Toward a Public Health Approach to Drug Policy

Alex Kreit*

I. INTRODUCTION

Nearly 40 years after President Richard Nixon signed the Controlled Substances Act into law and subsequently declared a "war on drugs," it is difficult to describe our drug policy as anything other than a failure. Despite an annual federal budget of over $13 billion—a number that does not include the costs of housing inmates who have been convicted of a drug offense—our drug control strategy appears to have had little impact on drug use rates or drug availability. Nearly half of high school seniors have used an illegal drug by the time they graduate,[1] more kids say it is easier for them to buy marijuana than alcohol,[2] and a 2008 World Health Organization (WHO) study of 17 countries found that the United States had the highest rates of illegal drug use.[3] Indeed, the WHO study presents a particularly vexing challenge to the efficacy of the United States' approach to drug policy. Among the report's findings was that the percentage of people who have used marijuana in America is more than double that in the Netherlands—42.4% to 19.8%.

Meanwhile, our punitive approach to drug policy has been a leading cause of the explosion in our prison population. In the last 20 years alone, the national prison population has nearly tripled, giving the United States the world's highest reported incarceration rate.[4] And, of the 2.3 million Americans in prison, approximately one quarter are there because of a drug offense. To put that in perspective, the number of Americans incarcerated for drug offenses today is larger than the entire United States prison and jail population was in 1980.[5]

---

* Assistant Professor and Director of the Center for Law and Social Justice at Thomas Jefferson School of Law.

[1] L.D. JOHNSON ET AL., NAT'L INST. ON DRUG ABUSE, MONITORING THE FUTURE: NATIONAL SURVEY RESULTS ON DRUG USE 1975-2007, at 102 Tbl.4-1a, *available at* http://www.monitoringthefuture.org/pubs/monographs/vol1_2007.pdf.

[2] NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE, NATIONAL SURVEY OF AMERICAN ATTITUDES ON SUBSTANCE ABUSE XIII: TEENS AND PARENTS 17 Fig.3.P, *available at* http://www.casacolumbia.org/articlefiles/380-2008%20Teen%20Survey%20Report.pdf (showing 23% of teens say marijuana is the easiest drug for them to buy while only 15% say beer is).

[3] Louisa Degenhardt et al., *Toward a Global View of Alcohol, Tobacco, Cannabis and Cocaine Use: Findings from the WHO, World Mental Health Surveys*, 5 PLOS MEDICINE 1053, 1057 Tbl.2 (2008) (hereinafter "WHO Survey"), *available at* http://medicine.plosjournals.org/archive/1549-1676/5/7/pdf/10.1371_journal.pmed.0050141-L.pdf.

[4] THE PEW CTR. ON THE STATES, ONE IN 100: BEHIND BARS IN AMERICA 2008, at 5, *available at* http://www.pewcenteronthestates.org/uploadedFiles/One%20in%20100.pdf.

[5] The most recent statistics show that 504,646 Americans are incarcerated for a drug offense, while 501,886 Americans were incarcerated for all offenses in 1980. Moreover, the actual number of drug offenders incarcerated today is very likely higher than 504,646 because offense-specific data for jail inmates has not been released since 2002. *Compare* TRACY L. SNELL, DEP'T OF JUSTICE, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 1983, at 5 Tbl.1.1 (1995) , *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/cpop93bk.pdf *with* HEATHER C. WEST & WILLIAM J. SOBEL, DEP'T OF JUSTICE, PRISONERS IN 2007, at 21-22 Tbls. 10 & 12 (2008), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/p07.pdf *and* DORIS J.

In short, after four decades, it is becoming increasingly clear that our current drug control strategy has not worked. Despite spending more money and imprisoning more people in our drug control effort than most other nations, we have among the highest drug use rates in the world.

While criticism of our drug policies is nothing new, politicians have been reluctant to tackle the issue because the war on drugs was immensely popular during the 1980s and early 1990s. The perception that supporting any change in our punitive drug policies is politically risky persists today. As Senator Jim Webb, who recently called for a national commission to re-assess criminal justice policy, put it, "few candidates or elected officials these days even dare to mention the mind-boggling inconsistencies and the long-term problems that are inherent in [our criminal justice system]" because they believe that "to be viewed as 'soft on crime' is one of the surest career-killers in American politics."[6]

Contrary to the conventional wisdom, however, public opinion polls and election results reveal that there has been a dramatic—though largely unnoticed—shift in support of drug policy reform among voters over the past decade. Today, a full three quarters of Americans say that they think our "war on drugs" policy is failing, according to a 2008 Zogby poll.[7] Similarly, ballot initiatives to reform state drug policies have met with resounding success, beginning with California's medical marijuana initiative in 1996. Since that time, a total of 13 states have adopted medical marijuana laws, the most recent being Michigan, where the measure passed with 63% of the vote. And the trend extends beyond medical marijuana. In 2000, for example, California voters passed Proposition 36, which diverts many first- and second-time drug offenders to treatment instead of incarceration. In November 2008 in Massachusetts, Bay Staters voted by 65% to decriminalize marijuana. To be sure, support for the more controversial measures advocated by some drug policy reform advocates remains low. However, a substantial and growing majority of voters today favor commonsense reforms that would have been politically untenable during the height of drug war politics in the 1980s, such as legalizing medical marijuana or expanding treatment-based drug court programs.

As we approach the 40th anniversary of the "war on drugs" and await the confirmation of Gil Kerlikowske, President Barack Obama's pick for Director of the Office of National Drug Control Policy (ONDCP) (a position commonly referred to as the "Drug Czar"), now is an ideal time to reassess our drug policy. There is no magic bullet that can solve the problem of substance abuse. And it would take volumes to fully examine the shortcomings of our current strategy. There are, however, a number of readily identifiable reforms that can help begin to set us on the right track and build a foundation for more significant improvements in the future. This paper discusses some of the main flaws in our drug policy and examines a handful of specific policy proposals that would improve our strategy and put us on the path toward a more efficient and humane public health approach to drug abuse.

James, Dep't of Justice, Profile of Jail Inmates, 2002, at 4 (2004) *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/pji02.pdf.

[6] Jim Webb, A Time to Fight 216 (2008).

[7] Zogby Int'l, Likely Voters 9/23/08 thru 9/25/08, at 43-45, *available at* http://www.zogby.com/news/X-IAD.pdf.

II. AFTER NEARLY 40 YEARS, IT'S TIME FOR A NEW APPROACH

The guiding tenet of the "war on drugs" strategy has been that vigorous enforcement of uncompromising criminal justice measures is the most effective method to reduce drug abuse and associated problems. This philosophy has manifested itself in an almost singular focus on supply-side initiatives, including the mass incarceration of drug offenders at all levels of offense severity in an effort to deter domestic drug manufacture and distribution, along with a militaristic approach to eradicating drug production abroad, and interdicting drugs at the border. The theory is that these policies will help to "keep drugs off our streets," and thereby lead to a reduction in drug use and drug-related crime. Efforts aimed directly at demand reduction have largely followed the same approach by increasing the number of arrests for drug possession and addressing drug use and addiction problems primarily within the criminal justice system. Another key component of the overall strategy has been to strictly follow this criminal justice model for all drug types, and to resist tailoring the level of enforcement to each substance based on the harm it inflicts on society by, for example, shifting resources from enforcement of marijuana laws to other areas.[8]

By contrast, public health policies, such as drug treatment and prevention measures, have played a secondary role in our drug strategy. This has led, for example, to a dramatic gap in drug treatment with the Substance Abuse and Mental Health Services Administration estimating that in 2007 only 17.8% of persons who needed drug treatment received it, a number that has remained largely unchanged throughout the decade.[9] Indeed, drug war advocates have actually opposed some state-level treatment initiatives—particularly those that offer treatment as an alternative to incarceration or remove certain classes of drug offenders from the criminal justice system—on the grounds that they would send a "soft on drugs" message. Similarly, harm reduction measures such as needle exchange—policies aimed primarily at reducing the harms caused by drug abuse rather than limiting drug supply or demand—have by and large failed to gain traction at the federal level because they are viewed as incompatible with the zero tolerance philosophy of the war on drugs.

Though the war on drugs strategy has long been subjected to criticism as ineffective, its proponents have countered by pointing to temporary reductions in use rates or supply measurements for particular drugs during specific time periods and arguing that more resources and even tougher laws would yield sustainable results. A number of recent studies and reports, however, point to an emerging consensus among policy analysts and foreign leaders that after 40 years, the war on drugs has proven to be less effective than cheaper and more humane policies adopted by other countries. In addition to the WHO's 2008 study mentioned above, the past year alone has seen prominent reports by the Brookings Institute's Partnership for the America's Commission and the Latin-American Commission on Drugs and Democracy calling for a fundamental reassessment of the United States' drug strategy.

At the heart of this trend is mounting evidence that four decades of steadily intensifying drug war policies—including increased numbers of drug arrests

[8] For example, 79% of the 450,000 person increase in drug arrests in the United States during the 1990s was for marijuana possession offenses alone. DAVE BEWLY-TAYLOR ET AL., THE BECKLEY FOUND. DRUG POLICY PROGRAMME, INCARCERATION OF DRUG OFFENDERS: COSTS AND IMPACTS 2 (2005), *available at* http://www.beckleyfoundation.org/pdf/paper_07.pdf.

[9] SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2007 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS 83 (2008), *available at* http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf.

and incarcerations, drug seizures, and spraying of crops overseas—has had at most a negligible impact on illegal drug use and availability. The temporary reductions that have been cited as drug war "successes" have all proved to be unsustainable—more likely caused by normal fluctuations of cultural preferences in the way that taste in music or fashion might change than by our drug policies. With respect to drug use, the 2008 WHO study marked the first major cross-national comparison of illegal drug use rates in all regions of the world. The study found that the "United States stands out with higher levels of [drug] use . . . despite punitive illegal drug policies[.]"[10] The number of Americans who have used cocaine is approximately four times higher (at 16.2%) than in any other country. Among those aged 15 and younger, nearly three times as many had tried marijuana in the United States (20%) than in the Netherlands (7%). And the study indicated that the number of Americans using drugs is actually rising, with 54% of those 21 and younger having used marijuana compared to only 42% total. Overall, the researchers concluded, the findings revealed "countries with more stringent policies toward illegal drug use did not have lower levels of such use than countries with more liberal policies."[11]

The drug war has similarly failed to reduce drug supply. A 2008 Brookings report on U.S.-Latin American Relations described the results under a blunt heading: "the Failed War on Drugs." According to the report, "the street prices of cocaine and heroin fell steadily and dramatically" between 1980 and 2007 despite a significant increase in United States spending on overseas supply control over the same time period. Similarly, although we have recently seen record-breaking figures for drug eradication and drug seizures at the border, "cocaine production in the Andean region is currently at historic highs."[12] The Brookings report concluded that demand reduction is the only long-term solution to the problem of drug abuse and recommended, among other things, that the United States government undertake a comprehensive reevaluation of its drug policies.

Among recent studies of United States drug policy, however, the Latin-American Commission on Drugs and Democracy's February 2009 report is perhaps the most striking. The Commission was comprised of a blue-ribbon panel of experts from throughout Latin America and headed by three politically conservative former Latin American Presidents: Fernando Henrique Cardoso of Brazil, César Gaviria of Colombia, and Ernesto Zedillo of Mexico. It concluded that the war on drugs was a "failed war" that has led to an increase in organized crime and drug-related violence without reducing drug use or availability.[13] The Commission called for a paradigm shift in drug policy to an approach that focuses on demand reduction and "[c]hanges the status of addicts from drug buyers in the illegal market to that of patients cared for in the public health system."[14]

All told, indicators from drug availability to drug-related violence to drug use rates reveal that our current drug strategy is fundamentally flawed. Over the past 40 years,

---

[10] WHO Survey, *supra* note 3, at 1062.

[11] *See id.* at 1057 tbl.2, 1059.

[12] The Brookings Inst., Rethinking U.S.-Latin American Relations: A Hemispheric Partnership for a Turbulent World, Report of the Partnership for the Americas Commission 25-26 (2008).

[13] The Latin Am. Comm'n on Drugs and Democracy, Drugs and Democracy: Toward a Paradigm Shift 1 (2009), *available at* http://www.drugsanddemocracy.org/files/2009/02/declaracao_ingles_site.pdf (noting that after a decades-long war "[w]e are farther than ever from the announced goal of eradicating drugs").

[14] *Id.* at 4.

we have spent billions of dollars and imprisoned millions of follow citizens without any discernible benefit to show for it. The scope of this problem suggests that only significant change to our overall strategy will be able to address the drug war's failures. Assessing the various options for a shift of that magnitude is not feasible to do here. There are, however, a number of specific reforms that are likely to produce improved results while decreasing human and economic costs, and that can be implemented without altering the overall structure of federal drug laws. At the same time, these proposals can help lay the foundation for more fundamental change in the future by beginning to re-orient our drug strategy away from a "war" posture and toward a more effective and humane public health model. I examine these proposals in two sections. First, I will discuss ideas for reallocating funds in the National Drug Control Strategy from measures that have proven costly and ineffective to more successful programs. Second, I will explore some of the excesses of the drug war—laws that are not only ineffective but counter-productive and should be repealed or dramatically reformed.

III. REALLOCATING FEDERAL SPENDING

One of the most direct ways for the new Drug Czar to address some of the shortcomings of our current strategy would be to seek spending reallocations in President Obama's National Drug Control Policy budget request that would decrease funding for ineffective strategies and put the money toward successful treatment and prevention measures. Studies have consistently shown drug treatment and prevention programs to be more cost effective than interdiction, incarceration, and eradication programs. For example, a detailed study conducted by the RAND Corporation at the request of the ONDCP compared treatment with other strategies in the context of cocaine. The study found that each cocaine-control dollar used for treatment generates societal cost savings of $7.48, compared to savings of only 15 cents for every dollar used for source-country control, 32 cents for every dollar used for interdiction, and 52 cents for every dollar used for domestic law enforcement.[15] Yet, only 35% of the National Drug Control Policy budget goes toward treatment and prevention initiatives (a figure that includes treatment and prevention-related research) while 65% is put to supply-reduction measures, including domestic law enforcement, interdiction, and international programs.[16] Moreover, these numbers have been trending in the wrong direction, with spending on demand reduction falling steadily from 46% of the total budget in 2002.[17]

The new administration should reverse course by significantly reducing the percentage of resources allocated to supply reduction and increasing funding for demand reduction efforts. While a detailed account of all federal drug control spending is beyond the scope of this paper, a handful of key programs deserve particular attention both for their own importance and as an illustration of the type of funding reallocations the ONDCP should seek in future budget proposals.

---

[15] C. Peter Rydell & Susan S Everingham, Controlling Cocaine 42 (1994).

[16] The White House, National Drug Control Strategy, FY 2009 Budget Summary 11 (2008), *available at* http://whitehousedrugpolicy.gov/publications/policy/09budget/fy09budget.pdf.

[17] *Id*. at 13. Importantly, the cost of incarceration of drug offenders is not included in the National Drug Control Policy budget and, accordingly, not factored into these allocation percentages. If these costs were included, the percentage of resources directed toward supply-reduction would, of course, be even higher.

With respect to treatment and prevention initiatives, three stand out as examples of programs that should receive significant funding increases: (1) the Substance Abuse and Mental Health Treatment (SAPT) Block Grant; (2) the Adult, Juvenile, and Family Drug Courts grant program; and (3) the Screening, Brief Intervention, and Referral prevention program. The SAPT Block Grant is the largest federal treatment funding source and the backbone of publicly supported treatment and prevention with annual funding of approximately $1.8 billion. The program awards grants to community organizations through the states to carry out a variety of treatment and prevention measures tailored to each community's needs. Despite the central importance of the SAPT Block Grant to public drug and alcohol treatment, recent years have seen only level or near-level funding for the Block Grant.[18] Perhaps the most effective step the new administration can take to quickly help address unmet drug treatment need is to significantly increase the spending on the SAPT Block Grant.

The Adult, Juvenile, and Family Drug Courts grant program, while less far-reaching than the SAPT Block Grant, is one of the key vehicles through which the new administration can increase its support for cost-effective alternatives to incarceration. Drug courts divert non-violent drug offenders with substance abuse problems into treatment and recovery programs with intense judicial supervision of each individual's progress. And, while drug courts are not without their flaws,[19] studies have consistently shown that they produce better results than incarceration with substantially reduced costs. As the 2009 National Drug Control Strategy explained, a "decade of drug court research shows that [drug] courts work better than jail or prison[.]"[20] An analysis in California, for example, found that the drug courts studied cost only $3,000 on average per client while generating an average savings of $11,000 per client in reductions in recidivism and costs to victims.[21] Despite broad agreement that drug courts are successful, however, a 2008 study by the Urban Institute determined that just 50% of those currently eligible for drug courts, and a mere 3.8% of all at-risk arrestees, are able to participate in a drug court program. The researchers estimated that if treatment were provided to all at-risk arrestees, it would produce a net benefit of approximately $32 billion.[22] Increasing funding to the grant program, particularly to courts that do not have overly restrictive eligibility requirements, would help existing courts serve all eligible offenders and encourage states to create additional programs.

Finally, the federal government should provide additional funding for innovative medical-based prevention programs like the Bush Administration's successful Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative. The federal government began funding screening programs through SBIRT in 2003 and the early results are encouraging. The programs incorporate drug and alcohol addiction

---

[18] *Id.* at 49, 54.

[19] For an interesting and persuasive argument that drug courts may actually lead to longer sentences for members of historically disadvantaged groups who can often receive harsher prison sentences after treatment failures than they would otherwise receive through a plea agreement, see Josh Bowers, *Contraindicated Drug Courts*, 55 U.C.L.A. L. Rev. 783 (2008). Bowers recommends uncoupling drug courts from criminal cases as a way to address this problem.

[20] Office of Nat'l Drug Control Policy, National Drug Control Strategy 2009 Annual Report 20 (2009).

[21] Office of Nat'l Drug Control Policy, National Drug Control Strategy 2008 Annual Report 29 (2008).

[22] Avinash Singh Bhati et al., The Urban Institute, To Treat or Not to Treat: Evidence on the Prospect of Expanding Treatment to Drug Involved Offenders xii, 33 (2008), *available at* http://www.urban.org/UploadedPDF/411645_treatment_offenders.pdf.

screening and counseling into general medical settings, such as visits to primary care providers. This method takes advantage of the fact that many individuals who have a drug abuse problem or are at risk of developing one do not proactively seek substance abuse treatment but will nevertheless continue to visit primary care physicians for routine examinations. SBIRT provides funding to develop and implement programs that aim to make drug screening and treatment referrals part of standard medical practice. The programs represent a common sense public health approach to substance abuse and have the potential to both help prevent problem use from becoming full-blown addiction through interventions and effectively facilitate treatment for those who are addicted.

To free up funds for additional expenditures on demand reduction programs, the ONDCP should reduce or eliminate funding for some of the "drug war" programs that have proven to be particularly ineffective. Source-country crop eradication programs like Plan Colombia, federal criminal investigation and prosecution of low- and mid-level drug offenders, and student drug testing grants are examples of programs that should be targeted for cuts. Eradication programs are a particularly stark example of the failure of our supply-side-oriented war on drugs strategy. These programs aim to reduce the supply of drugs like cocaine and heroin in the United States by wiping out coca and poppy crops in source countries, primarily through aerial fumigation. The strategy is incredibly expensive but does little to reduce drug supply. Among the reasons that crop eradication programs have not succeeded is that production simply shifts from the targeted region to a new one. At the same time, the herbicides used to spray coca and poppy fields also damage the legal crops of local subsistence farmers and may have negative environmental and health effects. A 2008 Government Accountability Office report on Plan Colombia, which featured perhaps the most prominent and expansive eradication effort to date, found that coca cultivation in Colombia had actually *increased* by 15% since 2000. During the same period, the United States provided over $6 billion in support to Plan Colombia, though some of these funds were put toward uses other than crop eradication. Expenditures on foreign aerial fumigation programs should be dramatically reduced, if not eliminated.

In terms of domestic programs, the ONDCP, in coordination with the Department of Justice and the Drug Enforcement Administration (DEA), should work to significantly reduce the number of federal drug prosecutions. Despite overwhelming evidence that mass incarceration of drug offenders has done little to reduce drug use or availability, drug offenses remain among the most frequently prosecuted offense category and comprised approximately 35% of all federal felony and Class A misdemeanor cases in 2007.[23] Although there is no current data regarding how many drug prosecutions overall are of low- and mid-level players—such as couriers, street dealers, or look-outs—a 2007 United States Sentencing Commission report on crack and powder cocaine sentencing revealed that 61.5% of crack cocaine offenders and 53.1% of power cocaine offenders fall into these categories.[24] Outside of a limited category of cases where, for example, federal prosecution of an underling is truly necessary to

[23] U.S. Sentencing Comm'n, Overview of Federal Criminal Cases: Fiscal-Year 2007, at 1 (2008).

[24] U.S. Sentencing Comm'n, Report to Congress: Cocaine and Federal Sentencing Policy 19 Fig. 2-4 (2007). Similarly, a 1994 Department of Justice report found that 36.1 percent of all federal drug offenders were "low-level" offenders under the Department's own criteria and that these offenders received an average prison sentence of 85.1 months. The 1994 report did not include mid-level offenders. U.S. Dep't of Justice, Analysis of Non-Violent Drug Offenders with Minimal Criminal Histories (1994).

reach a kingpin or dismantle a large-scale criminal organization, there is no reason why most offenders in these categories should be the subject of federal law enforcement resources. However, a 2004 study of predictive factors on federal decisions about which cases to prosecute found that drug prosecutions are the least likely of all federal crimes to be declined for prosecution.[25] Domestic federal drug investigations and prosecutions, and the lengthy sentences they entail, should be reserved for high-level drug offenders. In addition to saving money, scaling back federal prosecutions of drug couriers and street dealers would be a much-needed first step toward addressing our embarrassingly high incarceration rate, and one that could be achieved without changing federal drug laws.

While supply-side programs should be the primary targets for cuts, the Obama Administration should also carefully review prevention spending and reduce or eliminate funding for ideologically driven programs that have not achieved results. The chief example in this area is the federal drug testing grant program, started by the Bush Administration in 2004. Each year since, ONDCP has sought funding increases for the program, which has been a darling of drug war adherents. Much of the funding is used to encourage and assist schools with the establishment of drug testing programs, even when they have not sought the programs, rather than responding to an unmet demand for drug testing program funding on the part of schools and communities. However, the only major study on student drug testing, conducted by the University of Michigan researchers for the National Institute on Drug Abuse, found that they are utterly ineffective and do not reduce drug use.[26] With so many programs that have a proven track record of results currently under-funded, federal resources should not be used on programs that have been shown not to work.

IV. LEGISLATIVE REFORMS

While a good deal of progress in setting our drug policy on the course toward a more effective and sensible public health model can be achieved by changing budget priorities, real change will also require the repeal or amendment of a number of federal laws and policies. In the long term, reversing the failures of the war on drugs will almost certainly require significant and far-reaching legislative action. There are, however, a number of discrete federal laws and policies that the Obama Administration should work to repeal or reform in the short term. These policies represent the fringe excesses of the drug war: laws that are not only ineffective but actually do more harm than good. In addition, these are areas in which there is broad agreement on the need for change among voters and policy analysts from across the political spectrum. This list is by no means exhaustive, but aims to identify some of the policies where change is especially needed and most likely to be achievable.

A. RESERVE MANDATORY MINIMUM DRUG SENTENCES FOR SERIOUS OFFENDERS

As discussed above, low- and mid-level drug offenders comprise a substantial percentage of federal drug prosecutions. Just as problematic is the fact that these offenders are very often subjected to long mandatory minimum sentences that should be

[25] Michael Edmund O'Neill, *Understanding Federal Prosecutorial Declinations: An Empirical Analysis of Predictive Factors,* 41 AM. CRIM. L. REV. 1439, 1454 (2004).

[26] RYOKO YAMAGUCHI ET AL., INST. FOR SOCIAL RESEARCH, DRUG TESTING IN SCHOOLS: POLICIES, PRACTICES, AND ASSOCIATION WITH STUDENT DRUG USE 2 (2003), *available at* http://www.rwjf.org/files/research/YESOccPaper2.pdf.

reserved only for drug kingpins and other top lieutenants. Drug sentencing has received a great deal of attention in the context of the "100 to 1" disparity between sentencing for crack and powder cocaine offenses, meaning that it takes 100 times the quantity of powder cocaine to trigger the same mandatory minimum penalty as for crack cocaine. The issue is an important one, and the Obama Administration has already formally announced its support for eliminating the disparity.[27] However, eliminating the disparity in crack and powder sentencing only scratches the surface of the real problem: a sentencing scheme in which sentences are based almost entirely on drug quantity.

The Anti-Drug Abuse Act of 1986 established the current framework for weight-based mandatory minimum drug sentences and the United States Sentencing Commission generally followed this weight-based approach in formulating federal sentencing guidelines. Under this scheme, a day laborer who unloads a truck full of cocaine for $100, or a mule who drives it across the border for $1,000, is exposed to the same mandatory minimum sentence and base level guidelines sentencing range as the drug ringleader who actually owns the cocaine and reaps all the profit.[28] The result is a system in which federal drug sentences are often minimally related to culpability[29] and federal tax dollars are being spent to warehouse small-time drug participants for years with no discernable benefit.

Solving this problem will require detailed changes to the federal sentencing guidelines in order to strike a more appropriate balance between drug quantity and an offender's role in a drug organization. And there is a strong case for eliminating mandatory minimum provisions entirely[30]. At a minimum, however, the Obama Administration should work with Congress to amend the mandatory minimum drug sentencing provisions in Title 21 of the United States Code to exclude low- and mid-level offenders from their reach. Specifically, mandatory minimum sentences based on drug quantity should not apply to offenders whose role is limited to that of a drug courier, street-level dealer, or peripheral player (such as those whose role is limited to providing the location for a drug transaction, loading and unloading drugs, or driving someone to a drug transaction.)[31] Removing these classes of offenders from mandatory minimum

---

[27] *See* The White House, The Agenda: Civil Rights, http://www.whitehouse.gov/agenda/civil_rights/ (last visited Mar. 13, 2009) ("President Obama and Vice President Biden believe the disparity between sentencing crack and powder-based cocaine is wrong and should be completely eliminated.").

[28] *See, e.g.*, Ian Weinstein, *Fifteen Years After the Federal Sentencing Revolution: How Mandatory Minimums Have Undermined Effective and Just Narcotics Sentencing*, 40 AM. CRIM. L. REV. 87, 107-08 (2003); U.S. SENTENCING COMM'N, REPORT TO CONGRESS: COCAINE AND FEDERAL SENTENCING POLICY 28-29 (2007) (noting that for cocaine and crack offenses, "[e]xposure to mandatory minimum penalties does not increase substantially with offender culpability as measured by offender function").

[29] *See* Paul J. Hofer & Mark H. Allenbaugh, *The Reason Behind the Rules: Finding and Using the Philosophy of the Federal Sentencing Guidelines*, 40 AM. CRIM. L. REV. 19, 70-71 (2003) ("In their concern to design a workable system and to minimize disparity, the original Commission clearly preferred objective factors, such as drug weight or dollar amount, to subjective ones, such as the offender's role or state of mind, which might be applied inconsistently. The result, however, is that important moral questions of culpability are relatively neglected, while more easily quantifiable issues of harm are elevated to a significance beyond their worth.").

[30] *See, e.g.,* Molly M. Gill, *Correcting Course: Lessons from the 1970 Repeal of Mandatory Minimums*, 21 FED. SENT'G REP. 55, 62 (2008) (proposing the elimination of mandatory minimum provisions for drug offenses).

[31] Currently, large percentages of offenders in these categories are exposed to mandatory minimum sentences. U.S. SENTENCING COMM'N, *supra* note 30, at 28-29 (2007). A 1994 "safety valve" law that permits courts to sentence below a mandatory minimum in certain limited circumstances provides relief for about one quarter of drug offenders, but still leaves a large number of low- and mid-level offenders subject

sentencing provisions will give judges the ability to apply the relatively more flexible sentencing guidelines to help eliminate some of the most egregious examples of unfair federal drug sentences.

B. REFORM FEDERAL MEDICAL MARIJUANA LAW

One of the most striking examples of the ideological excesses of the war on drugs, where scientific evidence and compassionate policies are rejected entirely on the basis that they are incompatible with the drug war's zero tolerance regime, has been the federal government's approach to medical marijuana. There is a broad scientific consensus that marijuana can help to control the symptoms of serious and chronic illnesses such as pain and spasticity, nausea, and loss of appetite. Most recently, for example, the American College of Physicians called for the federal government to review reclassifying marijuana from its status as a Schedule I controlled substance, a category defined as drugs that have no currently accepted medical use and a high potential for abuse, in light of the scientific evidence of its efficacy and safety. Similarly, nearly every government commission to investigate the issue has concluded that marijuana has proven value as a medicine, including a 1999 review by the Institute of Medicine of the National Academy of Sciences, and commissioned by the ONDCP, which concluded that "[s]cientific data indicate the potential therapeutic value of cannabanoid drugs ... for pain relief, control of nausea and vomiting, and appetite stimulation."[32]

The overwhelming scientific evidence has led 13 states to enact their own medical marijuana laws since 1996 and opinion polls consistently show that more than 70% of Americans support allowing the medical use of marijuana. The federal government, meanwhile, has moved in the opposite direction and adopted an increasingly hostile view toward medical marijuana. Starting in 1978, the federal government operated the Investigative New Drug Compassionate Access Program ("Compassionate IND"), which provided marijuana to a limited number of patients through a cumbersome and detailed application process. But the program was abruptly discontinued in March 1992. Then, in the aftermath of the passage of California's medical marijuana ballot initiative, the Clinton Administration sought to effectively dismantle the law by seeking an injunction against medical marijuana providers and threatening that doctors who recommended marijuana to patients might have their license to prescribe controlled substances revoked.[33] According to then-Drug Czar Barry McCaffrey, the actions were necessary because allowing the medical use of marijuana would "threaten to undermine efforts to protect our children from dangerous psychoactive drugs."[34] Under the Bush Administration, federal anti-medical marijuana efforts reached a new height, with the DEA routinely conducting armed raids of medical marijuana hospices in California.

Attorney General Eric Holder recently announced that the new administration would end the medical marijuana raids in accordance with statements President

---

to a mandatory minimum sentence. *See, e.g.,* Gill, *supra* note 32, at 59-60 (2008) (discussing the safety-valve provision).

[32] INST. OF MED., MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE (Janet E. Joy et al. eds., 1999).

[33] The effort to punish physicians was enjoined by the Ninth Circuit on the grounds that it would infringe on their First Amendment speech rights. *Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002).

[34] *Prescription for Addiction? The Arizona and California Medical Drug Use Initiatives: Hearing Before the S. Comm. on the Judiciary,* 104th Cong. (1996) (Statement of General Barry R. McCaffrey, Director of National Drug Control Policy).

Obama made during his campaign.[35] Ending the DEA's raids is an important and necessary step that will allow states to implement their medical marijuana laws without undue federal interference. It is, however, only a temporary solution to the underlying dissonance between federal law on the one hand and the scientific evidence and public opinion on the other. In addition to stopping the raids, the Obama Administration should work to support legislative proposals that would formalize federal respect for state medical marijuana laws. Prominent bills in this category that have been introduced in recent years have included the Patients' and Providers' Truth in Trials Act, which would have allowed defendants to raise medical necessity as a defense to federal marijuana prosecutions and the Hinchey-Rohrabacher Amendment, which would have prevented the Justice Department from using federal funds for interfering with the implementation of state medical marijuana laws. The Administration should also assist patients in states that have not yet adopted their own medical marijuana laws by re-opening the Reagan-era Compassionate IND program. Finally, the new Drug Enforcement Administrator should recognize the overwhelming scientific evidence that marijuana has a currently accepted medical use and grant the rescheduling petition, filed by the Coalition to Reschedule Cannabis in 2002 and still under review, to remove marijuana from the list of Schedule I controlled substances.

C. LIFT THE 1988 BAN ON FEDERAL FUNDING FOR NEEDLE EXCHANGE PROGRAMS

Needle exchange programs are a prominent example of the "harm reduction" approach to addressing problems related to drug abuse. The programs allow individuals to trade used syringes for clean syringes in order to help reduce the transmission of HIV/AIDS and Hepatitis C among intravenous drug users. Eight federally-funded reports and a 2005 international scientific review have concluded that the programs are effective at reducing the spread of disease without increasing incidents of illegal drug use. In 1997, for example, the National Institutes of Health Consensus Panel on HIV Prevention found that needle exchange programs led to a 30% or greater reduction in HIV transmissions. With approximately 25% of new HIV cases attributed to intravenous drug use, these programs could result in a substantial reduction in new transmissions. Yet, since 1988, there has been a ban on federal funding for needle exchange programs under an amendment to the Public Health and Welfare Act.

Despite the federal funding ban, and laws in a number of states that criminalize the unauthorized possession and distribution of syringes, there are over 200 needle exchange programs operating in 38 states, the District of Columbia, and Puerto Rico. These programs, however, have a significant need for federal funding. The Obama Administration has already expressed its support for lifting the federal funding ban on needle exchange programs[36] and should act on this position at the earliest opportunity by supporting the Community AIDS and Hepatitis Prevention (CAHP) Act of 2009 introduced by Representative Jose Serrano. Once the ban has been removed, ONDCP should allocate funding to establish a needle exchange grant program, with a particular emphasis on programs that provide other services such as substance abuse treatment. Federal needle exchange funding would be a cost-effective method for reducing

---

[35] Alex Johnson, *DEA to Halt Medical Marijuana Raids: Holder Confirms States Have Final Say on Use of Drug for Pain Control*, MSNBC.com, Feb. 27, 2009, http://www.msnbc.msn.com/id/29433708/ (last visited Mar. 14, 2009).

[36] *See* The White House, *supra* note 29 ("The President also supports lifting the federal ban on needle exchange, which could dramatically reduce rates of infection among drug users.").

the spread of HIV/AIDS and, by coupling the funding with support for substance abuse treatment services, could also help to reduce addiction rates. Indeed, early studies have indicated that needle exchange programs that have integrated treatment services may decrease intravenous drug use.

D. REPEAL THE HIGHER EDUCATION ACT DRUG PROVISION

In 1998, Representative Mark Souder added an amendment to the Higher Education Act reauthorization bill to strip federal financial aid from students if they are convicted of any drug offense, including simple possession. Since then, nearly 200,000 students have been denied federal financial aid under what has become known as the HEA Drug Provision. This law, while relatively limited in scope, is emblematic of some of the more bewildering legislation that has been enacted, and remains in place today, because of the dominance of the "get tough" ideology of the war on drugs. Indeed, while the law singles out drug offenses for removal of financial aid, all other criminal offenders—including rapists and murderers—remain eligible to receive federal financial aid.

Putting roadblocks on the path to education for students who are at risk of abusing drugs is counterproductive to the goal of reducing drug abuse. Students who are forced to drop out of school because they cannot receive financial aid are more likely to continue using or abusing drugs and less likely to become productive members of society. Furthermore, because students from wealthy families can afford college without financial aid, the law has a disproportionate impact on students from low- and middle-income families. Finally, because students must maintain good academic standing to receive aid in the first place, the HEA Drug Provision only affects people who are working hard and doing well in school.

In 2006, in response to growing support for repealing the HEA Drug Provision, Congress scaled back the law so that it does not apply to students who are convicted of a drug offense before they begin college. However, students who are convicted of a drug offense during college are still ineligible for aid. In 2008, Representative Barney Frank and Senator Christopher Dodd each introduced bills to repeal the financial aid elimination penalty. The Obama Administration should support repealing the HEA Drug Provision and work to ensure passage of repeal legislation the next time it is introduced. Repealing this law would not only help to keep thousands of at-risk students on the path toward an education and a productive life, it would send a strong signal that the era of judging drug policies based on how "tough" they are rather than how effective they are is coming to an end.

V. CONCLUSION

As Congress prepares to consider President Obama's nomination of Seattle Police Chief Gil Kerlikowske to head the ONDCP, now is an ideal time to come to grips with the fact that adopting a "war" strategy to address a public health problem has not worked. After 40 years, there is a rapidly growing consensus among policy analysts, foreign leaders, and the public that our war on drugs has been a failure. It has cost us billions of dollars and been chiefly responsible for making the United States the number one incarcerator in the world. And, yet, our drug use rates are higher than in countries that have adopted a more humane and less costly approach. On the campaign trail, President Obama voiced support for shifting toward a public health-oriented approach to drug policy and his administration has sent early signals in support of initial reforms, such as ending the medical marijuana raids and eliminating

the crack and powder cocaine sentencing disparity. This paper has proposed a number of somewhat more substantial, though still modest and achievable, actions that the new administration can take to begin the process of re-orienting our federal drug strategy. None of these proposals is groundbreaking—indeed, most have been the subject of debate for some time—but together they can point the way toward a new and more effective approach to dealing with the problem of drug abuse.

Finally, while the proposals discussed in this paper will result in dramatic improvements, in the long term more substantial change will be required. The recent explosion in drug cartel violence at the Mexican border, which is reminiscent of the days of Al Capone during alcohol prohibition, serves as a stark reminder of the depths of the problems that remain after our 40-year war on drugs. Thus, perhaps more than any specific policy reform, the most important action President Obama can take would be to follow the Brookings Institute's recommendation and form a commission to conduct a comprehensive reevaluation of our drug policies in light of the evidence from our own experiences, as well of the experiences in other countries over the past four decades.