

COKE AND SMACK AT THE DRUGSTORE:
HARM REDUCTIVE DRUG LEGALIZATION:
AN ALTERNATIVE TO A
CRIMINALIZATION SOCIETY

Noah Mamber†

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† J.D., Cornell Law School; B.A., Yale University; Cornell Journal of Law and Public Policy Symposium Editor. This Note is dedicated to Jeb Oblak, Jessie and Omar Ho-Sang, Stacey Wertlieb, Josh Kagan, Professor Trevor Morrison, Aliza Mamber, and my family and friends, who inspired me to think outside the box on drug policy.

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INTRODUCTION

The United States is a society that imposes a value judgment on the personal use and sale of certain natural and artificial substances. Both federal and state laws, to varying degrees, criminalize drugs and imprison their purveyors and users, often in accordance with mandatory minimum sentences, which judges lack the discretion to override.¹ However, this criminalization model is not necessarily the most obvious solution for reducing the abuse of dangerous substances. For example, the Netherlands² and Canada³ offer alternative regulatory models, as does the U.S. in the context of alcohol and tobacco.⁴ This Note will explore these various models, and attempt to choose the one with the best fit for American society.

In perpetuating the criminalization model, American legislators have prioritized certain values. Legislators have decided that it is wrong to use substances that they have labeled as “narcotics” and have adopted a zero-tolerance policy towards their use. They have drawn a bright line between these illegal drugs⁵ and legal drugs, such as caffeine,⁶ nicotine,⁷

¹ Examples of Federal mandatory minimum sentences law are 21 U.S.C. § 841 (manufacture and distribution of controlled substances), 21 U.S.C. § 844 (possession of controlled substances), 21 U.S.C. § 960 (penalties for the importation/exportation of controlled substances), and 18 U.S.C. § 924(c) (minimum sentence enhancements for carrying a firearm during a drug or violent crime). Moreover, the Omnibus Anti-Drug Abuse Act of 1988 created a mandatory minimum of five years for simple possession of more than five grams of “crack” cocaine, and doubled the existing ten-year mandatory minimum for anyone who engages in a continuing criminal enterprise. See Family Against Mandatory Minimum, History of Mandatory Sentence, http://www.famm.org/si_history_of_mandatory.htm (last visited Sep. 28, 2006). Examples of state mandatory minimum sentence laws are the Michigan “650-Lifer” laws which mandated a life sentence for possession, sales or conspiracy to sell or possess 650 grams (about 1 1/4 pounds) of cocaine or heroin and the New York Rockefeller Drug Laws which mandated 15-year prison sentences for possession or sales of small amounts of narcotics. National Drug Strategy Network, Michigan Enacts Reform of “650-Lifer” Law, <http://www.ndsn.org/julaug98/sent.html> (last visited Sep. 28, 2006); Alan Rosenthal, *A Guide to Rockefeller Drug Reform: Understanding the New Legislation*, http://www.communityalternatives.org/articles/sentencing_guide.html (last visited Sep. 28, 2006).

² DAVID F. DUNCAN & THOMAS NICHOLSON, *Dutch Drug Policy: A Model for America?* 8 J. Health & Soc. Pol’y 1, 5 (1997).

³ The National Organization for the Reform of Marijuana Laws, http://www.norml.org/index.cfm?Group_ID=5774 (last visited Sept. 28, 2006).

⁴ 27 U.S.C. §§ 201–212 (2006); 23 U.S.C. § 158 (2006); 18 U.S.C. §§ 2341–2346 (2006).

⁵ Office of National Drug Control Reauthorization Act of 1998, 21 U.S.C. §§ 1701–1712 (repealed 2003).

⁶ Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 301–399, 182.1180 (2006).

⁷ 18 U.S.C. §§ 2341–2346 (2006).

alcohol,⁸ prescription drugs,⁹ and dangerous products like automobiles¹⁰ and guns,¹¹ ostensibly because their value is exclusively recreational. However, the term “narcotics” encompasses a wide range of substances, including marijuana¹² and MDMA (which have various legitimate medical uses),¹³ cocaine and peyote (which have cultural or religious significance to South American immigrants and certain Native American tribes),¹⁴ and very dangerous and addictive substances like heroin (which lacks any religious value). In creating a bright line between illegal and legal drugs, legislators are prioritizing a simplistic and archaic policy, in which all currently criminalized drugs will remain illegal and any newly created drug will join them.¹⁵ Legislators believe that it is the government’s responsibility to incentivize its populace not to use dangerous products.¹⁶ Therefore, they apply a straightforward zero-tolerance policy to prevent any potential drug users from misunderstanding which drugs

⁸ 27 U.S.C. §§ 201–212 (2006); 23 U.S.C. § 158 (2006).

⁹ 21 U.S.C. §§ 351–360 (2006).

¹⁰ 49 U.S.C. § 30302 (2006).

¹¹ 18 U.S.C. §§ 921–931 (2006).

¹² Marijuana has been used effectively as an anti-emetic for chemotherapy and HIV patients and as an anti-convulsant, and it has other proven medical uses as well. See WAYNE HALL, ET AL., *THE HEALTH AND PSYCHOLOGICAL CONSEQUENCES OF CANNABIS USE* (AusInfo for Commonwealth Department of Health and Aging 2d ed. 2001) (1994), available at [http://www.health.gov.au/internet/wcms/publishing.nsf/content/5A648B4BA51D4891CA25703400033ED6/\\$File/mono44.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/content/5A648B4BA51D4891CA25703400033ED6/$File/mono44.pdf).

¹³ MDMA is currently being researched for its use in psychological treatment of Post-Traumatic Stress Disorder (PTSD) victims. The FDA approved a research protocol to study the effects of MDMA on PTSD sufferers in 2002, and the IRB (Institutional Review Board) and DEA followed suit in 2003. MICHAEL C. MITHOEFER, *Study Protocol: Phase II clinical trial testing the safety and efficacy of 3, 4-methylenedioxymethamphetamine (MDMA)-assisted psychotherapy in subjects with chronic posttraumatic stress disorder* (2006), http://www.maps.org/research/mdma/ptsd_study/protocol/protocol051606.pdf.

¹⁴ Coca, known as the “sacred coca leaf,” has lain at the heart of Andean folk religion since ancient times. See Jeremy Mumford, *Coca Politics*, THE BOSTON GLOBE, Sep. 28, 2003, http://www.boston.com/news/globe/ideas/articles/2003/09/28/coca_politics/. *Employment Division v. Smith* banned the use of peyote for religious purposes in the United States, but Congress recognized its religious importance, and overturned that decision in creating an exception for peyote in the federal drug laws in the Religious Freedom Restoration Act of 1993. Louis O’Neill, *Freedom of Religious Practice and the FDA: the Use of Regulated Substances and Devices as Sacraments* (1995 Third Year Paper), <http://leda.law.harvard.edu/leda/data/114/loneill.pdf>.

¹⁵ As the market creates new popular drugs, such as methamphetamine, club drugs, and Oxycontin, the government responds with a slew of legislation. See Drug Policy Alliance, <http://www.drugpolicy.org/> (follow “Drug by Drug” hyperlink; then follow “Methamphetamine,” “Club Drugs,” and “Oxycontin” hyperlinks).

¹⁶ A Drug Control Policy in the United States: Historical Perspectives, <http://www.druglibrary.org/sci/affair/library/studies/ota/appa.htm> (last visited Sep. 11, 2006).

are legal.¹⁷ This policy also prioritizes the effectiveness of criminal sanctions as a means of reducing the number of drug users.¹⁸

A. PHILOSOPHICAL BASES FOR VARIOUS DRUG POLICY MODELS

Although the United States embraces criminalization as the sole model for dealing with the problems associated with illegal drugs, a society guided by different values might choose to utilize other models. For instance, John Stuart Mill and Isaiah Berlin suggested a society ordered by the concept of negative liberty.¹⁹ Negative liberty emphasizes freedom from coercion by the state, so long as the individual refrains from harming anyone else.²⁰ Therefore, a pure negative libertarian government would legalize all drugs, and refrain from any type of regulation.²¹ Mill states:

The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil, in case he [does] otherwise The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.²²

How does one define “harm to others” in Mill’s scenario? Is it when a drug addict inflicts emotional damage on his family by pulling away, or forgetting to feed his infant child, or is it when he robs a store to

¹⁷ *Id.*

¹⁸ See The Effective National Drug Control Strategy 1999, <http://www.csdp.org/edcs/theneed.htm> (last visited Sep. 11, 2006) (discussing in the 1999 Drug War, the Office of National Drug Control Policy (“ONDCP”) ineffectively allocated three times the budget of rehabilitation to interdiction).

¹⁹ John Stuart Mill, *On Liberty*, in READINGS IN SOCIAL AND POLITICAL PHILOSOPHY 113, 113–41 (Robert M. Stewart ed., 1996); Isaiah Berlin, *Two Concepts of Liberty*, in READINGS IN SOCIAL AND POLITICAL PHILOSOPHY, *supra*, at 92, 92–96.

²⁰ Mill, *supra* note 19, at 125.

²¹ See *id.*

²² *Id.*

get money for drugs? Although Mill does not directly address the effects of drug abuse, he does discuss legislative interference concerning drunkenness.²³ Mill acknowledges that drunkenness tends to encourage those who already possess a criminal mind to harm others, but he argues that the solution is not to ban liquor, but to increase the penalties for committing crimes while intoxicated.²⁴ Hence, Mill would most likely approach drug abuse similarly and would disincentivize the occurrence of its resultant emotional harms by increasing sanctions for crimes committed under the influence of drugs.²⁵

Nevertheless, while Mill's arguments are intellectually appealing, it is unlikely that the United States will ever adopt a true negative libertarian policy. The Libertarian Party's failure to gain more than 1.1% of the popular vote in any presidential election demonstrates the remote likelihood that this belief system will ever take hold of American society.²⁶ Moreover, negative libertarianism also appears to be at odds with the overall American political discourse. Even though the Founding Fathers and their conservative spiritual descendants in the National Rifle Association of America exhibit a libertarian streak regarding the availability of arms and other selected issues, the majority of American legal history has supported governmental interference into its citizens' lives.²⁷ Such interference is rooted in the strong Puritan streak that has dominated American cultural and political life since the country's inception.²⁸ This strong religious backbone inspires legislators to craft laws that reflect their version of morality, in order to ensure that everyone has the opportunity to fulfill their potential as human beings.²⁹ This religious message is heavily influenced by Berlin's conception of negative liberty's rival: positive liberty.³⁰

According to Berlin, who did not care much for the idea, positive liberty enables a government to convince its citizens that they are not actually being coerced, but are exercising their individual will, and are

²³ Mill, *supra* note 19, at 113, 130–31.

²⁴ *See id.* at 131.

²⁵ *See id.* at 131–32.

²⁶ The Libertarian Party's appeal to the presidential voter is even smaller than it first appears. If one discounts Ed Clark's extremely successful 1980 campaign, The Libertarians have actually never polled above 0.5%, and their average in the other seven elections occurring between 1976 and 2004 is 0.35%. *See* Wikipedia, Libertarian Party in United States, http://en.wikipedia.org/wiki/United_States_Libertarian_Party (last visited Sep. 11, 2006).

²⁷ U.S. CONST. amend. II; *See* <http://www.nraila.org>, Who We Are and What We Do, <http://www.nraila.org/About/NRAILA.aspx> (last visited Apr. 14, 2006).

²⁸ Sebastian Scheerer, Political Ideologies and Drug Policy, <http://www.drugtext.org/library/articles/scheer1.html>. (last visited Sept. 30, 2006).

²⁹ *See e.g.*, Sheldon Alberts, Legislating Morality in the Land of the Free, <http://www.sodomylaws.org/usa/virginia/vanews153.htm> (last visited Sep. 11, 2006).

³⁰ Berlin, *supra* note 19, at 96–97.

therefore free.³¹ A less cynical Charles Taylor describes positive liberty as an exercise-concept in which “one is free only to the extent that one has effectively determined oneself and the shape of one’s life.”³² Under either definition, it is easy to see how a well-meaning government, pursuing positive libertarian principles would choose to protect a drug addict from his worst impulses and encourage his self-actualization by effecting a drug criminalization policy.

Alternatively, if the United States were to balance the principles of positive and negative liberty, with an understanding of the limitations of criminal sanction, it might consider a more nuanced drug policy model. Specifically, the government could continue to incentivize its citizens not to abuse drugs, while also accepting a certain amount of safer use in order to focus on those who truly need the government’s help for self-actualization. This policy model would also involve the acceptance of the greater principle that “the use of mind-altering drugs and drug-induced behavior is a common thread in the social fabric of humanity.”³³ Moreover, “given the seemingly innate human craving for mind-altering substances, and the desperate need at times to relieve physical pain or emotional misery,” a more practical goal is harm reduction, rather than criminalization.³⁴ The Drug Policy Alliance, a leading advocate for drug policy reform, argues that the harm reduction philosophy can successfully mitigate the negative effects of drugs on society through education, prevention, and treatment, without the threat of criminal sanction.³⁵ In addition, there are other drug policy models that a government might impose, such as partial or full decriminalization or a medical/prescription model.³⁶

This Note will examine the current policy of criminalization and why it is counterproductive to the social goals of reducing drug use and protecting society. It will also analyze various drug policy models and identify each of their various failings. Finally, this Note will propose a new regulatory model that is a hybrid of harm reduction principles and libertarian legalization and discuss its effects on various areas of the law. Under this model, the federal government will need to develop a regulatory framework that balances the negative liberty principle with an ac-

³¹ *Id.*

³² Charles Taylor, *What’s Wrong With Negative Liberty*, in READINGS IN SOCIAL AND POLITICAL PHILOSOPHY (Robert M. Stewart ed., 1996).

³³ Laura L. Hirschfeld, *Legal Drugs? Not Without Legal Reform: The Impact of Drug Legalization on Employers Under Current Theories of Enterprise Liability*, 7 CORNELL J.L. & PUB. POL’Y 757, 767–68 (1998).

³⁴ *Id.*

³⁵ Drug Policy Alliance, *Reducing Harm: Treatment and Beyond*, <http://www.drugpolicy.org/reducingharm> (last visited Sep. 11, 2006).

³⁶ ERICH GOODE, *BETWEEN POLITICS AND REASON: THE DRUG LEGALIZATION DEBATE* 78 (St. Martin’s Press 1997), available at <http://www.druglibrary.org/special/goode/bpr6.htm>.

knowledge of humanity's frailty. The ultimate goal of this proposed structure is to create a situation in which as many citizens as possible have the opportunity to self-actualize. This model will include the establishment of a National Recreational Drug Registry (the "Registry"), the creation of mandatory current use workplace testing, a legal limit of purchasable drugs, penalties for extralegal use and use by minors, advertising and quality control regulations, and education and rehabilitation efforts. In addition, this Note will discuss the effects of this model on the health insurance industry.

B. PROBLEMATIC EFFECTS OF ILLEGAL DRUGS

A regulatory model must not only embody a society's core values, it must also effectively resolve its targeted problems. Hence, before developing a regulatory model, one must acknowledge the problems that drugs cause. Most people would agree that the use of illegal drugs is generally unhealthy, and that the use of cocaine and heroin can be especially deadly because of their addictive capacities.³⁷ Among the harmful consequences drugs can cause are death from overdose; damage to the user's health; damage to the health of unborn and newborn children of pregnant female users; decrease in work productivity; injuries, fatalities and property damage from industrial and traffic accidents; and damage to family relationships.³⁸ Additionally, the criminalization of drugs produces many unwanted secondary effects, including murder, robbery, assault between drug dealers and drug users; murders and assaults of the public servants who fight the drug war; street crime (mostly robbery) by desperate drug users who need more drug money; corruption of public officials by drug dealers; and various financial crimes used to conceal drug profits.³⁹

To be successful, this new regulatory scheme must eliminate the majority of the secondary effects associated with drug use while minimizing harm from the primary effects. Additionally, it may need to tailor unique solutions for different drugs. For instance, if cocaine is available

³⁷ Frank O. Bowman, III, *Playing "21" with Narcotics Enforcement: A Response to Professor Carrington*, 52 WASH. & LEE L. REV. 937, 967 (1995). However, a study presented at a recent meeting of the American Thoracic Society stated that smoking marijuana does not cause cancer, suggesting that marijuana may cause lesser physical harm than the legal drug tobacco. The study found that people who smoked marijuana, even those who smoked heavily for years, were at no greater risk of developing cancer than those who did not smoke. In contrast, people who smoked more than two packs of cigarettes per day were 20 times more likely to develop cancer than those who did not smoke. Marc Kaufman, *Study Finds No Cancer-Marijuana Connection*, WASH. POST, May 26, 2006, at A3; Drug Policy Alliance, *Study Shows Marijuana Smoke Does Not Raise Cancer Risk*, <http://www.drugpolicy.org/news/052506cancer.cfm>.

³⁸ Bowman, *supra* note 37, 967-68.

³⁹ *Id.* at 968-69.

at a drugstore or dispensary, and an addicted user continually returns all day for three- or five-dollar hits, when does the store close, and how does it do so safely given that the user is likely to become wildly paranoid and psychotic at a certain point?⁴⁰ Do you adopt the bartender model — in which a bartender “cuts off” people who are clearly intoxicated — and force a dispenser to refuse to sell drugs to people who appear obviously paranoid and psychotic?⁴¹ If so, will that necessitate the presence of a bouncer to protect that dispenser, and will a bouncer even be effective against a raging cocaine addict?⁴²

I. CURRENT SCHEME-CRIMINALIZATION AND ITS EFFECTS

As previously stated, in the current criminalization scheme, both federal and most state agencies impose a zero tolerance policy for all narcotics.⁴³ Federally, drug prohibition developed gradually until the Controlled Substances Act of 1970⁴⁴ consolidated over fifty federal narcotic, marijuana, and dangerous drug laws into one law designed to control the legitimate drug industry, and curtail importation and distribution of illegal drugs throughout the United States.⁴⁵ The Controlled Substances Act also changed the Constitutional basis for its regulatory power, relying upon the Commerce Clause for its support, making a showing that the law was an exercise of the “police function as a revenue measure” unnecessary.⁴⁶ Finally, the Controlled Substances Act created a five-schedule hierarchy of illegal narcotics that ranked each drug by its potential for medical use and addiction, imposing greater penalties for offenses involving the more serious drugs.⁴⁷ Schedule I lists substances that have no accepted medical utility, but have substantial potential for abuse, according to a determination made by the Drug Enforcement Administration (“DEA”) in consultation with the Food and Drug Adminis-

⁴⁰ New York Society for Ethical Culture, *Towards a Compassionate and Cost-Effective Drug Policy: A Forum on the Impact of Drug Policy on the Justice System and Human Rights*, 24 *FORDHAM URB. L.J.* 315, 343–44 (1997).

⁴¹ *See id.*

⁴² *See id.*

⁴³ Bookrags, Zero Tolerance, <http://www.bookrags.com/other/drugs/zero-tolerance-dat-03.html> (last visited Sept. 30, 2006).

⁴⁴ 21 U.S.C. §§ 801–904 (2006).

⁴⁵ U.S. NEWS AND WORLD REPORT, WHAT EVERYONE NEEDS TO KNOW ABOUT DRUGS 90 (Joseph Newman ed., 1970); *See* U.S. DRUG ENFORCEMENT ADMINISTRATION, 1970-1975, in *DEA HISTORY BOOK*, available at <http://www.usdoj.gov/dea/pubs/history/1970-1975.html>.

⁴⁶ *Raich v. Ashcroft*, 352 F.3d 1222, 1227 (9th Cir. 2003), *vacated sub nom. Gonzales v. Raich*, 125 S. Ct. 2195 (2005); BUREAU OF JUST. STAT., DRUGS, CRIME, AND THE JUSTICE SYSTEM: A NATIONAL REPORT FROM THE BUREAU OF JUSTICE STATISTICS 84 (1992).

⁴⁷ 21 U.S.C. § 811(c); U.S. DRUG ENFORCEMENT ADMIN., DRUGS OF ABUSE PUBLICATION: CONTROLLED SUBSTANCES ACT (Donald E. Joseph ed. 2005), available at <http://www.dea.gov/pubs/abuse/doa-p.pdf>.

tration (“FDA”).⁴⁸ Found on this schedule are heroin, marijuana, and various other hallucinogens including peyote, psilocybin (“shrooms”), and LSD.⁴⁹ Schedule II lists substances having a high abuse liability combined with some accepted medical purpose.⁵⁰ Substances listed on Schedule II include morphine, methadone, methamphetamines and cocaine.⁵¹ Schedules III through V include less potent drugs that have less potential for abuse than those in Schedules I and II and various precursors to the harder drugs.⁵²

Pro-criminalization advocates defend the Drug War both by citing public policy and philosophical justifications and by noting its effectiveness. These advocates cite the importance of safeguarding the health of society’s citizens, the economic and social costs resulting from drug use,⁵³ increased drug-related crime,⁵⁴ commercial exploitation of addictive drugs,⁵⁵ and moral and religious justifications.⁵⁶ Advocates of the

⁴⁸ 21 U.S.C. § 812(b)(1). When a citizen petitions to reschedule a drug, the DEA makes the determination, after reviewing the recommendation of the FDA. A petitioner then has an appeal of right on that determination to the United States Court of Appeals for the District of Columbia Circuit, such as when *High Times Magazine* unsuccessfully appealed the DEA’s refusal to reschedule marijuana in 2002. See U.S. Drug Enforcement Admin., High Court Upholds Marijuana As Dangerous Drug, <http://www.usdoj.gov/dea/pubs/pressrel/pr060602.html> (last visited Sept. 30, 2006).

⁴⁹ 21 U.S.C. § 812(c).

⁵⁰ *Id.* § 812(b)(2) .

⁵¹ *Id.* § 812(c).

⁵² Schedule III includes amphetamines, Schedule IV is anabolic steroids, and Schedule V restricts smaller amounts of various lesser opiates. *Id.* § 812(b)(3)–(b)(5) .

⁵³ According to the advocates of the Drug War, psychoactive substances, both licit and illicit, bear a substantial “cost to society”. Social costs may include short- and long-term healthcare provisions; prevention campaigns; harm reduction programs; addiction treatment; public nuisance and third party damage; and absence from work and lost productivity. Wikipedia, *Arguments for and against drug prohibition*, http://en.wikipedia.org/wiki/Arguments_for_and_against_drug_prohibition (last visited Sept. 30, 2006).

⁵⁴ *Id.* Proponents of drug prohibition fear the creation of a post-legalization society with more addicts and drug pushers. They believe addicts are more likely to commit more crimes because their minds are altered, much as drunken criminals do sometimes.

⁵⁵ *Id.* Tobacco and alcohol are extremely popular even though they are relatively more dangerous than many illegal drugs and are subjectively less pleasurable. Critics say this is attributable to the profit motive and large marketing campaigns and tremendous lobbying power of tobacco and alcohol companies. If these same companies were able to sell drugs that were arguably more addictive and pleasurable, then it is likely that even more people would become addicted, through marketing and additives.

⁵⁶ Some Drug War advocates believe that consciously altering one’s mind or state of consciousness is morally unjustifiable, and or against G-d’s will as the creator of the human mind. Dale A. Robbins, *Drugs & the Christian*, <http://www.cannabis.net/justsayno/> (last visited Sept. 30, 2006). For example, the Qur’an advises against the use of “al-khamri,” (substances that cover one’s mind or cloud one’s judgment). Qur’an 2:219. It states that “in [al-khamri] there is a gross sin, and some benefits for the people. But their sinfulness far outweighs their benefit.” *Id.* Moreover, Qur’an pronounced these “al-khamri” as “abominations of the devil; you shall avoid them, that you may succeed.” *Id.* In Judeo-Christianity, the Bible is famously silent on drugs that are illicit today, though makes frequent mention of wine. Isaiah 5:11-12 was a key quote of the Temperance movement: “Woe to those who rise early in

Drug War have also claimed that criminalization has been effective since President Nixon appointed the first White House drug czar, Dr. Jerome H. Jaffe, in 1971. Two years later, in 1973, the Nixon administration declared that the nation had “turned the corner” on addiction and drug use. In 1990, drug czar William Bennett claimed that the U.S. was “on the road to victory” over drug abuse.⁵⁷

More recently, in the 2006 International Narcotics Control Strategy Report, the U.S. State Department declared that steadily increasing cooperation among nations had led to “significant successes” in reducing international drug trafficking and criminal activity in 2005.⁵⁸ Moreover, Ohio State University historian John C. Burnham, in summarizing the conclusions of a June 17, 2006 meeting of seven former U.S. drug czars at the University of Maryland, states, “The United States has won the war against illegal drugs.”⁵⁹

Throughout the 1980s and 1990s, Congress amended its drug laws in several bills in order to stiffen penalties for possession and distribution, and expand the reach of federal law enforcement.⁶⁰ Although the states have followed similar norms, their laws vary widely. For instance, a few states have passed personal use marijuana decriminalization statutes and several larger cities have gone even further passing “lowest law enforcement priority” and “tax and regulate” measures, even though marijuana cultivation and distribution remain illegal.⁶¹

the morning to run after their drinks, who stay up late at night till they are inflamed with wine. They have harps and lyres at their banquets, tambourines and flutes and wine, but they have no regard for the deeds of the L-rd, no respect for the work of his hands.” *Id.*

⁵⁷ Join Together, I, <http://www.jointogether.org/news/headlines/inthenews/2006/drug-war-success-claims.html> (last visited Sept. 30, 2006) (*hereinafter* *Join Together*).

⁵⁸ DEPT. OF STATE, 2006 International Narcotics Control Strategy Report, <http://usinfo.state.gov/gi/Archive/2006/Mar/01-431912.html> (last visited Sept. 30, 2006).

⁵⁹ Burnham noted that drug use is down from its peak in 1979-80, and that specifically, heroin use had declined, and heroin-related deaths had declined dramatically. Bob Curley, *Mission Accomplished in War on Drugs?*, <http://www.jointogether.org/news/features/2006/mission-accomplished-in-war.html> (last visited Sept. 30, 2006); John C. Burnham, *Former Drug Czars Believe Their war Has Been Won*, COLUMBUS DISPATCH, Jun. 30, 2006, <http://www.dispatch.com/editorials-story.php?story=dispatch/2006/06/30/20060630-A15-00.html>.

⁶⁰ See Lana D. Harrison et al., *Cannabis use in the United States: Implications for Policy*, in CANNABISBELEID IN DUITSLAND, FRANKRIJK EN DE VERENIGDE STATEN 244-45 (Peter Cohen & Arjan Sas eds. Centrum voor Drugsonderzoek, Universiteit van Amsterdam 1996), available at <http://www.cedro-uva.org/lib/harrison.cannabis.05.html>.

⁶¹ Currently, eleven states, California, Colorado, Maine, Minnesota, Mississippi, Nebraska, Nevada, New York, North Carolina, Ohio, and Oregon, have decriminalized marijuana possession. Additionally, ten states, Alaska, Arizona, California, Colorado, the District of Columbia, Maine, Montana, Nevada, Oregon, and Washington, have legalized medical marijuana. Mpp.org, *Marijuana Prohibition Facts 2006*, <http://www.mpp.org/pr.ohfact.html> (last visited Apr. 14, 2006). Since 2003, referenda in Seattle and Oakland amended local law to make marijuana intended for adult personal use the lowest law enforcement priority. In November 2005, the boldest new marijuana initiative, Denver’s Alcohol-Marijuana Equalization Initiative, which wholly legalized personal use of one ounce or less of cannabis, passed with

The federal government tried to discourage state drug policy innovation by appealing *Raich v. Ashcroft* to the Supreme Court.⁶² As a result, the Court found that the DEA, a federal agency, has the power to raid the homes of and arrest sick medical marijuana patients, even in states where those actions directly contradict state law.⁶³ However, this has only emboldened certain states to continue medical marijuana reform in the face of federal interference, as the Rhode Island State Senate did in passing a medical marijuana bill a day after the *Raich* decision.⁶⁴

However, this zero tolerance criminalization policy has not reduced the number of drug users.⁶⁵ Instead, it has created a whole new set of problems, including massive land eradication programs in several South American countries, the creation of an artificial price support for organized crime, an overcrowded prison system filled disproportionately with people of color, revocation of educational funding from thousands of underprivileged students with drug convictions, and an increase in gang activity and violence.⁶⁶ Specifically, U.S. drug policy has contributed to the AIDS crisis by ensuring the absence of clean needles for intravenous drug use.⁶⁷ U.S. federal, state, and local governments have spent hun-

54%. Safer Alternative For Enjoyable Recreation, the non-profit behind the lobbying drive, won the campaign by proposing a society in which the private adult possession and use of marijuana is treated in the same or similar manner as the private adult possession and use of alcohol. Drugsense.org, <http://www.drugsense.org/html/modules.php?name=Oldsite&page=initiatives/index.htm> (last visited Sept. 30 2006).

⁶² *Raich v. Ashcroft*, 352 F.3d 1222, 1227 (9th Cir. 2003), *vacated sub nom. Gonzales v. Raich*, 125 S. Ct. 2195 (2005).

⁶³ The justices based their opinions on the tricky questions of federalism and the expansion of the Commerce Clause and not on the best interests of Ms. Raich. The 6-3 outcome was predictable, with the exception of Justice Scalia's vote. "Liberal Justices", Stevens, Ginsburg, Souter and Breyer, along with center-right noted drug war sympathizer Justice Kennedy cast their votes to expand the powers of Congress, even in the case of the Controlled Substances Act. The "conservative Justices" Rehnquist and Thomas, along with center-right Justice O'Connor dissented, describing this application of Congressional power as a violation of federalism. However, apparently noted federalist Justice Scalia holds particular dislike for medical marijuana legalization, as he joined the majority with a concurrence.

⁶⁴ StoptheDrugWar.org, Medical Marijuana: One Day After Raich, Rhode Island Senate Passes Medical Marijuana Bill, <http://stopthedrugwar.org/chronicle-old/390/rhodeisland.shtml> (last visited Sept. 30, 2006). Though the Governor vetoed the bill, the Rhode Island House and Senate overrode the veto and the bill became law in January 2006. StoptheDrugWar.org, Rhode Island Overrides Governor's Veto to Become 11th State Okaying Medical Marijuana, <http://stopthedrugwar.org/chronicle-old/417/notocarcieri.shtml> (last visited Sept. 30, 2006).

⁶⁵ Federal surveys show an increase in use, especially by adolescents, since 1990. More reliable data on trends than surveys are overdose deaths and emergency room mentions of drugs. These numbers have also escalated consistently since the 1980s, and both are at record highs. Drugwardistortions.org, Distortion 2: Drug Use Estimates, <http://www.drugwardistortions.org/distortion2.htm> (last visited Sept. 28, 2006).

⁶⁶ See Drug Policy Alliance, What's Wrong with the Drug War?, <http://www.drugpolicy.org/drugwar/> (last visited Apr. 14, 2006).

⁶⁷ *Id.*

dreds of billions of dollars trying to make America “drug-free.”⁶⁸ Yet heroin, cocaine, and other illegal drugs are cheaper, purer and easier to obtain than ever before.⁶⁹ The United States incarcerates nearly half a million drug offenders, a number greater than the entire prison population of all of Western Europe, which has a larger general population than the United States.⁷⁰ Finally, criminalization actively causes many overdose and other drug-related deaths.⁷¹ There are about 3,000 annual heroin- and cocaine-related deaths per year. James Ostrowski of the Cato Institute estimates that 80% of these deaths (2,400) are caused by black market factors, while only 20% of these deaths (600) are caused by the intrinsic effects of the drugs.⁷² Although the problems associated with the criminalization model have appeared in many articles, here again, briefly, are some of the major issues.

⁶⁸ In 1999, combined expenditures by federal, state, and local governments on the Drug War exceeded \$30 billion. National Research Council, National Academy of Sciences, “Informing America’s Policy on Illegal Drugs: What We Don’t Know Keeps Hurting Us” (Washington, DC: National Academy Press, 2001), p. 1; Drugwarfacts.org, Economics, <http://www.drugwarfacts.org/economi.htm> (last visited Sept. 30, 2006).

⁶⁹ The indicators of a successful supply-reduction effort are rising drug prices and decreasing drug purity levels. OFFICE OF NAT’L DRUG CONTROL POL’Y, PERFORMANCE MEASURES OF EFFECTIVENESS: A SYSTEM FOR ASSESSING THE PERFORMANCE OF THE NATIONAL DRUG CONTROL STRATEGY 1998-2007 13 (1998). Data from ONDCP demonstrates that the price of heroin has instead dropped significantly over time, from approximately \$3000 per gram in 1981 to approximately \$1000 per gram in 1996, while its production has risen greatly. Additionally, the price of cocaine has dropped from \$275.12 per gram in 1981 to \$94.52 in 1996. NETWORK OF REFORM GROUPS & NAT’L COALITION FOR EFFECTIVE DRUG POLICIES, THE EFFECTIVE NATIONAL DRUG CONTROL STRATEGY 1999 3-4, available at <http://www.csdp.org/edcs/edcs2.pdf>.

⁷⁰ PAIGE M. HARRISON & JENNIFER C. KARBERG, PRISON AND JAIL INMATES AT MIDYEAR 2003 1 (2004), <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim03.pdf> (last visited Sept. 30, 2006); SentencingProject.org, The Sentencing Project, Facts About Prisons and Prisoners (2005), <http://www.sentencingproject.org/pdfs/1035.pdf>.

⁷¹ James Ostrowski, Thinking About Drug Legalization, Cato Policy Analysis No. 121, May 25, 1989 available at <http://www.cato.org/pubs/pas/pa121.html>.

⁷² See generally *id.* Legal drug use is generally less dangerous than illegal drug use and is more amenable to influence by the mores of society. Legal drug use involves non-lethal doses, non-poisoned drugs, clean needles, and warning labels. The night basketball star Len Bias died from a cocaine overdose, his friends, fearing the police, waited until after his third seizure before calling an ambulance. Illegal drug users have been arrested at hospitals after seeking medical attention. Ending criminalization would put an end to this kind of nonsense. Users would be free to seek medical attention or counseling, if needed, and would not be alienated from family and friends as many are now. For a drug user to kill himself with drugs under these conditions would be tantamount to suicide. A realistic estimate is that illegal drug use is five times more dangerous than legal use. Thus, even a highly unlikely five fold increase in drug use under legalization would not increase the current number of drug overdose deaths. If, under full legalization, legal use remained at the same level as current illegal use, Ostrowski estimates only 600 deaths each year. Only a 500% increase in use would match the current black market death toll. Ostrowski.

A. ENVIRONMENTAL CONSEQUENCES

Aerial herbicide spraying in Latin America creates serious health problems for the *cocaleros*, or coca farmers.⁷³ It damages their land, forcing them to retreat deeper into the Amazon basin. Once there, they become even more dependent on coca as a cash crop, thus extending the vicious cycle of cocaine production.⁷⁴ In the United States, methamphetamine laboratories forced underground by the threat of heavy penalties are ticking time bombs poised to explode and wreak havoc on the environment.⁷⁵ Finally, to assist in coca, opium, and marijuana eradication, U.S. scientists have developed genetically engineered killer fungi that have a tendency to evolve rapidly, are prone to mutation, and remain active in warm soils for years.⁷⁶ As a result, these fungi pose grave threats to both the environment and the local inhabitants.⁷⁷

B. ECONOMICS

The government's policy of supply-side eradication of illegal drugs creates an artificial price support for organized crime.⁷⁸ Because de-

⁷³ About 41% of the herbicide misses its targeted coca, and may hit food instead, resulting in a 90% loss of food crops. Additionally, eradicators use the herbicide Roundup Ultra, which is hazardous even in concentrations of 1% (as is common in the U.S.). In Colombia, eradicators reportedly sprayed Roundup Ultra concentrations as high as 26%, resulting in chemical poisoning, rashes, vomiting, headaches, and diarrhea among exposed individuals. Luis Angel Saavedra, *Colombia's drug war: safety concerns grow about U.S. funded spraying*, NAT'L CATH. REP., Nov. 16, 2001, at 13.

⁷⁴ Betsy Marsh, *Going to Extremes: The U.S.-Funded Aerial Eradication Program in Colombia*, <http://www.lawg.org/docs/extremes.pdf>.

⁷⁵ Methamphetamine ("Meth") is a flammable and corrosive mixture of pharmaceutical extracts with poisonous materials. After a methamphetamine lab has been discovered, buildings may actually have to be razed and thousands of dollars spent to rehabilitate the area. Additionally, some 15% of methamphetamine labs in this country are discovered as the result of an explosion or fire at the lab, presenting a further risk to nearby innocent property owners. See generally *Facing the Methamphetamine Problem in America: hearing on July 18, 2003 Before the Subcomm. On Crim. Just., Drug Pol'y and Hum. Resources, 108th Cong. (2003)* (statement of John C. Horton, Associate Deputy Director for State and Local Affairs, ONDCP, available at <http://www.whitehousedrugpolicy.gov/news/testimony03/071803/071803.pdf>). Finally, meth labs can contaminate the area so seriously that the government must redevelop them as brownfields. Office of Brownfield Cleanup and Redevelopment Brochure, http://www.epa.gov/swerosps/bf/policy/methlab_brochure.pdf (last visited Sept. 30, 2006).

⁷⁶ The fungus, *Fusarium oxysporum*, is highly toxic to both animals and humans. The mortality rate for people infected (mostly individuals with lowered resistance due to immunological diseases or malnutrition) is 76%. Sharon Stevenson & Jeremy Bigwood, *Drug Control or Biowarfare?*, MOTHER JONES, May 3, 2000, <http://www.motherjones.com/news/feature/2000/05/coca.html>.

⁷⁷ *Id.*

⁷⁸ Join Together, *supra* note 57. The government proudly trumpets these price supports as an integral part of criminalization. It reasons that if the price of drugs is high, use will drop. Ultimately, these price supports failed. This year, ONDCP pointed to a short-term increase in cocaine prices as evidence of success. However, drugs are more available than they were in at the height of the drug war, and cheaper, too. "The price decline began in 1979 and the down-

mand stays relatively constant, reducing supply through eradication and interdiction efforts artificially props up the price of what would ordinarily be an inexpensive product and the massive profits create an opening for organized crime to get involved.⁷⁹ Thus, the incarceration of street-level dealers, kingpins, and foreign producers only incentivizes others to replace them, because the market maintains its attractiveness. The cost to the government to maintain its current drug policy also has a significant effect on the U.S. economy. In 2005, the White House Office of National Drug Control Policy requested \$12.6 billion for its budget.⁸⁰ This amount is in addition to the concealed billions of dollars spent on international military activities and in perpetuating the world's largest prison system (drug offenses account for the majority of federal incarcerations).⁸¹ In July 2005, out of 2.1 million U.S. prisoners, drug offenders made up an estimated 489,000 prisoners, accounting for 22.8% of the total prison population.⁸²

The federal government argues that such spending has been effective and that the country is winning the more than century-old "War on Drugs."⁸³ For example, government reports indicate that regular drug

ward trend has been steady," said Mark Kleiman, director of the drug policy program at UCLA.

⁷⁹ See Jonathan P. Caulkins & Peter Renter, *What Price Data Tell Us About Drug Markets*, 28 J. DRUG ISSUES 593 (1998).

⁸⁰ Office of National Drug Control Policy, NATIONAL DRUG CONTROL STRATEGY: FY 2005 BUDGET SUMMARY 8 (2004), available at <http://www.whitehousedrugpolicy.gov/publications/policy/budgetsum04/budgetsum05.pdf>.

⁸¹ See Drug Policy Alliance, "Fuzzy Math" in *New ONDCP Report*, http://www.drugpolicy.org/news/02_12_03fuzzy.cfm (last visited Sept. 30, 2006).

⁸² As of July 30, 2005, there were 90,049 drug offenders (53.5% of the federal prison population). See Quick Facts about the Bureau of Prisons, <http://www.bop.gov/news/quick.jsp> (last visited Sept. 30, 2006). As of December 31, 2001, there were 246,100 drug offenders (20.4% of the state prison population). Harrison, Paige M. & Allen J. Beck, US Department of Justice, Bureau of Justice Statistics, Prisoners in 2002 (Washington, DC: US Department of Justice, July 2003), Table 17, p. 10. As of 6/30/04, state prisons held 1,241,034 prisoners, and local jails held 713,990 offenders. Harrison, Paige M. & Allen J. Beck, US Department of Justice, Bureau of Justice Statistics, Prison and Jail Inmates at Midyear 2004, <http://www.ojp.usdoj.gov/bjs/abstract/pjim04.htm>. Hence, if one extends the 20.4% figure to the most current statistics for prison and jail occupants, it suggests that there were an estimated 253,171 prisoners in state prisons, and an estimated 145,654 prisoners in local jails on 6/30/04. If you combine that estimate with the 7/30/05 estimate of national prisoners (90,049), you arrive at an estimation of the number of drug offenders behind bars in July 2005. Out of a total of 2,140,325 prisoners (using 7/30/05 numbers for the federal numbers [185,301], and 6/30/04 numbers for state and local) there are an estimated 488,874 prisoners, which is 22.8% of the prison and jail population.

⁸³ Criminal Justice Policy Foundation, Statement of Eric E. Sterling, <http://www.cjpf.org/drug/2000strategy.html> (last visited Sept. 30, 2006). In a 1989 report, the Congressional Research Service of the Library of Congress noted that the nation's war on drugs had actually started in public policy in November 1880, when the U.S. and China completed an agreement that prohibited the shipment of opium between the two countries. By February 1887, the 49th Congress enacted legislation making it a misdemeanor for anyone on American soil to be found guilty of violating this ban. It became officially the "war on drugs" in the 1930s, with

use has been cut in half since 1979.⁸⁴ However, the amount of drug use has not decreased significantly since the federal government intensified the Drug War.⁸⁵ The government often relies on surveys to calculate the number of drug users, but these surveys are notoriously unreliable.⁸⁶ Survey participants largely underreport their actual drug use because of the heavy stigma associated with narcotics.⁸⁷ Yet, even these federal surveys identify an increase in drug use among adolescents since 1990.⁸⁸ A more effective barometer of national drug use is data regarding overdose deaths and emergency room drug episodes.⁸⁹ These numbers have consistently increased since the 1980's, and both were at record highs in 2001.⁹⁰ Between 1990 and 1996, drug-related deaths grew from 5,628 to 9,310, representing a 65% increase.⁹¹ According to the U.S. Department of Health and Human Services, "[f]rom 1990 to 2000, total drug-related episodes increased 62[%], from 371,208 to 601,776. Mentions of the four major illicit drugs increased from 1990 to 2000 as follows: marijuana/hashish (514%, from 15,706 to 96,446), heroin/morphine (187%, from 33,884 to 97,287), methamphetamine/speed (158%, from 5,236 to 13,513), and cocaine (118%, from 80,355 to 174,896)."⁹²

the marijuana scare that banned possession and cultivation of cannabis (including hemp). In 1971, President Nixon began the modern-day War on Drugs, by characterizing the abuse of illicit substances as "America's public enemy number one," and by pouring taxpayer money into fighting this enemy. Wikipedia, War on Drugs, http://en.wikipedia.org/wiki/War_on_Drugs (last visited Sept 29, 2006).

⁸⁴ According to the U.S. House Committee on Government Reform, between 1979 and 1992, anti-drug efforts cut regular drug use in half among all Americans (from 25 million to 11 million), by two thirds among adolescents and young adults, and cut daily marijuana use among seniors by 500 percent (from 11 percent to 2 percent). U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON GOVERNMENT REFORM, *Bush Administration Drug Policy in the United States: A Record of Success*, (Nov. 1, 2004).

⁸⁵ While the government's efforts have produced large numbers of arrests, incarcerations and seizures, drug overdose deaths have increased 540% since 1980, and drug-related problems have worsened. Dr. Ernest Drucker, *Drug Prohibition and Public Health: 25 Years of Evidence*, 114 PUBLIC HEALTH REPORTS 14 (Jan./Feb. 1999).

⁸⁶ NATIONAL RESEARCH COUNCIL, INFORMING AMERICA'S POLICY ON ILLEGAL DRUGS: WHAT WE DON'T KNOW KEEPS HURTING US, 321-22 (National Academy Press 2001).

⁸⁷ *Id.*

⁸⁸ LLOYD JOHNSTON ET AL., NAT'L INST. ON DRUG ABUSE, U.S. DEPT. OF HEALTH AND HUM. SERVICES, 1 MONITORING THE FUTURE: NATIONAL SURVEY RESULTS ON DRUG USE, 1975-2000, 115 (2001); LLOYD JOHNSTON ET AL., NAT'L INST. ON DRUG ABUSE, U.S. DEPT. OF HEALTH AND HUM. SERVICES, 2 MONITORING THE FUTURE: NATIONAL SURVEY RESULTS ON DRUG USE, 1975-2000 102 (2001).

⁸⁹ Office of Applied Studies, Substance Abuse and Mental Health Services Administration, US Dept. of Health and Human Services, "Year-End 2000 Emergency Room Data from the Drug Abuse Warning Network 2 (Washington, DC: DHHS, July 2001); Drugwardistortions.org, *supra* note 65.

⁹⁰ *Id.*

⁹¹ Drug Policy Alliance, Public Health Casualties of the Drug War, http://www.drugpolicy.org/library/factsheets/publichealth/fact_health.cfm (last visited Oct. 1, 2006).

⁹² drugwardistortions.org, *supra* note 65.

C. MANDATORY MINIMUM SENTENCES

Arguably the most egregious element of federal drug policy that Congress has enacted is the mandatory minimum sentencing laws, passed in 1986.⁹³ Mandatory minimums tie judges' hands and force them to deliver fixed sentences, regardless of mitigating factors. Judges instead must determine sentences using three inflexible criteria: type of drug, weight of drug or drug mixture, and number of prior convictions.⁹⁴ Judges cannot consider other important factors such as an offender's role in the crime, her motivation, the likelihood of recidivism, or her potential to succeed in a treatment program.⁹⁵ Therefore, under this system, prosecutors usurp the court's judicial function simply by deciding which crimes to charge. Prosecutors sometimes use this discretion to obtain sentence reductions if a defendant can provide "substantial assistance" to the state in other proceedings.⁹⁶ Unfortunately, as a result, low-level offenders often end up serving longer sentences because they have little or no information to provide the government in exchange for a reduced prison term.⁹⁷

The U.S. Sentencing Commission and the Department of Justice have both concluded that mandatory sentencing fails to deter crime.⁹⁸ Moreover, mandatory minimums have worsened racial and gender disparities and contributed greatly to prison overcrowding.⁹⁹ Consequently, many prominent jurists have begun to speak out against mandatory minimums.¹⁰⁰ For example, noted non-sympathizer, Supreme Court Justice

⁹³ American For Safe Access, Federal Marijuana Laws, <http://www.safeaccessnow.org/article.php?id=2638> (last visited Sept. 30, 2006).

⁹⁴ Drug Policy Alliance, Mandatory Minimum Sentences, <http://www.drugpolicy.org/drugwar/mandatorymin/> (last visited Apr. 14, 1996).

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ In a special report to Congress, in August 1991, the United States Sentencing Commission found that mandatory minimums do not effectively deter crime. See Drug Policy Alliance, *supra* note 94.

⁹⁹ See Drug Policy Alliance, Race and the Drug War, <http://www.drugpolicy.org/communities/race/> (last visited Sept. 29, 2006); Drug Policy Alliance, Women and the War on Drugs, <http://www.drugpolicy.org/communities/women/> (last visited Sept. 29, 2006). In 1999, there were more than 1.5 million drug arrests occurring per year which has taken its toll on prison overcrowding. Drug convictions accounted for over 80 percent of the increase in the federal prison population from 1985 to 1995. David Boaz, Drug Legalization, Criminalization, and Harm Reduction, <http://www.cato.org/testimony/ct-dbz061699.html> (last visited Sept. 25, 2006).

¹⁰⁰ Federal District and appellate judges have joined local judges in criticizing mandatory minimums. U.S. District Judge William E. Smith sentenced a Pawtucket man in September, saying he would not "blindly apply" federal sentencing guidelines that treat 5 grams of crack as the equivalent of 500 grams of powder cocaine. Edward Fitzpatrick, Judge Rails Against Drug Sentencing, <http://www.november.org/dissentingopinions/Torres.html> (last visited Sept. 30, 2006). Judge Alfredo Marquez of California refused to impose a mandatory minimum sentence on a "mule" hired in Mexico to drive a car containing drugs to the United States.

Anthony Kennedy, “railed against mandatory minimums in a speech to the American Bar Association.”¹⁰¹ Recently, the Supreme Court slightly boosted the fight against mandatory minimums in their decision, *U.S. v. Booker*.¹⁰² In this case, the Court invalidated 18 U.S.C. § 3553(b), which made the Federal Sentencing Guidelines mandatory by saying that a court, “shall impose a sentence of the kind, and within the range [established by the Guidelines].”¹⁰³ After *Booker*, judges have regained their sentencing discretion for most criminal cases, and the Federal Sentencing Guidelines have become merely advisory, including those pertaining to drug offenses.¹⁰⁴ However, while *Booker* restores some lost discretion to judges, it offers no assistance to prisoners previously sentenced under mandatory minimum sentencing laws.¹⁰⁵ Moreover, judges still lack discretion in the application of the commonly used mandatory minimum sentences in 21 U.S.C. § 841, which override the Federal Sentencing Guidelines.¹⁰⁶

Judge Marquez ruled that imposition of the five-year sentence would violate the defendant’s due process rights under the Fifth Amendment. Doug Linder, *Evil in the American Justice System*, <http://www.law.umkc.edu/faculty/projects/ftrials/evil/evilP13.html>. Judge Robert W. Sweet District Judge in New York City; served as an Assistant US Attorney and as Deputy Mayor of New York City under John Lindsay; a graduate of Yale and of Yale Law School. “Congress should end the criminalization of marijuana, which is now widely acknowledged to be without deleterious effect. That reform alone would take 450,000 arrests out of the system.” Dissenting Opinions, *Judges Against the Drug War*, *Today’s Drug Enforcement is Swamping the Judicial System*, <http://www.november.org/dissentingopinions/dissentingopinions.html> (last visited Sept. 30, 2006); Frontline, Public Broadcast Service, Interview with Judge Robert Sweet, <http://www.pbs.org/wgbh/pages/frontline/shows/snitch/procon/sweet.html> (last visited Sept. 30, 2006). Additionally, many District Attorneys, including Manhattan DA Robert Morgenthau, Brooklyn DA Charles Hynes and Albany County DA David Soares have come out against mandatory minimums and draconian drug laws in general, and have turned them into successful campaign issues. District Attorney, New York County, News Release for Dec. 6, 2004, <http://www.manhattanda.org/whatsnew/press/2004-12-06.htm>; Charles Hynes, Forum Opinion on Drug Warriors, <http://www.issues.org/15.2/forum.htm> (last visited Sept. 30, 2006); Drug Policy Alliance, Warning: Oppose Rockefeller Reform at Your Own Risk, <http://www.drugpolicy.org/news/pressroom/pressrelease/pr091504.cfm> (last visited Sept. 30, 2006).

¹⁰¹ Emily Bazelon, *Bench Pressed: When the Judge’s Hands are Tied*, SLATE, Nov. 23, 2004, <http://www.slate.com/id/2110067> (last visited Sept. 29, 2006).

¹⁰² *United States v. Booker*, 125 S.Ct. 738 (2005).

¹⁰³ 18 U.S.C.A. § 3553(b)(1) (2003); *See Booker*, 125 S. Ct. at 749.

¹⁰⁴ 8 U.S.C.S. app. § 2D1.1 (2006); 18 U.S.C.A. 3553(b)(1) (2006); *See Booker*, 125 S. Ct. at 757.

¹⁰⁵ Families Against Mandatory Minimums, Understanding Booker and Fanfan: Federal sentencing guidelines are advisory, but mandatory minimum sentences still stand, http://www.famm.org/nr_sentencing_news_bookerealert_1_13_05.htm (last visited Sept. 28, 2006).

¹⁰⁶ 21 U.S.C. § 841 (2006).

D. HIGHER EDUCATION ACT

In 1998, Congress, under the leadership of Representative Mark Souder (R-IN), amended the Higher Education Act of 1965.¹⁰⁷ The Act created federal grant and loan programs to assist low income students with tuition costs.¹⁰⁸ Federal financial aid programs are currently the single largest source of student aid in the United States, annually providing an estimated \$40 billion to 7 million students.¹⁰⁹ The 1998 amendment, also known as the Souder amendment, denies federal financial aid to any student with a drug conviction.¹¹⁰ Because drug laws are enforced in a racially discriminatory manner, the Souder amendment disproportionately takes away much-needed college funds from people of color and working-class students, the primary recipients of these funds.¹¹¹ Thus, by erecting a bar to the education of those for whom such opportunities are most important, this discriminatory and counterproductive amendment prevents individuals convicted of drug offenses from bettering themselves. Moreover, the Souder amendment ignores other violent criminals, such as rapists or muggers, and those other students that abuse the most popular campus drug, alcohol.¹¹² According to the Department of Education, 43,000 students during the 2001-2002 academic year and more than 180,000 students overall have lost their federal financial aid as a result of the Souder amendment,¹¹³ leading to rampant criticism of the

¹⁰⁷ Higher Education Act of 1965, Pub. L. No. 89-329, 79 STAT 1219 (1965) (amended 1998).

¹⁰⁸ *Id.*

¹⁰⁹ Drug Policy Alliance, Safety First: Parents, Teens and Drugs—Higher Education Act, <http://www.drugpolicy.org/safetyfirst/higheredact> (last visited Apr. 14, 2006).

¹¹⁰ 20 U.S.C. § 1091(r) (2006).

¹¹¹ While White youth sell and use drugs at the same or higher rates as youth of color, Black and Latino youth are arrested, prosecuted and imprisoned at dramatically higher rates for drug crime. Drug Policy Alliance, Education vs. Incarceration, <http://www.drugpolicy.org/communities/race/educationvsi/index.cfm> (last visited Sept. 27, 2006). By 1990, 48.8% of juvenile drug arrests were Black youth. Human Rights Watch, *Punishment and Prejudice: Racial Disparities in the War on Drugs*, A HUMAN RIGHTS WATCH REPORT, May 2000, <http://www.hrw.org/reports/2000/usa/>. Among young people incarcerated in juvenile facilities for the first time on a drug charge, Black youth were represented 48 times more than Whites, and Latinos 13 times more than Whites. DeComo, R. (1993, September). The Juveniles Taken into Custody Research Program: Estimating the prevalence of juvenile custody rates by race and gender. *NCCD Focus*. National Council on Crime and Delinquency. Homepage of the National Council on Crime and Delinquency, http://www.nccd-crc.org/nccd/n_pubs_main.html (last visited Sept. 30, 2006).

¹¹² Druglibrary.org, <http://www.druglibrary.org/Schaffer/other/harmcov.htm> (last visited Oct 2, 2006).

¹¹³ Mark Eddy, WAR ON DRUGS: LEGISLATION IN THE 108TH CONGRESS AND RELATED DEVELOPMENTS 11 (2003), <http://fpc.state.gov/documents/organization/23184.pdf> (last visited Sept. 30, 2006); Stoppedrugwar.org, Congress Passes Partial Reform to Law Barring Financial Aid to Students with Drug Convictions, <http://stoppedrugwar.org/chronicle/421/heachange.shtml> (last visited Sept. 30, 2006).

new law.¹¹⁴ In January 2005, the Advisory Committee on Student Financial Assistance, a Congressional Committee that provides advice and counsel to Congress and the Secretary of Education, called the drug provision “irrelevant” and advised Congress to remove it.¹¹⁵

Finally, in the face of calls for a complete repeal of the provision, Representative Souder changed course, stating that he had intended all along for the law to apply only to currently enrolled students.¹¹⁶ He offered another amendment that would remove the retroactivity from the provision and restore aid to some students with past offenses but would continue to apply the penalty to those students who committed the offenses while enrolled in school and receiving aid.¹¹⁷ Both houses approved the amendment as part of the Deficit Reduction Act of 2005, and President Bush signed it on February 8, 2006.¹¹⁸ However, drug policy reform advocates have vowed to continue the campaign until they have succeeded in removing the entire provision.¹¹⁹

E. PUBLIC HEALTH CRISIS

The current zero-tolerance criminalization policy has created a catastrophic public health crisis. Without needle exchange programs and access to clean needles, the AIDS epidemic continues to spread.¹²⁰ Thirty-six percent of AIDS cases in the United States can be traced back to intravenous drug use.¹²¹ Syringe exchange decreases risky injection behavior by as much as 73%.¹²² Despite this rate of success, syringe exchange programs (“SEPs”) are not prevalent in the United States. In 2001, there were an estimated 164 U.S. SEPs in 29 states, Washington,

¹¹⁴ Press Release, Coalition for Higher Education Act Reform Congressionally-Appointed Committee Calls for Repeal of Anti-Education Policy (Jan. 25, 2005), <http://www.raiseyourvoice.com/pressrelease-jan25-05.pdf>; Emily Anthes, Student Aid Rule Put Under Review, *St. Petersburg Times*, July 21, 2005, http://www.sptimes.com/2005/07/21/Worldandnation/Student_aid_rule_put_shtml.

¹¹⁵ ADVISORY COMM. ON STUDENT FIN. ASSISTANCE, *THE STUDENT AID GAUNTLET: MAKING ACCESS TO COLLEGE SIMPLE AND CERTAIN* 16 (2005).

¹¹⁶ *Stophedrugwar.org*, *supra* note 113.

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ See *Stophedrugwar.org*, *supra* note 113. DRCNet’s David Borden, who has led the efforts to repeal the HEA Souder Amendment since the drug provision was passed in 1998, stated, “We intend to press for Congress to remove the drug question from the FAFSA (Free Application for Federal Student Aid) form — which their own Advisory Committee [that] Congress appointed recommended — the next time they look at the Higher Education Act, which will probably be this year [2006].”

¹²⁰ CDC.org, Drug-Associated HIV Transmission Continues in the United States, <http://www.cdc.gov/hiv/pubs/facts/idu.htm> (last visited Apr. 14, 2006).

¹²¹ *Id.*; see also Ostrowski, *supra* note 71.

¹²² Des Jarlais DC, Marmor M, Paone D, et al. *HIV incidence among injecting drug users in New York City syringe-exchange programs*, 90 AM. J. PUB. HEALTH 352–59 (2000).

D.C., and Puerto Rico.¹²³ These SEPs, however, only served 10% of the U.S. intravenous drug user (IDU) population.¹²⁴ In a study of high-risk IDUs in Oakland, CA, users who attended a SEP were two and a half times more likely to stop sharing needles than non-attending IDUs after just six months.¹²⁵ Moreover, a worldwide study found that human immunodeficiency virus (HIV) seroprevalence, which is the frequency of individuals who test positive for blood serum HIV antibodies, among IDUs decreased 5.8% in cities with SEPs and increased 5.9% in cities without SEPs.¹²⁶ Additionally, SEPs help reduce the spread of Hepatitis B and C.¹²⁷ Despite this track record, SEPs remain rare and are often unsupported by governmental entities because of political (and not policy) considerations.¹²⁸ The federal government has even gone so far as to ban the use of federal funding to support SEPs, even while acknowledging their effectiveness.¹²⁹

Another major drug-related public health issue is the lack of consistent quality control for drugs sold on the black market.¹³⁰ As a result, many people have died from complications related to adulterated

¹²³ JULIE RUIZ-SIERRA, *Syringe Access* (2001), p. 4, http://www.drugpolicy.org/doc/uploads/syrings_access_brief.pdf.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ Susan F. Hurley, *Effectiveness of needle-exchange programmes for prevention of HIV Infection*, LANCET, Jun. 21, 1997, at 1797.

¹²⁷ PREVENTING HIV TRANSMISSION: THE ROLE OF STERILE NEEDLES AND BLEACH, 240-43 (Jacques Normand et al. eds., National Academy Press 1995). Participants in a Tacoma SEP were six to seven times less likely to contract Hepatitis B or C. Holly Hagan et al., *Reduced Risk of Hepatitis B and C among Injection Drug Users in the Tacoma Syringe Exchange Program*, 85 AM. J. PUB.HEALTH 1531 (1995).

¹²⁸ "For most of the countries that have not implemented appropriate HIV prevention programs, however, the problem is not one of resources, but one of political attitudes Rather than taking a public health approach to the problems of HIV infection among IDUs, many countries have applied moralistic approaches coupled with law enforcement, or have attempted to prevent public health problems primarily by eliciting fear about using drugs." RUIZ-SIERRA, *supra* note 123. Political attitudes have particularly hamstrung SEP funding efforts in the United States. Under the terms of Department of Health and Human Services Appropriations Act of 1998, Congress conditioned the federal funds to support needle exchange programs on a determination by the Secretary of Health and Human Services that such programs reduce the transmission of HIV and do not encourage illegal drug use. Department of Health and Human Services Appropriations Act, 1998 (Pub. L. No. 105-78, Title II, Nov. 13, 1997, 111 Stat. 1477 (1997)). In April 1998, the Secretary of Health and Human Services, Donna E. Shalala, made that determination, stating that "a meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs." RUIZ-SIERRA, *supra* note 123. Yet, the Act's restriction on federal funding was not lifted. U.S. Department of Health and Human Services, *Research Shows Needle Exchange Programs Reduce HIV Infections Without Increasing Drug Use*, <http://www.hhs.gov/news/press/1998pres/980420a.html> (last visited Sept. 26, 2006).

¹²⁹ RUIZ-SIERRA, *supra* note 123.

¹³⁰ Mark Greer, head of the Media Awareness Project, stated, "The cause of death among most drug addicts is accidental overdose and adulterated drugs (inconsistent potency or dan-

paramethoxyamphetamine (“PMA”), an ecstasy variant, and accidental overdoses from uncut, nearly pure heroin.¹³¹ The majority of heroin deaths are caused by an allergic reaction to the unpredictable potency and composition of the street mixture of the drug which can be directly tied to the black market context of drug use.¹³² As with heroin, adulterants and uncertain potencies—as well as genetic tendencies, which can only be identified in a non-criminalization context—also appear to play a major role in cocaine-related deaths.¹³³

F. DRUG CRIME

The criminalization regime contributes to an increase in street violence. Gangs, dealers, and drug traffickers are attracted to the business by large profit margins, which force them to protect their “turf”, often through violent means.¹³⁴ While gangs existed before the popularization of the drug trade, many have theorized that without the business of illegal drugs, organized criminal enterprises and street violence would decrease significantly.¹³⁵ Although gangs might retain their influence over the inner-city children, their ability to do violence to the rest of society

gerous ‘cuts’). These deaths would cease to exist with consistent quality control.” <http://www.lycaem.org/drugwar/map.html>.

¹³¹ PMA closely resembles Ecstasy and when users think they have taken “weak” Ecstasy, they frequently increase their dosage in order to capture the “high”, which can lead to overdose or death. *PMA*, DRUG PREVENTION RESOURCE CENTER, 2001, <http://www.drugpreventionresource.org> (follow “Informative Topics” hyperlink; then follow “PMA” hyperlink); Drug Policy Alliance, Public Health Crisis, <http://www.drugpolicy.org/drugwar/publichealth> (last visited Sept. 30, 2006).

¹³² In 1989, James Ostrowski reported that medical literature indicates that the main causes of acute heroin death are the use of heroin with alcohol, the presence of quinine and other impurities in the heroin street mixture, and the unpredictable and unknown potency of black-market heroin. Given a social philosophy of “zero tolerance” for drug use, no attempt is made to publicly warn heroin users not to mix alcohol and heroin which drastically heightens the chances of overdose. Additionally, 30 % of the heroin deaths are caused by “tetanus, hepatitis, or bacterial endocarditis, all contracted from bad heroin or dirty syringes,” and all preventable in a non-criminalization system. Ostrowski, *supra* note 71; NSW Dept. of Health, Heroin Fact Sheet, <http://www.health.nsw.gov.au/public-health/dpb/publications/pdf/fact-sheets/heroin.pdf> (last visited Sept. 30, 2006).

¹³³ The purity of cocaine purchased on the street may vary from 25% to 90%, with unpredictable effects. The sporadic outbreak phenomena of “epidemics” of cocaine-related deaths, such as a 1985 epidemic in Utah strongly support this thesis. There is also speculation that a relatively small number of people are particularly sensitive to cocaine because they lack the enzymes needed to metabolize the drug. Under prohibition, however, no structure or incentives exist to determine, in advance of tragic death, just who these people are. Ostrowski, *supra* note 71.

¹³⁴ See Enotes.com, Drug Legalization, <http://www.enotes.com/drug-legalization> (last visited Sept. 24, 2006).

¹³⁵ Meaghan Cussen & Walter Block, *Legalize Drugs Now! An Analysis of the Benefits of Legalized Drugs*, 59 AM. J. ECON. & SOCIO. 525, 528 (2000) (arguing that if drugs were legal dealers would be able to sue in open court, thus eliminating the need to use violence to gain redress).

would be lessened without the constant infusion of capital and weapons from organized crime and foreign drug lords.¹³⁶ As the American Civil Liberties Union (“ACLU”) puts it, drug legalization “would sever the connection between drugs and crime that today blights so many lives and communities.”¹³⁷

G. CONCLUSION

In sum, while the government’s goal is to reduce drug use, and promote public health and safety, its criminalization policies actually subvert these goals. Additionally, these policies create many secondary effects that far exceed the inherent concerns associated with drug use. It is therefore imperative to evaluate other possible regulatory models based on a harm reduction platform, and determine whether they might satisfy the goals of American society in a more efficient way.

II. ALTERNATIVE DRUG POLICY MODELS

A. DECRIMINALIZATION MODELS

One alternative to the current scheme is the decriminalization of hard drugs. Decriminalization can either be full or partial.¹³⁸ Similar to the libertarian model, full decriminalization would remove all state controls over hard drugs and adopt a legal “hands off” policy.¹³⁹ Drug use would be punished by fines, but narcotics would still not be legally available.¹⁴⁰ Interestingly, under full decriminalization, drug regulations would actually be less restrictive than those which now apply to legal drugs, such as alcohol and tobacco.¹⁴¹ This policy, however, is completely unrealistic; the U.S. government will never allow substances which have a powerful effect on the mind, and great potential for harm, to go completely unregulated.¹⁴²

Under partial decriminalization, some legal restrictions on the possession, sale, and distribution of a drug are removed either by law or by lack of enforcement. The Netherlands pursues a bold policy of partial decriminalization.¹⁴³ Even though small-quantity marijuana possession is technically illegal, the 1976 Amendments to the Opium Act permit the Public Prosecutions Department to refrain from prosecuting drug offend-

¹³⁶ *See id.*

¹³⁷ Am. Civ. Liberties Union, *Against Drug Prohibition*, <http://www.aclu.org/drugpolicy/gen/10758pub19950106.html> (last visited Sept. 30, 2006).

¹³⁸ GOODE, *supra* note 36.

¹³⁹ *Id.*

¹⁴⁰ *Id.* at 79.

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

ers if such prosecution is against a weighty public interest.¹⁴⁴ Today, marijuana is predominately sold in “Koffiehuizen”, or coffeehouses.¹⁴⁵ These transactions are typically ignored by the police, and only in exceptional cases, such as advertising, loud music, crowds or other nuisances, minors on premises, or heroin or cocaine being sold on premises, will legal action be taken.¹⁴⁶ The Dutch police also ignore possession of small quantities of heroin or cocaine.¹⁴⁷ The Dutch, however, will prosecute the open sale of even small quantities of heroin or cocaine in commercial establishments.¹⁴⁸

The Amsterdam experiment has yielded some interesting results. Since the revision of the Opium Act in 1976, the Dutch policy of “separation of markets” has kept the number of “hard” drug addicts considerably lower than the rest of Western Europe and the United States.¹⁴⁹ However, it has become apparent that decriminalization serves only a limited purpose, and that it does not provide any guidance in certain areas of drug policy, most importantly on the supply side.¹⁵⁰ For instance, even though coffeehouse proprietors invest a lot of capital into their fa-

¹⁴⁴ *Id.*; DUNCAN & NICHOLSON, *supra* note 2; The Hague, MINISTRY OF WELFARE, HEALTH AND CULTURAL AFFAIRS FACT SHEET (19-N 1989).

¹⁴⁵ Dirk J. Korf, *Cannabis retail markets in Amsterdam*, 2 INT. J. DRUG POLICY 23, 23–24 (1990).

¹⁴⁶ *Id.*

¹⁴⁷ See A.C. M. JANSEN, *CANNABIS IN AMSTERDAM: A GEOGRAPHY OF HASHISH AND MARIJUANA* (Dick Coutinho 1991); see also *BETWEEN PROHIBITION AND LEGALIZATION: THE DUTCH EXPERIMENT IN DRUG POLICY* (Ed Leuw & Marshall I. Haen eds., Kugler Publications 1994). In 1976, the Netherlands re-examined its drug policy, revising the Opium Act, and issuing new enforcement regulations that followed the “Expediency Principle.” While the revised Opium Act did not explicitly legalize any drugs (in fact, it increased penalties for drug trafficking), regulations issued under the act called for police to ignore possession and sale of small quantities of cannabis, and generally, to ignore small quantities of cocaine, heroin, and other hard drugs. Eisenach, Jeffrey A Eisenach & Andrew Cowin, *Fighting Drugs in Four Countries: Lessons for America?*, <http://www.heritage.org/Research/Religion/bg790.cfm> (last visited Oct 1, 2006).

¹⁴⁸ Mark Stevenson, *Mexico Poised To Legalize Some Drug*, CBS News, Apr. 18, 2006, http://www.cbsnews.com/stories/2006/04/12/world/main1491595.shtml?source=RSS&attr=HOME_149 1595.

¹⁴⁹ Drug Policy Alliance, Netherlands, <http://www.drugpolicy.org/global/drugpolicyby/westerneuop/thenetherlan/> (last visited Oct 1, 2006); CSDP.org, Advertisement of Dutch Drug Policy, <http://www.csdp.org/ads/dutch2.htm>. check

¹⁵⁰ Frank Kuitenbrouwer, a legal commentator and member of the editorial board of the NRC Handelsblad, a leading centrist Dutch newspaper, states: “This is the inherent paradox of the Dutch drug policy. It’s known as the front-door/back-door problem: if the Dutch government tolerates people going in the front door of the coffee shop, what about the back door, the supply?” According to 2000 article in Salon by David Downie, unofficially, police allow “ethical dealers” (individual small-scale suppliers unrelated to international trafficking rings) to supply the coffeehouses. However, Downie also reported the speculation of an Amsterdam city official who, speaking on condition of anonymity, believed that 90% of coffeehouses in the city were controlled by organized crime. David Downie, *Going Dutch: Can America learn from the Netherlands’ drug policy of tolerance and ambiguity?*, SALON, Mar. 13, 2000, http://archive.salon.com/health/feature/2000/03/13/dutch_drugs/print.html.

cilities and services, they continue to live in fear of arrest and subsequent inability to pursue their livelihood. In addition, an important part of any intoxicant economy is the development of a class of connoisseurs and the resultant specialty shops at which they consume. However, in Amsterdam's decriminalized society, the development of the marijuana industry remains stunted because without governmental (such as the German beer purity laws) or self-regulatory (such as the International Trappist association brewing regulations) guarantees of quality and specificity, a connoisseur cannot rely on the consistency of a certain product.¹⁵¹

If these decriminalization models were applied to hard drugs like cocaine and heroin, they would only address some of the issues created by the current criminalization scheme and the quality of the drugs that people use would still be unregulated and erratic. Furthermore, a decriminalized society would not benefit from a reduction of negative secondary effects, such as gang violence and a virulent black market, because the supply of hard drugs would continue to arrive through the same channels. As a result, drug dealers would receive no benefit, and American society would continue to fill its prisons with drug offenders, mostly people of color.¹⁵² Even if the decriminalization regime ceased its interdiction efforts, and removed criminal penalties for drug sale, the secondary effects would persist. Without a societal attitude adjustment, the nation still would not treat drug use as a public health problem. Bad quality drugs would continue to abound, and there would be no concerted effort to save people from the harms that drugs may cause.

B. MEDICAL/PRESCRIPTION MODEL

Problems also exist with the medical approach to drug abuse, in which drug abuse is seen as a disease that doctors can treat by making illegal drugs available to addicts in limited doses.¹⁵³ Doctors prescribe a

¹⁵¹ The German Beer Purity Law of 1546, passed by the Duchy of Bavaria and later adopted by the rest of Germany, made it a crime to make beer from anything other than barley, hops, and pure water. Brewery.org, Germany's Purity Law, <http://www.brewery.org/library/ReinHeit.html> (last visited Oct. 2, 2006) (citing Karl J. Eden, *History of German Brewing*, 16 ZYMURGY (SPECIAL ISSUE) 4 (1993)). The seven member breweries of the International Trappist Association (known for producing some of the finest beer in the world) self-regulate, demanding adherence to three strict conditions: the beer must be brewed within a Trappist abbey, under the supervision and responsibility of the monks, and the majority of the revenue must be dedicated to charitable work. Trappist Association Home Page (English), http://www.trappistbeer.net/trappist_portalEN.htm (last visited Oct. 2, 2006).

¹⁵² Today, Black males have a 1 in 3 chance of serving time in prison at some point in their lives, while Hispanic males have a 1 in 6 chance, and White males have a 1 in 25 chance). BUREAU OF JUST. STAT., U.S. DEPT. OF JUST., SPECIAL REPORT: PREVALENCE OF IMPRISONMENT IN THE U.S. POPULATION, 1974-2001 1 (2003), available at <http://www.ojp.usdoj.gov/bjs/pdf/piusp01.pdf>.

¹⁵³ The medical/prescription model, as practiced in the Netherlands, does not have an answer for what to do when drug abusers refuse to participate in the program, demand to use

certain amount of drugs to addicts to maintain their habits, and in some cases attempt to gradually wean them off of drugs.¹⁵⁴ If this model were to be implemented in the United States, the Food and Drug Administration (FDA) would likely monitor the quality of the drugs and certify that they are safe and effective medicines.¹⁵⁵ While this approach is laudable for its focus on drug abuse as a public health problem, it unfortunately only concentrates on drug users who are already addicted. The program fails to address other problems related to drugs (such as a user's pre-addiction interactions), contains no other incentives to ignore drugs other than the spectre of addiction (which, though powerful, has not yet been sufficient for many) and does not promote safe use for non-addicts. As a result, unless the bar for addiction is set impossibly low, this scheme does nothing to eliminate the black market and its concomitant secondary effects for recreational drug users, who will continue to buy their drugs on the street.

C. HARM REDUCTION

Harm reduction, as it appears in the Netherlands, Switzerland, and certain jurisdictions in the United Kingdom, cherry-picks pieces of various plans, and advocates different programs for different drugs.¹⁵⁶ As previously stated, this model accepts that drug distribution, addiction, and use will always exist, and thus tries to reduce the harms they inflict upon society.¹⁵⁷ Harm reduction emphasizes practicality and encourages creating needle exchange programs and a law enforcement philosophy that distinguishes between "soft" and "hard" drugs and between users and small-time sellers on the one hand, and high-volume dealers on the other.¹⁵⁸ Additionally, education and treatment proposals receive much attention from harm reduction advocates.¹⁵⁹ Harm reduction plans often expand existing drug maintenance programs, especially those related to methadone.¹⁶⁰ In a harm reductionist society, policymakers would study the feasibility of maintenance programs for other drugs, such as her-

other drugs in addition to the legal drugs they are being administered, or demand a significant escalation in the dose they are administered. It also will not help those recreational users who are not chemically or psychologically dependent and who demand quantities of a given drug from the program. Finally, this program sees the primary motivation of drug abusers as maintenance, not recreation. GOODE, *supra* note 36.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ Druglibrary.org, *supra* note 112; Drug Policy Alliance, *supra* note 35.

¹⁶⁰ Methadone Centers, Harm Reduction, <http://www.methadonecenters.com/MChar-mReduction.htm> (last visited Oct. 2, 2006).

oin.¹⁶¹ Drug education programs would be expanded, and heroin and marijuana would be made available by prescription for medical treatment.¹⁶² Most importantly, harm reduction schemes are flexible, pragmatic, and willing to drop failing programs while continuing to innovate.¹⁶³ They maintain this flexibility by confining the government's role to ameliorating harm to the society, rather than combating drugs.¹⁶⁴ Unfortunately, the problem with most harm reduction plans is that they do not go far enough. They fail to address harm to the user in not guaranteeing a clean product and safe distribution scheme, they fail the manifold sellers still being imprisoned, and they fail society in not eliminating the black market and its deleterious secondary effects.

Therefore, a successful regulatory plan must move farther than these schemes and embrace the flexibility and broad scope of a harm reduction plan, while relying heavily on a strategy of regulated legalization. I have named this approach: harm reductive legalization.

III. PROPOSED MODEL-HARM REDUCTIVE LEGALIZATION

Given the inherent flaws in the other proposed models, this Note proposes a new scheme, harm reductive legalization, in which the principles of harm reduction are applied to a legalization state. Although theoretically and practically difficult, under a harm reductive legalization scheme, the government examines all of the various competing harms associated with drug use and creates a regulatory scheme that ameliorates as many as possible. To be successful, the plan must address the following: (1) the need of the user for a safe product and distribution scheme; (2) the libertarian desire of a recreational user to occasionally use mind-altering substances and continue to function highly; (3) the desire of the sellers, who often have little other economic opportunity, to stay out of prison; (4) the needs of society in destroying the black market and the inherent violence that accompanies it; (5) the needs of society and the user to expand treatment and help as many addicts as possible break the cycle of addiction; and (6) the desire of society to minimize the creation of new users, especially addicts and children. While all of these principles are integral to achieving a just regulatory system, they inexorably conflict with one another. For example, the desire of a recreational user to occasionally use a dangerously addictive drug will often be at odds with society's goals of minimizing new users and preventing addiction. Also, the desire of sellers, who want to maintain their freedom and ac-

¹⁶¹ GOODE, *supra* note 36.

¹⁶² GOODE, *supra* note 36; Druglibrary.org, *supra* note 112.

¹⁶³ *Id.*

¹⁶⁴ David Beers, *Just Say Whoa!*, MOTHER JONES, July/August 1991, at 36–43, 52–56.

quire capital, will conflict with society's goal of crushing the black market, if the market remains profitable.

Even if government regulations and programs manage to address all of these issues and actually reduce drug-related harm, the regulations themselves will result in much greater state intervention into the lives of persons affected by them. Harm reduction, however, is ultimately pragmatic. It suggests drug use is not a right, but a privilege. Accordingly, the accompanying intense state intervention is the price needed to maintain that privilege.

In order to demonstrate the harm reductive legalization plan clearly, this Note will discuss the two drugs considered the most dangerous and whose legalization would be most controversial: heroin and cocaine. Obviously, this plan will not exist in a vacuum, and every drug will be addressed separately, but the plan is best illustrated by delineating and confronting its extreme edges. The plan creates the (A) National Recreational Drug Registry, which gives drug users the ability to purchase heroin and cocaine legally. The plan discusses the limit on the (B) allowable amount of drugs that a user may purchase each day and the ramifications of setting it at various points. The plan includes the (C) use of safeguards and mandatory testing of employees in certain professions. It will also outline the effects of this system on the (D) health insurance community and hypothesize as to criminal penalties for (E) extralegal use and use by minors. The plan will also address the resources needed for (F) effective administration of the registry. It discusses the drug production side with sections on (G) advertising and the limitations on drug producing corporations and (H) quality control. Finally, the plan addresses (I) improved drug education and treatment options, and their significance in the larger scope.

A. NATIONAL RECREATIONAL DRUG REGISTRY

The solution to some of these problems is to create the National Recreational Drug Registry (NRDR). This registry will be a national database of registered recreational drug users and will issue identification cards that provide an instant check on whether the user has exceeded her daily allotment of drugs. Under a libertarian scheme, drugs would not be regulated and could be sold anywhere to anyone at any time. Harm reduction necessitates a different response, focused on preventing a user from acquiring enough cocaine or heroin at one time to overdose and die. Unfortunately, one proprietor would have no idea whether a user had previously bought the drug at another establishment. Therefore, with the creation of this identification card, which works much like a credit card

check, a proprietor will be able to instantly access the user's recent drug purchasing history and sell drugs to her accordingly.¹⁶⁵

The limits on this daily allotment serve a dual purpose. First, in setting a limit, the government will at least be able to ascertain whether a user is receiving as safe an amount of the drug as possible (disregarding possible black market transactions). Second, to drastically reduce the possibility of these black market transactions, this limit will discourage users from hoarding non-personal use drugs and reselling them for profit (which is more likely to occur in a deregulated society without a daily limit). Moreover, even if a user does manage to hoard some drugs, there will be no economic incentive for other users to purchase these drugs at black market prices because they will be able to purchase them legally at a cheaper price.¹⁶⁶

However, if an addicted user is turned away by a dispensary utilizing the bartender model, will a dealer be waiting around the corner to sell her additional extralegal heroin for an inflated price? It is possible. A

¹⁶⁵ A publicly accessible national database of individuals who admit to doing something societally frowned upon will raise civil liberties questions. However, the databases recently judged legal by the Bush administration, and the less controversial example of the widely accessed credit card database suggest that future Supreme Court decisions might not consider such a database to be an invasion of privacy under the Fourth Amendment.

¹⁶⁶ Many critics of the Drug War believe that one of the goals of the government in emphasizing interdiction is to artificially raise the price of illegal drugs so as to price users out of the market. Bill Walker, the Cocaine Price Support Program, <http://www.lewrockwell.com/orig5/walker6.html> (last visited Oct. 2, 2006). Hence, without the artificial price support caused by the Drug War, when cocaine and heroin production is controlled by a stable section of the legal U.S. economy, prices will fall to more natural, market-based levels, while any black-market drugs will continue to remain overpriced. Users will receive stiff financial penalties for extralegal use, and black-market dealers will face large criminal terms for illegal sale (although without the current emphasis and expenditures on interdiction), and will need to continue to pay more for the product to be shipped and sold illegally. These "costs" added to black market sales will make them prohibitively expensive, and the regulators who decide on the taxation and licensing schemes for the cocaine and heroin producers will take these costs and the dangers of a thriving black market into consideration. In addition, cigarettes offer a hopeful example about the non-development of a major black market, even under significant taxation. After New York City Mayor Bloomberg raised the tax on cigarettes in July 2002 to \$5/pack, critics claimed that the emergence of a thriving black market would cancel out any significant city revenue. Patrick Fleener, *Cigarette Taxes, Black Markets, and Crime Lessons from New York's 50-Year Losing Battle*, Cato Policy Analysis No. 468, Feb. 6, 2003 *available at* <http://www.cato.org/pubs/pas/pa468.pdf>. Instead, according to the Campaign for Tobacco-Free Kids, research shows smuggling and tax avoidance is actually a minor problem, especially compared to the additional new revenues, public health benefits, and smoking-caused cost reductions from state cigarette tax increases. A 2000 study found that cigarette smuggling and cross-border cigarette purchases accounted for no more than 5% of all cigarette sales; while a 2003 study stated that all state smuggling and tax avoidance revenue losses totaled less than 8% of total state cigarette tax revenues. Furthermore, preliminary data from the states that raised their cigarette tax rates between 2002 and 2004 confirms that state cigarette tax increases always raise state revenues despite reducing pack sales. Tobacco-free Kids, *Raising State Cigarette Taxes Always Increases State Revenues (and Always Reduces Smoking)*, <http://tobaccofreekids.org/research/factsheets/pdf/0098.pdf> (last visited Oct. 2, 2006).

robust police or security presence near dispensaries (whose officers have been properly trained to assist, and not harass, the dispensary attendees) and aftercare programs, will discourage extralegal dealers. Also, operating on the assumptions that most users will not attempt overdose in buying more than their share of heroin, and the limits will have limited success, the demand for these dealers will decrease significantly. Significantly smaller demand and lesser profitability on individual sales¹⁶⁷ will bring less investment and product from larger criminal syndicates, crippling, but not destroying, the black market.

Additionally, there will be no qualifications to join the registry other than age, competency, and mandatory attendance at a “safe drug use” class. This class will emphasize the major risks of the drugs and how to use them in the safest manner possible. It will also offer information on Narcotics Anonymous and relevant health care professionals in the hopes of creating a safety net for its attendees. Additionally, former drug addicts can share their stories and warn against abuse of the drugs in class. Although some of the elements sound similar to current drug education techniques, the important difference with the mandated NRDR class is that the tone will be non-judgmental, honest, and safety-oriented as opposed to didactic and hyperbolic. Attendance at the class is mandatory for becoming a member of the registry, and as an incentive, at the conclusion of the class, the users will receive their identification cards.

B. HOW TO SET THE ALLOWABLE AMOUNT

The creation of the National Recreational Drug Registry leads to the question of where to set the daily limit of allowable cocaine and heroin use. In order to not subvert the registry’s purpose, the limit must attempt to protect a user from herself and her potential desire to acquire and use as many cheap and accessible narcotic drugs in a day as possible. Thus, if the limit is too low, drug users are likely to opt out of the system and continue using the black market. The most practical solution is to defer to a scientific study that will determine the mean average daily amount of cocaine or heroin that drug users may consume, while minimizing the risks of overdose and hospitalization.¹⁶⁸ This standard will not apply

¹⁶⁷ Currently, an addicted user will buy as much heroin as he has appetite for, and that he can afford. In this model, addicted users will only need to buy a “fix” to last them until the next morning, when the dispensary reopens. Hence, the profit per sale will drop sharply as well.

¹⁶⁸ Although not much is definitively known about overdose, there are three factors that appear to influence whether a user overdoses: the user’s current drug tolerance, the user’s use of multiple drugs, and the purity of the drug. If a user relapses after a period of non-use, her drug tolerance can be significantly lower. If she follows her previous usage habits in an effort to get high, this lower tolerance level may cause a potentially fatal overdose. Users who use multiple drugs risk overdose when they mix different drugs, including sleeping pills, alcohol, Valium and heroin. In fact, the single largest cause of fatal overdose is using “downer” pills

equally to all users, as they have differing drug tolerance levels; Thus, there will continue to be hospitalizations and health care costs resulting from drug use. These costs to the individual and to society, however, must be balanced with the goal of inducing a vast majority of drug users to participate in the registry, which would mandate the incentive of a higher limit so that the users can still get their fix. In the worst-case scenario, where the daily allotment causes a user to enter a hospital, the government at least then has the opportunity to attempt to get her into the rehabilitation system.

Finally, the NRDR would apply a sliding scale for combinations of various drugs under this regulatory scheme. For instance, if a user wants a speedball, a cocaine-heroin mix,¹⁶⁹ she would not be able to buy the maximum amount of each drug, but rather only the appropriate pre-hospitalization dosage relevant to the specific combination.¹⁷⁰ The sliding scale would also prescribe different cutoffs based on weight, gender, amount of recent use, and other factors that might affect drug tolerance. Based upon the amount given, the NRDR might also consider dispensing an appropriate amount of naloxone, a specific opiate antagonist with no agonist properties and no euphoriant potential which emergency rooms routinely use to reverse the effects of opiate overdose.¹⁷¹

C. EMPLOYMENT SAFEGUARDS-NOTIFICATION AND MANDATORY TESTING

While this registry may reduce harm to drug users, it does not necessarily reduce any of the harm to society, nor does it attach much stigma to drug use, which might facilitate the growth of the drug-using popula-

and heroin within 12 hours of each other. Finally, according to the Department of Alcohol and Drug Programs (ADP), heroin is more potent now than in the past and this increased potency (up to 80% today) can contribute to overdose deaths. In addition, no one tests the purity of street drugs. Users risk a surprise in the drug's potency or the presence of an unexpected contaminant as drug purity varies greatly. According to the ADP, street heroin overdoses increase exponentially when purer heroin becomes unexpectedly available. Department of Drug and Alcohol Program, Overdose Intervention, http://www.adp.cahwnet.gov/OARA/pdf/overdose_interventions.pdf (last visited Oct. 3, 2006).

¹⁶⁹ Urbanictionary, Speedballing, <http://www.urbandictionary.com/define.php?term=speedballing> (last visited, Oct. 3, 2006).

¹⁷⁰ Additionally, combinations of drugs not discussed in this paper, such as PCP, methamphetamine, and ecstasy would be included as well.

¹⁷¹ Drug Policy Alliance, DPA Participates in LA Overdose Prevention Summit, <http://www.drugpolicy.org/news/032306od.cfm> (last visited Oct. 3, 2006). An encouraging preliminary report on home naloxone programs in Germany and in England. Early reports was encouraging in finding 10% of distributed naloxone had saved lives and no adverse effects had been reported. New Mexico has also recently adopted legislation allowing the distribution of home naloxone and has given more public safety personnel the power to use it, and doctors in northern New Mexico have already begun to distribute it with state sanction. Karl A Sporer, Strategies For Preventing Heroin Overdose, *BMJ*, 2003 February 22, 442-444, <http://www.pubmedcentral.gov/articlerender.fcgi?tool=pubmed&pubmedid=12595388%20#B30>.

tion. This will be especially problematic for employers who may be subject to liability for their registered workers' actions (particularly those that require their workers to function at extremely high levels in life-and-death situations such as transportation companies, hospitals, and manufacturing plants with dangerous machinery). Even now, employers are sometimes held responsible for having the bad judgment to hire an illegal drug user.¹⁷² Once heroin and cocaine are legalized, employers will be more severely penalized for their lack of awareness regarding their employees' drug habits. One possible remedy is to allow certain employers to access the registry, which will function much like New York's Sex Offender Registry, so that they can avoid hiring recreational drug users for certain professions.¹⁷³ This remedy, however, would pose an ideological and practical problem. Ideologically, if the goal of legalizing drugs is to reduce the stigma of criminalization and to move society toward a public health perspective, then equating legal drug use with sex

¹⁷² Under federal law (OSHA) an employer has a duty to maintain a workplace "free from recognized hazards that . . . cause death or serious physical harm to its employees." In addition, judges have found for plaintiffs in similar situations in negligent hiring suits. In *Or v. Edwards*, 62 Mass. App.Ct. 475 (2004), a landlord was held civilly liable for the negligent hiring of a drug user in a wrongful death action. The court found the landlord negligent for hiring as a custodian and entrusting apartment keys to a "a jobless, homeless drifter with an alcohol addiction probably compounded by a drug habit". *Id.* at 482. After smoking \$300 worth of coke, unidentified amounts of pot, and drinking a forty or more of beer, the custodian subsequently kidnapped, raped, and murdered a five-year-old girl, which the court found to be a foreseeable consequence of landlord's failure to make inquiry. *Id.* Federal laws, in certain instances like the Omnibus Transportation Employee Testing Act go even farther. This law mandates that businesses must drug test holders of CDLs (commercial driver's licenses) and persons in safety-sensitive jobs or risk denial of insurance claims and litigation alleging negligent hiring, failure to take corrective action, and entrusting an unfit employee with the means of harming others. Among those who must be drug tested are part-time, full-time or temporary employees with CDLs; truck and bus drivers; railroad and airline employees; and employees of federal, state and local governments, schools, public works, utilities, churches and civic groups who hold a CDL. However, the ADA imposes restrictions on what an employer may do with information on an employee's illegal use of drugs. An employee's "current" use of illegal drugs is not protected under ADA as a disability. However, a recovering or recovered addict is protected. Practice Risk Management, Employment Practices Liability, <http://www.pracrisk.com/visitor/G-19.html> (last visited Oct. 3, 2006).

¹⁷³ NY Correct § 168 (2006). Registered sex offenders in New York are classified by the risk of reoffense. A court determines whether an offender is a level 1 (low risk), 2 (moderate risk) or 3 (high risk) and whether the offender should receive the designation of a sexual predator, sexually violent offender or predicate sex offender. Level 1 offenders with no designation must register for 20 years. Level 1 offenders with a designation, as well as all level 2 and level 3 offenders must register for life. Members of the public may call an 800 information line to search the registry for a specific name with an address of any offender. However, members of the public can also search an online database by zip code to find the profile of a Level 3 offender, and local law enforcement agencies have the power to release information on sex offenders residing in the community to "entities with vulnerable populations related to the nature of the offense". NY Criminal Justice System, New York Sex Offender Registry Information Page, <http://criminaljustice.state.ny.us/nsor/index.htm> (last visited Oct. 3, 2006). In the interests of privacy, access to the NRDR will be limited to those employers who have a need for the information, but the delivery system and categorization by courts are useful concepts.

offenses (the most abhorrent crime in American society) fails to meet this goal.¹⁷⁴ Furthermore, stripping legal drug users of their privacy and allowing employers to discriminate against them seems like a major step backwards. Practically, if drug users do not believe that they can achieve the life that they want as a member of the registry, they will simply use the black market and not join the registry.

Finally, employers should not have access to this knowledge because they do not have current access to similar knowledge. Under this plan, the extracurricular use (non-work use) of drugs, hard or soft, should be considered just another “stress factor”, or external factor that creates stress for an employee and affects employee performance. Current legal “stress factors” that affect employee performance include: a partner’s infidelity, impending separation or divorce, a death or tragedy in the family, consistent alcohol use, a steep reduction in tobacco use, situational or chronic depression, sexual dissatisfaction or dysfunction, gender dysphoria or a “coming out” experience, a racist/sexist/ethnist/homophobic experience, Post Traumatic Stress Disorder resulting from a violent crime (such as a mugging or an instance of partner abuse), and, on the positive side, the planning and execution of a modern wedding, and birth of a child. As long as the broker is properly managing his funds, employers and clients do not have the right to know that his partner recently left him. Similarly, they do not have the right to know if the sous chef at Jean Georges does a line or two after work as long as the food quality remains intact.¹⁷⁵ Therefore, under this regulatory scheme, legal drug users need not notify their employers of their status.

Because the number of drug users might increase slightly at the beginning of legalization (before the new education and improved rehabilitation programs have had a chance to take effect), some employers will need a mechanism to prevent against worst-case scenarios such as a bus driver, high on crystal meth, crashing a school bus full of kids. To remedy this, employers must be able to utilize a reliable drug test that will alert them if their employees are using drugs in that moment. The current drug testing regimes is unable to test whether the user is actually high on the drug during work. Since drug use is legal under this regulatory scheme, employers can only concern themselves with actual intoxi-

¹⁷⁴ In upholding the Alaskan sex offender registry in *Smith v. Doe*, the Supreme Court acknowledged the public shame and humiliation suffered by registered sex offenders and the Internet’s limitless reach in propagating that shame, but dismissed it as a “collateral consequence of a valid regulation.” *Smith v. Doe*, 538 U.S. 84 (2003); Phil Reisman, *N.Y. Lawmakers Must Stop Sexual Predators*, J. NEWS, Jul. 1, 2006, <http://www.thejournalnews.com/apps/pbcs.dll/article?AID=/20050701/COLUMNIST08/507010364/1023/NEWS07>.

¹⁷⁵ Hence the lack of public uproar upon the “revelation” that drug use is, or at least was, rampant in most major restaurant kitchens. ANTHONY BOURDAIN, *KITCHEN CONFIDENTIAL: ADVENTURES IN THE CULINARY UNDERBELLY*, (Harper Perennial 2001).

cation at the workplace, and not a user's outside life. Current tests, like the hair follicle test, only measure whether a drug has been present in the user's system in the last three months.¹⁷⁶ Yet, the drug testing industry apparently has the ability to develop a current use test if given the incentive to do so.¹⁷⁷ Legalizing drugs would make previous drug testing processes outdated and, thus, provide the necessary incentive. The ideal test would establish a legal limit of the amount of drug that can be present in a user's body. This limit, similar to the Blood Alcohol Content limit, ensures a user's functions are not impaired to the extent that she is unable to competently complete her work. Although this limit should be based on scientific evidence, given the severity of cocaine and heroin, most employers, if not all, will likely establish a zero tolerance policy for drug intoxication at the office. Still, it is important to note that there is

¹⁷⁶ When an individual ingests drugs, they circulate in the bloodstream, which nourishes developing hair follicles. As a result, trace amounts of the target drug or drug metabolite remain in the hair follicle and become entrapped in the core of the hair shaft as it grows out. Generally, the drugs will appear in the hair approximately 5 days after use, and will continue to be detectable in new hair growth for several months. Since target drug or drug metabolite residues are chemically and structurally stable for a period of time, gas chromatography /mass spectrometry forensic laboratory testing for the presence of drugs at various levels in the hair shaft core can achieve highly accurate drug test results and provide a historical use record. Craig Medical, Personal Forensic Drug of Abuse Testing Service, http://www.craigmedical.com/Hair_Drug_Test.htm (last visited Oct. 3, 2006). Current tests do not measure current drug usage, as they all require a post-consumption period for the drug to be metabolized and excreted before testing can pick it up. Urine takes 6-8 hours, hair requires two weeks, and sweat, seven days. Wikipedia, Drug Test, http://en.wikipedia.org/wiki/Drug_test (last visited Sept. 26, 2006).

¹⁷⁷ Though this point remains conjecture, Valentine and Psaltis suggested use of fluorometric assay for detection of cannibinol (the active ingredient in marijuana) in saliva as a correlate of current use, and also suggested the possibility of breath testing. J.L. Valentine & Phillip Psaltis, *Detection of Marijuana Use in Human Saliva Using A Fluorometric Assay Based on Cannabinol Decomposition*, 12 *Analytical Letters* 855, 855-66 (1979); JL Valentine et al., *Detection of ?9-Tetrahydrocannabinol in Human Breath Following Marijuana Smoking*, 12 *ANALYTICAL LETTERS* 867, 867-80 (1979); V. Kircher & H. Parlar, *Determination of Delta 9-tetrahydrocannabinol from human saliva by tandem immunoaffinity chromatography—high-performance liquid chromatography*, 677 *J. CHROMATOGRAPHY B: BIOMED. APPLICATIONS* 245, 245-55 (1996). The ONDCP is particularly enthused about the prospect of current impairment saliva tests, suggesting that this method shows more promise in determining current use and impairment. ONDCP, Developing a Test Program, http://www.whitehousedrugpolicy.gov/publications/drug_testing/testing.html (last visited Oct. 3, 2006). Additionally, some experimental non-invasive current use systems such as the ADMIT SYSTEM (which measures brain waves) and the Veritas 100 Analyzer (which uses electrodes to measure the influence of specific drugs on the balancing mechanisms of the body), exist, but are remain uncommon and unexplored because of lack of demand. Australisian Centre for Public Research, Drug Driving, 20, <http://www.acpr.gov.au/pdf/ACPR56.pdf> (last visited Oct. 3, 2006); University Career Service, Campus to Career: Pre-employment Testing, <http://careers.unc.edu/yourjobsearch/campustocareer/testing.html> (last visited, Oct. 3, 2006). Hence, while it remains conjecture, drug testing is closer to creating a valid current use test than is generally thought.

no reliable evidence to prove that drug testing has reduced drug use on campus or in the workplace.¹⁷⁸

D. HEALTH INSURANCE CONCERNS

It would be unrealistic to expect health insurance providers to cover drug users without knowledge of their status as registry members. However, granting insurance providers access to registry information would allow them to raise premiums for drug users but would not allow them to discriminate against insuring the users. The possibility that users will have to pay higher premiums will not be enough to motivate them to return to the black market, because the pursuit of illegal drugs will still carry a much heavier risk than merely paying a higher insurance premium. In addition, many users will not even feel the economic brunt of this policy because their employers pay their insurance premiums.¹⁷⁹

After legalization, it is possible that actual drug use might slightly increase, with a consequent increase in drug-related healthcare. Skyrocketing healthcare costs, though, will not ensue because the number of users will not grow indefinitely, reducing the strain on the healthcare system. Since the registry will allow users to continue to hurt themselves without the stigma of criminal sanction, the number of users

¹⁷⁸ According to the two major studies that have been conducted on student testing, it doesn't actually reduce drug use. Ryoko Yamaguchi, Lloyd Johnston, and Patrick O'Malley from the University of Michigan (who also produce Monitoring the Future, the highly regarded annual survey of student drug use, whose numbers the White House regularly cites) published the first study in early 2003, which looked at 76,000 students in 8th, 10th, and 12th grades in hundreds of schools, between the years 1998 and 2001. The White House criticized the Michigan study for failing to look at the efficacy of random testing. So, Yamaguchi, Johnston, and O'Malley added the random element and reran their study, adding data for the year 2002. The follow-up study, published in late 2003, tracked 94,000 middle- and high-school students and reached the same results as the first with one major difference: in schools that randomly tested students, 12th-graders were actually more likely to smoke marijuana. This led the authors to conclude: "Of most importance, drug testing still is found not to be associated with students' reported illicit drug use—even random testing that potentially subjects the entire student body." Ryan Grim, *Blowing Smoke: Why Random Drug Testing Doesn't Reduce Student Drug Use*, SLATE Mar. 21, 2006, <http://www.slate.com/id/2138399/>. A comprehensive 1994 review of the scientific literature by the National Academy of Sciences stated, "Despite beliefs to the contrary, the preventive effects of drug-testing programs have never been adequately demonstrated. . . The data obtained in worker population studies do not provide clear evidence of the deleterious effects of drugs other than alcohol on safety and other job performance indicators." Even the Drug-Free America Foundation admitted on its Web site in 2002 that "Only limited information is available about the actual effects of illicit drug use in the workplace. We do not have reliable data on the relative cost-effectiveness of various types of interventions within specific industries, much less across industries. Indeed, only a relatively few studies have attempted true cost/benefit evaluations of actual interventions, and these studies reflect that we are in only the very early stages of learning how to apply econometrics to these evaluations." Jacob Sullum, *Urine — or You're Out*, REASON, Nov. 2002, <http://www.reason.com/0211/fe.js.urine.shtml>.

¹⁷⁹ This section assumes that a nationalized health care plan has not yet been created, and that most people depend on employer-based plans.

will grow. Three factors will stem this growth: (1) in lieu of criminal sanction, increased focus on and innovation in education and rehabilitation will provide the majority of the stigma against drug use, and as it improves, it will peel off potential and actual users; (2) there is a finite number of Americans interested in ingesting substances that they are aware will seriously screw up their lives; (3) the user population is continually decreasing as users overdose, and eventually that decrease will be larger than the influx of new users. Hence, the growth of user population after implementation should eventually plateau. The number of users will continue to shrink and one day, drugs will occupy a space similar to guns in the American psyche. At a gun show or even at Walmart, almost anyone can buy a gun (like a drug, a dangerous product that only adults can purchase) but most Americans choose not to do so in avoidance of its inherent risks.¹⁸⁰ In this way does the model hope to prevent an epidemic of addiction, and keep healthcare costs from rising significantly.¹⁸¹

E. MAINTAINING STIGMA: PENALTIES FOR EXTRALEGAL USE AND USE BY MINORS

Because the stigma of a criminal record and prison have been removed for minors, this new system must develop more creative ways to reduce drug use aside from increased education and rehabilitation efforts. To disincentivize drug use, minors who are caught possessing drugs will receive high fines, which can raise their car insurance rates, much like receiving a very large traffic fine. The courts responsible for adjudicating drug-related fines will resemble drug courts and emphasize rehabilitation for perpetual users as opposed to large fines. The courts will also make every effort to alert a minor's parents and school, when a fine has been issued. Minors, however, will only receive a limited expungement of their juvenile records. After several drug offenses, these non-criminal offenses will remain on a minor's records. Schools will be responsible

¹⁸⁰ Pro-gun magazine Reason admits only 39% of Americans keep a gun in the house. Reason, Gun Ownership: the Numbers, <http://reason.com/0105/sb-guns.shtml> (last visited Oct. 3, 2006) (citing Gallup Polls of 1,012 adults from August 29 to September 5, 2000; and 1,054 adults from February 8 and 9, 1999). Even before implementation, that number is almost five times the 8.1% of Americans that reported using a currently illegal drug in the past month (and six times the number of Americans that reported being current drinkers), seemingly suggesting that guns are more significant problems than drugs. Associated Press, *Report: Illegal Drug Use Up For Boomers*, MSNBC, Sept. 7, 2006. <http://www.msnbc.msn.com/id/14712630/> (last visited Oct. 3, 2006).

¹⁸¹ "It should be noted that there is no evidence that the low price of heroin (or cocaine) under legalization would lead users to consume ever-increasing concentrations of the drug until they died from an overdose. Historically, very few users with cheap and easy access to narcotics have done so, whether in 19th-century England or America, in Vietnam during the war, or among physicians and pharmacists at any time." Ostrowski, *supra* note 71.

for the creation of special probationary programs to assist minors involved in the rehabilitation process. Moreover, in one of the few remaining criminalized acts, sellers who sell to minors will receive large criminal penalties, and possible prison time, so as to emphasize the importance of keeping children away from heroin and cocaine.¹⁸²

The age of consent for drug use should be 18, not 21. The later age of consent for alcohol is a complete failure, as evidenced by rampant alcohol use and its importance in college social life.¹⁸³ Moreover, once a child moves out of his parents' house and can serve in the army, American society treats him as a thinking citizen who must take responsibility for his actions. Therefore, not only is the 21-year age limit hypocritical, it would also be vastly ineffective for this plan. Sending more sellers to jail and charging more fines are not the goals of harm reductive legalization. Unfortunately, if a minor is committed to trying drugs, he will. Nevertheless, if a minor is thinking about trying drugs, and can do so legally at 18 (as opposed to 21), he may wait until then, which will provide a greater opportunity for anti-drug education to succeed. Under this plan, the age of consent would be the same for all problematic substances (e.g. soft and hard drugs, alcohol, and cigarettes). The seriousness of heroin and cocaine, and possibly other drugs like LSD, PCP and speed,

¹⁸² Unauthorized (outside the system) sale to non-minors and unauthorized possession will result in incremental fines similar to those given to owners of unregistered cars. Sellers will receive higher fines than users because it is their actions that create the supply for the black market. However, the government will not spend much money on enforcement of these regulations (as opposed to those dealing with sale to minors).

¹⁸³ On April 9, 2002, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) released a groundbreaking report, "A Call to Action: Changing the Culture of Drinking at U.S. Colleges," outlining the problem of high-risk drinking on U.S. college and university campuses. Rather than defining the issue by examining the level of drinking among college students, the report focused on the detrimental and damaging consequences of high-risk drinking. It found that each year, 1,400 college students die from alcohol-related unintentional injuries and alcohol is involved in 500,000 unintentional injuries, 600,000 assaults, and 70,000 cases of sexual assault and acquaintance rape. Higher Education Center, NCCA College Drinking Report, <http://www.edc.org/hec/niaaa/report.html> (last visited, Oct. 3, 2006). Additionally, according to the NIAAA, there is evidence that more extreme forms of drinking by college students are escalating. In one study, frequent binge drinkers (which is typically defined as consuming five or more drinks in a row for men, and four or more drinks in a row for women) grew from 20 to 23 % between 1993 and 1999. College Drinking Prevention, High-Risk Drinking in College: What We Know and What We Need To Learn, http://www.collegedrink-prevention.gov/NIAAACollegeMaterials/Panel01/HighRisk_02.aspx (last visited Oct. 3 2006). Dr. Hoyt Alverson, an anthropology professor conducted a study, asking his undergraduate students to spend three years studying fellow students' social behavior at Dartmouth University. He found that alcohol was inextricably linked with social life on campus. In his study, he notes that first-year students especially fear being alone in their new environment, and drinking is simply the best and easiest way of "forming friendships, competing, blowing off steam . . . , hooking up, fitting in and getting ahead amongst one's peers," which causes heavy drinking to be "ritually scripted on campuses." Jonann Brady, *Binge Drinking Entrenched in College Culture*, ABC News, Sept. 7, 2005, <http://abcnews.go.com/GMA/Health/story?id=1085909>.

would be denoted by the disparity in the penalties for selling these drugs to minors as opposed to alcohol or marijuana.

Another interesting problem that this plan creates is its intersection with prescription drugs, specifically those related to cocaine and heroin, such as OxyContin, morphine, codeine, and Percocet. Although heroin and cocaine will be available, some users will likely prefer the effects of the softer prescription versions. The two issues that arise are the fear that users will stop going to their doctors and just self-medicate by getting prescription drugs from the registry, and that users who have previously taken these drugs using a prescription will become recreational users, because of the new source of availability. To encourage legitimate patients to see their doctors, as opposed to self-medicating, the federal government will install a price control in which the prices of these drugs sold by prescription will be significantly lower, possibly up to 15%-20%, than the same drugs sold recreationally through the registry. Additionally, the punishment for faking prescriptions will be severe so as to discourage those without prescriptions from getting the drugs for a cheaper price outside the registry. Thus, patients who actually want to get better will see their doctors and follow their prescriptions, because that will be cheaper than self-medicating. Nonetheless, because of the addictive power of these prescription opiates, even legitimate patients might become addicted during the course of their prescriptions.¹⁸⁴ Consequently, to reduce harm and prevent patients from transitioning from the end of their prescriptions to recreational drug use through the registry, the government will mandate that doctors may also have access to the registry, to check for the names of patients who were previously prescribed certain medications. If a person, having finished his course of medication, signs up for the registry, the doctor will be notified and will be required to schedule a conference to discuss rehabilitation options with the patient.

Finally, in imposing the previously discussed Millian scheme to reduce drug-related crime, any crime committed while under the effects of these dangerous drugs will be punished much more severely, more harshly even than the increase resulting from the use of alcohol in a sim-

¹⁸⁴ Even without blurring the lines between legal and illegal drugs, prescription drug abuse is already a problem. The 2005 Partnership Attitude Tracking Study (PATS), which was commissioned by the Partnership for a Drug-Free America, surveyed more than 7,300 teenagers in grades 7-12. It found that 19 % of teens (4.5 million) have tried prescription medication (pain relievers such as Vicodin and OxyContin or stimulants like Ritalin and Adderall) to get high. 10 % of teens (2.4 million) report abusing cough medicine to get high; and abuse of prescription and over-the-counter medications is equivalent or greater than the abuse of illegal drugs such as Ecstasy (8 % of teens), cocaine/crack (10 % of teens), methamphetamine (8 % of teens) and heroin (5 % of teens). PNN Online, *Study Says Prescription Drug Abuse "Normal" for Teens*, <http://pnnonline.org/article.php?sid=6729> (last visited Oct. 3, 2006).

ple traffic violation.¹⁸⁵ Public use of these drugs will also be forbidden (users must consume their drugs in private residences), and a user who violates this regulation will incur a fine similar to that resulting from a public intoxication conviction. In addition, semi-public establishments that tacitly allow individuals to flout this regulation will receive hefty fines, equivalent to those incurred for violating New York City's smoking ban.¹⁸⁶

F. ADMINISTRATION

The creation of the registry will require the creation of a large bureaucracy to ensure that the identification checking system is efficient. Moreover, given that there will be no need for the majority of the Drug Enforcement Agency, a small portion of their budget should fund the creation of the registry.¹⁸⁷ Since a dispensary system has never been attempted on a national scale, the government should establish certain baselines of competence, but should give them a certain amount of freedom to adapt to their localities. Dispensaries should be allowed to set their own hours, according to profit margin, safety concerns, or other factors they deem relevant. The dispensaries may (but are not mandated to) adopt the bartender model of "cutting off," before they reach their personal allowable amount, customers who are incapable of controlling themselves. The individual dispensaries can initially decide which safety measures to implement, such as employing bouncers, installing bullet-proof glass enclosures for the dispensers, or providing aftercare programs. If the crime rate increases, the government must also have the ability to step in and mandate certain protections. The government should also pledge money to at least three future studies (five, ten, and fifteen years from the date of implementation) on the status of dispensary customer-related crime and its prevention.

¹⁸⁵ Mill acknowledges that drunkenness tends to encourage those who already possess a criminal mind to harm others, but he argues that the solution is not to ban liquor, but to increase the penalties for committing crimes while intoxicated. Mill, *supra* note 19.

¹⁸⁶ City and county officials can levy fines of up to \$1,000 per smoking ban violation, and state enforcement officials have a cap of \$2,000 per violation. New York Department of Health, A Guide for Employers to New York State's Clean Indoor Air Act, http://www.health.state.ny.us/nysdoh/clean_indoor_air_act/pdf/employers.pdf (last visited Oct. 3, 2006).

¹⁸⁷ In 2005, the DEA spent \$431.8 billion on interdiction (without taking into account investigations, intelligence, and state and local assistance) and only \$5.5 billion on treatment (down more than a billion from the previous year). <http://www.whitehousedrugpolicy.gov/news/testimony05/051005>. Hence, without interdiction, there will be ample money to fund treatment, education, and the creation of the registry.

G. ADVERTISING

This new scheme also addresses the supply-side of drug use, specifically controls on advertising and production quality. For recreational drugs to be available through licensed sellers, such as pharmacies and specially-created dispensaries, corporations and small businesses must have a financial incentive to produce them, and must be able to get their brand into the market through advertising. Heroin and cocaine, however, are extremely addictive, and as a result the government does not want to promote the industry. The government will likely enact legislation to handicap the recreational drug industry, because it is confident that the product will sell itself. Recreational drug advertising will be banned during primetime and will only be legal at night, similar to advertising for "Girls Gone Wild."¹⁸⁸ To cripple the industry at the outset, the government will force corporations who want to buy a license for the production and distribution of recreational drugs to agree to donate a certain amount of their profits to counter-advertising programs, similar to the anti-smoking "www.thetruth.com," and to rehabilitation programs.¹⁸⁹

¹⁸⁸ A state government can place restrictions on commercial speech, but rarely bans. As recounted in 2005 in Tennessee Attorney General Opinion No. 05-040, in commercial speech jurisprudence, and especially in *44 Liquormart, Inc. v. Rhode Island*, 517 U.S. 484 (1996), outright bans on the public dissemination of truthful and non-misleading information, related to the availability and prices of alcoholic beverages, are unlikely to withstand a First Amendment challenge. Furthermore, it appears that the state interest in promoting temperance is not enough by itself to persuade a court to uphold a ban on alcohol advertising. Unless another real state interest can be identified, and unless there is a strong showing that the ban actually promotes such an interest, it is unlikely that any outright ban on liquor advertising will be upheld. However, a law restricting the content of television and radio advertising without banning it (such as Tennessee Alcohol Beverage Commission Rule 0100-1-.01(3)(a)) might withstand a First Amendment challenge. Paul G. Summers, Att'y Gen, TN, The Constitutionality of Alcoholic Beverage Commission, Rules 0100-1-.01(3)(a), 0100-3-.04(2) and 0100-3-.04(3)(b), <http://www.attorneygeneral.state.tn.us/op/2005/OP/OP40.pdf>. Hence, it is likely that as long as the corporations have some ability to get their message out and exercise their First Amendment rights, any laws restricting the "time, place, and manner" of their speech will probably be deemed reasonable for problematic substances,

¹⁸⁹ In November 1998, the attorneys general in 46 states and five U.S. territories signed with Master Settlement Agreement with the tobacco industry. This agreement resolved all of the individual state lawsuits, and provided funding to the states to compensate them for taxpayer money spent on patients and family members with tobacco-related diseases. The agreement required the tobacco companies to stop using billboard advertising, to make most of their internal documents available to the public, and to not target youth in the advertising, marketing, or promotion of their products. It also required the tobacco industry to create and directly fund the American Legacy Foundation (which is the parent company of the www.thetruth.com), which works to counter the use of tobacco. See American Legacy Home Page, <http://www.americanlegacy.org> (last visited Oct. 3, 2006). In order to improve this plan's political feasibility, it is important that these profits are not simply given only in a block grant to a www.drugtruth.com program, but that they are also divided up into individual grants to local rehabilitation programs. A legislator, armed with a local cash infusion, will have an easier time presenting this plan to his constituents, and will increase the chances for legislative success.

The government's goal is to hold these corporations responsible for the social costs of their products and not let them treat these costs as externalities.

H. QUALITY CONTROL

To meet its goal of preventing individuals from overdosing, the harm reductive legalization model must provide a mechanism to regulate the ingredients and potency of the drugs available at the registry. Currently, to approve a legal drug, a pharmaceutical company must submit applications to the FDA and conduct clinical trials over the course of several years.¹⁹⁰ All active ingredients of a drug must be identified, and its exact potency must be determined. The harm reductive legalization model can adopt this FDA approval process with several changes. Before approval, an FDA review team —medical doctors, chemists, statisticians, microbiologists, pharmacologists and other experts — evaluate evidence of the drug's "safety" and "effectiveness".¹⁹¹ A drug is safe if its benefits appear to outweigh its risks, and a drug is effective if it works in people who have a certain disease or condition.¹⁹²

In the case of illegal drugs, such as heroin and cocaine, the safety and effectiveness balancing analysis seems to miss the mark, because the risks of these drugs will almost always outweigh their benefits. Therefore, the FDA should draw from its approach to food products, and mandate that a product be labeled truthfully, without forcing that product to include any health benefits.¹⁹³ The FDA approval processes will then serve as a check to ascertain that drug manufacturers actually produce and label what they claim to, giving registry members the opportunity to

¹⁹⁰ A drug sponsor first files an Investigational New Drug Application (IND) which must show the FDA results of pre-clinical done in laboratory animals and what the sponsor proposes to do for human testing. The FDA and a local Institutional Review Board (IRB), a panel of scientists and non-scientists in hospitals and research institutions that oversees clinical research, decide whether it is reasonably safe to move forward with testing the drug on humans. Four phases of clinical trials ensue using both healthy and sick volunteers to test the drug's safety and effectiveness in different populations and the effects of different dosages and of different combinations with other drugs. After clinical testing, the drug sponsor files a New Drug Application (NDA), the formal step asking that the FDA consider approving a new drug for marketing in the United States. An NDA will include all animal and human data and analyses of the data, as well as information about how the drug behaves in the body and how it is manufactured. If the FDA decides that the benefits of a drug outweigh the risks, the drug will receive approval and can be marketed in the United States. But if there are problems with an NDA, the FDA may decide that a drug is merely "approvable" (which will make approval contingent on the amelioration of several issues) or "not approvable." Michelle Meadows, *The FDA's Drug Review Process: Ensuring Drugs are Safe and Effective*, http://www.fda.gov/fdac/features/2002/402_drug.html (last visited Oct. 3, 2006).

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ FDA, *A Food Labeling Guide*, <http://www.cfsan.fda.gov/~dms/flg-5-1.html> (last visited Oct. 3, 2006).

make an informed decision when purchasing their drugs at the dispensary.

The volunteer pool used in the clinical trials will present another inherent challenge. While a healthy volunteer cannot be given an addictive drug simply for the sake of testing, clinical testing performed solely on current users will likely yield skewed results on the existence of side effects, given the probability of already existent health issues. Additionally, after further studies on the actual causes of overdose and their relationship to heroin potency, the FDA will have the power to determine which concentrations of the drugs are safest to offer to the public.

I. RENEWED EMPHASIS ON DRUG EDUCATION AND TREATMENT

The linchpin to the success of harm reductive legalization model is a renewed emphasis on drug education and rehabilitation programs. This model focuses on reducing the secondary effects that stem from criminalization, and remedying the problems the NRDR creates for various societal institutions. Non-criminal adult drug users are left to fend for themselves, even as they ingest dangerous substances. Moreover, removing the stigma of criminalization through legalization may create a short-term bump in the number of drug users. Law abiding citizens who previously refrained from using drugs may choose to indulge, and possibly overindulge. Therefore, a renewed commitment to rehabilitating addicted users and educating potential users is essential to the model's success.

Current drug rehabilitation programs are effective. Research indicates that drug-involved offenders who were treated in prison and after release are more likely to stay drug-free and arrest-free than those who received no treatment.¹⁹⁴ However, because of the societal focus on incarceration as opposed to treatment, there are not enough rehabilitation programs to meet the massive demand. As a result, many users who need treatment do not receive it.¹⁹⁵ Depending on the type, treatment costs between one-fourth and one-sixteenth the price of incarceration per inmate.¹⁹⁶ Under this model, in a post-criminalization society where

¹⁹⁴ Jeremy Travis, *But They All Come Back: Rethinking Prisoner Reentry*, SENTENCING & CORRECTIONS 7 (May 2000).

¹⁹⁵ 70% to 85% of offenders in state prisons need drug treatment; however, just 13% receive it while incarcerated according to the ONDCP. Joan Petersilia, *When Prisoners Return to the Community: Political, Economic, and Social Consequences*, Sentencing & Corrections 9, (Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of U.S. Department of Justice, November 2000)

¹⁹⁶ Between 1996 and 1999, the Substance Abuse and Mental Health Services Administration (SAMHSA) found the average cost of an outpatient methadone program to be \$7,415/admission (an average stay lasting 520 days), the average cost of an outpatient non-methadone program to be \$1,433/admission (an average stay lasting 144 days), and the average cost of a non-hospital residential program was \$3,840/admission (an average stay lasting 45 days). U.S.

users are not incarcerated, the government will save billions of dollars, and if even a tenth of the surplus was pledged to create new rehabilitation programs, the number of successful graduates could be staggering.

But if adult drug use is no longer a crime, how do addicted users enter the rehabilitation system aside from voluntary commitment? If a defendant is convicted of committing a crime on drugs, the judge should have the ability to mandate a long rehabilitation sentence, as opposed to or in addition to a heightened criminal sentence, to get the user into the system. However, critics of coerced treatment argue that it is ineffective to mandate a long rehabilitation sentence, because an addict's desire to change is the most important factor in the success of rehabilitation.¹⁹⁷ An alternative to long mandated rehabilitation stints would be an adaptation of UCLA professor Mark Kleiman's strategy of "coerced abstinence."¹⁹⁸

Finally, to encourage drug users to rehabilitate, we must ensure that rehabilitated drug users will not be discriminated by others, especially their employers. For example, under the Americans with Disabilities Act, employers may not discriminate against drug addicts who are currently enrolled in a rehabilitation program and must extend reasonable accommodation efforts (such as allowing time off for medical care, self-help programs, and etc.) to rehabilitated drug addicts or individuals undergoing rehabilitation.¹⁹⁹ In practice, however, employers are able to exploit loopholes, and rehabilitated users often lose their jobs. One solution might be to offer tax breaks to companies that guarantee job security for long periods of time and offer comprehensive services to help recovering addicted users transition back into the workforce.

Current drug education programs are ineffective. Today's adolescents have been exposed to the most intensive and expensive anti-drug campaign in history, the cornerstone of which was the Drug Abuse Re-

Dep't. Health and Human Services, Alcohol and Drug Services Study (ADSS) Cost Study, The DASIS Report, June 18, 2004, <http://www.oas.samhsa.gov/2k4/costs/costs.pdf>. In 1997, the national average annual cost of incarceration was \$25,900/year. Physician Leadership on National Drug Policy, Position Paper: On Drug Policy, http://plndp.org/Physician_Leadership/Resources/researchrpt.pdf.

¹⁹⁷ Maia Szalavitz, *Coerced Treatment: Too Many Steps in the Right Direction*, Alternet, Sept. 4, 2001, <http://www.alternet.org/story/11425/>.

¹⁹⁸ In a coerced abstinence program, offenders convicted of drug-related petty crime are sentenced to intensive probation, primarily frequent drug-testing. With each positive test, they face swift, sure consequences — rapidly increasing sanctions, up to a day or two in a treatment facility, isolated from participating users (so as to not affect their enthusiasm for the program). Behavioral research shows that immediate penalties are far more likely to change behavior than the far-off possibility of a long, harsh sentence. After a few rounds of sanctions, people who thought they could quit on their own realize that they can't — and are more likely to seek help. Treatment is made easily accessible at the first sign of interest. *Id.*

¹⁹⁹ U.S. Dep't of Labor, ADA & Rehabilitation Act, <http://www.dol.gov/asp/programs/drugs/workingpartners/regs/ada.asp> (last visited Oct. 3, 2006).

sistance Education (“DARE”) program.²⁰⁰ Yet, in study after study, DARE failed to change its graduates’ drug use behavior or attitude towards drugs.²⁰¹ According to the most recent *Monitoring the Future* survey, 51% of high school seniors have already experimented with illegal drugs, 39% had used a drug in the past year, and 24% had used a drug in the last month.²⁰²

These alarming results stem from various problems with current drug education programs. Often, drug education programs do not target highest-risk teens; instead, they use a “one size fits all” approach.²⁰³ Existing programs focus only on drug abstinence and rely on resistance or refusal skills to peer pressure (such as DARE’s ubiquitous “Just Say No!” slogan). This approach is problematic because it mistakenly assumes that peer pressure is the primary cause of all drug use;²⁰⁴ that the majority of people don’t use drugs; that abstinence is the social norm; and that it is socially acceptable to refuse drugs.²⁰⁵ Moreover, this approach also ignores teens’ exposure to drug use and fails to engage them in a meaningful way.

Drug educators lose their credibility when they offer students mixed messages,²⁰⁶ fail to differentiate between use and abuse,²⁰⁷ and use scare

²⁰⁰ Marsha Rosenbaum, *Safety First: a Reality-based Approach to Teens, Drugs, and Drug Education*, <http://www.safety1st.org/pdf/safetyfirst.pdf> (last visited Oct. 3, 2006).

²⁰¹ *Let’s Talk: A Video for Adults about Teens and Drug Education*, prod. and dir. M. Lange, 13.5 min., Street Media Inc., 1999, videocassette; Dawn MacKeen, *Just Say No to Dare*, SALON, Feb. 16, 2001, <http://archive.salon.com/mwt/feature/2001/02/16/dare/index.html>.

²⁰² *Monitoring the Future Home Page*, <http://www.monitoringthefuture.org> (last visited Oct. 3, 2006).

²⁰³ An alternative would be to design programs that would appeal more directly to high-risk teens. Hence, if one of the individual risk factors for drug use is high-sensation seeking, the style of the program must reflect that concern. MacKeen, *supra* note 202.

²⁰⁴ Don Lynam, of the University of Kentucky, concluded in a study of DARE graduates that, “DARE’s longtime target of intervention has been peer pressure resistance. But the image you get from that is that good kids use drugs because bad kids pressure them. I think kids use drugs because they’re available and kids are curious. It’s not the case that there are all these bad kids lurking around in the corners, trying to get the good kids to try drugs. DARE may be targeting the wrong mechanism.” MacKeen, *supra* note 202.

²⁰⁵ Rosenbaum, *supra* note 200, at 6.

²⁰⁶ Mandating zero-tolerance in these programs conflicts with the generally accepted pop-culture messages encouraging them to imbibe and medicate with alcohol, tobacco, caffeine, and over-the-counter and prescription drugs. *Id.* at 8. Today’s teens have also witnessed the “Ritalinization” of their fellow difficult-to-manage students, casting even more doubt on zero-tolerance. B. Knickerbocker, *Using Drugs to Rein in Boys*, THE CHRISTIAN SCIENCE MONITOR, 19 May 1999: 1.

²⁰⁷ Adults have the ability to differentiate between use and abuse, and young people learn these skills rapidly while watching their parents use alcohol without abusing it. Programs that blur these distinctions run counter to students’ own experiences and tend to undermine the whole drug education program. As one 11th-grader in Fort Worth, TX put it, “They told my little sister that you’d get addicted to marijuana the first time, and it’s not like that. You hear that, and then you do it, and you say, ‘Ah, they lied to me.’” M. Taylor and Y. Berard, *Anti-*

tactics and misinformation (including the “gateway theory” of marijuana).²⁰⁸ Students, having discovered this deceit, often completely “turn off” and miss the valuable information that drug educators have to offer. In addition, most drug education programs begin and end with abstinence, and do not teach teens how to avoid problems or prevent abuse among those teens who experiment.²⁰⁹

Marsha Rosenbaum, PhD, working for the Drug Policy Alliance, has proposed an alternative model, the Safety First program. This program emphasizes abstinence while teaching harm reduction techniques as a fallback strategy that puts “safety first”, and has changed the way many school districts approach drug education.²¹⁰ Rosenbaum states that:

Educational efforts should acknowledge teens’ ability to sort through complex issues and make decisions that ensure their own safety. The programs should offer credible information, differentiate between use and abuse, and stress the importance of moderation and context. Curricula should be age-specific, stress student participation, and provide objective, science-based materials.²¹¹

In the Safety First program, drug education is comprehensive and ongoing, and is woven into various subjects, including biology, psychology, chemistry, history and government. The program is also available in after-school programs as opposed to in stand-alone courses.²¹² While teens have not matured intellectually, they are capable of rational thinking and careful decisions about drug abuse.²¹³ To be effective, drug edu-

drug Programs Face Overhaul, FORT WORTH STAR-TELEGRAM, 1 Nov. 1998: 1. Most importantly, the vast majority of students who try drugs do not become abusers. D.F. Duncan, *Problems Associated with Three Commonly Used Drugs: A Survey of Rural Secondary School Students*, PSYCHOLOGY OF ADDICTIVE BEHAVIOR 5.2 (1991): 93-96.

²⁰⁸ Educators often exaggerate the risks of drugs, particularly marijuana, in order to promote drug abstinence. When the students realize that they received misinformation about the myriad of harms caused by marijuana (none of which can be supported scientifically) or the myth that marijuana is a “gateway drug” to other harder substances (which has been refuted by the National Survey on Drug Use and Health, the American Journal of Public Health, and the Institute of Medicine), they tend to assume that all of drug education relies on the same dubious science. Rosenbaum, *supra* note 200, at 11; L. Zimmer and J.P. Morgan, MARIJUANA MYTHS, MARIJUANA FACTS: A REVIEW OF THE SCIENTIFIC EVIDENCE (New York: The Lindesmith Center, 1997); A. Golub and B. Johnson, *Variation in Youthful Risks of Progression from alcohol/tobacco to marijuana and to hard drugs across generations*, AM. J. OF PUB.HEALTH 23.2 (2001): 225-232.

²⁰⁹ Rosenbaum, *supra* note 200, at 12.

²¹⁰ More than 145,000 copies of the Safety First booklet (the 1999 version) have been distributed to individuals and educational, health, governmental institutions across the country. *Id.* at 4-5.

²¹¹ *Id.* at 5.

²¹² *Id.* at 14.

²¹³ *Id.* The 2002 National Survey on Drug Use and Health found that though experimentation was widespread, 88% of 12-17 year olds refrained from regular drug use. D. Moshman,

cation programs must be based on sound science and must acknowledge a teen's intelligence and ability to understand, analyze, and evaluate her options.²¹⁴ It must also distinguish between use and abuse, specifically discouraging use of intoxicants at school, at work, while participating in sports, or while driving.²¹⁵ Finally, alongside the abstinence program, programs informing teens of safer ways to use drugs must be included as a fallback strategy.²¹⁶

CONCLUSION

In conclusion, United States' current criminalization scheme creates greater social harm than that of drug abuse, which it sets out to mitigate. Given an American society committed to the ideas of positive and negative liberty, a new scheme is needed to solve the drug abuse problem. Although several alternatives to criminalization have been proposed (libertarian legalization, full and partial decriminalization, the medical and prescription models, harm reduction), each of them fails to address all of the complex issues involved in drug policy. For that reason, this Note proposes that the United States adopt the harm reductive legalization policy. Harm reductive legalization is a hybrid of harm reduction and legalization, in which drug users are allowed to join the National Recreational Drug Registry, which monitors their drug intake. This plan recognizes and accepts the facts concerning drug use, and it attempts to provide for the safety and desires of both the users and the society, even though they often conflict with one another.

Finally, this Note is simply an attempt to think "outside the box" in an attempt to identify a successful proactive drug policy. Otherwise, our drug policy will remain reactive, and our hegemony over international drug policy will continue to fade, as it has in Mexico and Bolivia.²¹⁷ It is

ADOLESCENT PSYCHOLOGICAL DEVELOPMENT: RATIONALITY, MORALITY AND IDENTITY, (Mahwah, NJ: Lawrence Erlbaum Associates, Inc., 1999); M.J. Quadrel, B. Fischhoff and W. Davis, Adolescent (in)vulnerability, *AMERICAN PSYCHOLOGIST*, 48.2 (1993): 102-116.

²¹⁴ *Id.*

²¹⁵ Rosenbaum, *supra* note 200, at 15.

²¹⁶ The success of this fallback strategy should resemble the path of sexuality education, which moved away from an abstinence-based platform to emphasize safer sex in order to stop the spread of STD's. According to the Centers for Disease Control, this approach has led to increased condom use among sexually active teens, and a decrease in sexual activity overall among teens. L. Kann et. al., *Youth Risk Surveillance Behavior* – United States, 1999, *MORBIDITY AND MORTALITY WEEKLY REPORT* 49.SS05 (9 June 2000): 1-96.

²¹⁷ In December 2005, Bolivia elected President Evo Morales, a former *cocalero* himself, who has pledged to normalize coca production in a country where it has a long history of traditional use. "Never, never will there be coca zero . . . But neither can there be unrestricted cultivation," said Morales at a news conference, draped in coca leaf necklaces. Stopthefwar.org, Latin America: Bolivian President Wins Voluntary Limits on Coca Production, <http://stopthefwar.org/chronicle-old/437/cocalimits.shtml> (last visited Oct. 3, 2006). More recently, on April 29, 2006, the Mexican Congress decriminalized possession small

important to note that the author does not expect the proposed reforms to be implemented in the near future, or even necessarily within his lifetime, because our society is not ready for this radical plan. Nonetheless, if this model serves as a launching point for a dialogue on drug legalization, then it will have achieved its purpose.

amounts of marijuana, opium, heroin, cocaine. LSD, hallucinogenic mushrooms, amphetamines, and peyote for personal use. Reuters, *Drug legalization nears in Mexico*, THE BOSTON GLOBE, Apr. 29, 2006, http://www.boston.com/news/world/articles/2006/04/29/drug_legalization_nears_in_mexico/. However, at the last minute, President Vicente Fox refused to sign the bill into law, supposedly as a result of U.S. pressure. Sam Enriquez, *Fox Decides Not to Sign Drug Legalization Bill*, L.A. TIMES, May 4, 2006.