OPIOIDS, ADDICTION, AND THE BRAIN

Presenters:

- Dr. Miriam Harris, Assistant Professor of Medicine and Addiction Medicine Fellow, Boston University School of Medicine; Department of Internal Medicine, Boston Medical Center
- Lisa Newman Polk, Esq. LCSW, lawyer and social worker

WHEN LESS IS MORE

Reforming the Criminal Justice Response to the Opioid Epidemic

By Jonathan Giftos and Lello Tesema

The young man in clinic, whom we'll call Angelo, bought his first bag of heroin when he was 19. At 24, he was in jail for the fourth time on charges related to his drug use. This time it was for selling a bag of heroin to an undercover police officer.

It started as a casual habit—sniffing a couple of bags a day with his girlfriend. With time, he needed more and more drugs to get the same effect. Angelo also began to get sick if too much time passed between use. As his tolerance for heroin increased, and the withdrawal symptoms became more severe, he found it more efficient to inject instead of sniff. Today he shoots 20 bags of heroin a day and lives with hepatitis C acquired through sharing needles.

To physicians who work in the largest jails in the country, Angelo's story is both tragic and familiar.

Half of U.S. state and federal prisoners and nearly two-thirds of jail inmates have a substance use disorder—a rate fourfold higher than the general population. Of this group, a large proportion have an opioid use disorder, typically involving heroin or prescription pain medication. Death rates from overdoses involving opioids have quadrupled since 1999, and overdose has eclipsed motor vehicle accidents as the number one cause of death in Americans under age 50. In addition to overdose, having an opioid use disorder also raises the risk of other medical conditions such as HIV or hepatitis C infection. The health and economic costs of the opioid epidemic range from $80 billion to $500 billion per year, a substantial portion of which is incurred by the criminal justice system.

While staggering, these numbers do not surprise us. We have seen too many people like Angelo cycle in and out of jails and prisons for reasons related to their drug use. Their continued struggle is a sign of both a broken safety net and excessive reliance on a criminal justice system ill-equipped to respond to their needs.

Each time Angelo gets arrested, he gets "detoxed," many times without appropriate medical supervision, only to relapse to heroin use soon after he is released. The one time he was referred to treatment, his insurance had been suspended while incarcerated, and so he was denied care due to lack of insurance coverage. Most recently, he overdosed and almost died just hours after leaving jail.

The criminal justice system confers significant additional health risks to patients with an opioid use disorder. Forced detoxification from opioids while incarcerated lowers a patient's opioid tolerance and is associated with a 129-times increased risk of overdose death in the first two weeks after release into the community. And untreated opioid withdrawal—a syndrome characterized by vomiting, diarrhea, intense muscle cramps, and paralyzing anxiety—is a major risk factor for suicide in jails and prisons.

Buprenorphine and methadone—medications collectively referred to as opioid agonist therapy—have been shown to reduce the opiod overdose death rate by as much as 50 percent for community-dwelling patients with an opioid use disorder when compared to detoxification and counseling alone. Prescribed by a medical provider and taken daily, these medications mimic short-acting opioids such as heroin or oxycodone by binding to the same receptors in the brain—the opioid receptors. The effect of this receptor binding is twofold. First, it prevents onset of withdrawal symptoms and reduces the patient's craving to use more dangerous illicit opioids. Second, by sufficiently occupying the opioid receptors, these medications effectively block the euphoric response to additional opioids the patient may take, thereby reducing the incentive to use. Collectively, the effects of opioid agonist therapy reduce the risk of relapse to heroin use, while also reducing the chance that a relapse event will be fatal.

Yet, despite their established effectiveness, use of opioid agonist therapy is exceedingly rare in correctional settings. Fewer than 40 of the 5,000 correctional institutions in this country offer methadone or buprenorphine maintenance. And the majority of individuals receiving these

medications prior to arrest are frequently forced to withdraw from them once incarcerated.

This disruption is problematic. Incarceration often undoes meaningful gains made toward long-term recovery. Research shows that forcing someone to withdraw from methadone while incarcerated leaves them less likely to restart treatment after leaving custody. And like Angelo, the majority of people with public insurance have their coverage suspended while incarcerated, leading to dangerous gaps in access to treatment upon return to the community.

Still, offering evidence-based treatment in custody can be life-saving. Despite scarce implementation, recent studies have shown that offering methadone or buprenorphine maintenance to incarcerated patients with an opioid use disorder is associated with an 85 percent reduction in overdose death in the first four weeks after release. Research also shows that when these treatments are available in correctional settings, fewer people die of overdose while in custody. In light of such strong supporting evidence, some jurisdictions are working to expand the availability of opioid agonist therapy. But lack of access to this vital treatment is still the pervasive norm in correctional settings across the country.

Reluctance to offer opioid agonist therapy in correctional settings is rooted in concerns both practical and philosophical—but not in science. Although these medications can be diverted, the health risks posed to other inmates is marginal when compared to the wider, long-term benefits of ensuring access to treatment. And careful oversight over the storage and administration of these medications can mitigate this risk, as demonstrated in New York City, which has used these medications successfully for many years. More problematic is the perception by many in corrections that maintenance on opioid agonist therapy is simply "replacing one drug with another" and therefore does not reflect authentic recovery. Despite decades of evidence demonstrating the public health benefits of these treatments, this bias has posed a durable barrier to more widespread acceptance of opioid agonist therapy in correctional settings.

The story behind a third and newer Federal Drug Administration (FDA)-approved medication for the treatment of opioid use disorder—injectable, long-acting naltrexone (also known as Vivitrol®)—underscores the long-standing bias against opioid agonist therapy. Despite its $1,000 a month price tag and a smaller body of evidence to support its use, this opioid antagonist (an opioid blocker) has seen remarkable uptake in criminal justice settings. Injectable, long-acting naltrexone is often marketed directly to stakeholders in criminal justice, potentially leveraging stigma against proven treatments such as methadone and buprenorphine. While the evidence base for naltrexone is growing, especially among self-selected and highly motivated patients, there is not sufficient data to support naltrexone being offered as the sole treatment to justice-involved patients. Ultimately, the best medication is the one that is specifically suited to a patient's needs and goals, and the one that the patient is motivated to continue taking. For this reason, we argue that all three FDA-approved medications—methadone; buprenorphine; and injectable, long-acting naltrexone—should be offered to justice-involved patients with opioid use disorder.

Naloxone—a rescue medication that reverses the effects of an opioid overdose—is another important tool in reducing overdose deaths. In many cities around the country, health departments have partnered with public safety to train police officers to identify an overdose event and respond appropriately with naloxone administration. This undoubtedly has saved many lives. Additionally, research has shown that people who use drugs are also likely themselves to be first responders to an overdose. In response to this finding, a few jail systems, such as New York City and Cook County, Illinois, and the New York State prison system have instituted programs to train and distribute naloxone to soon-to-be-released inmates or their families. Still, this crucial harm reduction strategy has yet to be adopted by the vast majority of jails and prisons.

Alternatives to Incarceration for Patients with an Opioid Use Disorder

Angelo's case is now being heard in a treatment court. But the judge is offering him a year in a residential treatment program that cannot provide him with buprenorphine, the only treatment that has allowed him to achieve abstinence in the past. He worries that he is being set up to fail and wonders if he should just take the two years in state prison instead.

In response to an evolving recognition of addiction as a chronic medical illness and not a moral failing, many jurisdictions are seeking alternative strategies to arrest and incarceration that promote public health while preserving public safety. This broad-based reform effort has taken many shapes, from treatment courts to pre-arraignment diversion. Thoughtful decriminalization also is being seriously considered.

Drug treatment courts represent an alternative to traditional criminal court for cases where problematic drug use was thought to be an underlying risk factor for the alleged offense. These specialized courts share the common feature that a court-supervised treatment alternative is offered to patients in exchange for deferred or suspended sentencing. But in practice, the 3,100 drug courts in the United States

Dr. Jonathan Giftos is a general internal medicine physician. He is the clinical director of substance use treatment and medical director of the Opioid Treatment Program for the NYC Health + Hospitals, Division of Correctional Health Services.

Dr. Lello Tesema is a general internal medicine physician. She is the director of population health at Correctional Health Services, Department of Health Services of Los Angeles County.

vary tremendously, even across individual states. The heterogeneity of drug courts makes it difficult to understand the key elements of their success or measure how well they work overall.

The theoretical benefit of the drug court model is that it provides a pathway for people to receive treatment while avoiding incarceration. Studies have shown some short-term benefits to these courts by way of reduced in-program drug use and reduced rates of re-arrest. But success largely hinges on one's ability to carefully navigate the court-supervised process, which can be challenging for patients without social support or stable housing. Additionally, there is some evidence that racial minority participants are more likely to be terminated from drug courts, raising concerns that long-standing racial disparities in the criminal justice system exist in treatment courts as well.

Some critics argue that drug courts are coercive. Patients often must plead guilty to the top arraignment charge in exchange for a treatment alternative. Others note that the treatment plans of drug courts are not always clinically appropriate, often mandating drug treatment for those who would not benefit from such services, while failing to render evidence-based treatment to those who need it. For example, a national survey in 2010 noted that less than half of drug courts offered opioid agonist therapy with methadone or buprenorphine for patients with an opioid use disorder.

Lastly, drug courts require abstinence. Given the chronic, relapsing, and remitting nature of addiction, an abstinence-only model reflects a narrow measure of recovery that can be hard to attain for many. If drug court participants "fail" court-supervised treatment, they too often face harsher, longer sentences than they would have received had they pled guilty to the original charge in criminal court. This calls into question whether drug courts are fulfilling their goal of transforming the way drug users are seen from criminal defendants to people in need of medical care or social support.

While drug courts provide select patients with a substance use disorder an opportunity to avoid incarceration, they still represent a criminal justice intervention to a public health problem with all the limitations noted above. As a result, a small but growing number of cities across the country are re-imagining the way law enforcement engages people who use drugs through an intervention called pre-arraignment diversion.

The Law Enforcement Assisted Diversion (LEAD®) program, first launched in Seattle, Washington, in 2011, is one such example. Through this program, police officers can direct low-level, nonviolent drug offenders directly to community services and support, while bypassing deeper involvement with the criminal justice system. Unlike drug courts, abstinence is not required to receive services, and success is measured by meaningful engagement in care. While the health outcomes of this pilot program are forthcoming, early studies have shown this model to reduce risk of subsequent incarceration—with all its attendant health risks—by 60 to 90 percent for program participants.

Despite less criminal justice system exposure, and more direct connection to services tailored specifically to patients' needs, pre-arraignment diversion still involves an initial arrest event. The fear of arrest is known to drive people who use drugs into the shadows, where the risks of adverse events like overdose and infectious diseases loom large, and access to treatment or harm reduction services is limited. One way to minimize these risks is to decriminalize certain types of possession or use.

Safe consumption spaces (also known as supervised injection facilities) are one such example. Safe consumption spaces are safe, sanitary locations where individuals can take or inject pre-obtained drugs in the presence of trained staff who can monitor users for adverse events such as overdose, as well as provide linkage to various health care services as necessary. Despite concerns that these facilities may increase drug use, evidence has shown this not to be the case. Instead, these programs have been shown to reduce public injection, reduce overdose death rates and HIV risk behaviors, and provide a portal of entry to care for an otherwise highly marginalized population. Several jurisdictions around the country are in various stages of exploring the role of safe consumption spaces as part of their local response to the opioid epidemic. Broader decriminalization of drug possession or use, with reinvestment of interdiction resources in prevention, harm reduction, and treatment, should be seriously considered as part of a public health strategy to reduce the harms of drug use.

Conclusion

As our country organizes its response to the opioid epidemic, it will be important to acknowledge the complicated role the criminal justice system plays in the lives of patients. We must recognize that drug use is primarily a public health problem. Arrest and incarceration confer substantial health risks to patients with an opioid use disorder—including an increased risk of overdose death—and the majority of correctional settings fail to provide the evidence-based treatments known to prevent relapse and save lives. Drug treatment courts represent one alternative to the traditional model, yet they retain many features of criminal courts such as coercion and looming sanctions for relapse that are hard to reconcile with a medical model of addiction. Pre-arraignment diversion has shown significant promise, balancing concerns of public safety with more patient-centered interventions. Ultimately, thoughtful decriminalization may allow the creation of safer spaces for patients to engage in harm reduction and treatment services, while freeing up important financial resources to support such efforts. The less we rely on the criminal justice system to solve this public health crisis, the closer we move toward meaningful reform. The lives of patients depend on it. ■

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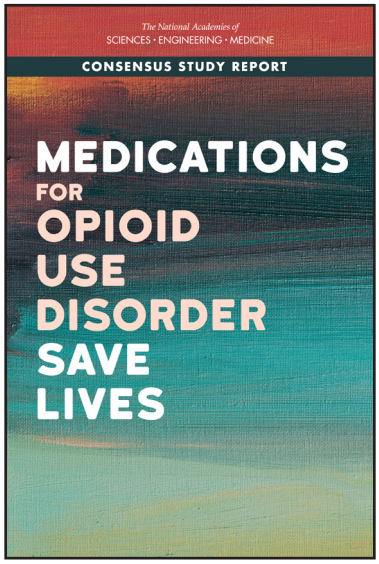
Consensus Study Report
HIGHLIGHTS
March 2019

Medications for Opioid Use Disorder Save Lives



More than 2 million people in the United States have opioid use disorder (OUD), a life-threatening chronic brain disease caused by prolonged use of prescription opioids, heroin, or other illicit opioids. People with OUD face a greatly increased risk of early death from overdose, infectious diseases, trauma, and suicide. Deaths related to OUD continue to escalate as the opioid crisis gathers momentum, with opioid overdoses killing more than 47,000 people in the United States in 2017.

Yet in the face of this public health crisis, existing tools to counter the epidemic—like evidence-based medications to treat OUD—are not being used to maximum effect. Methadone, buprenorphine, and extended-release naltrexone are approved medications to treat OUD. Methadone and buprenorphine alleviate withdrawal symptoms, and all three medications reduce opioid cravings and decrease the response to further drug use, making people with OUD less likely to return to opioid use and risk fatal overdose. These medications also help people restore their functionality, improve their quality of life, and reintegrate into their families and communities.

Medications for OUD save lives. Yet most people with OUD in the United States receive no treatment at all, and only a fraction of those who do receive medications for OUD.

With support from the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration, the National Academies of Sciences, Engineering, and Medicine convened an expert committee to examine the evidence base for medications to treat OUD and to identify barriers that prevent people from accessing safe, effective, medication-based treatment. The resulting report, *Medications for Opioid Use Disorder Save Lives,* presents the committee's findings and conclusions.

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"People with OUD have a chronic disease that warrants long-term medical management, like insulin for diabetes or blood pressure medication for hypertension."

ABOUT OPIOID USE DISORDER

Addiction is a chronic disease involving compulsive or uncontrolled use of one or more substances in the face of negative consequences. As with other chronic medical conditions, a combination of genetic, environmental, and social factors affect how vulnerable a person is to addiction, how likely a person is to start and continue using drugs, and how easy it is to recover. They also shape how susceptible a person is to the particular types of changes in the brain that characterize the progression to addiction. Decades of scientific research support the brain disease model of addiction; that is, that prolonged drug use causes lasting effects on the brain structure and function.

Opioids produce powerful and sustained effects on the brain. Their repeated use can lead to tolerance, physical dependence, and addiction. The science shows that these brain changes can be treated effectively with medications that help people refrain from using drugs, sharply reducing the risks of overdose and death and leading to improvements in behaviors associated with addiction.

This scientific understanding of OUD differs from public perception of the disorder, which is colored by the misconception of addiction as simply a moral failing. The social stigma that has long been directed at people who use drugs has now spread to the medications used to treat OUD. In fact, people with OUD have a chronic disease that warrants long-term medical management, like insulin for diabetes or blood pressure medication for hypertension.

MEDICATIONS FOR OUD SAVE LIVES

The medications currently approved by the FDA for treating OUD are evidence-based, safe, and highly effective. Medication-based treatment for OUD focuses first on managing withdrawal symptoms and then on controlling or eliminating the patient's compulsive opioid use, most commonly with the medications methadone or buprenorphine. For patients who have gone through withdrawal from opioids for a sufficient time, extended-release naltrexone may be used for maintenance treatment.

Evidence shows that people who receive longer-term treatment with medication for OUD have better treatment outcomes. They are also less likely to die from overdose if they return to opioid use while on medication. In fact, people with OUD are up to 50 percent less likely to die when they are being treated long term with methadone or buprenorphine.

OVERVIEW OF CONCLUSIONS

To read the full text of the committee's conclusions, visit nationalacademies.org/OUDtreatment.

1. Opioid use disorder is a treatable chronic brain disease.
2. FDA-approved medications to treat opioid use disorder are effective and save lives.
3. Long-term retention on medications to treat opioid use disorder is associated with improved outcomes.
4. A lack of availability of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.
5. Most people who could benefit from medication-based treatment for opioid use disorder do not receive it, and access is inequitable across subgroups of the population.
6. Medication-based treatment is effective across all treatment settings studied to date. Withholding or failing to have available all classes of FDA-approved medication for the treatment of opioid use disorder in any care or criminal justice setting is denying appropriate medical treatment.
7. Confronting the major barriers to the use of medications to treat opioid use disorder is critical to addressing the opioid crisis.

"Making access to medications for OUD much broader and more equitable is a high priority for making meaningful progress in addressing the opioid crisis and saving lives of those with OUD."

Treatment with a combination of medication and evidence-based behavioral interventions, such as contingency management, can be useful in engaging people with OUD in treatment and improving outcomes. Little is known about which combinations of medication and behavioral interventions are most effective, which patients are most likely to benefit from behavioral interventions, and which patients may do well with medications and appropriate medical management alone. The science shows life-saving aspects of medications for OUD even without behavioral therapies. It is crucial that medications not be withheld just because behavioral interventions are not available.

BARRIERS TO TREATMENT

Most people with OUD in the United States do not receive any treatment at all—and only a fraction of people who do receive medications for OUD. Access to evidence-based treatment is poor across the board, but it is starkly inequitable among certain generational, racial, ethnic, social, and economic groups.

Access also varies among different treatment settings. For instance, for those entering the criminal justice system, evidence-based medications are often withheld or provided on a limited basis. Most residential treatment facilities do not offer medications, and if they do, they rarely offer all three medications. Expanding access through settings such as community health centers and mobile medication units would save lives and build the capacity to make real progress against the epidemic.

Stigma is a major barrier to people seeking and staying in treatment. Medications for OUD also may be stigmatized. Providers may be unwilling to prescribe medications due to concerns about misuse and diversion, or illegal channeling of regulated medications to the illicit market. In fact, the rate of diversion is lower than for other prescribed medications, and it declines as the availability of medications to treat OUD increases.

Other barriers include stringent laws and regulatory policies not rooted in evidence; a fragmented system of care delivery; and inadequate education of professionals working with people with OUD in health care and law enforcement settings.

CONCLUSION

More research is needed to define the best treatment regimen for each of the available medications and to directly compare the effects of the three medications' long-term use. Research should focus on developing new and better medications to treat OUD, on determining the most effective behavioral therapies to be used with medications, and on refining the most appropriate protocols for their effective use. Despite the need for more research, evidence gathered over the past 50 years underscores the benefits of long-term retention on OUD medication.

Curbing the epidemic will require an "all hands on deck" strategy—involving health care, criminal justice, patients and family members, and beyond—because no one group alone will be able to resolve the crisis. Making access to medications for OUD much broader and more equitable is a high priority for making meaningful progress in addressing the opioid crisis and saving lives of those with OUD.

To read the report, please visit **nationalacademies.org/OUDtreatment.**

Committee on Medication-Assisted Treatment for Opioid Use Disorder

Alan I. Leshner (Chair)
American Association for the Advancement of Science (emeritus)

Huda Akil
University of Michigan

Colleen Barry
Johns Hopkins Bloomberg School of Public Health

Kathleen Carroll
Yale School of Medicine

Chinazo Cunningham
Montefiore Medical Center

Walter Ginter
Medication Assisted Recovery Support Statewide Network

Traci Green
Boston University/ Boston Medical Center

Yasmin Hurd
Icahn School of Medicine at Mount Sinai

Alan Jette
MGH Institute of Health Professions

Laura R. Lander
West Virginia University

David Patterson Silver Wolf
Washington University

Seun Ross
American Nurses Association

Scott Steiger
University of California San Francisco

David Vlahov
Yale University School of Nursing

Study Staff

Michelle Mancher
Study Director

Clare Stroud
Senior Program Officer

Emily Busta
Associate Program Officer
(until September 2018)

Benjamin Kahn
Associate Program Officer

Daniel Flynn
Research Associate
(until December 2018)

Meredith Hackmann
Research Associate
(until December 2018)

Michael Berrios
Senior Program Assistant

Mariam Shelton
Health Sciences Policy Board Program Coordinator

Daniel Bears
Research Librarian

Andrew Pope
Director,
Board on Health Sciences Policy

Study Sponsors

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Substance Abuse and Mental Health Services Administration

To read the full report, please visit
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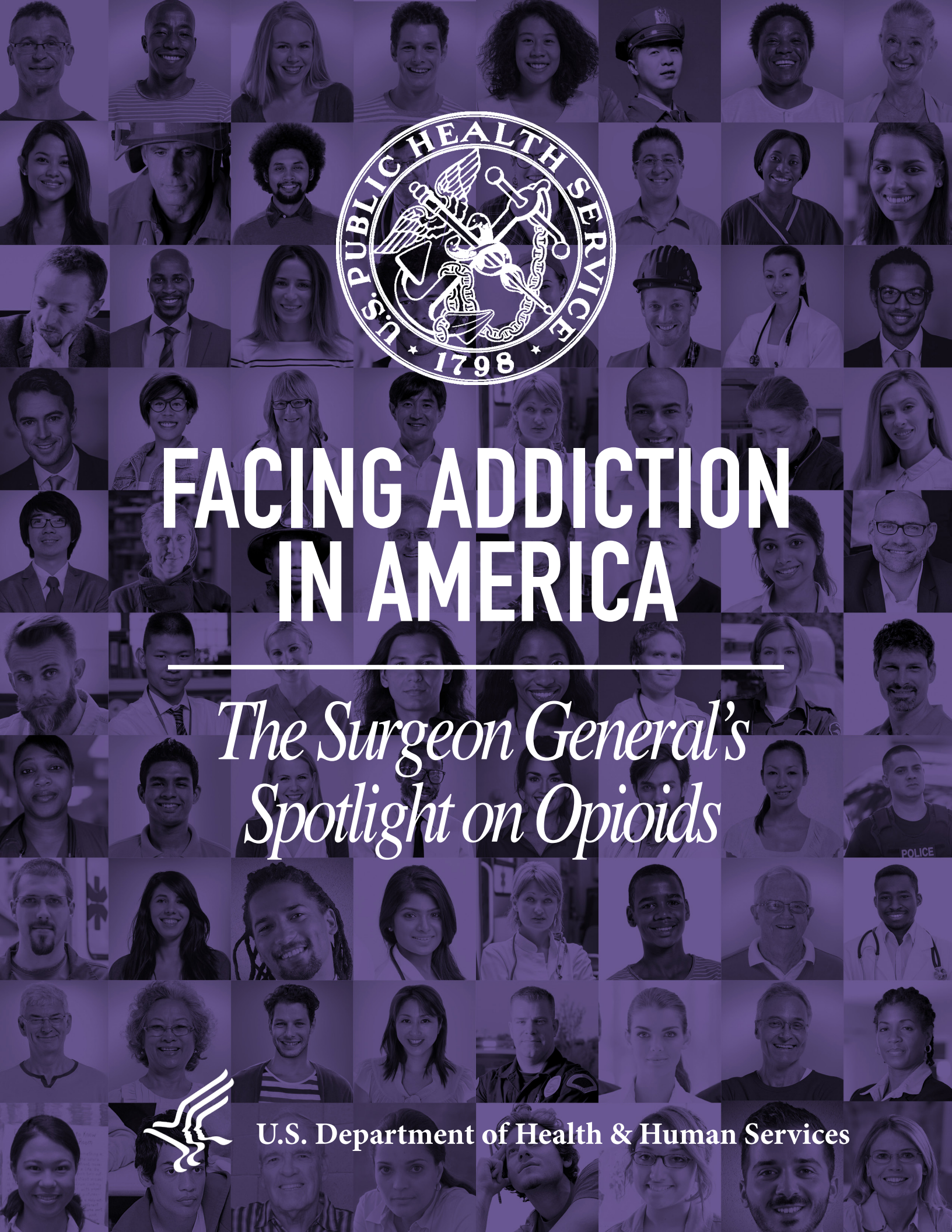

FACING ADDICTION IN AMERICA

The Surgeon General's Spotlight on Opioids

U.S. Department of Health & Human Services

Facing Addiction in America
The Surgeon General's Spotlight on Opioids

SAMHSA
Substance Abuse and Mental Health Services Administration

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FOR MORE INFORMATION

For more information about the Surgeon General's *Spotlight on Opioids* or to download copies, visit Addiction.SurgeonGeneral.gov.

Message from the Secretary, U.S. Department of Health and Human Services

The opioid misuse and overdose crisis touches everyone in the United States. In 2016, we lost more than 115 Americans to opioid overdose deaths each day, devastating families and communities across the country. Preliminary numbers in 2017 show that this number continues to increase with more than 131 opioid overdose deaths each day. The effects of the opioid crisis are cumulative and costly for our society—an estimated $504 billion a year in 2015—placing burdens on families, workplaces, the health care system, states, and communities.

Addressing the opioid crisis is a priority for this Administration, and the U.S. Department of Health and Human Services (HHS) is leading the public health-based approach to understanding the problem and taking action to fight it. HHS is tackling this crisis through our comprehensive five-point strategy focused on improving access to prevention, treatment, and recovery services; promoting use of overdose reversing drugs; strengthening our understanding of the epidemic through better public health surveillance; providing support for cutting-edge research on pain and addiction; and advancing better practices for pain management. Our efforts are collaborative—with all federal agencies and state and local partners working together to equip health care providers, communities, policymakers, law enforcement, and others with the information and tools they need to stem this growing epidemic.

HHS also brought a new level of awareness and commitment to the cause by declaring the opioid crisis a nationwide Public Health Emergency on October 26, 2017. Since 2017, HHS has disbursed more than $2 billion in grants to fight the opioid crisis, more than any previous year.

The *Spotlight on Opioids* document is another important step in our efforts to address the issue. This document assembles opioid-related information from *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* in one document and provides updated data on the prevalence of substance use, opioid misuse, opioid use disorders, opioid overdoses, and related harms. As the Secretary of the Department of Health and Human Services, I encourage you to use the information and findings in this document and join us in taking action on this vital issue and making our communities healthier and stronger.

ALEX M. AZAR II
Secretary
U.S. Department of Health and Human Services

Foreword from the Assistant Secretary for Mental Health and Substance Use

After many years combating the opioid epidemic on the front lines of addiction psychiatry, I returned to the Substance Abuse and Mental Health Services Administration (SAMHSA) to do everything possible to ensure that American families and communities do not continue to lose their loved ones to opioids.

Now is the time to work together and apply what we know to end this epidemic once and for all. Medication-assisted treatment (MAT) combined with psychosocial therapies and community-based recovery supports is the gold standard for treating opioid addiction.

There is strong scientific evidence that this combination of therapeutic interventions is life-saving and can enable people to recover to healthy lives. SAMHSA is joining forces with agencies across HHS and the federal government to increase access to these evidence-based interventions—especially in communities hardest hit by the opioid crisis. We are (1) working with states and their communities to increase access to prevention, treatment and recovery support services for opioid use disorder; (2) supporting providers' efforts to offer specialized treatment to pregnant and postpartum women with opioid use disorder and their opioid-exposed infants; (3) promoting early intervention and treatment as healthier alternatives to detaining people with opioid addiction in our criminal justice systems; (4) and facilitating the expansion of telemedicine to deliver MAT to people in need in rural communities and to enhance rural providers' skills.

To help remove the societal stigma for those seeking addiction treatment, we have implemented new changes to the federal rules governing confidentiality and disclosures of substance use disorder patient records. Our workforce efforts include support for a variety of trainings and resources to prevent over prescribing and diversion of prescription medications and initiatives to increase the number of qualified health care providers who can offer treatment for opioid use disorder. In the crucial area of overdose prevention, we are increasing the distribution of naloxone and expanding training to first responders, prescribers, patients, employers, and family members on how to administer this live-saving antidote.

With the Office of the Surgeon General, SAMHSA has produced the *Spotlight on Opioids*—a document that offers practical information and guidance that individuals and systems can use to take action. I urge you to use it as a resource as you consider what you can do to help end this crisis and save lives. Inside and outside of government, at the national, state and local level, and in every community across this nation, we must join forces to turn the tide against the opioid crisis.

ELINORE F. McCANCE-KATZ, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration

Preface from the Surgeon General, U.S. Department of Health and Human Services

My family and I are among the millions of Americans affected by substance use disorder. My younger brother has struggled with this disease, which started with untreated depression leading to opioid pain reliever misuse. Like many with co-occurring mental health and substance use disorder conditions, my brother has cycled in and out of incarceration. I tell my family's story because far too many are facing the same worries for their loved ones. We all ask the same question: How can I contribute to ending the opioid crisis and helping those suffering with addiction?

The first step is understanding that opioid use disorder is a chronic but treatable brain disease, and not a moral failing or character flaw. Like many other chronic medical conditions, opioid use disorder is both treatable, and in many cases, preventable. It is also a disease that must be addressed with compassion. Unfortunately, stigma has prevented many sufferers and their families from speaking about their struggles and from seeking help. The way we as a society view and address opioid use disorder must change—individual lives and the health of our nation depend on it.

I believe that the best way to address the opioid crisis is to work towards achieving better health through better partnerships. Health advocates must involve businesses and law enforcement organizations—they have witnessed the negative effects of opioids and have a strong interest in helping end the epidemic. Educators and the faith-based community have unique touchpoints and resources that can be brought to bare for prevention and treatment efforts. We must listen to all communities affected by the opioid crisis—speaking with them versus at them, leveraging their strengths, and addressing their priorities. Through partnerships, we can address the overall health inequities and determinants of health that exist where we live, learn, work, and play. Together we can reduce the risks of opioid misuse, opioid use disorder, and related health consequences such as overdose and infectious disease transmission.

As Surgeon General, I care about the health and well-being of all Americans. My office worked with SAMHSA to create the *Spotlight on Opioids* so that people with a broad range of backgrounds can reference opioid-related information from *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* in one document. I hope that all readers use this document to determine specific actions they can take to mitigate the opioid crisis.

JEROME M. ADAMS, M.D., M.P.H.
Vice Admiral, U.S. Public Health Service
Surgeon General

Introduction and Overview

All across the United States, individuals, families, communities, and health care providers are struggling to cope with the impacts of the opioid crisis. Opioid misuse and opioid use disorders have devastating effects. As we see all too often in cases of overdose deaths, lives end prematurely and tragically. Other serious consequences include neonatal abstinence syndrome and transmission of infectious diseases such as HIV and viral hepatitis, as well as compromised physical and mental health. Social consequences include loss of productivity, increased crime and violence, neglect of children, and expanded health care costs. However, it must be noted that there are certain populations who rely on prescription opioids and are taking them responsibly under the care of a trusted provider. These include, but are not limited to: individuals in hospice care; individuals who are undergoing cancer treatment; people who recently experienced a traumatic injury; or those with long-term disability and chronic pain.

In November 2016, the Office of the Surgeon General released *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (the Surgeon General's Report).[1] This landmark publication provided the latest research-based information on substance misuse, substance use disorders, and their health impacts for the general public. It provided suggestions and recommendations for action that everyone can take to prevent substance misuse and reduce its consequences. The Surgeon General's Report described a public health–based approach to substance misuse and substance use disorders. A public health approach recognizes that substance misuse and its consequences are the result of multiple interacting factors (individual, environmental, and societal) and requires that diverse stakeholders work in a coordinated way to

address substance misuse across the community.

The Office of the Surgeon General and the Substance Abuse and Mental Health Services Administration (SAMHSA) developed this *Spotlight on Opioids* from the Surgeon General's Report, in order to provide opioid-related information in one, easy-to-read document. Although *Spotlight on Opioids* does not include new scientific information, it provides the latest data on prevalence of substance use, opioid misuse, opioid use disorders, opioid overdoses, and related harms. This document sometimes discusses substance use disorders rather than opioid use disorder specifically. As indicated in the section "The Neurobiology of Substance Use, Misuse, and Addiction," opioids and other substances have similar effects on the brain's reward pathways. Additionally, it is common for people who misuse opioids to misuse other substances or to have multiple substance use disorders or co-occurring mental disorders. Therefore, the general principles related to substance use disorders often apply to opioid use disorder.

KEY TERMS

Opioid: Natural or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and feelings of pain. This class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. Opioid pain medications are generally safe when taken for a short time and as prescribed by a health care professional, but because they produce euphoria in addition to pain relief, they can be misused.

Substance Misuse: The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them.

Prescription opioid (or opioid pain reliever) misuse: Use of an opioid pain reliever in any way not directed by a health care professional.

Substance Use Disorder: Occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Opioid Use Disorder: A disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal.

Opioids: The Current Landscape

To obtain a copy of *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, please visit https://addiction.surgeongeneral.gov. Please refer to that Report for more in-depth discussion of the topics presented here.

Historically, opioids have been used as pain relievers. However, opioid misuse presents serious risks, including overdose and opioid use disorder. The use of illegal opioids such as heroin—a highly addictive drug that has no accepted medical use in the United States—and the misuse of prescription opioid pain relievers can have serious negative health effects. Fentanyl is a synthetic opioid medication that is used for severe pain management and is considerably more potent than heroin. Sometimes, prescription fentanyl is diverted for illicit purposes. But fentanyl and pharmacologically similar synthetic opioids are also illicitly manufactured and smuggled into the United States.[2]

These illicitly made synthetic opioids are driving the rapid increase in opioid overdose deaths in recent years.[3-5] Illicitly made fentanyl and other pharmacologically similar opioids are often mixed with illicit substances such as heroin. They can also be made into counterfeit prescription opioids or sedatives and sold on the street.

PREVALENCE OF OPIOID MISUSE AND OPIOID USE DISORDER

Based on data from SAMHSA's National Survey on Drug Use and Health, in 2017, 11.1 million people aged 12 and older had misused prescription pain relievers in the past year.[6] Repeated use of opioids greatly increases the risk of developing an opioid use disorder.

In 2017, about 1.7 million people aged 12 and older had a prescription pain reliever use disorder in the past year. In 2017, 953,000 people received treatment for the misuse of opioid pain relievers.[6]

Heroin use is also a concern. In 2017, about 886,000 people aged 12 or older reported having used heroin in the past year.[6] During that same time period, about 652,000 people aged 12 or

older were estimated to have a heroin use disorder.

Specialty treatment is defined as receiving treatment at a substance use rehabilitation facility (inpatient or outpatient), hospital (inpatient services only), and/or mental health center. Only 54.9 percent of those aged 12 and older with heroin use disorder received treatment for illicit drug use at a specialty treatment facility.[6] Only 28.6 percent of those aged 12 and older with an opioid use disorder in the past year received treatment for illicit drug use at a specialty treatment facility.[6]

OPIOID OVERDOSE DEATHS

Opioids can depress critical areas in the brain that control breathing, heart rate, and body temperature and cause them to stop functioning. Opioids were involved in 42,249 deaths in 2016—more than 115 deaths every day, on average. According to preliminary estimates from the Centers for Disease Control and Prevention (CDC), 47,872 people died from an opioid overdose in 2017. [7] Opioid overdose deaths were five times higher in 2016 than in 1999. The majority of these opioid overdose deaths were unintentional.[3,4]

The opioid crisis is being driven by three trends: (1) an increase of prescription opioid overdose deaths since 1999; (2) the four-fold increase in heroin overdoses since 2010; and (3) the tripling death rate for synthetic opioids like fentanyl since 2013. As a result, the number of people dying from opioid overdoses has increased dramatically.[8] In fact, the average life expectancy in the United States decreased for the second year in a row in 2016, falling by about 1.2 months, in part due to opioid overdose deaths.[9]

NEONATAL ABSTINENCE SYNDROME (NAS)

Newborns may experience NAS, a withdrawal syndrome following exposure to drugs while in the mother's womb.[10] NAS, also known as neonatal opioid withdrawal syndrome, is an expected and treatable condition following repeated substance exposure in utero, which may have long-term health consequences for the infant.[11] NAS signs include neurological excitability, gastrointestinal dysfunction, and autonomic dysfunction.[12] Newborns with NAS are more likely than other babies to have low birthweight and respiratory complications. The incidence of NAS has increased dramatically in the last decade along with increased opioid misuse.[13] These data suggest the need to develop and test measures to reduce the impacts of prenatal exposure to opioids (e.g., skin to skin care, and rooming in). Healthcare providers should discuss possible risks associated with opioid use during pregnancy to both the mother and fetus.[14] Given that prescription opioid pain relievers are at times deemed clinically appropriate during pregnancy and there may be medical consequences when an individual with an opioid use disorder discontinues opioids abruptly, the *CDC Guideline for Prescribing Opioids for Chronic Pain* includes information specific to implications for pregnant women in particular.[15] SAMHSA's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* also provides guidance for the management of pregnant and parenting women with opioid use disorder and their infants.

INFECTIOUS DISEASE TRANSMISSION

Injection drug use (including injection of prescription opioid medications and illicit opioids such as heroin) is integrally linked

with transmission of HIV, viral hepatitis, other blood-borne diseases (e.g., endocarditis, a life threatening heart valve infection), and bacterial infections, including antibiotic resistant organisms (e.g., Methicillin-resistant Staphylococcus aureus or MRSA).[16] Approximately, one in 10 new HIV diagnoses occur among people who inject drugs. The CDC has observed a steady decline in HIV diagnoses attributable to injection drug use since the mid-1990s, but progress may be slowing.[17] Reported rates of acute hepatitis C virus (HCV) infection have also increased significantly.[18] The opioid crisis is helping to fuel these increases as well as rising health care costs associated with treating these conditions.

IMPORTANCE OF PREVENTION, SCREENING, EARLY INTERVENTION, AND TREATMENT

The risk of death and other significant consequences of opioid misuse highlight the importance of prevention, screening, and treatment for substance use disorders. Evidence-based interventions to prevent substance use, misuse and addiction target risk factors and enhance protective factors. Such interventions need to begin early in life to delay or prevent initiation of substance use and continue throughout the lifespan. For example, childhood trauma like adverse childhood experiences (ACEs) have been repeatedly linked to substance misuse.[19, 20] Primary prevention can also begin in the healthcare setting with prescribers using effective strategies to reduce overdoses involving prescription opioids such as safe prescribing practices. Currently, few primary care providers screen for or treat substance use disorders. Additionally, it is common for people who misuse opioids to misuse other substances or to have multiple substance use disorders, childhood trauma, or co-occurring physical and mental disorders. This highlights the need for full clinical assessment and comprehensive treatment services that are matched to an individual's needs. Prevention, screening, early intervention, and treatment—including medication-assisted treatment, which combines medication with behavioral therapies and psychosocial supports—are discussed in this report.

ACCESS TO TREATMENT

Despite the fact that effective treatments for opioid use disorder do exist, only about one in four people (28.6 percent) with this disorder received specialty treatment for illicit drug use in the past year.[6] This "treatment gap" is not unique to opioid use disorder. Only about 12.2 percent of adults who need treatment for a substance use disorder receive any type of specialty treatment.[6,21] Additionally, 45.5 percent of people with a substance use disorder also have a mental disorder, yet only about half (51.0 percent) receive treatment for either disorder and only a small minority receive treatment for both.[21]

Many factors contribute to this "treatment gap." For far too long, too many in our country have viewed addiction as a moral failing rather than a disease. This stigma has made people with substance use disorders less likely to seek help. Other contributing factors include the inability to access or afford care and a lack of screening for substance misuse and substance use disorders in general health care settings. Furthermore, 39.7 percent of individuals who know they have an alcohol or drug problem are not ready to stop using. Others simply feel they do not have a problem, do not have a need for treatment, or believe they can handle the problem without treatment.[6]

Integrating substance use disorder services, as well as screening for early risk factors for

substance use disorders, into mainstream health care and ensuring all Americans have access to those services has the power to substantially improve outcomes for individuals and reverse the opioid crisis. These actions may reduce overall health care costs for individuals and their families, reduce health disparities among high-risk groups, and reduce costs for health care systems and communities.

Despite the promise that integration offers for the prevention and treatment of substance use disorders, challenges remain. Specifically:

- The substance use disorder treatment system is underprepared to support care coordination;
- The primary care system has been slow to implement medication-assisted treatment (MAT) as well as prevention, early identification, and other evidence-based recommendations;
- The existing health care workforce is already understaffed and often lacks the necessary training and education to address substance use disorders; and
- The need to protect patient confidentiality creates hurdles for sharing of information.

Additionally, some ingrained attitudes must change. For example, as is discussed later in this report, the use of some medications for opioid use disorder (methadone and buprenorphine) remains surrounded by misconceptions and prejudices that have hindered their delivery.

However, the federal government is currently collaborating with key stakeholders to address the challenges discussed above. HHS has invested $2 billion in opioid-specific funding for states, which encompasses the State Targeted Response (STR) to the Opioid Crisis and the State Opioid Response (SOR) grant programs administered by SAMHSA to support a comprehensive array of prevention, treatment, and recovery services. This includes funding to expand provider capacity and increase patient access to evidence-based treatment for opioid use disorder.

The Health Resources and Services Administration (HRSA) has invested funds to support community health centers in implementing and advancing evidence-based strategies, including expanded MAT services, expansion of mental health and substance use disorder services focusing on treatment, prevention and awareness of opioid misuse, and the integration of substance use disorder services into primary care. Since January 2017, over 200 health centers have been engaged in a HRSA-funded technical assistance opportunity through the Opioid Addiction Treatment Extension for Community Healthcare Outcomes project, a virtual, national technical assistance effort to enhance health center capacity to treat substance misuse. HRSA is also providing funds to train the primary care and behavioral health workforce in opioid addiction.

The National Institutes of Health (NIH), in collaboration with other federal agencies, is developing a study as part of the Helping to End Addiction Long-term (HEAL) Initiative called the HEALing Communities Study. This comprehensive study will test the implementation of an integrated set of addiction prevention and treatment approaches across healthcare, behavioral health, justice systems, state and local governments, and community organizations to prevent and treat opioid misuse and opioid use disorder.

The Agency for Healthcare Research and Quality (AHRQ) in investing in research grants to discover how to best support primary care practices and rural communities in delivering MAT for opioid use disorders. AHRQ has release a report that

includes links and descriptions to nearly 250 tools and resources available for health care professionals, patients, and communities to help implement MAT in primary care settings.[22]

The Centers for Medicare and Medicaid Services (CMS) is now offering a more flexible, streamlined approach to accelerate states' ability to respond to the national opioid crisis through section 1115 demonstrations announced in November 2017. The Medicare program is focused on prescription opioid safety, access to MAT, and non-opioid alternatives for pain management.

The HHS Center for Faith-Based and Neighborhood Partnerships created the *Opioid Epidemic Practical Toolkit* to equip local communities—lay persons, faith groups, non-profits, and health care providers—with practical steps to bring hope and healing to the millions suffering the consequences of opioid misuse.

REASONS FOR OPTIMISM

Despite the challenges, this is a time of great hope and opportunity. Research on alcohol and drug use and addiction has led to an increase of knowledge and to one clear conclusion: Addiction to alcohol or drugs is a chronic but treatable brain disease that requires medical intervention, not moral judgment. Additionally, policies and programs have been developed that are effective in preventing alcohol and drug misuse, and reducing its negative effects. Addressing risk and protective factors for individuals and communities can help prevent opioid misuse. Evidence-based treatments—both medications and behavioral therapies—can save lives and restore people's health, well-being, and functioning, as well as reduce the spread of infectious diseases and lessen other consequences. Support services such as mutual aid groups, recovery housing, and recovery coaches are increasingly available to help people in the long and often difficult task of maintaining recovery after treatment. Transformations in the health care landscape are supporting integration of substance use disorder treatment with general health care in ways that will better address the needs of the millions of people with substance use disorders. Technology-based interventions offer many potential advantages and can increase access to care in underserved areas and settings. Use of health information technology is expanding to support greater communication and collaboration among providers, fostering better-integrated and collaborative care, while at the same time protecting patient privacy. Together, these changes are leading to a new landscape of care for alcohol and drug misuse problems in America, and to new hope for millions of people.

The over-prescription of powerful opioid pain relievers was associated with a rapid escalation of use and misuse of these substances. The good news is that a decrease in the amount of opioid pain relievers prescribed has been reported.[20] However, the amount of opioids prescribed in 2015 remained approximately three times higher than in 1999 and varied substantially across the country.[23]

Progress has been made regarding the prescribing of buprenorphine and naltrexone-extended release (XR)—medications that, with psychosocial supports, are part of evidence-based medication-assisted treatment for opioid use disorder. Individuals receiving buprenorphine with counseling have significantly lower total health care costs than individuals receiving little or no treatment for their opioid use disorder ($13,578 compared to $31,055).[24] Buprenorphine may be prescribed by qualifying health care professionals who have met the statutory requirements for a waiver in accordance with the Controlled Substances Act

(21 U.S.C. 823(g)(2)(D)(iii)).[25] Naltrexone-XR can be precsribed by any licensed clinician who has prescribing authority. Although there is no limit to the number of patients a prescriber can treat with naltrexone-XR, qualifying physicians can request to treat up to 275 patients with buprenorphine, subject to renewal and reporting requirements. Raising the number of patients that qualifying physicians can treat with buprenorphine ("the cap") may increase access to this medication, though this may not be the primary barrier to accessing treatment. Broader efforts to ensure appropriate training for more health care professionals continue. Nurse practitioners and physician assistants can prescribe naltrexone-XR without limitations and, if they qualify, can also prescribe buprenorphine. Currently, 44,968 physicians and 8,825 nurse practitioners and physician assistants, are approved to prescribe buprenorphine (as of September 8, 2018).

Neurobiology of Substance Use, Misuse, and Addiction

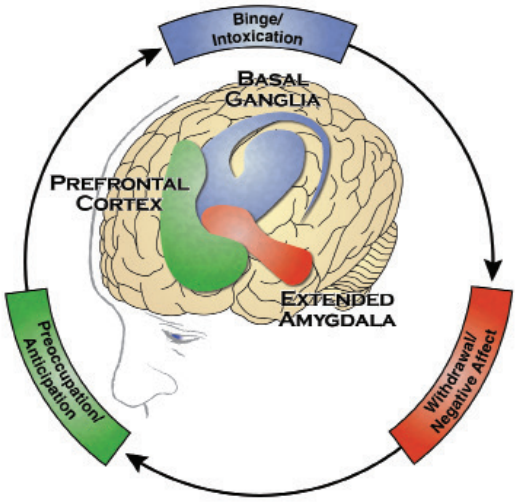

Figure 1: The Three Stages of the Addiction Cycle and the Brain Regions Associated With Them

KEY TERMS

Relapse: The return to drug use after a significant period of abstinence.

Severe substance use disorders (commonly called addictions) were once viewed largely as a moral failing or character flaw, but are now understood to be chronic diseases that are subject to relapse, and characterized by clinically significant impairments in health, social function, and voluntary control over substance use.[26] All addictive substances—including opioids—have powerful effects on the brain. They "hijack" the brain's reward system by inducing feelings that motivate people to use those substances again and again, despite the risks for significant harms. With repeated exposure, progressive changes occur in the structure and function of the brain, compromising brain function and driving chronic misuse. These brain changes endure long after an individual stops using substances and may produce continued, periodic cravings for the substance that can lead to relapse for many years.[27, 28]

Well-supported evidence suggests that the addiction process involves a three-stage cycle: (1) Binge/Intoxication, the stage at which an individual consumes an intoxicating substance and experiences its rewarding or pleasurable effects; (2) Withdrawal/Negative Affect, the stage at which an individual experiences a negative physical and emotional state in the absence of the substance; and (3) Preoccupation/Anticipation, the stage at which one seeks substances again after a period of abstinence. This cycle becomes more severe as a person continues substance use and as it produces dramatic changes in brain function that reduce a person's ability to control his or her substance use. The three stages are linked to and feed on each other, but they also involve different brain regions: (1) the basal ganglia (binge/intoxication), (2) the extended amygdala (withdrawal/negative affect), and (3) the prefrontal cortex (preoccupation/anticipation).[29]

Like other drugs, opioids affect the brain's reward system. Opioids attach to opioid receptors in the brain, causing euphoria (the high), drowsiness, and slowed breathing, as well as reduced pain signaling (which is why they are frequently prescribed as pain relievers).

Opioid addiction typically involves a pattern of: (1) intense intoxication, (2) the development of tolerance, (3) escalation in use, and (4) withdrawal signs that include profound negative emotions and physical symptoms, such as bodily discomfort, pain, sweating, and intestinal distress. As use progresses, the opioid must be taken to avoid the severe negative effects that occur during withdrawal. With repeated exposure to opioids, stimuli associated with the pleasant effects of the substances (e.g., places, persons, moods, and paraphernalia) and with the negative mental and physical effects of withdrawal can trigger intense craving or preoccupation with use.

KEY TERMS

Dependence: A state in which an individual only functions normally in the presence of a substance, experiencing physical disturbance when the substance is removed. A person can be dependent on a substance without being addicted, but dependence sometimes leads to addiction.

Addiction: Common name for a severe substance use disorder, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.

Tolerance: Alteration of the body's responsiveness to alcohol or a drug such that higher doses are required to produce the same effect achieved during initial use.

Withdrawal: A set of symptoms and signs that are experienced when discontinuing use of a substance to which a person has become dependent or addicted, which can include negative emotions such as stress, anxiety, or depression, as well as physical effects such as nausea, vomiting, muscle aches, and cramping, among others. Withdrawal symptoms often lead a person to use the substance again.

The Continuum of Care for Substance Misuse and Substance Use Disorders

Effective identification, intervention, and integration of prevention, treatment, and recovery services across health care systems is key to addressing substance misuse and its consequences, and it represents the most promising way to improve access to and quality of treatment. The continuum of care approach is a strategy to promote this integration by providing individuals an array of service options—including prevention, early intervention, treatment, and recovery support—based on need.

PREVENTION

Substance misuse can put individual users and others around them at risk of harm, whether or not they have a disorder. Also, early initiation of substance use, substance misuse, and substance use disorders are associated with a variety of negative consequences, including deteriorating relationships, poor school performance, loss of employment, diminished mental health, and increases in sickness and death (e.g., motor vehicle crashes, poisoning, violence, or accidents).[30-32] It is therefore critical to prevent the full spectrum of substance misuse problems in addition to treating those with substance use disorders. Although there are exceptions, most risk and protective factors associated with substance use also predict other problems affecting youth, including delinquency, psychiatric conditions, violence, and school dropout. Therefore, programs and policies addressing those common or overlapping predictors of problems have the potential to simultaneously prevent substance misuse as well as other undesired outcomes.[33-35]

Evidence-based interventions to prevent substance use, misuse, and addiction, target risk factors and enhance protective factors. For example, effective school-based strategies that combine substance use prevention and health

education curricula, link students to youth friendly mental and behavioral health providers in the community, and increase protective factors such as parent engagement and school connectedness can prevent the initiation of drug use.

The Institute of Medicine (IOM), now known as the National Academy of Medicine, has described three categories of prevention interventions: universal, selective, and indicated.[36] With respect to substance use interventions, universal interventions are aimed at all members of a given population (for instance, population-level strategies); selective interventions are aimed at a subgroup determined to be at high-risk for substance use (for instance, justice-involved youth); and indicated interventions are targeted to individuals who are already using substances but have not developed a substance use disorder. Schools and communities are encouraged to use a combination of these three types of preventive interventions based on their needs. Further research is needed to determine the best mix of prevention interventions.

Evidence-based prevention interventions, carried out before the need for treatment, are critical because they can prevent initiation of substance use, delay early use, and stop the progression from use to problematic use or to a substance use disorder. The good news is that there is strong scientific evidence supporting the effectiveness of prevention programs and policies. The *Surgeon General's Report* identified 42 prevention programs that met criteria for inclusion based on an extensive review of published research studies. These are described in the *Surgeon General's Report* Appendix B ("Evidence-Based Prevention Programs and Policies"). In addition, education campaigns target the overall public to improve general understanding about addiction, community health and safety risks, and how to access available treatment services.[37-39] An example is CDC's Rx Awareness Campaign, which aims to increase awareness that prescription opioids can be addictive and dangerous.[40]

The *Surgeon General's Report* also discusses the economics of prevention. Evidence-based prevention interventions can decrease costs related to substance use-related crime, lost work productivity, and health care. Research has found that for every dollar spent on prevention programs, the program returns between $0.62 and $64.18 in reduced costs.[41] Most of the rigorous research on the effectiveness and population impact of prevention policies and programs has addressed alcohol rather than opioids. Nevertheless, prevention is critical to addressing the opioid crisis.

KEY TERMS

Risk factors: Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioral health problems associated with use.

Protective factors: Factors that directly decrease the likelihood of substance use and behavioral health problems or reduce the impact of risk factors on behavioral health problems.

Evidence-based interventions: Refers to programs and policies that are supported by research and proven to be effective.

SCREENING AND EARLY INTERVENTION

Given the impact of opioid misuse on public health and the increased risk for long-term medical consequences, including opioid use disorders and overdose, it is critical to prevent misuse from starting and to identify those who have already begun to misuse these substances and intervene early. Health care professionals

can offer prevention advice, screen patients for substance misuse and substance use disorders, as well as risk factors for substance use such as childhood trauma and ACEs, and provide early interventions in the form of motivational approaches.[42, 43]

Primary care has a central role in this process, because it is the site for most preventive and ongoing clinical care for patients and the hub for specialty care. The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risk or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.[42] This approach is called Screening, Brief Intervention and Referral to Treatment or SBIRT for adult alcohol use. While the evidence rating from USPSTF for screening and intervention for illicit substance use remains "I" for insufficient evidence, asking about alcohol use may present a natural opportunity to ask about other substance use—including opioids.

To curb the rise in opioid overdose deaths, CDC recommends screening for substance use and substance use disorders before and during the course of opioid prescribing for chronic pain, combined with patient education.[15] The National Institute on Drug Abuse's (NIDA) Opioid Risk Tool and the NIDA Quick Screen are available to help practitioners screen for substance use in general medical settings.

Prevention strategies specifically targeting prescriber behavior have also been developed. In March 2016, the *CDC Guideline for Prescribing Opioids for Chronic Pain* was released.[15] The guideline informs health care professionals about the consequences and risks of using opioids to treat chronic pain and provides research-based recommendations regarding when to start opioids for chronic pain, how to select the appropriate dosage, and how to assess risks and address harms from opioid use. This guideline can help providers reduce opioid misuse and related harms among those with chronic pain and is intended for use by primary care providers in caring for patients aged 18 and older outside of cancer, palliative, or end-of-life care. To help encourage uptake and use of the guideline, CDC has developed a suite of translational materials (e.g., fact sheets, training modules, videos, mobile apps, etc.) for clinicians and patients. Additionally, it is crucial to improve access to non-opioid pain management options, and more research is needed in this important area.

As part of prevention, it is important to develop better pain management strategies. In March 2016, the *National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain* was released. The report addresses the current pain management environment and describes strategies and objectives to improve pain management, including improving access to non-pharmacologic and non-opioid pain management options. More research is needed in this important area.

Research has documented the effects of prescription drug monitoring programs (PDMPs) on misuse of prescription medications.[44] PDMPs are state-controlled electronic databases that track controlled substance prescriptions within a state and provide prescribing and patient behavior information to prescribers and other authorities who are granted access to the information. Findings have been mixed.[45] However, studies have shown that certain characteristics of PDMPs enhance their impact. For example, specific PDMP policies, such as mandated use and timely reporting, are

associated with reductions in opioid overdose mortality.[46] PDMPs serve many purposes beyond preventing inappropriate prescribing—they can be leveraged as a clinical decision support, a public health surveillance tool, and have utility to the public safety sector, especially as interstate and intrastate interoperability improve.

TREATMENT AND MANAGEMENT OF OPIOID USE DISORDERS

Substance use disorder treatment is designed to help individuals stop or reduce harmful substance misuse, improve their health and social function, and manage their risk for relapse. In this regard, substance use disorder treatment is effective and has a positive economic impact. Research shows that treatment improves individuals' productivity,[47] health,[47, 48] and overall quality of life.[49-51] Incorporating treatment for multiple substance use disorders could also be beneficial. For example, integrating tobacco cessation programs into substance use disorder treatment does not jeopardize treatment outcomes, and is associated with a 25 percent increase in the likelihood of maintaining long-term abstinence from alcohol and drug misuse.[52, 53] Consequently, substance use disorders can be identified quickly and reliably in many medical and social settings, including primary care. In contrast, severe, complex, and chronic substance use disorders often require specialty substance use disorder treatment and continued post-treatment support to achieve full remission and recovery.

KEY TERM

Substance use disorder treatment: A service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability.[54]

TREATMENT PLANNING.

Among the first steps involved in substance use disorder treatment are assessment and diagnosis. The diagnosis of substance use disorders is based primarily on the results of a clinical interview, and several assessment instruments are available. The diagnosis of a substance use disorder is made by a trained professional based on 11 symptoms defined in the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Conducting a clinical assessment is essential to understanding the nature and severity of the patient's health and social problems that may have led to or resulted from their substance use. This assessment is important in determining the intensity of care that will be recommended and the composition of the treatment plan.[55] After a formal assessment, the information is discussed with the patient to jointly develop a personalized treatment plan designed to address the patient's needs.[55, 56] The treatment plan and goals should be person-centered and include strength-based approaches, or ones that draw upon an individual's strengths, resources, potential, and ability to recover, to keep the patient engaged in care. As mentioned previously, co-occurring mental health conditions are common among individuals with substance use disorder. Therefore, individualized treatment plans should consider these conditions and ensure that co-occurring mental health conditions are addressed. Tailoring treatment to the patient's specific needs increases the likelihood of successful treatment engagement and retention, and research shows that those who participate more fully in treatment typically have better outcomes.[57] Throughout treatment, individuals should be periodically reassessed to determine response to treatment and to make any needed adjustments to the treatment plan.

HARM REDUCTION STRATEGIES.

Strategies to reduce the harms associated with opioid misuse and opioid use disorder have been developed as a way to engage people in treatment and to help preserve the life and health of those who are not ready to participate in treatment. Strategies include outreach and education programs, syringe services programs (sometimes called needle/syringe exchange programs), overdose prevention education, and access to naloxone to reverse potentially lethal opioid overdose.[58, 59] The goal of syringe services programs is to prevent transmission of infectious agents and other harms by giving individuals who inject drugs sterile equipment and other support services at little or no cost and linking them to medical and mental health services, including substance use disorder treatment programs, as well as social services such as housing assistance and case management.[60] Evaluation studies have clearly shown that syringe services programs are effective in reducing HIV and HCV transmission and do not increase rates of community drug use.[61] They help individuals engage in treatment to reduce, manage, and stop their substance use when appropriate. Harm reduction programs provide public health-oriented, cost-effective, and often cost-saving services to prevent and reduce substance use-related risks among those actively using substances, and substantial evidence supports their effectiveness. [59, 62, 63]

NALOXONE.

Naloxone is an opioid antagonist medication approved by the U.S. Food and Drug Administration (FDA) to reverse opioid overdose. Naloxone is available in injectable and nasal spray forms. It works by displacing opioids from receptors in the brain, thereby interrupting and blocking their effects on breathing and heart rate. Typically, there is a 1- to 3-hour window of opportunity after an individual has taken the drug in which bystanders can take action to reverse the overdose and prevent death.[59] However, the introduction of illicitly manufactured fentanyl and other highly potent synthetic opioids to the drug supply makes immediate access to naloxone (and perhaps multiple administrations) crucial to effective overdose death prevention.

KEY TERM

Antagonist: A chemical substance that binds to and blocks the activation of certain receptors on cells, preventing a biological response. Naloxone and naltrexone are examples of opioid receptor antagonists.

The rising number of deaths from opioid overdose has led to increasing public health efforts to make naloxone available to at-risk individuals and their families, as well as to emergency medical technicians, police officers, other first responders, or community members through community-based opioid overdose prevention programs. Although regulations vary by state, most states have passed laws expanding access to naloxone without a patient-specific prescription.[64] The distribution of take-home doses of naloxone, along with education and training, for those actively using opioids and their peers and family members have the potential to help decrease opioid overdose-related deaths.[65, 66] Research demonstrates that naloxone does not increase the prevalence or frequency of opioid use.[67] SAMHSA has develped an *Opioid Overdose Prevention Toolkit* for community members, first responders, prescribers, patients and families, and those recovering from opioid overdose.[68] Good Samaritan Laws exist in most states. In the event of an overdose, these types of laws may protect the victim and/or the person seeking medical help for the vctim from drug possession charges.[69] Given that most people overdose

at home or outside of a medical setting, the Surgeon General released a public health advisory on community use of naloxone to reduce deaths from opioid overdose.

WITHDRAWAL MANAGEMENT.

Withdrawal management, often called "detoxification" or medically supervised withdrawal, includes interventions aimed at managing the significant physical and emotional distress that occurs after a person stops using opioids.[70] When clinicians follow evidence-based standards of care,[71] withdrawal management is highly effective in preventing immediate and serious medical consequences associated with discontinuing substance use.[72] However, it is not an effective therapy for any substance use disorder by itself and should always be followed by evidence-based treatment, such as injectable naltrexone for opioid use disorder.[73]

Because withdrawal management reduces much of an individual's acquired tolerance to opioids, any return to use increases the risk of overdose and even death. Therefore, a person with opioid use disorder who undergoes medical withdrawal should be offered injectable naltrexone to protect him or her in case of relapse to opioid use.[73] It is critically important for health care providers to facilitate engagement into the appropriate intensity of treatment.[72] Medically supervised withdrawal is *not* indicated for pregnant women who use or misuse opioids. Medically supervised withdrawal is associated with a high rate of return to substance use, which puts both the pregnant woman and the fetus at risk.[11] Medication-assisted treatment with buprenorphine or methadone for pregnant women with opioid use disorder has been shown to improve outcomes and should be offered.[15]

EVIDENCE-BASED TREATMENT: COMPONENTS OF CARE

As discussed in the *Surgeon General's Report* Chapter 4 ("Early Intervention, Treatment, and Management of Substance Use Disorders"), evidence-based treatment involves particular components of care. Table 1 (page 20) summarizes what people should look for in a treatment program.

All substance use disorder treatment programs are expected to individualize treatment using evidence-based clinical components. These components are clinical practices that research has shown to be effective in reducing substance use and improving health and functioning. These include behavioral therapies, medications, and recovery support services (RSS). Treatment programs that offer more of these evidence-based components have the greatest likelihood of producing better outcomes.

Table 1: What People Should Look for in a Treatment Program

COMPONENTS OF CARE
Personalized diagnosis, assessment, and treatment planning—one size does not fit all, and treatments should be tailored to you and your family.
Long-term disease management—addiction is a chronic disease of the brain with the potential for both recovery and recurrence. Long-term outpatient care is the key to recovery.
Access to FDA-approved medications.
Effective behavioral interventions delivered by trained professionals.
Coordinated care for other/co-occurring diseases and disorders.
Recovery support services—such as mutual aid groups, peer support specialists, and community services that can provide continuing emotional and practical support for recovery.

MEDICATIONS AND MEDICATION-ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDERS.

Comprehensive MAT programs include behavioral therapies and psychosocial supports as well as medication. The FDA has approved medications for use in the management of opioid use disorder (see table below).

Methadone use in treatment of opioid use disorders can only be dispensed in a federally-regulated opioid treatment program (OTP). Buprenorphine and naltrexone can be dispensed in an OTP and also can be prescribed in medical care settings, such as primary care, and do not require an OTP. Use of these drugs is an individual decision for prescribers and their patients.

Table 2: Medications/Pharmacotherapies for Opioid Use Disorder (OUD)

Medication	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense
Methadone	Daily	Orally as liquid concentrate, tablet, or oral solution of diskette or powder	SAMHSA-certified outpatient OTPs dispense methadone for daily administration either onsite or, for stable patients, at home.
Buprenorphine	Daily for tablet or film (also alternative dosing regimens)	Oral tablet or film dissolved under the tongue	Physicians, nurse practitioners, and physician assistants with a federal waiver. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. OTPs can prescribe buprenorphine within the rules that regulate these facilities.
	Every 6 months	Subdermal implant	
	Monthly	Injection (for moderate to severe OUD)	
Naltrexone	Monthly	Intramuscular injection into the gluteal muscle by a physician or other health care professional	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, or nurse practitioner) may prescribe and/or order administration by qualified staff.

NOTE: Adapted from *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide* (SMA14-4892R).[73]

KEY TERM

Opioid Treatment Program (OTP): SAMHSA-certified program, usually comprising a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using methadone, buprenorphine, or naltrexone, of individuals who have opioid use disorders. An OTP can exist in a number of settings, including but not limited to intensive outpatient, residential, and hospital settings. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.

Those FDA-approved medications listed in Table 2 demonstrate "well-supported" evidence of safety and effectiveness for improving outcomes for individuals with opioid use disorders.[74, 75] Only appropriately trained health care professionals should decide, in conjunction with the person in need of treatment, whether and which medication is needed as part of treatment, how the medication is provided in the context of other clinical services, and under what conditions the medication should be discontinued. MAT for patients with an opioid use disorder must be delivered for an adequate duration in order to be effective. Patients who receive MAT for fewer than 90 days have not shown improved outcomes.[76] One study suggested that individuals who receive MAT for fewer than 3 years are more likely to relapse than those who are in treatment for 3 or more years.[77]

In 2018, SAMHSA released *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*. This Clinical Guide provides comprehensive, national guidance for optimal management of pregnant and parenting women with opioid use disorder and their infants.

It helps health care professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions.

MAT FOR PREGNANT WOMEN

Long-term methadone maintenance treatment has demonstrated improved outcomes for individuals (including pregnant women) with opioid use disorders. Buprenorphine is associated with improved outcomes compared to placebo for individuals (including pregnant women) with opioid use disorders. The safety of naltrexone for pregnant women has not been established.

KEY TERM

Agonist: A chemical substance that binds to and activates certain receptors on cells, causing a biological response. Fentanyl and methadone are examples of opioid receptor agonists.

State agencies that oversee substance use disorder treatment programs use a variety of strategies to promote implementation of MAT, including education and training, financial incentives (e.g., linking funding to the provision of MAT), policy mandates, and support for infrastructure development.[78] Nevertheless, multiple factors create barriers to widespread use of MAT. These include provider, public, and client attitudes and beliefs about MAT; lack of an appropriate infrastructure for providing medications; payment policies; need for staff training and development; and legislation, policies, and regulations that limit MAT implementation.[78]

The use of opioid agonist medications to treat opioid use disorders has always had its critics. Many people, including some policymakers, authorities in the criminal justice system, and treatment providers, have viewed maintenance treatments as "substituting one substance for another"[79] and have adhered instead to an abstinence-only philosophy that avoids the use of medications, especially those that activate opioid receptors. Such views are not scientifically supported; the research clearly demonstrates that opioid agonist therapy leads to better treatment outcomes compared to behavioral treatments alone. Moreover, withholding medications greatly increases the risk of relapse to illicit opioid use and overdose death. Decades of research have shown that the benefits of opioid agonist therapy greatly outweigh the risks associated with diversion.[80-82]

MAT FOR CRIMINAL JUSTICE POPULATIONS

Upon release, incarcerated individuals will have lower tolerance to opioids. They are at high risk for overdose and death if they return to opioid use in the community. There is typically insufficient pre-release counseling and post-release follow-up provided to this population to reduce these risks. Research findings from randomized controlled trials indicate that people involved in the criminal justice system benefit from methadone maintenance (pre- and post-release) and extended-release naltrexone treatment.

BEHAVIORAL THERAPIES.

These structured therapies help patients recognize the impact of their behaviors—such as dealing with stress or interacting in interpersonal relationships—on their substance use and ability to function in a healthy, safe, and productive manner. They can be provided in individual, group, and/or family sessions in virtually all treatment settings.[72, 83] Behavioral therapies also teach and motivate patients to change their behaviors as a way to control their substance use disorders.[72] Most studies support the use of individual counseling as an effective intervention for individuals with substance use disorders as part of MAT.[75, 84] Group counseling should primarily be used only in conjunction with individual counseling or other forms of individual therapy.[77, 79] Despite decades of research, it cannot be concluded that general group counseling is reliably effective in reducing substance use or related problems.[84, 85]

RECOVERY SUPPORT SERVICES (RSS).

RSS, provided by both substance use disorder treatment programs and community organizations, help to engage and support individuals in treatment and provide ongoing support after treatment. These supportive services are typically delivered by trained case managers, recovery coaches, and/or peers. Specific supports include help with navigating systems of care, removing barriers to recovery, staying engaged in the recovery process, and providing a social context for individuals to engage in community living without substance use.[86] Individuals who participate in substance use disorder treatment and RSS typically have better long-term recovery outcomes than individuals who receive either alone.[86] Furthermore, active recovery and social supports, both during and following treatment, are important to maintaining recovery.[86]

Recovery: The Many Paths to Wellness

People can and do recover. Recovery from substance use disorders has had several definitions. Although specific elements of these definitions differ, all agree that recovery goes beyond the remission of symptoms to include a positive change in the whole person. In this regard, "abstinence," though often necessary, is not always sufficient to define recovery. There are many paths to recovery. People will choose their pathway based on their cultural values, their psychological and behavioral needs, and the nature of their substance use disorder.

Successful recovery often involves making significant changes to one's life to create a supportive environment that avoids substance use or misuse cues or triggers. Recovery can involve changing jobs or housing, finding new friends who are supportive of one's recovery, and engaging in activities that do not involve substance use. This is why ongoing RSS in the community after completing treatment can be invaluable for helping individuals resist relapse and rebuild lives that may have been devastated by years of substance misuse.

RSS are not the same as treatment and have only recently been included as part of the health care system. The most well-known approach, mutual aid groups, link people in recovery and encourage mutual support while providing a new social setting in which former alcohol or drug users can engage with others in the absence of substance-related cues from their former life. Mutual aid groups are facilitated by peers, who share their lived experience in recovery. However, health care professionals have a key role in linking patients to these groups, and encouraging participation can have great benefit.[87]

Recovery coaches, who offer individualized guidance, support, and sometimes case management, and recovery housing—substance-free living situations in which residents informally support each other as they navigate the challenges of drug- and alcohol-free living—have led to improved outcomes for participants.[88-92] Several other common RSS, including recovery community centers and recovery high schools, have not yet been rigorously evaluated.

Health Care Systems and Opioid Use Disorder

Services for the prevention and treatment of substance misuse and substance use disorders have traditionally been delivered separately from other mental health and general health care services. Because substance misuse has traditionally been seen as a social or criminal problem, prevention services were not typically considered a responsibility of health care systems; and people needing care for substance use disorders have had access to only a limited range of treatment options that were generally not covered by insurance.

Effective integration of prevention, treatment, and recovery services across health care systems is key to addressing opioid misuse and its consequences, and it represents the most promising way to improve access to and quality of treatment. When health care is not well integrated and coordinated across systems, too many patients fall through the cracks, leading to missed opportunities for prevention and early intervention, ineffecive referrals, incomplete treatment, high rates of hospital and emergency department readmissions, and individual tragedies (e.g., opioid overdoes) that could have been prevented.

The good news, however, is that a range of promising health care structures, technologies, and innovations are emerging, or are being refined and strengthened. These developments are helping to address challenges and facilitate integration. Is so doing, they are broadening the focus of interventions beyond just the treatment of severe substance use disorders to encompass the entire spectrum of prevention, treatment, and recovery.

Conclusion

The opioid overdose epidemic brings into sharp focus how myths and misconceptions about addiction have led to devastating consequences for individuals and communities. The evidence-based public health approach described in the *Surgeon General's Report* offers a positive way forward to reducing the opioid crisis by addressing factors that contribute to the misuse and its consequences. By adopting this approach—which seeks to improve the health, safety, and well-being of the entire population—we have the opportunity as a nation to take effective steps to prevent and treat opioid misuse and opioid use disorder and reduce opioid overdose. A public health approach to the opioid crisis will also reduce other harmful consequences, such as infectious disease transmission and NAS. States that have had success in implementing the public health approach and slowing their overdose rates have emphasized the importance of partnerships. Given that too many individuals are dying every day from opioid overdose, shifting our attitudes and working together to widen access to prevention, treatment, and recovery services for opioid misuse and opioid use disorders are essential for saving lives.

The responsibility of addressing opioid misuse and opioid use disorders does not fall on one sector alone, and the health care system cannot address all of the major determinants of health related to substance misuse without the help of the wider community. Everyone has a role to play in changing the conversation around addiction, to improve the health, safety, and well-being of individuals and communities across our nation.

Below are suggestions for various key stakeholders.

Individuals and Families:

- Reach out, if you think you have a problem with opioid misuse or a substance use disorder.
- Be supportive (not judgmental) if a loved one has a problem.
- Carry naloxone and be trained on how to use it.
- Show support toward people in recovery.
- Parents, talk to your children about substance use.
- Understand pain. Many scientifically proven pain management options do not involve opioids. Talk to your health care provider about an individualized plan that is right for your pain.
- Be safe. Only take opioid medications as prescribed to you. Always store in a secure place. Dispose of unused medication properly.

Educators and Academic Institutions:

- Implement evidence-based prevention interventions.
- Provide treatment and recovery supports.
- Teach accurate, up-to-date scientific information about substance use disorders as medical conditions.
- Enhance training of health care professionals.

Health Care Professionals and Professional Associations:

- Address substance use-related health issues with the same sensitivity and care as any other chronic health condition.
- Support high-quality care for substance use disorders.
- Follow the gold standard for opioid addiction treatment.
- Follow the *CDC Guideline for Prescribing Opioids for Chronic Pain*.
- When opioids are prescribed, providers can assess for behavioral health risk factors to help inform treatment decisions, and collaborate with mental health providers.
- Check the PDMP before prescribing opioids.
- Refer to patients to opioid treatment providers when neccessary.
- Become qualified to prescribe buprenorphine for the treatment of opioid use disorder.

Health Care Systems:

- Promote universal, selective, and indicated prevention.
- Promote use of evidence-based treatments.
- Promote effective integration of prevention, treatment, and recovery support services.
- Work with payers to develop and implement comprehensive billing models.
- Implement health information technologies to promote efficiency, actionable information, and high-quality care.
- Create stronger connections across behavioral health providers and mainstream medical systems.
- Engage primary care providers as part of a comprehensive treatment solution.

Communities:

- Build awareness of substance use as a public health problem.
- Invest in evidence-based prevention interventions and recovery supports.
- Implement interventions to reduce harms associated with opioid misuse.

Private Sector—Industry and Commerce:

- Support youth substance use prevention.
- Continue to collaborate with the federal initiative to reduce prescription opioid- and heroin-related overdose, death, and dependence.
- Reduce work-related injury risks and other working conditions that may increase the risk for substance misuse.
- Offer education, support and treatment benefits for workers affected by the opioid crisis.

Federal, State, Local, and Tribal Governments:

- Provide leadership, guidance, and vision in supporting a science-based approach to addressing substance use-related health issues.
- Collect and use data to guide local response to people and places at highest risk.
- Improve coordination between social service systems and the health care system to address the social and environmental factors that contribute to the risk for substance use disorders.
- Implement criminal justice reforms to transition to a less punitive and more health-focused approach.

Researchers:

- Conduct research that focuses on implementable, sustainable solutions to address high-priority substance use issues.
- Identify research gaps in understanding the complexity of opioids addiction and pain.
- Promote rigorous evaluation of programs and policies.

Key Federal Resources

The Surgeon General's Report
https://addiction.surgeongeneral.gov/

CDC Guideline for Prescribing Opioids for Chronic Pain
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

MMWR Opioid Reports
https://www.cdc.gov/mmwr/opioid_reports.html

SGR Appendix B: Review Process for Prevention Programs
https://addiction.surgeongeneral.gov/sites/default/files/appendices.pdf

NIDA Opioid Risk Tool
https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf

NIDA Quick Screen
https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen

CDC general resources
https://www.cdc.gov/drugoverdose/prescribing/resources.html

CDC resources related to People Who Inject Drugs (PWID)
https://www.cdc.gov/pwid/index.html

CDC's Rx Awareness Campaign
https://www.cdc.gov/rxawareness/index.html

CDC Adverse Childhood Experiences page
https://www.cdc.gov/violenceprevention/acestudy/index.html

Preventing the Consequences of Opioid Overdose: Understanding the Naloxone Access Laws
https://www.samhsa.gov/capt/sites/default/files/resources/naloxone-access-laws-tool.pdf

The Surgeon General's Advisory on Naloxone and Opioid Overdose
https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html

SAMHSA Opioid Overdose Prevention Toolkit
https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA16-4742

SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants
https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054

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Policing space in the overdose crisis: A rapid ethnographic study of the impact of law enforcement practices on the effectiveness of overdose prevention sites

Alexandra B. Collins[a,b], Jade Boyd[b,c], Samara Mayer[b], Al Fowler[b], Mary Clare Kennedy[b,d], Ricky N. Bluthenthal[e], Thomas Kerr[b,c], Ryan McNeil[b,c,*]

[a] Faculty of Health Sciences, Simon Fraser University, 8888 University Drive, Burnaby, BC V5A 1S6, Canada
[b] British Columbia Centre on Substance Use, 400 - 1045 Howe Street, Vancouver, BC V6Z 2A9, Canada
[c] Department of Medicine, University of British Columbia, St. Paul's Hospital, 608 - 1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada
[d] School of Population and Public Health, University of British Columbia, 2206 E Mall, Vancouver, BC V6T 1Z9, Canada
[e] Department of Preventive Medicine Keck School of Medicine, University of Southern California, 1975 Zonal Ave, Los Angeles, CA 90033, United States

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ABSTRACT

North America is in the midst of an overdose crisis. In some of the hardest hit areas of Canada, local responses have included the implementation of low-threshold drug consumption facilities, termed Overdose Prevention Sites (OPS). In Vancouver, Canada the crisis and response occur in an urban terrain that is simultaneously impacted by a housing crisis in which formerly 'undesirable' areas are rapidly gentrifying, leading to demands to more closely police areas at the epicenter of the overdose crisis. We examined the intersection of street-level policing and gentrification and how these practices re/made space in and around OPS in Vancouver's Downtown Eastside neighborhood. Between December 2016 and October 2017, qualitative interviews were conducted with 72 people who use drugs (PWUD) and over 200 h of ethnographic fieldwork were undertaken at OPS and surrounding areas. Data were analyzed thematically and interpreted by drawing on structural vulnerability and elements of social geography. While OPS were established within existing social-spatial practices of PWUD, gentrification strategies and associated police tactics created barriers to OPS services. Participants highlighted how fear of arrest and police engagement necessitated responding to overdoses alone, rather than engaging emergency services. Routine policing near OPS and the enforcement of area restrictions and warrant searches, often deterred participants from accessing particular sites. Further documented was an increase in the number of police present in the neighborhood the week of, and the week proceeding, the disbursement of income assistance cheques. Our findings demonstrate how some law enforcement practices, driven in part by ongoing gentrification efforts and buttressed by multiple forms of criminalization present in the lives of PWUD, limited access to needed overdose-related services. Moving away from place-based policing practices, including those driven by gentrification, will be necessary so as to not undermine the effectiveness of life-saving public health interventions amid an overdose crisis.

Introduction

Although North America's overdose crisis is often framed as a consequence of the over-prescription of opioids (Madras, 2017), it is now understood that the crisis is primarily driven by the proliferation of fentanyl and fentanyl-adulterated drugs (Seth, Scholl, Rudd & Bacon, 2018; Smolina et al., 2019). However, the epidemic is intimately linked with structural inequities (e.g. entrenched poverty, strained health care systems) (Dasgupta, Beletsky & Ciccarone, 2018; Davis, Green & Beletsky, 2017; McLean, 2016) in ways that disproportionately impact structurally vulnerable populations. Here, we define structural vulnerability as a marginalized position within a social hierarchy that renders particular populations or individuals (e.g. people who use drugs [PWUD], sex workers) more susceptible to forms of suffering due to social and structural violence (e.g. racism, gender inequities, poverty) (Farmer, Connors & Simmons, 1996; Quesada, Hart & Bourgois, 2011). The synergistic relationship between substance use and poverty is reinforced in spaces of advanced marginality (Wacquant, 2007) – that is,

* Corresponding author at: British Columbia Center on Substance Use, 400-1045 Howe Street, Vancouver, B.C. V6Z 2A9, Canada.
E-mail address: ryan.mcneil@bccsu.ubc.ca (R. McNeil).

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where a dearth of economic opportunity, spatial segregation, and an amplification of the criminal justice system reinforce inequity (Wacquant, 2008).

Areas of advanced marginality are often spatially bound and concentrated in urban neighborhoods that are subsequently stigmatized (Wacquant, 2007). To regulate such marginality, including drug use, local governments have increasingly drawn on mechanisms of urban control (Merry, 2001; Smith, 1996; Wacquant, 2007). Such spatialized practices and strategies have aimed to regulate public spaces and displace, exclude, and incarcerate structurally vulnerable populations, including PWUD, through by-laws (e.g. anti-loitering ordinances) (Beckett & Herbert, 2008), the implementation of urban control strategies (e.g. security cameras, 'community policing') (Hermer & Mosher, 2002; Wallace, 1988), and socio-legal mechanisms such as area restrictions (i.e. court-ordered restrictions prohibiting an individual from re-entering an area where they were arrested) (Beckett & Herbert, 2009; McNeil, Cooper, Small & Kerr, 2015; Sylvestre, Damon, Blomley & Bellot, 2015). These mechanisms of urban control, however, are typically more pronounced in areas that are targeted for 'revitalization' or gentrification (i.e. the process of transforming vacant or low-income inner-city areas into economic, recreational, and residential use by middle- and upper-income individuals), and are thus intimately linked with broader economic, political, environmental, and social contexts (August, 2014; Blomley, 2004; Hackworth, 2006; Smith, 1996; Wallace, 1990). Given this, there is a need to understand how such mechanisms are connected to and reinforced by broader environmental milieus within the context of an urban public health crisis.

While street-level policing practices in street-based drug scenes are often cited as critical to limiting access to the drug supply and reducing violence and disorder (Aitken, Moore, Higgs, Kelsall & Kerger, 2002; Maher & Dixon, 1999; Werb et al., 2011; Zimmer, 1990), they disproportionately target and impact racialized persons (Beletsky, 2019). Moreover, research has demonstrated how such models are not effective, but rather contribute to additional harms for PWUD, including increased violence (Cooper, 2015; Werb et al., 2011; Wood, Tyndall et al., 2003). An extensive body of research has also highlighted the adverse impacts drug scene policing can have on the health of PWUD (e.g. Bluthenthal, Kral, Lorvick & Watters, 1997; Cooper, Moore, Gruskin & Krieger, 2005; Kerr, Small & Wood, 2005; Maher & Dixon, 1999). Within this work, street policing has been associated with risks such as reduced access to harm reduction and ancillary services (Bluthenthal et al., 1997; Cooper et al., 2005; Davis, Burris, Kraut-Becher, Lynch & Metzger, 2005; Werb et al., 2015; Wood, Kerr et al., 2003), rushed injections (Cooper et al., 2005; Small, Kerr, Charette, Schechter & Spittal, 2006; Werb et al., 2008), increase risk of overdose (Bohnert et al., 2011; Dovey, Fitzgerald & Choi, 2001; Maher & Dixon, 1999), and an increased risk of disease transmission (Cooper et al., 2005; Friedman et al., 2006; Rhodes et al., 2006; Werb et al., 2008). Given these factors, the continued use of place-based policing practices (e.g. increased police presence in specific areas, street checks, utilization of civil statutes), or policing that targets crime "hot spots" or segments of place (e.g. street blocks, buildings) (Eck & Weisburd, 1995; Weisburd, 2008), particularly within the context of a public health crisis, can negatively impact the health and well-being of structurally vulnerable PWUD and reinforce their susceptibility to harm. Importantly, it has been argued that to be effective, harm reduction interventions should be established in the settings where drug use occurs (Moore & Dietze, 2005). However, research has documented that these same spaces overlap with law enforcement presence (Bluthenthal et al., 1997; Cooper et al., 2005; Davis et al., 2005; Kerr, Small et al., 2005). As such, there is a further need to understand the social-spatial practices of PWUD within these settings and how these spatial practices are altered by broader structural factors that contribute to the making and remaking of space (Duff, 2010).

Understanding these dynamics is particularly important across North America, where the current overdose crisis has led to the retrenchment of tactics utilized in the War on Drugs. This has included strategies targeting both the legal and illegal drug markets to reduce supply, such as prescription opioid monitoring systems, increased border policing, and an intensification of prosecuting and incarcerating drug dealers and other PWUD (e.g. drug-induced homicide charges) (Beletsky & Davis, 2017; Davis et al., 2017; Werb, 2018), which systematically target racialized persons (Beletsky, 2019). However, this supply-side focus, largely spurred by the view that the current overdose crisis is a 'white opioid epidemic' (Netherland & Hansen, 2016), is occurring alongside the implementation of – or in some instances, efforts to implement – overdose prevention interventions and evidence-based public health initiatives (e.g. widespread naloxone distribution, expanded access to opioid agonist therapies). Examining how these factors intersect given the potential for policing practices to shape the effectiveness of such interventions (Cooper et al., 2005; Werb et al., 2015; Wood, Kerr et al., 2003) is thus needed.

These dynamics are particularly relevant in Vancouver, Canada, which has rolled out a robust overdose response effort, spearheaded by community activists, since December 2016. As part of these efforts, low-threshold drug consumption facilities – termed overdose prevention sites (OPS) – have been rapidly implemented (Collins, Bluthenthal, Boyd & McNeil, 2018). OPS are staffed by peers or support workers, who administer naloxone and, in some locations, oxygen in the event of an overdose. Unlike sanctioned supervised consumption sites (SCS), OPS do not require federal approval as these have been implemented as temporary public health interventions amid a public health emergency by order of the provincial Ministry of Health. By pushing for overdose prevention interventions, and specifically OPS, activists, drug user-led groups, and public health officials have sought to create neighborhood conditions that improve the ability for PWUD to use in safer environments in the context of a public health emergency (Boyd et al., 2018). Five OPS were opened in Vancouver by December 2016, all in the Downtown Eastside neighborhood, with additional OPS opening in subsequent months.

Vancouver's OPS are largely clustered within the street-based drug scene, most visible through income generating activities (e.g. vending, drug selling, sex work). During the course of this study, all OPS established in Vancouver were situated in the most visible area of the drug scene and the epicenter of Vancouver's overdose crisis, which also contains one of city's SCS (see Fig. 1). In addition to their close proximity to the SCS, three of the city's OPS were integrated within existing services within an approximate one-block radius from the Street Market – a daily, community-driven vending space and one of the central points of the street economy. The Street Market acts as a social hub for many neighborhood residents, in that it provides a space for income generating activities and socializing, while geographically overlapping with primary drug purchasing and consumption locales.

In addition to the robust public health response in the Downtown Eastside and the location of OPS in this study, the neighborhood is also the site of increasing gentrification and 'revitalization' efforts aimed at meeting the growing demand for housing amid an ongoing housing crisis driven by factors such as external capital flows, an increasing population, and weak housing policies (Bardwell, Boyd, Kerr & McNeil, 2018; Collins, Boyd et al., 2018; Lee, 2016). Specifically, the Downtown Eastside is experiencing an influx of high-end condominiums whose placement overlaps with the main economies of the drug scene. Such gentrification efforts have also been paired with mechanisms of urban control, including private security guards, security cameras, and local policing (Kerr, 2018; Markwick, McNeil, Small & Kerr, 2015). Given these overlapping practices, as well as inadequate social assistance rates (Klein, Ivanova & Leyland, 2017), and the gentrification of low-income neighborhoods like the Downtown Eastside, PWUD have experienced increasing housing instability (Bardwell, Fleming, Collins, Boyd & McNeil, 2018; Collins, Boyd et al., 2018; Fleming et al., 2019), with Vancouver's homelessness rate having increased over 60% from 2005 to 2018 (Urban Matters CCC & BCNPHA, 2018). However, no research to

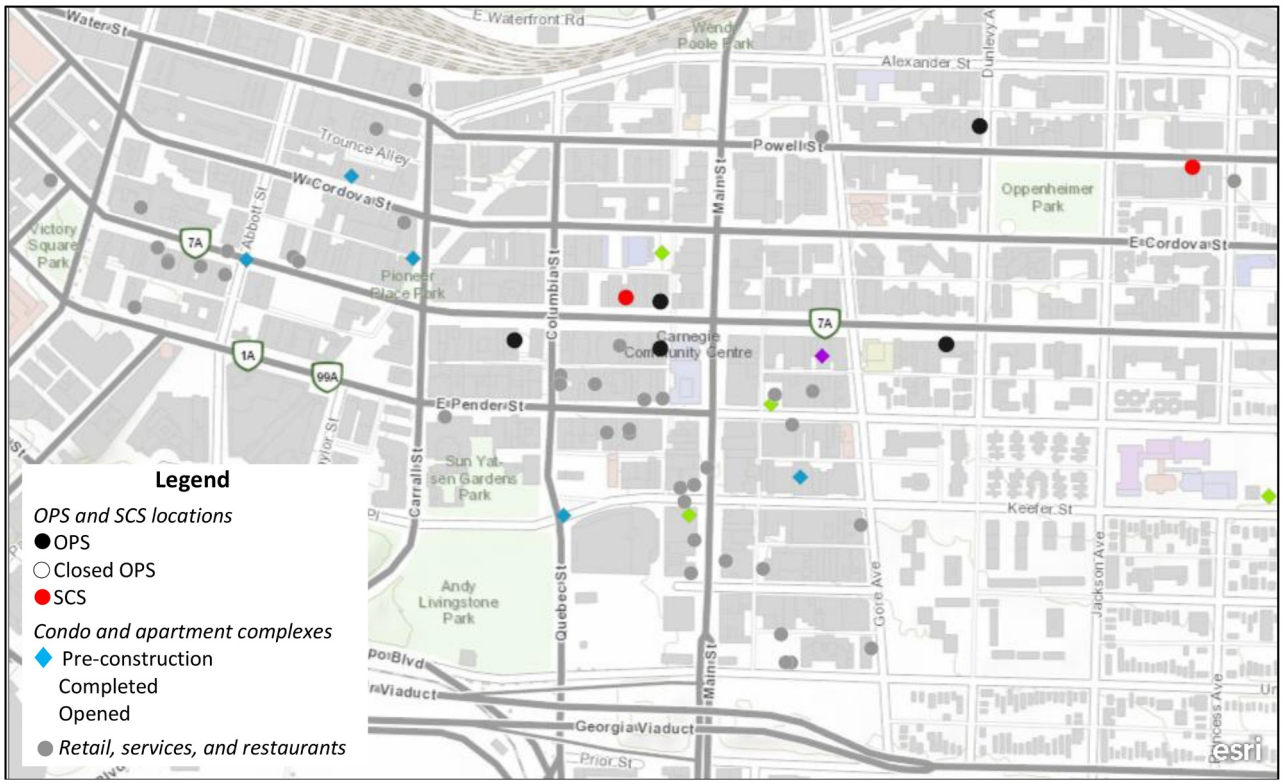

Fig. 1. Overdose prevention interventions in relation to gentrifying businesses.
City of Vancouver, Province of British Columbia, Esri Canada, Esri, HERE, Garmin, INCREMENT P, Intermap, USGS, METI/NASA, EPA, USDA, AAFC, NRCan
*Map only includes a subsection of businesses, condos, and services opened in 2016 or later.

date has examined the impact of neighborhood-level policing on OPS utilization within the context of overlapping housing and overdose crises. Understanding the impacts of such urban social-spatial control is imperative to increasing the effectiveness of OPS as a response to a public health emergency.

To discern the impact of these neighborhood changes, we undertook this study to examine how drug-scene policing practices intersected with the social-spatial practices of PWUD to shape the utilization of OPS implemented as part of a public health response. In doing so, we explore how law enforcement practices within a street-based drug scene contribute to the making and remaking of space, and the impact such space-making has on the health and well-being of PWUD.

Methods

We undertook rapid ethnographic research between December 2016 and April 2017 as part of an established community-based research program in Vancouver. This research examined the implementation and utilization of OPS, focusing on structural forces (e.g. policing, territorial stigmatization) and the implications of such factors on the implementation and operation of OPS services within the broader neighborhood. Conducting rapid ethnographic research has been highlighted as an important methodological adaptation within the context of public health emergencies (Johnson & Vindrola-Padros, 2017; Pink & Morgan, 2013). Further, when paired with community-based research methods, rapid qualitative research can more adequately advance understanding of concerns within the communities under study (McNall & Foster-Fishman, 2007).

The larger study included over 200 h of observational fieldwork at OPS and surrounding areas conducted by team members and peer researchers. During fieldwork, informal and unstructured conversations occurred between team members and individuals accessing the OPS. After each session, detailed fieldnotes were written, which documented observations and interactions in relation to the implementation of OPS. Additional fieldwork was conducted by the lead author and two peer researchers during October 2017, to further elucidate social-spatial practices of PWUD in and around five OPS as part of this analysis. Fieldwork sessions were conducted in close proximity to OPS, including adjacent alleys and streets, and lasted between 2 and 3 h. These sessions were spread out to cover various days of the week as well as times of day, including evening sessions. Fieldwork observation sheets specific to each location were developed to record physical and social information about the sites, including presence of security cameras, lighting, social-spatial practices of individuals in the area (e.g. sleeping, socializing, working), presence of police and first responders, as well as documenting overdose-related events. Each team member completed fieldwork observation sheets, which were reviewed together after the fieldwork session and used to construct more robust fieldnotes.

Additionally, semi-structured, qualitative interviews were conducted with 72 PWUD who were engaged in the street-based drug scene. Participants were recruited by team members, including peer researchers, directly from four OPS during fieldwork. After recruitment at the OPS, a peer researcher walked each participant back to our field office for the interview. An interview guide was used to facilitate discussion on topics such as experiences at OPS, overdose-related events, the impact of housing on OPS access, interactions with police, and income generating activities. Interviews lasted approximately 30–60 min, were audio recorded, and transcribed verbatim by a transcription service. After the interview, participants received $30 CAD honoraria for their time. Of the 72 participants, 43 identified as women (including three transgender and Two Spirit persons), 33 identified as Indigenous, and the average age was 42 years old (see Table 1). Additionally, 44 participants reported experiencing an overdose event in the last year and 13 participants reported being incarcerated in the two weeks prior to interview.

Written fieldnotes and interview transcripts were imported into

Table 1
Participant demographics (n = 72).

Participant characteristic	n (%)
Age	
Mean	42
Range	20–64 years
Ethnicity	
Indigenous	33 (45.8%)
White	32 (44.4%)
Other (Hispanic, Black)	7 (9.8%)
Gender[a]	
Women	43 (59.8%)
Men	29 (40.2%)
Transgender persons	3 (4.2%)
Two Spirit persons[b]	1 (1.4%)
Overdoses in past year	
One	15 (20.8%)
Two	10 (13.9%)
Three or more	19 (26.4%)
Incarceration[c]	
In the two weeks prior to interview	13 (18.1%)
In the six months prior to interview	10 (13.9%)
In the last year prior to interview	9 (12.5%)
Current housing	
Apartment	8 (11.2%)
Unstably housed[c]	40 (55.5%)
Unsheltered	24 (33.3%)

[a] Participants could select more than one response.
[b] A non-binary and fluid term denoting Indigenous persons with both a masculine and feminine spirit, used to describe one's gender or sexuality (Ristock, Zoccole & Passante, 2010).
[c] Defined as currently living in a single room accommodation hotel, shelter, hostel, or having no fixed address.

NVivo qualitative software, where they were analyzed using the same coding framework. Initial coding frameworks were comprised of a priori categories derived from fieldnotes and the interview guide and emergent themes identified by the research team (Creswell, 2009). Throughout the analytical process, data were interpreted by drawing on structural vulnerability frameworks (Quesada et al., 2011) and elements of social geography related to the 'disciplining' of populations (Beckett & Herbert, 2008; Merry, 2001) to better understand the ways in which space was made and remade, and how this impacted the social-spatial practices of PWUD (Deleuze & Guattari, 1987; Duff, 2007). Pseudonyms were created using an online pseudonym generator and assigned to participants. ArcGIS online software by Esri was used to create the map, with geographic coordinates sourced from Google Maps. Ethical approval for this study was received from the Providence Healthcare/University of British Columbia Research Ethics Board.

Findings

Shifting social-spatial practices of daily life

Given their location within the larger drug scene, OPS were situated within the established social-spatial practices of structurally vulnerable PWUD as they overlapped with existing drug selling and consumption locations, low-income housing, health services, and other resources (e.g. food services, drop-in centers). Simultaneously, however, OPS locations also intersected with place-based policing efforts occurring within the same spaces, driven in large part, according to participants, by the rapid gentrification of the Downtown Eastside neighborhood. As a result, space immediate to OPS was continuously being constructed and reconstructed in ways that altered the 'boundaries' of the street-based drug scene. Strategies used to secure space in the neighborhood included relocating PWUD further from areas where OPS were readily accessible through the displacement of dealers by law enforcement and a persistent police presence that participants described as "*pushing*" people back into alleys. Many participants described these placed-based policing practices as producing new "*hotspots*" of drug use and overdose risk as the drug scene was pushed eastward by new, gentrifying businesses entering the area. Additionally, changes to neighborhood environment, including the installation of multiple, large flood lights in the alley behind the Street Market, also deterred people from accessing particular spaces as it increased their visibility. These intersecting policing and gentrification practices thus created additional displacement and barriers for certain participants, and contributed to the ever-evolving boundaries of the drug scene. In describing neighborhood-level changes and their impact on PWUD, one participant explained:

> *There's people being displaced all the time. They're* [i.e. cops] *pushing us all – I don't know where they're going to put us, right? …Go down there and start walking up this way. You'll see it. All brand new, all brand new, new and old mixed. And pretty soon that'll be all – there'll be no more old.* ('Matthew,' 44-year-old Indigenous man)

Similarly, 'Jason,' a 56-year-old white man, described the impact of gentrification he saw within the neighborhood in relation to the housing and overdose crises:

> *Part of what is going on…is that gentrification is happening. Things are changing and a new attitude moving in, new people and things like that. They don't want things openly out there…open drug use around the park up and down the street, you don't see that anymore. It's in the alleys and the police will tolerate that more.* […] *I think there is a more overriding long-term agenda of moving people out of this area or at least making it so that they're not as visible and stuff like that.*

Both of these examples highlight the ways in which participants' daily activities both constructed space and were shaped by the construction of space in the neighborhood.

Given participants' structural vulnerability, there was a need to regularly access public spaces which became more problematic as the neighborhood changed. Specifically, the influx of high-income apartment complexes and condominiums, cafés and restaurants, and other retail spaces in the neighborhood contributed to pervasive surveillance and place-based policing practices, which placed a strain on individuals who regularly engaged with this particular space as visible drug use became more contentious. As one participant described:

> *People are kind of getting pushed. Like they closed down one side of the street, but everybody just moved to the other side. …Now they started the little market for people to go there and sell their stuff, but you still see people out on the sidewalks selling all their shit.* […] *It's hard to kind of put your finger on exactly what is going on. But I think also, with a lot of the trendier stores and stuff coming, like they don't want people standing in front of your store, you know, smoking a crackpipe or shooting up or something, right? So you know, they frown upon that, which is understandable. But…people aren't able to be as open about it as they used to be.* ('Laura,' a 52-year-old white woman)

As Laura highlighted, the decreasing of accepted locations for these street-based economies by gentrification created challenges for participants who had to navigate this area to meet basic needs (e.g. food services, health services). Such efforts aimed at redefining the Downtown Eastside necessitated a renegotiation of participants' social-spatial practices. It also underscores what participants described as a city-wide effort driven by policing practices and gentrification to dismantle their sense of place within the neighborhood as their ability to access and engage with needed services became more challenging.

As made evident within these examples, the overlapping housing and overdose crises shifted the environment of the Downtown Eastside neighborhood in a way that was at times contradictory to the overdose response. In particular, media coverage of the overdose crisis had spotlighted the neighborhood, while additional city efforts (e.g. urban redevelopment, increased police visibility) simultaneously created barriers to particular spaces that could exacerbate drug-related harms. Importantly, gentrification practices in the Downtown Eastside

neighborhood were intimately linked with policing. Specifically, an increase in complaints from surrounding businesses, residents, and visitors, incited heightened foot patrol within a main area of the street-based drug scene (Eagland, 2018; Kerr, 2018; Rabinovitch, 2018). Such policing practices by law enforcement, while implemented to increase a sense of safety for condo-owning residents, visitors, and business owners (Eagland, 2018; Rabinovitch, 2018), represent a more modern approach to urban policing in street-based drug scenes, aimed at altering the spatial patterns of PWUD. As such, the increased visibility of the neighborhood due to its high-volume of overdoses and rapid response to the crisis through the implementation of OPS was often undermined by the proliferation of law enforcement in the same area.

Zones of surveillance – policing around OPS

Mistrust and potential arrest

The majority of participants described having negative interactions with police in the neighborhood at some point, which created a lack of trust. Such interactions were linked to participants' structural vulnerability – including being harassed while using outside, being forcefully displaced while sleeping outside, and having tents, tarps, and other belongings disposed of while unhoused – and reinforced their marginality and drug-related risks. However, it is important to note that the City was complicit in such efforts, as municipal workers were often tasked with removing and disposing of individuals' belongings as police stood by; a practice we regularly observed across the neighborhood in parks, alleys, and on sidewalks. We also observed police regularly stopping and searching individuals, particularly Indigenous people and people of color, within the drug-scene and within the immediate areas surrounding OPS, including blocking OPS alley entrances with a police car while searching individuals. For many participants, these interactions reinforced their mistrust of law enforcement, including their view that they disproportionately target particularly groups, and extended to their perceptions of the role of police within the overdose response. As one participant explained:

> *I think they're* [cops] *a bunch of hypocrites. They'll say one thing and then say something else, or do something else, when there's no cameras around, right? …They just think of themselves better and us as just waste of space, waste of taxpayers' money, just a waste. Right? For the most part, that's the attitude that I get from them.* ('Mark,' 53-year-old Black man)

As such, police surveillance created space in ways that was deemed unsafe by participants given the criminalization of drug use, which impacted how participants responded to overdoses and utilized OPS. Several participants recounted interactions they had with police during an overdose response, underscoring the potentially negative consequences such policing strategies could have for PWUD. This included leaving someone who was overdosing for fear of arrest or being the "*fall guy*" (i.e. blamed for someone's overdose and facing subsequent legal consequences) in the case of a fatal overdose, with such narratives particularly common among racialized PWUD and those with histories with the criminal justice system. Additionally, participants described hesitation in engaging emergency medical services during overdose situations as they were uncertain whether police would also attend, and if they would run a warrant search upon arriving. 'Brad,' an OPS peer worker, explained:

> *I've seen people leave* [the site] *and then they come back into* [the OPS] *and then they're like, 'This guy OD'd outside, but his friends left.' …They know that the police are going to show up. Maybe they have warrants. They just don't want to be jacked up* [i.e. searched by police] *…so they just leave.* (56-year-old Indigenous man)

Other participants reported aggressive interactions with police following overdose events. After responding to an overdose in an apartment building, 'Michael' described:

> *They* [paramedics] *were walking him down to the ambulance to take him to the hospital and there was the ambulance and there was a couple of police, and they were kind of like, you know, a little bit rude, eh? And I've experienced that before: 'Just stand back! Stand back!' But they want to know like, do you know this person, what you gave him…so I know the routines. As they work I stand back and just tell him what I know and what I gave him and stuff.* […] *One of the cops, he ran a CPIC* [criminal record search] *on me. …Maybe* [he thought] *I was his dealer or something. He should have asked who we are first, instead of jumping to conclusions, judging, right? That's what some police do.* (52-year-old Indigenous man)

Although the Vancouver police have a policy of non-attendance at overdoses unless advised to do so by emergency services (Vancouver Police Department, 2006a), their existing, heavy presence in various spaces left participants to choose between responding to an overdose alone, not responding, or responding with the assistance of emergency medical staff and potentially being arrested. As such, participants often chose to administer naloxone themselves and not call for emergency services as this was viewed as the safest response for both themselves and the person they were responding to within the broader context of drug criminalization.

Importantly, we observed an officer attend to an overdose call alongside a paramedic inside one of the OPS. While the officer's assistance was requested by the paramedic, individuals accessing the service were visibly surprised and unsettled by the presence of law enforcement within a space they viewed as safe from arrest. Such remaking of space by the officer and the paramedic reinforced fears of arrest from the majority of those present, including individuals who were breaching area restrictions to access the service. This further highlights the ways in which the criminalization of drug use can undermine public health initiatives aimed at reducing overdose.

Alley patrol, cop cars, and open surveillance

While describing their engagement with OPS, participants noted how routine police surveillance occurred within the street-based drug scene and included the areas immediately surrounding OPS. Participants reported that police were *"always just sitting in their cars just watching"* and that *"they're on the street everywhere."* Routine police surveillance altered the social-spatial practices of participants by impacting their abilities to access certain OPS and pushing them into unsafe injecting environments, with racialized participants reporting the highest degree of surveillance. 'Emily,' a 25-year-old Indigenous woman, highlighted how police-implemented surveillance strategies increased drug- and health-related risks for PWUD:

> *I don't trust them* [cops] *at all. And I do think that they are kind of preventing people from using in safe places, you know. Like they're* [PWUD] *going further into unknown like empty alleys and where nobody could see them if they overdose. Well, if you're like in the alley, let's say, behind Insite, then at least there's people around who could see you fall down or whatnot.* […] *But sometimes they* [cops] *park their cars in front of like Insite, and so nobody wants to be around there, right? So we're going into unsafe alleys and whatnot.*

As this participant highlighted, daily practices and engagement in space within the neighborhood were also contingent upon the visibility of law enforcement officials. Another participant reiterated these sentiments:

> *There are certain areas that you don't want to really be there because the cops will drive up and down and you never know what they are going to say or do. It is mostly* [the 100 block] [i.e. the epicenter of the drug scene], *but they do circle around pretty well all over the Downtown Eastside, but yeah, mostly in that area – there is a heavier presence in that area.* ('Melanie,' 55-year-old white woman)

While participant narratives underscored the normalcy of police presence within the neighborhood given its advanced marginality,

tensions arose in relation to participants' need to navigate highly-surveilled spaces to access OPS. For some participants, this created ongoing barriers to accessing specific sites, including the only site in which inhalation is allowed. As Brad, who both injected and smoked drugs, described:

> *Police cruise that alley* [i.e. where an OPS entrance in located] *a lot and there is a lot of drug dealers around, a lot of transactions, so the police are always patrolling that area…police are walking through, police are driving through. They could choose a different spot* [for the OPS] *maybe and have it taped off or something. A closed off area.* [Having an OPS] *inside is always the best.* (56-year-old Indigenous man)

Despite the entrance being in the alley, which falls within most participants' existing social-spatial practices and is thus widely accessed, this narrative magnifies the continuing visibility of such spaces due to police surveillance in the adjoining area. Such visibility was particularly worrisome for some participants at this OPS as it was established outside as a tent, and later trailer, and was thus viewed as more 'open' to police surveillance. While conducting fieldwork, we regularly observed police slowly driving through alleys both adjacent to and at OPS entrances and surrounding areas, or parking cars at alley entrances with the lights turned on. In these instances, individuals selling or using abruptly stopped, turned their backs, or left the area. These practices were further reflected by local graffiti. This particular alley was marked by a wall-sized mural of a police officer with a warning that "cops have this entire alley on 24/7 video" surveillance (see Fig. 2). As such, these surveillance practices remade spaces in ways that increased risk of drug-related harms for structurally vulnerable individuals and were in conflict with public health efforts that were aimed at addressing the overdose crisis.

Fig. 2. Graffiti of policing in the alley behind the Street Market.
Smokey D, artist | Alley behind the Street Market | Photograph by authors JB and RM (February 21, 2017).

Further, during fieldwork sessions conducted in and around OPS, more police presence was observed the week preceding and the week of check week (i.e. the week in which social assistance cheques are received). In these instances, surveillance tactics included drive-bys in alleys where OPS entrances were located, foot patrol around OPS, and parking police vehicles in close proximity to OPS. The increased observation of policing around check week has significant implications as drug use often increases during this time given the increase of income, and thus for some participants, an increased need to access safe spaces to use.

Red zones as barriers to OPS engagement

For others, however, law enforcement techniques such as area restrictions or "red zones" (McNeil et al., 2015) prevented participants' access to needed services as they could subsequently be arrested if seen by police within these spaces. In these instances, participants' approaches to navigating these zones of exclusion varied, including keeping their distance as well as covert navigation. 'Joshua,' a 32-year-old Black man who had only accessed one OPS, explained: "*I've heard about them* [other OPS] *but it's in my red zone. I'm red zoned from the whole Downtown Eastside.*" As such, this participant reported using "*mostly on the street*" now as he had been incarcerated within the two weeks prior to the interview.

Other participants who were currently red zoned described needing to re-engage with prior social-spatial practices in the neighborhood to reduce their risk of overdose and other health-related harms. In doing so, these participants actively challenged law enforcement tactics that not only shaped space, but also restricted their movements, as this was perceived as vital to staying alive. One participant, 'Shawn,' described using "*lots in the alley*" despite not feeling safe there. Continuing, Shawn shared how he negotiates the complexity of area restrictions and overdose prevention:

> *I got a red zone so I'm not allowed to be in a certain area.* […] *It's the areas that I want to go to and use and all the accessibility and all the sites that I need or want to access – they're all in my red zone.* […] *Like, I'm not supposed to be in certain areas, but I'm there… I feel safer in the injection sites than I do just like in the alley…I know that the cops there will let you use. You're allowed to use there and the cops acknowledge that and they won't look twice at you if you're in there.* (43-year-old South Asian man)

Although OPS are off-limits from police interference related to drug law enforcement, and thus seen as 'safer,' policing practices, including patrolling areas around OPS and implementing red zones, continued to impede OPS access, particularly for participants who had area restrictions. This retention of social-spatial practices, despite the constant surveillance of the same zone, was viewed as imperative to reduce drug- and health-related harms for participants.

Discussion

Although established within the existing social-spatial practices of PWUD in the neighborhood, ongoing 'revitalization' efforts intersected with law enforcement measures re/making space in ways that created barriers to needed harm reduction services for participants. Given participants' structural vulnerability, including factors such as housing instability, types of work (e.g. sex work, drug dealing), and involvement in the street-based drug scene, they were more susceptible to placed-based policing practices. In particular, increased visibility of law enforcement and surveillance undertaken in the same areas as OPS discouraged participants from engaging in the street-based drug scene and incited fears of arrest. As such, despite OPS serving as safer environments to consume drugs amid an overdose crisis, drug-scene policing practices (e.g. neighborhood sweeps, foot patrol) created barriers to engagement for many participants, reinforcing their structural vulnerability and increasing their risk of drug-related harm.

Other research has highlighted how despite supervised consumption sites (SCS) providing a safer place to use drugs away from police (Fairbairn, Small, Shannon, Wood & Kerr, 2008; McNeil, Small, Lampkin, Shannon & Kerr, 2014; Small, Moore, Shoveller, Wood & Kerr, 2012), policing around SCS and other harm reduction services can impede access and reduce PWUD's ability to engage in risk reduction practices (Cooper et al., 2005; Kerr, Oleson, Tyndall, Montaner, & Wood, 2005; Kimber & Dolan, 2007; Petrar et al., 2007; Werb et al., 2008). This study expands on these findings by highlighting how the process of gentrification led to evolving expectations and influence on space by new occupants (i.e. business and condo owners, visitors), which was operationalized through the mobilization of police against existing residents, and specifically, PWUD. Of note, condo owners filed complaints with the Vancouver Police Department (VPD), requesting additional officers be deployed to address crime, street disorder, and public safety in the Downtown Eastside (Rabinovitch, 2018). As documented, this included place-based policing practices and surveillance – as well as "above minimal staffing levels" in the Downtown Eastside (Rabinovitch, 2018, p.5) – which directly interfered with an emergency public health response in ways that can increase drug- and overdose-related risk for PWUD. Importantly, community activists, drug user-led organizations, and public health officials pushed for the rapid implementation of OPS in the Downtown Eastside neighborhood (Boyd et al., 2018; Collins, Bluthenthal et al., 2018), thereby creating safer neighborhood conditions for PWUD to use. However, as gentrification is occurring within the same areas as OPS, the shifting population risks undermining life-saving interventions by influencing policing. Unlike other forms of urban policing (e.g. 'broken windows' policing) (Beckett & Herbert, 2008), these findings demonstrate a form of place-based policing that is driven by gentrification, instigated by newcomer residents, visitors, and business owners, and thereby aligned with more longstanding and emerging police practices targeting PWUD even amidst an overdose crisis. Significantly, policing efforts that reinforced displacement in the Downtown Eastside neighborhood necessitated a renegotiation of participants' daily social-spatial practices that often included more clandestine drug use that exacerbated risk as provincially-supported overdose prevention interventions were made inaccessible. As such, placed-based policing within this setting was found to increase risk of overdose and other drug-related harms for PWUD as it required them to use in less visible areas (e.g. alleyways, single room accommodations).

In line with previous research on the impact of policing strategies on health outcomes (Bohnert et al., 2011; Cooper et al., 2005; Davis et al., 2005; Friedman et al., 2006; Markwick et al., 2015; McNeil et al., 2015; Small et al., 2006; Werb et al., 2011) and engagement with SCS (Kerr, Oleson et al., 2005), our findings highlight how policing mechanisms designed to promote safety can inadvertently intensify harms for PWUD. Similar outcomes were highlighted in previous research, as PWUD sought to evade police surveillance occurring in and around a SCS in Vancouver (Kerr, Oleson et al., 2005). Our research illustrates how place-based policing practices within the epicenter of the province's overdose crisis can exacerbate the overdose-related risks and harms faced by structurally vulnerable PWUD as they feared arrest in particular spaces, thus limiting the effectiveness of harm reduction interventions.

The increase in police surveillance experienced within the Downtown Eastside was implemented to increase neighborhood safety (Rabinovitch, 2018; Vancouver Police Department, 2018a). However, this study has illustrated the unintended consequences of visible police presence within the drug scene, as it represents a threat to participants aiming to access OPS, and thus alters where they consume drugs. Such implications can increase risk of harms for PWUD and limit the coverage of OPS. Despite the VPD's open support of evidence-based harm reduction (Vancouver Police Department, 2006b), our findings underscore how police efforts to increase neighborhood safety reinforce the marginalization of PWUD in the same neighborhood as they sought to avoid police. The scope of policing in the Downtown Eastside under the Beat Enforcement Team (BET) (i.e. targeted police force in the Downtown Eastside neighborhood) compared to other policing districts in Vancouver, further illustrates how particular populations are targeted. For example, from 2008 to 2014, there were 4301 recorded municipal bylaw infractions (e.g. street vending, public urination) in the Downtown Eastside, compared to 2448 elsewhere in Vancouver (Vancouver Police Department, 2015). Moreover, Indigenous and racialized persons, particularly Indigenous women, are disproportionately impacted by street checks (i.e. the stopping, questioning, and recording individuals when no specific offense is being investigated) (Vancouver Police Department, 2018b). Such racialized policing practices may partially explain disparities in overdose deaths within the local context, in which Indigenous persons are the most impacted (First Nations Health Authority, 2017). Given these diverse ways in which particular populations are targeted by policing efforts in Vancouver, and despite the VPD's stated support of harm reduction, people will remain fearful of police interactions so long as drugs remain criminalized and other forms of policing and surveillance are deployed in ways that disproportionately target PWUD. As such, it is critical to rethink place-based policing practices as these can directly interfere with evidence-based harm reduction services aimed at addressing an overdose crisis.

Given these factors, this research suggests a reconfiguration of urban policing, in which socio-legal and spatial forms of urban control (e.g. area restrictions, gentrification, police surveillance) (Beckett & Herbert, 2008; Foucault, 1991; Merry, 2001; Sylvestre et al., 2015) both intersect with and impact upon a public health emergency and responses. This is particularly problematic given that 'disciplining' strategies (e.g. surveillance) are implemented in such a way – and in such a space – that they not only reinforce the marginalization and structural vulnerability of PWUD, but increase their risk of morbidity and mortality by frequently rendering OPS inaccessible. While research has illustrated similar contemporary approaches to policing urban spaces elsewhere (e.g. Bancroft, 2012; Draus, Roddy & Asabigi, 2015; Pennay, Manton & Savic, 2014), this research highlights how place-based policing tactics still persist even within a public health emergency. As such, this research illustrates how many participants must continuously negotiate a risk of arrest or a risk of overdosing alone, and how such tension is exacerbated for individuals who have current area restrictions or outstanding warrants. Although previous research has demonstrated that public health and police partnerships can be beneficial in connecting PWUD with harm reduction services (DeBeck et al., 2008), our research illustrates that such practices undermine the ability for PWUD to engage in risk reduction amid a public health crisis. There is thus an urgent need to abandon place-based policing practices utilized within street-based drug scene settings.

As participant narratives demonstrated efforts to undermine these overlapping practices by remaking space, there remains a need to revisit law enforcement strategies, including the discontinuation of red zones and ending police surveillance near OPS, so as to increase accessibility of OPS for PWUD and decrease risk of harm. In particular, participants' accounts underscore the urgent need to decriminalize drug use as the risk of punitive repercussions weakens the effectiveness of public health interventions. In 2017, 72% of drug-related arrests in Canada were for personal possession of criminalized drugs (e.g. opioids, heroin) (Boyd, 2018; Statistics Canada, 2018) and, even as the VPD has stated publicly that arrest for possession is not a priority (Lupick, 2019), there was a slight increase in drug-related arrests in Vancouver (297 as of September 2018) (BC Coroners Service, 2018; Boyd, 2018). Importantly, these statistics still fail to capture the scope of policing in relation to PWUD, as documented in our study (e.g. red zoning, street checks, warrant searches). Such patterns further underscore the need to decriminalize drug use and possession, and shift resources away from policing efforts to areas more likely to reduce the unprecedented harms of the overdose crisis (e.g. harm reduction services, housing). This can

be further substantiated by revising the Good Samaritan Act to provide adequate legal protection for individuals who call emergency services during an overdose event who have an outstanding warrant (Good Samaritan Drug Overdose Act, 2017). Given the heavy police presence in the Downtown Eastside neighborhood, there remains an ongoing risk of police being at the scene of an overdose. In these cases, we recommend police not get involved – including, not running warrants, arresting, or searching individuals – unless it is to administer naloxone. While this research is specific to Vancouver, the harmful impacts of policing in drug economies has also been established in other settings (Beletsky et al., 2014; Davis et al., 2005; Hayashi, Small, Csete, Hattirat & Kerr, 2013; Maher & Dixon, 2001; Rhodes et al., 2006; Werb et al., 2011). As such, our findings may be applicable to other urban areas with street-based drug scenes working to establish overdose prevention interventions.

This study has several limitations that should be noted. Firstly, this study includes data from four OPS that were established at the start of this study. As such, findings may not be representative of experiences in and around other OPS that have since been implemented. Additionally, transgender and two-spirit persons were underrepresented in this study, and thus findings may not be representative of their experiences. Because participants were recruited directly from OPS, the experiences of PWUD who were red zoned from the neighborhood are likely not fully represented.

Despite these limitations, this study furthers our understandings of how street-based drug scene policing practices can re/make space in ways that increase experiences of harm for PWUD. Similar to previous research (Wallace, 1988, 1990), this work underscores how the political economy of the city can exacerbate the health- and drug-related outcomes experienced by PWUD. Moreover, these findings add to the literature on policing in areas being 'revitalized' (e.g. Smith, 1996; Wacquant, 2007) to demonstrate how law enforcement practices working alongside gentrification efforts can undermine the implementation of needed health and ancillary services for PWUD. Considering how surveillance and policing in spaces that overlap with harm reduction services may contribute to additional risks for PWUD amid an overdose crisis is essential. However, abandoning urban control strategies that undermine the effectiveness of evidence-based interventions, including drug scene surveillance, area restrictions, and drug criminalization, are critical to addressing the overdose crisis in a more effective way.

Declaration of Competing Interest

We declare no conflicts of interest.

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Opioid Crisis: No Easy Fix to Its Social and Economic Determinants

The accepted wisdom about the US overdose crisis singles out prescribing as the causative vector. Although drug supply is a key factor, we posit that the crisis is fundamentally fueled by economic and social upheaval, its etiology closely linked to the role of opioids as a refuge from physical and psychological trauma, concentrated disadvantage, isolation, and hopelessness.

Overreliance on opioid medications is emblematic of a health care system that incentivizes quick, simplistic answers to complex physical and mental health needs. In an analogous way, simplistic measures to cut access to opioids offer illusory solutions to this multidimensional societal challenge.

We trace the crisis' trajectory through the intertwined use of opioid analgesics, heroin, and fentanyl analogs, and we urge engaging the structural determinants lens to address this formidable public health emergency. A broad focus on suffering should guide both patient- and community-level interventions. (*Am J Public Health.* 2018;108:182–186. doi:10.2105/AJPH.2017.304187)

Nabarun Dasgupta, PhD, MPH, Leo Beletsky, JD, MPH, and Daniel Ciccarone, MD, MPH

The accepted wisdom about the US opioid crisis singles out opioid analgesics as causative agents of harm, with physicians as unwitting conduits and pharmaceutical companies as selfish promoters.[1] Although invaluable for infection control, this vector model[2] of drug-related harm ignores root causes. Eroding economic opportunity, evolving approaches to pain treatment,[1,3] and limited drug treatment have fueled spikes in problematic substance use, of which opioid overdose is the most visible manifestation. By ignoring the underlying drivers of drug consumption, current interventions are aggravating its trajectory. The structural and social determinants of health framework is widely understood to be critical in responding to public health challenges. Until we adopt this framework, we will continue to fail in our efforts to turn the tide of the opioid crisis.

THREE PHASES OF AN INTERTWINED EPIDEMIC

The roots of the opioid crisis are deeper than popular narrative suggests.[4,5] In 1980, acute pain was so frequently treated with opioids that propoxyphene was the second-most dispensed drug in the United States.[6] The Carter White House stated, "Diversion, misuse, and abuse of legal drugs may be involved in as many as seven out of ten reports of drug-related injury or death."[7(p301)] A decade later, US medicine was shaken by revelations of undertreated chronic pain, motivating normative practice and policy shifts.[8] Previously, chronic pain was managed largely with cognitive behavioral therapy, even hypnosis.

An Institute of Medicine report[9] attributed the rise in chronic pain prevalence during the 1990s to the following:

1. greater patient expectations for pain relief,
2. musculoskeletal disorders of an aging population,
3. obesity,
4. increased survivorship after injury and cancer, and
5. increasing frequency and complexity of surgery.

As insurers limited coverage of behavioral pain therapy, biopharmaceutical manufacturers sensed an opportunity. Pharmaceutical innovation propagated extended-release formulations, transdermal patches, nasal sprays, and oral dissolving strips. Medical device manufacturers drove a proliferation of novel pain-modulating implants. By 2000, chronic pain was big business. Withdrawals from the market of popular nonopioid analgesics because of cardiovascular risk and acetaminophen toxicity raised concerns about nonopioid alternatives.[10] Short lived but indelible, some pharmaceutical marketing improperly minimized addiction potential (OxyContin)[11] and promoted off-label use (Actiq),[12] later giving rise to physician kickback schemes (Subsys),[13] lucrative speaking fees,[14] and lobbying.[15] In addition, a small proportion of physicians were unscrupulous, doling out opioids without adequate regard for medical need.[16,17] These factors are widely believed to have caused the steady rise in opioid analgesic consumption over the past three decades, while rates of overdose and addiction increased in tandem.

Around 2010, the second phase started, marked by concern over intertwining opioid analgesic and heroin use.[18] After remaining relatively stable for years, heroin overdose deaths spiked, tripling between 2010 and 2015.[19] The vector model attributes this transformation to

ABOUT THE AUTHORS

Nabarun Dasgupta is with the Injury Prevention Research Center and the Eshelman School of Pharmacy, University of North Carolina, Chapel Hill. Leo Beletsky is with the School of Law and the Bouvé College of Health Sciences, Northeastern University, Boston, MA and is also with the University of California, San Diego School of Medicine, La Jolla. Daniel Ciccarone is with the Department of Family and Community Medicine, University of California, San Francisco.

Correspondence should be sent to Nabarun Dasgupta, 137 E. Franklin St., Suite 500, CB 7505, Chapel Hill, NC 27599 (e-mail: nab@unc.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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an expanded pool of susceptible individuals: with rising dependency and tolerance, some people who used prescription opioids transitioned to a more potent and cheaper alternative.[20] This phase is contemporaneous with the reformulation of OxyContin that made it difficult to crush, although this reformulation's contribution to the increase in heroin use is contested.[21] More broadly during this time, clinicians and policymakers widely reassessed the effectiveness and safety of outpatient use of opioid analgesics.[22]

The third phase began in late 2013 and continues today.[23] Increasingly efficient global supply chains and a sharp intensification in interdiction efforts created the conditions for the emergence of potent and less bulky products, for example, illicitly manufactured fentanyl and its analogs,[24] which are increasingly present in counterfeit pills and heroin.[25] Between 2013 and 2016, deaths attributed to fentanyl analogs spiked by a shocking 540% nationally,[26] with pronounced regional increases.[19,25] The rapid acceleration of the crisis has led to its designation as a national public health emergency. Contradicting the singular blame on health care as the gateway to addiction, individuals entering drug treatment are now more likely to report having started opioid use with heroin, not a specific prescription analgesic.[27]

In the vector model, the blame for this trajectory of opioid analgesic to heroin to synthetic opioid use rests with the drugs themselves and those who make them available. Although increased availability of prescription opioids fueled the overdose crisis, we have not adequately explored the source of the demand for these medicines.

ROOT CAUSES

The vector argument must grapple with contradictory data. Prescription opioid overdose death rates have not yet dropped following declining opioid prescribing: the number of outpatient opioid analgesic prescriptions dropped 13% nationally between 2012 and 2015[28] (with sharper regional declines). Yet, the national overdose death rate surged 38% during those years.[29] Overdose deaths attributable to prescription opioids have not decreased proportionally to dispensing. Although there is a strong historic linear association between dispensed volume and overdose nationally,[2] these associations are less pronounced at the county level.[30] Alternative explanations include misclassification of synthetic opioid deaths,[31] evolving autopsy protocols, time lag effects,[32] and unused medication.

There are intuitive causal connections between poor health and structural factors such as poverty, lack of opportunity, and substandard living and working conditions. A comprehensive discussion of structural determinants of pain, addiction, and overdose is beyond the scope of this commentary. What is pertinent is that, although expansion of opioid availability may have catalyzed overdose rates,[33] an exclusive focus on opioid supply hampers effective responses.[27]

One powerful line of structural analysis focuses on "diseases of despair," referring to the interconnected trends in fatal drug overdose, alcohol-related disease, and suicide.[34] Since 1999, age-specific mortality attributed to these conditions has seen an extraordinary rise.[34,35] The trend is especially pronounced among middle-aged Whites without a college degree, who are now dying earlier on average than did their parents—which is anomalous outside of wartime. In an analysis focused on the Midwest, Appalachia, and New England (where the heroin, fentanyl, and both comingled epidemics are most pronounced), combined mortality rates for diseases of despair increased as county economic distress worsened.[36]

An alternate hypothesis suggests that an environment that increasingly promotes obesity coupled with widespread opioid use may be the underlying drivers of increasing White middle-class mortality.[37] Complex interconnections between obesity, disability, chronic pain, depression, and substance use have not been adequately explored. Additionally, suicides may be undercounted among overdose deaths.[38] Under both frameworks, social distress is a likely upstream explanatory factor.

The "reversal of fortunes"[37,39] in life expectancy saw rapid diffusion, going from largely limited to Appalachia and the Southwest in 2000 to nationwide by 2015.[34] The unprecedented 20-year difference in life expectancy between the healthiest and least healthy counties is largely explained by socioeconomic factors correlated with race/ethnicity, behavioral and metabolic risk, and health care access.[40] These indicators are the most recent evidence of a long-term process of decline: a multidecade rise in income inequality and economic shocks stemming from deindustrialization and social safety net cuts. The 2008 financial crisis along with austerity measures and other neoliberal policies have further eroded physical and mental well-being.[41]

Poverty and substance use problems operate synergistically, at the extreme reinforced by psychiatric disorders and unstable housing. The most lucrative employment in poorer communities is dominated by manufacturing and service jobs with elevated physical hazards, including military service. When sustained over years, on-the-job injuries can give rise to chronically painful conditions, potentially resulting in a downward spiral of disability and poverty. Although opioid analgesics may allow those with otherwise debilitating injuries to maintain employment, individuals in manual labor occupations appear to be at increased risk for nonmedical use.[42] In much of the country, the counties with the lowest levels of social capital have the highest overdose rates.[43] The interplay between social and genetic factors, too, is being elucidated. Individuals living in low socioeconomic neighborhoods were more likely to develop chronic pain after car crashes, a process mediated by stress response genes.[44] Interactions between environment and genetic polymorphisms may in part explain substance use early in life.[45]

The interpretation of the vector model has justified mass incarceration for minor drug charges, creating further tears in the social fabric of communities already reeling from a lack of opportunity.[46] Perversely, incarceration of people with opioid dependence leads to interrupted opioid tolerance and a drastic elevation in overdose risk.[47] Having a public record because of a drug conviction limits one's ability to obtain meaningful employment, reinforcing the penury that drove problematic drug use in the first place. Although those who see the crisis through the vector lens do not necessarily advocate punishment, the rhetorical dominance of this model has crowded out

investment in evidence-driven demand reduction and harm reduction approaches.[24]

In recasting pain as a broader condition that includes economic and social disadvantage, we urge an alternative explanation for the rising demand for opioids. It has been observed that people somaticize social disasters into physical pain. Subjective economic hardship was associated with new onset low back pain following the Great East Japan Earthquake.[48] Intensifying substance use may be a normal societal response to mass traumatic events, especially when experienced by people in lower socioeconomic strata. Increased alcohol use and binge drinking were noted after Hurricanes Katrina and Rita, with the greatest compensatory drinking among those with lower lifetime income trajectories.[49] Women experiencing work stressors after September 11, 2001, were more likely to have increased alcohol use.[50] Longitudinal housing relocation studies suggest that drug use improves when people move to neighborhoods with less economic disadvantage.[51] Adverse childhood experiences have been strongly linked to subsequent substance use; likewise, childhood trauma, is associated with increased opioid use years later.[52] People who use heroin in a deindustrialized steel production area of Pennsylvania cited economic hardship, social isolation, and hopelessness as reasons for drug use, explicitly calling for jobs and community reinvestment to stem overdoses.[53] Yet, some communities' protective family[54] and social structures generate resilience that mitigates negative impacts from the collision of economic hardship, substance use, and depression.[55]

Collectively, these observations challenge us to expand our conceptualizations of the opioid crisis beyond the vector model. A seminal National Academy of Sciences report provides this summary:

> overprescribing was not the sole cause of the problem. While increased opioid prescribing for chronic pain has been a vector of the opioid epidemic, researchers agree that such structural factors as lack of economic opportunity, poor working conditions, and eroded social capital in depressed communities, accompanied by hopelessness and despair, are root causes of the misuse of opioids and other substances.[56(p1–9)]

TO TURN THE TIDE, FOCUS ON SUFFERING

The observation that Canada and the United States have the highest per capita opioid analgesic consumption is central to the belief that these medicines are overprescribed, leading to the unrealistic expectation that curtailing dispensing will automatically reduce overdose. In practice, overprescribing is an amalgamation of prescribing behaviors encompassing starting dose, number of units in a prescription, dosing schedules, potency, and other factors. A rational approach would treat these as parallel but distinct issues. Yet, the legislative and clinical reaction has included efforts to bring dosage below arbitrary targets or abandon patients who do not conform to clinically arbitrary expectations.[30]

The emphasis on prescribing volume may be a manifestation of subconscious racial bias that frames the famously White opioid crisis as inadvertently induced by physicians; this stands in direct contrast with previous drug panics perceived to afflict minorities, whose drug use was considered a moral failing.[57,58] This framing, along with the medicalized view of addiction, leaves intact the dignity of people seeking drug treatment—no doubt a positive rhetorical change if applied to all people. Yet, we have spent decades pathologizing members of minority communities for turning to drugs to cope with social stressors and structural inequities. That these phenomena may also afflict White, rural, and suburban communities is emerging as a new realization in public discourse. However, overdose is not isolated to these areas: approximately 41% of drug overdose deaths occur in urban counties, 26% in the suburbs, 18% in small metropolitan areas, and 15% in rural communities.[59] Native Americans are disproportionally affected by overdose deaths as are African Americans in Illinois, Wisconsin, Missouri, Minnesota, West Virginia, and Washington, DC, among other places.[60a, 60b]

This is not merely a story about disadvantage (in income, race, place, etc.). On the basis of epidemiological studies, structural advantages in health care access may have contributed to increased opioid prescribing[61] and availability[62] among White patients. However, reverse associations were observed in controlled clinic-based experiments in which Black patients ended up receiving more opioids, possibly mediated through interactions with patient assertiveness,[63] physician gender, and cognitive load.[64] Regardless, the experience of many seeking health care to manage long-term pain and substance use disorders is tinged with racial undertones. Diez Roux warns:

> We should guard against the unintended consequence that the focus on the increase in death rates in some Whites (significant as they are) detract attention from the persistent health inequities by race and social class, which are so large that they dwarf the size of what is a very troublesome increase in some Whites.[65(p1566)]

Alas, the US health care system is unprepared to meet the demands elucidated by a structural factors analysis. Even at the patient level, the intersection of social disadvantage, isolation, and pain requires meaningful clinical attention that is difficult to deliver in high-throughput primary care. Some providers struggle with addressing complex, chronic medical conditions requiring regular follow-up, especially with limited recourse to nonpharmacological alternatives and the predominantly urban concentration of specialty services. Patient contracts, urine drug tests, and prescription monitoring can generate mutual distrust in the provider–patient relationship when applied inconsistently, giving rise to uneven care delivery and inducing perceptions of intentional mistreatment.[66] In Wisconsin, the prescription drug monitoring program includes patients' convictions and suspected drug violations, straying into ethically hazy realms of social control. Patients suspected of drug-seeking behavior are "fired" instead of receiving enhanced care, as compassion would dictate.[67] Institutional, legal, and insurance architecture have robbed clinicians of time and incentives to continue care for these patients.

Access to evidence-based treatment for opioid use disorder, such as methadone and buprenorphine, must be rapidly improved. The hardest hit states, such as West Virginia and Kentucky, prohibit Medicaid coverage of methadone maintenance, and insurance preauthorization prevents low threshold

access among privately insured patients. The Appalachian Regional Commission recommended economic development strategies in addition to increased access to treatment services, prevention, and overdose medications.[68] Yet, proposed federal health care reforms threaten to further exacerbate existing service gaps.[69] Although national policy emphasizes medically assisted treatment, the social stigma of these treatments is widespread, carrying unrealistic expectations for quick fixes and a pervasive belief in "detox," as exemplified by television shows popularizing coercive interventions.

"Suffering" may be a better focus for physicians than "pain."[70] Others have argued for "compassion."[67] Health care providers have a role in reducing suffering historically and ethically. We have lost the commonsense imperative to engage those who use opioids in comprehensive care, especially during periods when access to opioids may be fluctuating. These tenets also may justify limited regimes to treat acute pain for veritable patient need.

The social determinants lens lays bare the urgency of integrating clinical care with efforts to improve patients' structural environment.[71] Training health care providers in "structural competency" is promising,[72] as we scale up partnerships that begin to address upstream structural factors such as economic opportunity, social cohesion, racial disadvantage, and life satisfaction. These do not typically figure into the mandate of health care but are fundamental to public health.

As with previous drug crises and the HIV epidemic, root causes are social and structural and are intertwined with genetic, behavioral, and individual factors. It is our duty to lend credence to these root causes and to advocate social change. AJPH

CONTRIBUTORS

N. Dasgupta and L. Beletsky contributed equally to this commentary. All authors participated in conceptualization, research, drafting, and editing of the commentary.

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Effective Drug Control: Toward A New Legal Framework

State-Level Regulation as a Workable Alternative to the "War on Drugs"

King County Bar Association
Drug Policy Project

1200 Fifth Avenue, Suite 600
Seattle, Washington 98101
206/267-7001

www.kcba.org

TABLE OF CONTENTS

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 reinstituting 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 comporting 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 1986[186] 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]

Diversion 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 voluntary 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 at 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 States[296] 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 Canada[351] 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) "S**ource 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 Unites 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 voluntary 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 prison[358] 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 schedules[361] 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 Act[371] 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 Act[378] 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 regulations[380] 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 crimes 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 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 Act[456] 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 Regimes[472]

REGIME			MODEL	
PROHIBITORY			**Pure Prohibition**: Full prohibition, with no allowed use for any purpose whatever (e.g., heroin, marijuana).	? DECREASING RESTRICTIVENESS
	PRESCRIPTION		**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 out 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 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 orders[636] 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 know 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 specie's unrelenting 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," *Refelections*, 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. Seigel (1989), *Intoxication: Life in Pursuit of Artificial Paradise*, New York: E.P. Dutton., pp. 19-146; Carol Kaesuk Yoon (2004), "Of Drunken Elephants, Tipsy Fish and Scotch With a Twist," *The New York Times*, March 23, 2004, p. D5.

[11] Ronald K. Seigel (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 Escohotado (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 Escohotado (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 test, *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 Escohotado (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 Acquirement 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 Capitalis m." *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.

[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.

[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 Reinarman, 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 INDRO, 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: QLG4-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] Seniorenpand, 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; Jurgen 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. Uctenhagen, "Summary of the Synthesis Report," in A. Uctenhagen, 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 Catalonian 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.suchtundaids.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.
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[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.
[344] Louise Sell and Deborah Zador (2004), "Patients prescribed injectable heroin or methadone – their opinions and experiences of treatment," *Addiction*, v.99, no.4, p. 442, April 2004.
[345] Self-reporting data estimates a habit can add up to $100-200 per day. Benedikt Fischer, Jurgen Rehm, Maritt Kirst, Miguel Casas, Wayne Hall, Michael Krausz, Nicky Metrebian, Jean Reggers, Ambros Uchtenhagen, Wim Van Den Brink and Jan M. Van Ree (2002), "Heroin Assisted Treatment as a Response to the Public Health Problem of Opiate Dependence," *European Journal of Public Health*, v.12, no.3, pp. 228-234, citing A. Bretteville-Jensen and M. Sutton (1996), "The income-generating behavior of injecting drug-users in Olso," *Addiction*, v.91, no.1, pp. 63-79.
[346] "Free Heroin Project Wins Federal OK," *Victoria Times Colonist*, August 19, 2004.

[347] North American Opiate Medication Initiative, *Project Backgrounder*, August 24, 2004.
[348] "North America's first clinical trial of prescribed heroin begins today," *Canadian Institutes of Health Research*, press release, February 9, 2005.
[349] Joel Baglole (2003), *op. cit.*
[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.
[351] Deany Beeby, "Federal Pot Pooh-poohed," *The Globe and Mail* (Canada), July 12, 2004.
[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),"*Diaro Medico*, April 1, 2004, available at http://www.diariomedico.com/edicion/noticia/0,2458,465993,00.html.
[353] Corinne Heller, "Israel to soothe trauma with marijuana," *Reuters UK*, October 3, 2004, available at http://www.reuters.co.uk/newsPackageArticle.jhtml?type=worldNews&storyID=595451&section=news.

PART III

CONTROLLING PSYCHOACTIVE SUBSTANCES: THE CURRENT SYSTEM AND ALTERNATIVE MODELS

[354] 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).
[355] "Role of INCB," International Narcotics Control Board, United Nations, *at* http://www.incb.org/e/index.htm.
[356] Robert J. MacCoun and Peter Reuter (2001), *Drug War Heresies*, Cambridge University Press, p. 206.
[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.
[367] *Id.* § 826.
[368] *Id.* § 827.
[369] *Id.* § 828.
[370] *Id.* § 829.
[371] *Id.* § 841(a).
[372] *Id.* § 846.
[373] *Id.* § 841(b).
[374] *Id.* § 842(a).
[375] *Id.* § 842(b).
[376] *Id.* § 844(a).
[377] *Id.*
[378] *Id.* §§ 301-397.

[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 Pangi, 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/.

[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.
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[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.
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[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. Skolnick, "'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 Reinarman, "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/kcscc/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.

[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 *Granholm 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 "myelinization," 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 myelinization 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 myelinization of the frontal lobe neurons, although it is important not to presume that alcohol, cannabis or other drugs retard the myelinization 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, "Affliliates" 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.