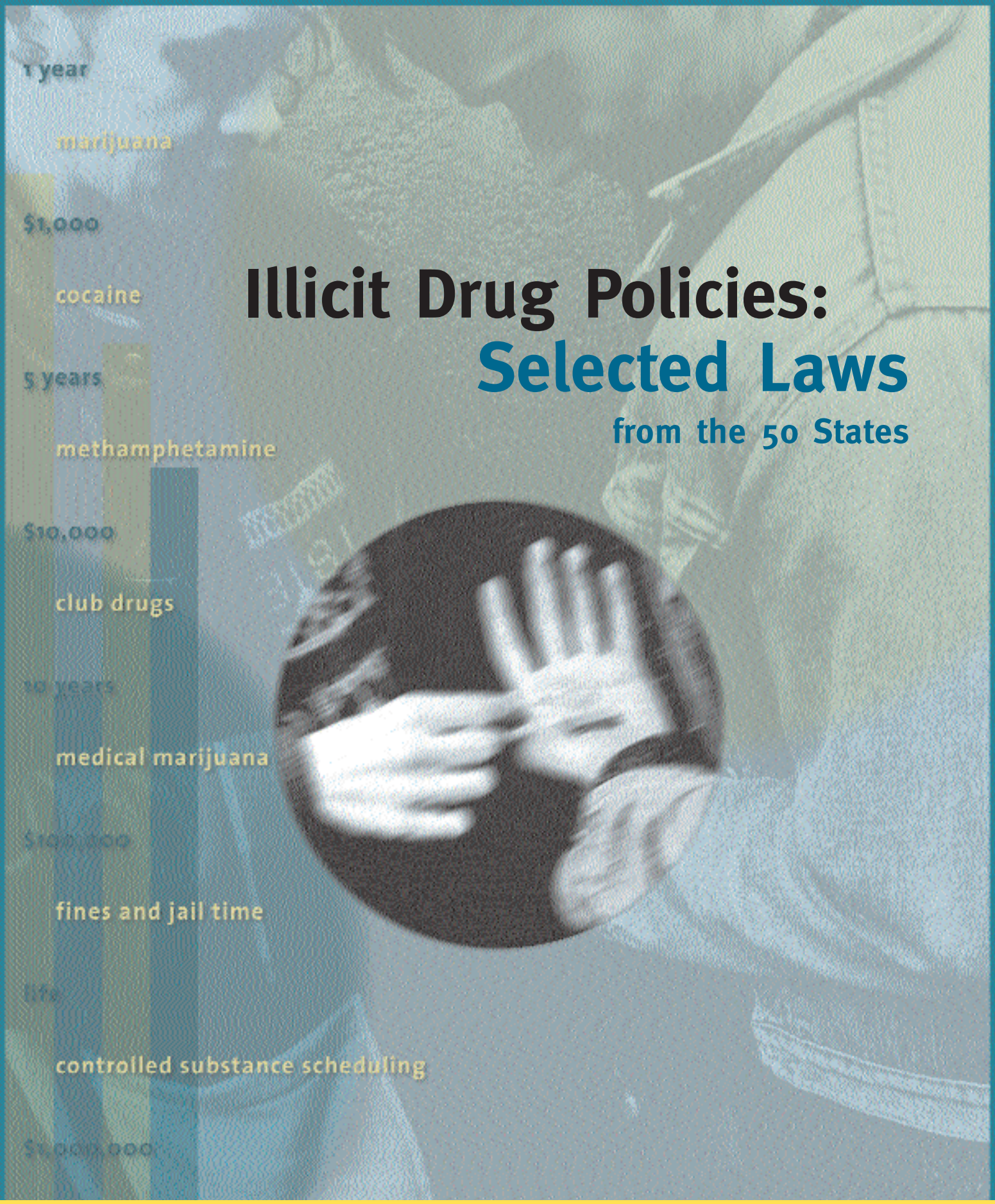

Illicit Drug Policies: Selected Laws from the 50 States

impacTEEN

A Policy Research Partnership to Reduce Youth Substance Use

Andrews University
The MayaTech Corporation
RAND

By

The ImpacTeen Illicit Drug Team

Contributors

JAMIE F. CHRIQUI, M.H.S., PH.D.
Legislative Database Director,
The MayaTech Corporation

ROSALIE LICCARDO PACULA, PH.D.
Co-Principal Investigator,
RAND

DUANE C. McBRIDE, PH.D.
Principal Investigator,
Andrews University

DEBORAH A. REICHMANN, J.D., M.P.H.
Legislative Database Coordinator,
The MayaTech Corporation

CURTIS J. VANDERWAAL, M.S.W., PH.D.
Project Director,
Andrews University

YVONNE TERRY-McELRATH, M.S.A.
ImpacTeen Liaison,
Institute for Social Research,
University of Michigan

For questions about the
content of this report, contact:

JAMIE F. CHRIQUI
The MayaTech Corporation
8737 Colesville Rd., Ste. 700
Silver Spring, MD 20910–3921 USA

For questions regarding the
ImpacTeen Illicit Drug Team
or for copies of this report, contact:

DUANE C. McBRIDE
Director, Institute for Prevention of Addictions,
Andrews University, Berrien Springs, MI 49104–0211 USA

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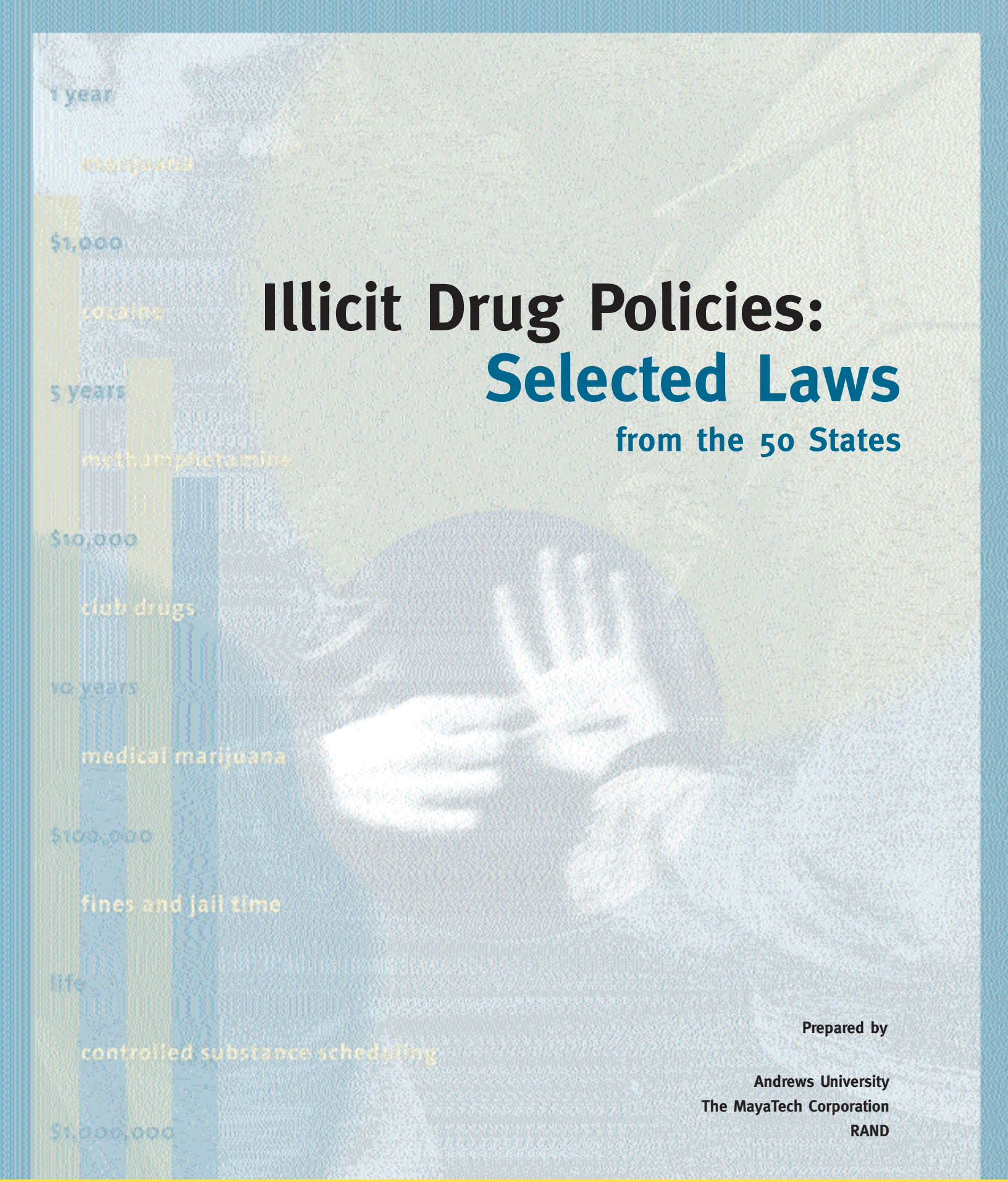

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from the 50 States

Prepared by

Andrews University
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January 2002

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FIGURES AND TABLES

Acknowledgments

The ImpacTeen Illicit Drug Team, a collaborative research group with investigators from Andrews University, The MayaTech Corporation, and RAND, developed this report. All legal data presented in this document were collected through original research conducted by The MayaTech Corporation in close coordination with the research team.

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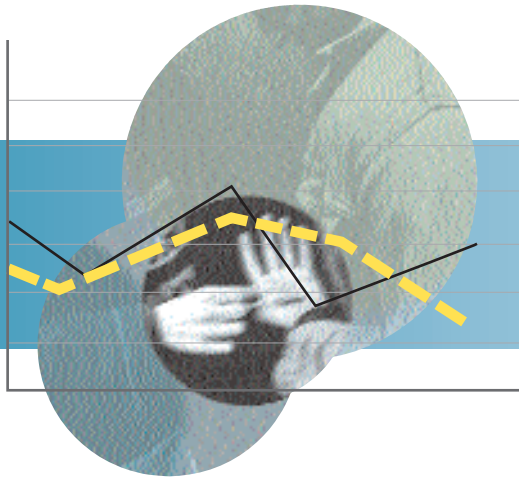
Executive Summary



Illicit drug use is associated with a wide variety of negative health and social consequences, the total cost of which was estimated to be approximately $110 billion in 1995 (Harwood et al., 1998). The Federal government has attempted to contain illicit drug use and its associated costs in a wide variety of ways, primarily relying on the use of criminal law to influence both the supply and demand for drugs. At the same time, each of the individual states and the District of Columbia has been experimenting with its own laws that influence the implementation of drug policies within these jurisdictions. Although these inter-state variations are often overlooked, it is possible that they could have a substantial impact on the consequences and costs incurred by the individual states given that the vast majority of individuals arrested for a drug offense are processed in state courts, where state law applies (Ostrom and Kauder, 1999; CASA, 2001).

Illicit Drug Policies: Selected Laws from the 50 States, prepared by the ImpacTeen Illicit Drug Team, provides the first comprehensive reference guide to selected illicit drug laws in all 50 states and the District of Columbia. This report has three broad purposes:

1. To provide those involved in drug policy development, research and enforcement with current information on specific state laws pertaining to drug scheduling and penalties for sale and possession of selected illicit drugs;

2. To demonstrate differences in state and federal approaches to drug policy by highlighting variation in state and federal scheduling of selected illicit drugs and state recognition of medical marijuana; and

3. To document the variation that exists across states in penalty provisions.

The report focuses on statutory law enacted in the states. While such law does not comprise the entirety of state law related to illicit drug policy, it is the basis for further application and evolution of administrative laws, case law, and sentencing guidelines that are used by some courts in the imposition of criminal penalties for specific drug offenses. The three major areas of illicit drug statutory law examined in this report are the following:

FEDERAL AND STATE CONTROLLED SUBSTANCES SCHEDULING

Identifies key differences in the use and types of schedules as they pertain to marijuana, cocaine, methamphetamine, Rohypnol, GHB, ecstasy and ketamine.

STATE PENALTY PROVISIONS

Examines key aspects of penalty provisions (quantity triggers, maximum/minimum jail and fine penalties) for first and subsequent sale and possession offenses for marijuana, cocaine, methamphetamine, and ecstasy.

MEDICAL MARIJUANA ALLOWANCES

Specifies whether the allowance is made through therapeutic research programs, a rescheduling of marijuana, physician prescription laws or medical necessity defenses.

Highlights

FEDERAL AND STATE CONTROLLED SUBSTANCES SCHEDULING

State legislatures' approaches to controlled substances scheduling of marijuana, cocaine, methamphetamine, Rohypnol, GHB, ecstasy and ketamine for the most part reflect the system set up by the Controlled Substances Act (CSA); yet, variations from the CSA do exist in both the number of schedules and the actual classification of drugs according to the schedules; specifically, there is far less conformity in the statutory scheduling of club drugs, with some states having yet to even schedule certain club drugs such as ecstasy and ketamine.

STATE PENALTY PROVISIONS

Statutory penalties for violating sale and possession provisions for marijuana, cocaine, methamphetamine and ecstasy vary greatly by substance, by the quantity of the substance sold or possessed, and by the type of offense (i.e., sale or possession). For example, the maximum statutory penalty for the sale of a standard retail amount of cocaine, methamphetamine, or ecstasy ranges from one year of imprisonment to life in prison. In addition, this report shows that states show significant variation in the number of quantity "trigger points" as well as the statutory penalties specified for sale and possession of these types of substances. These variations motivate an examination of the natural policy experiments that exist across states in their approach to specific illicit substances.

One of the most hotly debated national drug policy issues is the sentencing disparity between powder and crack cocaine. The federal sentencing guidelines currently require 100 times more powder than crack in order to equal the same sentence. This report shows that only six states have separate statutorily-based penalties for crack and powder cocaine possession offenses and only nine states' statutes specify separate penalties for crack and powder cocaine sale offenses. Such data suggest that what is of significant importance at the federal level may be considerably less important at the state level if similar differences do not exist in state sentencing guidelines.

MEDICAL MARIJUANA ALLOWANCES

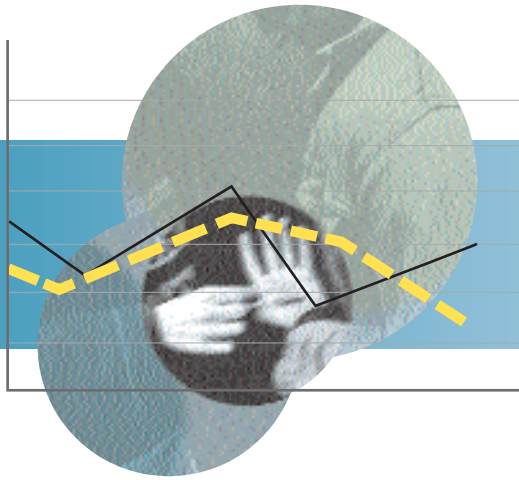
As of January 1, 2000, 24 states and the District of Columbia had enacted some sort of medical marijuana law and many states had more than one type of provision. Medical allowances enacted within the past six years are far more likely to include physician prescription provisions and medical necessity defenses than laws passed prior to 1995. This may explain the increased public attention given to these laws versus other types of medical marijuana provisions. It is interesting to note that of the seven states with medical necessity defense provisions for patients and/or their caregivers, all have physician prescription laws as well, thereby creating an environment where both physicians and patients are presumably protected from state prosecution.

Summary

This report demonstrates that substantial variation exists in state statutory approaches to drug policy, as is indicated by their scheduling of specific drugs, penalties associated with possession and sale of specific drugs, and medical marijuana allowances. While not inclusive of all drugs or laws, *Illicit Drug Policies: Selected Laws from the 50 States* is an essential first step in this process because it documents where variation does and does not exist in several key areas. Further, it provides necessary data that can be used by policy analysts and researchers to initiate research that examines the association between specific criminal justice approaches and the negative consequences and outcomes associated with illicit drug use. This document forms the foundation from which future research on state-level illicit drug policy will be conducted by the ImpacTeen Illicit Drug Team.

Section

1 Introduction



Attempts to control illicit drug use have generally emerged out of concern over the negative health consequences of drug use (Chitwood et al., 1999), the relationship between drug use and crime (Inciardi, 2001), and the associated costs.

The use of illicit drugs is associated with a wide variety of direct and indirect health consequences. In 1999, an estimated 3.6 million people met diagnostic criteria for dependence on an illicit substance, including approximately 800,000 youths between the ages of 12 and 17 (Substance Abuse and Mental Health Services Administration (SAMHSA), 2000). In the same year, there were an estimated 554,932 illicit drug-related emergency department episodes (SAMHSA, 2001) and 18,433 drug-related deaths (Centers for Disease Control and Prevention (CDC), 2001). Other psychiatric co-morbidities found to be associated with drug abuse include depression (McBride et al., 2000), accidents (Waller, 1995) and lost workdays (Zhang et al., 1999). Researchers have also found relationships between illicit drug use and increased health service need and more costly health system utilization (Chitwood et al., 1999; French et al., 2000).

Research conducted over the past three decades has found a consistent, though complex, relationship between drug use, crime, and violence (MacCoun et al., in press; McBride, VanderWaal, & Terry-McElrath, in press). Community data from the Arrestee Drug Abuse Monitoring (ADAM, 2000) Project indicate that in most cities where these data are collected, over two-thirds of felony arrestees test positive for an illicit drug, with over 50 percent of juveniles arrested testing positive. Over 80 percent of state, and 70 percent of federal prisoners

reported past drug use (Mumola, 1999). A recent report from the Bureau of Justice Statistics shows 57 percent of convicted inmates in state prisons and 55 percent in local jails used drugs in the month prior to the offense that put them in prison/jail (Wilson, 2000). Costs of incarceration for these inmates are significantly higher than those of non-drug using offenders because of poorer health status and higher recidivism rates (Leukefeld, et al., 1998). When factoring in the additional costs of arrests, incarceration, and treatment, the total cost of the negative consequences of illicit drug use in the United States was estimated at $110 billion in 1995 (Harwood et al., 1998).

Over the past century, the Federal government has attempted to contain illicit drug use in a wide variety of ways, ranging from a punitive/deterrent approach with a focus on enforcing criminal and civil law, to a public health approach, focusing on treatment and prevention. However, by far the most dominant policy approach to controlling drug use at the national level has been to utilize the deterrent effect of law and the incapacitative effect of penalties to control illicit drug possession, use, sale, distribution, and manufacturing. For instance, an examination of the federal drug budget shows that enforcement is funded at a higher level than treatment and education (Office of National Drug Control Policy (ONDCP, 2000a)). Some researchers have noted that this emphasis on law and enforcement has resulted in a virtual saturation of local, state, and federal correctional facilities by drug users, with a disproportionate minority representation (Beck & Mumola, 1999).

Although federal law applies to all states, historically states have experimented with different policies. The Federal government has subsequently adopted some of these state experiments (Musto, 1999; Belenko, 2000). For example, states were the first to experiment with prohibitions on the sale and distribution of marijuana during the 1920s and 1930s. By 1937, when the federal government finally passed the Marijuana Tax Act, all 50 states had their own laws forbidding the non-medical use of marijuana (Belenko, 2000). One explanation for states' willingness to explore alternative policies is that illicit drug use imposes enormous costs on the states. According to a recent study, state governments spent $1.1 billion in 1998 to deal with consequences associated with illicit drug use alone (National Center on Addiction and Substance Abuse (CASA), 2001). Another $63.6 billion was spent on consequences attributed to the joint consumption of illicit and licit substances. The national drug policy, with its emphasis on enforcement, for example, has led to significant increases in drug arrests within each state and a subsequent increase in state court drug caseloads (Ostrom and Kauder, 1999). The criminal justice costs associated with these activities alone totaled more than $30 billion (4.9 percent of state budgets) for states in 1998 (CASA, 2001).

As a way to reduce the costs and other social consequences they have incurred, states continue to experiment with various policies such as medical marijuana provisions, treatment on demand, and decriminalization of possession of small amounts of marijuana. The variation of state drug policy approaches provides an intriguing natural experiment in which policy analysts and others can begin to evaluate the impact of particular drug policies.

Although significant attention is given to U.S. national drug policy, each of the 50 states and the District of Columbia has its own state laws that considerably affect drug policies and their implementation within these jurisdictions. The purposes of this report are to:

1. provide those involved in drug policy development, research and enforcement with current information on specific state laws pertaining to drug scheduling and penalties for sale and possession of marijuana, cocaine, methamphetamine, and selected club drugs;

2. demonstrate differences in state and federal approaches to drug policy by highlighting variation in state and federal scheduling of selected illicit drugs and state recognition of medical marijuana; and

3. document the variation existing across states in penalty provisions.

The data presented in this report represent a snapshot of selected legislative data collected as part of the ImpacTeen Illicit Drug Project.[1] An important contribution of the project is the identification of state-level legal statutes that define or parameterize drug policies within each state. From March through April 2000, we conducted a 10-state pilot study in which we selected enacted legislation pertaining to illicit drugs, including controlled substances scheduling, penalties, drug testing, driving under the influence of a controlled substance, insurance coverage for treatment services, and paraphernalia laws. The purpose of the pilot study was to obtain a relatively comprehensive assessment of the policy areas in which states were enacting illicit drug legislation, the volume of legislation in particular areas, and the drugs that are most often addressed in this legislation. The pilot study revealed that states have created a wide variety of statutes related to many aspects of illicit drug production, distribution, and use.

Both resource and time constraints made it impossible for this project to track all existing state statutes at one time. The research team had to prioritize drug policy areas based on project objectives and the anticipated importance of particular drug laws. Upon careful review

of the pilot findings and discussions with our expert panel, we determined that this project would best be served if resources were spent collecting some laws that could be found consistently across all states, although with some inter-state variability, as well as some laws that represented experiments in drug policy being tried in selected states. We therefore chose to begin our effort by collecting laws in three main legislative areas: scheduling; penalties for simple possession, sale, manufacturing, and use of selected drugs; and medical marijuana. Other areas of illicit drug law identified in the pilot were prioritized for collection in future years pending resource availability.

This report is a first step in the research objectives of the ImpacTeen Illicit Drug Team. Our overall long-term objectives include the creation of a comprehensive state-level database that can be used by policy makers and analysts to examine the impact of drug policies and environmental factors on youth drug use and the consequences of use.

Rationale for Topical Selection

Since the Harrison Act of 1914 and the Marijuana Tax Act of 1937, the major policy approach to preventing illicit drug use in the United States has been one of deterrence, in which law enforcement personnel arrest and prosecute those who were caught manufacturing, distributing, selling, or using illegal drugs. An understanding of drug scheduling and the legislated sanctions associated with violation of state drug laws, therefore, is important for setting the framework of each state's approach to drug policy. Every state has created some sort of penalty structure, and so this is an area of law in which data are available for all 50 states and the District of Columbia.

One of the most active legislative areas of state drug policy in recent years pertains to the provision of marijuana for medicinal purposes. Although the federal government does not recognize the medicinal value of marijuana and opposes the formal rescheduling of it, many states have taken steps to legitimize its use for certain medical conditions. Between 1995 and 2000, nine states enacted legislation recognizing the medicinal value of marijuana and another 16 states have medicinal marijuana legislation on their 2001 legislative dockets.[2] The heightened attention to this topic area makes it an intriguing policy experiment to watch.[3]

Data Sources and Limitations

The ImpacTeen Illicit Drug Team collected data on state illicit drug laws primarily from statutory law (i.e., the official compilation of laws established by state legislatures as of a given point in time). Secondary sources such as research articles, law review articles and reports by policy research groups were used to check the accuracy and verify the interpretation of our primary sources. The statutory laws reported in this document are those in effect as of January 1, 2000.

Other sources of state legislative information, including administrative laws promulgated by state executive branch agencies and case law generated through court decisions, are not included. Statutory law does not comprise the entirety of state law in the arena of illicit drug law, but it is the basis for the further application and evolution of administrative laws, case law, and sentencing guidelines that are used by some courts in the imposition of criminal penalties for specific drug offenses.

The data presented in this report have three significant limitations that influence their usefulness for examining policies within a state.

1. Relevant provisions contained in other legal compilations (e.g., rules and regulations implemented by state administrative agencies) are not typically captured in state statutes, and thus not reflected herein.

2. The data do not include information on each individual session law enacted by state legislatures. Therefore, the data presented here reflect the statutes as they exist at a given point in time or the cumulation of the law (incorporating amendments, repeals, and reenactments) at a given point in time.

3. The penalty data only reflect sanctions imposed by statute and do not reflect the actual penalties/sanctions imposed during the sentencing phase of trial.

It is also important to keep in mind that these data may reveal little about the application of the law in local jurisdictions. Variation in the implementation and enforcement of these laws will likely exist across jurisdictions within the state. At the same time, drug policy at the state level is of interest because the volume of criminal drug prosecutions are highest at the state level, although violations are typically for small amounts of controlled substances. In contrast,

criminal drug law prosecution at the federal level is more often associated with trafficking and conspiracy violations (Glaeser et al., 1998).

ORGANIZATION OF THE REPORT

The remainder of this report is organized into three main sections. Section 2 provides a brief description of each of the policy areas being presented. Section 3 provides a national overview of these policy areas by providing descriptive summary information of particular policies across all the states and noting the variability in these policies. Section 4 provides detailed data on the selected policies for each state.

For the purposes of this report, we use the term **policy** to refer to legislatively enacted policies. The term **club drugs** is being used to refer to four specific substances: Rohypnol, GHB, ecstasy, and ketamine. Finally, the term **state** is used to refer to any of the 50 U.S. states and the District of Columbia.

Endnotes

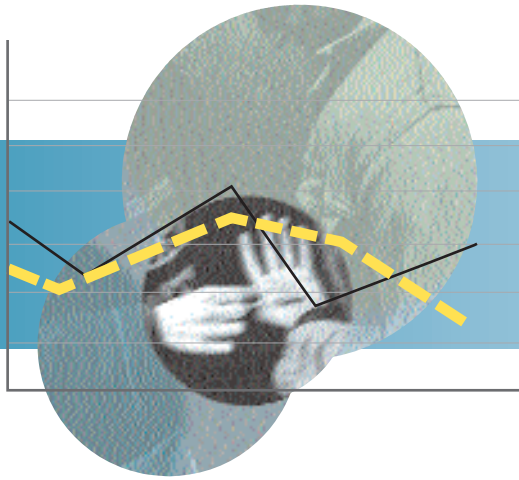
1 For more about the ImpacTeen Illicit Drug Project, please visit our website at *www.andrews.edu/BHSC/ImpacTeen-IllicitDrugTeam.*

2 States enacting medical marijuana laws since 1995 include: Alaska, Arizona, California, Colorado, Connecticut, Hawaii, Maine, Oregon, and Washington. Ten of the 16 states with medical marijuana legislation on their 2001 legislative dockets (Iowa, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, Texas, and Vermont) proposed legislation that would amend existing medical marijuana laws. The other six states (Arkansas, Maryland, Nevada, North Carolina, South Dakota, and Wyoming) introduced legislation in this area for the first time.

3 It is possible that particular aspects of these medical marijuana laws will influence the recreational use of marijuana among adults and youth, most notably the allowance to cultivate marijuana at home.

Section

2 Policy Areas Covered



Federal and state legislatures adopt various drug policies that limit and sometimes completely ban access to a wide variety of legal and illegal drug compounds. We examine three major areas of illicit drug law in this report: (1) controlled substances scheduling, (2) penalty provisions, and (3) statutes allowing for medical marijuana. Readers should note that we report whether a state legislature has enacted, as of January 1, 2000, each type of law outlined below. The variations that occur across states in the implementation and enforcement of these laws are not described. Other drug-related policies and environmental variables being collected under this initiative but not presented in this report will be made publicly available through the ImpacTeen Illicit Drug Team's website as soon as they are compiled.

Controlled Substances Scheduling

In 1970, the United States Congress passed the Controlled Substances Act (CSA) (21 U.S.C. 811 et seq.). This Act established federal guidelines still in effect for regulating the manufacture and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the illicit production of controlled substances. The law categorizes drugs into five schedules based on their potential for abuse, likelihood for dependence, and currently accepted medical use. The schedules are listed in decreasing order of danger or abuse, with Schedule I referring to controlled substances that have a high potential for abuse and little or no known medical utility. Schedule V substances, on the other hand, represent substances that have a very low potential for abuse and proven uses in medical treatment.

Although the federal law applies to each state, state legislatures have developed their own controlled substances guidelines to facilitate sentencing decisions for drug offenders processed in state courts. By creating their own schedules, states maintain some autonomy and flexibility in how they wish to treat particular drug offenses processed in state courts. For example, states can choose to add or remove particular substances from a schedule, thus changing the penalties associated with the sale, manufacture, distribution, cultivation, possession, or use of that substance. Alternatively, they can reclassify specific drugs (e.g., marijuana) under certain circumstances (e.g., medical reasons), so to remove penalties when specific conditions are met. Although the vast majority of states have established the five-schedule system created by the CSA, many states have chosen to reclassify particular substances within those five schedules. Variation also exists in the number of schedules employed by the states and in the purpose of these schedules.

This report presents state statutory and federal scheduling information for marijuana, cocaine, methamphetamine, flunitrazepam (Rohypnol), gamma-hydroxy butyrate (GHB), methylene-dioxymethamphetamine (MDMA or ecstasy), and ketamine. Identifiers are included for those cases where hashish is scheduled differently than marijuana and/or crack cocaine is scheduled differently than powder cocaine. These drugs were selected because of their popularity, particularly among youth, and because they have been the focus of recent state legislation.

Penalty Provisions

The vast majority of states use their controlled substances schedules as their guiding criteria for developing legislated penalty provisions to be used in state courts (in conjunction with sentencing guidelines, as applicable) for the sentencing of offenders who illegally manufacture, distribute, possess, or use various controlled substances. For example, in general, Schedule I substances have greater penalties than Schedules II and III, with lesser to no penalties associated with Schedules IV and V. In some cases, states choose to deviate from penalties applied to general schedules of drugs and enact separate statutes that provide detailed penalties for particular drug offenses. Typically, these statutes specify a minimum and/or maximum fine and jail sentence associated with each drug and each offense. An offense is typically characterized in these laws by the drug involved, the action involved (e.g., use, simple possession, possession with the intent to sell, sale, distribution, or trafficking), and the number of prior such charges (first or subsequent offense).

This report presents state-level data for four specific drugs (marijuana, cocaine, methamphetamine, and ecstasy), and two penalty categories (sale and simple possession). For these selected penalty categories, the report lists: (1) the number of quantity triggers identified in the statute; (2) the minimum and maximum fine for first offense within the first three quantity triggers; (3) the minimum, maximum, and mandatory minimum (if present) jail term for the first offense within the first three quantity triggers; (4) indicators where states have increased penalties for subsequent offenses; and (5) checkmarks for states that treat crack cocaine offenses differently than powder cocaine offenses.

DEFINITIONAL RULES AND GUIDELINES

In order to show uniform penalty data across all 50 states and the District of Columbia, certain definitional rules and guidelines were developed to ensure the compatibility of the data. These rules encompass the definition of the terms within the penalty statutes themselves, as well as the kind of data captured from the code sections.

QUANTITY TRIGGERS

A quantity trigger is defined as the numerical value and measurement unit (e.g., 10 grams) used to identify the differentiation in penalties associated with a particular offense and the next highest or lowest penalty category. For each state we present the first three quantity triggers specified in each state's law and the penalties associated with possession and sale of those particular quantities. By presenting the first three quantity triggers, we are able to provide the reader with a sense of just how complicated these penalty structures are across states as well as convey the most information possible regarding how states differ in their approach to particular drug offenses. Trigger amounts are presented in grams, the most common unit specified in state statutes, even though state laws are not uniform concerning the units specified. To facilitate the use of these data for analysis purposes, the penalties associated with a standardized retail quantity are highlighted for each drug. The standardized quantities for cocaine (1 gram), marijuana (10 grams), and methamphetamine (10 grams) represent low-level retail trades identified by researchers at Abt Associates (Johnston et al., 1999). The standardized quantity for ecstasy (125 milligrams) represents a typical dose in one pill (ONDCP, 2000b).

SALE OFFENSES

There are a number of different ways to convey the concept of "sale." In some cases, the various nuances that are possible are combined into one section. However, when faced with different iterations, (e.g., possession with intent to sell, delivery, conveyance, etc.) only the most direct reference to "sale" has been captured. In instances where a specific fine amount was specified (e.g., a fine of $25,000) for violating a sale provision, the fine is presented in the "maximum fine" column of the data.

POSSESSION OFFENSES

Possession can be defined within a statute in various ways. For the purposes of this report, only penalties for simple possession of an illicit substance have been captured. In instances where a specific fine amount was specified (e.g., a fine of $25,000) for violating a possession provision, the fine is presented in the "maximum fine" column of the data.

SUBSEQUENT OFFENSES

For purposes of this report, subsequent offense refers to instances where enhanced penalties are applied on the second violation of any given offense. If a state law identified enhanced penalties beginning with three or more violations of the same offense, it is not captured by this variable.

PENALTIES

For determining the applicable years of imprisonment and fines, only those that are clearly delineated in the law have been captured. Penalties based on a percentage of ill-gotten gains, additional fines relating to administrative expenses, court and laboratory fees, and penalties that are entirely based upon judicial discretion are not reflected here. Penalty schemes that include aggravating and mitigating factors are also not included, except when they are part of an enhanced penalty for second or subsequent offenses. Enhanced penalties for such offenses are identified as a checkbox. Additional aspects of penalty schemes, such as probation and/or diversion to rehabilitation other than incarceration, are ignored. Finally, if the imprisonment penalty is defined as being a certain amount of years or "life" imprisonment, the quantity captured was the "life" penalty.

Discussion of penalties associated with possession of marijuana frequently leads to a discussion of the policy of decriminalization. Eleven states decriminalized possession of marijuana during the 1970s: Alaska, California, Colorado, Maine, Minnesota, Mississippi, North Carolina, Nebraska, New York, Ohio, and Oregon (Kleiman, 1992; MacCoun & Reuter, 2001; Murphy, 1986; NORML, 2001). However, careful review of the 11 statutes passed during the 1970s reveals that there is little homogeneity in the policies adopted by the 11 so-called decriminalized states (see side bar on page 11 for further discussion). We therefore decided to withhold a presentation of this policy until it can be investigated further.

MARIJUANA DECRIMINALIZATION

Technically, the term decriminalization, as defined by the National Commission on Marihuana and Drug Abuse, was meant to define state laws in which possession of marijuana for personal use or casual distribution of small amounts for no remuneration would no longer be a criminal offense. Those states that retained the level of offense corresponding to a crime, which includes all misdemeanor and felony charges, but simply lowered the severity of penalties for possession of small amounts of marijuana were not to be properly termed decriminalized (National Commission on Marihuana and Drug Abuse, 1972).

In our review of the marijuana penalty statutes, we discovered that four of the 11 so-called decriminalized states (California, Minnesota, North Carolina, and Ohio) retained marijuana possession as a misdemeanor offense in their statutes from the 1970s. Although all of the so-called decriminalized states provided reduced penalties for possession of "small" amounts of marijuana in the case of first time offenders, the only common denominator across the 11 statutes was the removal of jail/prison terms.[1] In some cases, these reduced penalties applied to first and subsequent offenses (e.g., Alaska, California, and Colorado) and in other cases the reduced penalties only applied to first time offenders (e.g., Minnesota, Mississippi, and North Carolina).

The common denominator of removing jail or prison sentences for first time possession offenders caught possessing small amounts of marijuana represents a characterization of these laws that is based on "depenalization," rather than decriminalization. However, such a characterization of the 11 statutes does not allow us to uniquely identify them from other states that have also reduced the penalties associated with possession of small amounts of marijuana. Further analysis of the state laws is required before states can be properly identified as "decriminalized" and/or "depenalized."

Medical Marijuana

Although the 1996 California and Arizona statutes are frequently identified as the first laws enabling the use of marijuana for medicinal purposes, these laws actually represent the beginning of a second wave of legislation passed by state legislatures pertaining to this issue. The first wave of state legislation began in the late 1970s in response to the Federal government's classification of marijuana as a Schedule I substance in the CSA. Although the Federal government took a harsh stance on marijuana in the 1970 Act, there were indications in the years immediately following the CSA that the Federal government might change its formal policy.[2] In anticipation of that change, states began enacting their own legislation.

Much of the early state legislation was fairly narrow in scope and required federal sanctioning. For example, most states passed legislation enabling Therapeutic Research Programs (TRPs), that require federal approval and oversight of research protocols. Several other states also chose to reschedule marijuana in their own state controlled substance guidelines, thus enabling physicians to legally prescribe marijuana for medicinal purposes. These laws had limited scope, however, because physicians' prescription licenses are granted by the federal government (not state governments), which still forbade physicians from prescribing marijuana. When it became clear in the mid-1980s that the federal government was not going to change its official position, many states let these early laws expire.

In part because the federal government's official position on the non-viability of marijuana as medicine did not change, states initiated a second wave of legislative activity in the mid-1990s. This second wave of legislative activity differs from the first in that more recent laws are much more likely to provide explicit defenses from prosecution for patients, physicians, and caregivers who use, prescribe, or supply marijuana for medicinal purposes. The constitutionality of these state laws has not been significantly challenged in federal court, although a recent U.S. Supreme Court decision held that the medical necessity defense provided in these state laws did not apply to third-party organizations distributing marijuana to patients (United States v. Oakland Cannabis Buyer's Cooperative, 2001). One key aspect of these state laws that is likely to draw federal attention pertains to how patients can obtain marijuana for medicinal purposes. Although the vast majority of state marijuana laws are silent regarding how patients are to obtain marijuana, recent legislation in seven states permits patients to grow marijuana at home. This policy, of course, contradicts the federal prohibition on cultivation of marijuana.

In this report we identify states that currently have medical marijuana provisions and identify whether the provision: (1) enables TRPs that explore the medicinal value of marijuana, (2) reschedules marijuana from Schedule I, (3) provides a defense from prosecution for physicians, or (4) provides a medicinal necessity defense to patients and/or caregivers.

THERAPEUTIC RESEARCH PROGRAMS (TRPs)

TRPs are federally sanctioned clinical research programs that protect participating physicians, pharmacies and patients from state and federal prosecution. These programs, which are usually administered by the state Board of Health or Board of Pharmacy, are required to adhere to specific federal regulations and must have their research protocols approved by the Federal Drug Administration in order to receive federal approval. Patients, physicians and pharmacies interested in participating in the research program must be approved by a state review board.

States are identified as having a TRP provision if the state law specifically authorizes and/or requires the establishment of a research program or protocol to study the potential medicinal value of marijuana for specific categories of patients and/or diseases. This classification of state laws merely identifies states that enable the development of a TRP, not states that actually implement these programs.

RESCHEDULING PROVISIONS

States are identified as having a rescheduling provision if: (1) marijuana is formally reclassified in the state controlled substances guidelines from a Schedule I substance to a lower schedule that recognizes its medicinal value, or (2) marijuana used for medicinal purposes is explicitly reclassified outside of a therapeutic research provision. States that have rescheduled marijuana to a lower category that does not recognize its acceptable medical use are not considered to have a medical marijuana rescheduling provision. In addition, states that base their scheduling on penalty categories instead of the potential harm and/or medicinal value are omitted. Finally, states that only reschedule THC (the active ingredient in marijuana) are not considered to have a medical marijuana rescheduling provision. Because THC is technically a derivative of the marijuana plant, the entire plant is not covered under these statutes.

PHYSICIAN PRESCRIPTION LAWS

These are defined as laws that: (1) enable physicians to prescribe marijuana for medicinal purposes, (2) provide physicians with an affirmative defense from state prosecution for prescribing medical marijuana, or (3) provide physicians with an affirmative defense from state prosecution for discussing the medicinal value of marijuana with their patients. These laws are considered physician prescription laws only if they apply outside of a TRP.

MEDICAL NECESSITY LAWS

These are defined as laws that: (1) provide patients with a defense from state prosecution for using and/or possessing (and caregivers for possessing) marijuana for medicinal purposes, and (2) authorize patients and/or their caregivers to obtain marijuana upon their physician's recommendation, authorization, certification, etc. Again, only those provisions that apply outside of a TRP are included in this category.

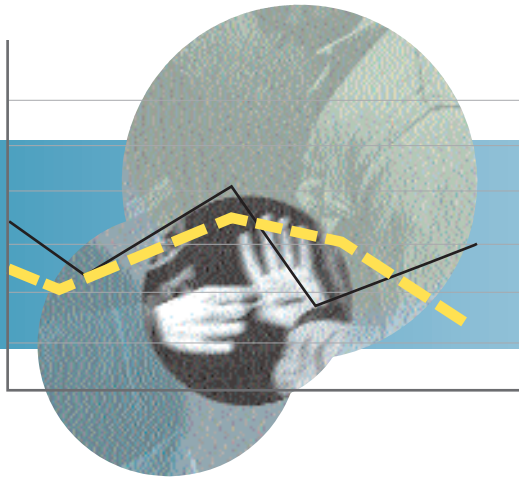
Endnotes

1 The definitions of what constitutes a small amount of marijuana also varies significantly across these 11 state statutes, although the majority of the states define small as "one ounce or less."

2 In 1972, a petition was submitted to the Bureau of Narcotics and Dangerous Drugs, now known as the Drug Enforcement Agency, to reschedule marijuana to Schedule II, enabling legal physician prescription. That same year, the National Commission on Marihuana and Drug Abuse published their final report on the harmfulness of marijuana, in which they recommended that the Federal government explore the scientific basis for marijuana as medicine (National Commission on Marihuana and Drug Abuse, 1972). In 1975, the Federal government acquiesced and began an Individual Patient Investigational New Drug (IND) Program exploring the medical use of marijuana for those patients who were selected to participate in the program.

Section

3 National Overview of Selected State Illicit Drug Laws



In this section, we provide a national overview of selected state illicit substance legislation. The number of jurisdictions included in each of the analyses presented here varies from policy to policy because not all states have enacted comparable legislation in each policy area. For each area of legislation, we present summary findings from only those states with comparable laws.

Controlled Substances Scheduling

State statutory approaches to controlled substances scheduling, for the most part, reflect the system set up by the CSA; yet, variations do exist in the number of schedules and the actual classification of drugs according to the schedules. Six states classify controlled substances by a different number of schedules than the Federal government. Alaska, Arkansas, North Carolina, and Virginia each uses a six-schedule system; while South Dakota has four schedules and Tennessee has seven schedules. Three other states developed classification systems that present a greater departure from the federal schedule. Vermont lists drugs according to type (e.g., depressant, stimulant, etc.) and does not rank drugs within these lists based on danger, potential for abuse, or medical utility. Massachusetts and Maine categorize drugs based on penalty severity rather than potential for abuse or medicinal value. The scheduling scheme in Massachusetts ranges from Class A through Class E and Maine's scheme ranges from Schedule W through Schedule Z.

Among the 47 states and the District of Columbia that schedule drugs according to their danger, potential for abuse, and medical utility, there is considerable uniformity across states in the scheduling of some substances, such as cocaine and methamphetamine. Most states follow the CSA and schedule cocaine and methamphetamine as Schedule II substances. The only exceptions are Alabama, which places methamphetamine in Schedule III; Kentucky, which does not schedule methamphetamine at all; and Nevada, which places cocaine in Schedule I.

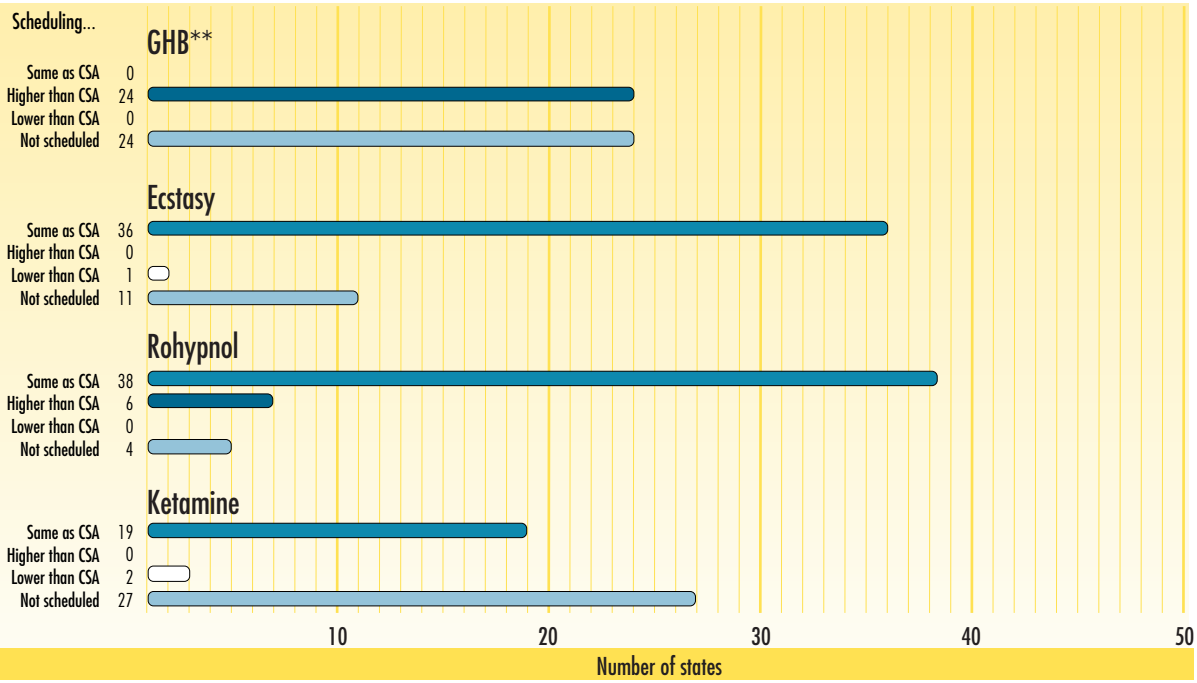
In contrast, some variation does exist across states in the scheduling of other drugs, most notably marijuana and club drugs. Although 37 states follow the CSA by listing marijuana as a Schedule I substance, six states (Colorado, Georgia, Illinois, South Dakota, Virginia, and Wisconsin) do not schedule it at all. Three states (Arkansas, North Carolina, and Tennessee) schedule marijuana below a Schedule I but recognize the high potential for abuse and limited scientific evidence regarding the medicinal use of the substance. Two jurisdictions (Alaska and the District of Columbia) classify marijuana below a Schedule I with the intent of allowing it to be used for medicinal purposes.[1]

There is also some variation from the CSA in the scheduling of selected club drugs, which may be due in large part to the fact that these drugs have only recently received national attention (see Figure A). As of January 1, 2000, *GHB* had not been listed in the CSA nor had it been scheduled in 24 states. However, 11 states classified it as a Schedule I substance, five states classified it as a Schedule II substance, two states classified it as a Schedule III substance, and six states classified it as a Schedule IV substance. *Ecstasy*, which is classified as a Schedule I substance in 36 states and the CSA, is classified as a Schedule II substance in Alaska, and is not scheduled at all in 11 states. *Rohypnol*, which is classified as a Schedule IV substance in 38 states and the CSA, is classified as a Schedule I substance in six states and is not scheduled at all in four states. Finally *ketamine*, a Schedule III substance in the CSA and in 19 states, is classified as a Schedule IV substance in two states and is not scheduled in 27 states.

Medical Marijuana

As of January 1, 2000, 24 states and the District of Columbia had enacted some sort of medical marijuana law and many states had more than one type of provision (see Figure B).[2] Fourteen states have laws enabling a Therapeutic Research Program (TRP). Information from a study commissioned by the Marijuana Policy Project suggests that only eight of these states received federal approval for their TRPs and only six states (California, Georgia, New Mexico,

Figure A: Comparison of State* and Federal Scheduling of Selected "Club Drugs" (as of January 1, 2000)



* N = 48; excludes ME, MA and VT.
** As of January 1, 2000, GHB was not listed in the CSA.

New York, Vermont, and Washington) currently operate TRPs enabled by their state legislation (Schmitz and Thomas, 2001). Three states have laws formally rescheduling marijuana so as to recognize its medicinal value. Eleven states have physician prescription provisions and seven states have medical necessity defense provisions.

It is interesting to note that all seven states with medical necessity defense provisions also have physician prescription laws, thereby creating an environment where both physicians and patients are presumably protected from state prosecution. Other combinations of specific medical marijuana provisions to a large extent reflect the timing of when specific provisions were passed. As Figure C shows, the vast majority of medical marijuana laws enacted after 1995 are physician prescription provisions and medical necessity defense laws. TRP and rescheduling provisions in existence as of January 1, 2000, to a large extent reflect laws that were passed during the first wave of medical marijuana legislation in the late 1970s and early 1980s when the federal government was more open to exploring the medicinal value of marijuana. The two notable exceptions are Alaska, which rescheduled marijuana for medicinal purposes at the same time it enacted physician prescription and medical necessity defense provisions in 1999, and California, which enacted legislation enabling the creation of a TRP three years after passing its physician prescription and medical necessity defense provisions.

Figure B: States with Medical Marijuana Laws by Type of Provision (as of January 1, 2000)

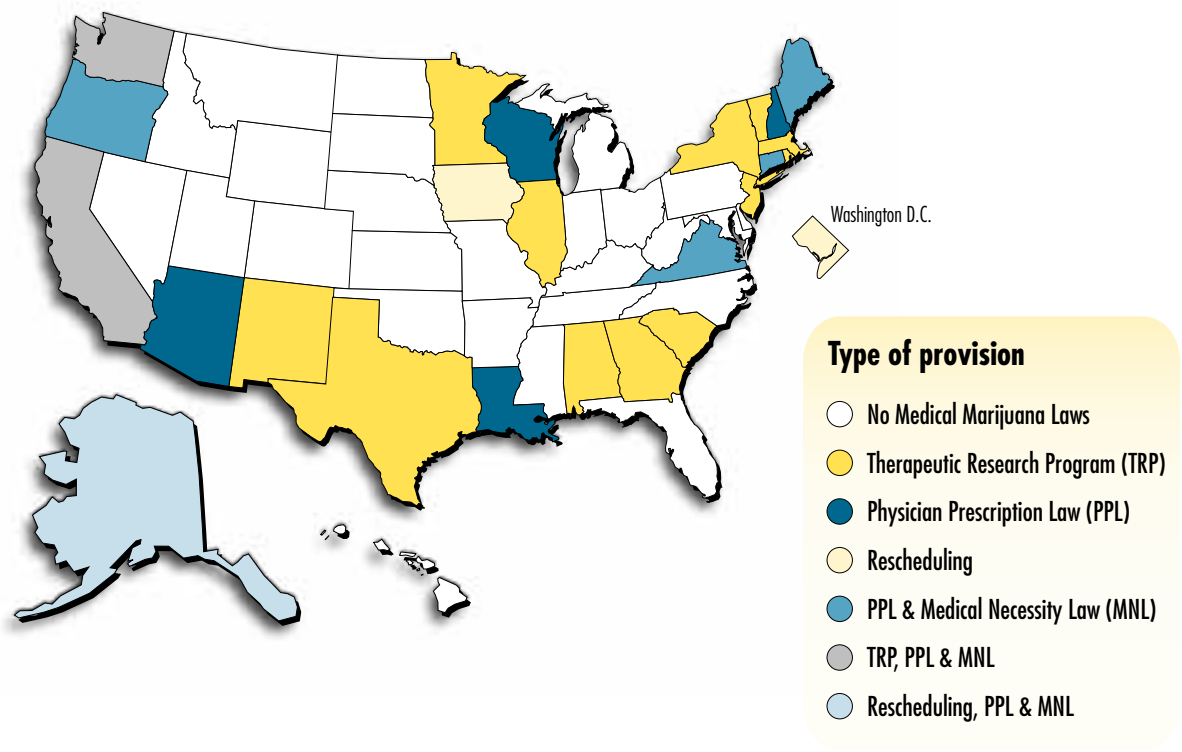
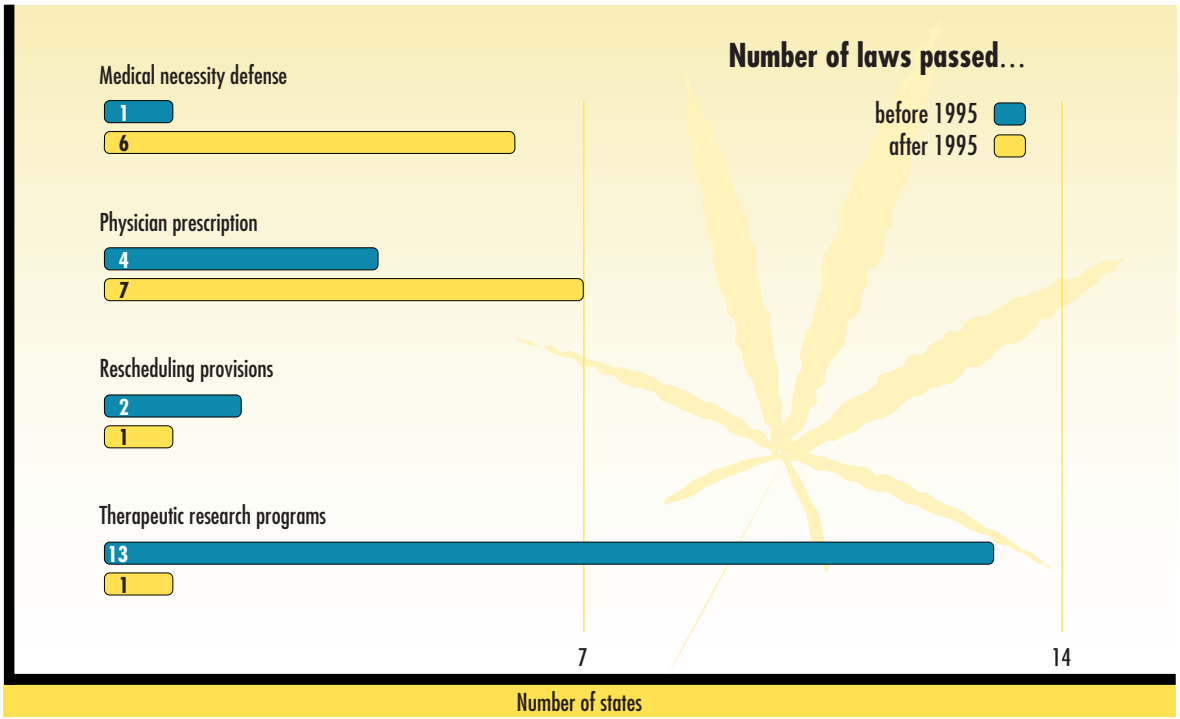


Figure C: Number of States with Specific Types of Medical Marijuana Provisions (as of January 1, 2000)



Penalty Provisions

Penalties for violating sale and possession provisions vary greatly by substance, by the quantity of the substance involved, and by the type of offense (i.e., sale or possession). These variations shed light on the relative lack of uniformity across the states and begin to illustrate the disparities that exist between state penalty schemes associated with violations of illicit substance sale and possession provisions. The following discussion highlights variations in the current status of state law addressing:

1. quantity triggers;
2. penalties for sale and possession of cocaine, marijuana, methamphetamine, and ecstasy;
3. penalties for subsequent offenses;
4. penalties for sale and/or possession of crack as compared to powder cocaine; and
5. penalties for sale and/or possession of selected club drugs.

It is important to remember that the penalties presented in this report are those provided in state statutes and are not necessarily those applied by judges in specific cases.

QUANTITY TRIGGERS

The number of quantity trigger levels in any given state ranges from one to over five.[3] The states with only one trigger level have broadly written criminal statutes for sale or possession offenses that do not delineate quantity amounts. Those that have multiple quantity triggers create a hierarchical scheme based on the quantity of a given drug, with larger quantities accorded higher penalties. As Figures D and E illustrate, the range of quantity triggers varies by the type of offense and substance. Most states specify at least two quantity triggers for *selling* cocaine, marijuana, and methamphetamine; however, only 11 states specify two or more quantity triggers for the sale of ecstasy. On the other hand, most states specify only one quantity trigger for violating provisions related to *possession* of ecstasy (N=28), cocaine (N=25), or methamphetamine (N=29). Quantity triggers related to possession of marijuana vary from one to five triggers; however, the majority of states (N=27) specify between three and five quantity triggers for violating the marijuana possession provisions.

Figure D: Distribution of Quantity Triggers Specified in State Legislative Penalty Schemes for Violating Sale Provisions by Substance (as of January 1, 2000)

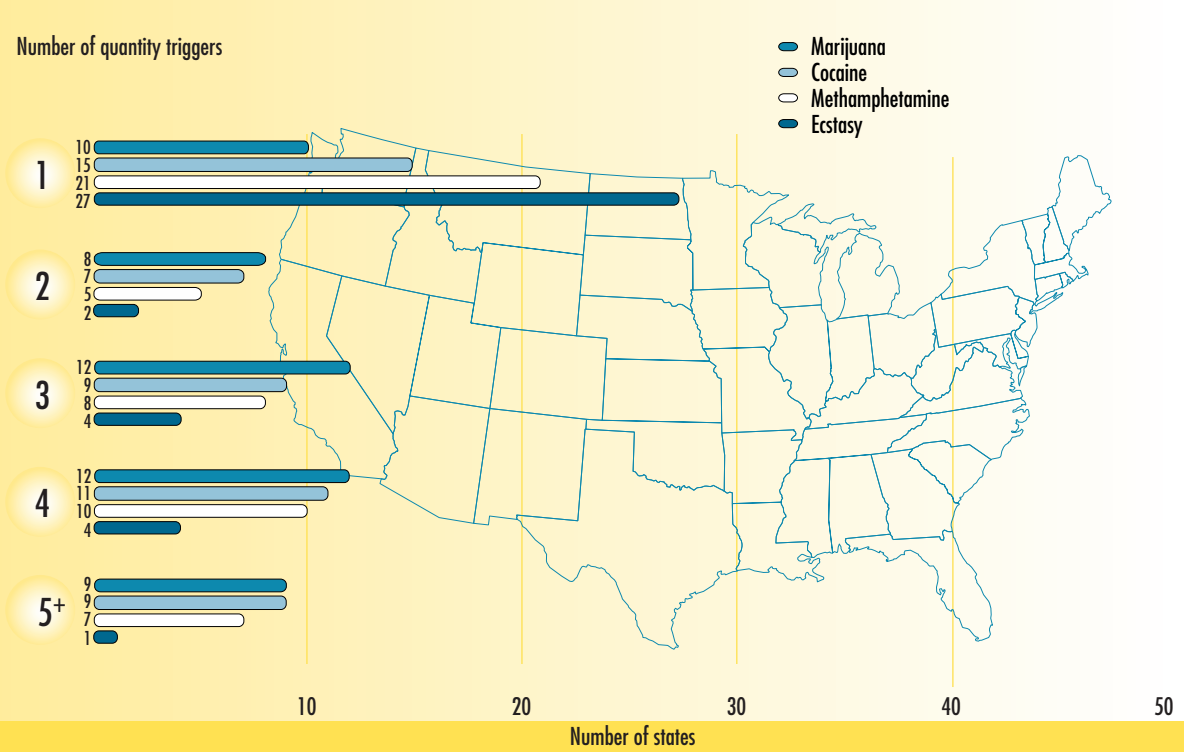
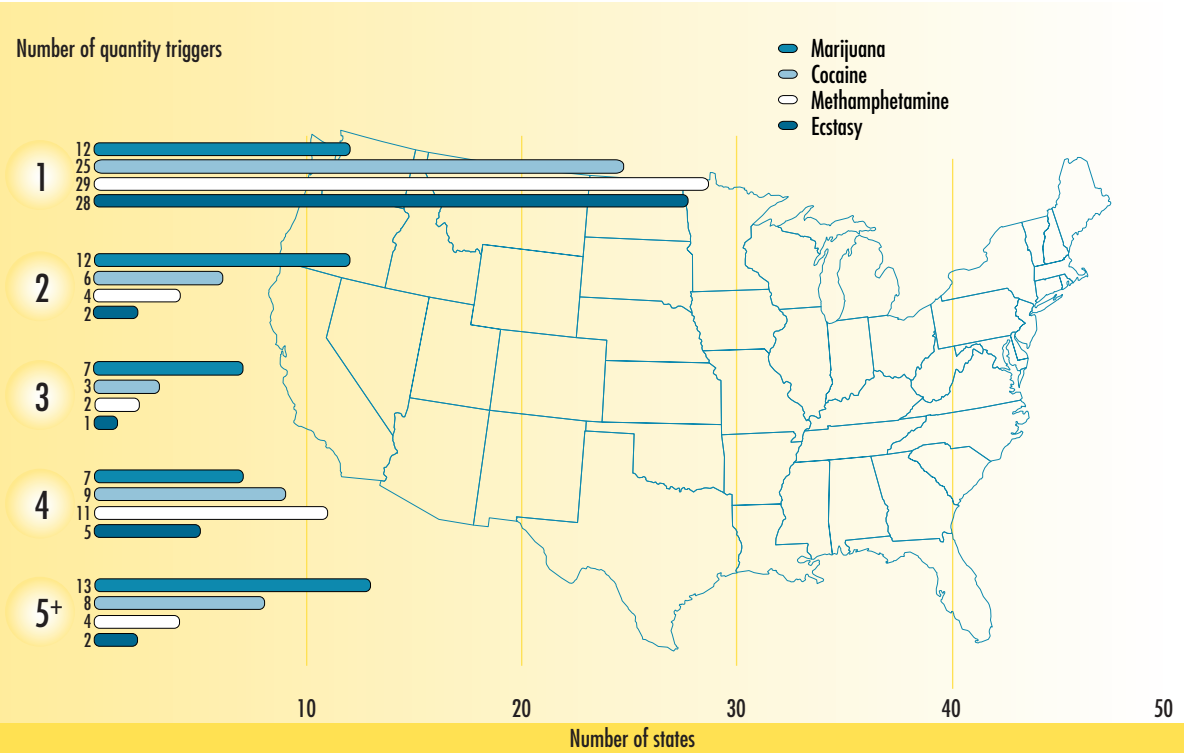


Figure E: Distribution of Quantity Triggers Specified in State Legislative Penalty Schemes for Violating Possession Provisions by Substance (as of January 1, 2000)



SALE AND/OR POSSESSION OF STANDARD RETAIL AMOUNTS

The standard retail amounts discussed previously do not result in standard penalties across the states. As shown by Table 1, there is considerable variation in the statutorily-imposed maximum imprisonment time for possession and sale offenses of the standard retail amount of each drug. The least variation exists in marijuana *possession* offenses, where 95% of the states reporting a statutorily-imposed maximum imprisonment time have a term of one year or less. Only two states, Minnesota and Nevada, specify maximum imprisonment periods greater than one year. However, the variability in statutorily-imposed imprisonment terms is significantly greater for possession of the standard retail amounts of cocaine, ecstasy and methamphetamine. The range of possible maximum imprisonment terms goes from less than 1 year to 15 years in the case of cocaine and ecstasy and from less than 1 year to 25 years in the case of methamphetamine. Only three states (6%) with a statutorily-imposed maximum imprisonment term impose a sentence of less than one year for cocaine and methamphetamine and only four states (11%) with statutorily-imposed maximum terms do so for ecstasy. However, over half of all states with statutorily-imposed incarceration times impose sentences of five years or more for possession offenses of the standard retail amount of each of the three drugs.

Table 1: Maximum Imprisonment Time for Standard Retail Amount by Type of Offense and Substance as of January 1, 2000 (in Years)

	Marijuana	Cocaine	Ecstasy	Methamphetamine
Possession				
Low	0.003	0.42	0.082	0.42
25th percentile	0.5	1	1	1.5
50th percentile	0.75	5	5	5
75th percentile	1	7	6	7
High	5	15	15	25
States that do not specify maximum imprisonment	9	0	14	1
Sale				
Low	0.5	1	1	1
25th percentile	1.375	10	5	6.75
50th percentile	5	15	10	10
75th percentile	7.75	30	20	25
High	Life	Life	Life	Life
States that do not specify maximum imprisonment	1	0	13	1

States impose a similarly wide range of maximum imprisonment terms for *sale* offenses of the standard retail amount of each of these drugs. However, the maximums imposed for violating sale provisions in each state are generally much higher than that imposed for violating possession provisions. In the case of marijuana, an offense for trying to sell 10 grams could be met with a maximum imprisonment term of less than one year in North Carolina but a term of life in Montana and Oklahoma. Similarly, a sale offense for the standard retail amounts of cocaine, ecstasy or methamphetamine could be met with a one year imprisonment term in North Carolina but a lifetime sentence in Montana. Although Montana is the only state that imposes a lifetime sentence for sale offenses of the standard retail quantity of ecstasy, three additional states (Arkansas, Idaho, and Oklahoma) impose lifetime sentences for sale offenses of the standard retail quantity of cocaine and four additional states (Arkansas, Idaho, Oklahoma and Texas) impose life sentences for the standard retail quantity of methamphetamine. At least half of all states with statutorily-imposed maximum imprisonment terms for sale of standard retail amounts impose terms of 10 years or more in the case of ecstasy and methamphetamine and 15 years or more in the case of cocaine.

State laws also include monetary penalties, or fines, for persons who sell or possess the standard retail amount of the four substances of interest. Table 2 shows that fines range from hundreds of dollars per infraction, to over $1 million, depending on the type of offense, state, and drug. As with the imprisonment data, the least variation exists in the maximum fines specified for marijuana *possession* offenses, with 96 percent of the states specifying a statutorily-based maximum fine of $5,000 or less for first offenders. Only Arizona and Minnesota specify maximum fines greater than $5,000 for a first offense involving possession of the standard retail amount of marijuana. The maximum fines specified for possession of the standard retail amount of cocaine, methamphetamine, and ecstasy are substantially greater. The statutorily-based maximum fines specified for possession of the standard retail amount of cocaine and methamphetamine range from $1,000 to $500,000 with more than 50 percent of the states specifying fines greater than $5,000. The greatest variation exists in the maximum fines specified for ecstasy possession—ranging from $500 to $750,000. Nearly 45 percent of the states with maximum fines for ecstasy possession specify a fine greater than $5,000. It should be noted that 15 states do not specify maximum fines for possession of the standard retail amount of ecstasy.

The statutorily-based maximum fines for *sale* of the standard retail amount of marijuana, cocaine, methamphetamine, and ecstasy are substantially greater than are the possession fines.

Table 2: Maximum Fine for Standard Retail Amount by Type of Offense and Substance as of January 1, 2000 (in Dollars)

	Marijuana	Cocaine	Ecstasy	Methamphetamine
Possession				
Low	100	1,000	500	1,000
25th percentile	500	5,000	2,125	5,000
50th percentile	1,000	10,000	5,000	10,000
75th percentile	1,075	25,000	21,250	25,000
High	150,000	500,000	750,000	500,000
States that do not specify maximum fines	2	3	15	5
Sale				
Low	100	2,500	5,000	5,000
25th percentile	5,000	17,500	10,000	10,000
50th percentile	10,000	27,500	20,000	25,000
75th percentile	23,750	100,000	100,000	100,000
High	500,000	1,000,000	1,000,000	1,000,000
States that do not specify maximum fines	3	5	16	4

As with the possession offenses, maximum fines for marijuana sales are much lower than those specified for cocaine, methamphetamine, and ecstasy. The maximum fines for marijuana sales range from $100 to $500,000, whereas the fines for the other three drugs range from $2,500 (cocaine) or $5,000 (ecstasy and methamphetamine) to $1 million. At a maximum fine of $1 million, Mississippi imposes the largest monetary penalty for sale of the standard retail amount of cocaine, methamphetamine, and ecstasy. Minnesota also specifies a $1 million maximum for sale of methamphetamine. At the other end of the spectrum, no maximum fines are specified for sale of the standard retail amount of any of the drugs in Georgia, Missouri, or North Carolina and 16 states do not specify maximum fines for sale of the standard retail amount of ecstasy.

A pullout chart located in the Appendix provides a graphical representation of the maximum statutory fines and imprisonment penalties for sale or possession for first offenses involving the standard retail amounts. These amounts are listed for cocaine, marijuana, and methamphetamine across all 50 states and the District of Columbia. The chart is divided into color-coded quartiles, allowing the reader to compare the maximum statutory fines or imprisonment for these three drugs across each state.

SUBSEQUENT OFFENSES

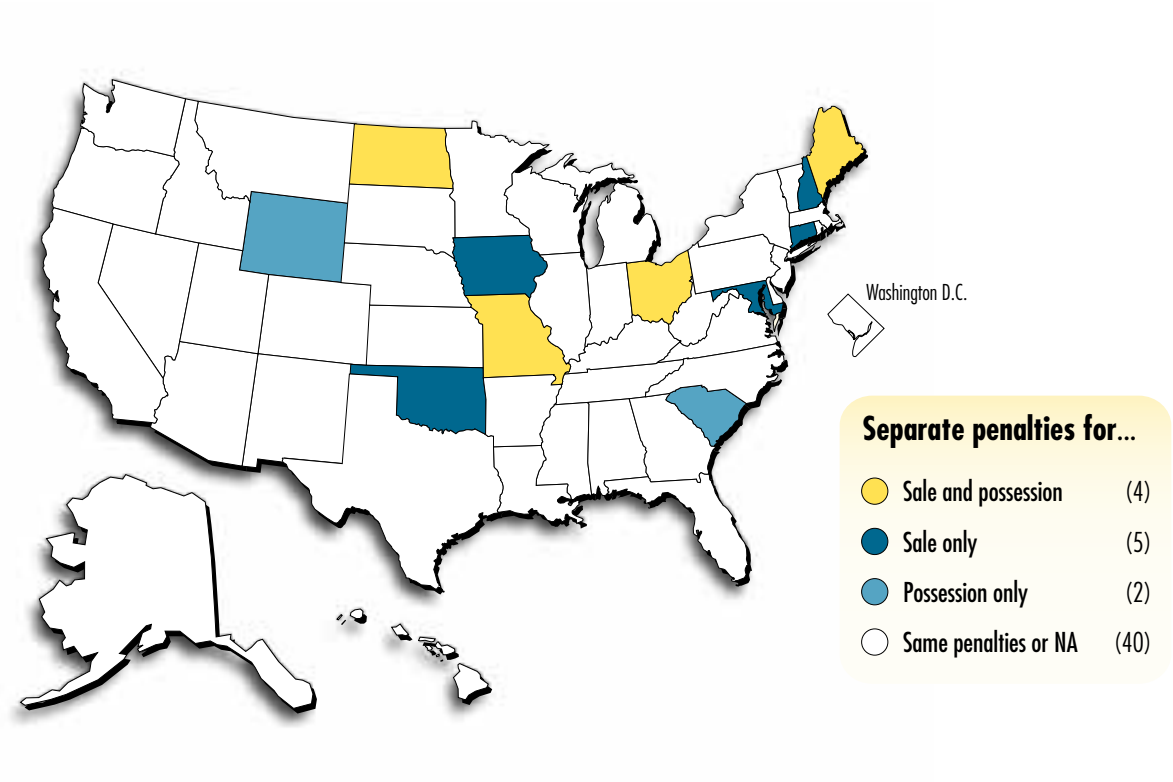
Most of the states have enhanced penalties for second, or subsequent, offenses for at least one type of offense and one trigger level. Five states (Delaware, Florida, New Jersey, Ohio, and Oregon) do not have increased statutory penalties associated with a second offense. This categorization does *not* represent the probability of a more severe sentence for a second infraction of an illicit drug law that is not the same offense, since in many cases the judicial system has other mechanisms in place to account for such enhancements. Instead, the data represented by this category only show those states that start increasing statutory penalties upon the second offense for the same violation. Other states that begin to enhance penalties based on multiple offenses, or based upon other regulatory schemes (e.g., sentencing guidelines), are not shown.

CRACK VS. POWDER COCAINE DISCREPANCIES

At the federal level, sentencing disparities between crack and powder cocaine emerged in the 1980s in the context of large increases in crack cocaine use, together with the conclusion that crack caused significantly more harm than powder cocaine to the individual and the community through increased violence (McBride et al., 2002). Congress eventually enacted legislation mandating five-year prison terms for the possession or sale of five grams of crack cocaine. This same legislation mandated the same penalty (five years) for the possession of 500 grams of powder cocaine. Thus, the Federal government defined the mandatory minimum sentencing disparity of crack to powder cocaine at 100:1 (U.S. Sentencing Commission, 1997). Interestingly, this dichotomy does not appear to occur as frequently in state law.

As Figure F illustrates, only 11 states (Connecticut, Iowa, Maine, Maryland, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, and Wyoming) have created a separate penalty scheme for crack cocaine.[4] Of those 11 states, Maine, Missouri, North Dakota and Ohio have separate penalties for both sale and possession offenses; the remaining seven states specify different penalties for smaller amounts of crack cocaine that are subject to higher penalties than is sale and/or possession of the same amount of cocaine powder. The reader is reminded, however, that even though the vast majority of states treat cocaine powder and crack cocaine offenses the same in legislative statutes, that does *not* mean that judges treat these offenses the same in the actual sentencing of offenders within the state. It just means that such sentencing disparity, if it exists, is not statutorily-based.

Figure F: Separate Penalties for Sale and Possession of Crack vs. Powder Cocaine (as of January 1, 2000)



CLUB DRUGS

While club drugs have only recently emerged in the national spotlight, many states have been creating a framework for penalizing persons found to be in violation of state law relative to the sale and/or possession of Rohypnol, GHB, ketamine, and ecstasy. Across the states, the statutorily-imposed maximum imprisonment for sale and possession of Rohypnol, GHB, and ecstasy range up to a maximum of lifetime imprisonment. Maximum imprisonment periods for sale and possession of ketamine are lifetime and 20 years, respectively. The maximum statutorily-imposed fine for the sale of Rohypnol, GHB, and ketamine is $750,000 while the maximum fine for sale of ecstasy is $1 million. Maximum fines for possession provisions are somewhat more varied—$500,000 for ketamine, $600,000 for GHB, $750,000 for Rohypnol, and $1 million for ecstasy.

The following *State Highlights* section allows for more detailed comparisons of federal and state controlled substances schedules, fines and imprisonment penalties for sales and possession of selected drugs, and variations in medical marijuana statutes.

Endnotes

1 This type of scheduling should be differentiated from those states that have listed marijuana as a Schedule I substance but that also reschedule it to a lower schedule for medicinal use purposes. The discussion related to medical marijuana further describes this latter scenario.

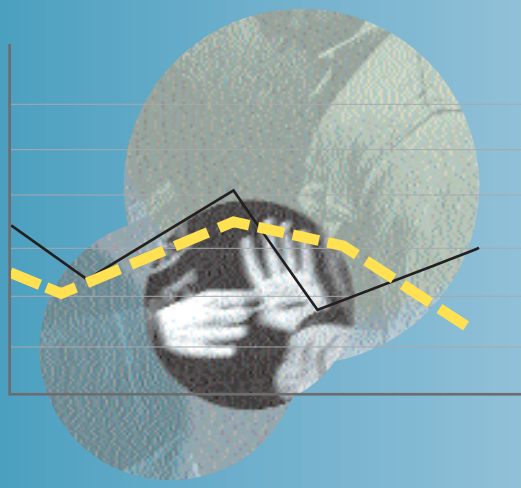
2 Several states have enacted medical marijuana laws since January 1, 2000, including Colorado, Hawaii, and Nevada.

3 In instances where a state does not specify penalties for a given substance, we classified the state as having zero trigger levels.

4 Virginia also specifies higher penalties for the sale of crack cocaine than for cocaine powder; however, this differential does not occur until very large quantities are involved—2.5 kilograms of crack cocaine and 5 kilograms of cocaine powder.

Section

4 State Data Pages



How to Interpret the State Highlights

1 States list controlled substances in lists, called schedules, ranking the substances by their perceived danger and medical utility. Most states follow the federal model of scheduling. For a more complete explanation, see page 7.

2 Penalties shown apply to the sale of the specified illicit substances, listing amounts in ascending order of quantity.

3 This column lists the four illicit drugs for which state-level sale penalty data are presented.

4 The number in parentheses reflects the number of quantity triggers specified in the statute. Up to three weight levels (triggers) are shown in Column 6 for each drug. For a more complete explanation, see page 9.

5 The starred rows represent the trigger level in which the standard retail amount for each drug falls. The standardized quantities are: 1g—Cocaine, 10g—Marijuana, 10g—Methamphetamine, and .125g—Ecstasy. For a more complete explanation, see the discussion of quantity triggers on page 9.

6 This column specifies the weight level associated with a given penalty scheme. All weights have been converted to grams to provide easy comparisons across the illicit substances, and across the different states. Notations are provided to identify the actual unit (e.g., ounces, pounds) specified in that state's law.

7 Dollar amounts reflect the minimum and maximum fines designated in the state statutes. If the law specifies only a single fine, it is shown in the maximum fine column.

Selected State Illicit Drug Laws as of January 1, 2000

Alabama

1 Controlled Substance Scheduling

Substance

		Selected illicit drugs			Selected club drugs			
Jurisdiction	# of Schedules	Marijuana	Cocaine	Methamphetamine	Rohypnol	GHB	Ecstasy (MDMA)	Ketamine
Federal	5	I	II	II	IV	NSch	I	III
Alabama	5	I	II	III	NSch	NSch	NSch	NSch

NSch–Not scheduled

2 Sale Penalties

★ = Quantity/trigger combination contains "standard retail amount"

3 Drug	4 (# triggers)		5 6 Quantity	7 Fine: S Minimum	7 Fine: S Maximum	8 Years of imprisonment: Minimum	8 Years of imprisonment: Maximum	9 Increased penalties for subsequent violations
Cocaine	(5+)	★	Any	0	10,000	2	20	☑
			28.0g	0	50,000	3		☑
			500.0g	0	100,000	5		☑
Marijuana	(5+)	★	Any	0	10,000	2	20	☐
			997.90g†	0	25,000	3		☑
			45359.2g†	0	50,000	5		☑
Methamphetamine	(5+)	★	Any	0	10,000	2	20	☑
			28.0g	0	50,000	3		☑
			500.0g	0	100,000	5		☑
Ecstasy (MDMA)	(0)		NS	0	0	NS	NS	☐
								☐
								☐

†Converted from lbs NS–Not specified

10 Different Sale Penalties for Crack

No ☑ Yes ☐

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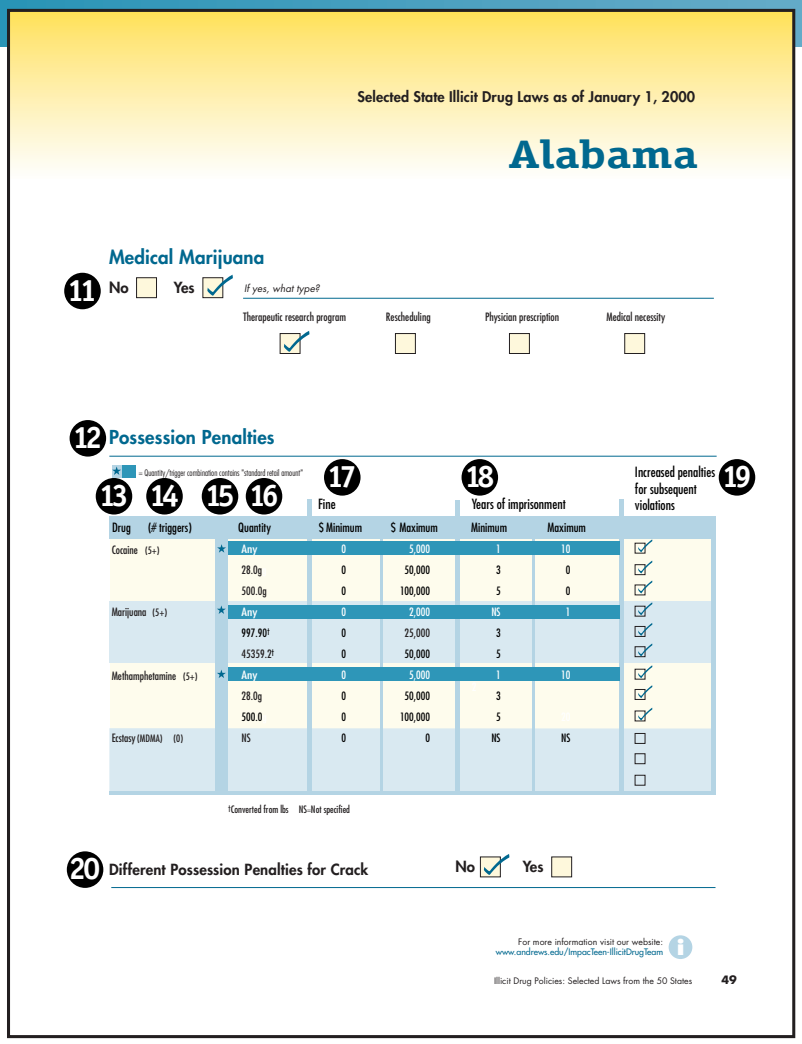
8 Incarceration penalties are shown in years. If an incarceration penalty is described in the state law as both a numeric amount and "life" imprisonment, only "life" is shown in this column. Mandatory minimum imprisonment periods are denoted with an "m" designator.

9 A checkmark indicates instances where the penalties for sale of a given weight of an illicit substance increase on the second violation.

10 A checkmark indicates those instances where crack cocaine has been assigned sale penalties that differ from powder cocaine.



Selected State Illicit Drug Laws as of January 1, 2000

Alabama

Medical Marijuana

11 No ☐ Yes ☑ *If yes, what type?*

Therapeutic research program	Rescheduling	Physician prescription	Medical necessity
☑	☐	☐	☐

12 Possession Penalties

★ = Quantity/trigger combination contains "standard retail amount"

13 Drug	14 (# triggers)		15 Quantity	16 Fine: S Minimum	Fine: S Maximum	17 Years of imprisonment: Minimum	Years of imprisonment: Maximum	18 Increased penalties for subsequent violations
Cocaine	(5+)	★	Any	0	5,000	1	10	☑
			28.0g	0	50,000	3	0	☑
			500.0g	0	100,000	5	0	☑
Marijuana	(5+)	★	Any	0	2,000	NS	1	☑
			997.90†	0	25,000	3		☑
			45359.2†	0	50,000	5		☑
Methamphetamine	(5+)	★	Any	0	5,000	1	10	☑
			28.0g	0	50,000	3		☑
			500.0	0	100,000	5		☑
Ecstasy (MDMA)	(0)		NS	0	0	NS	NS	☐
								☐
								☐

†Converted from lbs NS–Not specified

20 Different Possession Penalties for Crack No ☑ Yes ☐

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11 Checkmarks indicate the type(s) of legislative provisions a state has passed enabling the medical use of marijuana. A state may have enacted more than one type of provision. For a more complete explanation, see pages 10–13.

12 Penalties shown apply to the possession of the specified illicit substances, listing amounts in ascending order of quantity.

13 This column lists the four illicit drugs for which state-level possession penalty data are presented.

14 The number in parentheses reflects the number of quantity triggers specified in the statute. Up to three weight levels (triggers) are shown in Column 16 for each drug. For a more complete explanation, see page 9.

15 The starred rows represent the trigger level in which the standard retail amount for each drug falls. The standardized quantities are: 1g—Cocaine, 10g—Marijuana, 10g—Methamphetamine, and .125g—Ecstasy. For a more complete explanation, see the discussion of quantity triggers on page 9.

16 This column specifies the weight level associated with a given penalty scheme. All weights have been converted to grams to provide easy comparisons between the illicit substances, and across the different states. Notations are provided to identify the actual unit (e.g., ounces, pounds) specified in that state's law.

17 Dollar amounts reflect the minimum and maximum fines designated in the state statutes. If the law specifies only a single fine, it is shown in the maximum fine column.

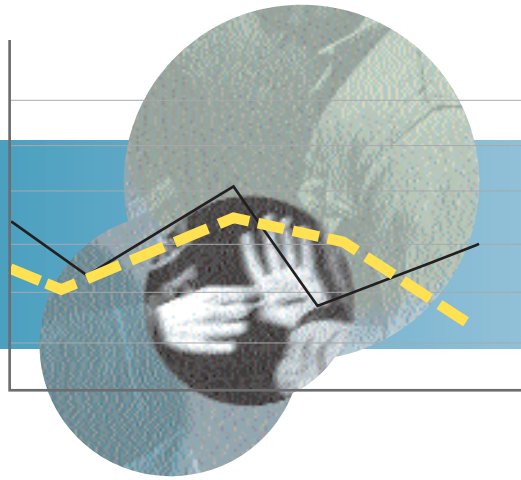
18 Incarceration penalties are shown in years. If an incarceration penalty is described in the statute as both a numeric amount and "life" imprisonment, only "life" is shown in this column. Mandatory minimum imprisonment periods are denoted with an "m" designator.

19 A checkmark indicates instances where the penalties for possession of a given weight of an illicit substance increase on the second violation.

20 A checkmark indicates those instances where crack cocaine has been assigned possession penalties that differ from powder cocaine.

Section

5 Conclusions



Our society has chosen to use law as a primary means of controlling both the supply and demand for illicit drugs. Specifically, individuals are prohibited from cultivating, producing, distributing, selling, or possessing certain substances, with only minor exceptions in cases where medicinal value is recognized. Many argue that these laws do not effectively deter drug using behaviors; others believe that the certainty, swiftness, and severity of punishment specified by these laws does deter drug using behavior. It is not our intent in this report to weigh in on this debate; instead, we seek merely to provide accurate data that can be used to help inform the discussion.

Often the public and policy makers believe that only federal drug policy matters. However, the majority of drug prosecutions in this country occurs in state courts and, therefore, are subject to state-level penalties. In addition, states have a tradition of drug policy experimentation that has, at times, differed from federal policy. This report shows that this tradition continues today. While the vast majority of states conform to the Federal Controlled Substances Act (CSA) in the statutory scheduling of cocaine, marijuana and methamphetamine, there is far less conformity in club drug scheduling: half of the states have scheduled GHB prior to federal scheduling; the majority of states have not scheduled ketamine, and 11 state legislatures have not scheduled ecstasy. In addition, this report shows that despite the federal position regarding the lack of medical utility of marijuana, as of January 1, 2000, 24 states and the District of Columbia recognize the medicinal value of marijuana and have adopted some type of legislation that enables its use.

This report also shows that across states there is significant variation in the legislated penalty structures for cocaine, marijuana, methamphetamine and ecstasy. First, states vary in the number and value of quantity trigger points by type of offense (sale or possession) and by substance. This could be an important policy indicator in that it signifies that some states disregard quantity when determining punishment, while other states try to link severity of punishment to the quantity of the substance possessed and/or sold. Second, states vary in the actual penalties imposed for the sale and possession of a standard retail amount of specific substances. Marijuana possession offenses are perhaps the most uniformly treated drug offense, with all but two states imposing maximum jail sentences of no more than one year for possession of a standard retail amount. However, even in this case, there is substantial variation in the legislated maximum fine, which ranges from $0 to $150,000 across states. Penalty ranges for the possession of standard retail amounts of other substances show considerably more variance across states. For example, the maximum statutory penalty for the sale of a standard retail amount of cocaine, methamphetamine, or ecstasy ranges from one-year imprisonment to life in prison. The significance of these variations in state penalty structures, of course, depends on the extent to which differences in legislated penalties translate into differences in penalties imposed.

The data in this report also show that there are ways in which state policies are similar to each other but different from federal policy. One of the most hotly debated national drug policy issues is the sentencing disparity between powder and crack cocaine. The federal ratio is 100:1. That is, it takes one hundred times the amount of powder cocaine to equal the same sentence as crack cocaine. The data presented in this report show that only six states have separate penalties for crack and powder cocaine possession offenses and only nine states have separate penalties for crack and powder cocaine sale offenses. These data suggest that what is of significant importance at the federal level may be of considerably less importance at the state level. Given that the majority of prosecutions occur at the state level, the lack of a difference in state statutory penalties offers an interesting new perspective on this policy debate.

Researchers have called for comparisons of U.S. drug policies with those of other countries. These data suggest that comparisons of different drug policies can occur within the United States. The diversity of state drug policy approaches with respect to scheduling, penalty structures, and medical allowances provides an intriguing natural experiment in which researchers,

policy analysts, and others can begin to evaluate the impact of particular drug policy applications. For example, the variation in state penalty severity for a standard retail amount of a particular substance can be used to determine if harsher statutory penalties for particular drugs are associated with youth perceptions of the risks associated with using that drug, their perceptions of its availability, and general use rates. Similarly, one could use inter-state variation to explore whether marijuana medical allowances have spillover effects on youth perceptions and/or recreational use.

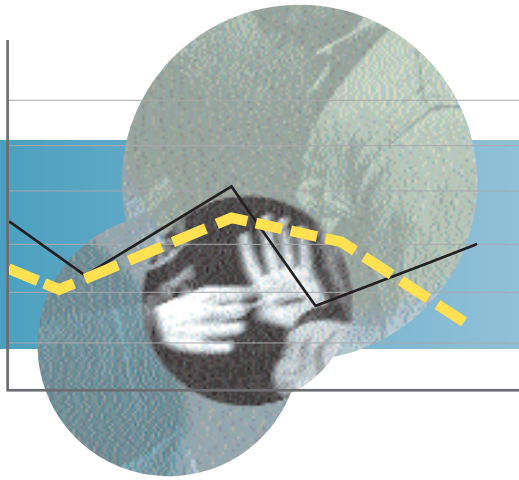
Our societal choice of the use of law, especially criminal law, as a major means of addressing drug use can have significant consequences. The approach has virtually saturated the criminal justice system with drug users and, perhaps, it may also have precluded the consideration of other policy alternatives to address the needs of drug users. We believe that insight can be gained from a more detailed and comprehensive analysis of what states are doing legislatively to address the drug problem. This report provides a critical first step by identifying some areas of statutory law where variation exists. Linking these state level policies with youth perception about drugs, drug use and outcomes associated with drug use is the next step to determine which (if any) of these state approaches influence the behaviors they target.

Future Directions

The conceptual model that guides the research questions being addressed by the Illicit Drug Team, as well as an overview of the entire ImpacTeen/Bridging the Gap initiative, is available at www.impacteen.org. Our future research agenda calls for examining the relationship between the types of statutory laws described in this report and other state policies such as diversion, budgetary allocations to enforcement and treatment and access to treatment and youth perceptions, drug use and consequences of use.

Section

6 References



Arrestee Drug Abuse Monitoring (ADAM) Project. (2000, July). 1999 annual report on drug use among adult and juvenile arrestees. In Research Report [Online]. Available: http://www.adam-nij.net/files/INTO.pdf.

Beck, A. J., & Mumola, C. J. (1999, Aug). Prisoners in 1998: Bureau of Justice Statistics bulletin. In U.S. Department of Justice, Office of Justice Prevention, NCJ 175678 [Online]. Available: http://www.ojp.usdoj.gov/bjs/abstract/p98.htm.

Belenko, S. R. (2000). *Drugs and drug policy in America*. Westport, CT: Greenwood Press.

Centers for Disease Control and Prevention. (2001). New CDC report on U.S. mortality patterns. Available: http://www.cdc.gov/nchs/releases/01facts/99mortality.htm.

Chitwood, D. D., McBride, D. C., French, M. T., & Comerford, M. (1999, Mar-Apr). Health care need and utilization: A preliminary comparison of injection drug users, other illicit drug users, and nonusers. *Substance Use & Misuse*, 34(4-5), 727-746.

The Controlled Substances Act (CSA), 21 U.S.C. § 811 *et seq* (1970).

French, M. T., McGeary, K. A., Chitwood, D. D., & McCoy, C. B. (2000). Chronic illicit drug use, health services utilization, and the cost of medical care. *Social Science and Medicine*, 50(12), 1703-1713.

Glaeser, E. L., Kessler, D. P., & Piehl, A. M. (1998, June). What do prosecutors maximize? An analysis of drug offenders and concurrent jurisdiction. Cambridge, MA: National Bureau of Economic Research, Working Paper Number 6602.

Harwood, H., Fountain, D., & Livermore, G. (1998). *The economic costs of alcohol and drug abuse in the United States*, 1992. Bethesda, MD: National Institute on Drug Abuse.

Inciardi, J. A. (2001). *The War on Drugs III: The continuing saga of the mysteries and miseries of intoxication, addiction, crime, and public policy.* Boston, MA: Allyn and Bacon.

Johnston, P., Rhodes, W., Carrigan, K., & Moe, E. (1999, Feb). The price of illicit drugs: 1981 through the second quarter of 1998 [Report]. Washington, D.C.: Office of National Drug Control Policy.

Kleiman, M. A. R. (1992). Against excess: *Drug policy for results*. New York, NY: Basic Books.

Leukefeld, C. G., Logan, T. K., Martin, S. S., Purvis, R. T., & Farabee, D. (1998). A health services use framework for drug-abusing offenders. *American Behavioral Scientist, 41*(8), 1123-1135.

MacCoun, R., & Reuter, P. (2001). Evaluating alternative cannabis regimes. *The British Journal of Psychiatry, 178*, 123-128.

MacCoun, R., Kilmer, B., & Reuter, P. H. (In press, Spring 2002). Research on drug-crime linkages: The next generation. In H. Brownstein (Ed.), *Drugs and Crime: A Research Agenda for the 21st Century*. Washington, D.C.: U.S. Department of Justice.

McBride, D. C., VanderWaal, C. J., Pacula R. L., Terry-McElrath, Y. M., & Chriqui, J. F. (2002). Mandatory minimum sentencing and drug law violations: Effects on the criminal justice system. In C. G. Leukefeld, F. M. Tims & D. Farabee (Eds.), *Treatment of Drug Offenders: Policies and Issues*. New York, NY: Springer Publishing Company.

McBride, D. C., VanderWaal, C. J., & Terry-McElrath, Y. M. (In press, Spring 2002). The drugs-crime wars: Past, present and future directions in theory, policy and program interventions. In H. Brownstein (Ed.), *Drugs and Crime: A Research Agenda for the 21st Century*. Washington, D.C.: U.S. Department of Justice.

McBride, D. C., VanBuren, H., Terry, Y. M., & Goldstein, B. J. (2000). Depression, drug use and health services need and utilization. *Emergent Issues in the Field of Drug Abuse*. In J. A. Levy, R. C. Stephens & D. C. McBride (Eds.), *Advances in Medical Sociology*. Stamford, CT: JAI Press.

Mumola, C. J. (1999, Jan). Substance abuse and treatment, state and federal prisoners, 1997. U.S. Department of Justice, Office of Justice Programs, NCJ 172871 [Online]. Available: http://www.ojp.usdoj.gov/bjs/pub/pdf/satsfp97.pdf.

Murphy, S. E. (1986). Marihuana decriminalization: The unfinished reform. Unpublished doctoral dissertation, University of Missouri, Columbia.

Musto, D. F. (1999). *The American disease*. New York, NY: Oxford University Press.

National Center on Addiction and Substance Abuse (CASA). (2001, Jan). Shoveling up: The impact of substance abuse on state budgets. Available: http://www.casacolumbia.org/usr_doc/47299.pdf.

National Commission on Marihuana and Drug Abuse. (1972, Mar). *Marihuana: A signal of misunderstanding*. Washington, D.C.: U.S. Government Printing Press.

Office of National Drug Control Policy (ONDCP). (2000a). The National Drug Control Strategy: FY 2001 budget summary: 2000 Annual Report. Available: http://www.whitehousedrugpolicy.gov/policy/budget00/.

Office of National Drug Control Policy (ONDCP). (2000b). MDMA (Ecstasy): ONDCP factsheet. Available: http://www.whitehousedrugpolicy.gov/pdf/ncj181141.pdf.

Ostrom, B., & Kauder, N. (1999). Drug crime: *The impact on state courts*. In National Center for State Courts Caseload Highlights, vol. 5(1).

Schmitz, R., & Thomas, C. (2001). State-by-state medicinal marijuana laws: How to remove the threat of arrest. Available: http://www.mpp.org/statelaw/index.html.

The National Organization for the Reform of Marijuana Laws (NORML). (2001, July 19). Bipartisan bill to legalize medical marijuana pending in congress. In Weekly News Bulletin [Online]. Available: http://www.norml.org/news/archives/01-07-19.shtml.

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2000). *Summary of findings from the 1999 National Household Survey on Drug Abuse (NHSDA)*. Rockville, MD: U.S. Department of Health and Human Services.

The Substance Abuse and Mental Health Services Administration (SAMHSA). (2001). *Year-end 2000 emergency department data from the Drug Abuse Warning Network (DAWN)*. Rockville, MD: U.S. Department of Health and Human Services.

United States Sentencing Commission. (1997, April). Special Report to the Congress: Cocaine and Federal Sentencing Policy. Available: http://www.ussc.gov/legist.htm.

United States v. Oakland Cannabis Buyers' Cooperative. (2001). Supreme Court of the United States, *No. 00-151*. Washington, D.C.

Waller, P. F. (1995). Crash characteristics and injuries of victims impaired by alcohol versus illicit drugs. *Proceedings of the 39th Conference of the Association for the Advancement of Automotive Medicine*, pp. 89-104.

Wilson, D. J. (2000, May). Drug use, testing, and treatment in jails. In Bureau of Justice Statistics Special Report [Online]. Available: http://www.ojp.usdoj.gov/bjs/pub/pdf/duttj.pdf (NIJ 179999).

Zhang, Z., Huang, L. X., & Brittingham, A. M. (1999). *Worker drug use and workplace policies and programs: Results from the 1994 and 1997 NHSDA*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): Office of Applied Studies.

APPENDIX