):431-442, August 1997.

⁶¹⁴ Robert Pear, "Investigators Find Repeated Deception in Ads for Drugs," *The New York Times*, December 4, 2002, p. A22.

⁶¹⁵ A study from the General Accounting Office found that some drug companies have been repeatedly using deceptive advertising by disseminating misleading information, even after being cited for repeated violations. The same study concluded that drug advertising does appear to have an effect on the increased use of prescriptions, as well as higher drug spending, as an estimated 8.5 million people per year request a certain drug after seeing an advertisement for it. Stuart Elliott and Nat Ives, "Selling Prescription Drugs to the Consumer," *The New York Times*, October 12, 2004, p. C1. For example, Nexium is one of the nation's best-selling drugs, with 2003 sales in the United States of \$3.1 billion, even though many experts say that

over-the-counter heartburn remedies such as Prilosec, made by the same company as Nexium, work just as well for most patients. The GAO report blames the prevalence of misleading commercials on delays in the enforcement of federal standards of accuracy in advertising, citing a change in procedure put in place by the Bush administration that lengthens the review process. Often the ads have finished their broadcast cycle before the agency has a chance to reprimand the drug manufacturer. In many cases the companies are overstating the effectiveness or minimizing the risks of medications. Robert Pear (2002), *op. cit.*

⁶¹⁶ Eduardo Porter. "Do New Drugs Always Have to Cost So Much?" *The New York Times*, Nov.14, 2004, p.C5.

⁶¹⁷ Janet Maslin, "Indicting the Drug Industry's Practices," *The New York Times*, September 6, 2004, p. B7.

⁶¹⁸ Robert MacCoun and Peter Reuter (2001), *op. cit.*, pp.7, 176-9.

⁶¹⁹ After New Hampshire started the lottery trend in 1963, lotteries have spread to 38 states. Craig Lambert, "Trafficking in Chance," *Harvard Magazine*, July-August, 2002, p. 34. Thirty states now allow or plan to allow gambling to help raise money for state expenses like education. Editors, "Lemons in a Row," *The New York Times*, July 13, 2004, p. A18.

⁶²⁰ Craig Lambert (2004), *op. cit.*, p. 37.

⁶²¹ Robert MacCoun and Peter Reuter (2001), *op. cit.*, p. 138.

⁶²² See, e.g., *Virginia Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 761-2 (1976).

⁶²³ *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of New York*, 447 U.S. 557, 566(1980).

⁶²⁴ *Lorillard v. Reilly*, 533 U.S. 525 (2001).

⁶²⁵ *Liquor Mart Inc. v. Rhode Island*, 517 US 484 (1996).

⁶²⁶ David B. Caruso, "Court Strikes Pennsylvania Ban on Campus Booze Ads," *Associated Press*, July 30, 2004.

⁶²⁷ An example of a contract for cannabis products is as follows:

State government ("Buyer") will contract with suppliers of various forms of pharmacoactive cannabis and will obtain each form of product from at least three suppliers. Each supplier will agree to the following provisions:

1. As used below, "Affiliates" means each party owning an interesting more than 10% of a company's profits or revenues (parent), each party in which a company owns more than a 10% interest (child), and each party where another owns more than 10% of each (sibling).
2. The license granted by Buyer and Supplier to grow, harvest, process, package and transport cannabis products may not be assigned or subleased by Supplier to any of Supplier's Affiliates or any other party.
3. Supplier will place on each package and on each carton of packages only those marks, labels and styles approved by Buyer in writing.
4. Supplier will give the supplied Products no distinctive characteristics that might distinguish Supplier's products from substantially equivalent products supplied to Buyer by others.
5. Supplier shall have no claim of trademark or trade dress rights in any mark of style applied to a package or carton of packages or distinctive characteristics of a supplied product, all of which shall be owned by Buyer.
6. Neither Supplier nor its Affiliates will provide consideration to another, including its own employees, for the creation, display, performance or distribution of advertising or promotional material for pharmacoactive cannabis anywhere in the world other than for creation of packages or cartons approved by Buyer in writing for delivery to Buyer.
7. Neither Supplier nor its Affiliates will contribute money or other consideration to an association or any entity other than an entity which promises in writing that it will not provide consideration to another, including its own employees, for the creation, display, performance or distribution of advertising or promotional material for pharmacoactive cannabis anywhere in the world other than for creation of packages or cartons approved by Buyer in writing for delivery to Buyer.
8. In its operations to produce Products for sale to Buyer, Supplier agrees to contract for goods or services from others equal in value to more than 10% of Buyer's expenses for any period only with sub-suppliers that agree in writing that neither they nor their Affiliates will provide consideration to another, including its own employees, for the creation, display, performance or distribution of advertising or promotional material for pharmacoactive cannabis anywhere in the world other than for creation of packages or cartons approved by Buyer in writing for delivery to

Buyer.

⁶²⁸ RCW 19.77.020 – Registration of certain trademarks prohibited.

⁶²⁹ K. Michael Cummings, Ph.D., M.P.H., and Hillary Clarke, J.D. (1998), *The Use of Counter-Advertising As a Tobacco Use Deterrent*, Department of Cancer Control & Epidemiology, Roswell Park Cancer Institute for the Advocacy Institute's Health Science Analysis Project.

⁶³⁰ The bill would amend RCW 66.08.050.

⁶³¹ RCW 70.96A.140(1).

⁶³² RCW 71.05.040.

⁶³³ RCW 26.09.191(3).

⁶³⁴ RCW 26.44.170(3) (abuse and neglect).

⁶³⁵ RCW 13.34.174 (order of alcohol or substance abuse diagnostic investigation and evaluation, treatment plan, breach of plan, reports).

⁶³⁶ RCW 13.34.176 (violation of alcohol or substance abuse treatment conditions, hearing, notice, modification of order).

⁶³⁷ RCW 69.50.414 (tort action for sale or transfer of controlled substance to minor, cause of action by parent, damages).

⁶³⁸ Mark A. R. Kleiman, "Controlling Drug Use and Crime with Testing, Sanctions and Treatment," in Philip B. Heymann and William N. Brownsberger, eds. (2001), *Drug Addiction and Drug Policy: The Struggle to Control Addiction*, Cambridge; Harvard University Press. *See also* Ernest Drucker (1999), "Drug Prohibition and Public Health: 25 Years of Evidence," *Public Health Reports*, v.114, no.1, January/February 1999.

⁶³⁹ Office of National Drug Control Policy (2004), *The Price and Purity of Illicit Drugs: 1981 Through the Second Quarter of 2003*, Washington, D.C.: Executive Office of the President (Publication Number NCJ 207768), November 2004.

⁶⁴⁰ Lloyd D. Johnston *et al.* (2003), *op. cit.*

⁶⁴¹ Merritt Long, Chair, and Rick Garza, Deputy Administrative Director, Washington State Liquor Control Board, presentation to the King County Bar Association Legal Frameworks Group, February 11, 2003.

⁶⁴² Kenneth W. Clements and Mert Daryal (2002), *The Economics of Marijuana Consumption*, Economic Research Centre, Department of Economics, University of Western Australia; Patricia Morgan *et al.*, "The legacy and the paradox: A comparative study of Methamphetamine in three communities," in H. Klee, ed. (1997), *Amphetamine Misuse: International Perspectives on Current Trends*, London: Harwood Press; Drug Policy Forum Trust (1997), *Alternative Systems of Cannabis Control in New Zealand: A Discussion Paper*, Wellington, New Zealand, July 1997; Karyn Model (1993), "The Effect of Marijuana Decriminalization on Hospital Emergency Room Drug Episodes: 1975-1978," *Journal of the American Statistical Association*, v.88, no.423, pp. 737-747; Frank J. Chaloupka and Adit Laixuthai (1992), *Do Youths Substitute Alcohol and Cannabis? Some Econometric Evidence*, University of Illinois at Chicago; John DiNardo and Thomas Lemieux (1992), Are Marijuana and Alcohol Substitutes? The Effect of State Drinking Age Laws on the Marijuana Consumption of High School Seniors. National Bureau of Economic Research. Working Paper No. 4212. *See generally* the January 2005 issue of *Alcohol and Alcoholism*, v.40, no.1, a special issue devoted to cannabis and alcohol.

⁶⁴³ See King County Bar Association (2005), "International Trends in Drug Policy: Lessons Learned from Abroad," *Report of the Legal Frameworks Group to the King County Bar Association Board of Trustees*, pp. 22-26.

⁶⁴⁴ *See, e.g.*, Daniel J. Nordlund *et al.* (2004), *Methadone and Non-Methadone Treatment of Persons Addicted to Opiates Results in Lower Health Care Costs and Reduced Arrests and Convictions: Washington State Supplemental Security Income Recipients*, Washington Department of Social and Health Services, January 2004.