A Wiser Course: Ending Drug Prohibition

A Report of
The Special Committee on Drugs and the Law
of the Association of the Bar of the City of New York

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Contents

Part I
Introduction

In 1986, the Association of the Bar of the City of New York, responding to a general perception that criminal and civil sanctions against the manufacture, distribution, or possession of drugs[1] were not "solving," or even ameliorating, the problems associated with drug use in our society, formed a Special Committee on Drugs and the Law (the "Committee") to study our current drug laws and to report its recommendations on the wisdom of such laws.[2]

The Committee has considered the complex legal, social, medical, economic, and political issues raised by our nation's current drug control policies. Despite billions of dollars spent on law enforcement, criminal prosecution, and incarceration during the past 80 years,[3] the United States has made little or no progress

[1]"A drug has been defined as 'any substance other than food which by its chemical nature affects the structure or function of the living organism.' " Steven Jonas, *Solving the Drug Problem: A Public Health Approach to the Reduction of the Use and Abuse of Both Legal and Illegal Recreational Drugs*, 18 Hofstra L. Rev. 751, 751 (1990) (quoting National Comm'n on Marihuana and Drug Abuse, *Second Report, Drug Use in America: Problem in Perspective* 9 (1973)). Many psychotropic drugs are socially acceptable and readily available either without a prescription (*e.g.*, alcohol) or with a prescription (*e.g.*, Prozac). See Milt Freudenheim, *The Drug Makers Are Listening to Prozac*, N.Y. Times, Jan. 9, 1994, at F7 (reporting that since 1988 more than six million people in United States have been prescribed Prozac, sales of which reached $1.2 billion worldwide in 1992); Sara Rimer, *With Millions Taking Prozac, A Legal Drug Culture Arises*, N.Y. Times, Dec. 13, 1993, at A1. Throughout this report the generic term "drugs" is used to refer to the numerous psychotropic substances, such as heroin, cocaine, and marijuana, that are now governed by state and federal prohibitionist laws. See, *e.g.*, 21 U.S.C.A. § 812 (West 1981 & Supp. 1994) (listing five schedules of controlled substances); see also 21 C.F.R. §§ 1308.11–1308.15 (1993). Nevertheless, these drugs are pharmacologically distinct from one another.

[2]Specifically, the Committee was charged with undertaking a study of present drug laws to: (a) determine the dimensions of the substance use and abuse problem; and (b) review how our society, and particularly its legal institutions, currently deal with the problems; and (c) develop options for the future by determining what the goals and objectives should be and by developing methods to implement those goals and objectives. . . . *Executive Committee Resolution*, Aug. 19, 1986, as amended Oct. 7, 1987.

[3]Drug prohibition in the United States began in 1914 with the Harrison Narcotic Act of 1914, Pub L. No. 63–223, 38 Stat. 785 (1914). See Robert W. Sweet & Edward A. Harris, *Just and Unjust Wars: The War on the War on Drugs—Some Moral and Constitutional Dimensions of the War on Drugs*, 87 Nw. U. L. Rev. 1302, 1367 & n.269 (1993) (noting that "[i]t was only with the Harrison Narcotic Act of 1914 and the Food, Drug, and Cosmetic Act of 1938 that individuals were no longer able to possess narcotics freely or to determine what counted as therapeutic drugs and as legitimate

toward reducing drug use or solving its "drug problem." On the contrary, illegal drug use remains a pervasive and powerful influence in our cities and in the nation at large.[4]

Beyond the continuing availability and consumption of drugs, the unintended consequences of our current prohibition policy are ubiquitous: our courts, both state and federal, are jammed; our prison populations are burgeoning; urban and ghetto children, as well as adults, are frequent victims of violent "turf wars"; our civil liberties are being eroded, along with our society's respect for the rule of law generally; our public health is threatened; the enjoyment of urban life has declined; and our nation's institutions, as well as those of our South and Central American neighbors,[5] are undermined by the immense wealth accumulated illegally under the current prohibition policies. The Committee has concluded, in some cases reluctantly, that the costs of drug prohibition are simply too high and its benefits too dubious.

The Committee recognizes that calling for an end to drug prohibition cannot be

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medical treatment.").

[4]See, *e.g.*, *And Still the Drugs Sit There*, The Economist, May 21, 1994, at 27 ("Since 1980 America has spent more than $100 billion in the war on drugs. Despite that, cocaine, heroin and marijuana are as available and as inexpensive as ever. Drug use fluctuates, but it is not going away. Indeed, surveys show that young people now seem increasingly tolerant of drugs and less worried about the health effects of them, if used in moderation."). Despite law enforcement efforts, use of even the so-called "hard drugs," like heroin, has failed to disappear. Trip Gabriel, *Heroin Finds a New Market Along Cutting Edge of Style*, N.Y. Times, May 8, 1994, at 1 (reporting that "[h]igh-grade heroin that can be smoked rather than injected has caught on, on both coasts, in circles whose habits often set trends—young people piloting the fast lane in the film, rock and fashion industries").

[5]See James Brooke, *In Colombia, One Victory in a Long War*, N.Y. Times, Dec. 3, 1993, at A12 (quoting Bogota prosecutor as saying, "It is a secret for no one that 99 percent of official [Colombian] institutions have problems with [drug] infiltration."). Faced with the devastation wrought by the "war on drugs," Colombians are calling for drug legalization. James Brooke, *Colombians Press for Legalization of Cocaine*, N.Y. Times, Feb. 20, 1994, at 6 (reporting that "influential opinion makers in Colombia, the world's largest cocaine producer, are increasingly backing . . . legalization"); see also Gabriel Garcia Marquez, *The Useless War*, N.Y. Times, Feb. 27, 1994, at 15 (calling for international agreement legalizing prohibited psychoactive substances because expensive law enforcement efforts in producing countries, such as Colombia, have not stemmed consumption in countries such as the United States). Perhaps in response to the public outcry in Colombia, a high court there has legalized the personal use of cocaine, marijuana, and other drugs. Joseph B. Treaster, *Use of Drugs is Legalized By Colombia*, N.Y. Times, May 7, 1994, at 3. But see James Brooke, *Colombia Reimposes Curbs on Marijuana and Cocaine*, N.Y. Times, June 2, 1994, at A14 (reporting that Colombian President Trujillo used his powers of decree to impose "a series of restrictions that essentially limit drug consumption to private residences where children are not present").

either the end of our inquiry or the sum of our recommendations. There are several difficult questions that remain to be answered: What forms of governmental regulation, if any, are appropriate instead of prohibition? To what degree, if any, should private distribution of drugs be permitted? Is a regulatory regime similar to one now used to control alcoholic beverages appropriate for some, if not all, drugs?[6] How should a new regulatory regime treat children, adolescents, or pregnant women? What kinds of prevention and treatment programs should there be and how should they be funded? These and other issues demand both the urgent attention and honest judgment of our Committee and, more broadly, our society.

The Committee believes the necessary inquiry cannot begin in earnest so long as our nation remains committed to the illusion that drug use can be prohibited at an acceptable cost. Only by recognizing that this is no longer true can we fashion a method of controlling drugs other than the current coercive drug laws, which have been largely ineffective and which are sapping the vitality of our cities, our legal system, and our society as a whole. It is the Committee's hope that this report will advance the discussion of this important issue.

Part II
The Costs of Prohibition

A. Distortion of the Judicial System

At a time of ever-increasing competition for scarce public funds, the volume of drug prosecutions and convictions continues to increase, as does the strain on judicial budgets, personnel, and facilities in the federal and state systems. The added burdens on the judiciary due to drug prosecutions have substantially diminished the courts' capacity to manage the civil docket. Criminal cases take priority, with civil jury trials relegated to the bottom of an increasing waiting list. Some courts, for purely budgetary reasons, have been forced to suspend all civil jury trials for periods of time.

[6]See Mark A.R. Kleiman & Aaron J. Saiger, *Drug Legalization: The Importance of Asking The Right Question*, 18 Hofstra L. Rev. 527, 565 (1990) ("The pragmatic question about drug control policy is how to manage the availability of a wide range of existing and potential psychoactives to get the best mix of cost and benefits.").

1. New York State

The majority of drug cases are handled by state and local courts. Consequently, it is instructive to review first the impact of these increased caseloads and costs on New York State.

In 1991, New York State spent a total of $8,641,418,000 for all judicial and legal services (including police protection, $3,662,389,000; courts, $932,314,000; prosecution and legal services, $461,790,000; and public defense, $197,194,000). It is difficult to obtain specific dollar figures for the cost of drug arrests and prosecutions in New York State, but by combining the available data on caseloads and judicial costs it is possible to make some rough estimates.[7] In 1987, total arrests in New York State were 481,676, whereas in 1991 the total was 506,710, an increase of 5.2%. During the same period, felony drug arrests rose from 42,655 (approximately 9% of total arrests) in 1987 to 54,184 in 1991 (11% of all arrests), a 27% increase. By contrast, between 1987 and 1991, misdemeanor drug arrests dropped from 53,621 to 36,489, a decrease of 32%.[8]

> In 1991 a tremendous volume of caseload activity confronted the Judiciary's judges and nonjudicial personnel. Nearly 79,000 felony indictments and superior court informations were filed in Supreme and County Courts throughout New York. That number represents a 54% increase compared with 1985. Most of the statewide increase was the result of phenomenal caseload increases in New York City. This year, the Supreme Court Criminal Term in New York City received over 52,000 felony filings, an astonishing 70% increase since 1985. The remarkable level in felony filings is primarily caused by increases in drug-related filings.

[7] Using arrest statistics rather than conviction statistics may provide a misleading overview of the situation. For example, it is common for the arresting officer to make a "felony arrest" only to have a prosecutor actually charge a misdemeanor. In addition, felony conviction statistics will undoubtedly be further affected by the New York Court of Appeals' decision requiring the prosecution to prove knowledge of drug weight, *People v. Ryan*, 82 N.Y.2d 497, 626 N.E.2d 51, 605 N.Y.S.2d 235 (1993).

[8] New York State Division of Criminal Justice Services, *Criminal Justice Indicators #8* (Nov. 1992). Interestingly, there was a 3% drop in felony indictments between 1991 and 1992. Office of Justice Systems Analysis, Bureau of Statistical Services, *Criminal Justice Indicators #1* (Mar. 1993) ("N.Y.S. Arrests and Indictments 1991 vs. 1992"). Although there was a significant increase in felony drug arrests in large upstate metropolitan areas, these were somewhat offset by fewer drug and non-violent felony indictments in New York City. *Id.* The actual meaning of these statistics remains murky, and they should be approached with caution.

> . . . Unquestionably, these caseload increases are the product of the drug crisis which, perhaps for the first time in our State's history, threatens to test our ability to administer justice on the local level, not just in New York City, but statewide.[9]

The increasing number of drug prosecutions in New York's courts has taken its toll on the judicial system. One New York State Supreme Court Justice has summarized the impact of the so-called "war on drugs" on New York's criminal justice system as follows:

> Our court calendars groan under the burden of ever-increasing new drug cases. New York City's Corrections Department estimates that 70 percent of its inmates are charged with drug-related crimes. Yet these ever-growing prosecutions and incarcerations are having little or no impact on drug crimes. In 1980 only 11 percent of the total inmate population was incarcerated for drug offenses, yet by 1992 this figure rose to 44 percent. At a cost of $30,000 per year to maintain each prisoner, our state spent over $195 million in 1992 to confine drug offenders alone. Last year the state's Office of Court Administration requested an additional $40 million just to cover the expense of drug cases. Since the advent of crack a decade ago, the city has hired 9,000 new police, 700 additional assistant district attorneys, and has added 18,000 new cells on Rikers Island. The total cost: $591 million a year.[10]

2. Other States

State court convictions for drug law violations have increased dramatically nationwide since the mid-1980s. Between 1986 and 1988, there was a nearly 70% increase in the number of persons convicted of felony drug trafficking or possession charges (from 135,000 to 225,000).[11] The number of persons convicted who

[9] *Report of the Chief Administrator of the Courts for the Calendar Year Jan. 1, 1991 – Dec. 31, 1991* 4 (1992).

[10] Abraham G. Gerges, *Changing Times Require Changing Strategy*, N.Y.L.J., July 14, 1993, at 3.

[11] Peter Reuter, *Hawks Ascendant: The Punitive Trend of American Drug Policy*, 121 Daedalus 15, 25 & n.24 (1992) (citing Bureau of Justice Statistics, *Felony Sentences in State Courts* (1989, 1990)). Possession with intent to sell is a felony in most states, whereas mere possession is often a misdemeanor.

received state prison sentences rose from 49,900 to 92,500.[12] In 1988, drug offenses accounted for approximately one-third of all felony convictions in all state courts.[13]

3. Federal Courts

The case loads and concomitant costs of managing drug cases in federal courts also have increased substantially over the past decade. In 1982, the budget for prosecution of all federal drug cases in the United States was $78.9 million; in 1993, the budget was ten times as much—$795.9 million.[14]

In federal district courts in 1989, a total of 54,643 criminal cases were prosecuted; of those 16,834 (approximately 30%) were for drug offenses.[15] In 1990, 19,271 defendants were prosecuted for drug offenses; of those 3,083 were not convicted, and 16,188 were convicted: 13,036 by guilty plea (81%), and 3,121 after trial (19%).[16] Between July 1992 and June 1993, 50,366 defendants were convicted in the federal courts, and 27% of these (18,576) were convicted of federal drug offenses.[17]

Expenses associated with appeals of federal drug cases rose from $8.2 million in 1982 to $104.2 million budgeted in 1993. A significant portion of this increase resulted from appeals filings in drug-related cases, which totalled 1,583 in 1981, 4,386 in 1989, and 5,658 in 1990 (a 29% increase from the previous year alone and, overall, a 383% increase in ten years).[18] In 1991, there were 5,570 federal drug-related appeals filed.[19]

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[12]Reuter, *supra* note 11, at 25.

[13]*Id.* at 25. Again, these statistics should be approached with caution. State possession and trafficking statutes tend to vary from state to state.

[14]Bureau of Judicial Statistics, United States Department of Justice, *Sourcebook of Criminal Justice Statistics – 1992* 20 (1993) (table 1.16). The total 1993 figure includes the folowing: Judiciary $281.3 million; United States attorneys $215.9 million; Criminal Division $17.2 million; United States Marshalls $186.0 million; Organized Crime Drug Enforcement Task Forces $83.9 million; Tax Division $1.5 million; Weed and Seed Program $10 million.

[15]United States Department of Commerce, *Statistical Abstract of the United States 1992, the National Data Book, No. 321* 194 (1993) ("U.S. District Courts—Criminal Cases").

[16]*Id.*

[17]Drugs & Crime Data Center & Clearinghouse, *Fact Sheet: Drug Data Summary* 2 (Apr. 1994).

[18]Bureau of Judicial Statistics, United States Department of Justice, *Sourcebook of Criminal Justice Statistics – 1992* 544 (1993) (table 5.78).

[19]*Id.*

4. The Judiciary is Impatient with the Present System

Federal and state judges throughout the United States have publicly expressed frustration with the present laws prohibiting drugs, and some senior federal judges have even refused to sit on drug cases. In the Southern District of New York and in the Eastern District of New York, Judges Whitman Knapp,[20] Robert Sweet, and Jack Weinstein have spoken out publicly against the present laws and their associated draconian penalties,[21] and Judges Knapp and Weinstein have refused, as is their right as senior judges, to preside over drug trials and sentences.[22] State judges in New York have also protested the increasing time on their calendars that drug cases take and the Second Offender sentencing rule that compels them to give lengthy prison sentences to second-time drug offenders.[23] These judges seek a solution to the "war on drugs" before the whole judicial system breaks down under the strain.

5. Efforts to Handle Court Congestion

Because of the enormous increase in drug cases, especially in large urban areas, several stop-gap solutions are being pursued to balance limited court resources against the burgeoning caseloads. In New York City and New Orleans, for instance, special narcotics divisions have been established to expedite processing of drug felonies. These experimental programs are designed to hear cases just prior to grand jury proceedings with the goal of inducing defendants to accept plea bargains that are better than would be expected if the case proceeded through the grand jury process.[24] Also, special court parts—staffed by personnel with expertise in drug cases, addiction, and community treatment centers—have been established

[20] See, *e.g.*, Letter to the Editor, *A Failed "War"*, N.Y. Times, Dec. 28, 1993, at A10.

[21] In the Northern District of California, Judge Vaughn R. Walker, a Reagan appointee, has been quoted as saying, "I make no bones about my personal view that the best course of action for us to take is exactly the same course of action we took after Prohibition, and that is decriminalization." The Drug Policy Letter, Spring 1994, at 32.

[22] See Joseph B. Treaster, *Judges Decline Drug Cases, Protesting Sentencing Rules*, N.Y. Times, April 17, 1993, at A1.

[23] See, *e.g.*, Abraham G. Gerges, *Changing Times Require Changing Strategy*, N.Y.L.J., July 14, 1993, at 3 (noting that "New York State's prison population has more than doubled over the last decade, largely due to mandatory sentencing laws and an increasing number of drug prosecutions. . . . A major contribution to the prison population explosion is the Rockefeller Drug Laws which require substantial prison terms for the possession or sale of small amounts of drugs.").

[24] Steven Belenko, *The Impact of Drug Offenders on the Criminal Justice system*, in *Drugs, Crime and the Criminal Justice System* 65 (Ralph Weisheit ed., 1990).

in New York City to deal exclusively with drug cases.[25] Unfortunately, none of these short-term solutions will correct the fundamental distortion of the priorities of the state and federal judicial systems caused by the "war on drugs."

B. The Prison State

One of the most tangible, measurable effects of the "war on drugs," has been the creation of a "prison state".[26] According to the Federal Bureau of Investigation's statistics, one million arrests are made annually for violations of the federal and state drug laws.[27]

Estimated Arrests for Drug Offenses[28]				
Year	Total Arrests	Sale/Mfg.	Possession	% of Arrests
1983	661,400	146,169	515,231	5.7%
1984	708,400	155,848	552,552	6.1%
1985	811,400	192,302	619,098	6.8%
1986	824,100	206,849	617,251	6.6%
1987	937,400	241,849	695,551	7.4%
1988	1,155,200	316,525	838,675	8.4%
1989	1,361,700	441,191	920,509	9.5%
1990	1,089,500	344,282	745,218	7.7%
1991	1,010,000	337,340	672,660	7.1%
1992	1,066,400	338,049	728,351	7.6%

As a result of these massive numbers of arrests each year, "the United States has a higher proportion of its population incarcerated than any other country in the

[25] *Id.* at 66.

[26] See Jarret B. Wollstein, *Turning the Tide: Winning Public Support for Ending Drug Prohibition*, in *New Frontiers in Drug Policy* 90 (Arnold S. Trebach & Kevin B. Zeese eds., 1991) (arguing that the "war on drugs" is really a war on liberty).

[27] Lester Grinspoon & James B. Bakalar, *The War on Drugs—A Peace Proposal*, 330 New Eng. J. Med. 357, 357 & n.2 (1994) (citing Federal Bureau of Investigation, *Crime in the United States* (1991)). Almost one quarter of these arrests are for simple possession of marijuana. *Id.* Indeed, being arrested for simple possession of marijuana is "the fourth most common cause of arrest in the United States." *Id.* Ironically, studies indicate that marijuana is the number one cash crop in the United States. Katherine Bishop, *Front in Marijuana War: Business Records*, N.Y. Times, May 24, 1991, at B6.

[28] Drugs & Crime Data Center & Clearinghouse, *Fact Sheet: Drug Data Summary* 1 (Apr. 1994).

world for which reliable statistics are available."[29]

Incarceration in America is now at an all-time high. From 1925 through 1973, the American prison population fluctuated between 90 and 120 people in prison per 100,000 of the population; in 1973 the rate was 98 per 100,000, a ten-year low. Between 1973 and 1980, however, there was a 40% increase, to 135 people in prison per 100,000; and by 1986, following the start of the modern "war on drugs," the incarceration rate had jumped to 200 per 100,000. In 1993, the rate of Americans serving prison time stood at 325 per 100,000.[30] In 1993, the number of inmates in federal and state prisons in New York increased by 4.6%, to 64,600.[31]

On average, it costs $20,000 per year to maintain one prisoner,[32] $100,000 to build a single prison cell, and $20,000 per year to staff a prison cell.[33]

More than one in forty American males between the ages 14 and 34 are locked up.[34]

Between 1980 and 1990, the total prison population in the United States increased by 133% to over 771,000 prisoners.[35] In 1993, the total prison population reached 949,000, nearly three times as many as in 1980.[36] During the 1980s, new imprisonments on drug charges increased over 1,000%.[37]

> Drug offenders have accounted for an increasing percentage of the population in State and Federal correctional facilities. Drug offenders

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[29]Grinspoon & Bakalar, *supra* note 27, at 357.

[30]Telephone interview with Todd R. Clear, Professor Criminal Justice, Rutgers University (Apr. 28, 1994).

[31]N.Y.L.J., June 2, 1994, at 1. "Only California, with 120,000 inmates, and Texas, with 71,000 prisoners, had more people in federal and state facilities." *Id.*

[32]*Department of Justice Report: Two-Thirds of Non-Violent Offenders Serving Mandatory Minimum Sentences*, The Drug Policy Letter, Spring 1994, at 28.

[33]Todd R. Clear, *Tougher is Dumber*, N.Y. Times, Dec. 12, 1993, § 1, at 21. The costs for building and operating prisons can add up quickly: "In the fiscal year 1992, which ended June 30, states spent more than $15 billion operating prison systems and more than $2 billion building prisons. The growth in operating costs is expected to increase about 5 percent in the current fiscal year, but spending on construction is expected to double, to about $4 billion as 112 new prisons are opened to house 75,000 more inmates." Michael deCourcy Hinds, *Feeling Prisons' Costs, Governors Weigh Alternatives*, N.Y. Times, Aug. 7, 1992, at A17.

[34]Clear, *supra* note 33, at 21.

[35]Anita L. Arcidiacono, Christopher A. Innes, Bernadette Pelissier & Susan Wallace, *Hope and Reality: Drug Treatment in Federal Prisons*, in *New Frontiers in Drug Policy* 143 (Arnold S. Trebach & Kevin B. Zeese eds., 1991).

[36]N.Y.L.J., June 2, 1994, at 1.

[37]Jerry Mandel, *A Racist Elephant in the Living Room?*, in *New Frontiers in Drug Policy* 176 (Arnold S. Trebach & Kevin B. Zeese eds., 1991).

> constituted an estimated 22% of the State prison population in 1991, up from 6% of the population in 1979. In Federal correctional facilities, drug offenders accounted for 61% of the population, up from 16% in 1970, 25% in 1980, and 52% in 1990.[38]

The vast majority of the prison population increase during the 1980s, which doubled the number of persons under custody for all charges, involved drug law violations.[39] Due to the great increase in drug-related incarcerations, the federal and state prison systems are overwhelmed, as reported almost daily in the newspapers. Prison overcrowding persists despite an unprecedented boom in prison construction. For example, between 1983 and 1992, New York State built 29 prisons, increasing the number of prisons in the state to 68 and the inmate capacity from 29,253 to 57,862.[40]

> No one wants overcrowding. It riles inmates, strains prison guards, encourages the spread of illness and generally makes prisons more volatile places. In the past, when there was money to spend, the solution to overcrowding would have been clear—create more space. Not any more. With money scarce and a sense that more prison beds have not resulted in less crime, many lawmakers are being forced to conclude they can no longer build their way out of the problem.[41]

According to the United States Department of Justice, "drug offenders" are becoming a larger share of the prison population for two reasons: first, the likelihood that a conviction will result in incarceration is increasing; and second, those convicted on drug charges are receiving longer prison sentences.[42]

Mandatory sentencing laws, such as the federal sentencing guidelines, exacerbate the problem by forcing judges to impose lengthy sentences for simple possession of small amounts of drugs.[43] These laws, first passed in the 1970s but increasingly relied on as a weapon in the "drug war" in recent years, have in large

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[38] Drugs & Crime Data Center & Clearinghouse, *Fact Sheet: Drug Data Summary* 3 (Apr. 1994.)

[39] Jerry Mandel, *A Racist Elephant in the Living Room?*, in *New Frontiers in Drug Policy* 176, 178 (Arnold S. Trebach & Kevin B. Zeese eds., 1991).

[40] Sarah Lyall, *Without the Money to Supply Prison Beds, Officials Consider Reducing Demand*, N.Y. Times, Feb. 17, 1992, at B5.

[41] *Id.*

[42] Office of Justice Programs, Bureau of Justice Statistics, United States Department of Justice, *Drugs, Crime and the Justice System* 195 (Dec. 1992).

[43] Some federal judges have complained bitterly about the federal sentencing guidelines for controlled substances offenses. *E.g.*, Deborah Pines, *Sweet Hits Mandatory Minimums*, N.Y.L.J., Dec. 1, 1993, at 1 (reporting that United States District Judge Robert W. Sweet "lashed out at the

measure been responsible for today's severe overcrowding.[44] Mandatory minimum sentences require judges to impose a statutorily-defined minimum period of incarceration without the possibility of parole, with no consideration of the specific facts of the crime or any mitigating circumstances.[45]

Faced with mandatory sentences laws, there has been at a growing movement at the state level to minimize their draconian effects. In New York, for example, the courts had been cooperating with prosecutors and defense attorneys to avoid the harsh effects on second-time drug offenders.[46] New York's Governor, Mario Cuomo, in his 1994 budget message has asked the Legislature to restore discretion to judges meting out second-time drug felony sentences "to relieve overcrowding in state prisons."[47]

For all of the extra burden on the prison and judicial systems and on the taxpayer caused by the "war on drugs," American society has little to show for it. "If such toughness had much to do with crime, you'd think we'd have seen some results by now. But . . . overall crime has decreased only 6% since 1973; vio-

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'rigidity of arbitrary mandatory minimum sentencing laws' as he imposed a sentence of life without parole on a first-time drug offender").

[44]See, *e.g.*, Katherine Bishop, *Mandatory Sentences in Drug Cases; Is the Law Defeating Its Purpose?*, N.Y. Times, June 8, 1990, at B16; see also Julie Stewart, *Are These Sentences Fair?*, in *New Frontiers in Drug Policy* 37, 37 (Arnold S. Trebach & Kevin B. Zeese eds., 1991) ("Each of the 12 federal judicial circuits that handles criminal cases and the Judicial Conference of the United States has passed a resolution opposing mandatory sentencing. The Federal Courts Study Commission has urged their repeal as has the U.S. Sentencing Commision."); see also *Department of Justice Report: Two-Thirds of Non-Violent Offenders Serving Mandatory Minimum Sentences*, The Drug Policy Letter, Spring 1994, at 28 ("The Justice Department review [of mandatory minimum sentencing entitled "An Analysis of Non-Violent Drug Offenders with Minimal Criminal Histories", released February 4, 1994] revealed that two-thirds of the low-level drug offenders in federal prison are serving mandatory minimum sentences of five or ten years. . . . The report also found that *16,316 federal inmates—one out of five federal prisoners—are low-level drug offenders*, which the report defines as individuals with no record of criminal violence or of sophisticated criminal activity.") (emphasis in original).

[45]Bishop, *supra* note 44, at B16 ("With the Anti-Drug Abuse Act of 1986, Congress intended to cripple illegal drug trafficking by requiring stringent Federal prison sentences for everyone from large-volume dealers to low-level couriers. The sentences were based solely on the amount of drugs possessed or sold: 10 years for 11 pounds of cocaine, 2.2 pounds of heroin or 1.7 ounces of crack. Then, the Anti-Drug Abuse Amendments Act of 1988 upped the ante, making life without parole the sentence for those with two or more prior convictions.").

[46]This type of dodge was dealt a setback by the New York Court of Appeals's decision reaffirming the strict application of the so-called Rockefeller Drug laws and leaving it to the Legislature to adjust their severity. *People v. Thompson*, No. 36, 1994 N.Y. LEXIS 329 (Mar. 30, 1994).

[47]Gary Spencer, *Cuomo Backs £1.1 Billion Courts Budget; 8.6 Percent Increase called "Necessary"*, N.Y.L.J., Jan. 19, 1994, at 1.

lent crimes are up 24%. The National Research Council of the National Academy of Sciences recently concluded that a tripling of time served by violent offenders since 1975 had 'apparently very little' impact on violent crime."[48]

With 61% of today's federal inmates incarcerated on drug law convictions,[49] judiciary and corrections overcrowding and escalated costs would necessarily be reduced were the current drug policy altered toward a less punitive, more humane approach which removes the profit motive fueling the black market in illegal drugs.

C. Erosion of the Rule of Law and Civil Liberties

One of the more insidious effects of the "war on drugs" has been the gradual erosion of the rule of law and the public's civil liberties. Several interrelated elements contribute to this particularly destructive consequence of the current drug laws.

1. Perception of Ineffectiveness

Politicians from the President of the United States to mayors running in local elections are importuned by the people for the assurance that increasing crime and the criminal element be contained in our society. Our country, with the highest rate of drug abuse of any industrial country in the world,[50] also has the largest budget in the world to enforce its laws prohibiting drugs. Despite huge increases in the federal government's budget for the "war on drugs," the so-called "drug problem" with all of its ramifications has not significantly abated. The public's perception of its political leaders' ineffectiveness in alleviating drug-related violence adds to the general atmosphere of lawlessness and breeds cynicism and disrespect for the law.[51]

Instead of progress since the first federal anti-drug law was passed in 1914,[52] nearly 80 years of drug prohibition have yielded few inroads against the sale or

[48]Clear, *supra* note 33.

[49]Drugs & Crime Data Center & Clearinghouse, *Fact Sheet: Drug Data Summary* 3 (Apr. 1994).

[50]See Mathea Falco, *The Making of a Drug Free America* (1992).

[51]See Jos. H. Choate, Jr., *Reasons for The Repeal of the Eighteenth Amendment, An Address before The New York Civic Forum On January 17, 1930* (library collection of the Association of the Bar of the City of New York) ("[W]hy does National Prohibition . . . seem to me, as a lawyer, unwise? First, because it is and has proved an unenforceable rule: and every such rule undermines the law-abiding disposition of the community.").

[52]The Harrison Narcotics Act, Pub. L. No. 63–223, 38 Stat. 785 (1914).

use of drugs. This, understandably, suggests to the public that the law itself is an ineffectual tool for dealing with the issue.

2. Perception of a Self-Perpetuating System

The large sums of money appropriated for law-enforcement create enormous, self-perpetuating bureaucratic agencies, such as the United States Drug Enforcement Agency ("DEA"), which fight for independence and scarce public resources while making little headway against the "drug problem."[53] These agencies have ample motivation to exaggerate or distort the extent and danger of "drug abuse" so as to justify (and thereby insure) their continued existence. Being inherently biased, they have great potential to ignore the public's true welfare.

3. Police Corruption

The fact that drug prohibition breeds corruption has been known for decades.[54] Every day there are news stories of law enforcement officers being arrested for their involvement with drug dealers.[55] The sums of money involved in the drug business are too great and too inviting for the law enforcers not to seek their share.[56] Corrupt police behavior creates a further disillusioned public.[57] In addition, just as

[53]The Clinton Administration sought to combine the DEA with the Federal Bureau of Investigation, but the DEA resisted such efforts. Marianne Lavelle, *Gore Sets His Sights on the DEA*, Nat'l L. J., Sept. 13, 1993, at 3; Neil A. Lewis, *White House Seeks to Combine F.B.I. with Drug Agency*, N.Y. Times, Aug. 19, 1993, at A1. Ultimately, the plan to merge the two was abandoned.

[54]See Felicia R. Lee, *On Front Line of the Drug Wars, Police Corruption is Nothing New*, N.Y. Times, Apr. 16, 1994, at A1.

[55]See, *e.g.*, Clifford Kraus, *12 Police Officers Charged in Drug Corruption Sweep; Bratton Sees More Arrests*, N.Y. Times, Apr. 16, 1994, at A1; David Kocieniewski, *"Dirty 30" Precinct—12 of City's "Finest" Accused of Outcrooking Crooks*, Newsday, Apr. 16, 1994, at A5; see also *Officer Charged in Drug Case*, N.Y. Times, Oct. 2, 1991, at B3 (reporting FBI's arrest of police officer, who headed local joint drug task force, for selling cocaine and marijuana).

[56]James Ostrowski, *The Moral and Practical Case for Drug Legalization*, 18 Hofstra L. Rev. 607, 663 & n.264 (1990) ("Drug money corrupts law enforcement officials. Corruption is a major problem in drug enforcement because drug agents are given tremendous power over desperate persons in possession of large amounts of cash. Drug corruption charges have been leveled against FBI agents, policemen, prison guards, U.S. Customs Inspectors, even prosecutors."); John T. Schuler & Arthur McBride, *Notes From the Front: A Dissident Law-Enforcement Perspective on Drug Prohibition*, 18 Hofstra L. Rev. 893, 914 (1990) ("corruption is a concomitance of narcotics enforcement").

[57]Police corruption also exists when overzealous police officers make drug arrests supported with perjured testimony, which undermines the core of the criminal justice system. See Joe Sexton,

organized crime became entrenched during Prohibition, the current prohibitionist regime is currently subsidizing the mafia and other organized crime groups because of the highly inflated prices on the black market.

4. Poor Children are Victims of the "War on Drugs"

There is no reason to believe that recognized market forces cease to apply where the drug business is concerned. There is public recognition that youths and unemployed adults often cannot just say "no" to drugs when saying "yes" as a dealer or a dealer's helper is much more profitable than are the alternatives. Children living in poor, urban neighborhoods are particularly susceptible to being drawn into illegal drug-related activities by visions of status and easy money.[58] Laws against drugs thus discourage many youths and adults from productive legitimate employment that would benefit society.

5. Selective Prosecution

Criminal prosecutions for violations of the federal and state drug laws appear to be disproportionately directed against minorities.[59] Understandably, there is widespread public concern that the drug laws are selectively enforced with vigor against the poor and disenfranchised,[60] while rich and middle class drug users are

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New York Police Often Lie Under Oath, Report Says, N.Y. Times, Apr. 22, 1994, at A1, B3 (reporting that "Charles J. Hynes, the District Attorney for Brooklyn, said that police officers often tried to get around the problem of needing probable cause before making an arrest by what he called the 'dropsy syndrome'—falsely testifying that a suspect 'tossed a package containing white powder to the ground' as he was approached."); *Today's News—Update*, N.Y.L.J., May 12, 1994, at 1 (reporting that Manhattan District Attorney Robert M. Morgenthau's office is reviewing 1,500 convictions obtained over past four years to determine if they should be vacated because of perjured testimony from police in 30th precinct in Harlem).

[58] See, *e.g.*, David Gonzalez, *Unmasking Roots of Washington Heights Violence*, N.Y. Times, Oct. 17, 1993, at 29 (reporting that Washington Heights is "a natural locale for selling drugs, which offers the promise of quick money to youths who find themselves idle on street corners day after day").

[59] *"War On Drugs" Seen As Threat to Constitution Minorities*, 49 Crim. L. Rep. (BNA) at 1477 (Sept. 4, 1991) (reporting that panelists at American Bar Association program opined that "war on drugs" is a "war on minorities" and that Bureau of Justice statistics show that in 1991 black males constituted 12% of overall population and almost 50% of prison population).

[60] See Rick Bragg, *Liberators or Oppressors? Two Views of the Police in Clifton, S.I.*, N.Y. Times, May 2, 1994, at B3 (reporting resident saying that "[t]here is a feeling that the community is being surrounded").

permitted to indulge without serious fear of legal consequences.

6. Erosion of Constitutional Rights

The pursuit of a "drug-free" society has resulted in a panoply of intrusions into the lives of United States citizens:

> The Bill of Rights is in danger of becoming meaningless in cases involving drugs. Tenants charged with no crime are evicted from homes where police believe drugs are being sold. Public housing projects are sealed for house-to-house inspections. The Supreme Court has permitted warrantless searches of automobiles, the use of anonymous tips and drug-courier profiles as the basis for police searches, and the seizure of lawyers' fees in drug cases. Property on which marijuana plants are found can be forfeited even if the owner is charged with no crime. Prosecutors have been allowed to try the same person at the state and federal levels for the same drug-related crime.[61]

A few examples will illustrate the erosion in individual civil liberties occasioned by the "war on drugs."[62] In 1991, the United States Supreme Court in *Florida v. Bostick*,[63] upheld the constitutionality of a police tactic of boarding long-distance buses and asking permission to search passengers' baggage, overruling the Florida Supreme Court's ruling that such an encounter with the police is so inherently coercive that no consent given for such a search could be truly voluntary.[64] The *Florida v. Bostick* decision was merely one of a number of rulings since the

[61]Grinspoon & Bakalar, *supra* note 27, at 357 (citing S. Wisotksy, *A society of Suspects: The War on Drugs and Civil Liberties* 180 (1992)); see also James Ostrowski, *The Moral and Practical Case for Drug Legalization*, 18 Hofstra L. Rev. 607, 664 (1990) ("Drug war hysteria has created an atmosphere in which long-cherished rights are discarded wherever drugs are concerned. Suspected drug users are subject to urine testing, roadblocks, routine strip searches, school locker searches without probable cause, abuse of the good faith exception to the exclusionary rule, preventive detention, and nonjudicial forfeiture.") (footnotes omitted).

[62]For a more extensive treatment of this subject, see Paul Finkelman, *The Second Casualty of War: Civil Liberties and the War on Drugs*, 66 So. Cal. L. Rev. 1389 (1993).

[63]111 S. Ct. 2382 (1991).

[64]Linda Greenhouse, *Police Are Backed On Bus Searches*, N.Y. Times, June 21, 1991, at A1. Justice Marshall stated in dissent, in which he was joined by Justices Blackmun and Stevens, "In my view, the Fourth Amendment clearly condemns the suspicionless, dragnet-style sweep of intrastate or interstate buses" due to coercion and unjustified intrusion upon citizens' Fourth Amendment rights. *Florida v. Bostick*, 111 S. Ct. at 2394 (Marshall, J., dissenting).

early 1980s which authorized police stops and questioning of airline, train, and bus passengers without the level of suspicion generally required for Fourth Amendment search and seizure purposes.[65]

The search for tell-tale evidence of drug use has even descended to the level of compelling federal employees to give urine samples for analysis, without regard to whether such a privacy intrusion is related to job performance.[66] The public—led by the government—appears to be willing to jump on the bandwagon "to restrict civil liberties, and even accept warrantless searches of homes and cars, in order to reduce the use of illicit drugs."[67]

7. Forfeiture's Heavy Hand

Forfeiture has become one of the most publicized and controversial weapons in the government's anti-drug arsenal.[68] Any assumption, however, that the law would be deployed only against "drug kingpins" and major players has proved unwarranted as small time dealers and marginal users are more often targeted:

> Under Zero Tolerance, which targets casual drug users, the government has seized thousands of cars, boats, and homes because occupants or guests allegedly carried drugs. In 1990, seizures exceeded $527 million, and they are expected to exceed $700 million in 1991. The U.S. Marshalls Services now has a $1.4 billion inventory of seized assets including more than 30,000 homes, cars, businesses and other property.[69]

[65] *Florida v. Bostick*, 111 S. Ct. at 2394 (Marshall, J., dissenting). These decisions include the approval of "drug courier profiles," which are based upon the appearance and behavior of the suspects and which are used by the police to identify persons who may be carrying drugs. See *United States v. Sokolow*, 490 U.S. 1, 13–14 (1989) (Brennan, J. dissenting) (listing cases showing profile's "chameleon-like way of adapting to any particular set of observations").

[66] Grinspoon & Bakalar, *supra* note 27, at 357 (citing S. Wisotksy, *A Society of Suspects: The War on Drugs and Civil Liberties* 180 (1992)).

[67] Grinspoon & Bakalar, *supra* note 27, at 359 & n.14 (citing R.J. Dennis, *The American People Are Starting to Question the Drug War*, in *Drug Prohibition and the Conscience of Nations* (Arnold S. Trebach & Kevin B. Zeese eds., 1990)).

[68] See, *e.g.*, *United States v. Daccarett*, 6 F.3d 37, 46 (2d Cir. 1993); *United States v. 384–390 West Broadway*, 964 F.2d 1244, 1248 (1st Cir. 1992); see also Pratt & Peterson, *Civil Forfeiture in the Second Circuit*, 65 St. John's L. Rev. 653 (1991) ("Perhaps no area of law embodies more legal fictions—and better illustrates their use and misuse—than does civil forfeiture.").

[69] Jarret B. Wollstein, *Turning the Tide: Winning Public Support for Ending Drug Prohibition*, in *New Frontiers in Drug Policy* 90, 90 (Arnold S. Trebach & Kevin B. Zeese eds., 1991)

In the fiscal year 1993, "the DEA made 14,430 domestic seizures of nondrug property, valued at approximately $669 million."[70] Moreover, forfeitures have become a popular way to generate additional revenue.[71]

The *in rem* nature of a civil forfeiture proceeding, replete with its many procedural pitfalls, rests on the legal fiction that the property itself is guilty of wrongdoing.[72] The uneven burdens of proof assigned the parties reveals the imbalance in the system. To prevail, the government need only have reasonable grounds to believe the property is subject to forfeiture.[73] It falls to the claimant to prove by a preponderance of the evidence the negative proposition that the property was "innocent."[74]

As a result of the over-zealous application of the forfeiture statutes, the judiciary has attempted to curb some of the more visible excesses.[75] For instance, ab-

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[70]Drugs & Crime Data Center & Clearinghouse, *Fact Sheet: Drug Data Summary* 2 (Apr. 1994).

[71]In *United States v. James Daniel Good Real Property*, 114 S. Ct. 492 (1993), the Supreme Court observed: "The extent of the Government's financial stake in drug forfeiture is apparent from a 1990 memo, in which the Attorney General urged United States Attorneys to increase the volume of forfeitures in order to meet the Department of Justice's annual budget target: 'We must significantly increase production to reach our budget target. . . . Failure to achieve the $470 million projection would expose the Department's forfeiture program to criticism and undermine confidence in our budget projections. Every effort must be made to increase forfeiture income during the remaining three months of [fiscal year] 1990.' " 114 S. Ct. at 502 n.2 (quoting Executive Office for United States Attorneys, United States Dep't of Justice, *38 United States Attorney's Bulletin* 190 (1990)).

[72]See, *e.g.*, *United States v. 92 Buena Vista Ave.*, 113 S. Ct. 1126, 1135 (1993).

[73]See *United States v. Daccarett*, 6 F.3d 37, 55 (2d Cir. 1993); *United States v. All Right, Title and Interest in Real Property*, 983 F.2d 396 (2d Cir. 1993). Even with this low standard, the courts have had to remain vigilant to root out governmental abuse. See, *e.g.*, *United States v. £31,990*, 982 F.2d 851, 856 (2d Cir. 1993) ("Since 'there is little to discourage federal agents from seizing property illegally, and then seeking evidence of probable cause,' courts must guard against the abuse of forfeiture in the government's zeal to apprehend and prosecute drug dealers."); *United States v. £19,910.00 in U.S. Currency*, 16 F.3d 1051, 1067 (9th Cir. 1994) ("Requiring the government to show that it had probable cause at the time it brought the action would only discourage filings of forfeiture when probable cause does not exist. Such a result is entirely proper. Without such a rule, government agents might be tempted to bring proceedings (and thereby seize property) on the basis of mere suspicion or even enmity and then engage in a fishing expedition to discover whether probable cause exists.").

[74]See, *e.g.*, *United States v. Daccarett*, 6 F.3d at 57.

[75]Adding a reasonableness component to the statutory innocent owner defense, some courts have asserted that they "do not expect the common land owner to eradicate a problem our law enforcement organizations cannot control." *United States v. One Parcel of Real Estate*, 963 F.2d 1496, 1506 (11th Cir. 1993) (citing cases); see also *United States v. All Right Title and Interest in Property*, 753 F. Supp. 721, 125 (S.D.N.Y. 1990) ("a property owner is not required to take heroic or

sent exigent circumstances, pre-hearing seizures of homes, where the tenants were either evicted outright or were permitted to stay at the sufferance of the United States Marshall, are no longer tolerated.[76] And the forfeiture of real property is now expressly subject to the limitations of Eighth Amendment proportionality analysis.[77]

A claimant's ability to defend against a forfeiture has long been compromised by the maze of rules allowing for the freezing of assets, which alone often discourages private counsel from taking on a case. Too often, the failure to secure experienced counsel results in the loss of the property.

Finally, with news accounts of law enforcement personnel driving around in expensive cars seized during drug operations, reports of police helicopters with sophisticated detection equipment hovering over homes, and the intrusive subpoenaing of records from bona fide businesses (such as those offering hydroponic gardening equipment),[78] it is clear that forfeiture laws require an overhaul.

8. Erosion of Privacy Rights

Although the Ninth Amendment guarantees that "[t]he enumeration in the Constitution of rights shall not be construed to deny or disparage others retained by the people,"[79] our society has struggled to find a balance between individual liberty and privacy and governmental intrusion. Although the United States Supreme Court has recognized certain activities as being beyond the reach of most state or federal governmental intrusion (e.g., birth control,[80] abortion during the first

vigilante measures to rid his or her property of narcotics activity. . . . Indeed encouraging such a standard would result in the dangerous precedent of making property owners in drug-infested neighborhoods into substitute police forces.").

[76]See, *e.g.*, *United States v. 4492 S. Livonia Rd.*, 889 F.2d 1258 (2d Cir. 1989).

[77]See *Austin v. United States*, 113 S. Ct. 280 (1993).

[78]Rorie Sherman, *Weeding Out Pot Growers*, Nat'l L. J., Sept. 23, 1991, at 10 (reporting DEA use of subpoena power against hydroponics industry).

[79]U.S. Const., amend. IX; see Robert W. Sweet & Edward A. Harris, *Just and Unjust Wars: The War on the War on Drugs—Some Moral and Constitutional Dimensions of the War on Drugs*, 87 Nw. U. L. Rev. 1302, 1346–72 (1993) (arguing that "defining the scope of the right to drugs as a fundamental constitutional right [protected by the Ninth Amendment] poses no greater difficulty than defining the scope of other unenumerated constitutional rights that have been recognized and protected previously by the Court.").

[80]*Griswold v. Connecticut*, 381 U.S. 479 (1965).

trimester,[81] and the possession of adult pornography in the home[82]), drug use has never been found to be within the "right of privacy" that the Court has forged.[83]

Because the law, as it stands today, does not recognize the right to use drugs, the "war on drugs" has become "in effect, if not in intention, a war on drug users."[84]

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[81] *Roe v. Wade*, 410 U.S. 113 (1973).

[82] *Stanley v. Georgia*, 394 U.S. 557 (1969). But see *Osbourne v. Ohio*, 110 S. Ct. 1691 (1990) (holding that states can outlaw private possession of child pornography with minors as subjects).

At least one commentator has noted the apparent lack of distinction between the private possession of adult pornography in the home and drug use: "If the Stanleys of the world could obtain from a new drug called 'obscenamine' the sensation that Stanley in fact obtained from the obscene film whose possession Georgia unsucessfully sought to make a crime, one might expect a legislative attempt to make possession or use of obscenamine a criminal offense. The precedents appear, on the whole to affirm the state's power to take such a step. Yet it does seem bizarre to draw the distinction implicit in such an outcome. To be sure, at stake in *Stanley* was the value of preventing government from rummaging through someone's library to discover evidence of his mental and emotional tastes. yet is it so much less offensive for government to rummage through someone's medicine chest, kitchen, and wine cellar to put together a picture of his oral and chemical predilections? In either case, the offense is governmental invasion and usurpation of the choices that together constitute an individual's psyche." Laurence Tribe, *American Constitutional Law § 15–7, at 1326 (2d ed. 1988).*

[83] See *Employment Div., Dep't of Human Resources v. Smith*, 494 U.S. 872 (1993) (holding that states may prohibit sacramental peyote use); see also *People v. Shepard*, 50 N.Y.2d 640, 409 N.E.2d 840, 431 N.Y.S.2d 363 (1980) (holding that possession of marijuana in home was not protected by right of privacy).

The courts in Germany, however, have held that it is unconstitutional for the government to tolerate the use of some intoxicants, such as alcohol, while criminalizing others, such as marijuana and hashish. Stephen Kinzer, *German Court Allows Possession of Small Amounts of Marijuana*, N.Y. Times, May 3, 1994, at A12 (reporting that Germany's highest court has ruled that equal protection provision of German constitution protects uses of small amounts of marijuana and hashish); see also Stephen Kinzer, *A Pro-Drug Ruling Stirs the Pot in Germany*, N.Y. Times, Mar. 3, 1992, at A5 (reporting that appeals court in Lubeck, Germany, "ruled that keeping alcohol legal while banning hashish and marijuana violated a constitutional provision guaranteeing all citizens equality before the law . . . [and] a provision guaranteeing personal freedoms that do not infringe on the rights of others"). For a similar analysis, see Laurence Tribe, *American Constitutional Law § 15–7, at 1325–26 (2d ed. 1988).*

[84] Grinspoon & Bakalar, *supra* note 27, at 357. Law enforcement techniques specially aimed at drug users tend to catch otherwise law-abiding citizens who are functioning members of society. See Steven Lee Meyers, *Washington Hts. Drug Sweep Nets 49*, N.Y. Times, Aug. 13, 1993, at B3 (reporting 12 hour operation in Washington Heights, New York, resulted in 49 arrests for possession of small amounts of controlled substances, including "a jeweler, a carpet layer, an electrical engineer, a pipe fitter, a college student and an auditor at the Internal Revenue Service"; "[t]here were men and women, from 18 to 63 years old, most of them white, most of them from New Jersey suburbs"); see also Lisa W. Foderaro, *An Arrest Divides the Generations*, N.Y. Times, Feb. 8, 1992, at 23 (reporting guilty plea by a 49-year old lawyer on federal charges of growing marijuana on 30

Year after year, state and federal laws that prohibit the possession of drugs, demonize and criminalize the users of drugs, estimated to be at least 20 million in the United States alone.[85] Yet, "[d]rugs have been used to alter consciousness in most societies throughout history, and different drugs have been considered acceptable at different times and places."[86] As Lester Grinspoon and James B. Bakalar have stated:

> Of all the Prohibition era mistakes we are now repeating, the most serious is trying to free society of drugs by the use of force. There is no reason to believe that the inclination to ingest substances that alter consciousness can be eradicated. A drug-free society is an impossible and probably an undesirable dream. . . . Our present drug policies are immoral because they require a war of annihilation against a wrongly chosen enemy. We will never be able to regulate the use of consciousness-altering drugs effectively until our ends are changed along with the means that serve them.[87]

Ending drug prohibition would enable the Court and our society to recognize

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acres of his property in upstate New York; felony charge carried potential sentence of 5 to 40 years in prison, $2 million in fines, forfeiture of property, and possible disbarment).

[85]Grinspoon & Bakalar, *supra* note 27, at 357; see also *id.* at 359 ("Federal involvement emphasizes the unfortunate imagery of a patriotic war in which drugs and drug users are the enemy."); Letter to the Editor, *Let's Take the Crime Out of the Drugs*, N.Y. Times, Jan. 20, 1994, at A20 (Dr. Howard I. Hurtig, Professor of Neurology, University of Pennsylvania, stating, "Congress and the White House could help mightily by dismantling the illogical cycle of law enforcement-punishment for 'crimes' fabricated by misguided policy makers.").

[86]Grinspoon & Bakalar, *supra* note 27, at 360; see also John Noble Wilford, *The Earliest Wine: Vintage 3500 B.C. and Robust*, N.Y. Times, Apr. 30, 1991, at C1 ("[A]rcheologists have now found chemical evidence that people were making and drinking wine at least as long ago as the fourth millennium B.C., the earliest established occurrence of wine anywhere in the world. . . . People probably imbibed to relieve the stresses of living in an increasingly complex and urbanized society."); L. Kutner, *Parent & Child*, N.Y. Times, Nov. 4, 1993, at C14 ("Many [drug-abuse] researchers . . . state that seeking altered states of consciousness is normal and healthy."). "Marijuana has been in use since at least A.D. 400, primarily for its euphoric effects and relatively low toxicity. The world's earliest known marijuana smoker was a 14-year-old girl who apparently died about 1,600 years ago while giving birth. THC was found in abdominal area of her skeletal remains in a tomb near Jerusalem." *"Marijuana Euphoria" Comes From Within, Too, Study Says*, Newsday, Aug. 17, 1993, at 63 (reporting that human brain contains natural substance that seems to be equivalent to tetrahydrocannabinol ("THC"), the principal psychoactive component of marijuana).

[87]Grinspoon & Bakalar, *supra* note 27, at 360.

the right of individuals to alter their consciousness (the most private of matters),[88] so long as they do not harm the persons or property of others.

D. Prohibition-Induced Violence

In New York and elsewhere in the United States, wild shootouts in urban areas are frequently publicized. These reports reveal that innocent bystanders in these areas are often caught in the cross-fire. It is, however, far from clear that the use of or need for prohibited drugs causes this sort of violent crime. Rather, the available evidence tends to support the conclusion that it is the prohibitionist laws against drugs that cause the violent crimes that people generally deplore.[89]

So-called "drug-related crime" is often related only indirectly to the drugs themselves, resulting instead from the illegal black market in drugs that is, in turn, spawned by laws prohibiting the legal sale of drugs.[90] For example, the Los Ange-

[88]The Court has recognized that "[t]he fantasies of a drug addict are his own, and beyond the reach of the state." *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 67 (1973).

[89]See James Ostrowski, *The Moral and Practical Case for Drug Legalization*, 18 Hofstra L. Rev. 607, 650 (1990) ("Prohibition also causes what the media and police misname 'drug-related violence.' This *prohibition-related* violence includes all the random shootings and murders associated with black market drug transactions: ripoffs, eliminating the competition, killing informers and suspected informers. Those who doubt that prohibition is responsible for this violence need only note the absence of violence in the legal drug market. For example, there is no violence associated with the production, distribution, and sale of alcohol. Such violence was ended by the repeal of Prohibition.") (emphasis in original).

[90]Researchers working with the New York City Police department analyzed approximately one-quarter of the city's 1988 homicides. The identified five types of relationships between drugs and murder: "Their term 'psychopharmacological' refers to homicides in which ingesting a drug or drug withdrawal caused a drug user to become excitable, irrational, and[/]or violent. Death might also have occurred because of alterations in the drug user's behavior that drew violence upon them from others. 'Economic-compulsive' refers to instances in which a drug user engaged in violent crimes in order to obtain money for drugs. 'Systemic' refers to instances in which a dealer or user became violent in order to compete within a violent black market. 'Multidimensional' refers to homicides that entailed more than one of these forms, making it difficult to say which was most responsible. In homicides with 'drug related dimensions' the drug was used by the perpetrator and/or the victim but was not sonsidered the primary reason for the homicide. These five categories were used to categorize all cocaine-related homicides.

... [T]he pharmacological model fits cocaine and crack related crime only rarely. Similarly, the economic-compulsive model applies to only a very small portion of the cocaine and crack related crime. However, the systemic model does account for a substantial amount of crime. ... [M]ost cocaine-related homicides are systemic and most systemic homicides are cocaine-related.

... [T]here is still nosubstantial evidence to support the hypothesis that drugs, in this case coles police have long known that the lucrative black market in cocaine has provided the incentive (as well as the financing) for the bloody gang turf wars in that city.[91] Similarly, it is estimated that 40% of the homicides in a study of 414 homicides in New York City precincts were indirectly attributable to black market trafficking in drugs.[92] Further supporting the fact that it is drug prohibition rather than drug use which is causing the alarming "drug-related" violence saturating our culture is the historical precedent of alcohol Prohibition which was accompanied by the same type of violence.[93]

There is no reason to believe that black markets would not disappear with the ending of drug prohibition. Common sense indicates that without the immense profits guaranteed by the necessarily restricted nature of the outlets, there would be little advantage to maintaining such black markets.[94] The current patterns of drug-sale related turf violence would be substantially, if not wholly, undermined.

E. Prohibition's Failure to Limit Drug Use

Proponents of the "war on drugs" often eagerly declare that the draconian prohibitionist laws of the state and federal government are causing a decline in drug use.[95] The evidence, however, tends to show that "the number of heavy drug users in the

caine, cause crime." Randy T. Salekin & Bruce K. Alexander, *Cocaine and Crime*, in *New Frontiers in Drug Policy* 105, 111 (Arnold S. Trebach & Kevin B. Zeese eds., 1991); *cf.* James Ostrowski, *The Moral and Practical Case for Drug Legalization*, 18 Hofstra L. Rev. 607, 647 (1990) ("It is estimated that at least forty percent of all property crime in the United States is committed by drug users so that they can maintain their expensive habits.").

[91] *F.B.I. Says Los Angeles Gang Has Drug Cartel Ties*, N.Y. Times, Jan. 10, 1992, at A12.

[92] See Joseph L. Galiber, *A Bill to Repeal Criminal Drug Laws: Replacing Prohibition with Regulation*, 18 Hofstra L. Rev. 831, 849 & n.89 (1990).

[93] "The murder rate rose with the start of Prohibition, remained high during Prohibition, and then declined for *11 consecutive years* when Prohibition ended. The rate of assaults with a firearm rose with Prohibition and declined for *10 consecutive years* after Prohibition." James Ostrowski, *Thinking About Drug Legalization*, Cato Institute Policy Analysis No. 121, May 25, 1989, at 1 (emphasis in original) (citation omitted).

[94] While a new approach to drug policy would not destroy markets created by use by the underaged, that problem could be dealth with separately and confronted directly, as is the case with alcohol and tobacco use.

[95] See, *e.g.*, H. Kleber, *Our Current Approach to Drug Abuse—Progress, Problems, Proposals*, 330 New eng. J. Med. 361, 361 (1994) ("Most drug-abuse experts and historians agree that we are in the declining phase of a drug epidemic that began about 30 years ago."). But see *Drug Use Increasing Despite Federal War*, Gannet Suburban Newspapers, May 12, 1994, at 16A (Quoting White house drug policy director Lee Brown as saying things are "not getting any better").

United States is undiminished."[96] In addition, recent surveys show an increasing number of high school students using marijuana and lysergic acid diethylamide ("LSD").[97] Even proponents of the "war on drugs" candidly admit that "drug abuse cannot be entirely eliminated."[98] Some experts have estimated that the government has spent close to $500 billion dollars over the past 20 years to enforce the prohibitionist laws against drugs, while during the same period use levels rose and the number of arrests and the amounts of drugs seized increased unabated annually.[99] 750,000 people were incarcerated for violating the prohibitionist drug laws during a twenty-year period, costing an average of $25 billion annually and $61 billion for 1991 alone.[100]

Although the vast majority of Americans polled stated that they would not take now-prohibited drugs if they were legalized,[101] many people voice the concern that use would escalate sharply upon legalization.[102] Implicit in the idea that use of

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[96]See Douglas Jehl, *Clinton to Use Drug Plan to Fight Crime*, N.Y. Times, Feb. 10, 1994, at D20 (reporting that experts estimate that 4 to 6 million Americans are heavy drug users); *Drug Use Increasing Despite Federal War*, Gannet Suburban Newspapers, May 12, 1994, at 16A (reporting that recent federal report found heroin use has increased in the Southwest, West, and part of the South, marijuana use continues to rise nationally, cocaine use remains stable; reporting that "the number of people using drugs monthly dropped about 21 percent from 1991 to 1992—from 14.5 million to 11.4 million" but that "the number of hard-core users—about 2.7 million people who consume the bulk of the nation's $49 billion worth of drugs annually—hasn't changed much since 1988").

[97]Joseph B. Treaster, *Survey Finds Marijuana Use is Up in High Schools*, N.Y. Times, Feb. 1, 1994, at A1, A14 (reporting that 26% of high school seniors acknowledged using marijuana in 1993, up from 21.9% in 1992; similarly 6.8% of high school seniors acknowledged using LSD in 1993, up from 5.6% in 1992).

[98]Kleber, *supra* note 95, at 361.

[99]Letter to the Editor, *Put Drug War Price at £500 Billion*, N.Y. Times, July 1, 1992, at A22 (Ernest Drucker and Peter R. Arno, respectively professor and associate professor of epidemiology and social medicine at Albert Einstein College of Medicine); see also Joseph P. Treaster, *Echoes of Prohibition: 20 Years of War on Drugs, and No Victory Yet*, N.Y. Times, June 14, 1992, § 4, at 7; James Ostrowski, *Thinking about Drug Legalization*, Cato Institute Policy Analysis No. 121, May 25, 1989, at 6 ("there is a real danger that escalating the war on drugs would squander much of the nation's wealth").

[100]Letter to the Editor, *Put Drug War Price at £500 Billion*, N.Y. Times, July 1, 1992, at A22.

[101]Grinspoon & Bakalar, *supra* note 27, at 358 ("Public-opinion surveys also suggest that few people who do not now use illicit drugs would use them if the laws changed. . . . Only 2 percent of people who do not use cocaine say they might try it if it were legalized, and 93 percent state vehemently that they would not.").

[102]See, *e.g.*, David T. Courtwright, *Should We Legalize Drugs? History Answers: No*, 44 Amer. Heriage 41, 50 (1993); Josepha A. Califano, Jr. *Battle Lines in the War on Drugs: No, Fight Harder*, N.Y. Times, Dec. 15, 1993, at A27.

drugs would rise upon legalization is the assumption that the current prohibitionist laws discourage many people from using them.[103] The available evidence tends to show that Americans can and do voluntarily control their use of drugs.

The recent decline in middle class use of drugs[104] as well as recent declines in alcohol and tobacco[105] consumption have been attributed by many experts to factors (such as education, health and fitness awareness, and social pressures) other than the prohibitionist laws against drugs.[106] Experts have recognized these other factors as the basis for the current levels of use of drugs (including alcohol and

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Many proponents of the current prohibitionist laws argue that users of psychoactive substances would not be able to control their consumption if such substances were legalized and readily available. *E.g.*, Letter to the Editor, *Can Drugs Be Used Only in Moderation*, N.Y. Times, Feb. 25, 1994, at A28 (Philip J. Pauly, an Associate Professor of the History of Science at Rutgers University, argues that it is unlikely that "recreational users of cocaine and heroin could indulge 'moderately' as part of genteel social behavior"); see also Letter to the Editor, *Why Marijuana Should Remain Illegal*, N.Y. Times, Feb. 26, 1994, § 1, at 22 (Stephen H. Green, Acting Administrator of the DEA, argues that marijuana should continue to be prohibited in part because users would not be content wit marijuana distributed by "health regulators" if the chemical causing its psychoactive effects, tetrahydrocannabinol ("THC"), were controlled; users would resort, instead, to "illegal growers pushing their higher potency marijuana"). These assertions, however, are propounded without any empirical supporting evidence.

[103] *E.g.*, Letter to the Editor, *Can Drugs Be used Only in Moderation*, N.Y. Times, Feb. 25, 1994, at A28 ("For today's situation to be comparable [to the circumstances leading to the repeal of Prohibition], we would need to establish a drug control system in which most recreational users of cocaine and heroin could indulge 'moderately' as part of genteel social behavior. I think that is unlikely.").

[104] Both "greater social disapproval of marijuana use and greater perceived risk of harm from marijuana use were found to account for a substantial portion of the decline both in the U.S. and Canada." Patricia G. Erickson & Yuet W. Cheung, *Drug Crime & Legal Control: Lessons from the Canadian Experience*, 19 Contemporary Drug Problems, 247, 260 (1992).

[105] "Over the past 30 years, tremendous public health efforts have been made to persuade smokers to quit and to discourage others from adopting their habit. As a result, cigarette smoking prevalence has declined significantly, especially among men. In 1955, nearly 60% of men and 28% of women were smokers. By 1990, only 28% of men and 23% of women reported that they smoked cigarettes." American Cancer Society, *Risk Report* 5 (1993).

[106] See, *e.g.*, J. G. Bachman, L. D. Johnston, P. M. O'Malley & R. H. Humphrey, *Explaining the Recent Decline in Marijuana Use: Differentiating the Effects of Perceived Risks, Disapproval, and General Lifestyle Factors*, 29 J. of Health and Social Behavior 92, 107 (1988). "[T]he data suggest strongly that if there had not been distinct increase in negative attitudes about marijuana, we would not have found steadily lower levels of marijuana use in each succeeding class of high school seniors since 1979. . . . [B]oth perceived risks and personal disapproval of marijuana use, especially regular use, have risen sharply since 1978. . . . [T]he analyses suggest that if perceived risks and disapproval associated with regular marijuana use had not risen substantially in recent years, the decline in actual use would not have occurred." *Id.*

tobacco) rather than the existence of prohibitionist laws.[107]

Indeed some observers have cited the prohibitionist laws against drugs as a significant factor leading to increased use and greater numbers of addicts than we would otherwise have:

> "[T]he growth of addiction over the last four decades in the US had little to do with price reductions or, for that matter, with the growth of real income. The crucial factor in the spread of the drug habit has been the unrelenting pressure exerted by legions of street pushers in the continuing endeavor to widen the circle of the customers. In other words, *the crucial factor in spreading the drug habit has been the super profits made possible only by governments' illegalization of the trade*."[108]

It is impossible to prove the levels of post-legalization use of now-prohibited drugs, but reasonable extrapolations may be made by referring to similar experiences in this country and abroad.

Prohibition of alcohol in the United States earlier in this century is a basis for comparison, albeit an imperfect one. A review of alcohol consumption pat-

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[107]"The thrust of numerous findings demonstrated the very weak role of legal threats compared with extralegal factors in decisions to use or not use cannabis. Marijuana use became the most studied crime in the deterrence literature, enabling one investigator who exploited it for a comparative analysis of methodologies to conclude that however and wherever studied, 'perceptions of formal sanctions play little or no role in explaining variance in rates of self-reported marijuana use.' " Erickson & Cheung, *supra* note 104, at 258 (citation omitted.)

Jeffrey Fagan and William Spelman, Associate Professors, respectively, of criminal justice at Rutgers University and of public affairs at the University of Texas, have argued that market forces, more than law enforcement efforts, have the greatest impact on the deleterious health effects of the so-called "drug problem": "Drug epidemics come and go in New York and other large cities. The behavior of legal institutions seems to be far less influential in these epidemics than the natural ebb and flow of each drug era. Acting much like consumers in a free market, drug users and sellers regulate their own affairs, setting rules and transmitting knowledge about the dangers and effect of particular drugs." Letter to the Editor, *Market Forces at Work*, N.Y. Times, Feb. 11, 1994, at A34.

[108]E.J. Mishan, *Narcotics: The Problem and the Solution*, 61 Pol. Quar. 441, 458 (1990) (emphasis in original); see also Sidney Zion, *Battle Lines in the War on Drugs: Make Them Legal*, N.Y. Times, Dec. 15, 1993, at A27 (" 'Under prohibition every addict becomes a salesman. . . . He has to bring in new customers so that he can earn enough money to feed his habit.' " (quoting British physician John Marks)). "[T]here is at least some evidence that the 'forbidden fruit' aspect of prohibition may lead to increased use of or experimentation with drugs, particularly among the young. . . . The case for legalization does not rely on this argument, but those who believe prohibition needs no defense cannot simply dismiss it." James Ostrowski, *Thinking About Drug Legalization*, Cato Institute Policy Analysis No. 121, May 25, 1989, at 1.

terns during and after Prohibition shows that during most of the Prohibition era per capita alcohol consumption actually increased.[109] After "Prohibition's repeal in 1933, consumption remained fairly stable until after the Second World War when, without any change in public policy, it began increasing."[110] The prohibitionist laws, therefore, seem to have little impact on an individual's decision whether to use drugs.[111]

Another useful example is the experience of the ten states that decriminalized the possession of small amounts of marijuana for personal consumption in the 1970s. There was no increase in the level of marijuana use in those states.[112] Indeed marijuana consumption declined in those states just as it did in states that retained criminal sanctions against marijuana.[113]

In 1976, the Dutch decriminalized marijuana consumption,[114] although possession and small sales technically remained illegal.[115] The level of use actually declined after decriminalization.[116] Indeed marijuana use in the Netherlands is substantially lower than in countries waging a "war on drugs," including the United States and, at least until recently, Germany.[117] Among Dutch youths aged 17–18, only 17.7% used marijuana at least once in their lifetimes, as opposed to 43.7% of Americans. Only 4.6% of the Dutch had used marijuana at least once in the past month, as opposed to 16.7% of the Americans. While indicating clearly that prohibitionist laws do not prevent the use of drugs, these statistics also tend to show

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[109] Letter to the Editor, *Just Say Yes*, The Village Voice, Jan. 18, 1994, at 6 (submitted by Dr. John P. Morgan, Professor, City University of New York Medical School).

[110] *Id.*

[111] *Id.*

[112] Grinspoon & Bakalar, *supra* note 27, at 358; see also Steve France, *Should We Fight or Switch?*, 76 A.B.A.J. 42, 45 (1990).

[113] Ethan Nadelmann, *Isn't it Time to Legalize Drugs?*, The Boston Sunday Globe, Oct. 2, 1988, at A23; see also J. P. Morgan, D. Riley & G. B. Chesher, *Cannabis: Legal Reform, Medicinal Use and Harm Reduction*, in *Psychoactive Drugs and Harm Reduction* (Nick K. Heather ed., 1993) (reporting that decriminalization, of small amounts of marijuana in Australian state of South Australia in 1985 did not result in any change in rates of marijuana use in South Australia; there were no significant differences in rates of use between South Australia and other Australian states which had not changed their laws regarding marijuana).

[114] See Nadelmann, *supra* note 113, at A23.

[115] See Henk Jan van Vliet, *The Uneasy Decriminalization: A Perspective on Dutch Drug Policy*, 18 Hofstra L. Rev. 717 (1990).

[116] Nadelmann, *supra* note 113, at A23.

[117] But see Marlise Simons, *Drug Floodgates Open, Inundating the Dutch*, N.Y. Times, Apr. 20, 1994, at A4 (reporting that "drug tourists" from Germany, Belgium, Luxembourg, and France flock to the Netherlands because of its "permissive rules for soft drugs").

that legalizing now-prohibited drugs, at least marijuana, does not inevitably cause an increase in use.

Under an exception to the British prohibitionist system, doctors may provide prohibited drugs to addicts. Dr. John Marks of Liverpool commenced such a program in 1982, and, to his astonishment, he noted that the number of new addicts decreased in Liverpool while in a nearby town operating under prohibition the rate of new addicts was twelve-fold higher.[118] Dr. Marks attributed the decline in the number of new addicts to the fact that addicts received their needed drugs from his program for pennies, thus there was no longer any need for addicts to bring in new customers to raise enough money to support their habits.

Others addressing the issue of whether the levels of use of now prohibited drugs would escalate to overwhelming proportions after legalization (as many prohibitionists have predicted) have likened possible patterns of illegal drug use to patterns of alcohol use, with which we have a solid familiarity. They point out that Western cultures have handled alcohol consumption with tolerable skill for centuries[119] and point out that most of the American population that drinks occasionally, or even every day, exercises moderation.[120]

Indeed the available data indicate that the vast majority of the American population that uses now-prohibited drugs does so with moderation. According to United States government statistics, more than 75 million persons in the United States household population have used prohibited drugs.[121] The National Institute on Drug Abuse estimates that close to 40 million Americans continue to consume these substances.[122] Yet, only a comparatively minuscule number of deaths due to drug overdoses, 4,242, occurred in 1991 according to medical examiner data com-

[118]Sidney Zion, *Battle Lines in the War on Drugs: Make Them Legal*, N.Y. Times, Dec. 15, 1993, at A27.

[119]France, *supra* note 112, at 45.

[120]"[W]hat grounds are there for the tacit assumption that if prohibition were lifted [drug] consumption would increase so dramatically as to create a social crisis? The citizens of the West do not customarily behave like an unthinking bovine herd, ready to ingest anything placed before them that is cheap and plentiful. After all, alcoholic liquors—regarded by drug specialists as the most dangerous of all drugs—are universally available. Yet the vast majority of citizens are not addicts. Nor is there any expectation that they ever will be. . . . [M]ost people drink occasionally, or even daily, but in moderation. Were the trade in cocaine to be decriminalized, it is reasonable to expect that, after some initial experimenting, the pattern would not be dissimilar to that of alcohol." E. J. Mishan, *Narcotics: The Problem and the Solution*, 61 Pol. Quar. 441, 442–43 (1990).

[121]Bureau of Justice Statistics, United States Department of Justice, *Drugs, Crime, and the Justice System* 26 (1992).

[122]Nadelmann, *supra* note 113, at A23.

piled by the Drug Abuse Warning Network.[123]

Once the distinction between use of prohibited drugs and abuse is acknowledged, the available statistics show that the vast majority of Americans who use drugs do not abuse them. Based on our experience with American states' and foreign decriminalization of marijuana, it appears that decriminalization does not lead to greater levels of use nor to abuse. Likewise there is evidence to support the proposition that the decriminalization of the so-called "hard drugs" does not lead to increased rates of addiction. Perhaps most importantly, data analysis strongly indicates that social factors wholly apart from the criminalization of drugs account in the greatest measure for reduced rates of use.[124] Based on the evidence, it would not be unfair to say that the predicted, post-legalization explosion in the use of drugs has been greatly overstated and that use in continued moderation would be the much more likely result. European countries, such as the Netherlands, have benefitted from an approach to drugs that focuses on "harm reduction" rather than draconian measures to enforce prohibition.[125]

F. Prohibition Threatens Public Health

1. Spread of Disease

a. Sharing Needles

Because the possession of hypodermic needles is generally illegal, users of injectable drugs routinely share needles and syringes with one another, often in

[123]Medical Examiner Data, Table 4.02—Distribution of drug abuse deaths by selected episode characteristics: 1988–1991, in *Annual Medical Examiner Data* 1991, Data from the Drug Abuse Warning Network, *NIDA Statistical Series*, Series I, Number 11-B, page 50.

[124]The drastic decline within the past thirty years in use of tobacco, perhaps the most addictive psychoactive substance of all, without resort to any criminal sanctions, stands as the paramount example of the power of social controls over patterns of use of psychoactive substances.

[125]Grinspoon & Bakalar, *supra* note 27, at 359 & n.27 (citing E. A. Nadelmann, *Thinking Seriously About Alternatives*); see also John Horgan, *A Kinder War*, Sci. Amer., July 1993, at 24 (citing Arnold S. Trebach). Arnold S. Trebach is the president of The Drug Policy Foundation, a non-profit group based in Washington, D.C. that explores alternatives to the current drug policies and which espouses an approach to "the drug problem" called "harm reduction." The idea behind harm reduction is that drug abuse whould be viewed, at worst, as a disease requiring treatment and not an absolute evil that must be eradicated at all costs. "The essence is the acceptance of the enduring reality of drug use, the absurdity of even attempting to create a drug-free society and the need to treat drug users and abusers as basically decent human beings." *Id.*

"shooting galleries" where dozens of addicts may line up to use a single needle rented out by the dealers and not sterilized between uses. This sharing of needles has become a major source of transmission of blood-borne diseases such as acquired immune deficiency syndrome ("AIDS") and hepatitis.[126] According to a recent national review, "more than 33% of new AIDS cases occur among injecting drug users or people having sexual contact with them."[127] In New York State, the majority of new AIDS cases since 1988 have been reported among users of injectable drugs and their sexual partners. Both the Centers for Disease Control and the New York State Department of Health have estimated that more than 75% of pediatric AIDS cases are children whose mothers either injected drugs or were the sexual partners of persons who injected drugs.[128] The data suggest, at the very least, that sterile hypodermic needles should be readily and freely available to drug users. So long as drug use remains unlawful, however, free needle distribution is not likely to attract a substantial portion of the user population.[129] In response, some courts have circumscribed laws dealing with the unlawful possession of hypodermic needles by applying defenses of medical necessity.[130]

b. Trading Sex for Drugs

Because illicit drugs are expensive, many addicts turn to prostitution to make money to support their habits, or exchange sexual services directly for drugs.[131] Prostitute drug addicts often do not protect themselves from contracting sexually

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[126] See Don C. Des Jarlais & Samuel R. Friedman, *AIDS and the Use of Injected Drugs*, Sci. Amer., Feb. 1994, at 82, 84; Don C. Des Jarlais, Samuel R. Friedman, Jo L. Sotheran, John Wenston, Michael Marmor, Stanley Yancovitz, Blanche Frank, Sara Beatrice & Donna Mildvan, *Continuity and Change Within an HIV Epidemic: Injecting Drug Users in New York City, 1984 through 1992*, 271 JAMA 121–27 (1994).

[127] Robert Wood Johnson Foundation, *Substance Abuse: The Nation's Number One Health Problem* 36–37 (1993) [hereinafter *Substance Abuse*].

[128] National Association of State Alcohol and Drug Abuse Directors, *Treatment Works* 10–12 (1990) [hereinafter *Treatment Works*].

[129] See *New York Needle Exchanges Called Surprisingly Effective*, N.Y. Times, Feb. 18, 1993, at A1, B4.

[130] See *People v. Bordowitz*, 155 Misc. 2d 128, 588 N.Y.S.2d 507 (Sup. Ct., N.Y. County 1991) (medical necessity defense sustained where defendants handed out clean hypodermic needles to drug addicts to prevent further spread of HIV and AIDS infections).

[131] See, *e.g.*, Richard B. Woodward & Eugene Richards, *Under Their Skin*, N.Y. Times Magazine, Dec. 5, 1993, at 58 (photo of woman performing act of prostitution for money to buy drugs); Sonia Nazario, *Sex, Drugs and No Place To Go*, Los Angeles Times, Dec. 12, 1993, pt. A, at 1, col. 1 (profiles of teenage prostitutes selling their bodies for drugs).

transmitted diseases carried by their customers, and they pass such diseases on to other customers, their lovers, and their children.[132] The crack epidemic, in particular, has been blamed for the recently noted resurgence of syphilis and other sexually transmitted diseases. Dr. Robert Rolfs of the Centers for Disease Control placed the blame squarely on cocaine and its high cost:

> People—especially women—have high-risk sex and practice prostitution to support their habits. And it is occurring in a relatively poor population where people have a lot of things that prevent their access to treatment. Therefore, they stay infected longer and are more likely to pass their infections on to others.[133]

Fewer addicts would be forced to resort to prostitution if the current prohibitions against drugs were lifted.

c. Neglect of Health

Because of addicts' preoccupation with obtaining and using drugs, and the debilitating effects of some of the drugs themselves, many addicts are in very poor health. Malnutrition is a frequent problem and, in turn, contributes to many others.[134] Addicts' poor health makes them especially susceptible to diseases ranging from scurvy and shingles to tuberculosis and the flu. Addicts are also more likely to contract communicable diseases and therefore more likely to spread them. The interrelated urban problems of homelessness and illegal drug abuse have contributed to the development of multi-drug-resistant strains of diseases such as tuberculosis, which was once thought to be on the verge of eradication.[135] These

[132]See, *e.g.*, Jonathan Eig, *Parental Addiction; Mother of Six Crack Babies Blames Drugs, Prostitution*, Dallas Morning News, Dec. 12, 1993, at 1A (profile of mother who "continues to sell her body for cocaine" and does not consistently use condoms); Katherine Boo, *Unpretty Woman*, Washington Post, Aug. 22, 1993, at C1 (reporting risky behavior of "crack whore").

[133]See Laurie Garrett, *Syphilis, Gonorrhea Cases Soar in U.S.*, Newsday, Sept. 19, 1990, at 2 (quoting Dr. Robert Rolfs).

[134]See, *e.g.*, Robert Lipsyte, *Ladling Out a Little Hope to the Hopeless*, N.Y. Times, Oct. 24, 1993, § 13, at 3 (describing various ills of addicted prostitutes); Richard P. Usatine, L. Gelberg, M.H. Smith & J. Lesser, *Health Care for the Homeless*, 49 Amer. Family Physician 139 (1994) (describing studies of general health problems associated with substance abuse).

[135]See, *e.g.*, Kathleen Neville, Assia Bromberg, Ruven Bromberg, Stanley Bonk, Bruce A. Hanna & William N. Rom, *The Third Epidemic—Multidrug-Resistant Tuberculosis*, 104 Chest 45 (1994) (multidrug-resistant TB linked to intravenous drug abuse, homelessness, HIV infection); Robert M. Morgenthau, *Efforts Needed on Behalf of Our Children*, N.Y.L.J., Jan. 19, 1994, at 2 (noting connection of injection drug use to drug-resistant TB, and consequent costs to society).

more virulent diseases know few geographical limitations and pose risks to the general population.

d. Avoidance of the Health-Care System

Individuals who use illegal drugs often put off addressing their health problems for fear of prosecution or other adverse consequences (*e.g.*, rebuffs by doctors, loss of job).[136] This reluctance to seek medical care is compounded by the fact that many drug addicts have no private physicians and rely instead on public hospitals or clinics for any care they might get.

Prohibition, therefore, has perverse results on health; drug abusers tend to enter the health-care system only if and when their need for care is acute, which is also when care is most costly to deliver. If, for example, a woman avoids pre-natal care, she may give birth to a baby with low birth weight and other medical difficulties. If a drug abuser puts off seeking treatment for illnesses and injuries, he or she may end up in the emergency room and the intensive care ward.[137]

Mothers and pregnant women face the additional and justifiable fear that any detectable drug use may be reported as a possible indication of child abuse or neglect. In many large city hospitals, the urine of newborn babies is tested for prohibited drugs, and mothers whose babies test positive for pre-natal exposure are reported to the child abuse authorities. Until recently, in New York City, such babies were routinely kept from their mothers pending investigations that often lasted many months, interfering with normal bonding and necessarily adversely affecting the infant's development and relationship with the parent. Moreover, these women have, in some jurisdictions, been prosecuted for pre-partum distribution of prohibited drugs.[138]

[136] See, *e.g.*, Andrea Hamilton, *Supporters Say Needle Exchange Works, and Addicts Like It*, Associated Press, Feb. 28, 1994 (quoting doctors discussing addicts' reasons for avoiding regular health care system).

[137] See *Substance Abuse*, *supra* note 127, at 38–39 ("[i]llicit drug users—particularly people using cocaine or heroin—make more than 370,000 visits to costly emergency rooms each year"); Joseph B. Treaster, *U.S. Reports Sharp Increase in Drug-Caused Emergencies*, N.Y. Times, Oct. 5, 1993, at B11 (quoting federal officials reporting steep rise in costly emergency room care for drug-related ills).

[138] See, *e.g.*, Philip J. Hilts, *Hospitals Sought Out Prenatal Drug Abuse*, N.Y. Times, Jan. 21, 1994, at A12 (reporting that "university hospital in South Carolina has been accused of testing pregnant women for drug use without their consent," sharing the test results with law enforcement authorities and threatening women with prosecution if they refused to attend drug treatment program); see also Gina Kolata, *Racial Bias Seen on Pregnant Addicts*, N.Y. Times, July 20, 1990,

In addition to the obvious costs to the individuals who become infected with catastrophic illnesses directly through drug use, and the high costs to the health care system of treating them, prohibition contributes to the spread of such diseases throughout society, particularly to the sexual partners and children of infected drug users. Left untreated, users and addicts are more likely to give birth to unhealthy children, to abuse or neglect their children after they are born, or to have their children placed in foster care.[139]

2. Lack of Information and Quality Control

a. Adulterated Drugs, Designer Drugs, and Drugs of Unknown Potency

Because drugs are manufactured and distributed in secret, it is impossible for users to guard against adulteration or to determine the purity and potency of the drugs they use. The problem is compounded by drug growers, manufacturers, and distributors who, to minimize the risks of apprehension, develop and purvey the drug varieties that pack the most intoxicating effect into the smallest package. According to an experienced New York City researcher,

> The fact that cocaine, heroin and related drugs are illegal encourages the use of injection. Severe statutory restrictions greatly increase the cost of illicit substances to nonmedical users. Injecting provides a way to economize. Injectable forms of opiates and coca are much more concentrated than traditional forms, such as opium or coca tea. Injection provides an intense and economical effect by maximizing the amount of drug that reaches the brain. People who sniff or smoke drugs say that if they inject they need only one third of the amount of the drug to maintain a habit.

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at A13 ("Most women prosecuted for using illegal drugs while pregnant have been poor members of racial minorities, experts say, even though drug use in pregnancy is equally prevalent in middle-class women."). The drug distribution criminal cases against pregnant women are somewhat ironic in view of the scientific evidence that nursing women deliver natural opioids to their children in their human milk. See Natalie Angier, *Mother's Milk Found to Be Potent Cocktail of Hormones*, N.Y. Times, May 24, 1994, at C1.

[139]See Wendy Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 Am. J. Pub. Health 483 (1990); American Public Health Association, *Illicit Drug Use by Pregnant Women, 1990 Public Policy Statement Adopted at 118th Annual Meeting, No. 9020* 4–6 (1990); State of New York Anti-Drug Abuse Council, *Anti-Drug Abuse Strategy Report 1990 Updates*, 6, 33–37.

> Because the injection forms of illicit drugs are concentrated, they are [also] relatively easier to ship.[140]

It has been demonstrated that, as law enforcement and criminal penalties intensify, dealers also find other ways to economize by inventing new drugs—so-called "designer drugs"—that are not yet prohibited. This places the ill-informed consumers of such drugs at greater risk of overdose and other health problems. Illnesses and deaths have resulted from (1) the introduction of dangerous substances into drugs that could otherwise have been used with greater safety, (2) inadvertent overdoses due to variations in potency, and (3) the development of "designer drugs" intended to give the effect of familiar intoxicants with new chemical compositions that put them beyond the reach of current laws.[141] Just as the prohibition against alcohol led to sales of poisonous wood alcohol and the prohibition against abortion led to coat-hanger abortions, the prohibition against drug manufacture, sale, and possession results in unnecessary deaths due to adulteration, variable purity, and "designer drugs."[142] This contrasts sharply with the government's current regulation of alcoholic beverages, which ensures that the beverages are pure and that buyers know how strong they are and what some of their health effects may be. Experts have noted that heightened efforts to enforce drug laws and amend them to encompass new formulations or ban precursor substances may only push dealers to take greater risks, selling ever more potentially dangerous substances.[143]

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[140] Des Jarlais & Friedman, *supra* note 126, at 85.

[141] See, *e.g.*, *A Potent "Designer" Drug*, N.Y. Times, Feb. 3, 1991, at 30 (reporting on more than 150 deaths from overdoses of different forms of synthetic heroin, devised "[b]ecause laws outlawing drugs are based on specific chemical formulas [and] 'designer drugs' are legal until they are broken down in government laboratories and laws are rewritten to ban them."); Michael Hedges, *DEA Nabs 2 For Making Ultralethal Drug Fentanyl*, Washington Times, Feb. 6, 1993, at A4 (reporting arrest of "highly skilled" manufacturers of drugs responsible for many overdose deaths in the Northeast); Chapin Wright & Peg Tyre, *Killer Drug's Toll Now 12*, Newsday, Feb. 4, 1991, at 3.

[142] See James Ostrowski, *The Moral and Practical Case for Drug Legalization*, 18 Hofstra L. Rev. 607, 652, 654 (1990) ("Because there is no quality control in the black market, prohibition also kills by making drug use more dangerous. Illegal drugs contain poisons, are of uncertain potency, and are injected with dirty needles. Many deaths are caused by infections, accidental overdoses, and poisoning. . . . In summary, the attempt to protect users from themselves has backfired, as it did during Prohibition. The drug laws have succeeded only in making drug use much more dangerous by driving it underground and out of reach of moderating social and medical influences.").

[143] See Malcolm W. Browne, *Problems Loom In Effort to Control Use of Chemicals for Illicit Drugs*, N.Y. Times, Oct. 24, 1989, at C1 (reporting experts' belief that prohibition is futile because of "seemingly endless alternative methods of synthesizing drugs" and the continuing development of "new and ever more powerful drugs").

b. Lack of Knowledge About Safer Use

Because many drugs are outlawed, individuals considering drug use rarely have access to accurate information about the effects of drugs. While a cautious user may err on the side of avoiding certain activities while under the use of drugs, he or she may have no way of knowing, beyond trial and error, the possible adverse health consequences of certain combinations of drugs and his or her individual tolerance for particular substances. Because of its penchant for exaggeration and cartoonish treatment of the issues, most current education about drugs is not taken seriously by young people. As a result, it is far less effective than other health education (e.g., about nutrition, fitness, and smoking cigarettes).

c. Using Alcohol and Tobacco Instead of "Soft Drugs"

Alcohol and tobacco are completely legal yet do much more harm, statistically speaking, than illegal drug use.[144] It is also generally recognized that alcohol, at least when used to excess, can cause aggressive, anti-social behavior.[145] The current prohibitionist laws against marijuana, generally considered an "a-motivational" drug, and other so-called "soft drugs" have the effect of influencing some people to choose alcohol over these "soft drugs." Peter Reuter, an economist at the Rand Corporation, concludes that "If marijuana is a substitute for alcohol . . . , alcohol is, by definition, a substitute for marijuana. Thus tough marijuana enforcement must increase drinking."[146] Similarly, Frank Chaloupka, an economist at the University of Illinois, found through statistical analysis "that states without criminal sanctions against marijuana possession suffered fewer

[144] See, *e.g.*, Jane E. Brody, *17 States in Vanguard of War on Smoking*, N.Y. Times, Nov. 10, 1993, at C17 (reporting that new study by Dr. J. Michael McGinnis and Dr. WIlliam H. Foege ranks top nine nongenetic causes of death in the United States in 1990 with tobacco first (400,000 deaths per yar), alcohol third (100,000 deaths per year), and illegal use of drugs ninth (20,000 per year)). The federal government's Food and Drug Administration has recently suggested that cigarettes should be regulated as "an addictive drug" because tobacco companies "manipulate the amount of nicotine in cigarettes to maintain smokers' addictions." Philip J. Hilts, *U.S. Agency Suggests Regulating Cigarettes as an Addictive Drug*, N.Y. Times, Feb. 26, 1994, at A1.

[145] See, *e.g.*, Letter to the Editor, *Marijuana vs. Alcohol for Teenagers*, N.Y. Times, June 30, 1992, at 22, col. 4 (New York City police officer recalls "when we cracked down on the beer drinking [at rock concerts], marijuana smoke wafted overhead, and the few problems we encountered were usually the result of police officers arresting marijuana users").

[146] Peter Passell, *Economic Scene: Less Marijuana, More Alcohol*, N.Y. Times, June 17, 1992, at D2.

auto fatalities."[147] Finally, Karen Model, a Ph.D. candidate at Harvard, found that "states decriminalizing marijuana reported lower overall rates of drug- and alcohol-related emergencies."[148] To the extent that users are choosing alcohol rather than marijuana or other "soft drugs," the overall public health effects are probably worse than they would be otherwise.

3. Injuries Due to Violence

The high prices commanded by prohibited drugs create competition among groups and individuals willing to break the law to supply drugs to consumers. Their competition often becomes violent and has contributed to the build-up of arms and the pervasiveness of violence in many areas.[149] Gunshot wounds and other traumas due to the illegal drug business have become commonplace in big-city hospital emergency rooms. Not only traffickers, but also law enforcement officers and innocent bystanders are often the victims.[150] Mayor Rudolph Giuliani recently noted:

> The victims of the [ ] gun battles [of street-level drug dealers] are innocent bystanders—and often young children. Last year alone, about 500 New York City children were shot; of these, 89 were innocent bystanders hit by crossfire.[151]

The cost of prohibiting drugs must be measured in terms of lost lives and expensive medical care and include the hidden costs of lost productivity and the psychological damage to individuals and entire communities living in fear, helpless and hopeless.

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[147] *Id.*

[148] *Id.*

[149] As was written about alcohol Prohibition (but equally applicable to today's illegalization of drugs), "[t]he underworlds of the larger cities have been termendously strengthened by the manufacture and distribution of intoxicating liquors. The immense profits derived from this source have become the backbone of criminal organizations in many of these cities." Arthur V. Lashly, *The Professional Criminal and Organized Crime, A Report to the Section of Criminal Law and Criminology of the ABA, 51st Annual Meeting, Seattle, WA, July 25–27, 1928* (Miscellaneous Bar Phamphlet, Vol. 36, Library of the Association of the Bar of the City of New York).

[150] See, *e.g.*, *People v. Hernandez*, 82 N.Y.2d 309, 604 N.Y.S.2d 524, 624 N.E.2d 661 (1993) (police officer fatally shot in gunfight during drug raid); Scott Ladd, *Drug Gang "Enforcer" Arrested*, Newsday, Mar. 30, 1994, at 4 (reporting that drug gang routinely killed bystanders).

[151] Rudolph Giuliani, *Control Guns Through Licensing*, USA Today, Mar. 3, 1994, at 13A.

With the possible exceptions of cocaine and PCP, drugs themselves do not generally cause violent behavior. It is, instead, turf wars for the control of black markets and the drug users' need for money to purchase such substances that leads to violence.[152] Indeed, marijuana and heroin have been shown to render their users disinclined to violence or incapable of violence while under the influence. These substances are much less dangerous in this regard than alcohol.[153]

4. Diversion of Resources from Treatment and Prevention

Prohibition diverts money that could otherwise be used for preventing and treating drug abuse.[154] Federal anti-drug legislation provides a single budget for "supply reduction" and "demand reduction" efforts. Law enforcement agencies have always received much more than prevention, treatment, and research programs combined. The ABA recently reported that "[s]ince the early 1980s, treatment has been a declining priority. In 1991, treatment received 14% of the $10.5 billion federal drug budget compared to 25% ten years earlier." During the same period, "federal spending on law enforcement increased 737%, with interdiction efforts leading the

[152] See Randy T. Salekin & Bruce K. Alexander, *Cocaine and Crime*, in *New Frontiers in Drug Policy* 105, 111 (Arnold S. Trebach & Kevin B. Zeese eds., 1991).

[153] "Alcohol is the drug most associated with many forms of violence, including domestic violence." American Bar Association, *New Directions for National Substance Abuse Policy* 15 (1994); see also *Substance Abuse*, *supra* note 127, at 34–35 (counting alcohol-related deaths from automobile accidents, falls, fires and drowning); Steven B. Duke, *To Reduce Crime, Legalize Drugs*, Chicago Tribune, Jan. 5, 1994, at 15 (tracing correlation of alcohol consumption and violent crime); Steven Jonas, *Solving the Drug Problem: A Public Health Approach to the Reduction of the Use and Abuse of Both Legal and Illegal Recreational Drugs*, 18 Hofstra L. Rev., 751, 752–53 (1990) ("It happens that the negative *health* effects of the two legal drugs are much more serious than those of the currently illegal ones. For example, smoking kills about 400,000 persons per year, while alcohol is associated with 80,000 to 200,000 deaths per year. Together, on the other hand, the currently illegal drugs were responsible for about six thousand deaths in 1987.") (emphasis in original) (footnotes omitted).

[154] Even supporters of the current prohibitionist laws have recognized that more resources should be devoted to treatment. See Edward A. Adams, *ABA Urges Additional Funding for Drug Treatment*, N.Y.L.J., Feb. 4, 1994, at 1 (noting that ABA "has called for more federal funding for treatment of drug abusers, saying education, prevention and rehabilitation should be 'on a par with law enforcement and interdiction efforts' "); see also Joseph B. Treaster, *New Focus on Drugs*, N.Y. Times, Feb. 12, 1994, at 7 (reporting Administration's introduction of "a model drug treatment program"); Joseph B. Treaster, *President Plans to Raise Drug Treatment Budget*, N.Y. Times, Feb. 8, 1994, at B9 (reporting that Administration has budgeted $5.4 billon for drug prevention and treatment); Joseph B. Treaster, *More Arrests, More Therapy in Drug Plan*, N.Y. Times, Jan. 27, 1994, at B1.

increase."[155] Ending drug prohibition would, by definition, eliminate the need for any special law enforcement funds for drug interdiction. It would also allow for the redirection of law enforcement resources to concentrate on violent crime and quality of life issues.

5. The Sense of Treating Drugs as a Public Health Problem

a. Treatment Works

The vast majority of resources in the United States available to meet this country's "drug problem" have been utilized for interdiction rather than education and treatment. This allocation of resources has skewed the public's perception of the problem, which is seen largely as one of law enforcement. However, drug abuse and drug addiction are fundamentally a public health problem.[156]

Reallocation of resources away from interdiction and into education and treatment is essential to the successful management of this problem. Drug abuse and drug addiction are health problems that can be treated. Dr. Herbert D. Kleber, former Deputy Director of the Office of National Drug Control Policy, now Medical Director of the Center on Addiction and Substance Abuse and lecturer in psychiatry at Columbia University College of Physicians and Surgeons, has identified a basic fallacy responsible for the predominant pessimistic outlook:

> Drug dependence has been viewed as a chronic relapsing illness with an unfavorable prognosis. However, there are thousands of formerly dependent individuals in the United States and elsewhere who have remained off both illicit drugs and excess use of licit drugs like alcohol for decades, functioning as productive citizens. . . . [T]here are already effective methods of treatment if the right approach [and] the right person can be brought together.[157]

No one should conclude that treatment is not effective just because drug abuse, like alcohol abuse and cigarette smoking, often cannot be "cured" with a single

[155] American Bar Association, *New Directions for National Substance Abuse Policy* 19 (1994).

[156] It must be remembered that forty million Americans are estimated to use drugs but only four to six million of these are considered to be addicts or abusers for whom usage of all types of drugs (licit and illicit) is beyond their control. It is these drug abusers to whom treatment must be fully available.

[157] *Treatment of Drug Dependence: What Works*, International Review of Psychiatry 81 (1989).

treatment effort.[158] Most people who do conquer drug addiction succeed only after multiple efforts and relapses. Because effective treatment depends on finding the best method of helping a particular person at a particular time, several attempts may be needed to discover what will work.[159]

b. Self-Help Groups

Some substance abusers manage their problem with the help of Alcoholics Anonymous ("AA"), Narcotics Anonymous ("NA") or similar groups. These voluntary self-help associations offer the structure of a program following "twelve steps" to sobriety and the support of fellow abusers in different stages of recovery. Since these groups maintain members' confidentiality and do not keep records of attendance at meetings, their success has not been measured statistically; however, anecdotal evidence of their effectiveness is strong. Additionally, many respected treatment programs rely on methods developed by the self-help groups and prescribe attendance at AA and NA meetings for their patients.[160]

c. Therapeutic Communities

One of the best-known methods of professional treatment for drug abuse is a highly structured, long-term residential inpatient program known as a therapeutic community. The Committee visited three therapeutic community facilities in New York City—programs operated by Daytop Village, Project Return and Phoenix House.[161] Patients in therapeutic communities generally spend one to two years, sometimes more, living and working in the facility. Through individual counseling and group therapy, the patients address the causes and effects of their substance abuse and other problems and attempt to rebuild their lives free of drugs. Education, vocational training and work experience are important components of the

[158] There is, however, at least one experimental therapy that may provide a "magic bullet" to cure addiction for extended periods. Ibogaine, a hallucinogenic drug that is now prohibited, has shown a remarkable ability to break a user's drug addiction to heroin, cocaine, and other drugs after a single administration. See Spencer Rumsey, *Addiction & Obsession*, Newsday, Nov. 19, 1992, at 72; Sandra Blakeslee, *A Bizarre Drug Tested in the Hope of Helping Drug Addicts*, N.Y. Times, Oct. 27, 1993, at C11; Dolores King, *Hallucinogen Being Studied as Treatment for Addiction*, The Boston Globe, Nov. 9, 1992, at 29.

[159] See Mathea Falco, *The Making of a Drug-Free America* 108–09 (1992); *Substance Abuse*, *supra* note 127, at 28–29 (reviewing relapse among smokers, drinkers, and users of illicit drugs).

[160] See Falco, *supra* note 159, at 116–19.

[161] See Falco, *supra* note 159, at 119–25 (descriptions of Phoenix House in New York and Amity, a therapeutic community in Phoenix, Arizona).

treatment, because therapeutic community patients frequently lack necessary skills for making their own way in society. Successful patients gradually re-enter the outside world, first obtaining jobs and ultimately moving to homes outside the program.

While many patients drop out of these challenging and restrictive programs, research has shown that three-quarters of the patients who stay for the prescribed course of treatment remained drug-free seven years later.[162] One study found that 56% of the individuals entering residential treatment (including those who dropped out) no longer used heroin or cocaine one year later. By the end of the study, more than 80% of the patients no longer used any prohibited drug other than marijuana. Another different national study that focused on opiate addicts revealed that nearly three quarters (74%) of the addicts who entered therapeutic communities were not using opiates regularly (i.e., on a daily basis) three years later.[163]

d. Other Inpatient Drug-Free Treatment Programs

Substance abusers with health insurance or other means of payment often seek residential treatment in less restrictive settings and for shorter periods of time. Two of the best-known programs providing this sort of inpatient treatment are the Betty Ford Center in Palm Springs, California, and the Hazelden program in Minnesota. Patients usually participate in intensive individual counseling, group therapy, and AA or NA meetings. Patients most commonly stay for four weeks and are then discharged to "aftercare" programs for continuing outpatient treatment or are advised to seek AA or NA meetings in the community. Many prominent citizens have testified publicly to the efficacy and value of these sorts of treatment programs.[164]

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[162] Falco, *supra* note 159, at 120; see also Douglas Anglin & Yih-Ing Hser, *Treatment of Drug Abuse*, in *Drugs and Crime* 393–460 (Michael Tonry & James Q. Wilson eds., 1990).

[163] Robert L. Hubbard, Mary Ellen Marsden, J. Valley Rachal, Henrick J. Harwood, Elizabeth R. Cavanaugh & Harold M. Ginzburg, *Drug Abuse Treatment, A National Study of Effectiveness* 102 (1989) [hereinafter *Drug Abuse Treatment*]; *Treatment Works*, *supra* note 128, at 17.

[164] See, *e.g.*, Sylvia Nasar & Alison Leigh Cowan, *A Wall St. Star's Agonizing Confession*, N.Y. Times, Apr. 3, 1994, § 3, at 1 (investment banker and former Reagan administration official Lawrence Kudlow); Peter J. Boyer, *The Ogre's Tale*, The New Yorker, Apr. 4, 1994, at 36 (Senator Bob Packwood); Carol Emert, *Alcoholism Among the Elderly Discussed on Capitol Hill*, States News Service, Feb. 7, 1992 (Reagan White House Deputy Chief of Staff Michael Deaver "credits his sobriety during the last six years to a stay at Ashley House"); Alison Bass, *Substance Abuse Centers Wither in Changing Times*, Boston Globe, Oct. 31, 1993, Metro sec., at 1 (Kitty Dukakis); Ronald Blum, *Sports News*, Associated Press, Jan. 29, 1994 (Mickey Mantle, Elizabeth Taylor, Liza Minelli, Betty Ford).

e. Outpatient Methadone Maintenance Programs

Methadone maintenance is the most widely used treatment for narcotics addiction in the United States. Drs. Vincent P. Dole and Marie Nyswander developed the treatment at Rockefeller University in the early 1960s. Heroin addicts who are medicated with an appropriate daily dose of methadone, a long-acting synthetic opiate, lose the desire to use heroin but do not experience either withdrawal symptoms or the euphoric or impairing effects of narcotic use. Methadone patients can function normally and perform successfully in the workplace in jobs ranging from attorney to architect to bus driver.

In the early stages of treatment, methadone patients visit the program daily to receive their doses. They are granted more flexible schedules as they show progress in treatment by remaining free of other drugs, maintaining steady employment, and making progress in other areas. Methadone programs also provide counseling and other health care and usually arrange for vocational rehabilitation, education, and other services. Successful methadone patients may remain in treatment for many years, often at reduced doses; and some eventually leave treatment entirely.

A high proportion of methadone patients stay in treatment (more than two-thirds, by many reports), and more than 85% of those remaining in treatment for a year never use heroin again. A substantial proportion also stop using alcohol and other drugs.[165] The results of research assessing the effectiveness of methadone maintenance have been strikingly consistent. One major study found that, within a year of beginning treatment, 70% of those who had entered methadone treatment were no longer using heroin. After three years, use by patients who had remained with the program for at least three months had declined by almost 85%.[166] Another study examining AIDS infection among injection drug users found that methadone maintenance treatment effectively reduced intravenous drug use by 71%.[167] An earlier study had found that more than three quarters of the patients who entered methadone maintenance treatment were still not regularly using opiates three years later.[168]

[165] See Falco, *supra* note 159, at 126–27.

[166] *Drug Abuse Treatment*, *supra* note 163, at 103, 180.

[167] J.C. Ball, W.R. Lange, C.P. Meyers & S.R. Friedman, *Reducing the Risk of AIDS Through Methadone Maintenance Treatment*, 29 Journal of Health and Social Behavior 214–26 (1988).

[168] *Treatment Works*, *supra* note 128, at 17.

f. Outpatient Drug-Free Therapy

Substance abusers who cannot commit themselves to inpatient treatment and do not want methadone treatment (or would not benefit from it because their primary drug of abuse is not heroin) can participate in a variety of outpatient drug-free therapies, including the full range of "talk" therapies, supervised twelve-step programs, and programs that use acupuncture to reduce the craving for drugs. Outpatient programs often are recommended as follow-ups to short-term hospital-based "detoxification" programs, which generally are effective only for short-term crisis intervention purposes.

The Committee visited the Lincoln Hospital Substance Abuse Division in New York City, which has been treating drug abuse patients with acupuncture for more than 15 years. Acupuncture treatment, which involves the insertion of five needles in the outer ear while the patients sit quietly in a common room for 30 to 45 minutes, is meant to control withdrawal symptoms and the craving for drugs and to have a general calming effect. At Lincoln Hospital it is used in combination with group counseling on the Narcotics Anonymous model, as well as urinalysis monitoring. Like methadone treatment, acupuncture begins as a daily treatment, with successful patients "graduating" to less frequent schedules. Outpatient drug-free treatment programs, whether they employ acupuncture or not, differ in the nature, length and frequency of treatment sessions. The usefulness of acupuncture treatment for substance abuse has been demonstrated in several studies.[169]

Outpatient programs, generally, have demonstrated a fair amount of success in treating substance abusers.[170] One national study found that nearly three-quarters of the patients who entered outpatient drug-free programs for opiate abuse were not using opiates regularly three years later.[171] A later study of similar scope revealed that, after a year in treatment, 42% of the regular cocaine users who stayed in outpatient drug-free treatment for at least three months had stopped using cocaine completely. Over three to five years, regular heroin use by patients who had received treatment for at least three months fell by half, and fewer than 20% of the patients who stayed in treatment for at least three months were regular users of any prohibited drug except marijuana.[172]

[169] Most studies have investigated its effect on alcoholism. See M.L. Bullock, P.D. Culliton & R.T. Olander, *Controlled Trial of Acupuncture for Severe Recidivist Alcoholism*, The Lancet, June 24, 1989, at 1434–39; M. Smith & K. Ra, *Use of Acupuncture in the Treatment and Prevention of Alcohol Abuse*, 23 Alcoholism 25–31.

[170] Falco, *supra* note 159, at 112–17.

[171] *Treatment Works*, *supra* note 128, at 17.

[172] *Id.* at 15.

6. Empirical Research on Effective Drug Treatment

Virtually all studies conducted over the last 20 years show that the most commonly practiced methods of treatment do work. Treatment has been shown to reduce substance abuse and ameliorate its consequences. The outcome of treatment has not been found to differ significantly with the type of treatment received. Methadone programs, inpatient residential programs, and outpatient drug-free programs all show dramatic results.[173]

a. Studies Examining the Effects of Treatment on Substance Use

The most comprehensive study of the effectiveness of drug treatment, the Treatment Outcomes Prospective Survey ("TOPS") funded by the National Institute on Drug Abuse ("NIDA"), strongly confirmed the efficacy of treatment in reducing drug use.[174] For up to five years after their treatment, TOPS followed 10,000 substance abusers who had been admitted to 37 different treatment programs across the country. The programs included residential and outpatient drug-free programs and outpatient methadone maintenance programs. Heroin and cocaine use declined significantly for patients in all treatment modalities. After a year in treatment, heroin use by patients in methadone maintenance programs declined by 70%, while 75% of outpatient drug-free patients and 56% of residential treatment patients had stopped using heroin or cocaine. By the end of the study, fewer than 20% of the patients regularly used any illegal drug except marijuana, and 40% to 50% of the patients abstained altogether.

Other studies have reached virtually identical conclusions. A study sponsored by NIDA to address the risk of AIDS infection for injection drug users found that methadone maintenance treatment effectively reduced intravenous drug use by 71% among those who remained in the program for one year.[175] An earlier NIDA study based on the Drug Abuse Report Program ("DARP") tracked the drug use of 44,000 opiate addicts admitted to treatment between 1969 and 1974. The study found that most patients stopped using opiates daily and had not resumed daily use three years after they were discharged from treatment. More than three quarters of the patients who entered methadone maintenance treatment (76%) and nearly three quarters of the patients who entered therapeutic communities (74%) or outpatient

[173] See *Drug Abuse Treatment*, *supra* note 163, at 179–84 (tables showing success rates for therapeutic communities, outpatient methadone and outpatient drug-free programs).

[174] The results of the study were published in *Drug Abuse Treatment*, *supra* note 163.

[175] Ball, Lange, Meyers & Friedman, *supra* note 167, at 214, 218.

drug-free programs (72%) were still not using opiates regularly three years later.[176] A recent follow-up study of 405 of the original 44,000 addicts found that 74% were not using heroin regularly twelve years after their treatment ended.[177]

Researchers have uniformly concluded that the three most common forms of treatment are effective despite "the variety of problems suffered by clients, their long histories of deviant and debilitating lifestyles, and a lack of support in the community" that lead so many addicts not to complete treatment programs at all.[178] Researchers also agree that the longer addicts remain in treatment, the better their chances of success. National studies of the behavior of thousands of addicts have shown that, while one-third of the patients who stay in treatment for more than three months are still not using drugs a year later, two-thirds of those who stay in treatment for a year or more stay off drugs.[179]

b. Studies Examining the Effects of Drug Treatment on the Consequences of Drug Abuse

Researchers have studied the impact of drug treatment on many of the health and social problems that drug abuse contributes to—the spread of AIDS and other diseases, premature death, crime, unemployment, costly medical care—as one way of assessing the success of drug treatment. Their studies have shown that treatment reduces these associated consequences of drug abuse.

Treatment prevents the transmission of HIV and other blood-borne diseases that spread when addicts share needles or sell sex for drugs. Two studies have shown that the rate of HIV infection among heroin addicts in New York City not in treatment (46%-47%) is twice the rate of infection among addicts in methadone treatment programs (23%-27%), and a recent study found that none of a group of methadone patients with ten or more years in treatment tested positive for HIV.[180]

Research has shown that treatment also prevents crime. The TOPS survey found that, in the six months following treatment, 97% of the residential therapeutic community clients and 70% of the outpatient clients who had admitted committing predatory crimes in the year before they entered treatment engaged in no

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[176] *Treatment Works*, *supra* note 128, at 17.

[177] *Id.* at 18; see also National Institute on Drug Abuse, *Effectiveness of Drug Abuse Treatment* (Jan. 20, 1988) [hereinafter *Effectiveness of Drug Abuse Treatment*]; Office of Technology Assessment, *The Effectiveness of Drug Abuse Treatment: Implications for Controlling AIDS/HIV Infection, Background Paper No. 6*, 56–77 (Sept. 1990).

[178] *Drug Abuse Treatment*, *supra* note 163, at 163.

[179] See Falco, *supra* note 159, at 110.

[180] *Effectiveness of Drug Abuse Treatment*, *supra* note 177.

criminal activity at all. Three to five years after treatment, the proportion of addicts involved in predatory crimes had fallen by one half to two-thirds.[181] The DARP study found that arrest rates fell by 74% after treatment, for all treatment modalities.[182]

Research reveals that treatment helps recovering addicts work, as well. Only 33% of the 44,000 patients in the DARP study worked in the year before admission to treatment, but 57% were employed in the year following their discharge.[183] Two-thirds of therapeutic community patients were gainfully employed after discharge. The employment rate of clients tracked in the TOPS study also surged. Three to five years after patients entered treatment, the employment of patients admitted to residential programs had doubled over pre-treatment levels, while the employment of addicts receiving outpatient treatment rose by more than half.[184]

The costs of medical treatment for all sorts of health problems decline when addicts receive treatment.[185] As noted earlier in this report, addicts themselves suffer many costly illnesses as a result of drug use, ranging from hepatitis, syphilis and tuberculosis to shingles, malnutrition and psychiatric problems.[186] In 1989, general hospital stays in which drugs or alcohol were identified as a major factor accounted for 1.9 million days of hospitalization in New York State alone.[187] Using a conservatively estimated average cost of $500 a day,[188] that amounts to $9.5 billion worth of medical care. Successful drug treatment starts addicts on their way to physical recovery and therefore reduces these medical costs. Successful drug treatment also prevents the spread of diseases to others, such as children born to addicted mothers, and stems the cost of medical care for them, as well as the cost

[181] *Drug Abuse Treatment*, *supra* note 163, at 128–29, 181.

[182] *Treatment Works*, *supra* note 128, at 17–18.

[183] *Id.*

[184] *Drug Abuse Treatment*, *supra* note 163, at 137–37.

[185] See generally Victor Tabbush, *The Effectiveness and Efficiency of Publicly Funded Drug Abuse Treatment and Prevention Programs in California: A Benefit-Cost Analysis* (Mar. 1986).

[186] One study of ten hospitals in upstate New York found that forty-four percent of the emergency room patients evaluated for psychiatric problems showed evidence of current substance use. M.E. Evans & R.J. Martin, *Description of Clients Using Psychiatric Emergency Room Services*, New York State Office of Mental Health, Bureau of Evaluation and Research Services (1989).

[187] State of New York Anti-Drug Abuse Council, *Anti-Drug Abuse Strategy Report 1990 Update*, at 29 (data from Statewide Planning and Research Cooperative System from all general hospitals in New York State).

[188] According to the American Hospital Association, 1989 the average cost per day, per room in a hospital in the United States was $637. The Association expected that figure to rise by 35% to 40% by 1992. Suzanne Gordon, *Hospices and the High Cost of Dying*, Chicago Tribune, Dec. 19, 1992, Zone N, at 23.

of foster care for children whose addicted parents cannot care for them.[189]

Other benefits of treatment flow from its effects on criminal behavior and employment. Treated addicts are much more likely to be employed and therefore to contribute to the public coffers rather than receive welfare. They make more productive employees and are less likely to have accidents at work. Treated addicts are far less likely to commit crimes and therefore will save society the cost of property loss and prosecuting criminal activity. One study that calculated the cost of crime, poor employment activity, and medical treatment attributable to drug addiction found that the total of these costs was ten to twenty-five times the cost of treating drug addiction, depending on the cost of the treatment chosen. The cost of treating an addict in a long-term residential drug-free program, for example, was found to amount to only four percent of the cost to society of *not* treating the addict.[190]

A comparison of costs also shows that treatment is much more cost-effective than incarceration. In New York City, residential drug treatment costs approximately $17,000 a year per treatment bed, and outpatient treatment costs only $2,300-$4,000 a year per treatment slot; the annual operating cost of a prison bed is about $40,000, and the cost of building new prison cells exceeds $100,000 each.[191] Diverting drug abusers from prison to treatment therefore saves New York State or City half the operating costs of incarceration. It also alleviates the need to build expensive new prisons. If the proven effect of treatment on criminal recidivism is included, the savings to the criminal justice system in the future would be even more substantial.

Treatment works and is, in fact, a much more cost-effective way of dealing with substance abuse than arresting drug offenders and locking them in prison. Successfully treated drug addicts give up crime, become productive and more healthy citizens, and ultimately make fewer demands on the public for social and medical services throughout their lives. Their cure also reduces the overall demand for drugs.

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[189] State of New York Anti-Drug Abuse Council, *Anti-Drug Abuse Strategy Report 1990 Update*, at 5–6, 36–37.

[190] *Id.*; see also *Treatment Works*, *supra* note 128, at 23–24.

[191] Francis X. Clines, *Dealing With Drug Dealers: Rehabilitation, Not Jail*, N.Y. Times, Jan. 20, 1993, at B2; Legal action Center, *Moving in the Right Direction: New York State's Fight Against Alcoholism and Drug Addiction* (Nov. 1, 1991).

7. Education Works

One way to reduce the demand for illegal drugs is to prevent individuals at an early and impressionable age from initiating drug use. Using the school system and community programs to educate children about drug use and its destructive consequences is an idea that would undoubtedly be supported by many segments of society. Logic suggests that education programs should be effective in diverting young people from experimenting with drugs.[192]

Mathea Falco, in her book *The Making of a Drug Free America*, details both school-based and community-based educational programs which have proven results in preventing drug, alcohol and tobacco use. Education has been shown to be effective in preventing and reducing drug as well as tobacco and alcohol use among children and teenagers. Simply to advocate "education," however, may not be enough; the assumption that "education," and any type of education program, will be effective may be erroneous.[193] Studies of the effectiveness of drug education and prevention strategies seem to suggest that long-term programs geared towards examining the "social influences" leading to drug, alcohol, and tobacco use are more successful in diverting and reducing subsequent use of drugs, alcohol, and tobacco. These successful educational programs are generally coupled with community and home prevention and education programs. In contrast, certain short-term education programs, which lack the corresponding community programs, have not proven effective in actually reducing drug use.[194]

a. Life Skills Training Program

This 15 session curriculum, which is geared towards junior high school students, is designed to teach students personal coping skills so that they may be better able to make decisions and feel more confident in social situations. Evaluations of this program, which has been taught in 150 junior high schools in New York and New

[192]To be effective, of course, such education programs must be credible and non-propagandistic.

[193]Even the United States Department of Health and Human Services recognizes that the effectiveness of many school-based prevention programs remains untested. See *Promoting Health Development Through School-Based Prevention: New Approaches*, in United States Department of Health and Human Services, *Preventing Adolescent Drug Use: From Theory to Practice*, OSAP Prevention Monograph-8, DHHS Pub. No. (ADM) 91-1725 (1991) [hereinafter OSAP Monograph-8].

[194]Falco suggests that school systems are too willing to implement programs like DARE (Drug Abuse Resistance Education) which limit the need to use school resources and are easier to implement because they bring in outsiders like police officers to lecture on prevention. These programs have not proven effective in reducing tobacco, alcohol, or drug use. Falco, *supra* note 159, at 43.

Jersey for the past ten years, show that rates of smoking and marijuana use are one-half to three-quarters lower among students who have participated in this program than those who have not.

b. Students Taught Awareness and Resistance

This program, taught to first-year high school students, combines a thirteen session classroom curriculum with coordinating community, media, and family programs in an effort to teach resistance skills to teenagers and reinforce the social desirability of not using drugs. The program is followed-up with a five-session booster course the following school year. This program, in a five-year follow-up study, has been proven effective in reducing the rate of tobacco, marijuana, and alcohol use by 20% to 40% and cocaine use by 50%.[195]

c. Project Healthy Choices

This program, geared towards sixth and seventh graders, integrates discussions about drugs and alcohol into the everyday curriculum by training teachers to incorporate the discussion of drugs and alcohol into their teaching of academic subjects. This program is currently implemented in approximately one hundred New York City schools. It is believed that this approach will reinforce prevention messages as the students will hear this discussion as part of their learning on a wide variety of subjects. The long-range effectiveness of this approach has not yet been determined.

d. Student Assistance Program

This program, which has been implemented in junior and senior high schools in twenty states, offers counseling during the school day on a voluntary, confidential basis. A study of the Westchester County, New York school system where the program was originally implemented showed a significant reduction in alcohol and marijuana use. More significantly, studies showed that the rates of drinking and drug use were 30% lower among students at schools which implemented the SAP program.[196]

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[195] Falco, *supra* note 159, at 41.
[196] Falco, *supra* note 159, at 56.

e. Smart Moves

"Smart Moves" is a program operated out of Boys and Girls Clubs in the inner-cities where children live in high crime neighborhoods. By offering after-school prevention programs and recreational, educational, and vocational activities, this program attempts to teach children to recognize the pressures to use drugs and how to develop the verbal and social skills to resist these pressures. Again, studies have shown that this type of program can reduce cocaine and crack use and improve school behavior and parental involvement.[197]

f. Seattle Social Development Project

This comprehensive program seeks to strengthen the bond between children from high crime neighborhoods and their families and schools. The program provides to parents techniques to monitor their children better; teachers get better training to maintain order and resolve conflicts; and children, as in the other programs, are taught skills to resist peer pressure. Interestingly, while the program has shown results in deterring girls from alcohol, tobacco, and drug use, it has not shown similar effectiveness with boys.[198]

g. Programs for Children of Addicts

Finally, a number of cities are attempting to develop prevention programs geared towards the children of drug addicts. These programs attempt to teach parents communication and parenting skills and provide children with support and social skills. Two such programs are "Strengthening Families," which has been implemented in Salt Lake City, Detroit, and Selma, Alabama, and the "Safe Haven" program in Detroit. Evaluations of the "Strengthening Families" program suggest it strengthens family and school relationships and affects attitudes towards alcohol and tobacco use.

This provides a summary of the types of successful programs already available in the communities. Their success depends upon a school and community commitment to implementing comprehensive programs geared towards preventing drug use by children. The diversity of the structure of the programs illustrates the complexity of the problem. In addition to reaching out to the "average" school age

[197] *Id.* at 59–60, 63–64.

[198] *Id.* at 64. A discussion of the SSDP project is also contained in the OSAP Monograph-8, *supra* note 193, at 147–152. There the authors report that the program resulted in more positive attitudes towards teachers and family and improved academic development.

youth and warning them about the dangers of substance abuse, there are children in high-risk homes and crime-ridden neighborhoods who need additional support structures to resist the pressures of drug use.

Part III
Toward a New Drug Policy

Joycelyn Elders, the United States Surgeon General, has suggested that a study be made of our current drug policies and perhaps a new drug policy adopted.[199] Despite the Administration's rejection of her suggestion, public perception is that she may be right. Our government tried to prohibit alcohol consumption and found it did not work.[200] As demonstrated in this report, drug prohibition is also a failure that causes more harm than the drug use it is purportedly intended to control. The obvious answer is that we must take the necessary steps towards a new approach to drug policy.

Several different alternatives to drug prohibition are being discussed. Federal District Judge Whitman Knapp suggests that Congress should repeal all federal laws banning drug sales or possession and permit states to devise alternatives to prohibition. This is the present approach to alcohol in the United States since the repeal of the 18th Amendment and the Volstead Act. Federal District Judge Jack Weinstein suggests "standing down" and making fewer arrests, having fewer prosecutions, and spending more money on treatment.[201] M.A.R. Kleiman of the Kennedy School of Government at Harvard suggests as a solution to the drug problem a "grudging toleration" allowing for sale of certain drugs through state-regulated stores, but the strategy would be to discourage consumption.

These and other alternatives to drug prohibition should be thoroughly considered so that our society may choose a new approach that will avoid the widespread evils caused by the current drug laws. Any alternative to drug prohibition should allow continued criminal sanctions against conduct affecting others (the most obvious example being operating a vehicle while under the influence).[202]

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[199] Stephen Labaton, *Surgeon General Suggests Study of Legalizing Drugs*, N.Y. Times, Dec. 8, 1993, at A23.

[200] See James Ostrowski, *The Moral and Practical Case for Drug Legalization*, 18 Hofstra L. Rev. 607, 647 (1990) ("The repeal of alcohol prohibition provides the appropriate analogy. Repeal did not end alcoholism—as indeed Prohibition did not—but it did solve many of the problems created by Prohibition, such as corruption, murder, and poisoned alcohol.").

[201] At least one state in Germany appears to have adopted a policy like this. See Stephen Kinzer, *German State Eases Its Policy on Drug Arrests*, N.Y. Times, May 18, 1994, at A5 (reporting that officials in Germany's most populous state, North Rhine-Westphalia, "say the police there will no longer arrest people for possessing small amounts of any drug, including cocaine, heroin, morphine, amphetamine pills or LSD").

[202] See Matthew L. Wald, *Learning to Screen Drugged Drivers on Nassau Roads*, N.Y. Times,

It is the Committee's belief that a new approach to drug policy should leave state and local governments free to employ the full panoply of coercive penal sanctions when drug use is relevant to conduct affecting others. For instance, as mentioned above, operating any vehicle while under the influence of drugs is not tolerated and that should not change. Although in New York, voluntary intoxication remains relevant to negate specific intent,[203] the Legislature may wish to restore individual liability in this area and make any intoxication that is voluntary irrelevant as to mitigation, on the theory that by this voluntary act the actor will be held responsible for the consequences of his conduct while under the influence. Such a sanction is hardly unreasonable, nor would it strike anyone as being unfair, especially if facilities to deal with cases of actual addiction were readily available.

Finally, any alternative to drug prohibition should not preclude state and local governments from addressing "quality of life" issues. Government should not be powerless to control persons who are obviously and publicly intoxicated. Through enforcement of the existing laws dealing with public behavior, or appropriate amendments to such laws to include specific conduct, government intervention would have greater effect and would be readily accepted as appropriate by the overwhelming majority of the population.

Part IV

Conclusion

The Special Committee on Drugs and the Law has spent the better part of a decade examining this country's "drug problem" and the mechanisms utilized to manage it, principally a federal and state system of criminal proscription.

In recent years, the criminal penalties for possession and distribution of proscribed drugs have increased, with mandatory sentences being imposed at both the state and federal levels. The prison population in the United States has more than doubled in the past ten years, largely as the result of these prohibitionist laws. The scarce resources of the federal and state judiciary have been increasingly devoted to drug cases. Despite all of these efforts, the drug war rages on.

Dec. 5, 1993, at 49 (reporting that at federal government's urging, police are being trained "in a rigorous, standardized program of learning to spot and analyze drug abuse" so as to catch drugged drivers.

[203] N.Y. Penal Law § 15.25 (McKinney 1987).

The Committee recognizes the urgent and compelling need to make additional resources available for education and treatment. We believe that even at increased levels, however, treatment and education are not enough to control this country's drug problem. The Committee opposes the present prohibitionist system and recommends the opening of a public dialog regarding new approaches to drug policy, including legalization and regulation.

Kathy Hellenbrand Rocklen, Chair*
Ann Robertson, Secretary

Hon. Harold Baer Jr.	Stephen L. Kass
Nancy A. Breslow	Charles Edward Knapp
Kenneth A. Brown	Daniel Markewich‡
Ellen M. Corcella†	Eleanor Jackson Piel
Edward John Davis	James Warwick Rayhill
Eugene R. Dougherty	Chester B. Salomon
John H. Doyle, III‡	Hon. Felice K. Shea†
Virginia M. Giddens	John Trub

* The Committee wishes to express its special thanks to the Honorable Robert W. Sweet, the former Chair of the Committee and a tireless advocate for drug policy reform.

† Justice Shea and Ms. Corcella abstained from voting on the report.

‡ Mr. Doyle and Mr. Markewich dissented, in part. See, Separate Statement, *infra*.